DEFINITION OF A GERIATRIC PSYCHIATRIST

Definition of a Geriatric Psychiatrist

Definition:
Geriatric Psychiatry, a psychiatric subspecialty, focuses on the assessment, diagnosis and treatment of complex mental disorders uniquely occurring in late life. In contrast to subspecialties that deal with organ-specific diseases, Geriatric Psychiatry is focused on providing care for intensive-needs patients and their caregivers at the end of the life cycle, a time when many complex physical and mental health issues coalesce. The subspecialty generates new knowledge through research, and interprets and disseminates new knowledge and best practices in geriatric psychiatry to all health care professionals and trainees involved in the care of the elderly. Geriatric Psychiatry organizes service delivery of psychiatric care to the elderly in multidisciplinary teams and in locations that best serve the needs of this elderly population. Geriatric Psychiatry is engaged in advocacy and development of health policy and planning related to late life mental illness and mental health, caregiver and care provider support, and systems of care.

Scope of practice and primary diseases seen:
The emergence of an expanding body of scientific knowledge over the past 30 years reinforces observations that the etiology and expression of disease and the response to treatment options for mental illness in the elderly is very different than for the younger adult population with mental illness. These differences have been well-documented for many illnesses (see Unutzer’s 2007 NEJM article as an example).

Primary disease entities and symptom presentations unique to the practice Geriatric Psychiatry include those diseases indicative of some degree of “brain failure”. Those diseases include:

- **Behavioral and Psychological Symptoms of Dementia (BPSD)**, a term adopted by international consensus and defined as “symptoms of disturbed perception, thought content, mood or behavior occurring in persons with dementia”. It includes, for example, verbal and physical aggression (at times lethal), agitation, paranoia, wandering, persistent vocalizing, depression. It is estimated to occur in 90% of persons during the course of dementia of any etiology and is the most frequent reason for long-term care placement or chronic hospitalization in these patients. Management of moderate and severe BPSD is the unique niche of geriatric psychiatrists alone.

- Primary dementias presenting with prominent, early psychiatric symptoms, often without obvious memory impairment, such as vivid visual hallucinations in **Lewy Body Dementia**, personality changes in **Fronto-temporal Dementia**, and apathy and executive dysfunction in **Vascular Dementia**.

- **Late-onset Depression**, a common condition that differs markedly from early onset depression in several ways. It is associated with structural brain changes on CT and MRI and profound functional decline for the patient. Presentation is often colored by somatic pre-occupation or somatic delusions, which are mistaken for medical conditions. Elderly patients with medical problems and depression have twice the length of hospital stay compared to those who are not depressed. It is a marker for future development of dementia. It is expected that aging baby boomers will have higher rates of depression than the current elderly cohort.

- **Complex and severe Depression** with clear suicide risk, psychosis or catatonia.
• **Suicide Risk Assessment.** Men over the age of 85 have the highest rate of completion of suicide of any age group in Canada, at twice the national average. This occurs usually, but not exclusively, in the context of depression, often complicated by alcohol abuse.iii

• **Late-onset Psychotic Disorders**

• **Complex presentations of Delirium,** with psychosis, behaviour disturbances, catatonia. An episode of delirium in older adults carries a 2-3 fold relative risk increase for functional impairment, and a 46% institutionalization rate post-hip fracture.iv

• **Psychiatric complications of Cerebrovascular Accidents (CVA’s).** Post-stroke incidence of depression is very high (41% in first year post-stroke).v Presence of untreated depression results in failure to successfully rehabilitate, and results in prolonged hospital stays and more frequent placement in Long Term Care Homes.

• Psychiatric complications of neurodegenerative disorders such as Parkinson’s Disease, Huntington's Disease.

In addition to these unique diseases, the Geriatric Psychiatrist is consulted in situations of atypical or unrecognized presentations, or treatment failures, of more common diseases such as:

• **Alzheimer Dementia,** especially when presenting in those less than 65 years of age.

• **Treatment-resistant Depression.**

• **Bipolar** disorder, either late onset of with unique treatment complications due to aging and/or co- morbid medical conditions.

• **Schizophrenia** with complications related to aging.

• **Developmental Delay,** with complications related to aging, including dementia. Most individuals with Down's Syndrome develop Alzheimer Disease in their fifth decade.

• **Substance Abuse,** usually alcohol and benzodiazepines.

• Complex situations of dementia plus another late-life mental illness, or **multiple concurrent mental disorders** presenting in one elderly individual.

Unique situations that are not disease specific, but requiring the expertise of the Geriatric Psychiatrist, and frequently prompting referrals from general psychiatry, geriatric medicine and neurology include:

• Complex capacity/competency assessments in frail elderly/dementia patients for decisions regarding medical treatment, finances, personal care/living independently, choosing a power of attorney, operating a motor vehicle.

• Poly-pharmacy (multiple prescriptions for medical conditions) and related side effects and drug-drug interactions. At times this situation mimics a psychiatric condition.

• Psychotropic medication use eg. Risk assessment regarding use of atypical antipsychotics: risperidone, olanzepine and quetiapine in the elderly when Health Canada and the FDA have issued warnings about their use in this population.

• ECT use in frail/demented elderly patients.

The scope of practice requires an understanding that all elderly patients, with unique disease presentations or atypical presentations of common diseases, have a complex interplay of structural and neurochemical brain changes, physiological and immunological reactions, personality structure, stressful life events, and early psychological development. Most have multiple chronic and
Management plans, in the Geriatric Psychiatrist’s scope of practice, often necessitate multiple strategies. In addition to expert use of safe, effective biological/pharmacological treatment options the Geriatric Psychiatrist is expert at psychological and environmental interventions adapted for the elderly. Caregiver support interventions are often crucial for success. The delivery of electroconvulsive therapy (ECT) for the treatment of depression in those frail elderly patients not responsive to, or unable to tolerate pharmacological interventions, is unique to Geriatric Psychiatry. The management plan is communicated and managed in collaboration with multiple disciplines, and usually involves multiple institutions and agencies.

Geriatric Psychiatrists are frequently required to work outside traditional hospital settings. Because of the nature of the illnesses described, the patient is best served in their place of residence, and for many it is impossible to access hospital-based specialty care. The importance of involving caregivers in the treatment plan, and the need to support those providing day-to-day care for older individuals in the community and long-term care, reinforces this practice. Elderly Canadians increasingly require care in their own homes, yet comprehensive outreach services that ensure older persons’ access to subspecialty-level care are seldom provided by disciplines outside Geriatric Psychiatry.

The rich scope of practice, described here, for Canadian Geriatric Psychiatrists ensures that all CanMEDS roles: Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional, are developed at the Expert/Master level.

TRAINING REQUIREMENTS & LENGTH of TRAINING.

A subspecialty resident in geriatric psychiatry will complete a total of 2 years of training in preparation for a career as a leader in Geriatric Psychiatry. To attain the required level of subspecialty expertise, not only in terms of Medical Expert skills, but also in each of the other CanMEDS competencies, particularly Collaborator, Scholar, Manager and Health Advocate, requires at least 2 years of dedicated training.

Up to 12 months of the two year training, if completed during fulfillment of the primary certification requirements in Psychiatry, may be credited toward subspecialty training with approval from the Subspecialty Program Director. The 6-month mandatory core experience in Geriatric Psychiatry completed during Psychiatry training would not be eligible for credit, as it is structured to develop foundational skills rather than subspecialty expertise.

From Geriatric Psychiatry Subspecialization document for the RCPS written by Dr. C. Shea and Dr. M. Andrew

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