

BC's
Mental
Health
Journal

Visions

Seniors' Mental Health



BC's
Mental
Health
Journal

Visions

is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the CMHA: the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of friends, family, service providers and community members. In this journal, we hope to create a place where the many perspectives on mental health issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal. Please send your letter with your contact information to:

Mail: Visions Editor, CMHA BC Division
1200-1111 Melville Street
Vancouver, BC V6E 3V6
Tel: 1-800-555-8222 or (604) 688-3234
Fax: (604) 688-3236
Email: office@cmha-bc.org

The opinions expressed in this journal are those of the writers and do not necessarily reflect the views of the Canadian Mental Health Association, BC Division or its branch offices.

Editorial Board

Nan Dickie, Dr. Rajpal Singh,
Dr. Raymond Lam, Victoria Schuckel

Executive Director

Bev Gutray

Editor

Eric Macnaughton

Production Editor / Design / Advertising

Sarah Hamid

Printing

Print&Run

CMHA is grateful to the Ministry of Health Services for providing financial support for the production of Visions.

In this issue of *Visions* we look at seniors' mental health. To help us in our examination of this topic, we are fortunate to have Dr. Martha Donnelly as Guest Editor. She, along with Dr. Penny MacCourt, co-chaired the Elderly Mental Health Care Working Group, which very recently produced a report for the Ministry of Health Services entitled *Elderly Mental Health Care Planning for Best Practices*. The report aided us immeasurably in preparing this issue of *Visions*.

The contributors to the *Best Practices* report comprised a wide network of people representing various professional disciplines, dedicated to helping elderly people deal with mental illness or with mental health-related issues. Fortunately, we've been able to enlist many of the same individuals to write articles for our current issue — describing initiatives with which they are involved, spanning most of BC, and helping elderly individuals from diverse ethnocultural backgrounds.

Despite the emphasis of the *Best Practices* report title on care planning, the focus of the report's contents is wide. Among other things, it looks at seniors' mental health promotion, at peer support, at approaches to ensuring accountable services, at protecting vulnerable seniors from abuse and neglect, and at the training needs of caregivers outside the formal mental health system, especially those who are "on the front lines," such as family members, home care and long-term care workers, and family physicians. Accordingly, we've been able to look at most of the same topics in the current issue of *Visions*.

For the most part, our "first-person" articles span the range of issues reflected in the rest of the journal. We'll hear the stories and perspectives of mental health consumers or caregivers who for much of their lives have lived with mental illness, as they describe how they've managed their illnesses over time. We'll also hear from individuals who have developed an illness, such as depression, later in life. And we'll read stories from both professional and family caregivers of individuals with dementia.

As one looks through these stories, and learns about the various programs available for seniors with mental health problems, two words — "complexity" and "connectedness" — come frequently to mind. The first indicates the multiple issues that seniors with mental health problems often deal with: not merely depression, for example, but perhaps chronic pain, or some other physical health problem too, may be part of the picture for the individual in question. By nature then, seniors' mental health interventions often require collaborative, multidisciplinary efforts.

The second word relates to another part of the solution, which is the recognition that our services and resources must not only deal with the mental illness itself, but with the elderly individual's relationship to his or her family and with society in general. Disconnection from the family unit, and devalued status within society are perhaps some of the biggest issues we can tackle as we promote seniors' mental health within our programs, and amongst our aging population as a whole.

Eric Macnaughton

subscriptions and back orders

Visions subscriptions are \$25 for four issues. Back issues are available to read on our web site at www.cmha-bc.org. Or call us to order hard copies at \$7 apiece. Back issue themes include:

- Seniors' Mental Health
- Anxiety Disorders in Children and Youth
- Employment
- Spirituality and Recovery
- Mood Disorders
- Housing
- Cross Cultural Mental Health
- Sexuality, Intimacy and Relationships
- Poverty, Income & Unemployment
- Approaches to Building Mental Health Accountability
- Community Inclusion
- What is Mental Health?
- Women's Mental Health
- Rehabilitation and Recovery
- Early Intervention

advertising

Complete advertising rates are available online at www.cmha-bc.org or contact Sarah Hamid, Visions Production Editor, for more information at shamid@cmha-bc.org or (604) 688-3234.

CMHA BC would like to thank Janssen-Ortho Canada for its sponsorship toward the printing costs of this issue of Visions.



what's inside

BACKGROUND

- 2 Editor's Message Eric Macnaughton
- 4 The State of Seniors' Health in British Columbia (guest editorial) Martha Donnelly
- 6 Depression among the Elderly Kevin Solomons
- 7 Depression Detection and Treatment across Cultures: Elderly Populations Hiram Mok/Kimberly Morishita
- 7 Study: Depression in Older Chinese Adults Daniel Lai
- 9 Elder Suicide in Native Communities: How Valuing and Including our Seniors Can Make All the Difference Paul Kettl
- 11 The Not-So-Shocking Facts About ECT Peter Chan
- 12 When Sedatives Do More Harm than Good: The Use and Misuse of Benzodiazepines Harkirat Kaur
- 13 Is This Supposed to Happen? Distinguishing Dementia from the Normal Cognitive Changes of Aging Holly Tuokko
- 14 Achieving a Balance: Relating Physical and Mental Health in Seniors Chris Rauscher
- 15 Support and Assistance for the Vulnerable Older Adult and Seniors with Dementia Sara Campbell

EXPERIENCES AND PERSPECTIVES

- 17 Dealing with Physical and Mental Health Conditions: Then and Now Barbara Berry
- 19 Through Sickness and Health: A Wife's Account of her Husband's Mood Disorder Sarah Hamid
- 21 Coming in From the Cold: Caregiving for Alzheimer's on Film and in Life Bruce Saunders
- 22 Seniors Caring for Friends and Family in Kelowna
- 23 Moving Seniors Can Be Detrimental to their Mental Health Patricia Harding
- 24 Time and Love: Gifts to the Caregiver Anne Duggan
- 25 Schizophrenia of My Times Walter Beier
- 26 Aging with Mental Illness May Louie
- 26 Sometimes Only on One Wing: Life and Illness over a 40-year Span Rhea Alexander

ALTERNATIVES AND APPROACHES: HEALTH PROMOTION AND PEER SUPPORT

- 28 Seniors and Mental Health Promotion Penny MacCourt
- 29 Nutrition in Mental Health: Focus on Seniors Erica Messing
- 31 Health Promotion for Seniors: The Healthy Brain Program Stephen Kiraly
- 32 Safety Nets: Avoiding Depression in the Elderly Janice McTaggart
- 33 The Therapeutic Activation Group: A Cognitive-Behavioural Group Therapy Program for Seniors Lynn Fairey
- 34 Helping Seniors in the Fraser Valley through Group Approaches [interview]
- 35 Seniors Friendly Visitors Program Jackie Rankel

ALTERNATIVES AND APPROACHES: OUTREACH-BASED CARE AND TRAINING

- 36 The Geropsychiatric Education Program Joan Hibbard
- 36 In Search of Meaning: An Approach to Educating Long-Term Care Staff Irene Barnes
- 37 Elderly Outreach Service: A Community Mental Health Program for Seniors Giuseppe Scaletta
- 38 The Upper Island Geriatric Outreach Team Sandie Somers
- 39 Helping the Forgotten Pioneers: A Northern Approach to Supporting Seniors with Mental Illness K. Staff/L. Holland
- 40 Salmon Arm Mental Health Service Elderly Services Program: How it Grew and Why it Works Lyle Petch
- 41 Listening to the North Okanagan: A Systems Approach to Accountability Catharine Hume
- 43 Vancouver's Geriatric Crisis Service Diane Martin

45 RESOURCES

The State of Seniors' Health in British Columbia

Martha L. Donnelly,
MD, FRCPC



Martha is the Director of the Division of Community Geriatrics, Department of Family Practice, and Head of the Division of Geriatric Psychiatry, within the Department of Psychiatry, at the University of British Columbia. She was co-Chair of the Ministry of Health Services' Elderly Mental Health Care Working Group which produced the recently-released publication *Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities*.

It should be no surprise to anyone who is a keen observer of society, that the number of seniors is rising dramatically in BC, Canada and the world as a whole. In fact, the over-85s in Canada are growing four times faster than younger segments of the population. BC has one of the longest life expectancies in Canada. This is possibly related to better lifestyles, including less smoking and more physical activity. There is evidence that we are not only living longer, but healthier into our older years.

Unfortunately, however, there are a number of seniors with significant mental health problems.¹ Established figures range from 15 to 30% — the 15% figure representing only the more serious problems. Some seniors come to older age with chronic mental illnesses including schizophrenia, bipolar disorders, substance abuse, or recurrent depressions, but most seniors' mental health problems arise in old age. These problems range from anxiety, mood disorders and substance abuse, to delirium (acute confusion) and dementia.

The *Canadian Study of Health and Aging*² showed that eight per cent of over-65 year-olds and 34.5% of over-85 year-olds suffer from dementia, the main causes being Alzheimer's and vascular dementia which is dementia caused by strokes. Most dementias have as their primary symptom memory problems that are difficult for both the patient and caregiver to deal with. However, psychotic disorders and behavioural problems also occur

with dementia, particularly in the middle and severe stages. Depression co-exists with dementia in 20 to 30% of cases. Frontal lobe dementias appear with behaviour problems and personality changes that predate the memory problems, and may be more difficult for caregivers to adapt to.

Depressive symptoms and disorders in old age are common, as are grief and adjustment disorders with depressed mood. Unfortunately depression is under-diagnosed and under-treated in seniors, even more so in a multicultural population. Suicide rates among older men are high, especially in those who have physical health problems. The interaction between physical and psychiatric problems in old age is a particular challenge for mental health professionals. Because of this, family physicians and mental health professionals must work closely together.

Compared to a younger adult population, young seniors who are physically healthy and have no cognitive impairment require little difference in approach to assessment and treatment. However, the over-85s, those with combined medical and psychiatric problems, or seniors with cognitive impairment often need comprehensive geriatric assessment by an interdisciplinary team — in particular an outreach team, where mental health professionals can see them in their own homes or facilities when needed. Outreach workers not only assess and case-manage, they also educate, liaise with other community resources, and act as ad-

vocates for those patients who cannot advocate for themselves.

The Geriatric Psychiatry Outreach Team has become a mandatory community service across the province. This was not always so, and prior to the 1980s, seniors' mental health services consisted largely of in-patient programs in provincial mental health hospitals. The development of community geriatric psychiatry in Canada and BC has been a relatively recent development over the past 25 years. In 1983, the Canadian Psychiatric Association's section on Geriatric Psychiatry recommended that guidelines be written which defined mental health services for seniors. These were completed in 1988 in a document developed by the Mental Health Division of the Health Services and Promotion Branch of the Department of National Health and Welfare. Titled *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders*,³ the document became known as the "silver bullet," and formed a framework for local service development across the country.

In 1992, BC developed its own mental health planning framework for seniors,¹ which defined a comprehensive service system. In February 2002, a report was written entitled *Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities*.³ In these guidelines, the outreach team was defined as a core service, but a wide variety of services of a biopsychosocial nature were also defined.

The document established

six principles of care, and all recommendations followed from these principles, which are:

1 Client and family centred:

- maintaining the dignity of older adults and treating them with respect
- involving the person and the family in care planning and management
- being culturally sensitive
- being sensitive to ethical issues and end-of-life issues.

2 Goal-oriented:

- reducing distress to the person and the family
- improving and/or maintaining function
- mobilizing the individual's capacity for autonomous living
- maximizing and maintaining independence at the highest level possible.

3 Accessible and flexible:

- being user friendly
- being readily available
- taking into account geographical, cultural, financial, political and linguistic obstacles to obtaining care
- integrating services to ensure continuity of care and coordinating care by all levels of service providers
- providing service to each person wherever most appropriate.

4 Comprehensive:

- taking into account all aspects of a person's physical, psychological, social, financial and spiritual needs
- making use of a variety of

professionals, resources and support personnel to provide a comprehensive range of services in all settings, including the community, facilities and acute care.

5 Defined, specific services:

- recognizing that the needs of older adults with mental health problems are qualitatively different than mentally well older adults
- recognizing that the needs of older adults with mental health problems are qualitatively different from the younger population with a mental health problem
- designing appropriate and relevant services, especially for this population.

6 Accountable programs and services:

- accepting responsibility for assuring the quality of service delivered and monitoring this in partnership with the client and family
- responding to reasonable expectations from the clients, family, and those providing service
- anticipating and responding to changing demographics
- incorporating relevant evaluation strategies and research findings to determine optimal methods of service delivery.

Several major report recommendations related to issues of education for all levels of staff who care for seniors with mental health problems, as well as education for clients, families and informal caregivers. Other recommendations focused on issues of coordination between various parts of the system, in particular, the need to create links for transitions between

acute care, facility care and community-based services, as well as the need to create links to tertiary care when needed. The *Guidelines* recognized that each community has developed its own community capacity, and is at a unique stage in terms of service development. The report thus supported the need for individual community creativity in developing a full range of services.

Seniors' mental health services must include a focus on family well-being, including both individual and group support for caregivers. It must be recognized that informal caregivers are the backbone of support for seniors with mental health problems. In order to remain healthy themselves, caregivers need to be educated and given concrete support, including respite. This formal support should not end until the caregiver feels that their informal supports are sufficient. As the province moves to an even more intensive initiative to keep seniors at home, or to provide assisted living, we must increase home supports to help seniors and their caregivers feel confident.

Formal mental health services must also increasingly collaborate with community organizations to provide education to consumers, caregivers, and the general public about mental health problems and solutions. The Canadian Mental Health Association, Alzheimer's Society, Parkinson's Foundation, VON, caregivers networks, and the Public Trustee's Office are all crucial partners.

Seniors' mental health promotion needs more research to demonstrate effective programs and policies. More seniors need to be active participants in planning, implementation and in evaluation of these programs. In the *Elderly Mental Health*

Best Practices document, one of the recommendations relating to client and family-centred care included a statement of the need to "develop and foster a culture of caring across the spectrum of care that acknowledges the need for a meaningful life (rather than just living), and recognizes people's relational needs. A culture of caring would prevent alienation, anomie and despair that mentally ill elderly people feel and would promote optimal mental health."⁴

Perhaps the most difficult areas that seniors' mental health professionals have to tackle are risk assessments, competency assessments, assessment for possible abuse, and protecting vulnerable adults from self-neglect, neglect or abuse. Unless there is proof to the contrary, all individuals are legally considered competent to make personal, health, living arrangement, financial, and lifestyle decisions. We as Canadians champion autonomy as one of our highest values, and because of this, health professionals must allow clients to live at some degree of risk before challenging their autonomy. However, acceptable levels of risk are difficult to define and must include some appreciation of previous personal values and lifestyle choices. It would be ideal if all people, young and old, considered the possibility of future incapacity and made clear advance directives, including choosing representatives to make decisions for them if and when they are not able to. New health care consent laws and guardianship laws do give directions for competency assessments and define processes for substitute consent, enforced support and assistance, or guardianship when needed.

Advocacy to continue the development of mental health

services for seniors is needed. The BC Psychogeriatric Association (BCPGA) is an interdisciplinary professional organization created in 1997 to specifically support interdisciplinary education and research in the area of mental health for seniors, as well as advocate for seniors' mental health services within the province. The organization has annual educational meetings, which revolve around the province, having been run in Nanaimo, Victoria, Richmond, Penticton and Nelson. The 2003 spring meeting will be in Prince George. The BCPGA lobbied the government to create a best practices document, and several of its members formed the working group that eventually wrote the report. The principles of elderly mental health care in this document are in fact revised from the BCPGA's own charter.

In tough economic times, when health care faces hard choices, it is important to provide evidence to support best practices. Perhaps the most compelling evidence is qualitative in nature, in the stories of consumers and their family members who have suffered from the effects of serious mental health problems. Their pain and their personal growth can translate into powerful advocacy for more and better services. We also, however, need combined qualitative and quantitative research to prove the effectiveness of particular services and approaches. This research should be the next area of growth or focus in seniors' mental health — and will hopefully happen soon enough to support the depth and breadth of services we have already developed. ■

footnotes

- 1 BC Ministry of Health and Ministry Responsible for Seniors, Mental Health Services, Continuing Care, Hospital Care, and Facilities, Planning and Construction. (1992). *Services for Elderly British Columbians with Mental Health Problems*.
- 2 Canadian Study of Health and Aging Working Group. (1994). Canadian Study of Health and Aging: Study methods and prevalence of dementia. *Canadian Medical Association Journal*, 150, 899-913.
- 3 Health and Welfare Canada. (1988). *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders*. Ottawa.
- 4 BC Ministry of Health Services. (2002). *Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities*. Available online at: www.healthservices.gov.bc.ca/mhd/pdf/elderly_mh_care.pdf

Depression among the Elderly

Kevin Solomons, MD

Depression occurs commonly in the aging population. The frequency depends on the setting, with estimates rising as high as ten to 12% in inpatient and long-term care settings. Symptoms can persist for up to three years or more if left untreated.

Kevin is Associate Medical Director at the Mood Disorders Clinic, Department of Psychiatry, University of British Columbia. This article is adapted from a piece he wrote for the BC Medical Journal.

The mortality rates for untreated depression in the elderly are high, attributable to both increased rates of completed suicide as well as increased mortality from cardiovascular and other medical diseases. The rate of completed suicide is twice that of younger people, i.e., 26 as opposed to 12 per 100,000 among 80 to 84 year-olds compared to the general population. A 75% increase in cardiovascular death rate has been documented for depressed compared to non-depressed elderly.

Morbidity, or diminished functioning, from major depression is a significant concern in the elderly, both because of diminished function from the depression itself, as well as from the worsening of other medical symptoms and conditions. Increased use of medical services with a 50% increase in outpatient costs has been noted among elderly depressed patients. Recovery from other medical illnesses is also delayed by co-existing depression. For example, untreated depression following a stroke is associated with prolonged hospital stays and lesser degrees of neurological and functional recovery.

Major depression may present more subtly in the elderly, who frequently do not report low or depressed mood as the primary complaint, even if asked directly; instead, they may complain of feeling unwell in a non-specific way, or they may complain of specific physical symptoms, particularly abdominal

pain, indigestion and constipation. Other physical symptoms may include generalized aches and pains, headaches, fatigue, low energy and just feeling “sick.” An overemphasis on the physical complaints may lead physicians to overlook the underlying depression. Predominant somatic complaints, particularly when investigations fail to reveal an organic cause, should be regarded as suspicious for depression.

Stereotypical attitudes towards the elderly may lead to rationalizing away important symptoms such as irritability, which can overshadow low mood as the primary depressive mood equivalent, and reduced activity level. These symptoms can be easily overlooked, particularly among elderly individuals who have significant cognitive or physical limitations. The early stages of depression are often not recognized in seniors. As a result, the depression may only present later and at a more advanced stage, for example, when the person has stopped eating. Older depressed people are also more likely to present with psychotic ideas, typically with nihilistic and negative-based delusions including themes of poverty and poor health. Poor self-esteem and themes of guilt are less common than they are with younger people.

Active and passive suicidal thinking is common among elderly patients and may be difficult to detect. A high index of suspicion for suicide risk is important, especially for recently bereaved, isolated men who are in physical pain and are drinking.

Grief is a common experience among the elderly, as the likelihood of multiple losses — such as relationships, independence, health, comforts, and activities — increases with advancing age. It may be difficult to differentiate bereavement from major depression, and the two may co-exist, but some features make major depression more likely, such as active suicidal thinking, and failure to function on a day-to-day basis.

In the very old, physical symptoms, irritability and decline in function may be the main clues to the presence of a depressive illness. Obtaining collateral information from family members may be essential to recognizing the illness. Risk factors for depression — such as medical illnesses, social factors and losses — are part of the common experience of advancing age. Treatment requires a combination of psychosocial rehabilitation and systematic medical interventions. The elderly are sensitive to medication side effects, but require the same assertive treatment shown to be effective in younger adults. Great caution and patience is required in slowly increasing the antidepressant doses into the therapeutic range for maximal therapeutic benefit. The results of antidepressant treatment, especially combined with psychosocial support, are most rewarding since elderly people respond almost as well as those who are younger.

So remember that depression in the elderly is common, serious and treatable. It is also possible with some experience to recognize, even though the signs and symptoms are not always characteristic of depression as seen in the broader population. ■

An overemphasis on the physical complaints may lead physicians to overlook the underlying depression



Depression Detection and Treatment across Cultures

Addressing Barriers within Elderly Populations

Depression is one of the most common emotional disorders in the elderly population. In Canada, it is estimated that depression affects approximately ten per cent of this population.¹ The prevalence rates of depression among visible minority elders, such as the elderly Chinese, have not been well studied; however, it is believed that similar prevalence rates apply across cultures. There are a number of barriers to the detection and treatment of depression in cross cultural elderly

populations. For this reason, depression in ethnic minorities is largely under-reported and under-diagnosed. In a country where minority populations continue to grow, it is of significance to address some of the difficulties that these individuals and their caregivers are faced with.

Detection of depression in elderly minorities may be difficult for a number of reasons. In some cultures, depression may be under-diagnosed because of alternate patterning or presentation.² In Chinese societies, metaphors such as “heartache”

— conveying sadness — and “fatigue” or “tiredness” — conveying hurt and despair — are examples of how complaints of emotional distress may be expressed in a culturally acceptable manner.³ In some cultures, it is more socially acceptable to seek help for physical complaints (somatization) than it is for psychological complaints.

The term *neurasthenia* is Greek for “lack of nerve strength” and was introduced into China in the early 1900s. Since then, the term has been used by the Chinese to account for a wide array of symptoms

including physical symptoms (such as fatigue and insomnia), cognitive symptoms (such as poor memory) and emotional symptoms (including symptoms of depression).² Neurasthenia has been used as a culturally acceptable diagnosis that is considered distinct from diagnoses of psychiatric illnesses. In fact in 1982, Kleinman observed that 87% of neurasthenic patients in Hunan could be reclassified as having “major depression” according to psychiatric diagnostic criteria.⁴

Another barrier to the detection of depression is the

Hiram Mok, MD, FRCPC and Kimberly Morishita, BSc

Hiram is a Consultant Psychiatrist at Vancouver General Hospital; Kimberly is a medical student at the University of British Columbia.

study: depression in older chinese adults in greater vancouver

Depression is one of the major mental health issues facing older adults in Canada. In general, close to ten per cent of those who are 65 years and older are affected by depression.¹ Despite the cultural diversity in the Canadian population, research on mental health issues of older adults in visible minority groups is lacking. As the largest visible minority group in Canada, the 860,150 Chinese accounted for 27% of all the visible minorities in 1996. In Greater Vancouver, 49% of the visible minorities were Chinese. This group also accounted for 15% of the total Greater Vancouver population. Yet, research attention on the mental health issues faced by this population group, particularly the older adults, is very limited. As a major effort to bridge this knowledge gap, this article summarizes the findings about depression among a randomly selected sample of older Chinese adults (55 years and older) in the Greater Vancouver area.

These findings were based on the data obtained from a major research project — *Health and Well Being of Chinese Seniors in Canada* — that examined the relationship between culture and health of Chinese seniors in seven Canadian metropolitan areas including Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal. The study examined a wide range of issues related to health status, health service use, and cultural health beliefs. In one of the sections of the study, depression levels of Chinese older adults were measured by a validated Chinese version of the Geriatric Depression Screening (GDS) scale.²

For the respondents in the Greater Vancouver area, 29% reported symptoms that indicated mild to severe levels of depression. Specifically, 23% of the respondents reported a mild level of depression while 5% reported a moderate to severe level of depression. No significant differences were reported in the prevalence rates between those who were under 65 and those who were older than 65. These prevalence rates were significantly higher than other Canadian sites in which this study was conducted. They were also higher than the combined rates of the seven cities in which only 15% reported a mild level of depression and 5% reported a moderate or severe level of depression.

What then are the implications of these findings? First of all, as pointed out earlier by the author,³ Chinese seniors are not free from mental health problems and concerns. The depression rates reported in the findings are much higher than the national estimate. These findings are congruent with the ones obtained in an earlier study by the author in Calgary³ in which the depression rates reported were also higher than the national estimate. Depression is a genuine and emerging issue faced by Chinese older adults. Contrary to the misconceptions that the Chinese are model healthy citizens without problems, older Chinese do have mental health needs similar to those of the general elderly population. However, is the existing mental health service delivery system ready to accommodate or fulfill these needs?

It is important for practitioners, policy makers, and researchers to re-orient themselves. Services for ethnic minority groups should no longer be at the fringe of the service delivery system. With the growing cultural diversity of the existing population, it is imperative that serving the needs of ethnic minority groups should be the utmost central theme of meeting the communities' health needs. In addition, to enhance understanding of the cultural differences in mental health in ethnic minority populations, further research is desperately called for in this particular area. ■

Daniel W.L. Lai, PhD

Daniel is an Associate Professor with the Faculty of Social Work at the University of Calgary.

footnotes

- 1 McEwan, K.L., Donnelly, M., Robertson, D., & Hertzman, C. (1991). *Mental health problems among Canada's seniors: Demographic and epidemiologic consideration*. Ottawa: Mental Health Division, Health Services and Promotion Branch, Department of National Health and Welfare.
- 2 Mui, A.C. (1996). Geriatric Depression Scale as a community screening instrument for elderly Chinese immigrants. *International Psychogeriatrics*, 8(3), 445-458.
- 3 Lai, D.W.L. (2000). Depression among the elderly Chinese in Canada. *Canadian Journal of Aging*, 19(3), 409-429.

stigma often associated with mental illness. Patients may be too ashamed to seek help for fear that they will no longer be accepted by society. Additionally, they may fear bringing shame to their families. In other instances, it may be the family who fears the implications of having one of its members affected by mental illness and the collective loss of face for the extended family. They may treat the illness as a secret, or deny that the person has a mental illness at all and thus delay seeking medical intervention until they can no longer cope, or until they have exhausted all of their family resources.

The difficulty in diagnosing depression in the elderly is further compounded by the high prevalence of concurrent illness and the use of multiple medications in this population. Both physical and emotional symptoms are often too easily attributed to underlying medical conditions, side effects of medications, or in cases of multiple medication use, drug interactions, making diagnosis of depression difficult.

In addition to the barriers affecting detection of depression, there are also a number of barriers to effective treatment. One of the major barriers to treatment is traditional disbelief in or reservation about Western medical practices. Many ethnic minorities have strong beliefs in their own traditional healing practices, which has an impact on both their willingness to try or seek out other methods of treatment, and on the likelihood that they will comply with prescribed treatment plans. For example, in many Asian cultures, talking about problems is not considered appropriate treatment for emotional illness. From that perspective, it is easy to understand why many of

these people from this background would question the use of psychotherapy as a form of treatment.

In Chinese cultures, it has been suggested that a further barrier to the treatment of depression may be an increased tendency to “accept depression as a way of life.” Cultural concepts such as *mingyun* (fate or destiny) may play a role in the Chinese because they believe a life of stress and hardship was predetermined for them.² Additionally, sociocultural factors such as a long-standing tradition of withstanding hardship in combination with culturally valued personality traits such as stoicism and tolerance may discourage help-seeking behaviours, and indeed signify character weakness in those who seek out help.²

Treatment may also be affected by cultural variability seen in drug metabolism, response to treatment, and side effect profile. For example, 33% of Asian-Americans have genetic variations in their liver enzymes such that they have lower levels of activity of these enzymes, compared to less than ten per cent of Caucasians.⁵ It is therefore often necessary to start an antidepressant at half of the initial recommended dose and titrate slowly upwards [that is, making small dose increments to find the least amount of medicine that will produce a desired effect], according to clinical response in patients from these ethnic groups.

From a cross cultural standpoint, patients are less likely to feel at ease discussing their personal concerns with a caregiver from another culture that they perceive as unlikely to understand their circumstances or cultural beliefs, even when there is no significant language barrier. At Vancouver General

☒	☒	☒	☒	☒
☒	☒	☒	☒	☒
B	I	N	G	O
☒	☒	☒	☒	☒
☒	☒	☒	☒	☒

When you play bingo at Burnaby Bingo Country, you help support the work of CMHA BC Division in our mission to promote the mental health of all British Columbians and change the way we view and treat mental illness in BC.

Burnaby Bingo Country
 Middlegate Mall
 302-7155 Kingsway
 (near Edmonds)
 Burnaby BC
 Tel: 604-523-1221
 Open daily 11am to 11pm

Hospital (VGH), efforts have been made to improve access to ethnocultural mental health through a Cross Cultural Psychiatry Outpatient Program that was established in 1988. The program provides patients with “ethnic-matched” psychiatrists who work to assess, treat and coordinate resources for patients in a culturally sensitive manner.

The VGH clinic has proven to be a useful resource for many ethnic patients, and demonstrates a positive step towards improving utilization of mental health services. Psychoeducation may be of great value in educating the public about different psychiatric disorders as well as helping to de-stigmatize mental illness. Increasing awareness of traditional beliefs, social stigmas and sociocultural ac-

ceptances will also help both ethnic and non-ethnic health care practitioners to provide care that is culturally sensitive. The development and distribution of culturally sensitive psychoeducational pamphlets might also help to facilitate the recognition, diagnosis and treatment of psychiatric disorders in different ethnic minorities. In addition, research in the areas of inter/intra-ethnic differences and inter-generational differences will also be valuable. Many ethnic groups are assumed to be homogeneous as a population when in fact there may be substantial within-group diversity and variation. Identification of these intra-cultural differences will further enhance utilization of mental health resources. ■

footnotes

- 1 McEwan, K.L., Donnelly, M., Robertson, D., & Hertzman, C. (1991). *Mental health problems among Canada's seniors: Demographic and epidemiologic consideration*. Ottawa: Mental Health Division, Health Services and Promotion Branch, Department of National Health and Welfare.
- 2 Parker, G., Gladstone, B., Chee, K.T. (2001). Depression in the planet's largest ethnic group: The Chinese. *American Journal of Psychiatry*, 158, 6.
- 3 Chang, W.C. (1985). A cross-cultural study of depressive symptomatology. *Culture, Medicine & Psychiatry*, 9, 295-317.
- 4 Kleinman, A. (1982). Neurasthenia and depression: A study of somatization and culture in China. *Culture, Medicine & Psychiatry*, 6, 117-190.
- 5 Canadian Network For Mood And Anxiety Treatments. (2001). Clinical guidelines for the treatment of depressive disorders. *Canadian Journal of Psychiatry*, 46 (supplement 1), 735.

Elder Suicide in Native Communities

How Valuing and Including our Seniors Can Make All the Difference

Among the many health challenges facing our elders, suicide is all too often a neglected problem. However, in the United States, suicide rates are highest among the elderly⁵ and continue to rise. Unfortunately, throughout the world, elders present with high suicide rates as well. In Spain¹² and Hungary¹⁵, suicide rates increase with age. In the United Kingdom, suicide rates peak after age 75.^{9,26} In Germany, over half of all suicides are committed by those over age 65.²⁸ Suicide rates are also high for the elderly in Canada.²⁴

High rates of suicide for the elderly, however, are not simply a phenomenon of the western world. In Japan, individuals over age 65 account for 12% of the total population, but account for 29% of all suicides.²⁹ In Singapore, suicide rates for those over age 65 are more than three times the national rate.²¹ Elderly suicide rates also are high in Australia and New Zealand.²⁴

Elderly suicide rates are generally accepted throughout the world to be the highest of any age group,²⁵ and many reasons have been postulated for this disturbing trend. Obvious biological factors occur with aging, and among these, reduced brain serotonergic activity [i.e., activity involving the brain chemical serotonin] may be associated with suicide.⁷ Postmortem studies demonstrate that a psychiatric disorder is almost always present in elderly persons who commit suicide. When their histories are reviewed, 90% of elder suicides have at least one Axis I diagnosis as outlined in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV²).^{6,14} Depression is the most common psychiatric diagnosis among these elderly persons. Psychological factors such as stressful life events or somatic illness can also serve as important precipitants for suicide in the elderly.¹³

Particularly intriguing, however, is the idea that cultural differences can affect elderly suicide rates. Even in countries with high elder suicide rates, such as Australia⁴ and Singapore,²¹ elder suicide rates differ among various ethnic groups within that society. Japanese suicide rates have also differed between urban areas, which had relatively lower rates, and some rural areas with very high rates of elder suicide.³⁰

The most prominent reflection on how culture affects suicide comes from Emile Durkheim.¹¹ At the turn of the century in his classic work *Suicide*, Durkheim introduced the notion that “suicide varies inversely with the degree of integration of domestic society.” [In other words, w]hen one is tightly bound to society, suicide rates should decline, and when one is more peripheral to society, suicide rates should increase. Durkheim theorized that during times of social or economic upheaval, such as the Great Depression, suicide rates rose, whereas at other

times when society was drawn together, such as World War II, suicide rates declined.

This theory is particularly useful to partially explain the high suicide rates among the elderly in much of the world. In the United States, for example, a person’s value and identity are often tied to one’s job; when that job is removed at retirement, that person is less “integrated” into “domestic society” and the suicide rate rises. Suicide rates are not only higher for the elderly, but are highest for elderly men who perhaps suffer more from the loss of their job and may be less well “integrated” into society. Our society has been accused of ignoring the elderly and not respecting them or asking them to contribute their years of experience to society. Their suicide rates reflect this sad statement. To further explore this idea, it would be helpful to investigate a culture where elders do not have higher suicide rates than the rest of the population to discover how social factors in a changing society may be protective for them. A study of Alaska Native suicide provides such a perspective.

Alaska Natives constitute Alaska’s indigenous population, numbering about 94,000 individuals, including Eskimos who live in the Arctic, Aleuts who live along the Aleutian chain of islands, and Indians who live in the interior and Alaska’s panhandle coast. Of the 94,000 Alaska Natives, 6,481 are above age 60 and 53% of those are female, according to the 1992 Alaska census estimates. Until the mid-1960s, suicide rates for Alaska Natives were the same as for the rest of the US population.¹⁸ However, after oil was discovered on the north slope of Alaska and economic development of the region expanded, Alaska Native suicide rates doubled that of the US rates by 1970.²² Alaska Native suicide rates more than tripled (43/100,000 persons) the US rate by the mid-1970s.¹ A review of death certificates of Alaska Natives who committed suicide from 1979 to 1984 showed that the prototype suicide victim was a young, single man who shot himself in the early morning hours.¹⁹ He was more likely to have a history of alcohol abuse than age-matched controls.²⁰

During the years suicide rates vastly increased, Alaska had an economic “boom” similar to the gold rush it experienced previously in its history. The development of vast oil deposits on the north slope of Alaska brought economic prosperity but also cultural confusion for Alaska Natives. With this influx of money through the “oil boom” and influence of western civilization through the oil industry and television, young Alaska Natives were offered many options for a new life but were removed from their own “domestic society.” The influx of money and social

Paul Kettl, MD

Paul is Chair of the Department of Psychiatry at Pennsylvania State College of Medicine, USA.

Excerpted from Kettl, P. (1998). Alaska native suicide: Lessons for elder suicide. *International Psychogeriatrics*, 10(2), 205-211. Publisher: Springer Publishing Company Inc., New York, 10012. Used by permission.

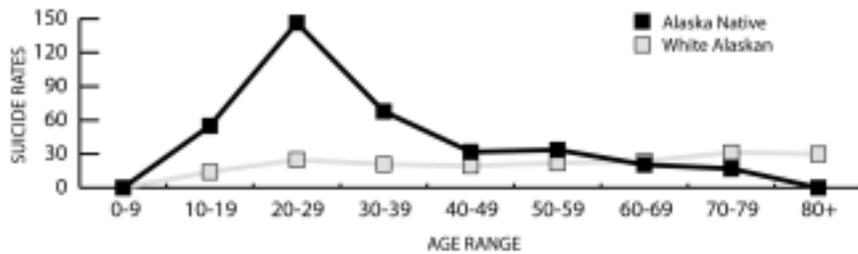


table 1 – suicide rates per 100,000 persons, 1985-1994, for both sexes

change offered Alaska Natives new choices in lifestyle but eliminated traditional ways. Young Alaskans often could choose any lifestyle, but were removed from their past and traditions. Another cost of this rapid economic development was an increase in suicide rates.¹⁷

Remarkably, however, the rise in suicide rates occurred entirely in young persons. In the late 1960s, there was no increase in suicide rates in those persons over age 35,³ and by the 1970s despite the general increase in suicide rates, Alaska Native elder suicide rates were decreasing.²³ Furthermore, from 1979 through 1984, no Alaska Native over the age of 55 committed suicide.¹⁹ While the Alaska Native lifestyle was undergoing a remarkable change, youth suicide rates skyrocketed but elder suicide rates dropped to zero.

An update and further exploration of these data help to provide clues to the cultural factors affecting elder suicide rates. ... Despite the increase in Alaska Native suicide rates with the Alaska oil boom, elder Alaska Native suicide rates decreased and then became nonexistent. These rates still remain much less than for age-matched White Alaskans or for those in the same age group in the United States or other countries [see Table 1]. This remarkable fact deserves further explanation.

When cultural change affected Alaska Native society, young people were further distanced from the teachings of their traditions and their suicide rates greatly increased. However, with this change, Alaska Native elders enjoyed growing respect and admiration for their knowledge of Alaska Native culture and tradition, which were being overwhelmed by economic growth and the introduction of television. Alaska Native elders were revered because they had survived several periods of change,

including a Japanese invasion of Alaska in World War II, the transition to statehood, and the economic expansion that came with the oil boom. These elders also knew, understood, practiced, and could teach others the traditions of a lifestyle that had nurtured a society for centuries at the inhospitable edge of the earth. The status and social importance of Alaska Native elders grew as the rate and amount of change increased. The maintenance of the traditional ways of the elder population, in the midst of social and cultural changes within Alaska Native society, helped prevent their suicide rate from rising and possibly may have contributed to the decline in the rate. Unfortunately, over the last decade, as cultural and economic changes settled, suicide rates for Alaska Native elders began to increase and now are approaching general US rates. Still, Alaska Native suicide rates decrease with age after age 50, and suicide is nonexistent after age 80.

Eastern Europe provides another example of how cultural change can raise general suicide rates. With the fall of communism, vast social change has occurred in these countries. Comparing suicide rates for 1987 with rates for 1991/1992 showed an increase in suicide rates in general in eastern European countries, but a decrease in suicide rates for those over age 75.²⁷

The cultural lesson from Durkheim's thoughts on suicide and the Alaska Native experience is that factors that bind elders to a society should decrease suicide rates. These need not be grand ideas or changes, but simple factors linking the elderly to the rest of society. In Italy, a study that examined a telephone service designed to provide elders with home assistance or an alarm that the elder can activate to call for help showed that those elders who were connected to the system had a much lower suicide rate than the general elderly population.⁸

Those who provide medical care for the elderly should also recognize depression and suicide as potential problems. In Ontario, Canada, over 80% of persons over age 65 who committed suicide had not had psychiatric care.¹⁰ The elderly may not express symptoms of depression directly,¹⁶ but any elder who does not have support from his or her family, peer group, or other social networks must be viewed as being more at risk for suicide.

Even though suicide rates throughout the world increase for the elderly, the epidemiology [i.e. the study of the factors associated with the presence or absence] of Alaska Native suicide over the last few decades demonstrates that elderly suicide rates need not be high. The economic and cultural changes associated with the "oil boom" in Alaska dramatically raised general suicide rates. At the same time, the Alaska Native elders were drawn closer to their "domestic society," and their suicide rates decreased. With the acculturation of these changes over the last several decades, Alaska Native elder suicide rates are beginning to come closer to general US rates.

The lesson from the Alaska Native experience is that high suicide rates among our elderly are not inevitable. Social changes that connect elders to the rest of society may reduce their suicide rates. ■

other ethnocultural aging resources

- Baker, F.M. (1996). Suicide among ethnic elders. In G.J. Kennedy (ed.), *Suicide and depression in late life: Critical issues in treatment, research, and public policy*. (pp. 51-79). New York: Wiley & Sons.
- American Psychiatric Association. (1994). *Ethnic minority elderly: A task force report of the American Psychiatric Association*. Washington, DC: American Psychiatric Press.
- Ferraro, F.R., Bercier, B. & Chelminski, I. (1997). Geriatric Depression Scale-Short Form performance in Native American elderly adults. *Clinical Gerontologist*, 18, 52-55.
- Hall, K.S., Gao, S., Emsley, C.L., Ogunniyi, A.O., Morgan, O. & Hendrie, H.C. (2000). Community screening interview for dementia: Performance in five disparate study sites. *International Journal of Geriatric Psychiatry*, 15, 521-531. (NOTE: The Community Screening Interview tool was specifically designed for cross cultural studies; one of the five study sites focuses on Cree Natives in Winnipeg)
- Harris, H.L. (1998). Ethnic minority elders: Issues and interventions. *Educational Gerontology*, 24, 309-324.
- Kaufert, J.M. & Shapiro, E. (1996). Cultural, linguistic and contextual factors in validating the mental status questionnaire: The experience of Aboriginal elders in Manitoba. *Transcultural Psychiatric Review*, 33, 277-296.
- Meisenhelder, J.B. (2000). Faith, prayer, and health outcomes in elderly Native Americans. *Clinical Nursing Research*, 9, 191-203.
- Padgett, D. (ed.). (1995). *Handbook on ethnicity, aging, and mental health*. Westport, CT: Greenwood Press.

footnotes

The complete list of the studies footnoted in this article is available upon request or by consulting the article in its complete and original journal format.

The Not-So-Shocking Facts About ECT

Electroconvulsive therapy (ECT) was first introduced in 1938 by Cerlitti and Bini in Italy. Since then, there have been numerous changes with regards to ECT devices, techniques, reasons to consider ECT, and anaesthetic procedures. ECT practice guidelines have been developed in Canada (1992), Great Britain (1995), Australia (2000), and the United States (2000), which update standards for delivering ECT. The recently-published BC Guidelines for ECT (2002), soon available online at www.healthservices.gov.bc.ca/mhd, attempt to set the standards for ECT in BC. Despite the stigma and media controversy surrounding ECT, “modern” ECT is safe and likely the most effective single treatment for certain psychiatric conditions. It can be life saving in some of those with suicidal behaviour, and in those with malnourishment and dehydration. The following attempts to dispel some of the myths surrounding “shock” therapy.

What is “Modern” ECT?

ECT involves the passage of electricity through the skull and into the brain in order to produce a brief convulsion. A typical successful course constitutes 6-12 treatments. Despite many hypotheses, the mechanism of action is unknown, but ECT effectively treats a number of psychiatric conditions, (most commonly for depression, sometimes for mania, and occasionally for schizophrenia), and medical conditions (e.g.

Parkinson’s Disease). Some will benefit from outpatient, less frequent continuation of ECT in order to maintain improvement. “Modern” ECT over the past 25 years incorporates the mandatory use of modern ECT devices, general anaesthesia, and muscle relaxation. Heart monitoring and oxygenation are essential during and after ECT. “Modern” ECT looks at the best available techniques in order to minimize side effects, and is stringently applied only for certain conditions deemed treatable by ECT, but not for individuals considered strictly “antisocial” or “criminal.”

Is ECT Painful?

ECT is performed under general anesthesia and no discomfort is experienced during treatment. Properly applied ECT does not lead to burns to the skin or hair. On occasion, headaches and muscle aches are side effects, which are not incapacitating and last less than a day.

Does ECT Cause Brain Damage?

There is no evidence that, in the era of “modern” ECT, it causes “brain damage,” (i.e. structural changes to the brain). ECT does not change a person’s personality, nor is it designed to treat those with just primary “personality disorders.” ECT can cause transient short-term memory — or new learning — impairment during a course of ECT, which fully reverses usually within one to four weeks after an acute course is stopped. Whether ECT can rarely cause

memory loss for certain (but not all) types of remote events is controversial and is an area of active research. Adjusting the dose of energy delivered and the ECT technique employed can minimize the risk of memory impairments.

Is ECT Risky for the Elderly?

In general, being elderly does not mean there is an increased risk for complications related to ECT. In fact, studies indicate the elderly respond to a higher degree to ECT than younger adults. Being elderly means the increased likelihood of having medical conditions and dementia. Having certain medical conditions can increase the risk when undergoing ECT, and need to be considered in light of potential benefits. It is generally safe to administer ECT in those with dementia, and could be considered in these individuals who may also have depression (though the evidence is less clear regarding its use for people with dementia without depression).

How Were the Guidelines Developed?

The guidelines were developed by several UBC-affiliated psychiatrists, a nurse clinician, and an anaesthetist. Dr. Martha Donnelly, Head of the Division of Geriatric Psychiatry, chaired the group. An advisory committee was also formed that was comprised of representatives from the UBC Department of Psychiatry based in Vancouver and Prince George, from the BC Ministry of Health, from

the Mood Disorders Association, and from the Department of Psychiatry at the University of Toronto. The guidelines establish contemporary standards for delivering ECT throughout the province, and deem each local health authority as the organization responsible for implementation and monitoring. The guidelines incorporate how consent for ECT should be obtained in the light of the recent Health Care Consent Legislation and Facilities Care Act (HCCFCA) of BC encompassing competency issues, and in light of the Provincial Mental Health Act governing voluntary/involuntary patient status and treatment. Those with dementia may not be competent to provide consent, and the guidelines have special sections dealing with these individuals who require ECT. In the HCCFCA, there is also a provision to automatically involve the Community Legal Assistance Society to advocate for such individuals deemed “incompetent to consent for ECT” under this piece of legislation.

Concluding Remarks

ECT is a safe and effective procedure for a variety of conditions in younger and older adults. Negative depictions of ECT in the press and cinema have contributed to misperceptions surrounding current ECT practice. This is unfortunate, as ECT remains an important tool in combating the devastating consequences of certain mental illnesses. ■

Peter Chan, MD

Dr. Chan is Head of the ECT Program at Vancouver General Hospital.

When Sedatives Do More Harm than Good

The Use and Misuse of Benzodiazepines

Harkirat Kaur

Harkirat is a Simon Fraser University co-op student presently working for CMHA BC Division.

Benzodiazepines are a class of sleeping pills and tranquilizers that are often prescribed to help people deal with sleep problems, muscle tension, anxiety, depression and stress. They are most commonly prescribed to older women. Also known as sedatives, nerve pills, and muscle relaxants, they work by depressing or slowing down the central nervous system.

Benzodiazepines can be helpful in the short-term for reducing anxiety and aiding sleep during a crisis in a person's life. However, they only provide temporary relief, as they treat the symptoms and not the cause. They should also only be taken for a short period of time (seven to ten days), as prolonged use can result in physical and mental dependency and severe withdrawal symptoms. Signs of dependency can include feelings that the effects are wearing off, the need to increase the dosage over time, the taking of extra pills in stressful situations, unsuccessful attempts to quit or reduce the dosage, inability to cope without the drug, and cravings.

While benzodiazepines are classed as "minor tranquilizers" to differentiate them from "major tranquilizers" (which are used to treat psychiatric problems like schizophrenia), this can be misleading as the effects of benzodiazepines are not "minor" at all. Some people can experience extreme side effects. These can include physical complaints like drowsiness, dizziness, heart palpitations, headaches, nausea and sensitivity to light, noise, touch or smell, as well as cognitive impairments like confusion, poor concentration, forgetfulness and moodiness. Perhaps even more disturbing is

that often, when benzodiazepines are taken on a long-term basis, they can instead worsen the symptoms of depression and anxiety that they were supposed to be alleviating. In addition, a 1999 study conducted at the National Institute of Public Health in Oslo found that women taking tranquilizers and sedatives (including benzodiazepines) were at a much higher risk of falling and consequently suffering from hip fractures than the general public.

Unlike other medications, the side effects of benzodiazepines often do not go away when drug use is stopped. In fact, women often experience intense withdrawal symptoms when trying to reduce their reliance

what are they?

There are currently about 16 different benzodiazepines available in Canada.

These include the following:

- | | |
|-----------------------------|-------------------------------|
| ■ Valium (Diazepam) | ■ Ativan (Lorazepam) |
| ■ Resoril (Temazepam) | ■ Halcion (Triazolam) |
| ■ Rivotril (Clonazepam) | ■ Xanax (Alprazolam) |
| ■ Librium (Clordiazepoxide) | ■ Tranxene (Clonazepam) |
| ■ Serax (Oxazepam) | ■ Mogadon (Nitrazepam) |
| ■ Imovane (Zopiclone) | ■ Somnal/Dalmane (Flurazepam) |

on the drug. Joan Gadsby, a vocal critic against benzodiazepines, points out that sudden withdrawal from these drugs can sometimes even precipitate psychosis, and in extreme cases, death. Moreover, combining benzodiazepine use with alcohol or other drugs can be lethal.

There are several possible reasons why benzodiazepines are most commonly prescribed to older women. Perhaps this is partly because many medical and neuropsychiatric conditions that are associated with sleep disturbance are common in the aged, such as strokes, dementia and heart failure. Moreover, benzodiazepines are often prescribed to older women to help them deal with the symptoms of menopause. A 1995 study conducted by BC's former mental health advocate, Nancy Hall, found 30% of North Shore senior women to be taking benzodiazepines.

Since the risk of over-reliance on benzodiazepines is so high in older women, it is important for them and others to learn ways to gain control over the use of their medication. The way they can do this is to educate themselves about the medications, ask the doctor and pharmacist for clarification, discuss it in relation to other medications they are taking, never borrow or share medications, and talk to the doctor if the pill does not seem to be working, or is making them uncomfortable.

Besides learning responsible use of medications, there are other ways in which a person can deal with transient stress and anxiety. For instance, there are many alternative ways to try and get a good night's rest. Making the bedroom as conducive to sleep as possible, drinking warm milk or water before bed, and avoiding caffeine in the evening are some things that can help reduce sleep problems. Learning relaxation techniques, finding enjoyable activities, and leading a healthy lifestyle by eating well and exercising can help alleviate anxiety as well. In addition, a person can build strength by connecting with others. Support from friends, family, counsellors, or support groups can be invaluable in helping a person deal with temporary anxiety and stress in their lives. Cognitive-behavioural therapy has much

withdrawal watch

Benzodiazepines are only meant for emergency, short term use. However, for some people who may have developed a dependency, withdrawal should be supervised by a health professional so that the person is better able to cope with the withdrawal symptoms which may result. Withdrawing from benzodiazepines can be a very erratic and uneven process, and every person's experience of it will be different. However, here is a list of some possible withdrawal symptoms:

- Symptoms common to all anxiety states (e.g., excitability, weakness, nausea, tremours, seizures)
- Tightness, like a band around the head
- Feelings of disconnect from oneself and one's environment
- Suicidal thoughts, paranoia
- Tingling, numbness
- Hallucinations
- Outbursts of rage and aggression
- Pins and needles, skin sensations
- Hypersensitivity to sound or touch
- Increased saliva, difficulty swallowing

success for more chronic anxiety or anxiety disorders.

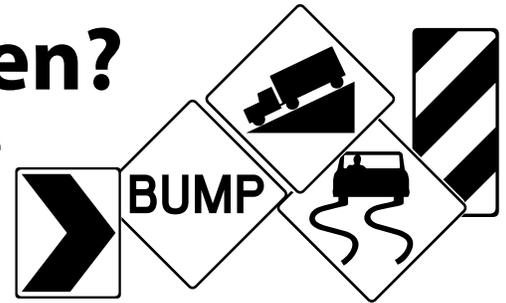
In conclusion, benzodiazepines are a class of drugs that can be helpful *in the short-term* to relieve a person of anxiety. However, more needs to be done to educate users of these drugs on their side effects and the possibilities for over-dependency. Benzodiazepine users also need to know that there are alternatives, and that it is possible to lead a healthy life without having to rely excessively on tranquilizers, and without excessive anxiety. ■

related resources

- **Tranquility without Tranquilizers: Stopping the Misuse of Benzodiazepines**
Available at www.cmha-bc.org/content/resources/cmhapubs/cmhapubs.htm
- **What are Sleeping Pills and Tranquilizers?**
Health Canada. Available at www.hc-sc.gc.ca/seniors-aines/pubs/sleep/en/senior-e.htm
- **Preventing Falls in Older Patients**
Produced by Janssen-Ortho Inc. Eldercare. Available at CMHA BC or check out their web site at www.janssen-ortho.com

Is This Supposed to Happen?

Distinguishing Signs of Dementia from the Normal Cognitive Changes of Aging



Recalling names, finding keys or glasses, and remembering just what it was you wanted in the basement once you are down there, are the types of memory problems reported with increasing frequency by people as they move into older adulthood. Are these changes that are to be expected with increasing age as a matter of course, or are they the subtle, early signs of a cognitive disorder, like Alzheimer's disease?

Over the past 20 years, a substantial amount of research has been conducted to address this question and it has been demonstrated that some modest degree of cognitive change is to be expected with increasing age. Most notably, these changes have been observed on some types of memory tasks, like finding words and names quickly. At the same time, some changes in cognition are important indicators of a variety of disorders affecting older adults. For this reason, it is important that changes in cognition that are occurring with increasing frequency, or come on suddenly, are not dismissed too casually or overlooked.

What then are the early

cognitive features that distinguish between those persons who will decline to dementia over time and those who will not? Although research has been active in this area for over 30 years, to date it has not been possible to make precise predictions of this kind. That is, no one test or type of impairment has been identified as always predictive of decline. However, a few valuable lessons have been learned that can be used as signposts to guide us.

First, it is clear from the research literature that not all people who report or show some signs of cognitive impairment will progress to dementia. There is great variability between studies in the estimates of what proportion of people will develop dementia. Even so, it is typically the presence of memory impairment — the kind that's both observed as increasing by family or close friends and evident on specialized memory tests — that is related to future decline.

Second, changes in how a person behaves may also indicate early signs of a problem. For example, dramatic changes in how a person acts, such as extreme suspiciousness, withdraw-

al, or inactivity, may require prompt attention. Similarly, if people begin to have difficulty performing familiar tasks they have done for years, like preparing a meal or balancing a chequebook, this too may warrant further investigation.

Third, cognitive changes may be indicative of a wide variety of conditions seen in older adults, not just dementia. Some of these other conditions may require prompt medical attention, if permanent problems are to be avoided. For example, any abrupt change in cognitive functioning (e.g., confusion or disorientation) or sudden onset of unusual behaviour is often indicative of an underlying physical problem that, without prompt treatment, can result in death. Similarly, low motivation and poor attention associated with depressive syndromes in older adults may affect cognitive abilities. Treatment of depression, with medications or through individual or group counselling, may elevate the person's overall level of functioning through improvement in mood, energy level, and/or sleep quality.

In conclusion, some chang-

es in cognitive functioning (e.g., recalling names quickly) in older adults are common, age-consistent, and are not cause for alarm. Others may be first indicators of an underlying problem. A variety of underlying problems may present with cognitive changes. Any abrupt or sudden changes in cognitive functioning are cause for concern and require prompt medical attention. Changes in cognition that seem to increase gradually over time require further evaluation, particularly when accompanied by changes in behaviour (e.g., withdrawal, suspiciousness, inactivity). A high degree of vigilance is required for the early detection of treatable emerging conditions, but this must be balanced with the understanding that some modest changes in cognition are to be expected with advanced age, and not all persons with mild cognitive problems show deterioration over time. ■

Holly Tuokko, PhD

Holly is the Associate Director of the Centre on Aging at the University of Victoria, where she is also an Associate Professor in the Department of Psychology.

related resource

Signs of Normal Memory Loss associated with Aging: www.baycrest.org/memory/memory.html. An interactive web site explaining the difference between the normal signs of memory loss and those associated with more serious problems.

Achieving a Balance

Relating Physical and Mental Health in Seniors

Chris Rauscher,
MD

Chris is a Clinical Assistant Professor of Medicine at the University of British Columbia and a Community Consultant in Geriatric Medicine for the Vancouver Coastal Health Authority.

There is much to be learned from ancient cultures that valued achieving a balance in all things, including a balance in our physical and mental states. With the advent of technology and a more “Western” way of thinking, there has been a shift away from viewing health as a balance achieved for living towards viewing the “parts” of a person that could be analyzed and treated through the technology of Western medicine. However, for people living with the complexities of life, and with complex health conditions, the struggle to maintain the balance in life and health is paramount. Health professionals working to support people whose health is affecting their quality of life can be most effective by helping individuals towards maintaining this balance in their health and lives. This particularly relates to situations where there are complex physical and mental health issues.

It is not uncommon for there to be mental health issues, particularly anxiety and depression, in association with chronic physical disease. For example, chronic pain is a condition where physical and mental health symptoms co-exist, and where a more holistic viewpoint and approach is necessary but, unfortunately, often not brought about. Often, this is because the mental health issues may not be recognized as part of the picture, or the mental state may be thought to be due to personality factors. Or, if the mental health issues are seen as significant, they may be dealt with separately from the management of the physical symptoms of the chronic pain.

There are many more specific and common scenarios that could be highlighted where it is necessary to recognize and work with both physical and mental health, particularly in working with the older adult:

- the person who is presenting with anxiety (perhaps a nursing home resident on the call bell at night) related to underlying and unrecognized physical symptoms, e.g., heart failure
- the person who is presenting with “lack of motivation” and possibly depression, related to unrecognized physical symptoms, e.g. heart or respiratory failure, or chronic pain
- the person who appears to have the recent onset of “confusion” and/or hallucinations, who may have a delirium as a result of an underlying physical health condition
 - the person with a chronic mental health condition whose symptoms get worse in relation to an unrecognized underlying physical health condition, e.g., a person with chronic schizophrenia who develops a thyroid disorder
 - the person with a chronic mental health condition who develops physical symptoms such as falls as a result of a mild physical health condition (mild stroke) with the psychiatric medications possibly now contributing to the falls.



There are many more examples that could be listed, but these are a few common situations illustrating the inter-relationship between physical and mental health that must be recognized and addressed to support the affected person to regain the balance in their health and life. Such complex situations are best addressed by the family physician supported by other health professionals, including medical and psychiatry specialists, through a holistic team approach.

The most successful approaches are those that recognize the need to approach both the physical and mental health aspects of the chronic condition, pain for example, and work to support the persons living with the chronic disease in the self-management of their health for achieving the desired balance in their life. These approaches combine multiple interventions, which involve a partnership between the persons living with chronic disease, their network of support, the family physician and other health professionals, health educators and community organizations.

In some jurisdictions, such “collaboratives” for management of chronic diseases, e.g., diabetes, have been pulled together. In this approach, teams form which can provide support from the primary health care level, on through to interdisciplinary care and support approaches. The family physician is often the central professional who coordinates with the other health professionals to ensure that the necessary care and support is delivered and that the necessary collaboration comes about.

Self-management education strategies and courses and community development strategies can also be included as part of the approach. In British Columbia, these more holistic approaches are in the early stages of development and still require being pulled together in a more cohesive way.

The existing elements include:

- provincial physician guidelines for support and management of specific chronic diseases (in progress)
- teams approaches (such as the “Falls Module” and other UBC projects)
- “shared care” or specialist physician support to primary care physicians dealing with chronic health conditions (in discussion)
- self-management courses for persons living with chronic diseases (Vancouver).

In conclusion, this article advocates a refocusing of our approach to health. Health should be seen as a balance of physical and mental functioning, which is necessary to achieve the desired balance for life and living. It is incumbent on those working to support people living with health impairments to promote and develop such approaches within their work and community settings. ■

Support and Assistance for the Vulnerable Older Adult and Seniors with Dementia

How To Plan Ahead

As we get older and as we watch our loved ones get older, making plans for our future becomes more and more of a priority. Today, there are several tools available to help individuals in planning for a time when they might need assistance to make personal, financial and/or legal decisions. A person might choose to give an Enduring Power of Attorney to a trusted family member, friend or financial institution. Alternatively, a person might choose to make a Representation Agreement that encompasses not only his/her financial affairs but also decisions about his/her health and personal affairs.¹

Both of these legal planning tools will allow your family to care for you at a time when you might need more support. A diagnosis of dementia can be terrifying for an adult and the adult's family. By planning in advance and ensuring there is someone you trust who can assist you with your financial and personal affairs, you lessen the stresses for yourself and your caregivers. An Enduring Power of Attorney or Representation Agreement can also help protect you from potential financial abuse or neglect. A health care Representation Agreement will allow your Representative to ensure you receive the right amount of support and assistance to help you maintain your independence in a manner consistent with your

values and principles.

How To Access Help

In British Columbia, *The Adult Guardianship Act* further protects all adults' right to a presumption of capability, right to self-determination and right to access support and assistance. If you know of any person who is not receiving support and assistance, suffering financial and/or physical abuse, neglect or self-neglect, and is unable to seek help on his/her own, there is a Designated Agency regulated by the *Adult Guardianship Act, Part 3* that can assist you. Your local health authority is the Designated Agency (e.g. Continuing Care, Mental Health) and the nearest location for your community is listed in the Blue Pages of the phone book. The Designated Agency is required to investigate circumstances of alleged abuse, neglect or self-neglect of vulnerable adults and ensure they are receiving the appropriate level of care to which they are entitled.

Often people have concerns about how a person's finances are being managed. The Public Guardian and Trustee of British Columbia has a mandate to protect the legal and financial interests of vulnerable adults. *The Public Guardian and Trustee Act* gives the Public Guardian and Trustee the authority to investigate situations of financial abuse by a Power of Attorney, Representation Agreement or Trustee:

what is abuse, neglect and self-neglect?

Abuse is deliberate mistreatment that causes physical, mental or emotional harm, or damage to or loss of assets. It includes:

- intimidation
- humiliation
- physical or sexual assault
- overmedication
- withholding needed medication
- censoring mail
- invasion or denial of privacy
- denial of access to visitors

Neglect is any failure to provide necessary care, assistance, guidance or attention if that failure causes, or is reasonably likely to cause, within a short period of time, serious physical, mental or emotional harm, or substantial damage to or loss of assets.

Self-neglect is any failure of an adult to take care of himself that causes, or is reasonably likely to cause, within a short period of time, serious physical or mental harm or substantial damage to or loss of assets. It includes:

- living in grossly unsanitary conditions
- suffering from an untreated illness, disease or injury
- suffering from malnutrition that is likely to severely impair a person's physical or mental health

- if the adult is mentally incapable of managing his/her financial affairs,
- there is identified risk, and
- there are no other family or friends available to assist.

The Public Guardian and Trustee's office also reviews situations where there is no pre-existing Power of Attorney/ Representative/Trustee and a vulnerable adult is unable to pay his or her bills, manage his or her investments, or is being financially abused or exploited by a third party. If there are no other family or friends who can help the vulnerable adult, the Public Guardian and Trustee will seek the legal authority to act as Committee of Estate for that person.

If you or your family want to investigate the best pre-planning tool to meet your needs, you can speak with a lawyer for legal advice or contact the Representation Agreement Resource Centre ((604) 408-7414). You can also contact the Assessment and Investigation Services Team at the Public Guardian and Trustee for general information or to discuss concerns you may have about a vulnerable adult living in your community ((604) 775-0202), or www.trustee.bc.ca. ■

related resource

Representation Agreement Resource Centre www.rarc.ca

Sara Campbell

Sara works with the Public Trustee's Office in Vancouver.

footnote

- ¹ The Provincial Government recently announced that changes will be made to the *Representation Agreement Act* which will likely occur in the Spring of 2003. Visit the Public Guardian and Trustee web site at www.trustee.bc.ca for more information.

In May 2002, a group of distinguished British Columbians wrote an open letter to the editor, expressing their concerns over the province's Assisted Living Strategy affecting seniors. The letter touches on issues that will potentially affect people with disabilities, including those with mental illness. The full text of the letter appears below.

We, the undersigned, have concerns about the provincial government's plan to divert federal funds for affordable housing to finance assisted living units for seniors in this province. Waiting lists for seniors housing and residential care are growing out of proportion, and with reductions in home support services, never was there a more important time to seek input from the community before embarking on redesign of how seniors housing and health care services are to be delivered.

In the government's pre-election promises, they said they would provide 5,000 long-term care beds by 2006. Instead, it appears that they are now ready to use recently-allocated federal government housing funding to create 3,500 assisted living units.

Although assisted living is an appropriate housing model for some, it should not be used to replace existing models such as long-term care facilities. We are concerned about the immediate needs of BC seniors. Our other concerns are:

- That by channeling housing dollars into the delivery of assisted living for the frail elderly, the housing, health and services needs of other low income seniors, families, individuals and the disabled may not be met.
- That community-based home nursing, home support programs and adult day cares may not be adequately funded to allow seniors not in care to live independently in the housing of their choice.
- That family and informal caregivers of individuals with dementia may not have access to appropriate supports, services and housing.
- That reductions of residential care beds may force seniors with moderate to high level care needs to live at risk in the community.
- That non-profit housing providers may be forced to offer care, supports and services without appropriate preparation, properly trained staff and adequate budgets.
- That the recent federal/provincial housing agreement of \$89 million dollars in matching funds will not be used to continue to provide housing for seniors, low income families and individuals, and the disabled through a variety of programs including supportive and assistive living.

Finally, we urge government to initiate a province-wide consultation with health care, housing and seniors' groups before embarking on what many are concerned may neither meet British Columbia's health or housing needs.

Dr. Margaret Fulton, Order of Canada
 Henry C. Hightower, PhD, Professor Emeritus, UBC Community and Regional Planning
 Mary Hill, Associate Professor Emerita, UBC School of Social Work
 Dr. Martha Donnelly, Geriatric Psychiatry, UBC
 Dr. Chris Rauscher, Geriatrician
 Dr. Gloria Gutman, Director, Gerontology
 Dr. Michael Hayes, Associate Professor, Dept. of Geography, SFU
 Dr. Neena Chappell, Director, Centre on Aging, University of Victoria
 Carol Ward Hall, BC Coalition to Eliminate Abuse of Seniors
 Ivan Cummings, Former Chair, BC Seniors Advisory Council
 Phil Lyons, Co Chair, BC Seniors Network
 Bruce Ellner, Chair, Caregivers Association of BC
 Rudy Lawrence, President, Council of Seniors Citizens Organizations
 Kimiko Karpoff, Advocate, Lower Mainland Network of Affordable Housing
 John Aubry, Seniors Summit Coordinating Committee
 Val MacDonald, Executive Director, Seniors Housing Information Program
 Vanessa Geary, Coordinator, Tenants' Rights Action Coalition

For information, please contact:

Vanessa Geary, Tenants' Rights Action Coalition: (604) 255-3099, ext. 222
 Val MacDonald, Seniors Housing Information Program: (604) 520-6621



Dealing with Physical and Mental Health Conditions

Then and Now

My name is Barbara Berry. I'm 56 years-old and I've lived in Dawson Creek since 1982. Some of you may know me, as I am the president of CMHA BC Division. I qualify as a senior — just. You would have had a little laugh, I'm sure, at the jig I did when I received my first senior discount. At this point it is so new to me that it is amazing; later I'm sure it will be just ho-hum!

This edition of *Visions* is about seniors and how dealing with our mental illness changes over time. I think for many of us as we age, it's also about dealing with both mental illness and physical illness and how that can impact the treatment of each.

When I crashed as a twenty-five year old, I was young and healthy. There was nothing wrong with me except chronic depression. In 1978, when I was thirty-two, I developed diabetes during a pregnancy which resulted in a stillbirth. As long as I ate in moderation and kept active, though, I was able to control my blood sugars. This even helped my depression.

For a long time, I was able to handle both the depression and the diabetes without medication. I did all things in moderation and was pretty darn proud of myself. Then in 1985, exercise and diet were no longer working for the diabetes and my metabolism was not responding well, so the doctor put me on insulin.

Over the next year, I became sicker and sicker with debilitating migraines. My depression worsened. I followed the diabetic diet to the letter. My mouth burned when I ate my meals, but I ate the six small meals prescribed. I was on a cocktail of pills that prevented me from taking even a decongestant.

Finally, a breakthrough came when I learned I was allergic to my insulin. I also found that I was allergic to half the foods I had been eating every two hours. Going back through my childhood with the allergy specialist, I discovered I had food sensitivities as a child. The beef-pork insulin I was given in 1985 reactivated those sensitivities, and now my bombarded system couldn't handle it any more.

They fasted me in hospital for three weeks, followed by over a year of avoiding the foods to which I was allergic, and then slowly reintroducing them. They were able to withdraw me from insulin for a few years, but my whole metabolism had been totally upset. We're still dealing with that.

Research has shown the impact of allergies on the brain. Even though I was able to maintain a good grade point average at university, in 1989 I couldn't read, comprehend and retain a single page of the text book for my marketing course at the local college. My depression was severe: I couldn't sleep, and I was overwhelmed with indecision and insecurity about my work. My mood swings were

affecting my employees and my family: melt down!

We've looked at how the onset and progression of my physical illness of diabetes adversely affected my depression and its treatment. Now, I'd like to look at how the hospitalizations which treated both each time, differed.

In the spring of 1989, my family doctor put me on Three East, the medical ward in Dawson Creek, for a three-week fast to clear my body of the allergens that had slowly been killing it. Because my metabolism had been so badly affected, the doctor also put me on twice-daily physiotherapy. My depression was bad, and I couldn't sleep and was jumpy, so he had the psychiatric nurses teach me relaxation techniques.

Most importantly, he had what I dubbed the "A Team" help me. The "A Team" consisted of the diabetic nurse educator, the psychiatric social worker (counsellor) and the dietitian. They met with me separately, and using their individual expertise helped me regain my confidence and learn new skills in coping with both the depression and diabetes — especially with the feeling of failure.

The nurse's station was an open station with a counter where you could lean and talk to the nurses. If they were busy, they would hurry you along, but for the most part, the nurses would find time to visit you in your room, especially the night staff, who gave me back

rubs at night to help me relax and sleep. You came to look forward to those twice-daily visits with the nursing staff. Those were special, and if you had no visitors, you at least had the staff.

Both my mental and physical health began to improve. My depression improved significantly, but we also discovered how responsive it was to the allergens. About a month after leaving the hospital, I began taking multi-vitamins to boost my immune system and subsequently began to feel poorly. It took us three weeks, but we discovered the culprit was a fish oil in the vitamins, and I am allergic to fish.

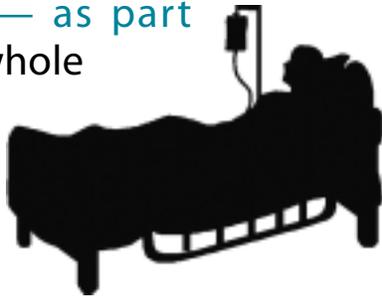
I continued weekly counselling sessions with the psychiatric social worker for about six months after my hospital stay, to help me cope with my return to work, but the treatment of my diabetes had set up a reaction which adversely affected my metabolism and my depression, and which still affects my mental health today.

Later, in the spring of 1996, I found myself in the garage, unable to turn off the car after I came home from a great evening watching a movie with a girlfriend. Suddenly, I didn't want to live any more. It seemed easier to simply "go to sleep" while listening to Brooks and Dunne on the tape deck. After about ten minutes, I was able to force myself to turn off the car, go into the house and call my girlfriend. She made me promise to call my doctor, who

Barbara Berry

Barbara is the President of CMHA BC Division. She lives in Dawson Creek.

As we get older, it's especially important that our physical health concerns are looked at as part of our mental health — as part of the whole picture.



referred me to our local psychiatrist. By June of that year, my fiftieth birthday, I was, for the first time in my life, on antidepressants.

I don't know what there is about spring. That's when I first crashed and that seems to be my pattern. When I crashed in 1989, I was on no psychiatric medications, and my family doctor put me on a medical ward. This year, since I was under psychiatric care, I was put on a psychiatric ward.

As in 1989, the depression and diabetes were intertwined. The diabetes is more advanced now. At first I was a Type II, but I am termed a Type IIa or a Type Ia, which means that my body is no longer producing insulin; so I must now take insulin shots, which I've been doing for quite a number of years. I also must take pills to counter my body's resistance to insulin. So it is diet, exercise, insulin and pills that make up my regime. All four are equally important.

The symptoms that presented with this crash, as for the last, were for depression. I had been hiding in my bedroom, lying in bed unwashed for two weeks, recoiling when the phone rang or the doorbell rang, or when someone

knocked on the door. Unbeknownst to my husband, I hadn't eaten in those two weeks, nor had I taken any medication. Somewhere in my mind I must have decided I didn't want to die, so I plucked out my eyebrows one day. When that didn't gain my husband's attention, the next day I shaved my head.

That gained his attention, and I went to see my psychiatrist. She put me straight into the hospital, and immediately informed my family doctor that I was on the unit and that I was showing ketones [a sign of malnourishment] — not a good thing for a diabetic.

In 1989, the psychiatric ward was Three West, a ward among other wards. The present ward is in a new wing on the ground floor, which gives it a patio with smoking privileges. While that is good for the many patients who smoke, it is separated from all the medical wings, which presents other problems.

On this ward, the nurse's station is quite large and is glass-enclosed, keeping the nurses and other staff are away from the patients. You speak to the nurses through the windows, which sets up a distance between the patients and the staff, and as a result I felt no sense that they had any genuine involvement with me. The nurses did come out of their "cage," but it wasn't often.

When I was initially taken to my room, the nurse immediately grabbed my bag and went through it, looking for any sharp items which were not allowed on ward. There was a brief *do you mind?* while the search had already begun. Scissors, etc. were confiscated, and would be returned to me when I left. Again, I didn't feel any sense of welcome: just in for "sharps" and gone! There wasn't

any animosity, just a message of "let's get the business done!"

All confiscated was all my diabetic supplies and testing equipment. All of that would be done at the nursing station under their supervision. Thus began my life of being called four times a day for medications: breakfast, lunch, dinner and bedtime. We lined up and took our medications, and did testing for diabetes or other conditions on a first come-first served basis.

There were two nurses on duty each twelve-hour shift — one of whom was designated for meds. Medications are a very serious duty on a psychiatric ward, as there are some heavy-duty psychotropic drugs they have to deal with. Whatever my family doctor ordered on my chart, the psychiatric nurses stuck to rigidly. However, on a medical ward, the nurses know that if you have an insulin reaction on that dose, you can, for the next dose, drop it by two units. I had to wait until my next visit from the GP for that to happen. Some days I had as many as three reactions in a day.

During my second night there, I had an insulin reaction after "lights out." My training is to go first to the fridge and get an orange juice; then, take my blood sugars, and after waiting ten to twenty minutes, depending on how low my blood sugars are, take some further orange juice and test my blood sugars again. I repeat this routine until my blood sugars are at an acceptable level, and finally eat a protein and a carbohydrate to stabilize my blood sugars.

I had been sleeping when the reaction woke me. I stumbled out of my bedroom on instinct and found the kitchen and a box of juice my husband had put in the fridge for just

this purpose. The nurse on duty came out of her nurse's station and scolded me severely. She sent me back to my room with strict instructions not to do this again. If I should have another reaction, I was to remain in my bed and ring for the nurse.

This dictate is, I'm sure, a ward policy made for the well-being of the diabetic patient. However, it would have been so much easier for me if it had been done as part of an orientation to the ward, rather than as a scolding during a reaction. But then, there had never been an orientation to the ward, except by my roommate who was not a diabetic.

It sure would have been nice to have had a little human warmth during a difficult time. I felt very alone and very determined not to have another nighttime attack!

The Diabetic Teaching Unit teaches us to have our diabetic testing equipment accessible at all times. They teach us to carry it on our person, so we don't get it in difficulty out shopping or at work. Now I had to wait on the convenience of others who were not always available.

I entered the psychiatric ward with feelings of extreme anxiety and suicidal thoughts. When I began eating properly and taking all my meds, those thoughts disappeared. However, events on the ward, the lack of reassuring contact with the nurses, and highly elevated anxieties around my diabetes, in fact, kept me from reaching the degree of wellness I had hoped to achieve upon entering the ward.

When you enter a hospital, we all know you give up some control, no matter what ward you're on. You give up control for the good of your health. I've been in and out of hospitals since I was nine months old. ►

Through Sickness and Health

A Wife's Account of her Husband's Mood Disorder

Verne Smithman, 76, of Langley is proof that depression can strike any gender and any age.

In the early 1990s, Verne and his wife of 52 years, Kay, went through a chain of life-changing events that would set the stage for Verne's subsequent depression. First, he retired, albeit reluctantly because he liked his job. The couple also moved from Burnaby to Langley, also a somewhat reluctant decision on Verne's part although he seemed to adjust well to the change, staying active in community life. Then in 1991, Verne suffered a heart attack.

"He had a triple bypass and a valve replacement," says Kay. "He was very, very ill and ended up in the psychiatric ward over that. His nerves were so bad. He was at home here — he'd been a long time in the hospital — but he just couldn't sleep. He was so weak, I'd have to get him into bed and cover him up and before I could get to sit down, he'd be up again. This went on and on and on. So a psychiatrist came from mental health and I was so glad when he put him back into the hospital because I just couldn't handle it any more."

After the hospital stay, Kay says, the depression set in. As she consults the journal chronicling those years, she notes that before the depression, Verne entertained, talked and laughed and took pleasure in small things. Once the depression set in, he lost interest in everything including his two loves: music and reading. His loss of appetite dropped him from 170 lbs to a meagre 148. He couldn't make decisions and had a lot of anxious symptoms like worrying all the time about nothing — even sleeping to avoid worry — and feeling shaky. He also didn't want to go out in company or talk to people; even with one visitor, he wouldn't join in the conversation like he used to.

The Smithmans went to see the family doctor. "I was telling the doctor what he was like and he said to go to mental health," says Kay. "It was there Verne was tested and he was right off the charts."

She realizes, of course, things would be a lot different now if Verne had refused to see his doctor. "The main thing is the men don't want to talk about it and women are usually quite willing to. But I think that's men in general about a lot of things. I was so lucky that he realized his problems and wanted help. He figures the mental health people and the Langley Seniors Centre really saved his life."

It would soon turn out that Verne was experiencing not a unipolar depression, but a bipolar disorder (manic-depression). "When he was manic, that was very much harder to handle," says Kay. "I hate to see him depressed; I wouldn't want that. But the manic phase, I found very hard."

What were Verne's key manic symptoms? They included the characteristic euphoria and racing thoughts. "He had thoughts whirling in his head all the time so he'd be making notes," remembers Kay. "We'd be out in company and he'd be sitting making notes. Also, he'd just sort of turned against me. He was figuring I was holding him back from all these wonderful things he wanted to do." ▶

Sarah Hamid

Sarah is Public Education and Communications Coordinator at CMHA BC Division and Visions' Production Editor.



Staff and clients of the seniors centre which would end up aiding the Smithmans immeasurably.

Hospitals and I are old friends. They, and the wonderful people who provide the care in them, have helped me overcome many illnesses and lead a happy and productive life.

Both wards — medical and psychiatric — cared for me and provided me with much needed medical care, but the difference was that the medical ward provided it in a warm atmosphere that fostered my well-being and independence.

When I left, I knew I had a way to go on my journey of recovery, but I felt I had a team behind me who thought I could succeed.

The psychiatric ward provided me with care in an atmosphere of isolation, coldness and dependence. When I left, my anxieties were still high, and I still felt inadequate to set out on my journey of recovery. I was anxious to leave because I felt I had no team behind me except

my psychiatrist. Within a week I nearly committed suicide.

Then and now, when it comes to the care of my doctors, the care is equally good: warm and human, yet professional. When it comes to the care in the hospital, there was no comparison; although this may be due partly to all the critical changes to health care which have taken place in the twelve years between hospital stays.

The bottom line, however,

is results. As we get older, it is especially important that our physical health concerns are looked at as part of our mental health concerns — as part of the whole picture. When I was first hospitalized, this was certainly the case, and I had the positive results to show for it. Now, all these years later, the care I received interfered with my physical health, and my recovery was that much harder. ■

fact

Many people think of depression as a woman's illness or a young person's illness, when in fact, senior citizens in Canada, as a group, report almost twice the number of weeks feeling depressed in a year than teenagers do. And men over the age of 65 are much more likely to commit suicide than their senior female counterparts.

SOURCE: Statistical Report on the Health of Canadians, 1999

Shopping sprees were another clue that Verne was experiencing mania. "Oh, he was a shopper alright," says Kay. "At first, shopping just worried the life out of me because we didn't have that much money. But he was a Value Village shopper so it turned out that it didn't amount to much in dollars and cents. We did gather a lot of junk and pictures around though," she laughs.

Getting the bipolar disorder under control has been a steady though gradual process. Kay says it's hard to put a figure to how long the upswing has been because Verne still has rough patches, but for the last couple of years, he's been doing well. Social supports and recreation have been particularly helpful for him.

"He started riding a bike and that's done him a world of good — physically and mentally," she says. "He really looks forward to getting out on his bike and he'll go for a long ways. It's level here and there's a path he can ride on and he can sneak off to Starbucks and have a coffee. He said just recently he's feeling better than he has in a long time. And he flew off to Calgary to visit our son and then took a trip out to Edmonton to visit his brother. He hadn't seen him in years."

Verne is still on lithium to balance out his mood swings and although his wife does say endearingly that he grumbles about taking all his medication — between the prescriptions, vitamins and supplements he's told to take, he takes 11 things a day, for both his physical and mental health — he does recognize how important staying on his lithium has been for him. "We do have a relative who is manic depressive and won't take his medicine," says Kay. "And Verne says 'God, isn't that awful, isn't that terrible?' We were very lucky that Verne wasn't like that about medicine."

Kay figures it's difficult to care for a spouse going through depression without having depression touch your life as well, however briefly. "Yeah, I guess I was also depressed with thoughts kind of racing through my head," says Kay. "I know at one point, I just went over to my daughter's and I just slept and read

and sort of got myself together again — this was when he was bad. I also got a peer counselor from the seniors centre. She didn't come very often but it really perked me up to have someone to talk to. She had sort of been through the same circumstances and she asked questions that got me thinking differently."

Peer support has been one crucial way the local seniors centre has supported the Smithmans. "Seniors centres are a wonderful place for spotting depression," Kay adds. "I know our seniors centre and their outreach department are just wonderful. I think that people who really need it most though don't attend these seniors centres — the ones who sit in their room and don't go anywhere or do anything."

In addition to connecting with community supports like seniors centres, Kay's strongest advice is to fight the stereotype that depression is an inevitable part of growing old and seek help instead.

"Depression is not a normal part of aging. But people think, 'Well, that's just because they're old' and I think that's a shame, because a lot of help could be got a lot sooner if people just recognized the problem and realized it's not something you have to go through."

"The main thing is to get professional help because you can't do it yourself. That's how I ended up speaking out. It's a hard thing to do, but if it's helpful to anyone, it's worth it. The best advice I can give is to get professional help as soon as possible. The caregiver needs help too." ■

why depression may go unrecognized in seniors

Seniors may:

- believe the myth that depression is just a natural part of the aging process
- see depression as a normal consequence of losing their independence
- already have other physical or mental illnesses (e.g., dementia or diabetes) and may not distinguish depression as a separate illness that can be treated
- experience depression as a side effect of medications (e.g., such as some drugs for high blood pressure)
- feel embarrassed or ashamed to even discuss it
- be living with a constant, low-level form of depression known as *dysthymia* so may not even recognize it or think it can be treated
- not see any life events that could have brought the depression on and so feel it must be a personal flaw; or, alternately, have so many life events going on that could trigger a depressive episode that the person feels going to a doctor could serve no purpose
- come from a culture that holds different perceptions about what depression is
- lack the mobility or family support needed for a trip to the doctor
- believe treatment would be too long-term or expensive
- get depressive symptoms (e.g., problems with sleep or appetite) diagnosed as signs of a physical illness — or ignored entirely

Coming in From the Cold

Caregiving for Alzheimer's on Film and in Life

About five years ago, I was videotaping an elderly woman's life story. Her husband had been a minister in the United Church, and she had met him as they studied to go into the field of mental health. He had risen to the position of Chief Inspector for the National Institute of Mental Health for the whole western region of the US. They'd had a wonderfully close marriage and working life together.

Although she took on the home support role, she continued to follow that field of study and his passion; at times, she had even stepped in to fulfill speaking engagements when he'd mistakenly been double booked. She described them as so close they "breathed the same air."

As we reached the end of her colourful life story she read, on camera, a touching letter he wrote her as he realized he was losing the integrity of his mind to Alzheimer's. He wrote expressing his love, his appreciation for their wonderful life together and his regret that he was slipping away. It was a heartbreaking moment. We were both in tears. It was so ironic that he fell ill to Alzheimer's disease, after leading such an illustrious career in the mental health field. It was every bit as dramatic and tragic a story as that of Iris Murdoch and John Bayley portrayed in the currently acclaimed film *Iris*. There are thousands of stories more or less romantic, but just as tragic happening every day in our aging population.

Years later, a CBC radio re-

porter was doing a pre-interview for a piece about my *Reel Madness Film Festival* program. I was featuring two films about Alzheimer's — *The Goodbye* and *Complaints Of A Dutiful Daughter* — and she wanted to make a distinction about whether Alzheimer's was a "mental" illness, or a physical condition such as a tumour. I understood her question, but having a mother with the condition and having heard many stories from my old friend and others, I know that the result is the same. The distress is similar in both the individual who is losing their mind by increments and in those close to them. Especially for the live-in partner, the effects of Alzheimer's can be "crazy-making."

The toll on the caregiver can be immense. The confusion, anxiety, repetition, paranoia, sometimes personality changes, anger — and did I mention repetition? — can test any person's sanity. As behaviours become gradually more difficult, the emotional and just plain long hours (think 24/7) can grind the caregiver's physical and mental health down. My mum used to repeatedly wake up my 83-year-old dad from a much-needed cat nap to be sure he was okay. Of course he wasn't.

So many partners of people with dementia soldier on in isolation, trying to honour their commitment to care for their spouse "til death do us part." Overwhelming fatigue and depression can be the result.

What really helped in my dad's case was "coming in out of the cold," but he needed a

push. After years of "coping" on their own, a minor but sudden surgery landed him in a Nanaimo hospital. Mum had no idea what had happened to him or where he had gone. I, as their only son, drove up from Victoria to their Parksville home to help out.

We realized that — diagnosed or not — it was clearly time to reach out for help. As Dad got out of hospital in Nanaimo, we met over coffee with a volunteer from the Alzheimer's Society. For Dad, it was a huge relief to connect with someone who knew what he was going through. Here was someone who knew the ropes, and as a son with a father who had the illness, he could empathize with everything Dad had been managing on his own.

Here was emotional validation for the difficulties he was going through: the repetition, the constant little things misplaced and the big losses, the anger at times, the ensuing guilt, the fatigue — and did I mention the repetition? Also, there was a lot of practical advice and support. It was hugely reassuring to know he was not alone and didn't have to manage this in the isolation that so often creeps into a household along with the onset of this illness.

We were greatly reassured and helped with the idea of eventual institutionalization by the video *Complaints of a Dutiful Daughter*. Told with humour and love, it is very bit as profound a love story as *Iris*.

Mum and Dad moved from their large retirement home in Parksville to a very

convenient 'care-a-minium' condo closer to my family in Victoria. The move was a very stressful transition, but a huge relief for us all. They continued to cope quite independently with gradually more support from long-term care, even pluckily traveling with friends on cruises and Reno bus trips. Dad, who like many men was never a "joiner," started attending an Alzheimer's support group with me, finding it hugely helpful. A day program for Mum gave her some welcome, comfortable socialization and meant a welcome respite twice a week for Dad. All these supports made it possible for them to live quite independently for another year and a half.

Mum had a stroke two and a half years ago that precipitated her move into a long-term care hospital. It's an excellent facility and conveniently close to their condo, so Dad is able to visit her daily. Their lunch together is a regular routine and a socialization opportunity in his life too.

My wife and I drop by three or four times every week, which seems like never enough time for her long days in the hospital, but a huge chunk of time from our frantic schedules. (It always strikes me as strange how time suddenly has a different quality when one walks through the doors of a long-term care hospital. It's a different world with different priorities.)

One thing I'm so glad I did about eight years ago was to sit down with my parents to capture on video much of their life

Bruce Saunders

Bruce lives in Victoria, and is the driving force behind Movie Monday.

More about Movie Monday can be found at www.islandnet.com/mm *Iris* can be found in the 'Archives'. *Complaints of a Dutiful Daughter* and *The Goodbye* were featured in our Reel Madness Film Fest 2001. Those films can be borrowed from the Riverview Hospital library (contact Jamie Smith at library@bcmhs.bc.ca or (604) 524-7422) and some Alzheimer's Resource Centres.

Seniors Caring for Friends and Family in Kelowna

In January 2002, CMHA completed a national study of the mental health needs of Canadians aged 65+ and the role home care can and does play in meeting these needs. Karen Parent and Malcolm Anderson of Queen's University conducted the national research and four local community research sites held a series of meetings with seniors and others to look at the issues. Meetings were held with clients and caregivers, both formal and informal.

In January 2003, CMHA National will publish two manuals based on the research report: a Policy and Planning Guide for home care planners and policy-makers, and a Service Delivery Guide for organizations that deliver services.

The article below summarizes the views of informal caregivers who participated at the Kelowna research site. Participants were asked to share their perspectives on mental health and give their input regarding how home care services can contribute to their own mental health and to that of their loved ones. The piece is reprinted from CMHA National's "Seniors' Mental Health and Home Care Newsletter" (Vol 1, Issue 3), January 2002. See www.cmha.ca for more information on this project.

Seniors who are caregivers in Kelowna told us that they require as much support as the care receiver. "When under stress as a caregiver, your own mental health is at risk too," [said one participant.]

Emotional Factors

Participants in our focus groups spoke about a need for emotional support and counselling. There is a need for an assessment that "goes beyond the diagnoses to explain what you [the family member] are going to face in these changes." It was suggested that home support providers also be trained in grief counseling.

Coming in From the Cold (cont'd from previous page)

story. It's a wonderful way to preserve some memories of 'the good old days' — the pivotal times and the small details that make them such special people. It's an invaluable record, especially now.

As an outreach of my Movie Monday program, I arranged three screenings of *Iris* in April at Sidney's Star Theatre. After showing the film, a panel of folks from the local Alzheimer's Society and support group spoke to the film and answered questions from the audience. In each audience, there were people "coming in from the cold," learning some of the supports that are available to help them through. When the film is avail-

able on video in the fall I'll be presenting it in my theatre in the same way. It's a remarkable film, and a great way to educate people through an entertaining film about real life issues. It is a wonderful love story that goes far beyond the flush of first romantic *Titanic* infatuation.

The wonderful book upon which the film is based, John Bayley's *Elegy For Iris*, is a wonderful, warm-hearted memoir. It reinforces the feel of the film, from the love of bathing in whatever body of water the couple could find to Bayley's initial and enduring, absolutely besotted, love for Iris. A lovely read. ■

Some senior caregivers referred to the personal sacrifices they had to make, such as giving up a job, to provide support to their elder spouse. The informal support of a friend in a similar situation (i.e., also a caregiver) helped them "survive this experience."

Minimization and Isolation

Caregivers reported that an elderly person receiving care may minimize or mask the real need in order to hide their shame, embarrassment or preserve their dignity regarding the losses they face. The impact on the caregiver can be very intense, beginning with inaccurate assessments of service needs due to the minimization, up to isolation of the caregiver and the client as the senior pulls away from social contact.

Prevention Strategies

Caregivers would like more of a focus on prevention strategies and programs that address the care receiver's social and emotional needs such as security, support, a sense of belonging and self-worth. It was thought that home care workers are often focused on doing "the job" and may not address these basic human needs.

A Personal Touch

It comforts both the caregiver and the senior when services focus on personal interests, likes and dislikes of a client, and when service providers formally acknowledge the importance of social contact, feeling secure, kindness, hugs, assistance to write letters and read the newspaper. In this way, the role of the caregiver is respected and the importance of these aspects of care can be taken into consideration when the person being cared for must be separated from their caregiver for respite or the longer term.

Transitions in Care and Advocacy

Caregivers reported specific challenges that impact mental health during care transitions. [One participant stated that] "difficulty getting help and someone to believe me nearly killed me." The transition from home to facility care was reported as "the most horrendous" [since] the familiar support services are severed and "care goes haywire" [and therefore the] family member is "forced to be there as an advocate." The need for advocacy was also noted for issues related to affordability and access to service, transportation and information, and help during and after a crisis.

Psychogeriatric Services

Caregivers reported that the needs of a psychogeriatric client pose [unique] challenges, often requiring specialized services. They observed that for families who care for the psychogeriatric client, many needs go unmet. For example, respite options are more restrictive if the senior who needs this service presents with disruptive behaviour, yet the senior spouse is expected to pro-

vide this care and support in the home environment. The informal caregivers suggested that the psychogeriatric mental health team should be the main set of people involved with these specialized care/service needs.

What's Needed?

What's needed are:

- more respite beds
- education and caregiver support groups
- more involvement with the caregiver during the home care assessment process
- affordable and user-friendly transportation services
- affordable programs that address the specific needs of the psychogeriatric client
- an advocate to lobby the government for more funds to support family home care and preventative mental health work
- and a single service where all information can be accessed. ■

Visions

Our next issue of Visions (due out this fall) is on **EATING DISORDERS AND DISORDERED EATING**. If you have a story idea you want to share, contact our editor Eric Macnaughton at (604) 688-3234, toll-free at 1-800-555-8222 or at emacnaug@cmha-bc.org

Moving Seniors Can Be Detrimental to their Mental Health

Two things inspired me to write this story: the upheaval that is happening in the lives of many seniors right now, and the need to improve services for the elderly in our province. Although I am not a senior yet, I have had experience with their issues through dear relationships with elderly family members. Based on what I've seen, I think doctors should be careful when they recommend moving a senior out of their home, as it has both physical and mental consequences. It would be a more healthy decision to improve home care services so that seniors can remain in their homes for as long as possible.

I was party to one

such decision that was not in the best interests of a person very dear to me. My aunt lived in a house out in the country on a parcel of land where she could be with nature and listen to the birds she loved so much. She had lived in this country setting for years, and I have many fond memories of my time out there, which I would not trade for anything! She was a retired elementary school teacher, and a kind, gentle woman, whose husband had been dead for many years. She lived alone, but her sister and my grandmother lived close by, and would spend weekends with her. My siblings and I also spent many wonderful days out in the country with our aunt.



Then one day, her doctor told her that her place was too much for her and recommended that she move into town. I don't think she had ever lived in town, and she dreaded it, but a place was found and the process of moving her began. As it turned out, she did not spend one night in the new place. Instead, she ended up in the hospital, and then was moved to an intermediate care facility. There was nothing wrong with the facility, but she hated it and her health slowly went downhill. I can remember the day she said goodbye to me, and just three months later she was dead.

At her real home, we had tried our best to get her out and take her places, but it was not enough. I remember her pleading with me not to go back, and if I had known better, I would have stayed, as I was of the age when I could have moved out to live with her. Hindsight is wonderful, but foresight would have been better.

After her death, it saddened us deeply to find suicide notes amongst her things at the facility. She was a caring, loving person who wanted to stay in her home. Instead she got depression and thought of suicide. My aunt's place did not take that much work, and with the help of a home care person, she could have died amongst her birds and the animals she loved. Of course, there were external pressures that may have contributed to the premature move, as other family members wanted the land. But, what is an elderly person supposed to do? She was of the old school and she trusted her doctor and family. Her mental health was deeply affected and the physical problems followed.

It's this experience that tells me that we should be improving home care services, not dismantling them. If seniors could stay in their homes longer, maybe there wouldn't be the need for these impersonal facilities. ■

Patricia Harding, MSc

Patricia Harding was born and raised in Vernon. She has been a consumer since the age of 11 and a family member of a person with mental illness all her life, which is why she is so dedicated to improving the lives of others with mental illness.

Time and Love

Gifts to the Caregiver

Anne Duggan **T**here is a gradual nature to the onset of signs and symptoms of Alzheimer's disease which can be interpreted and accepted as a gift of time.

Anne is from Parksville, and writes from the perspective of a professional caregiver, a family caregiver and a long-time advocate of the idea that we have much to learn from people with dementia. This article is adapted from a speech she delivered at the CMHA in Duncan earlier this year.

Time is not often given when life-changing events occur. What is the best way to make use of this gift of time? What decisions and actions does time allow which will make the course of Alzheimer's a calmer and steadier process, rather than an extended crisis?

Start with an acknowledgement of the problem. Talk about it, ask questions, read the literature, discuss all the fears. It is astonishing to find that when talked about, there is always someone close by who has experienced the same fear, guilt, frustration and anger. Knowing that one is not alone makes a huge difference in gathering the resources needed to go on.

The most fundamental and necessary activity, once the Alzheimer's process is recognized, is to plan for change — and to put the plan in place. It is essential to prepare for the kinds of changes that are inevitable.

It is time to remove the frustrations and reduce the level of decision-making in everyday life, to simplify every aspect of living. It is both a courtesy and a commitment to the person with Alzheimer's. It indicates that we understand that the complex decisions and processes of daily living can, and will, be made easier and less confusing. Now is the time to start gradually and consistently to put affairs in order. Downsize or simplify the house, cars and garden. Take a trip now that you were hoping to take later on.

What is the best way to make use of this gift of time? What decisions and actions does time allow which will make the course of Alzheimer's a calmer and steadier process, rather than an extended crisis?



This is a really good opportunity for spouses to learn how to do those long-avoided and unfamiliar tasks such as doing the laundry, cooking, banking, repairing a leaky faucet or changing the furnace filter, and many other things that can keep a home running smoothly when one partner is not functioning at capacity.

It is also time to develop a good working relationship with the family physician. There may be new drugs to try, or new research programs in which to participate. It is helpful if the doctor is kept up to date with the signs of physical and mental changes and the rate at which they occur.

It is important not to focus so much on memory loss that new or ongoing medical problems are overlooked or sidelined. If a person with Alzheimer's suffered from angina or arthritis before the signs of dementia showed up, it stands to reason that he or she suffers the same pain now. They may not interpret and translate it in the same way, so friends and doctors must now become detectives. Pain is often the cause of restlessness and fear.

The health of the caregiving partner must be on the agenda at every doctor's visit. It is all too common for a spouse to devote so much time and energy to the person with Alzheimer's that his or her own health suffers. A balance is needed and the physician can be a knowledgeable and objective advisor to both.

A practical action in the early stages is to set up a program with friends and neighbours in which they visit or drop in to your home frequently and spontaneously. This not only creates a diversion, it is an easy way to familiarize the person with Alzheimer's to people coming and going in the house: something which is difficult to introduce later on when it is essential but often strongly resisted.

The whole idea of building a network of willing and able people is foreign and awkward to many who have lived a private and independent life. Yet, it is one of the most effective and reliable support services available. When people say "let me know if I can do anything," accept the offer. Give them each a job. Everyone will benefit.

By learning about the patterns of Alzheimer's, one can anticipate which activities or thought processes may next become difficult. As the person with the disease diminishes in some aspects of life, it is reassuring to think that a loving caregiver grows and strengthens to meet the challenge.

A big part of the growth process is in changing expectations and re-ordering the priorities in life. A day now becomes 24 hours, not just nine to five; exercise and nutrition can be balanced over two or three days, rather than one; a full bath or shower can be reduced to two or three per week from an everyday routine. There are ways that fashionable clothing and accessories can be modified for comfort and simplicity, without the loss of dignity. ►

Schizophrenia of My Times

In the past five years, I was given the freedom to ask for the treatment records concerning my schizophrenia, but I didn't ask. This is my mental health history as I remember it.

In 1964, I entered formal treatment for my illness with a psychiatrist. I also entered group therapy. That did not work, nor did the time spent one-on-one with the psychiatrist.

Over time, several mind-altering prescription drugs were tried on me. Each did something different. One, I remember, made me fat. Another, a sibling told me years later, made me look like a zombie. A minimal dose of Haldol worked best among its generation of medications. I am now on Risperdal, a new generation drug.

I strove to be amiable in real terms, but I found that very stressful in my various social groupings. I felt depressed because I could not hear my voice in the public dialogue. There were no mentors or role models or codes of ethics for people like myself, who had such tender sensibilities.

Until the mid-70s, there was no subsidized housing for people like me. There was also

no legislation concerning disabilities and entitlements. I felt I had no choice but to live with my parents through my adulthood, until they died when I was in my 30s. After my parents' deaths, I stayed with a brother for some time. I was greatly relieved when I found a suite I could afford. I also found work for a few years, but the jobs did not work out.

In 1977, I found out that I qualified for a provincial disability allowance. This also allowed me, at a mere 37 years old, to get into a Lion's Club seniors' residential complex. It was a bachelor suite, which I could afford with money to spare! I could also afford to go for coffee in nearby restaurants for a change of pace.

In 1984, Langley Stepping Stone Rehabilitative Society was founded. Few people with mental illness came to it in the beginning. I went, but not with regularity. Over time, the membership kept increasing. I felt structure developing, and I began to go more often.

Somewhere in the 1990s I was involved, in a small way, in helping the Society raise over a million dollars to build a lovely, larger clubhouse. Langley city contributed a fif-

ty-year lease on the property for the clubhouse. The province reluctantly contributed a quarter of a million dollars, and charitable organizations contributed the rest of the required amount. Although my part had been small, I felt proud as punch to have contributed in my way. It's up and running now and has over two hundred members. While I have outgrown it, the clubhouse was the only social body I felt sure would accept me.

Also during the 1990s, I was a member of the local advisory council on mental health. Along with others, I spoke on the mental health experience to secondary schools, colleges, and a university. During the same period, I was elected to the Langley Stepping Stone Member's Committee. A few years ago I was part of the BC Minister's Advisory Council on Mental Health. I also became a member of the Board of Stepping Stone Rehabilitative Society. I felt productive. I felt good.

In 1990, I was accepted into a new, subsidized one-bedroom suite created for clients with mental illness, which costs me only \$200 a month. During the past 10 years I have also got a computer with Windows

95 on it, and I also have TV and cable connections that enable me to get good programs.

I would like to be more involved without being more stressed out. I guess it is not unnatural for me to want something more and/or better. I do appreciate what I have though. My ears perk up when I hear on the news about people with mental illness who are materially disadvantaged in ways I have never experienced. I always had a roof over my head and enough money for food, and I was quietly grateful for those two things, quiet because I did not want to jinx my good fortune. Maybe I want something better because I have more self-worth. More people with mental illness should have it as good or better than I do.

While I no longer go to Stepping Stone very often, I do have social contacts. One is a supported independent living worker. The other is a retired, now disabled, program director. I count my blessings for them. For 44 years, I have known God was a valuable element in my life. Having some people in your life is also valuable. All things considered, life is good. ■

Walter Beier

Walter lives in Langley. In this article he relates how he has dealt with his illness over the years.

It is sometimes much more effective to sit quietly with the person with Alzheimer's and let them know they are safe, than to attempt to keep them engaged. Our own fear of boredom or idleness often seems not to be shared, at all, by someone with Alzheimer's. Of course, each person is an individual, and there are many different ways to find the most comfortable routines and pastimes that support and maintain a sense of value, dignity and pleasure in life.

The fundamental principle underlying all of these coping strategies is that while a person is experiencing memory loss and other changes associated with Alzheimer's disease, he or she remains a whole person, consumed with fear and anxiety at the

prospect of losing mental acuity. Memory may be affected, but intellect and the desire for information, control of decision-making and individuality are sustained.

The need for love, reassurance, a sense of personal worth and safety is intense. The caregiver, in whatever relationship he or she may have with the person with Alzheimer's, is the absolute and essential element in determining how this sense of security will be maintained.

Music, rhythm, spirituality, a sense of surprise and fun: all of these gifts are there for the sharing and they can all be incorporated into the activities of each day. ■

Aging with Mental Illness

May Louie

May lives in Burnaby. In high school, she was interested in the Long-Term Care Aide program. After completing high school, she was a volunteer friend with a senior in a rest home.

We all grow old — like it or not. As one grows older there are many problems. There are physical problems such as arthritis, osteoporosis and stamina. Because of this, seniors may need housing without too many stairs, or without too many hills in the surrounding area. Sometimes older people lose their status and feel they are not as useful. They may be more isolated and go out less, because they don't have to go to work or school. At times, they may have concerns and uncertainty over how to improve their life, or about who will listen to them. Seniors from different cultures may come up against different circumstances. It's a double whammy for seniors with a mental health problem.

Let's take Raymond, who is 67 years old with a mental illness. He has lived in the Capitol Hill boarding home for more than ten years. He feels the staff treats him well. The food is so-so; could be better. They say that group home food is not very good and that the staff doesn't eat the food they prepare. Maybe things would be more home-like for Raymond if the staff ate with the residents. This would give the staff more incentive to prepare delicious food.

The Capitol Hill home is a good location for Raymond because it's near bus stops and there's also the Senior Confederation Centre where he goes twice a week for coffee. Raymond doesn't feel isolated and goes to mental health organizations such as the 7:30 Club and Burnaby Mental Wealth Society. At the 7:30 Club, he plays card games and board games with his friends and at Burnaby Mental Wealth Society he can get a good

home-cooked meal, cooked by consumer staff, for \$2. However, money is a problem for Raymond if he goes out too often for dinners to restaurants, and he's limited to low-cost restaurants only.

He feels pretty good for a 67-year-old but he has a little bit of a sore leg, which he is concerned about because he needs to walk to places and doesn't have a car. He is concerned about his health and takes medication for his mental illness. Side effects like tardive dyskinesia (uncontrolled Parkinson-like movements that are irreversible even after discontinuing the medication) or acute dyskinesia (uncontrollable movement that is reversible or short-term) can be a problem for people like Raymond who have been taking medication like Haldol for a long period of time. The new atypical drugs are supposed to have fewer side effects, but because they are new, there is no research about what the long-term side effects might be. Raymond fortunately does not have these side effects. He is very capable and independent.

In general, there needs to be more focus on seniors with mental illness, so people have a better life and don't get isolated. Mental health organizations could provide bus trips for people who have difficulties walking long distances — for example, weekly bus outings to places of peoples' choice, and maybe a two-dollar incentive for coffee. Group homes could provide transportation to mental health organizations' events. When locating a place for seniors like Raymond, you need to find a quiet place, and focus on the amenities around the home such as bus stops and seniors centres. ■

Sometimes Only on One Wing

Life and Illness over a 40-year Span

Rhea Alexander

Rhea lives in Fort St. John

My name is Rhea. I was born in Fort St. John in 1933. I've spent most of my life here in Fort St. John with my parents and siblings. I moved away on a number of occasions, but the support of family and friends always brought me back home.

My first breakdown was in September 1959, when I was visiting my sister and her family in Sitka, Alaska. This was my first attempt at suicide. I had swallowed cleanser, but luckily my nephew found me before

it was too late. My husband and brother-in-law then came and picked me up and brought me home. Back in Fort St. John, I waited for 2 weeks before I was admitted into Riverview Hospital, in Port Coquitlam. At the time I had very little medical history for the doctors to work with. My stay at Riverview lasted for four months, where I was given shock treatments as well as insulin treatments.

When I returned to Fort St. John, I left my husband and moved in with my sister, bring-

ing my five-year-old son with me. In 1963, my husband and I made a second attempt at our marriage. This only caused more problems to my health, since I had to deal with him having affairs with other women, and in 1964 I had another breakdown while I was 5 months pregnant with my second son.

I returned to Riverview, this time for a period of 6 weeks. However, while I was in there, they were unable to give me shock treatments because I was pregnant. Instead, the doctors

worked with me to bring me out of my depression with counselling and by altering my medication.

When I returned to Fort St. John, I moved in with my sister and her family. I was very depressed at times, so she would take over and help me look after my sons when I was not well enough to do it myself. I owe a lot to her and my family as they stood behind me through thick and thin.

In 1966, I became pregnant with twins. Being single and

already having two children, I decided to give them up for adoption to my cousin in Dawson Creek. After giving up my babies, I became deeply depressed and attempted to take my life again, this time by overdosing on my medication. I was admitted into the hospital in Fort St. John for a short period of time, where I was given counselling and watched closely by the medical staff.

After leaving the hospital, I moved into a house that my mother had given me in her will, and over the next nine years, I lived there on my own, with my two sons. As they were growing up and going to school, I worked outside of the house when I could, but not for long periods of time. I kept in close contact with my doctor and saw a psychiatrist when he or she came to Fort St. John.

At one time, I was taken off of tranquilizers. This lasted for a couple of years until one of my doctors felt that I needed the medication again. In hindsight, I feel bad that I went on them, since I've never been able to be completely off them again.

In 1977, I married a man I had known when I was a teenager. Our marriage lasted for nine years, and during that time I went through stages of depression and my general health was very poor. After a bitter divorce, I moved in with my sister Greta. I was able to deal with my depression and tried to keep my life as uncomplicated as possible.

In 1986, I moved to Kamloops to stay with a friend, but being away from my family and friends sent me back into depression, and I was once again hospitalized. I spent approximately 3 weeks there and have very little recollection of my stay at the Kamloops hospital. After I left, I moved to Enderby where I lived for 3 years with

my sister and her husband.

Still having problems with depression, my family decided I still needed more medical attention, so I was taken to the Vernon hospital where I stayed for six weeks. While I was there, I worked with a psychiatrist, and I was given a number of shock treatments. But after returning to Enderby, I was still feeling very confused and disoriented.

When I went downtown with my sister, I couldn't remember where any of the stores and buildings were located. I was gradually able to regain some of my memory back, but there are still parts of my past that I can't remember to this day. While still in Enderby, I tried living out on my own again. However, this lasted a very short period of time, as I was feeling homesick for my family in Fort St. John.

For the past three years now, I have been back living with my sister and nephew in Fort St. John. I meet with a psychiatric nurse weekly who checks my blood pressure and medications. I see a psychiatrist periodically and keep in close contact with my doctor if I'm not feeling well.

I am living my life day by day, dealing with spells of depression and sometimes feeling very tired and exhausted. Sometimes it is hard for me to remember things and I get confused putting my thoughts together. I keep busy with my grandchildren and by helping out other family members as much as I can.

There have been some things that have helped over the years: one thing I was told which really helps is to hold my head up high no matter what happens. I also like a good joke and this also helps me, if I'm able to laugh. I've been taking medication and counselling

over the years, and this has kept me going, even if it was only on one wing.

I would like to thank all the doctors and psychiatrists, and anyone else who helped me deal with my illness over the

past forty years, including my family and friends. I've met many nice people while going through treatment, and some became very good friends who I've kept over the years. ■

Depression Screening and Education DAY

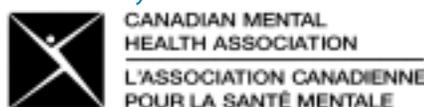
Thursday, October 10, 2002

1.866.917.HOPE | www.cmha-bc.org

FREE CONFIDENTIAL ANONYMOUS

40 sites will be set up around BC to help you learn more about the signs of depression, how treatable it is, and the range of supports in your community that can help you or a loved one. You also have the option of filling out a short quiz on depression symptoms and then meeting with a clinician to discuss the results.

Presented by



Funding provided by the Ministry of Health Services

With generous support also from



LITE BOOK™



Seniors and Mental Health Promotion

Penny MacCourt,
MSW, PhD (ABD)

Penny MacCourt is the past President of the BC Psychogeriatric Association and was co-Chair of the Ministry of Health Services' Elderly Mental Health Care Working Group. She is a clinician with the Seniors Outreach Team for Nanaimo Mental Health, Vancouver Island Health Authority.

This article focuses on the findings of a report done for Health Canada about mental health promotion in relation to older adults. The study was based on a thorough literature review and a survey of key informants.

Introduction

The number of seniors is growing. Recent Statistics Canada figures estimate that 13% of the population is 65 years of age and older; by 2016, it is estimated that seniors will represent over 16% of the population. Equally important, the senior years constitute a time of life when the majority of health care use and expenditure occurs. Both physical and psychosocial well-being influence the demand for health services.

Mental health problems in late life usually occur in the context of medical illness, disability and psychosocial impoverishment. Individuals may experience age- or illness-related challenges — such as cognitive or sensory impairments, mobility issues or chronic pain — that limit their ability to function socially. Other challenges are retirement, widowhood, mental or physical illness of a spouse or other relative that leads to caregiving, and diminishment of their social support system through loss of peers to relocation, illness, caregiving or death. Many older adults remain in good mental health in spite of these challenges. For others, these challenges may lead to social and emotional isolation, sometimes depression, alcoholism and occasionally suicide. Additionally, such issues as lack of accessible transportation or low income may be barriers to maintaining good mental health for some seniors.

In order to promote and support the mental health of older adults as they face the challenges of aging, and to address mental health problems that occur, a mental health promotion approach is required. Health Canada defines mental health promotion as “the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections and personal dignity.”

Literature Review

Although there is a large body of literature both on health promotion and on the prevention of mental illness, there is relatively little literature on mental health promotion, either in the general population or in the elderly. This reflects the fact that the concept of mental health promotion is relatively new.

There are several changes that occur as part of the normal aging process that may affect psychological and social well-being in seniors. These events affect the majority of seniors and include retirement, changes in income level, physical changes, and

changes in social support networks. Seniors may respond to these events in many different ways. Some may see the changes as positive, for example, as an opportunity to build new relationships. Others may take the changes in stride and be relatively unaffected by them. Still others may become lonely, depressed, or suicidal as a result of the changes. It is important to understand why individuals are each affected differently by natural transitions. While it is known that some seniors fare better than others, why this occurs is not fully understood.

Numerous strategies, interventions and programs have been designed to improve the physical and/or psychosocial well-being of seniors, but little is known about why some programs are more successful than others.

There is still much that needs to be done to ensure that older individuals are as healthy as possible for as long as possible. Some of this must begin with developing and implementing research and policies designed to improve the psychological and social well-being of seniors.

In the research domain, there is a need to:

- develop an inventory of community-based services, interventions, and programs that are designed to promote mental health in seniors
- continue explorations of the impact of various determinants of health on the psychological and social well-being of seniors
- identify appropriate indicators of success and outcome measures
- develop longitudinal studies focusing on physical, psychological, social and emotional aspects of aging
- develop appropriate ways to communicate information to a variety of audiences.

There is a need for programs that would:

- prepare individuals for retirement, reduced incomes and loss of social contacts
- increase income levels
- continue to encourage and promote physical, psychological and social well-being
- target seniors at increased risk for health problems because of psychosocial barriers.

Key Informant Survey

Forty-five key informants were interviewed (1) to develop an overview of how mental health promotion strategies are currently being used in Canada to address challenges to adults' mental health as they age; and, (2) to identify factors that either facilitate or make it difficult to apply mental health promotion strategies to promote and support seniors' mental health.

Findings and Issues Identified

- Key informants provided many examples of strategies and approaches that promote and support seniors' mental health. The approaches identified were community development, policy development, education, training and prevention.
- Generally, informants from urban areas believed that there are adequate resources to assist elderly persons to cope with many of the challenges often associated with aging, or to facilitate their recovery from mental health problems/disorders. In rural and remote/northern regions, fewer of these supports were available, due to accessibility/transportation issues, lack of human resources to provide services, and not enough seniors to create need for programs.
- In regards to programs to prepare aging adults for potential challenges, there were few of these reported by any of the participants with the exception of retirement programs, which were focused largely on finances.
- There were fewer programs of any type to prepare seniors for potential mental health problems reported by respondents in the three territories.
- Overall, relatively few programs were identified that specifically address barriers to good mental health, and those that were reported came from both rural, remote and urban parts of the country.
- Nowhere was it reported that special strategies are being used to prevent older adults from taking their own life.

Issues that emerged from the key informant interviews are listed below:

- Older aboriginals in the territories, and ethnoracial minority groups are unique populations requiring unique approaches.
- Unique generational challenges face aboriginal and other ethnoracial groups.
- There are different age groups within the age 65+ category, with different needs.
- Access to appropriate support is limited in rural and remote areas.
- Transportation is a barrier to accessing support.
- Ageism and stigma of mental illness affect seniors directly and indirectly.
- Caregiving is a risk to seniors' mental health.
- Poverty affects seniors' access to supports.
- Males have special needs that require special approaches.
- Leadership in seniors' mental health promotion is under-developed and under-supported.
- Communication in the seniors' mental health promotion field is limited.
- Dissemination of knowledge about seniors' mental health promotion strategies is limited.
- Mandate and jurisdiction issues create barriers.
- Partnership development is limited.
- National frameworks and best practices for seniors' mental health promotion are lacking.
- Funding for seniors' mental health promotion is limited.
- Human resources — health care providers, volunteers and caregivers — are limited.

Future Directions

In order to further explore and to address the issues revealed about seniors' mental health promotion, both research and policy development are required. The development and implementation of policies regarding the promotion of mental health in seniors must explicitly incorporate the basic principles of health promotion. For example, seniors need to be actively and meaningfully involved in the development, implementation, evaluation, and review of policies. If policies are designed for specific subgroups, members of these subgroups should be included as part of the process. Policies need to emphasize health promotion as well as the prevention of illness. Policies need to be developed and implemented collaboratively with the active and meaningful involvement of representatives from various public, private and not-for-profit sectors.

Conclusion

There has been much interest in the psychological and social well-being of seniors in recent years, and many successful applications of mental health promotion strategies to support seniors' mental health. Nevertheless, there is still much that needs to be done to ensure that older individuals are as healthy as possible for as long as possible. ■

Nutrition in Mental Health

Focus on Seniors



Older adults are sensitive to nutritional deficiencies and imbalances. Although they have at least the same needs for vitamins, minerals and other nutrients as younger people, they need fewer calories. In other words, seniors require less food but more nutrients. Ideally, seniors could solve this problem by eating more “nutrient-dense” foods such as whole grains, whole fruits and vegetables, low-fat dairy (or alternatives), and low-fat meat and alternatives. However, this often does not occur in healthy seniors, never mind seniors with mental illnesses. A person with a mental illness experiences the

“nutrient/energy paradox,” as well as their own unique problems that makes him or her very susceptible to nutritional compromise.

Seniors Who Have Long-Term Mental Illnesses

As people with mental illnesses age, the potential for nutritional compromise increases. Chronic use of psychotropic medications, chronic concurrent disorders and symptoms of the illness itself all contribute to the increased nutrition risk as people age.

Medications

Many psychotropic medications have nutritional side effects. People using lithium, for exam-

Erica Messing, RDN

Erica is a Registered Dietitian in Mental Health for the Vancouver Island Health Authority.

Erica can be reached
by phone at
(250) 370-8263 or
by email at
emessing@caphealth.org

ple, must maintain a consistent level of hydration in order to avoid lithium toxicity. Antipsychotics often cause weight gain, carbohydrate cravings and dry mouth. Antidepressants may help to alleviate the appetite (and weight) loss associated with depression, and some may force the patient to restrict their tyramine [an enzyme occurring in commonly eaten foods like cheese] intake to avoid hypertensive crises. Mood stabilizers such as anti-convulsants can cause secondary folate, B12, B6 and vitamin D deficiencies if they are used for long periods of time, especially in combination with certain other medications. Finally, all medications can cause weight loss, gastrointestinal upset, and constipation or diarrhea. With such diverse reactions, people taking these medications often undergo changes in eating habits.

Chronic Co-occurring Disorders

Substance abuse and dependence is widespread in people with mental illnesses. Alcohol is a common choice among older adults. Chronic alcohol abuse

has many nutritional side effects, both in the short and long-term. In the short-term, people abusing alcohol may find that they lose their appetite, and thus stop eating, which in turn leads to malnutrition.

The long-term effects of alcohol abuse become evident as people age. Chronic alcohol use impairs the ability of the gut to absorb nutrients. The result is diarrhea from malabsorption. Chronic alcohol abuse also makes it difficult for the liver to process nutrients once they are absorbed. This can result in secondary vitamin and mineral deficiencies, such as scurvy (vitamin C deficiency), osteopenia, osteomalacia, and osteoporosis (calcium, magnesium, and vitamin D deficiencies), clotting disorders (vitamin K deficiency), and a whole host of symptoms from B vitamin deficiencies. Thiamin and magnesium deficiencies are dangerous complications that can have devastating side effects if a person goes through withdrawal without medical supervision. During withdrawal, supplemental thiamin and magnesium are needed to prevent permanent brain damage from Wernicke-Korsakoff's syndrome [a condition associated with memory loss and other symptoms]. If a person has abused alcohol to the point of alcoholic hepatitis and cirrhosis [diseases of the liver], there are many more nutrition complications.

Mental Illness Symptoms

Symptoms of mental illnesses can sometimes interfere with an individual's ability to maintain good nutrition. For example, people with chronic eating disorders are almost always malnourished. People with delusional systems around food and eating are at risk for malnutrition, overnutrition, or

oversupplementation [overnutrition results from eating too much, eating too many of the wrong things or not exercising enough. Oversupplementation is a specific form of overnutrition resulting from taking too many vitamins or other dietary replacements]. People in manic phases of illness often stop eating, as do people in depressed phases of illness.

Seniors Developing Mental Illness As They Age

Mental illness can develop at any age. Illnesses such as Alzheimer's disease, Parkinson's disease, multiple sclerosis, and multi-infarct disease [a condition resulting from stroke or heart attack] can have a profound effect on people's dietary intakes. This in turn affects people's nutritional status.

As these illnesses progress towards dementia, some people experience an increased sweet tooth. Research is being conducted into why this occurs; there is some speculation that the carbohydrate craving may be secondary to one or more B-vitamin deficiencies. Other people begin to "wander," expending large amounts of energy. At the same time, they may lose recognition of food, or be unable to stay still long enough to eat or drink anything substantial. These behaviours can result in profound weight loss, coupled with malnutrition. Finally, many diseases that result in mental illness also result in dysphagia, or compromised ability to swallow safely and effectively. This may also lead to poor nutrition intake and malnutrition. If a person experiences dysphagia but is no longer able to explain his or her symptoms, it can be difficult for clinicians to understand why the patient has suddenly stopped eating or drinking.

What Can Be Done?

Regardless of the cause of the nutrition compromise, the solutions are the same.

Encourage the person with the illness to eat as wide a variety of foods as is tolerable to them. Dietitians are available to provide help, advice and advocacy in hospitals, facilities and the community. For people who have developed a nutritional side effect of a medication, co-occurring disorder, or mental illness, a referral to a dietitian is a good idea.

In the meantime, liquid nutrition supplements (commercial or homemade) are often indispensable in hydration, protein supplementation, and in helping maintain adequate nutrition if the person has trouble tolerating eating, chewing or swallowing. They can be used to satisfy the sweet tooth of the person who is developing dementia while at the same time providing some of the potentially-lacking nutrients. These can be used for short or long durations. People who do not wish to have liquid supplements may find it more difficult to obtain adequate nutrition, especially in hospitals and facilities. "Wanderers" should be tried with foods that they can take with them, such as finger foods or a nutrition "tool belt," fitted with munchies to help them achieve their energy and nutrient needs.

Food textures and fluid consistencies must strike the balance between safety and pleasure for the person with dysphagia.

Finally, it's a good idea for most seniors with mental illnesses to take a multivitamin and mineral supplement daily, if they can afford it. Further supplementation should only be done at the advice of a dietitian and physician. ■

suggested resources

To access a dietitian:

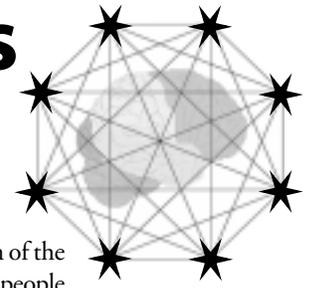
- Dial-a-Dietitian: 1-800-667-3438 or online at www.dialadietitian.org (Free nutrition information from registered dietitians in BC.)
- Call your local health unit to find out about home care and private practice dietitians.
- Call Nutrition Services at your local hospital to find out more about dietitians in primary health care.
- Ask the administrator of intermediate and long-term care facilities about registered dietitians in that facility.
- Dietitians of Canada: visit the web site at www.dietitians.ca for general nutrition information, as well as a list of consulting registered dietitians in your area.

Suggested Readings:

- Dietitians of Canada and American Dietetic Association. (2000). *Manual of Nutritional Care, 2nd ed.*
- Shils, M.E., Olson, J.A. & Shike M. (1992). *Modern Nutrition in Health and Disease, 8th ed.* Lea & Febiger.

Health Promotion for Seniors

The Healthy Brain Program



The Healthy Brain Program (HBP) was first developed for seniors in British Columbia and has since been adapted for all age groups. In the beginning, it was sponsored by St. Vincent’s Hospital Foundation in Vancouver, and the primary message conveyed by the program was: “add life to your years.” The communities of Coast Garibaldi and Sunshine Coast have had presentations and workshops from the program, which trained geriatric mental health workers to use this innovative approach for health promotion and disease prevention.

Currently, we are working with the University of British Columbia (UBC) and Centre for Telehealth at the Mental Health Evaluation and Community Consultation Unit (MHECCU) to bring the Healthy Brain Program to Fort Nelson, Fort St. John, Dawson Creek, Squamish, Sechelt and Powell River. We thank the participating communities and seniors for sharing their insights and reinforcing all that has been positive in the HBP. Young and old continue to benefit.

The Problem

Brain disease is reaching epidemic proportions.^{1,2,3} It is already the leading cause of age-adjusted disability worldwide and is projected to become the leading cause of death by 2040.⁴ While we successfully reduced mortality from heart disease⁵ and major killers,⁶ we have little success in reducing the occurrence of brain disorders. The brain is an organ of the body, yet compared to other organs, medicine has little to offer to guide people who are at risk for or who are developing brain disease. We believe that physicians and consumers must develop a new perspective on the brain — one that goes beyond mere, often-too-late diagnosis; we must incorporate principles of health promotion and disease prevention specific to the brain.

Recently, researchers have generated well-designed, large scale studies of healthy and diseased, aged human brains,⁷ resulting in a rapidly expanding amount of data. Sifting this information, and translating it into prevention and treatment options is important for care providers and health care consumers alike. We all need fundamentally sound advice and practical approaches to improve brain health. Unfortunately, we are bombarded by conflicting and competing claims about treatments and procedures offering health and longevity. This information explosion is taking place in a disorganized, anti-intellectual environment where “junk science” proliferates.⁸ Accessible, accurate information is often unavailable.

The Solution

That the HBP evokes memories of the Healthy Heart Program is not a coincidence. We use strategies that underlie highly successful healthy heart programs and apply them to the most important organ: the brain.

The HBP draws from evidence-based knowledge, debunks

junk science, is user-friendly and client-focused. The aim of the HBP is to give people a fresh look at the brain and to help people to understand the brain as an organ of the body.

The program is based on eight categories of brain health, each of which is supported by sound empirical research. Through workshops, participants are introduced to each category and are provided both basic information and practical health strategies to improve their function in each area:

1 Safety: Even mild head injuries are risk factors for early onset depression and dementia. Care practices begin at birth. Concussion and mild traumatic brain injury (MTBI) may initially be asymptomatic but subsequent impacts carry increasing risk. The young and old are high risk groups for head injury.⁹

2 Nutrition: There is nothing that a person who is in a good state of nutrition can eat to improve brain health. Mild nutrient deficiency states are common, however, and they do have psychiatric presentations. Obesity, which is now an epidemic, is a risk factor for diabetes and vascular disorders, both of which lead to brain disease. We need to be aware of the dangers of ‘natural’ remedies which can interact with medications.¹⁰

3 Physical exercise: The effects of exercise are so profound that exercise comes closest to what might be a fountain of youth. It improves circulation and produces many natural brain-boosting chemicals. Hormone balance, insulin resistance, sleep and general body chemistry are all improved. Exercise slows age-related organ deterioration.¹¹

4 Mental exercise: Brain stimulation increases blood flow and growth of specific brain regions and supports cells which feed neurons. Activity supports brain development and builds brain reserves against dementia.¹²

5 Sleep: Sleep is a complex process that is vital not only to rest, but to consolidation of learning, optimal cognitive function, mood regulation, and feeling of well-being. Most people do not get enough sleep: those under stress, children and the elderly need more, not less sleep.¹³

6 Stress management: While stress is ubiquitous, as are diseases related to it, most people are unaware of either the mechanisms of stress or the effects of stress on the brain. Excess stress hormones cause brain cell shrinkage and neuron death.¹⁴

7 Hormone management: The brain is exquisitely sensitive to hormones. We need accurate information on the relationship between hormones and brain function. Orientation to benefits as well as hazards are very important.¹⁵

Stephen J. Kiraly, MD, FRCPC

Stephen is a geriatric psychiatrist with the Department of Psychiatry at St. Vincent’s Hospital and a Clinical Assistant Professor in the Department of Psychiatry at UBC. He also works with the mental health team in Squamish, at Squamish General Hospital, and with the West Side Team of Vancouver Community Mental Health Services.

footnotes

For a full list of references, see www.healthybrain.org

The BC College of Family Physicians will be holding the 2nd Annual Healthy Brain Symposium on November 14 & 15, 2002 in Richmond. Information is available at the BCCFP office. Call Susan Roberts at (604) 736-1877. We have the honour of the presence of the Minister of State for Mental Health who has agreed to give the opening remarks on the morning of Nov 14th.

8 Treatment of risk factors: The most common causes for doctor's visits are depression, hypertension and diabetes — all risk factors for early-onset dementia. Physicians should be more assertive to educate and treat because evidence indicates that treatment will not only delay end-stage manifestations affecting the body, but what is more important, treatment delays premature deterioration of life quality accompanying early onset of brain impairment.¹⁶

There is collateral evidence for the efficacy of this type of health promotion. Healthy Heart Programs have been thoroughly studied^{17,18} with results generally indicating that these programs have positive impact on management of health risk factors and health care costs.^{19,20,21}

Conclusions

Working with the HBP has taught us two clear lessons. First, when people encounter brain impairment they are totally unprepared. Second, the average person has no idea of how to care for the brain. People simply do not know how the brain is built, what the brain does, nor how to take care of it. The unfortunate result is that people often turn to junk science for explanations of the brain and to dangerous quack treatments. The HBP's response to this is to teach people more about the brain, providing information at a very basic level of how the brain works and about safe, useful brain health practices.

The HBP is the first program of its kind. It has been accepted as the platform for mental health promotion by the [former] Coast Garibaldi Health Region. ■



Safety Nets

Avoiding Depression in the Elderly

Janice McTaggart, RN

Janice is Outreach Community Liaison and Coordinator of the Langley Seniors Peer Support Program.

Call your local seniors organization or community centre for resources in your area. Janice can be reached by email at lsrs@telus.net

There are many statistics that could be cited to support the notion that depression is a major health concern in the elderly. Instead, let's look at real people and real situations. It's a reality that this population endures more life changes in a shorter period of time than most adults. We commonly recognize significant life events as triggers for depression in other populations, but for seniors it can go unnoticed as just one of those things to expect as you get older.

Changes include:

Retirement

Retirement can be freeing, but can also lead to a loss of purpose and reduction in income.

Health

Chronic disease or sudden illness or injury can take a toll on one's self-confidence, especially for those who live alone. Many conditions or medications also carry with them the added symptom or side effect

of depression. Caregiver spouses are often victims of stress-related conditions and frequently die before their loved one.

Mobility

Challenges may range from the loss of a driver's license to the inability to walk. These changes can lead to a major loss of independence.

Bereavement

Whether it's due to loss of spouse, siblings and/or friends, it's difficult to replace relationships that have been nurtured for fifty years or more. Even the loss of a treasured pet has a significant impact.

Moving

Changes in health status or income are often accompanied by a change in housing needs. The loss of neighbours and familiar surroundings can lead to isolation and confusion. The loss of privacy, especially in care home situations is particularly difficult. Families are often far-flung

geographically and have limited time to spend visiting.

Social

Any of the changes listed above can contribute to the loss of social contacts and networks. Choices are reduced and seniors find themselves in survival mode. Fear and anxiety further reduce the senior's ability to reconnect.

How can seniors prepare themselves to manage these many life-altering events? Information is a key component. Having an understanding of and access to community resources allows more choice. More choice allows more freedom, more control and more independence. Making use of community support programs provides more human contact, more frequently. Knowledge reduces fear and anxiety and allows the seniors to again develop relationships of trust.

Most communities have recreational opportunities for

their senior population. Many have practical resources such as transportation assistance, telephone contact programs, meal delivery, and shopping and "home helps." Some may even have Wellness Centres or Peer Support Programs. Volunteering has become a popular way for seniors to continue to make a contribution in their community, make use of their valued skills and find a renewed sense of purpose. Weaving a safety net calls for strong connections. Tying those knots before you really need them will help to prevent the downward spiral that depression can become.

At the Langley Seniors Recreation and Resource Centre, we see the transformation in people on a daily basis. The many senior clients that I visit through the Seniors Outreach Program literally breathe a sigh of relief when they learn of the options that are open to them to enhance their quality of life. Sometimes, a little support and information is all it takes! ■

The Therapeutic Activation Group

A Cognitive-Behavioural Group Therapy Program for Seniors

Wanda is a seventy-eight year old widow. Her husband of 54 years died suddenly two years ago, just a few months after the couple moved to Kelowna from their prairie farm to be closer to their children and grandchildren. For the first few months after her husband's death, her children and a neighbour were attentive and considerate. However, as time went by, they called and visited less often, and Wanda found herself feeling increasingly depressed and anxious. Suicidal thoughts prompted her to seek help from her physician, who prescribed antidepressant medication and referred her to the Elder Services Program for additional support and assistance. She was visited by an Elder Services Program nurse, who suggested that she join the next Therapeutic Activation Group.*

The Elder Services Program (ESP) at Kelowna Mental Health has offered an eight week Therapeutic Activation Group (TAG) for women for several years, and piloted a similar group for men over the past two years. Both groups are modeled on the Changeways Program developed at UBC Hospital, but have been specifically adapted for either senior men or women. [Changeways is a group-based psychoeducational program that incorporates the techniques of cognitive-behavioural therapy.] At the present time, only the women's TAG is operational, due to staffing and budget constraints. Participants are cognitively-intact people over the age of 65 who have experienced depression, anxiety, panic or other difficulties adjusting to changes associated with aging. The purpose of the group is, over the eight sessions, to provide information about health and illness, enhance self-understanding, provide support and encourage individual strength.

Both TAG groups have been held at the Water Street Seniors' Centre in downtown Kelowna, a location intended to decrease the stigma associated with mental illness. It also encourages group participants to become more socially and recreationally active by introducing them to at least one community resource. When possible, the last meeting of the group is held in a private room at the nearby public library, thus acquainting group members with an additional community resource.

Facilitators of the women's group are Pam Mason, a Recreation Therapist contracted from the CMHA, and either Eleanor Fox or Lynn Fairey, Registered Nurses from the Elder Services Program. These same nurses from the ESP have also facilitated the men's group. Transportation for group members who do not drive is provided in partnership with the CMHA which supplies a bus and driver, Phil Abrams. Phil also provides rides for those who choose to attend the Primetimer's Group, a group for women

who have previously attended TAG. Because the women already know and trust Phil, they are more likely to attend Primetimers and this further assists them in remaining active and well. Primetimers and a Therapeutic Pool Exercise Group are special programs facilitated by Diane Muric under another partnership of the Elder Services Program and the CMHA.

The TAG sessions last for two hours with a brief break in the middle. Following the formal meeting, participants move to a dining area where a delicious soup and sandwich lunch is supplied at a nominal cost. If this is a financial hardship for any member, the cost is discretely paid with funds from the Mental Health Centre. Many of the ladies live alone and welcome an opportunity to share a meal and fellowship with others. Mealtimes facilitate the informal sharing of both social and therapeutic information by both group participants and leaders.

The formal group sessions consist of verbal presentations by the leaders and occasionally by guest speakers. These presentations are augmented by use of flip charts and printed handouts which may be kept for future reference. Group members are invited to participate in discussions and to ask questions, but are not required to speak if they are not comfortable.

Many topics are discussed over the course of the eight sessions. These include the causes and symptoms of depression, anxiety, and panic, and strategies for coping effectively. Helpful ways of adapting to stress are reviewed and time is spent practicing various relaxation techniques. A model for changing one's behaviour, thinking, and emotions is demonstrated, and each group member is encouraged to set and attain small, achievable goals each week.

Successes in achieving goals are lauded and difficulties are viewed as opportunities to learn more about oneself. Group members are asked to find one or more "highlights" each week and report them to the group. These may be as simple as enjoying watching birds nesting in a backyard tree, but these "highlights" promote the positive habit of actively seeking out enjoyment and pleasure on a daily basis. This is done because depressed individuals often lack energy or motivation to participate in previously-enjoyed activities, and may now derive little pleasure from them.

The importance of maintaining a balanced lifestyle, including good nutrition, sleep habits, and making time for emotional, spiritual, and physical activities is also stressed. Developing strategies for augmenting social support networks is a topic of particular importance as many group members suffer from social isolation. Unlike the women's group, the men's group complained

Lynn Fairey, RN, BSN

Lynn is based in Kelowna. He is a Registered Nurse and works out of Kelowna Mental Health's Elder Services Program.

* Wanda is a fictitious person who represents a composite member of the group.



Helping Seniors in the Fraser Valley through Group Approaches

The following is an interview with Dianne Liddle, Director of the Abbotsford Mental Health Centre. Visions asked her about two innovative group programs run by the Centre: the senior ladies' support group, and the early stage memory loss group, run in partnership with the Alzheimer's Resource Centre.

Senior Ladies' Support Group

Visions: Tell us a bit of the history of the senior ladies' support group.

DL: The senior ladies' support group has been available to women who are clients on the psychogeriatric team's caseload since I came to this office in May of 1994. I think it had a start before that. It has been a very successful resource to the

team for women who primarily have a diagnosis of depression and/or anxiety. It evolved because it became evident that many of the clients we were seeing had similar stage-of-life issues such as multiple loss, loneliness, feelings of inadequacy, regrets, family issues, etc.

Group work seemed a good way to approach an identified need to offer these women education about their illness, support, empathy, caring (and sometimes some gentle confrontation) from a trained facilitator (nurse/social worker) in a setting with peers with similar characteristics.

Visions: How do people come into the group? How long do they stay?

DL: The women in the group meet weekly at the mental health centre. The group is open and ongoing. The women have bonded, and for many of the women, the group is the major support in their life.

The group is a great way for the case managers to monitor their clients' progress. As client problems become more manageable and files can be closed, clients will leave the group. Some clients may feel that they no longer need the weekly group work and will come occasionally as issues arise in their lives.

Visions: What kinds of issues typically come up in the meetings?

DL: Case managers are always promoting and assisting clients to meet their emotional and functional optimal levels. Group work has been a great therapeutic tool in dealing with issues that relate to dealing with emotional and functional issues. As I mentioned, the stage-of-life issues related to family issues and losses are quite similar and often come up.

Visions: Is there anything else you would like to add about the group?

DL: The women's group was so successful that a men's group was started for a time a few years ago. However, the group format was not as comfortable for the men as it is for the women's group. It seems that most of the men we see in our work would not benefit from this approach.

Early Stage Memory Loss Group

Visions: Has there been a change in attitudes and awareness about people in the early stages of Alzheimer's or about Alzheimer's in general, about how capable people are, about what can be done to slow down the progression of the disease, or how to cope with it more effectively?

DL: The public in general is more aware of Alzheimer's disease. This is likely because of the huge effort in support and education sponsored by the Alzheimer's Society.

There also has been a lot of research interest in the field of

The Therapeutic Activation Group (cont'd from previous page)

of difficulty finding meaning in their lives after retirement, and time was devoted to addressing this key issue with them. Both men and women benefit from practicing assertive communication skills, and some groups express a need to explore grief and mourning. Anger management is identified as an important topic for men, while both groups appreciate information about medications presented by a family physician or mental health pharmacist. At the last session, ways of maintaining good health and preventing relapse are discussed. At the conclusion of the eight sessions, group members are given an opportunity to provide written and verbal evaluations of the experience, which provides helpful information for facilitators planning subsequent programs.

Women are strongly encouraged to join a Primitimers Group at the end of their participation in TAG. If Diane Muric, Primitimers facilitator, notices that a participant is becoming unwell, she requests permission to contact the appropriate ESP team member and the woman is visited to provide support and prevent the development of more serious problems. There has been no Primitimers Group for the men and so a men's support group has been formed. This group meets every second week, facilitated by an ESP nurse, and provides ongoing support, activation and social opportunities for the men. Both men and woman have found that the TAG sessions and integrated follow-up groups are helpful in assisting them to maintain optimum health and to prevent relapse.

Wanda* attended all of the TAG sessions and participated enthusiastically. Although initially nervous about the group, she quickly realized that others shared her feelings and she felt relieved to find that her experiences were not so unusual. She particularly enjoyed meeting the other women and her weekly goals included phoning them and later going for walks with several of them. With the encouragement of the group, she decided to join a church near her home and found some new friends and activities there. She joined the Primitimers Group and continues to participate actively. She is now more aware of her health and notices if her stress levels increase. If that occurs, she speaks with Diane or requests a visit with her ESP therapist. She is doing very well and now describes TAG and Primitimers as "the best thing that has happened to me since I moved here." ■

aging, and specifically in the area of Alzheimer's disease and other dementias.

In the *Commentary* page of the *Vancouver Sun* on January 6, 2001, there was an article titled "Flexing our Brains" that talked about recent developments in dealing with dementia in a more preventive manner. The article states that "researchers are discovering the keys to keeping mentally fit ... for example, continuing education throughout life, stimulating the mind by playing difficult games, [and] seeking ways to be creative and tackle a new challenge each day."

The article goes on to say that "generally this stimulation helps increase self-esteem and confidence and even seems to help people overcome illness or recoup from [dementia], ... [and it results in] fewer doctor visits." The article also notes that "research on rat brains indicated that even an elderly brain, with the right stimulation, can grow more of the connections called dendrites, which are part of neural pathways."

Visions: How did the early stage memory groups get started?

DL: The Alzheimer's Society spearheaded this initiative, I believe, from the Langley group, and I think most communities now have these type of groups running.

Visions: How does your partnership with the Alzheimer's Resource Centre work?

DL: Gwen Pym is the Support and Education Coordinator for the Abbotsford Alzheimer's Resource Centre. Abbotsford Mental Health has a wonderful working relationship with the Centre. To begin with, we

offer our site for her caregivers support group to meet, and we sit on a variety of community networking committees, including our local mental health advisory council. So, when Gwen approached us with the idea, the staff of the psychogeriatric team thought it was a great idea to offer a 'memory group.'

Visions: How is the group structured?

DL: It is really a support group for people experiencing memory problems. It allows these individuals to be together in a caring and understanding environment. They share experiences, express feelings, learn more about memory problems, learn about helpful resources, and hear about advances in research and advocacy. People are screened before coming to the group. The group is open-ended, and as I said, it focuses on socialization, education and support. The group has goals and rules and they follow a group process model to ensure a safe, trusting and confidential environment. Gwen and Rose Adrian, an RN, facilitate the group.

Visions: What kinds of benefits does the group offer to the participants in dealing with their memory loss?

DL: One of the many benefits of the group is that it offers its participants a shared awareness. Members offer each other tips for what they are doing to remember things. The group also has some mental aerobic exercises (games and such) they do in the group. ■

Seniors Friendly Visitors Program

The Seniors Friendly Visitors Program is offered through the Volunteer Bureau at Canadian Mental Health Association for the Kootenays. This program addresses the risks and needs of the isolated frail elderly in the community. Seniors Friendly Visitors are trained volunteers who are willing to commit two to three hours per week to visit a senior. Included is a mandatory seven-hour basic training specific to seniors visitation. Visitors may choose to visit with the senior in their home or take them on an outing, help with house or yard work, play cards, or any other activity agreeable to both.

Contributing partners include Involve BC, The Vancouver Foundation, and the Interior Health Authority.

At-risk seniors are referred to the program through a variety of sources, including the Cranbrook Community Response Network, various social services agencies, mental health organizations and family members.

The Seniors Friendly Visitors Program is designed to provide services to:

- socially isolated seniors
- at-home seniors requiring assistance to continue independent living
- seniors living in supportive housing
- those seniors at risk of self-neglect due to lack of family or social supports
- seniors at risk of physical, emotional, psychological or financial abuse by others
- seniors at risk of substance abuse
- physically disabled seniors
- seniors who are reluctant to, or not capable of, making referrals for themselves.

Volunteers provide services that include:

- basic assessment of domestic conditions (volunteers may be the first to notice changes in function or habits that add to a participant's risk)
- social interaction; this may include home visiting, visits to friends or family, or social activities
- home care, maintenance, and other services
- friendship and understanding.

Community benefits include:

- quality-of-life improvement for at-risk seniors
- an anticipated reduction of demand on health and community care services
- greater integration of seniors into the community. ■

Jackie Rankel

Jackie is from Cranbrook, and works with the Volunteer Bureau for CMHA for the Kootenays.

For more information on the Seniors Friendly Visitors Program, contact Jackie Rankel at (250) 426-8019 or visit CMHA for the Kootenays' web site at www.cmhakootenays.org

The Geropsychiatric Education Program

Joan Hibbard, BScN

Joan works as an Educator with the Geropsychiatric Education Program in Vancouver, of the Vancouver Coastal Health Authority.

What should we do with Helen? She's a resident on our special care unit and always resists having a bath." The Geropsychiatric Education Program (GPEP), an education service of the Vancouver Coastal Health Authority, would be quick to respond to this request. They would assist the staff to do a resident care review, exploring the resident's behaviour in relationship to her physical and mental health diagnoses, her personal history, the physical environment and the staff's approach.

Established in 1995, in response to the downsizing of Riverview, the Geropsychiatric Education Program was a joint venture of Vancouver/Richmond Continuing Care and Mental Health. It is comprised of educators from a variety of health care disciplines. The mandate of the Program is to address the psychogeriatric education needs of staff who work

in residential care facilities, adult day centres, home support agencies and community health services.

The core programs offered by GPEP range from one to eight hours, and address a variety of topics including the "3 D's" (dementia, depression and delirium), managing verbal and physical aggression, communicating with clients with dementia, bipolar disorder, and team building. Following a workshop addressing challenging resident behaviours, one staff member stated, "This course helped me understand more about the person, where he might be coming from, and how I could communicate with him better."

Underlying all GPEP programs is the basic principle of person-centred care — care that addresses the specific needs, interests and personality styles of each client or resident. Staff are encouraged to explore the life history of residents, to under-

stand the "who" of the person, not just their diagnoses or health concerns. As one residential care staff stated, "it's about honouring who they are as persons ... it takes the resident out of the passenger seat and puts him behind the steering wheel."

Over the past three years, GPEP has offered several care facilities an opportunity to be part of an innovative nine-month person-centred care project. The project includes staff and family education, resident care reviews, and creative projects designed to enhance care that is person-centred. Administration, staff and families continue to attest to the positive benefits experienced by both residents and participants.

The Caring and Learning Together Program (CLT) is another GPEP program that targets community health care workers and family members. A 24-hour mental health education program, CLT is de-

signed to enhance the caregiving abilities, skills and confidence of family caregivers and home support workers. Now in its fourth year, CLT has graduated over 500 participants. One family member had this to say about the program: "as a caregiver you begin to feel overwhelmed, frustrated, incompetent, discouraged and disappointed ... this course gave me helpful hints and guidelines for understanding mental illness, how to care and communicate with my family member, and how to care for myself."

With ongoing challenges to the health care system, and the increased demands of caring for older adults with mental health concerns, the Geropsychiatric Education Program plays an essential role in supporting staff and family members to provide quality care. GPEP can be contacted at (604) 742-5240 or through its web site at www.gpep.ca ■

In Search of Meaning

An Approach to Educating Long-Term Care Staff on Meeting Seniors' Mental Health Needs

He enjoyed the new place. The stairs were a little tricky but once he found the way it was easier. The others found them more difficult. He was doing his best to help the others but the younger ones only talked in that weird language and kept taking him back to do the stairs again.

Dementia is an acquired illness that affects the functioning of a once-normal brain. There are several causes like Alzheimer's disease or brain attacks (strokes). The key feature is that the person has memory loss. In Alzheimer dementia, the person cannot

remember after a short time frame and as a result is unable to learn anything new. With brain attacks, depending on the location of the assault, the person will experience either short-term memory loss — the inability to learn new information — or the loss of segments of past memories. The disease does not stop but goes on to affect other brain functions like speech, understanding words, inhibitions, planning, and even the loss of bladder and bowel control.

With the progression of the disease, the person requires an

increasing amount of care that can be complicated by behaviours that place them or others at risk. It is usually at this time that the person will be admitted to facility care.

As a nurse with the Elderly Outreach Service, my focus is to assist staff in providing care for seniors who are presenting with challenging behaviours due to dementia as well as other mental health challenges. This is accomplished by blending formal teaching sessions with specific resident-focused care conferences. In other words, I assist the staff in finding meaning for the person's behaviours and assist in developing other ways to respond to the underlying needs, or in adapting the environment.

To begin, it is important to gather all the facts like past occupations, medical history, past personality and coping skills, present cognitive abilities, staff reports of the behaviours and attempted interventions, and staff and family expectations for the person with dementia. Our search is for the skills that are still present rather than just the deficits. In a case in-service/conference all the information relating to understanding the disease and the person is shared. It is from this sharing that possible meanings for the challenging behaviour unfold. Once a meaning for the behaviour is discovered, a brainstorming exercise requires all partners in the person's care to be creative and flexible in coming up with an intervention, and to be willing to try the interventions discussed.

In the scenario outlined in the opening passage, the gentleman had lost the ability to understand the spoken word, but could still read and understand what he read. As he had always been a helpful person, and since the sign over the door in red

lights said "EXIT," he would help the other residents to follow the directions. The solution to the situation? A sign on the door at his eye level that said, "Pete, do not open this door."

Our seniors with dementia are doing the best they can. Because they physically look the same as when they were able, it is difficult for some people to see how hard they are trying. As a human, we tend to cover up for what we can no longer do, and as a result family and friends can become alienated when the person hides behind a difficult behaviour or an ineffective coping skill.

With dementia, memories unravel and the person relives previous life events. This same gentleman, who would climb into other resident's beds with them, was not making a sexual overture, but looking for the comfort of another person. He came from a large family, where several children shared a bed, and he had been married for many years, so he had never had slept alone.

In our fast-paced society, we rely on the spoken word, but once the person has lost that skill, we tend not to stop long enough to get the message from their behaviours. If you are in a foreign place with people who do not speak your language, and you need to go the bathroom, what would you do? After you have searched the area, tried to do the needing-the-bathroom dance, and the urge continues, would you find a dark corner, wet yourself, or just pull down your pants and go wherever you are? You have just had a glimpse into the world of a person with dementia. ■

Irene Barnes, RN, BSN, GNC(C), PMHN(C)

Irene is certified as a Gerontology Nurse and a Psychiatric Mental Health Nurse. She works with the Elderly Outreach Program in Victoria and has authored *Musings From A Dementia Unit* (available from the Alzheimer's Resource Centre on Quadra Street) and several articles on dementia in facilities for the journal *Canadian Nursing Home*, based in White Rock.

Elderly Outreach Service

A Community Mental Health Program for Seniors

The Elderly Outreach Service (EOS) is an interdisciplinary community mental health program for seniors that started as part of the Victoria Health Project in 1989. The Victoria Health Project started with a commitment by the government of British Columbia to dedicate \$4 million in each of two years to develop services for the elderly in the region. EOS was one of 11 successful proposals out of the 113 submissions generated by the call for proposals.

The program serves the Greater Victoria area of BC including the southern gulf islands, Salt Spring, Galiano,

North and South Pender, Mayne and Saturna — a region where about 19% of the population is over 65 years of age. The EOS provides comprehensive, coordinated, and prompt interdisciplinary assessment, consultation and short-term treatment to individuals aged 65 and older experiencing a late-onset mental health problem. In its fourteenth year, the program has responded to over 9,000 referrals of seniors experiencing mental health problems. EOS was the first program of its type in BC and was the model for similar programs in over 50 communities in the province.

Education to seniors — and to both formal and informal caregivers — is an integral part of the program mandate (see the article by Irene Barnes, above). Team members have presented hundreds of educational sessions over the years. With the Alzheimer's Society, the program has initiated and co-sponsored six conferences on dementia care. The program has also acted as a training centre for professionals by hosting many student practicum placements from universities in BC and other provinces. In addition, EOS staff have presented our use of Goal Attainment Scaling (GAS) to many mental

health programs in Edmonton, seven of which adopted the use of GAS following the presentation. Clinically, Goal Attainment Scaling is used to track outcomes in service provision and show that clinicians are meeting clinical goals set for/with clients.

Community linkages are vital to the work of the program. Linkages have been proactively established with hospital-based programs, not-for-profit agencies such as the Alzheimer's Society, long-term care services and any service that works with seniors. Some community

Giuseppe (Joe) Scaletta, MSW

Joe is the Coordinator of the Elderly Outreach Service for the Vancouver Island Health Authority (South Island).

stats

Program team disciplines include:	
Geriatric Psychiatry	0.9
General Practice Physician	1.8
Nursing	4
Social Work	2
Occupational Therapy	1
Psychology	1
Neuropsychology	1
Admin. Support	2.6
	14.3
Full-time Equivalents (FTEs)	

initiatives include the establishment of a dementia-specific day centre, development of a video library on seniors' mental health issues, the presentation of numerous educational sessions for formal and informal care providers, as well as the co-hosting of six conferences on dementia care. In a survey of referral agents, over 90% of respondents indicated that they were

ty care staff. The program has two intake/clinical meetings a week at which new referrals are discussed and assigned, where clinicians do case presentations on clients recently accepted into the program. Each client has a clinical assessment by one of the team members. Depending on client need, more than one discipline may be involved in completing the team assessment. The results of the team assessment are then sent to the client's family physician and long-term care facility if a person resides in one. Care plans and treatment goals are agreed on during clinical meetings using the Goal Attainment Scaling format. The team uses a case management approach, with each client having one case manager on the team who is primarily responsible for assessment and follow-up within the program.

EOS was surveyed and accredited by the Canadian Council on Health Services Accreditation in November 1996 as a Ministry of Health Mental Health program, and in February 2000 as part of the Capital Health Region accreditation.

The trend for the program over the past several years is that it is seeing an older population and an increasing number of people with dementia.

Recent Developments

With the regionalization of health care that has taken place over the past several years, there were new opportunities for collaboration and development of services, and a review of psychogeriatric services in the region was undertaken. The result was the development of a geriatric psychiatry continuum of care, encompassing community outreach mental health services to seniors (EOS), an outreach substance abuse pro-

gram for seniors (VISTA) and two inpatient services: a 25-bed geriatric psychiatry assessment and treatment unit and a 36-bed behaviour stabilization

unit. Clients are able to move within this continuum as their care needs require and also have access to long-term care services in their home. ■

The Upper Island Geriatric Outreach Team

The Upper Island Geriatric Outreach Program provides a multidisciplinary, comprehensive, individualized psychiatric consultation service for the residents and health care providers of North Vancouver Island. This service addresses the special and often complex mental health needs of seniors through assessment and diagnosis; treatment recommendations; outreach consultation to Indian Bands and remote Northern communities; liaison with all health care service providers; individual and family education; in-services and workshops for caregivers, professionals and the public; consultation to hospital and care facilities; program development; research; and the prevention of illness and the promotion of health.

As the number of older adults with complex health care issues increases, the demand for coordinated health care is growing. There are different types of health care delivery systems and a vast array of community-based services, both public and private. Matching this complex system to the multiple needs of older adults requires a coordinated, collaborative effort by a team of professionals and caregivers across the entire continuum of care.

The philosophy of today's health care delivery system focuses on health promotion and illness prevention. With this shift in philosophy towards optimal health rather than treatment of illness, mental health is being seen as an essential component of a healthy lifestyle for seniors. Recognizing their responsibility as active participants in their health, the residents and health care professionals of the North Vancouver Island communities lobbied for enhanced resources and for equal access to programs that support effective health promotion and optimal level of functioning. They were successful in acquiring funding to develop this traveling team.

The goal of the Upper Island Geriatric Outreach Program is to collaborate with all of these communities to enhance their health potential through specialized assessment, treatment and education for seniors, and consultation and education for service providers. The program functions within a community collaborative care model that has evolved in cooperation with health care professionals, administrators, educators, volunteers, and the residents of each community. This cooperation led to the

2001 referral stats

Total referrals = 794

Age Range	Female	Male	Total	Percentage
Under 65	11	7	18	2%
65-74	70	39	109	14%
75-84	272	101	373	47%
85+	208	86	294	37%
Total	561	249	794	100%

Cases closed during 2001

590

Total Cases Open during 1999

905

Average length of stay

137 days

Cases open @ Dec.31, 2001

315

satisfied or very satisfied with the program.

Ongoing quality improvement is an important part of the program. All cases are presented at interdisciplinary clinical meetings to ensure that each client has the benefit of an interdisciplinary assessment. Other quality improvement measures include tracking service delivery to ensure equitable access to the service by each region.

EOS has an open referral process. About half of the referrals to the program come directly from family physicians. Another 25% to 30% come from long-term care and facili-

creation of formal and informal health care service provision links throughout the North Island.

Collaborative care is a process of needs identification and service coordination that is designed to maximize the function and independence of the individual, while also recognizing the individual's right to self-determination. It involves coordinating the different types of health care provided in all settings, including the home, medical clinic, hospital or long-term care facility. It involves collaboration among all of the health care providers: physicians, nurses, social workers, psychologists, occupational therapists, physiotherapists, home support workers, volunteers and most importantly, families.

Effective collaborative care is a dynamic process that allows for change in accordance with each individual's needs. Individuals and their families are informed of options for care, both in their immediate environment as well as throughout British Columbia, in line with their needs. Care is provided from a conceptual perspective that recognizes and appreciates the medical,

functional, psychological, social, environmental and spiritual needs of each individual. Individuals actively participate in the formulation of the plan for care and the evaluation of the plan's effectiveness.

Given precious financial, time and professional resources, the Upper Island Geriatric Outreach Program delivers services via consultation. Assessment reports are generated and liaison established with the referring source(s) who then make independent decisions regarding any recommendations.

Team Statistics

The team consists of 1.6 FTE nursing, 1.75 FTE occupational therapists, 1.0 FTE administrative support and 2.0 FTE geriatric psychiatrists. In the fiscal year 2001/02, team members provided 686 assessments to referring sources, 359 of which were for new clients. Direct client contact occurred 4,392 times during this period. ■

Sandie Somers,
RPN, MEd

Sandie is based in Comox and is the Coordinator of the Upper Island Geriatric Outreach Team. She is a geriatric nurse clinician/educator with 26 years experience in the field of geriatric psychiatry and is a founding member of the BC Psychogeriatric Association where she currently is on the Board of Directors.

Helping the Forgotten Pioneers

A Northern Approach to Supporting Seniors with Mental Illness

 Older adults with mental health problems face a life with many barriers and problems. Living in the northern half of the country adds extra challenges. The people who call northern BC home have a sense of isolation from the ease of southern climates and southern solutions. The term 'pioneer' describes northern seniors well (however they come to be here) as there is a shared identity of independence and self-reliance that runs deep in these hearts. Acquiring a mental health problem does not change this identity. The things that make northern pioneers stand apart from other seniors have shaped the services that Community Mental Health offers to them.

Mental illness in old age has many different faces, and consequently many different ways

of assisting these people have evolved. The Elderly Services Team has targeted help to seniors with severe behavioural problems and to the caregiver systems of these seniors. While Alzheimer's disease is commonly known, in our practice, it is one of the challenges that family doctors and long-term care facilities handle quite well. Our efforts are more needed for other situations.

Northerners across Canada have a tendency to drink harder and smoke more than people living in the south, and this leads us to strokes and the late-life effects of alcoholism and lung disease. Diabetes rates in the North are high. In addition, working in the bush and on the land is dangerous work, and head injuries are also common. Any of these factors can lead to brain damage and subsequent behaviours and think-

ing problems that make others shun the sufferer. We have come to think of older adults with this range of difficulties as 'forgotten pioneers.'

Some of the common problems in serving seniors with mental health problems are that the health and social services designed for older adults do not take into account those with no families to assist them, or those whose thinking is poor but whose bodies are relatively healthy. Many of our clients fall into one or both of these groups. Mainstream housing services for seniors are scarce in our towns, and mental health services for younger adults concentrate on rehabilitation, not retirement.

Our clients over the years were having a hard time keeping a roof over their heads, food on the table and remembering when or how to take medicines.

The finer points of their illnesses couldn't even be worried about until these things were handled.

In the mid-1990s, our team spent innumerable hours negotiating on behalf of clients who had been evicted for disorderly conduct, drunkenness, or extreme poor hygiene. We even had a client who lost his housing, slept in a ditch, spent a few nights at a local men's shelter and subsequently suffered from a delirium and died shortly thereafter.

Another set of challenges was that home support workers had been forbidden to socialize except in the most rudimentary fashion with clients, assisted shopping was seen as too time consuming, and unless being taken to a health service, transportation was not allowed. Consequently many of our clients were left lonely,

Karla Staff MSW,
Louise Holland RSW,
and the Elderly Services Team

The Elderly Services Team is part of Community Mental Health Services based in Prince George under the Northern Health Authority. The authors wish to acknowledge Operation Friendship of Edmonton for the term 'Forgotten Pioneers' and CMHA Prince George for leadership and support.

Dedicated to the memory of Leslie Ann Perkins (1946 ~ 1999).

disconnected from services, and due to the mental disorders could not organize their own shopping, banking or even meals at seniors centres.

Financial problems were possibly the biggest underlying factor in the loss of housing, poor nutrition, and poor connections with the community. Many of the clients were no longer able to organize themselves to pay the rent and purchase groceries. Even though most of these clients were only on basic pensions, they were ineligible for crisis grants from the province because their pension incomes were still higher than the provincial welfare rates.

One of the things we envied were the talents and services of Lee Perkins who worked at CMHA Prince George. She had developed a special set of

skills to assist younger consumers. Through negotiation and firm fairness, she taught many young men and women the hard truths about living on small incomes. She also knew how to find resources and key people in organizations to give her clients all available opportunities. For a brief period, Lee worked on our team and taught us to put the bottom line and the creative mind together. While redeveloping her techniques, we learned how stabilizing income could be the key to housing, nutrition and enormous gains in health for cognitively-impaired seniors.

Because Prince George has the qualities of a small town in its connectedness and shared sense of community, Lee and our life skills staff, Maureen, Pat and Linda could turn their personal knowledge of resour-

ces into opportunities for our clients by working with service clubs, seniors centres and other community members to build a network of recreation, meal supports and social skill building, all of which enhances our other work. Mental health professionals are scarce resources in the North, and using this approach allows us to stretch our services much wider.

The most visible asset we have created to serve older adults with mental illnesses in Prince George is the supported housing program. Due to the amalgamations of services that took place in 1998, seniors housing became part of the health authority's responsibilities. We lobbied and received permission to use one block of seniors' subsidized housing specifically for our clients. This allowed us to cluster home

supports, health services like medication administration and symptom monitoring, the social programs and individual financial management into an 'assisted living' model. This has led to gains for the 20 people who live there, but also for up to 30 more people we can continue to support in their own homes with the stabilization and enhancements we have learned to provide.

Because we didn't believe we couldn't, because we used everything we could find like a farmer uses baling wire, and because we have such a good time doing it, we now have an excellent community-based service which other seniors often ask to join, not being able to see the problems which used to cause these pioneers to be 'forgotten.' ■

Salmon Arm Mental Health Service Elderly Services Program

How it Grew and Why it Works

Lyle Petch, MSW

After many years, Lyle has very recently retired from his position as Director of the Salmon Arm and Revelstoke Mental Health Service.

The development of community mental health services for adults over 64 years of age followed the implementation of services for the 19–64 age group. The elderly mental health service beacon was not switched on until the mid to late 1980s, when the Ministry of Health, Mental Health Division launched a program to address the specific mental health service requirements of this group.

In Salmon Arm, our first exposure to the program was through educational workshops, offered to physicians and interested agency staff by geriatric psychiatrists working in provincial mental health facilities like Riverview or Valleyview. These sessions were of limited use from a service point of view, but they did signal the presence of an entire population group that the mental health service had neither the knowledge, skill nor resources to recognize, let alone assess and treat.

The initial model, proposed by the Mental Health Division, called for multidisciplinary teams, which would receive referrals, conduct assessments and provide care-plan recommendations back to the referral source. These Geriatric Assessment Teams (GATs) were the suggested framework for development of the

elderly mental health service in the Mental Health Centres.

There were some problems with the implementation of the GAT format, beginning with the funding of the teams. Generally, larger centres received funding before the smaller communities. In Salmon Arm, the physician sessional funds were available at least two years before the first staff funding appeared.

The sessions signaled the presence of an entire population group that the mental health service had neither the knowledge, skill nor resources to recognize, let alone assess and treat.

That first sessional physician functioned in an assessment capacity, usually within the long-term care facilities and in concert with the Continuing Care assessors. During this initial phase, we began to address the inappropriate, albeit well-intentioned, prescribing practices of attending physicians, who were unaware of the special medication requirements of their elderly patients.

Eventually, in 1993, a staff social worker was hired into the Elderly Service Program, rendering the team two-dimensional, and now on its way to multidisciplinary status. At this point, another problem appeared. The GAT model, as proposed by the Mental Health Division, seemed incomplete. Receiving referrals, conducting assessments and handing the care-plan recommendations back to the referral source, although tidy, left someone else holding the treatment and implementation bag. Frequently, those service providers felt abandoned by the Mental Health Service and wanted more support.

We resolved that dilemma by deciding to provide not only assessment, but treatment and case management services as well. This was in keeping with the Adult Services, which had always assumed that responsibility. In hindsight, it seems incongruent that the Elderly Service would not have offered that full spectrum of service.

The decision was well received by the community, which perceived the Mental Health Centre Elderly Service Program as offering real service where it was needed. Our willingness to respond, however, led us inevitably to our next problem, which was the limit on our ability to respond to requests for service, and the resulting pressure on the two-member team.

All of our best intentions and hopes notwithstanding, five long years passed before additional funds were available to make this team truly multidisciplinary. In 1998, a second social worker was hired and in 1999, a nurse joined the team. In 2000, a part-time contract position was expanded to provide full-time case management services to Enderby and Armstrong. Some of these funds came from the first, and so far only, mental health plan funding to come our way.

Most recently, in May 2002, after 2 years of negotiation, the Interior Health Authority transferred 3.14 FTE Elderly Outreach Workers to the ESP from the Home Support Service, clearing the way for daily support service offered in a flexible and responsive way, and freeing us from the rigid hourly scheduling process entailed by Home Support.

The Elderly Service Program has benefited from the collegial and collaborative teamwork in the Mental Health Centre. The Adult Services Program Coordinator offered the ESP an evening nurse position that was clearly more necessary in ESP than in Adult Services. This evening nurse works from 5pm to 9pm on weekdays and 4 hours each on Saturday and Sunday, providing after-hours follow-up and support where and when needed.

The current Program Coordinator of the Elderly Service Program, Dustine Tucker, has provided excellent leadership to this team, which is now able to provide a full spectrum of service to clients in the Shuswap area. In Revelstoke, we do not have the capacity to provide direct service, but we do offer a regular case conference format with Community Health Care assessors and we deliver some educational programs. The ESP consultant physician provides assessments and treatment recommendations.

Why does this program work?

- 1 **First**, the Mental Health Centre recognized that this population was a neglected group, and embraced the concept of developing a service that catered to their particular needs.
- 2 **Second**, the service was designed to be helpful and hands-on, providing not only consultation and assessment recommendations, but treatment and case management, in keeping with the standards established by the Adult Mental Health Service.
- 3 **Third**, the Elderly Services Program identity was thoughtfully nurtured and clarified as we grew to understand the very special mental health service needs of elderly adults.
- 4 **Finally**, the ESP was defined as a core program in the Mental Health Centre and was given an appropriate share of new funds as they became available.

These four measures have put the Elderly Services Program where it rightfully deserves to be: on the same playing field as the Adult Mental Health Service, offering the same standard of service. ■

Listening to the North Okanagan

A Systems Approach to Accountability

In 1999/2000 as part of a mental health system review conducted in what was then the North Okanagan Health Region (NOHR), CMHA BC Division completed a Regional Seniors' Mental Health System Progress Report.

CMHA BC and the NOHR heard from over 200 respondents, including seniors who had received mental health services, family members of seniors receiving mental health services, mental health service providers, family doctors and a wide range of respondents external to the formal mental health system, including people from Continuing Care, Home Support, the Hospice Society, the Caregivers' Associ-

ation, and the Alzheimer's Society, among others. Based on the information gathered, local Progress Report steering committees identified strengths of the regional seniors' mental health system and areas for improvement.

System Strengths

Three areas of the seniors' mental health system were identified as working particularly well in the North Okanagan. These three areas were the Geriatric Assessment Team, front-line mental health personnel, and support groups and companionship. The quotes that follow illustrate some of the key strengths identified.

Catharine Hume

Catharine works for CMHA BC Division, where she is the Coordinator of the Progress Report initiative. She and Shelagh Turner, from CMHA's Kelowna-based Consumer Development Project, completed the North Okanagan Progress Report.

- *“In this last year we have been able to utilize a visiting psychiatrist service for our seniors (which is working well).”*
– Revelstoke Hospital
- *“[There were V]ery caring and supportive people (staff).”*
– family/caregiver (Vernon)
- *I have received help from various sources in the Shuswap but my group has helped me the most.”*
– senior (Salmon Arm)

The ability to get out for activities and companionship as well as attending information sessions and support groups were repeatedly identified by respondents as strengths of the system. This finding highlights the importance of bringing seniors together for support and mutual aid thereby reducing the isolation experienced by many.

Areas for Improvement

In addition to the strengths, the following three key areas for improvement were identi-

fied: increasing access to mental health supports for seniors, strengthening the integration of the seniors’ mental health system within the larger seniors support system and the community at large, and improving both the provision of information to seniors and caregivers and their involvement in decision-making.

Access

In the area of access, the following four key themes were identified: lack of knowledge of seniors’ mental health services among seniors and the general public, poor early identification of mental health issues among seniors, internalized barriers to accessing services among seniors, and limited seniors’ mental health resources particularly in outlying and remote areas of the region.

The area most identified as needing increased attention was the area of outreach and education with the goal of raising awareness about the supports and services available to seniors with mental health difficulties in the region.

- *“I had trouble finding information ... felt like I had to fight to get anything.”*
– family/caregiver (Enderby)
- *“The first bout I didn’t know where to turn to. Now I do.”*
– senior (Salmon Arm)

In terms of early detection, the findings suggested that mental health supports only become available at the point of crisis.

- *“Problems go unnoticed or not reported until it becomes a crisis.”*
– crisis line (Vernon)
- *“I believe that mental illness in the elderly often goes undetected. Therefore it is difficult to say they get the help they need.”*
– family doctor (Revelstoke)

A number of possible responses to improve early identification were suggested, including increasing general awareness of the early signs of mental health difficulties among seniors. Another barrier to effective early identification identified was seniors’ own internalized barriers to asking for help.

Increasing access to local and regional mental health services for people living outside the core service areas was also identified for improvement. While the Geriatric Assessment Team was identified as a key strength of the Vernon seniors’ mental health system, concerns were expressed regarding its accessibility to outlying areas. In addition, in Revelstoke at that time, very few respondents experienced the presence of a mental health system for seniors at all due to a lack of human and financial resources.

- *“90% of resources are centred in Vernon. [This] makes access difficult for many.”*
– “external” (Armstrong)
- *“We have no mental health services for seniors.”*
– “external” (Revelstoke)

Integration

The area of system-community integration, that is to say, the extent to which the mental health system for seniors works with, and responds to, external groups and the community as a whole, was also frequently identified by respondents as an area for improvement.

Within this area, the following three key themes emerged: the lack of role clarity between and among seniors’ mental health services, continuing care and community groups and organizations working with seniors, particularly with respect to the lack of clarity about criteria for involvement in specific services; the need to strengthen the involvement of

family doctors in the seniors’ mental health system; and the lack of effective care coordination when multiple services are involved in a senior’s life.

- *“The reality is that mental health and physical concerns are difficult to separate, so the artificial jurisdictional separation sometimes causes coordination problems.”*
– family doctor (Salmon Arm)
- *“As a professional dealing with seniors, I need direction and I need someone sitting at the table with us weekly. We don’t have that.”*
– “external” (Revelstoke)
- *“Fragmented, unclear communication regarding what services are available when and where.”*
– caregiver (Salmon Arm)
- *“Stronger networking between the clergy and other mental health professionals (is needed).”*
– religious leader (Revelstoke)

Information and Involvement

Finally, in the area of providing seniors and caregivers with relevant and timely mental health and medication information, and meaningfully involving them in care decisions, two themes emerged. Firstly, the provision of information from the mental health system to seniors and caregivers tends to be passive; that is to say the onus is often on the senior or caregiver to ask for information and/or clarification rather than it being provided as a matter of course and in a way that is easily understood.

- *“You have to ask the right questions.”*
– family/caregiver (Vernon)
- *“There is a need for less medical jargon and more simple, down-to-earth information.”*
– religious leader (Vernon)
- *“This information (re: the*



illness or medications) is usually given while the individual is still in crisis, during the early stages of medication, and the information is not retained or understood.”

—residential facility (Vernon)

The second theme in this section was the finding that seniors are generally not involved in decision-making. A significant number of quotes from service providers within and beyond the mental health system suggest that some assume that seniors lack the competence and/or motivation to be meaningfully involved, either through the provision of information or direct involvement in decision-making. Quotes from seniors and family members, however, generally suggested that more information and involvement is needed.

There were a number of system-level findings that were common to both the adult and senior mental health system Progress Reports in the North Okanagan. Areas for improvement common to both systems included the need to:

- increase public awareness of existing mental health resources
- strengthen early identification capabilities
- ensure better access to core regional and community-based services for people from outlying areas
- create coordinated networks of services and supports
- provide clear and helpful information to people with mental illness and their families.

While these findings are specific to the North Okanagan, it is likely that these broad areas for improvement are common to many local and regional adult and senior mental health systems.

Since the Progress Report was completed in 2000, a number of recommendations have been implemented in an attempt to improve local and regional mental health services.

Involving seniors, their families and key external groups in accountability exercises such as the Progress Report has proven to be an effective way to create local momentum for change,

as well as a concrete way to demonstrate the value of incorporating people's direct experiences into mental health service reform efforts. ■

Vancouver's Geriatric Crisis Service

A psychiatric geriatric emergency is an event with a psychiatric/behavioural component, involving an elderly individual, requiring a rapid response to ensure the safety of the individual and others, that can't be managed initially in the current environment.¹ The Geriatric Crisis Service exists to fill gaps in the emergency and crisis services to the psychogeriatric population through improved communication with the client and caregiver. This service was initiated in the late 1980s, operated seven days a week and was staffed by two nurses, one full-time and one part-time. The program expanded; now there are two full-time nurses.

Mission Statement

The Geriatric Crisis Service provides support to frail seniors in psychiatric crisis and their formal and informal caregivers. This enables them to engage appropriately with community resources. The support provided includes emergency assessment; assistance with accessing hospitals if needed; links to community services; short-term follow-up; client advocacy; education of clients, family and facility staff; consultation and assistance from the mental health teams when available. This client-centred service is offered with the least restrictive approach to care, driven by the principles of safety, expediency, and clear communication based on the values of respect and autonomy.

Goals

- 1 To decrease the time in which clients are in distress from a crisis through outreach support and/or referral to appropriate resources.
- 2 To facilitate hospitalization and wherever possible, prevent hospitalization or decrease time spent in hospital.
- 3 To help sustain the well-being and highest level of functioning for our clients and their caregivers.
- 4 To act as a link between community resources which currently provide services to older adults.

Organizational Context

The GCS is a unique program because it is positioned within the organization between Mental Health Emergency Services and the Geriatric Service. It specializes in offering service to a population of older adults presenting with a potential or existing psychogeriatric diagnosis, who are experiencing a crisis or emergency. The clients served are usually over the age of 65, with concurrent psychiatric and medical conditions. The average age of clients is around 85 years.

Process

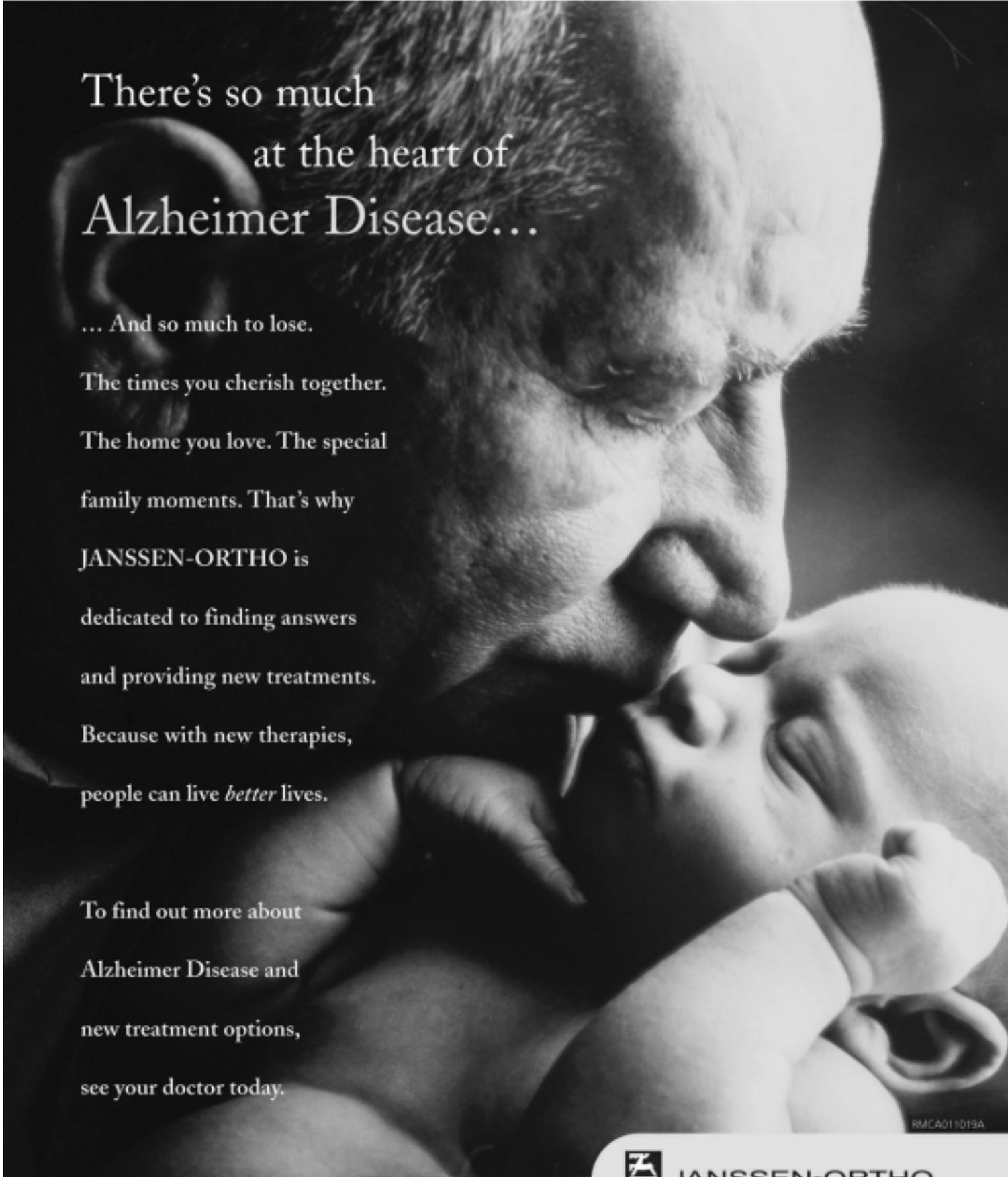
The Geriatric Crisis Nurses perform assessments at client homes, at care facilities and by telephone. Referrals come from geriatric mental health teams, police, physicians, care facilities, hospital emergencies, health units, Public Trustee, home support agencies, families, apartment managers, Seniors Well-Aware Programs, concerned friends and neighbours. Referrals are made to mental health teams, health units, mental health residential service, Venture, family doctors, and hospitals. ■

Diane Martin

Diane is one of two nurses that work with the Geriatric Mental Health Emergency Services team of Vancouver Community Mental Health Services. She works with her colleague Terry Doherty.

footnote

- 1 Romilly, L. (1995). *The report on geriatric mental health emergencies: A review of emergency services for the Vancouver/Richmond psychogeriatric population*. Romilly Enterprises, p. 3



There's so much
at the heart of
Alzheimer Disease...

... And so much to lose.

The times you cherish together.

The home you love. The special

family moments. That's why

JANSSEN-ORTHO is

dedicated to finding answers

and providing new treatments.

Because with new therapies,

people can live *better* lives.

To find out more about

Alzheimer Disease and

new treatment options,

see your doctor today.

www.janssen-ortho.com

* All trademark rights used under license
© 2002 JANSSEN-ORTHO Inc. 5641



JANSSEN-ORTHO

19 Green Belt Drive
Toronto, Ontario M3C 1L9

*A new approach in the treatment
of Alzheimer Disease.*

RMCA011019A

For Seniors and Caregivers

- Office for the Special Advisor for Women and Seniors Health, Ministry of Health Services:**
www.healthservices.gov.bc.ca/seniors
 Includes a new information guide for seniors programs and benefits in BC.
- Government of Canada seniors services web portal:**
www.seniors.gc.ca
- American Association for Geriatric Psychiatry:**

 - *Geriatrics and Mental Health — The Facts*
www.aagpgpa.org/prof/facts_mh.asp
- The Care Guide:** www.thecareguide.com
 Category topics include health and wellness, caregiving, legal issues, government resources, financial matters, and finding housing and care.
- Take Care Handbook** for families caring for older adults:
www.vcn.bc.ca/vrhb/Down_Loads/CaregiverSupport/TakeCareHandBook.pdf
- Canada's Association for the 50+:** www.50plus.com
- Alzheimer Society of BC:** www.alzheimerbc.org
- Alzheimer Society of Canada:** www.alzheimer.ca
- Planned Lifetime Advocacy Network:** www.plan.ca
 Resources for aging caregivers of people with disabilities including people with mental illness.
- Medication Info BC:**
 (604) 822-1330 or toll-free in BC: 1-800-668-6233
 A free medication information telephone consultation service. Licensed pharmacists provide BC residents with information on side effects of medications, interactions between medications, new drugs, herbs and vitamins, and foreign medications.
- Seniors Peer Counselling of BC:** (604) 859-2767
 Helps network senior peer counselling groups in BC. Senior peer counsellors are lay counsellors who have been trained to deal with the special problems of the senior years. Counsellors have undergone an intensive training course following guidelines set by the Ministry of Health Services.
- Caregivers Association of BC:** 1-800-833-1733
 Supports, educates, informs, and advocates for unpaid caregivers in BC. Provides information and referral to services and support groups, coordinates and maintains a network of volunteer regional representatives, and works with health- and caregiver- related organizations to share information and resources. Call for an information package.
- Canada Caregivers Resource Inventory:**
www.vac-acc.gc.ca/providers/sub.cfm?source=caregiver
- Canadian Caregiver Coalition:** www.ccc-ccan.ca
- Caregiver Resources:** www.clickintocaregivers.com
- BC Coalition to Eliminate Abuse of Seniors:**
 (604) 437-1940 or ceas@telus.net
 Provides information, training, community development, and materials regarding abuse and neglect of seniors, and on the legal issues confronting seniors in BC. Promotes seniors' self-determination and independence. Provides information about adult guardianship legislation. Can provide speakers for groups or workshops.
- Health Canada. National Advisory Council on Aging's Expression** bulletin. 28 issues on various topics; all online.

 - *Dealing with Depression* issue (Vol. 13, No. 3)
www.hc-sc.gc.ca/seniors-aines/pubs/expression/13-3/exptoce.htm
- Council of Senior Citizens' Organizations of BC:**
www.coscobc.ca
 Advocacy group and coalition.
- Seniors' Well-Aware Program:** www.swapbc.ca
- NAMI Maryland Aging Caregiver Project:**
md.nami.org/newsami.htm#Aging
 Resource booklet available for those caring for relatives with mental illness.
- Health and Age:** www.healthandage.com

For Service Providers

Organizations

- BC Psychogeriatric Association:** www.bcpga.bc.ca
- Canadian Association on Gerontology:** www.cagacg.ca
- Centre on Aging, UVIC:** www.coag.uvic.ca
- Gerontology Research Centre, SFU:**
www.harbour.sfu.ca/gero
- Canadian Academy of Geriatric Psychiatry:** cagp.ca
- Canadian Association for Community Care:**
www.cacc-acssc.com

This list is meant as a guide only and not meant to be exhaustive. While we have attempted to include helpful references, inclusion in this resource list does not necessarily reflect content endorsement by CMHA BC Division

Other Programs, Web Sites and Papers of Interest

- **Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities**
www.healthservices.gov.bc.ca/mhd/pdf/elderly_mh_care.pdf
- **Manual Of Geriatric Mental Health Resources:**
geropsych.cstudies.ubc.ca/toc.html
- **Geropsychiatric Education Program:** www.gpep.ca
- **Health Canada:**
 - *A Portrait of Dementia in Canada*
www.hc-sc.gc.ca/seniors-aines/pubs/vignette/vig3e.pdf
 - *Mental Health and Aging*
www.hc-sc.gc.ca/seniors-aines/pubs/writings/writ10_e.htm
 - *Coping and Helping With Alzheimer's Disease*
www.hc-sc.gc.ca/seniors-aines/pubs/alzheimers/alz-eng.htm
- **Canadian Association on Gerontology:**
Issues in the Delivery of Mental Health Services to Older Adults
www.cagacg.ca/english/pdf/issuesmental_561.pdf
- **Centre on Aging, University of Victoria:**
 - *Dementia: Caregivers and Stress*
www.coag.uvic.ca/publications/pdfs/dementia.pdf
 - *Health Promotion Strategies for Building Partnerships With Older Persons Who Experience Psychiatric Disabilities*
www.coag.uvic.ca/publications/pdfs/health_promotion.pdf
- **Janssen-Ortho Canada:**
Order by fax: (416) 382-5992, Attn: Community Relations
 - *The Challenges of Managing Alzheimer's Disease* (from the Journal of Pharmacotherapeutic Strategies)
 - *After the Diagnosis: Supporting Alzheimer's Patients and their Families* (from the journal, Postgraduate Medicine)
 - *Dysfunctional Behaviour in Dementia: A Clinician's Guide*. M. O'Donnell, D.W. Molloy & K. Rabheru (Newrange, 2001)
- **Seniors and Alcohol Issues:**
www.agingincanada.ca
- **Canadian Mental Health Association:**
Seniors' Mental Health and Home Care Research Report
www.cmha.ca/english/shmcare/index.html
- **Geriatrics and Aging:**
www.geriatricsandaging.ca
A physician's guide to the key issues and current trends in geriatric medicine and research. Has sections for mental health, alzheimer's/dementias and health promotion.
- **MyHealthandAge [professionals area]:**
www.healthandage.com/PHome?g.switch

Mental Health and Aging Network:

www.asaging.org/mhan.html
A constituent group of the American Society on Aging. Vast publication inventory.

Books

- *Mental Health Practice in Geriatric Health Care Settings*. Peter Lichtenberg (Haworth, 1998)
- *Mental Health Care of Elderly People*. Ian Norman (ed.) (Churchill Livingstone, 1996)
- *The Elderly with Chronic Mental Illness*. Enid Light & Barry Lebowitz (Spring Publishing, 1991)
- *Mental Health and the Elderly: Social Work Perspective*. Francis Turner (Simon & Schuster, 1992)
- *Aging and Mental Health*. Michael Smyer & Sarah Qualls (Blackwell, 1999)
- *Mental Disorders in Older Adults: Fundamentals of Assessment and Treatment*. Steven Zarit & Judy Zarit (Guilford, 1998)
- *Psychological Problems of Ageing: Assessment, Treatment and Care*. Robert Woods (ed.) (Wiley, 1999)
- *Aging and Posttraumatic Stress Disorder*. Paul Ruskin & John Talbott (eds.) (American Psychiatric Press, 1996)
- *The Delicate Balance: Case Studies in Counseling and Care Management for Older Adults*. Berit Ingersoll-Dayton & Ruth Campbell (Health Professions Press, 2001)
- *Depression in Late Life*. Dan Blazer (Springer, 2002)
- *Comorbid Depression in Older People*. Cornelius Katona & Gill Livingstone (Martin Dunitz, 1997)
- *Suicide and Depression in Late Life: Critical Issues in Treatment, Research, and Public Policy*. Gary Kennedy (ed.) (Wiley, 1996)
- *Mental Health Issues & Aging: Building on the Strengths of Older Persons*. Carolyn Tice & Kathleen Perkins (Brooks/Cole, 1996)
- *Journal of Mental Health and Aging*
www.fmhi.usf.edu/amh/journal/home.html
- *Elsie's Silent Cries: A True Life Experience Coping with Alzheimer's*. Barbara Copeman-High (Copeman-High, 2000)
- Alzheimer's and dementia books, manuals and videos:
www.therapeuticresources.com/alzheimers.html or your local Alzheimer's Society resource centre.

resource addition to last issue of Visions**OCD resource not listed in previous issue of Visions on Anxiety Disorders in Children and Youth:**

Richmond Mental Health Outpatient Services

- Cognitive-behavioural therapy groups for adults and youth (13-18)
- Need doctor's referral
- Contact (604) 244-5535 for general information or Ingrid Sochting, psychologist, for detailed information

2002 Bottom Line Conference

The Impact of Untreated Depression & Anxiety Disorders in the Workplace

October 31, 2002 ■ The Hyatt Regency, Vancouver

Mental illness is the fastest growing cause of workplace disability.

Companies are losing their most creative and productive employees to depression and anxiety disorders.

The bottom line costs are staggering.

In today's competitive work environment, many employees are reluctant to admit to having difficulty handling stress in the workplace.

Even fewer are comfortable discussing their mental health history with their employers.

The CMHA Bottom Line Conference is designed to help small and large businesses, organizations, unions, and benefit providers reduce the impact of stress and depression in the workplace.

SPONSORED BY



ENDORSED BY

BC Chamber of Commerce

BC Federation of Labour

Vancouver Board of Trade

HOSTED BY



The Canadian Mental Health Association's BC Division is proud to host the Bottom Line Conference. Sponsors include Scotiabank and GlaxoSmithKline. Our media sponsor is CKNW radio. Session sponsors include Eli Lilly Canada, Novartis Pharmaceuticals Canada, and Warren Shepell Consultants Corp.

CONFERENCE HIGHLIGHTS

1 BC Premier Gordon Campbell will deliver the keynote at the CMHA-BC Bottom Line Conference's first annual Rafe Mair Luncheon

2 Kevin Evans, Vice-President, Western Canada, of the Retail Council of Canada will discuss the cost of mental illness

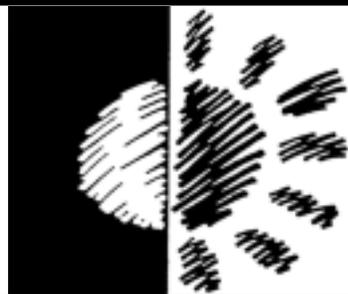
3 Bill Wilkerson, CEO, Global Business and Economic Roundtable on Addiction and Mental Health will explore the impact of untreated mental illness on the economy

4 Ten sessions will focus on untreated depression and anxiety disorders from the perspective of the employer, the employee, the EAP server, and the health care professional

5 Topics include the economic and social impact of mental illness, identifying and reintegrating employees, unionized situations, diversity and equity in cross-cultural environments, and the legal aspects of mental illness in the workplace

www.cmha-bc.org/bottomline 604.688.3234

If you have a medical condition,



**you are far more likely to have depression
than someone who doesn't.**

Learn more about depression this October
10th. All sites in BC welcome seniors; and
one is exclusively for seniors:

411 Seniors Centre
411 Dunsmuir St.,
downtown Vancouver
Oct. 10, 9am-noon

Can't make it that day? Book an appointment for
telephone screening October 10-19th by calling toll-free
1-866-917-HOPE (4673) during September or October 2002.



CANADIAN MENTAL
HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE

CMHA BC Division
1200 - 1111 Melville Street
Vancouver, BC V6E 3V6

