



CAGP BULLETIN

THE NEWSLETTER OF THE CANADIAN ACADEMY OF GERIATRIC PSYCHIATRY



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PRESIDENTS REPORT

Martha Donnelly

This is my first year as President of the Canadian Academy of Geriatric Psychiatry. So far it has been an exciting learning experience. Accepting the portfolio from Dr. David Conn in November was somewhat humbling, as his four years as President certainly had a major impact on geriatric psychiatry in Canada. I am certain these will not be easy foot steps to follow. Thanks to David, the CAGP will continue to provide leadership in the fields of geriatrics and mental health.

I hope to follow my predecessors by ensuring the CAGP remains in a strong financial position. Our resources need to be directed where

they are needed most; education, research and advocacy. I also know that our capacity to influence change is strengthened by the membership. Effective education, research and advocacy initiatives require the active support of psychiatrists and other professionals who work with aging adults with mental health needs. Throughout the next few years I hope to see the CAGP membership numbers grow.

Of particular importance is the CAGP's capacity for collaboration. Various members of the CAGP currently



provide leadership to collaborative initiatives (such as the Canadian Coalition for Seniors Mental Health and the Shared Mental Health Care: Primary Care Toolkit). We have recently been afforded the unique opportunity to work with the Canadian Geriatrics Society (CGS) as partners on the Journal "Geriatrics Today". I believe these initiatives have begun to lay the foundation for continued alliances that enhances the mental health care of the older adult population in Canada. The CAGP is uniquely positioned to accept the challenges of leadership and I am pleased to participate in this evolution.

UPCOMING CONFERENCES

- 12th International Congress**
 Aging with Dignity "new challenges-new possibilities - new solutions"
 Stockholm, Sweden
September 20 - 24, 2005
www.ipa-online.org
- Canadian Coalition for Seniors Mental Health - Best Practices in Seniors' Mental Health Conference**
 Ottawa, ON
September 26 - 27, 2005
www.ccsmh.ca
- Third Canadian Colloquium on Dementia (3rd CCD)**
 Westin Ottawa, ON
October 27 - 29, 2005
www.ccd2005.ca
- Canadian Academy of Geriatric Psychiatry Annual Scientific Meeting**
 Vancouver, BC
November 3, 2005
<http://www.cagp.ca/en/annualScientific.cfm>

CAGP REGIONAL UPDATE: NOVA SCOTIA

Terry Chisholm

Hello from Nova Scotia. Our Seniors Mental Health service is located in Halifax - Dartmouth and provides service to the district (CDHA), which stretches from Windsor at one end to Musquodoboit at the other. The service also provides tertiary care to other areas of the province with outpatient consultations and admissions. As of August 2005 we will grow from 4 psychiatrists to six. There are also geriatric psychiatrist in Sydney and Kentville. There is one in PEI. There are none in New Brunswick although we hope to have one in the next year or two.

The primary focus of our service is outreach to homes and nursing homes. We also have outpatient clinics and a 19-bed inpatient unit. Our Day treatment program has been revamped in the last two years with two of our physicians who have an interest in Cognitive Behavior Therapy for seniors.

Our fellowship program, which started in 2002, has now produced two specialists, each works in the province – one has started a new program in Cape Breton to complement the excellent Geriatric Medicine services already there. Our third fellow will join our team in August of this year and we have a fourth fellow starting in the summer. We have been fortunate to have CAGP Fellowship Award support for 3 of our fellows to support their research

and education endeavors. We are well below the projected need of 16 geriatric psychiatrists for our population, but we are a growing!

In 2003 we worked with Nova Scotia's Department of Health and other mental Health representatives in the province to develop standards of care for seniors mental health. This process ignited the process of further service development in the province. Yarmouth is now developing a new service and we, in combination with Geriatric Medicine, will be involved in education and consultation. Also leading from this we will be involved in a provincial network that will meet regularly

PIECES – a program of psycho geriatric learning strategies to aid in providing continuing care - came to Nova Scotia in September 2004. It is one important piece of the puzzle in preparing Nova Scotia for the ever-growing numbers of seniors who will populate LTCs in the future.

Projects for the future involve the further development of telemedicine to the province, work on a shared care model, and activation of a provincial network of seniors mental health services and other seniors' services to improve communication and foster program development.

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GERIATRIC COLLABORATIVE CARE TOOLKIT FOR PRIMARY MENTAL HEALTH CARE

Martha Donnelly

An interdisciplinary cross Canadian group is working under the co-direction of Dr. Ken LeClair, (Kingston) and Dr. Martha Donnelly (Vancouver) to write a 'toolkit' on development of primary mental health care collaborative projects in geriatrics. This is part of a larger project to define general toolkits and eight subpopulation toolkits for collaborative mental health care in Canada funded through the Canadian Collaborative Mental Health Initiative (CCMHI). This toolkit will be aimed at a practical level to help clinicians and health care

planners develop, implement and evaluate collaborative geriatric mental health care services. The goal of the CCMHI is to enhance the capacity of primary health care providers to meet the mental health care needs of consumers through collaboration among health care partners, including: primary and mental health care providers, consumers and caregivers. The CCMHI believes that collaborative mental health care in primary health care settings decreases the burden of illness experienced by individuals with a mental illness by optimizing their care and

increasing access to mental health services, mental health promotion and wellness.

The first draft of this geriatric toolkit will be discussed at the Annual Shared Mental Health Care Conference in Ottawa in June. Further drafts will be discussed at the Best Practices Conference of the Canadian Coalition of Seniors Mental Health in September, 2005 in Ottawa and again at the Canadian Academy of Geriatric Psychiatry in Vancouver, November 2005.

PSYCHOPHARMACOLOGICAL UPDATE

Gill SS, Rochon PA, Herrmann N et al.

Institute for Clinical Evaluative Sciences, Toronto, Canada

Atypical antipsychotic drugs and risk of ischaemic stroke: population based retrospective cohort study.

BMJ. 2005 Jan 24.

- Objective:** To compare the incidence of admissions to hospital for stroke among older adults with dementia receiving atypical or typical antipsychotics.
- Design:** Population based retrospective cohort study.
- Setting:** 32 710 older adults with dementia (17 845 dispensed an atypical antipsychotic and 14 865 dispensed a typical antipsychotic).
- Results:** Participants receiving atypical antipsychotics showed no significant increase in risk of ischaemic stroke compared with those receiving typical antipsychotics (adjusted hazard ratio 1.01, 95% confidence interval 0.81 to 1.26).
- Conclusion:** Older adults with dementia who take atypical antipsychotics have a similar risk of ischaemic stroke to those taking typical antipsychotics.

For the full article please view (<http://bmj.bmjournals.com/cgi/rapidpdf/bmj.38330.470486.8Fv1>)

THE BEHAVIOURAL VITAL SIGNS (BVS) TOOL

Kiran Rabheru

Did you know ...

Did you know that it is essential to know the target cluster(s)/symptom(s) one is treating to guide and monitor non-pharmacological approaches and pharmacological treatment?

Did you know that once the target cluster(s)/symptom(s) are identified, their magnitude can be quantified (the BVS Tool)?

Did you know that the BVSTool helps in assessing the efficacy of the interventions?

Key Teaching Points

Characterize the behaviour precisely with special attention to the circumstances under which it occurs, when it started, and whether onset was gradual or sudden.

- The symptom of “agitation” can be part of one or more behavioural clusters.
- Prescribing medication for behavioural disturbances in dementia requires systematic measurements of target symptoms, their frequency, severity, and impact. It also helps monitor the effectiveness of interventions.
- The ongoing measurement of target symptoms requires:
- Direct assessment by interview and examination
- Proxy reports from caregivers.

Assessment and Monitoring Review

- The authors examined several tools for assessing and monitoring BPSD and found that there is no ideal practical tool for clinical use.
- Some of these tools are in Appendix A. Each is useful in many ways, but has several limitations, e.g., time, ease of availability, lack of established cut-off scores, regional differences in usage.
- We suggest a user-friendly, one-page, observational chart for monitoring of BPSD called “The Behavioural Vital Signs (BVS) Tool.”

To access this tool, to to http://www.cagp.ca/en/newsletters/e_newsletter1/bvs_tool.pdf

CANADIAN COALITION FOR SENIORS MENTAL HEALTH

Faith Malach, David Conn & Ken LeClair

The Canadian Coalition for Seniors' Mental Health recently held its Annual Steering Committee meeting in Toronto, Ontario to review the past year and plan for the future.

Last year, the CCSMH attracted 152 new members, bringing the total number to over 450 individuals and 85 organizational members. Key strategic initiatives over the past year include:

- The September 2004 Research Workshop which reviewed the state of seniors' mental health research in Canada and identified new opportunities;
- Dissemination of over 1200 education catalogues for front-line workers and caregivers;
- Development of a pilot survey to identify assessment and treatment practices and opportunities in LTC.

Key initiatives for 2005 include

- The CCSMH National Best Practices Conference: Focus on Seniors' Mental Health that will take place in Ottawa, Ontario on September 26th and 27th 2005. Registration will begin mid April;
- Development of National Guidelines specific to seniors' mental health in the areas of depression, delirium, suicide and mental health issues in long-term-care. Draft guidelines will be presented in full-day workshops at the September conference. Funding for this initiative has been provided by Health Canada, Population Health Fund.

For further information on the CCSMH initiatives or to get involved in the CCSMH work, please contact Faith Malach at fmalach@baycrest.org or visit the website www.ccsmh.ca



EVIDENCE BASED MEDICINE

N.P.L.G.Verhoeff, MB

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Baycrest Centre for Geriatric Care

CLINICAL CASE #1

Clinical Case #1: 80-Year-old woman with a 10-year history of untreated sub clinical hypothyroidism who now has clinical hypothyroidism and mild Alzheimer's disease (AD)

Clinical Question: Does hypothyroidism cause Alzheimer's disease?

Keywords: Hypothyroidism; Cretinism; Myxedema; Dementia; Alzheimer's disease; Amyloid; beta-amyloid; Brain; SPECT; PET; Post mortem; Neuropathology

Findings: It is not clear whether hypothyroidism directly causes Alzheimer's disease. No direct relationship between hypothyroidism and subsequent Alzheimer pathology (beta-amyloid plaques, neurofibrillary tangles) in the brain has been demonstrated – but this has also not explicitly been looked for. Possible relationships are: (1) Hypothyroidism indirectly causes AD by increasing vascular risk factors such as type II diabetes and hyperlipidemia [14,25-27]. (2) Hypothyroidism directly causes AD [3,12,13]. (3) Early presymptomatic AD pathology causes hypothyroidism [3]. (4) Another – possibly autoimmune – factor causes both hypothyroidism and AD [3].

Clinical Recommendations: Since even a slightly increased TSH may be a harbinger of sub clinical or overt hypothyroidism [3,9,10], it remains imperative that TSH tests be performed for screening of patients with dementia.

Research Priorities: (1) Epidemiologic tests should include analyses of vascular risk factors as possible mediators or moderators of the increased risk for AD in patients with hypothyroidism. (2) Longitudinal in vivo studies with both markers for hypothyroidism (blood plasma TSH and thyroid function tests) and markers for AD (plasma, CSF and/or cerebral beta-amyloid [28-30]; similar markers for neurofibrillary tangles if available [28] will be able to more convincingly demonstrate the temporal relationship between the earliest manifestations and further development of hypothyroidism versus AD. (3) More intense research needs to take place to determine the relationships between autoimmune factors such as thyroid peroxidase (previously called antimicrosomal) autoantibodies, hypothyroidism and AD [4].

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CLINICAL CASE #2

Clinical Case #1: 56 year-old male with chronic daily headaches following a blow to the head. Taking acetaminophen 500mg 1-3 tabs per day.

Clinical Question: Do analgesics cause headaches?

Keywords: Medline text-word searches: "medication-overuse headaches", medication-induced headaches, "rebound headaches".

Findings:

- Analgesics use and chronic daily headaches (CDH) are associated (1,2,3). Many CDH patients "over-use" analgesics (of all types). "Over-use" is defined as using analgesics

more than 4 times a week (or more than twice a week in the case of opiates/ergotamine).

- However, patients taking large amounts of ASA for arthritis do not develop CDH.
- Discontinuing analgesics often leads to improvements in CDH, however other treatments (e.g. headache prophylaxis) are usually started. 82% were improved 4 months after discontinuing treatment ("improved" = 2/3 reduction in frequency of headaches). Long-term follow-up (e.g. up to 5 years) shows that about 50% of CDH patients whose analgesics were stopped remain free of headaches (50% still have headaches though!).
- The temporal sequence may, or may not be, covered, as headache ! analgesics, and then, over time, more headache and more analgesics.
- There are many possible biological mechanisms, but none have been directly studied in humans: e.g. stimulation of the locus ceruleus causes vascular changes similar to those seen with migraines; ergotamine use might (no evidence cited) increase norepinephrine activity in the locus ceruleus. Many other mechanisms have been proposed - e.g. withdrawal effects, changes in serotonin system activity, etc.
- There is no evidence for a biological gradient, and nor is there any experimental evidence.

Clinical Recommendations:

There is little solid evidence that analgesics cause headaches, and hence analgesics should still be considered as potential treatment for headaches.

Research Priorities:

Randomized controlled trial of analgesic discontinuation (without co-intervention there after) in chronic headache sufferers. Note: The available data does not support the statement that it would be unethical to "leave a patient on analgesics when we know that it will perpetuate the headache syndrome" (taken from reference 6).

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EDUCATION REPORT

2005 Fellowships:

I am pleased to announce that the CAGP will award two Fellowships beginning July 2005. The two candidates are Dr. Sarah Thompson and Dr. Mark Bosma . Dr Thompson will be working with Martha Donnelly at the University of British Columbia. Her academic project will be on "The Efficacy of Psychotherapy for Depression in late Life". Dr. Bosma will be working with Terry Chisholm at Dalhousie University. His academic project is on "Geriatric Psychiatry Education Modules for Residents".

2004 Fellowships:

I hope you will join us at the Annual Scientific Meeting this year in Vancouver to hear the findings of last years Fellowship projects. Dr Cheryl Murphy will be reporting on the question of how best to increase awareness regarding stigma in geriatric psychiatry patients for medical students and residents. Dr Laura

Catherine Shea

McCabe will be presenting a review of the 2002 Canadian Community Health Survey (CCHS) data on the mental health in the Canadian geriatric population.

Core Competencies:

The "Working Group on a National Strategy for Postgraduate Education, subcommittee on core competencies" of the Canadian Psychiatric Association continues to meet to develop a set of core competencies for the psychiatry generalist. As all of you are aware, the CPA sent out a survey asking its membership what they believed were the critical core competencies for general practice. This information has been collected and reviewed. Each of the Academies will be providing specific recommendations related to their specialty. The CAGP has developed a draft of the core competency guidelines for psychiatry residents. These are available for review on the CAGP website. All comments are welcomed.

2005 ANNUAL SCIENTIFIC MEETING BUILDING NETWORKS, CRAFTING EXCELLENCE

THURSDAY, NOVEMBER 3, 2005

THE FAIRMONT HOTEL VANCOUVER

The CAGP will be holding its Annual Scientific Meeting on November 3rd 2005. The meeting has been designed to address the information and networking needs for all professionals who work with older adults with mental health problems.

There will be key note speakers, interactive interactive workshops, and panel discussions on current issues.

GET VITAL INSIGHT ON:

Minimal Cognitive Impairment
Competency Assessment
Personhood and Dementia
Hope and Hopelessness in Late Life
Panel Debate "Off Label Use of Psychoactive Medications for the Elderly"

Keynote Address by Dr. Howard Chertkow and Dr. Michel Silberfeld.

Please visit www.cagp.ca to download
Brochure & Registration Form

COMMUNICATIONS REPORT

Terry Chisholm

This winter the CAGP Board of Directors negotiated an agreement with Geriatrics Today; a peer-reviewed medical journal that addresses the information needs of physicians who provide medical care to older Canadians. The Magazine's new name will be "Geriatrics Today". **The Canadian Journal Of Geriatric Medicine & Psychiatry.** All CAGP members will receive copies of the Journal.

The website has been newly designed and updated. The newer version will make it user friendly and provide more information targeted specifically for geriatric psychiatrists and other professionals concerned with the mental health of the aging population. Please view our new website at www.cagp.ca

Furthermore, this is the first edition of the CAGP Bulletin that will be delivered electronically. We will, however, be producing some hard copies for distribution.