Geriatric Psychiatry or Psychogeriatrics? Partnership at the CAGP/CCSMH 2012 Scientific Meeting

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The 2012 joint Canadian Coalition for Seniors' Mental Health (CCSMH) and Canadian Academy of Geriatric Psychiatry (CAGP) conference was held at the Banff Centre in Banff Alberta on September 21st and 22nd, drawing record attendance of 268 physicians, health-care providers, and stakeholders in the care of the elderly. Co-sponsored by the CAGP and CCSMH, the meeting was followed by the inaugural Geriatric Psychiatry annual review course, which was also sponsored by the CAGP. The meetings provided an opportunity for us to reflect on the areas of overlap in the fields of geriatric medicine and geriatric psychiatry over the years, and to speculate on where we are heading in the future.

The keynote addresses were given by two visionaries in the field of Geriatric Psychiatry and Geriatric Medicine, Dr. Ken Shulman (Richard Lewar Chair in Geriatric Psychiatry, University of Toronto) and Dr. David Hogan (Brenda Strafford Foundation Chair in Geriatric Medicine, University of Calgary). Dr. Shulman provided an overview of the evolution of Geriatric Psychiatry over time, both in Canada and abroad, highlighting important historical figures and events. He alluded to the literature of the 1950s and 1960s, in which an age of 55 years was listed as the cut-off for being considered geriatric, as opposed to our current standard of 65 years. Furthermore, he informed us that there were no Old Age Psychiatry Programs prior to 1950 and noted that a geriatrician, Dr. Ignatz Nascher, published the first textbook on diseases of old age in 1915.(1) He paid homage to Dr. Marjorie Warren who, in 1935 in the United Kingdom (UK), formed the first geriatric medicine service, emphasizing the principles of adequate treatment, assessment, aftercare, multidisciplinary treatment, and holistic approaches—principles very much at the core of geriatric medicine today. In the early days, he suggested, geriatricians attended to both the medical and psychiatric needs of their patients and thus were the first "psychogeriatricians". Services were then reclaimed by psychiatry in the 1950s, becoming "Old Age Psychiatry" in the UK and "Geriatric Psychiatry" in North America. In the 1970s, governments began to mandate the creation of psychogeriatric units within general hospitals, ushering in a new era. Dr. Shulman praised his mentor, Prof. Tom Arie, with whom he trained in East London, England. He explained how Prof. Arie's service exemplified the core principles of comprehensiveness, defined target population, accountability, availability, community focus, and caregiver support, principles that still guide outreach programs today. The experiment in Nottingham of combining the Departments of Geriatric Psychiatry and Geriatric Medicine unfortunately ended with his retirement.

In terms of academic milestones, Dr. Shulman referenced Sir Martin Roth, who published a landmark paper in 1955 entitled the "Natural History of Mental Disorders in Old Age".(2) Sir Martin followed 318 patients, admitted to a geriatric psychiatry services with a variety of diagnoses, for two years and discovered that most patients with affective disorders were discharged, most patients with dementia and senile psychosis were deceased, most patients with paraphrenia were hospitalized, and half of delirious patients were discharged while the other half were deceased.

Dr. Shulman alluded to many seminal figures in the development of geriatric psychiatry, including Drs. Felix Post, Bruce Pitt, and Robert Butler. Dr. Butler was credited with founding the National Institute of Aging (NIA) in 1975. Also seminal to the development of geriatric psychiatry were the development of rating scales, such as the Folstein Mini-Mental Status Exam (MMSE) by Marshall Folstein in 1975,(3) the Neuropsychiatric Inventory (NPI) by Cummings et al.,(4) and the Geriatric Depression Scale (GDS) by Yesavage et al.(5) He also alluded to the contribution of professional organizations, including the American Association of Geriatric Psychiatry (AAGP) founded in 1978, the International Psychogeriatric Association (IPA) founded in 1982, and the CAGP founded in 1991.

In terms of Canadian milestones, the first academic Division of Geriatric Psychiatry was established at the University of Toronto in 1978, and training in geriatric

psychiatry became a mandatory requirement for residents by the Royal College of Physicians and Surgeons of Canada (RCPSC) in 1985.

Turning to more modern times, he also spoke of the RCPSC's recent emphasis on "focused competencies" as being the way of the future, and alluded to a diploma program being established in "Brain Medicine" for trainees in geriatrics, psychiatry, neurology, and other fields to cross-fertilize in their areas of expertise. In closing, he acknowledged that although geriatric psychiatry now has subspecialty status, this should not make us complacent, as medicine is in constant flux and there is an ongoing need to redefine who we are and what we do.

Dr. David Hogan, the second keynote speaker, spoke about the overlapping interest of geriatric psychiatry and medicine in dealing with dementia, delirium, and depression, and provided an excellent update on the latest evidence for treatment of these disorders. He talked about progress in the area of delirium research since 2006 when the initial CCSMH guidelines[6] were published. He emphasized recent research about the serious long-term consequences including mortality and the persistence of delirium, as well as the importance of sub-syndromal delirium. He spoke of the potential role of low-dose antipsychotics for short-term use in both targeted prevention and treatment of select behaviours. Further research, though, is required to clarify the role of anitpsychotics, as the evidence to date is inconsistent, such as a recent study suggesting that olanzapine may reduce the risk of delirium but increase its severity if it appears.[7] He also discussed five negative studies of cholinesterase inhibitors to treat or prevent delirium, including one in which rivastigmine increased the risk of death.[8]

He reviewed the current proposals for the upcoming DSM-V regarding the classification of cognitive impairment into categories of delirium, major neurocognitive disorder, and minor neurocognitive disorder with etiological subtypes. A good part of his presentation dealt with the evolving view of dementia as the end-stage of Alzheimer's disease amyloidopathy, reviewing pathological, genetic, and biomarker studies. He presented the 2011 NIA–AA criteria for Alzheimer's disease dementia and mild cognitive impairment (MCI),[9] and also discussed the controversies surrounding the concept of pre-clinical Alzheimer's disease. He emphasized the dangers of labeling that may accompany biomarker testing, and gave the example of a recent report that an "Alzheimer's CSF pattern" was found in one-third of cognitively normal 75-year-olds.[10] He reviewed possible reasons that 12 of 13 recent phase III trials of predominantly anti-amyloid drugs for Alzheimer's disease have failed in recent years. These reasons included starting the treatment too late in the course of the illness, using drugs with a low therapeutic index or poor CNS penetration, insensitive outcome measures, and focusing on the wrong treatment target. He described updates from the fourth Canadian Consensus Conference on the Diagnosis and Treatment of Dementia (CCCDTD), which took place in Montréal in May of 2012. At that meeting, there was consensus to adopt the NIA–AA criteria for dementia and MCI secondary to Alzheimer's disease, but not to advocate for the use of the pre-clinical Alzheimer's disease category at this time, as the proposed biomarkers need validation. There was agreement to discourage amyloid imaging except in a research setting by those knowledgeable in its interpretation.

Dr. Hogan also spoke about the challenges of assessing and treating depression in the medically ill. He argued that the symptom overlap should not be viewed with an "either–or" mentality. He spoke of how the medically ill often have a worse prognosis for depression, are excluded from clinical trials, have more contraindications for therapy, and are perceived as being less responsive to treatment. He argued, however, that this should not lead to therapeutic nihilism, and spoke of the important cognitive consequences of untreated persistent significant depressive symptoms.

In addition to the two keynote addresses, there were six symposia and workshops and nine concurrent papers sessions given by members, which spanned a broad variety of topics and featured both medical and allied health presenters. Innovative programs designed to help clinicians deal with behavioural and psychological aspects of dementia were highlighted in a number of presentations. There were several presentations that focused on models of health-care service delivery, including a presentation from the Mental Health Commission of Canada on their "Guidelines for Comprehensive Mental Health Services for Older Adults in Canada". Other topics discussed included delirium, psychosis and dementia, driving and dementia, and quality of care of older adults living with mental illness.

The inaugural CAGP Review Course in geriatric psychiatry provided an opportunity to review a wide array of 15 topics in geriatric psychiatry at an advanced level. Knowledge was consolidated, and clinically relevant literature updates were presented. Over the course of two days, ten speakers covered major topics in geriatric psychiatry, including disorders such as major depression, dementia, substance abuse, and delirium. There were also talks on epidemiology of late-life mental illness, consent legislation, and pharmacological changes associated with aging. Treatment of psychiatric disorders was explored in detail with lectures about cholinesterase inhibitors, benzodiazepines, antipsychotics and antidepressants, psychotherapy, nursing home psychiatry, and non-pharmacological management of behavioural disturbances in dementia. Dr. Hogan was on the CAGP Review Course organizing committee, and the talks were planned so as to be relevant to geriatric psychiatrists and geriatricians, as well as family physicians.

Clearly, training in geriatric psychiatry in Canada is evolving. Dr. Shulman pointed out that the first "psychogeriatricians" were geriatricians in an era when psychiatrists were not interested in the elderly. Gradually, some psychiatrists drew inspiration from the work of the geriatricians, and the fields of geriatric medicine and geriatric psychiatry

evolved together. In 2009, the Royal College of Physicians and Surgeons of Canada (RCPSC) finally formally recognized Geriatric Psychiatry as a subspecialty, and the new cohort of geriatric psychiatrists will be required to complete two additional years of training, on top of the mandatory six-month rotation in residency and a separate written examination, in order to become accredited by the RCPSC. Today, there are three programs in Canada accredited to provide this extra training, and selectives or electives in geriatric medicine are encouraged. As we understand the current situation, existing psychiatrists who are caring for the elderly will be "grandfathered" or "grandmothered" from completing additional training, at least for several years, but will have to write the RCPSC examination. Thus, in a "declaration of parentage", the "psychogeriatricians" were the parents of the "geriatric psychiatrists", and the "geriatric psychiatrists" are now to be grandparents to the new RPCSC-accredited Geriatric Psychiatrists. With the "Brain Medicine Diploma" proposal on the horizon and the ongoing integration of geriatric medicine and psychiatry at meetings, in research, and in clinics across the country, we may see an increasing sharing of the unique knowledge and skills of each of our specialties, as well as, hopefully, an increased capacity to care for the elderly and to attract trainees into our fields.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that no conflicts of interest exist.

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