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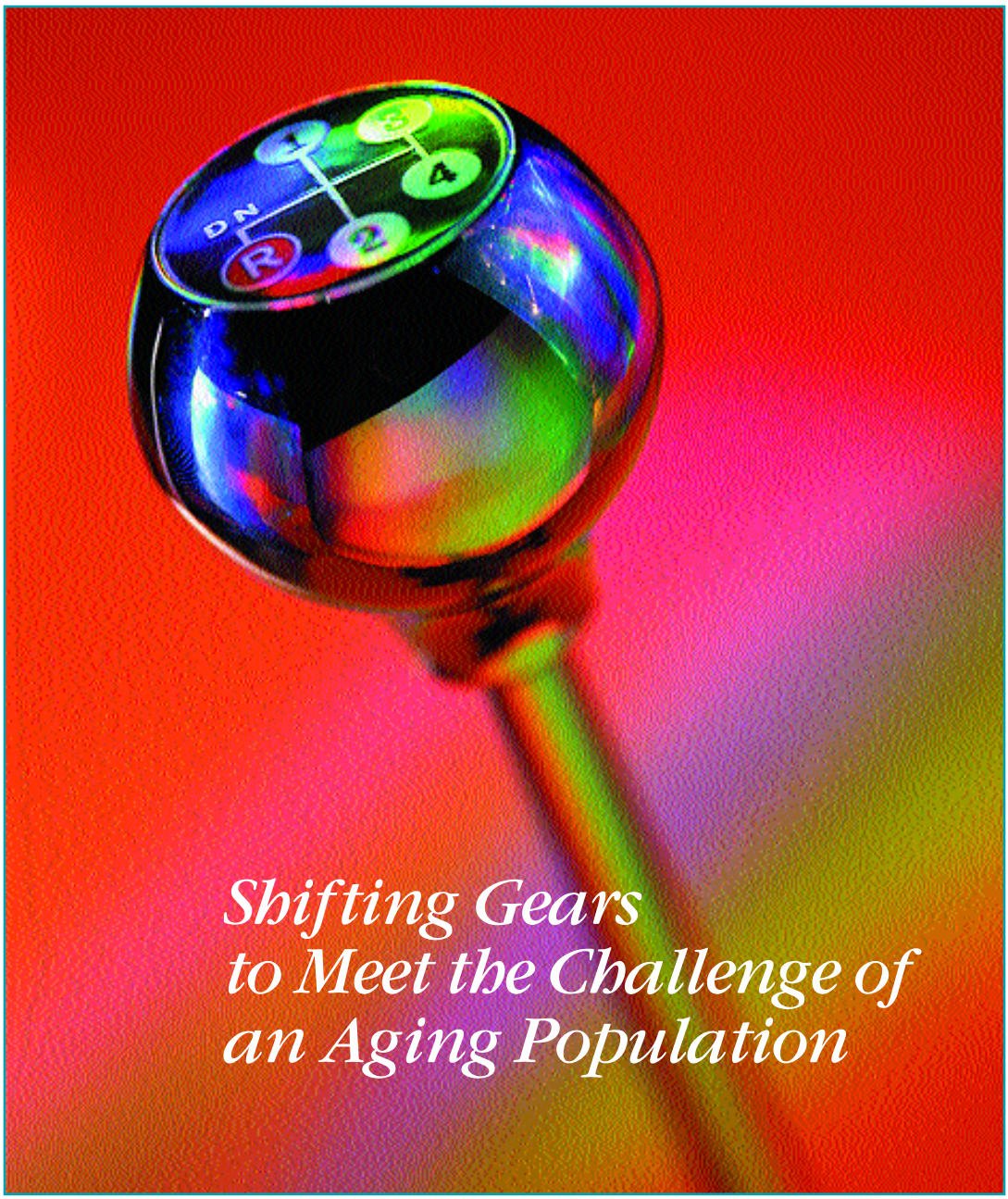

CANADIAN MENTAL
HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE
Ontario Division/Division de l'Ontario

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OUR MISSION:
To advocate with and provide programs and services for people with mental disorders, and to enhance, maintain and promote the mental health of all individuals and communities in Ontario.

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Telephone (416) 977-5580/Fax (416) 977-2264
E-mail: division@ontario.cmha.ca
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Changing Demographics

This issue of *Network* addresses a subject that is of importance to each and every one of us. We will all be impacted by the shift in demographics which shows us a picture of an aging population. A population that will represent 23% of all Canadians by the year 2041. Quite a jump from our current 12%. What are the pressures that will come to bear on society and how are we preparing for them? Dr. Ken Shulman, Head of Psychiatry for Sunnybrook and Women's College Health Sciences Centre, says that he believes dementia is one of the greatest public health challenges of the coming generation. Gloria Chaim, Clinical Director of Addiction Treatment Programs for Special Populations at the Centre for Addiction and Mental Health (CAMH) points to the lack of adequate housing and social supports as two of the biggest issues of concern for an aging population. "These resources are at crisis level for all kinds of populations," she says, "but when you look at seniors, they are at a stage in life where it's more difficult to do so many things – to access resources and to take action. We need to pull together across sectors and try to deal with addictions and mental health from a broad perspective."

Helping to maintain the independence of seniors for as long as possible through community programs was another issue raised as we spoke to professionals in their different fields. Thom Morris, Manager, Prevention and Specialized Services at the CMHA, Windsor-Essex County Branch, in talking about a program which they co-sponsor with the Windsor Regional Hospital, said that their primary goal through this program is to assist seniors to be maintained in the community. The key outcome is to help seniors to maintain their independence and their self-determination for as long as possible.

The tough ethical issues that must be faced by family members when faced with Alzheimer Disease; the burden carried by caregivers; the often "hidden" problem of substance use by seniors and the barriers to mental health care for ethnoracial seniors are also examined in this issue of *Network*.

Our Social Policy column also focuses on this important theme as we look at Elder Abuse, defined as "any action or lack of action by a person in a position of trust – a friend, family member, neighbour or paid caregiver – which causes harm to an older adult." On page 18 you will see a list of seven recommendations made by the CMHA, Ontario Division for use in advocacy efforts aimed at this unique population. We hope that you will join us in speaking out on these issues.

GLENN R. THOMPSON
Executive Director

An Aging Population

The world's population is rapidly aging. Over the next few years, the average lifespan worldwide will increase by almost 20 years. At the same time, the proportion of older persons (defined by the United Nations as 60 years of age and over) will increase from one in 14 to one in four. The United Nations General Assembly recognized the significance of this demographic trend and declared 1999 the International Year of Older Persons, (IYOP) in an attempt to foster international awareness of the importance of the role of seniors in society, and the need for intergenerational respect and support.

Canada's senior population is among the fastest growing in the world. Our senior population, which today makes up 12% of Canada's total population, will account for an estimated 23% of all Canadians by the year 2041. This demographic shift will impact on families and communities and alter the economic, social and cultural fabric of our country.

How are we preparing for the pressures that will come to bear on society as our elderly population increases so dramatically? What are their major needs and are these being recognized and addressed? How prevalent is suicide and substance use? Are the barriers to mental health care for seniors and family members from different ethnoracial groups being torn down? And how do we prepare for what Dr. Ken Shulman believes is the greatest public health challenge of the coming generation – dementia?

As we identify the primary needs of the elderly population from a mental health perspective we also, in the words of Gloria Chaim, "have to develop relationships with clients so that we learn about all of their concerns, all of their issues, and so pull in the resources that they need."

Shifting Gears to Meet the Challenge of an Aging Population

Identifying the Primary Needs

Dr. Ken Shulman is a geriatric psychiatrist. Previous to his present position as Head of Psychiatry for Sunnybrook and Women's College Health Sciences Centre, he was the Head of the Division of Geriatric Psychiatry for Sunnybrook.

Dr. Shulman, what are the primary mental health needs of seniors?

DR. KEN SHULMAN: I think the needs of the elderly population fall into two or three broad areas. One of these areas is the mood disorders of late life which include depression and bi-polar disorder. Mood disorders can themselves be broken down into early onset and late onset. In general, we think that early onset is associated with a higher genetic predisposition than late onset, although late onset does seem to have a genetic component. Late onset seems to have a higher neurobiological basis.

Are there statistics on how many people, as they get older, can expect to have some kind of mental health problem?

DR. KEN SHULMAN: It really depends on what you include in your statistical base. If you include dementia and Alzheimer, it tends to get very high. As far as major mood disorders, you are talking about less than 5% of the elderly population, but if you include minor depression, and depressions associated with dementia, then the number rises to closer to 10-20% of the population. Another big area when we talk about the mental health needs of this population is of course dementias in late life. Degenerative brain disorders including Alzheimer Disease, vascular dementia, and Lewybody dementia, which is a more recently defined type of dementia. Lewybody is associated with a particular pathology which includes pathological structures called Lewybodies, and it is associated with Parkinsonism, with visual hallucinations, a hypersensitivity to medication and gait disturbances. There are multiple dementias but these are the main ones. The Canadian Study on Health and Aging shows that 8% of elderly people over the age of 65 suffer from dementias. But once they are over 80, probably over 25% suffer from dementias.

And of course we are looking at a segment of society which is rapidly increasing.

DR. KEN SHULMAN: That's correct. The fastest growing segment of our population is indeed the very old, so we can expect that the incidence and prevalence of dementia will increase dramatically over the next few decades. I believe that dementia is arguably one of the greatest public health challenges of the coming generation.

What is being done to meet that challenge?

DR. KEN SHULMAN: Well, there is increased awareness now through the Alzheimer Society. There are some long term care initiatives going on that the government is dealing with. But we haven't done enough to gird ourselves for the coming pressures. These pressures will be very substantial on the community-based sector and on the acute care hospital based sector, so we will have to have adequate community supports in place, and long term care facilities in place.

How do families deal with the pressures involved? Is there less stigma when an elderly person has mental health issues that have to be dealt with? Is it more acceptable socially because they are older?

DR. KEN SHULMAN: I think the stigma is still something we have to overcome and deal with. I think it is getting better, but there is a lot more work that needs to be done. Some seniors are reluctant to ask for help, although generally I find that when people are suffering from depression they are more inclined to accept help no matter where it comes from. One of the problems with dementia of course is that the insight into the condition is compromised, so that people who are dementing often think that there is nothing wrong with them. Sometimes they will develop paranoid defences to explain the changes that they are experiencing. For instance, if they can't remember where they have put things, it's not that they can't remember, it's that somebody is stealing them.

But we haven't done enough to gird ourselves for the coming pressures. These pressures will be very substantial on the community-based sector and on the acute care hospital based sector, so we have to have adequate community supports in place, and long term care facilities in place.

In these types of cases is it generally a family member who would notice their behaviour and encourage them to seek medical help?

DR. KEN SHULMAN: Usually family members are the most sensitive to changes in brain functions. We always pay a lot of attention to what family members have to say. In fact, when I do a geriatric assessment I believe that it should always include a family member or an objective informant, because without that you run the risk of missing some very important information. When it comes to cognitive impairment and dementia in particular,

"I believe that dementia is arguably one of the greatest public health challenges of the coming generation."

DR. KEN SHULMAN

Community Supports:

The Need to Commit Funding

Are we doing enough to prepare for the pressures that will come to bear on society as our elderly population increases from 12% to 23% of the population by the year 2041? Doreen Caron R.N. is currently the Manager of P.A.C.E. (Psychogeriatric Assessment Consultation and Education) Central and for the past 15 years has functioned in various other roles in the Geriatric Psychiatry Program at The Centre for Addiction and Mental Health Queen Street site. She has been the intake worker for the program since 1989.

Her earnest hope is that baby-boomer politicians will recognize that there will be an increased need for community based services to parallel the rapid growth of this aging population. There is a definite need to commit funding to establish facilities that are appropriate for the level of care that people need. Some supportive housing initiatives are currently being undertaken wherein Personal Support Workers will be on site in an apartment building 24 hours a day 7 days a week. This means that seniors have the extra support they need to stay in situ for as long as possible at a fraction of the cost of providing the same services in an institutional setting.

"Basically it is a quality of life issue," says Caron. "In my experience, clients express a desire to remain in their own homes. They value their independence and wish to retain it for as long as possible. In many cases this can only be accomplished by the provision of community-based services to enhance their ability to function in their own homes. We must have supports built into the community, not only for the elderly but across the entire spectrum of users of the health care system."

The Geriatric Psychiatry Program is located at the CAMH, Queen Street site. There are two in-patient units; The Geriatric Assessment Unit and the Geriatric Continuing Treatment Unit (for clients who have longer stay needs). In addition, there are three out-patient P.A.C.E. (Psychogeriatric Assessment Consultation and Education) clinics.

Seniors' Mental Health:

Identifying the Primary Needs

Continued from page 7

the individual afflicted with the illness is often not in a position to recognize it or have insight. You may miss something. You also need to enlist the help of family members so that you can help them to support the individual who is afflicted, and assist them in monitoring and managing them. Which of course brings up the whole issue of

Society has to be increasingly aware of the tremendous burden that caregivers carry on behalf of the rest of us. They are saving society significant dollars by virtue of the fact that they are keeping family members at home.

caregiver burden, caregiver stress. Society has to be increasingly aware of the tremendous burden that caregivers carry on behalf of the rest of us. They are saving society significant dollars by virtue of the fact that they are keeping family members at home. We don't want caregivers to burn out because the quality of life of the caregiver and the quality of life and the survival of their loved ones depends on them being in a position to continue giving care. I think the myth of families dumping elderly people on the hospitals is probably being dispelled. More often than not you need to encourage families to give up care in extreme situations.

Is substance abuse a major problem for seniors?

DR. KEN SHULMAN: I think it is a significant problem, and one that we probably don't know enough about. In a survey we did here at Sunnybrook a number of years ago, close to 20% of the assessments done in the community indicated that there was a significant alcohol problem. For those who have late onset of a substance abuse problem it is generally being used in an attempt to symptomatically treat depression. They are trying to find relief through alcohol, which of course only serves to aggravate the depression.

What about suicide?

DR. KEN SHULMAN: Historically the suicide rates have been highest among elderly men. Recent data suggests that the rate of suicide is rising in young people relative to old people, but there is an even more disturbing statistic and that is that there is a cohort effect. Even though the rate is rising in young people, in as much as they are committing suicide in rates close to the elderly, as that cohort ages the suicide rate also goes up. So we can expect an even higher suicide rate among the elderly as this young cohort of high suicide risk gets older.

Why do you feel that it is higher in terms of elderly men as opposed to women?

DR. KEN SHULMAN: Well that's an interesting question. I know people have speculated about that. Often the factors associated with suicide in old age – bereavement, living alone, etc. – are more difficult for men to deal with. They are more vulnerable to those factors. Living alone for elderly men of that generation is particularly stressful and emotionally unsatisfying. But let me

The one factor that is the most important related to completed suicide in the elderly is the presence of a depressive illness. If we want to prevent suicide we have to be able to identify depression in the elderly.

just say this about suicide in the elderly. The one factor that is the most important related to completed suicide in the elderly is the presence of a depressive illness. If we want to prevent suicide we have to be able to identify depression in the elderly. So the best way to reduce suicide rates and to prevent suicide is to identify and treat depression early and effectively. Living alone, recent bereavement, the presence of a serious medical illness, a family history of suicide, are all risk factors, but the most important condition is a depressive illness. By and large, elderly people do not commit what we call rational suicide. If the depression is treated the suicidal ideation, in most cases, will disappear.

The Tough Issues Facing Families

The letter came as a shock.

June, 1995. Twenty-five years with the same company. Eight years to go before retirement. And they were saying "Sorry we have to let you go. There are just too many problems affecting your work. Perhaps you should see a doctor. You might have a medical problem."

What Mike Crowe and his wife, Nona, of Penticton, B.C. didn't realize was that Mike was in the early stages of Alzheimer Disease.

Alzheimer Disease deeply affects every person whose life is touched by the disease: the person diagnosed with it, family members and friends, and those who provide care, whether family or professionals. The social and economic costs of the disease are just as far-reaching, and a number of tough ethical issues surround the diagnosis and progression of Alzheimer Disease and related dementias.

In 1995, the Alzheimer Society of Canada gathered together a Task Force on Ethics to explore and consult nation-wide on some of these tough issues. The task force included caregivers, researchers, health-care professionals, ethicists and lawyers. The result of this process is a number of "tough issues information sheets" made possible through a grant from The Harry E. Foster Foundation. These sheets can be accessed through the Alzheimer Society's web page at www.alzheimer.ca or from your local Alzheimer Society.

"These ethical guidelines take difficult ethical issues out of the academic boardroom," says Dr. Carole Cohen, Clinical Director of the Community Psychiatric Services for the Elderly at Sunnybrook and Women's College Health Science Centre in Toronto. "There may be more sides to the story than you might have thought about. The guidelines help people look at the other side of the coin."

Ethical issues include communicating the diagnosis to loved ones – a decision that families often agonize over. Dr. Serge Gauthier, a neurologist at the McGill Centre for Studies in Aging in Montreal advises that it is important to be sensitive when telling someone he or she has Alzheimer Disease. In addition, the guidelines advise that the person with the disease and the family should be directed to appropriate support services if they need help understanding the disease and planning for the future.

As the disease progresses, families often find they are called upon to make more and more decisions on behalf of the person with Alzheimer Disease. "Families don't expect to have to take on the responsibilities of making decisions for others," says Dr. John Dossetor, Chair of Bioethics at the University of Alberta. The guidelines help to prepare people to take on these responsibilities and begin to work through tough decisions as their caregiving role increases. Dossetor advises that families may also find it helpful to get professional help and to talk to other caregivers who have faced these issues.

It is estimated that 316,500 people in Canada have dementia and 202,560 have Alzheimer Disease. By the year 2031, the number of people in Canada with dementia is expected to grow to over 750,000. Although there is currently no cure for Alzheimer Disease, there is medication available to treat some of the symptoms. Aricept is the first drug to be approved for marketing in Canada. It is intended to treat symptoms in individuals with mild to moderate Alzheimer Disease. In clinical trials, individuals who took Aricept, when compared to individuals who took a placebo, showed improvement or no further decline in cognition and function. Aricept may take as long as 12 weeks to begin working, and the type and length of response to this medicine will vary from individual to individual. Aricept is not a cure for Alzheimer Disease as it

The Tough Issues Facing Families

does not affect the underlying degenerative process of the disease. Researchers continue to test a number of other drug treatments in Canadian drug trials, and drugs are available to treat secondary symptoms such as depression, anxiety, sleeplessness and paranoia, however the use of these drugs needs to be carefully monitored.
It is well recognized that the physical and social environment in which a person with Alzheimer Disease lives can influence disease symptoms and quality of life. A supportive environment can help the person manage better with failing abilities and can help him or her maintain independence. A caregiver can reduce difficult behaviour by understanding the disease process, being sensitive to emotions and feelings, and learning to communicate in a variety of ways.

Caregiving: A Lifetime Commitment

At 23 years of age, fresh out of university with a BA in Geography and a new husband, Linda Furlini Mulé of Montreal, Quebec was thinking about pursuing a Master's degree.

"I got married in May, 1979," says Linda. "By August I was working as a teaching assistant. Then I went to help my dad with his business a couple of days a week. As time went on, I just assumed more and more responsibility at his store. I saw him make a lot of mistakes and react in strange ways. And slowly, everything else got obliterated. I just took over the store and I was running the whole thing."
Linda embarked on what became a 19-year odyssey of Alzheimer caregiving. And not just for her father who died in 1989 after a 10-year battle with Alzheimer Disease. At the time of his diagnosis, her mother had also begun showing subtle signs and symptoms of Alzheimer Disease. "My sister and I knew something was terribly wrong but outsiders couldn't see it." Her symptoms evolved much more slowly and she was adept at hiding them. It took five long years before an Alzheimer diagnosis for Linda's mother would be confirmed. Throughout the whole time people said, "It can't be the same as your father."
Today, Linda's mother is in a nursing home. She doesn't speak. She barely opens her eyes. She's on medication to calm her spasms. And she's virtually confined to bed. Visiting her is difficult.
"You see this person whom you've known your entire life slowly change. Even from the beginning of this disease, there's a change. You lose them. You don't understand why. And the losses just compound to the end. So you search for meaning. You try to relate it to something in your religion or something that you know about and you have a very hard time making the connection."
Linda's search for meaning took her back to McGill University, Montreal, where she completed a Master's degree program in Educational Psychology. Her major research paper was an

Is It Alzheimer Disease?

10 WARNING SIGNS

Alzheimer Disease is the leading cause of dementia – a set of symptoms that includes loss of memory, judgment and reasoning and changes in mood and behaviour. Sometimes people fail to recognize that these symptoms indicate that something is wrong. They may mistakenly assume that such behaviour is a normal part of aging – it isn't. Symptoms may develop gradually and go unnoticed for a long time. The Alzheimer Society has developed a checklist of common symptoms:

- **1. Memory loss that affects day-to-day function**
- **2. Difficulty performing familiar tasks**
- **3. Problems with language**
- **4. Disorientation of time and place**
- **5. Poor or decreased judgment**
- **6. Problems with abstract thinking**
- **7. Misplacing things**
- **8. Changes in mood or behaviour**
- **9. Changes in personality**
- **10. Loss of initiative**

If you notice several of these symptoms, see your doctor for a complete examination.

in-depth study of three daughters reflecting on their Alzheimer caregiving experiences. The research was fuelled by Linda's need to understand why. "Why I had such trouble getting services and support. Why this disease is so misunderstood. Why others cannot see the seriousness of this disease." Linda believes the answer has to do with a general lack of understanding of what she calls "the dimensions of dementia". Alzheimer Disease is so pervasive and its consequences are so far-reaching that it's difficult for outsiders and even family members to relate to what caregivers tell them because it's so far removed from anything they have experienced.

Alzheimer caregiving has made Linda a more reflective person. It has changed her outlook on life and made her realize that what is important in life is how you live day to day. She has learned to focus on her own needs, moving from the city to the suburbs, taking vacations with her husband and teenage son and socializing with her friends. She is also giving back to the Alzheimer Society which handed her a lifeline during those early caregiving years. "Of all the people I wrote to about my dilemma, they were the only ones who responded. And they didn't tell me, it can't be Alzheimer Disease."

Today, Linda is Past President of the Quebec Federation of Alzheimer Societies and a board member of the Alzheimer Society of Canada. She is working on a Needs Assessment through the Alzheimer Society of Montreal and has also held workshops on Alzheimer Disease and caregiving. And she has organized support groups for people in the early stages of Alzheimer Disease and their caregivers, something she wishes had been around for her parents.

Alzheimer caregiving has consumed most of Linda's adult life. Yet she remains dedicated to improving the situation for others. Her caregiving, research, volunteer work and future job aspirations all support her mission to communicate what goes on with Alzheimer Disease and make it visible. She encourages other caregivers to do the same. And she asks family, friends and health professionals to listen to what caregivers tell them and "don't deny the caregiver's reality".

THE FACTS

1 in 20 Canadians over the age of 65 is affected by Alzheimer Disease:

- **1 in 100 between ages 65-74**
- **1 in 14 between the ages 75-84**
- **1 in 4 over age 85**

Caregivers:

Twice as many women as men have dementia
50% of people with dementia live in the community, of these:

- **97% have a caregiver**
- **2.4% have no caregiver**
- **29% live alone**
  (typically, they have a daughter living close by)
- **8% have only one caregiver for support**
- **75% of informal caregivers are women, most often wives (24%) or adult daughters (29%)**
- **half of the informal caregivers are over age 60**
- **92% of people with dementia living in the community have two or more relatives or friends beyond their primary caregiver who provide assistance, however they have fewer friends and relatives to count on beyond the primary caregiver than do people without dementia**
- **spouse caregivers are less likely to have back-up support than others and yet are more likely to be caring for a person with severe dementia**

The Health of Caregivers:

Caring for people with dementia is associated with chronic health problems among informal caregivers

- **16% of people caring for someone with mild dementia in the community report symptoms of depression**
- **40% of those caring for someone with moderate dementia in the community report symptoms of depression**
- **18.4% of informal caregivers who are helping someone with severe dementia in an institution report symptoms of depression**
- **depression is nearly twice as common in people caring for someone with dementia as in other caregivers**

The Economic Cost of Dementia

- **total annual net cost of dementia in Canada: over $3.9 billion**

THESE FIGURES ARE TAKEN FROM THE CANADIAN STUDY ON HEALTH AND AGING.

THANKS TO THE ALZHEIMER SOCIETY OF CANADA FOR THE INFORMATION THEY PROVIDED FOR THIS ARTICLE. FOR MORE INFORMATION ON ALZHEIMER DISEASE CALL YOUR LOCAL ALZHEIMER SOCIETY OR VISIT THEIR WEB SITE AT WWW.ALZHEIMER.CA.

The Hidden Problem

Gloria Chaim is the Clinical Director of Addiction Treatment Programs for Special Populations at the Centre for Addiction and Mental Health (CAMH). OPUS 55 (Older Persons Unique Solutions) is one of the CAMH's special population programs dedicated to working with older adults. OPUS 55 has a full continuum of care to address addiction or concurrent disorder needs for those over the age of 55. Between 40 - 70% of the people who come for a primary substance use concern also have a co-occurring mental health disorder.

How big a problem is substance use for senior Canadians?

GLORIA CHAIM: It's a very big problem, especially since for many seniors, it's a hidden problem. We see essentially two groups of people: those who started early on in life, referred to as early onset substance abuse and those who started using later in life, late onset. Often people get involved in late onset substance abuse because they are trying to medicate themselves or they are misusing prescribed medication. People who are lonely, isolated or grief stricken may be prescribed medication to cope and end up abusing the medication, or drinking to deal with their problems. It's a way of masking what they are feeling. Those who are considered "early onset" may have been drinking or using medication for years, and although they may have had some substance use related problems in the past, they may start to have either new or different physical symptoms, or mental health symptoms such as anxiety or depression. In many cases what has happened is that, due to the body aging, they are experiencing new reactions to substances they have been using for years. They may not realize that the problems they are experiencing are related to alcohol or drugs because they never experienced or acknowledged such problems in the past. Therefore they can show up at a mental health facility rather than an addictions facility. Really, they have had this ongoing issue for years but were able to manage it until their bodies began to change. People with late onset substance abuse often have trouble acknowledging to themselves that they have substance use related problems. They are probably using their substances to deal with other issues and concerns but what they don't realize is that their issues are being exacerbated by their drug or alcohol use. Most often, the substances being used are alcohol or prescription or non prescription (over the counter) drugs, as opposed to street drugs. This makes the situation even more complex because they feel that what they are taking is okay; it's socially acceptable. The drugs may have been prescribed for them or they may have seen them advertised on television or in a magazine. But it's not okay because either they are not taking the drugs as prescribed or as they are intended to be used, or because they are combining prescription medication and alcohol. For seniors who have used substances for many years with little ill effect, the situation can also be very complex, because they have not changed their behaviour, but nonetheless have developed a substance problem that they never experienced before. Because the body's metabolism tends to slow down with age, seniors generally require less of a substance to feel the same effects they might have when they were younger.

When you add to that mix, that scenario, an older person who also has a mental health problem – maybe the onset of Alzheimer – how much more complex does that make the mix and

how much harder is it to determine if there is a substance use problem?

GLORIA CHAIM: Very complex and very hard to determine. Having collateral information is extremely helpful in sorting out whether the problems an individual is experiencing are related to substance use or entirely a mental or physical health problem. Family members or others who are close to the person can provide useful information. Caregivers who visit people in their homes are in an excellent position to gain a better sense of what is actually going on. For example, if someone seems to have some symptoms of dementia and you go and visit the home and see lots of empty beer bottles in the corner, that might give you a clue that alcohol may be a factor related to some of these symptoms. People tend not to volunteer that kind of information about themselves; they might not even connect it. Also, in terms of medication, it seems that prescribing drugs like sleeping pills and tranquilizers is more common in this population. It seems to be less common for a doctor to say to a patient, "maybe you need somebody to talk to", or "let's find an alternative", than to say "take a pill, you'll sleep better". I also think that people, including family members and physicians, often have a different attitude towards older people. Why should they have to suffer? If they feel better taking a sleeping pill or a few tranquilizers so be it. What's the big deal, there's no harm done. Whereas in fact there's a lot of harm done! The other reason it's sometimes harder to diagnose substance abuse is that a younger person would consume more to get the same effect, so it would be more noticeable. Maybe gran has a glass of sherry every night and the family think that's kind of cute, but that one glass of sherry might be the equivalent of a whole bottle of sherry for someone younger. And if she is on some medication for her arthritis say or for rheumatism, the interaction of the medication and the alcohol can wreak havoc.

It's not a great picture for an aging generation is it?

GLORIA CHAIM: Part of it is a scary picture, but at the same time I think that it's our job to do as much education as we can to make things better. We have to be aware of the overlap between symptoms; the different needs of seniors; of educating people in the mental health field and in the general health care field about addictions – what they look like and what the concerns and issues are. We have to learn what questions to ask and start getting a more holistic view of people. We have to develop relationships with clients no matter which "door" they come in, so that we learn about all of their concerns, all of their issues, and pull in all the resources that they really need. Also, with seniors there are some nuances and issues that you must be attentive to when you are building a relationship. We are talking about an age and stage in life when people have had a lot of life experience. A stage when people are frequently dealing with loss or change: changes related to physical functioning, changes or loss related to social or family life, through death, illness and the like. People who have been working who have now retired; people who have been very active but who can no longer be as active because of constraints which may be medical or financial. We have to be attentive to all of those things and develop relationships around them whether we are dealing with someone who has entered the door of substance use, or the door of mental health. Above all we must have respect for each individual, their wealth of experience, their desire for independence, and their right to the best treatment available.

"Sometimes what people use to cope with a situation actually exacerbates it. I'm thinking of an older woman whose great pleasure in life was babysitting her grandchildren on a regular basis. The grandmother, however, was having a drink in the afternoon because she felt lonely, and then later in the day babysitting the grandchildren. It got to the point where her children could see that she was a bit tipsy and no longer felt comfortable leaving their children with her. This was a huge blow. Devastating not only to the grandmother but to her children and grandchildren and that became pivotal in her taking a look at what she was doing. Yes, maybe she did feel lonely in the afternoons, but now she was going to be lonely all the time if she didn't do something about it."

Barriers to Mental Health Care

Dr. Rosemary Meier is Assistant Professor, Department of Psychiatry, Division of Geriatric Psychiatry Culture Community & Health Programme, Faculty of Medicine, University of Toronto. ***An Integrated Response to the Mental Health Needs of Ethnoracial Seniors in Metropolitan Toronto examines the barriers to mental health care for ethnoracial seniors and looks at ways that these can be addressed.***

Dr. Meier what was the catalyst for this program?

DR. ROSEMARY MEIER: Some time back the Division of Geriatric Psychiatry at the University of Toronto was looking at barriers to mental health care. We were trying to understand why it was that seniors from what we then called minority groups did not seem to be being seen in what were developing as programs, particularly in the community, but were being seen in crisis, or the more extreme ends of the spectrum of services. And leading off from this concern was the fact that given that the Division of Geriatric Psychiatry is training residents, how could we train them better in this area? To do both of these things we needed to develop what we then called cultural sensitivity and what we now call cultural competence.

So you began to develop your program with these goals in mind?

DR. ROSEMARY MEIER: Yes, and we've been working with two communities [the Tamil Seniors Wellness Centre and the Chinese Seniors Health Centre]. One of the things I think we should emphasize at this point is that there aren't specific ways that a specific community may react. Although there are commonalities across cultures there are different conceptualizations of mental illness and so it's important to have a sense of the individual and the individual family. Alzheimer, for example, is a concept that not every culture would be able to live with, so we realized we had to look at distress rather than illness. Distress seemed to be a way that the communities we were working with could conceptualize things. So how you name things, how you see things is really quite important. Prior to our study we had focus groups with seniors, family members, and community agency people. The community agencies really seemed to be caring for most of the seniors from the ethnoracial minority groups. They are available and accepted, but they are not really trained in mental health, and certainly they are not funded for the mental health work that they are increasingly doing. We also had a series of vignettes [in our focus groups] and those vignettes described the major, most frequent conditions that we in geriatric psychiatry would see, or that geriatric psychiatry would see as being important mental health issues for seniors. These were described in behavioural terms and we asked the various groups what they thought of these. Did it seem a familiar scenario? Did it seem frequent? Did it seem typical? Would this type of situation be seen as a problem, and if it was where would you go for help? The response to these vignettes gave us a lot of information and a deeper understanding of the way that communities perceived changes in behaviour, mood, thinking and so on.

Did you get what might be considered "untypical" responses?

DR. ROSEMARY MEIER: Well, some of the groups we worked with didn't necessarily see some of them as problems. They didn't consider them to be something that would cause a lot of distress or would cause a lot of concern in the community. It would be accepted, or ascribed to aging. But I think another point would be that the acknowledgement of mental illness does tend to be very stigmatizing. Even among so-called main stream populations that is true too. The phrase "you must be crazy to see a psychiatrist" is pretty prevalent, and so there

maybe some generational issues. Older people, even growing up in Canada, are more accustomed to the idea of psychiatric hospitals or psychiatrists being involved with very extreme situations or psychotic conditions, so the stigma of mental illness was something that we were aware of for seniors in general. Also, with seniors from minority groups, from ethnoracial groups, there may be implications that go beyond their generation. Marriageability for their children or grandchildren for example, so that the consequences and implications of acknowledging a mental disorder also have to be taken into account.

How do you see the magnitude of this problem as more and more people emigrate to Canada?

DR. ROSEMARY MEIER: Well rather than a problem I see it as a demographic fact of life. One of the really important issues that seniors encounter is of course the effect of migration, and at what point in their life they migrate. Filial piety, respect for their parents, may be expressed by the younger generation, who are already in Canada, by bringing their parents here. However, these sponsors may be experiencing quite a lot of economic hardship themselves . Language may be a problem. All these things make a difference and can affect the inter-generational relationships.

I understand that there are a number of homes for seniors that are specific to their culture.

DR. ROSEMARY MEIER: Yes, and as well as the homes there are programs in the community developing with some of the larger groups. Certainly when you think about acquired language, if you are looking at a condition like Alzheimer where there is cognitive change, then one does tend to lose one's acquired language or languages. It's important to provide service that is acceptable. And back to our study, we found that there were programs that were available, but what makes programs acceptable? They have to be linguistically and culturally available and acceptable, but you may not be able to provide them specifically in every single mother tongue for every single cultural group.

You mentioned that training psychiatrists, training residents, is an important part of this program.

DR. ROSEMARY MEIER: Yes, part of our particular project has been looking at education in an integral kind of way, both within the community for families, for community agencies and for the residents in psychiatry. We have piloted an approach to cross-cultural therapeutic communication which involves seniors and members of the community, but it goes beyond language or even cultural interpretation. People may not act in a stereotyped way. That's one of the risks of trying to label people in terms of their cultural group.

Are there other key issues that are coming out of this study that you feel are important to address?

DR. ROSEMARY MEIER: Our hope is to see changes in the larger system. It's important to work with communities rather than just study them. In the two communities that we are working with we are helping to educate not only potential patients and families but also social service workers in the community. The question of anti-racism and equity principles in practices is something which is an important strand. The anti-racism strategy ensures equitable access. The final thing that we are hoping to look at, and this goes back to the origins of the study, is the intersection between mental health and physical well being, as well as the social and spiritual aspects both for individuals and communities. When one is looking at the provision of services it goes beyond the immediate assessment/diagnosis/specific treatment model. You are really looking at the person in their context. Their cultural and religious background – all these things are important to recognize. And the fact that people are unique, even within their cultures. One of the important things to remember is that although somebody may be from a particular ethnic group, their own family issues and interactions are what the individual therapist and mental health worker really has to try to understand.

One of the important things to remember is that although somebody may be from a particular ethnic group, their own family issues and interactions are what the individual therapist and mental health worker really has to try to understand. People may not act in a stereotyped way. That's one of the risks of trying to label people in terms of their cultural group.

CANADIAN MENTAL HEALTH ASSOCIATION Program Profile Report – Windsor-Essex County Branch

(AGES) Mental Health Program for Older Adults

CMHA Windsor-Essex County Branch co-sponsors a unique program with the Windsor Regional Hospital which addresses the needs of community based older adults who are experiencing mental health problems. In addition, the Mental Health Program for Older Adults (MHPOA) provides the Essex County Community with education and support on caregiver stress for both professional and non-professional caregivers. The Windsor-Essex County Branch, along with the Community Psychogeriatric Program of Windsor Regional Hospital, provide not only case management (counselling, support, life skills training, etc.) to psychogeriatric clients, but also help caregivers to deal with the physical and emotional stress placed on them as they support their loved ones at home.

Over the past several years, Ontario Long Term Care Facilities have experienced a marked reduction in their staff-to-patient ratio's. Consequently, the education component of the MHPOA has been called upon by these residential facilities, to provide advice, support and education on managing professional caregiver stress.

As the provincial government continues its mandate to support people with appropriate health and long term care resources, the families and friends of community based seniors have been shell-shocked trying to maintain their aging loved ones in the community for as long as possible. Canadian families, in recent times, have not had the major responsibility of caregiver of their seniors. As this shift occurs, the stress associated with this role is fairly substantial, hence the work that the CMHA, Windsor-Essex County Branch is doing to provide support in that area.

The Branch also works with the multi-cultural community to develop care plans, and address the needs of persons who contact them for services. Although they may not always have a worker that can provide that service in the client's mother tongue, the Branch is in contact with the Multicultural Council on a regular basis to explore issues associated with barriers to ethnic groups. CMHA will bring the Multicultural Council in to assist if need be. The Multicultural Council have also conducted presentations and workshops to help staff at the Windsor-Essex County Branch become more sensitized to the various considerations of multicultural groups.

The shift toward maintaining seniors in the community for as long as possible is something which Thom Morris, Manager, Prevention and Specialized Services, says that everyone agrees with, because it helps to maintain seniors' independence and autonomy.

The partnership CMHA, Windsor-Essex County Branch has with the Windsor Regional Hospital means that the referral or intake process is done through the Community Psychogeriatric Program at the hospital, and then transferred to CMHA for case management. Program referrals come from the Community Care Access Centre (CCAC), physicians and family practitioners in the community as well as the general public, so the referral base is very broad.

When asked what major mental health needs they are seeing, Thom Morris identified "depression, anxiety disorders, late onset schizophrenia, and behaviour management are all significant issues. We also have a formal partnership with the Geriatric Assessment Program so in essence we can meet all the bio-psychosocial needs of the psychogeriatric population in our community. Combined with the support from our local Alzheimer Society, which is very effective in Essex County, we are able to provide a fairly comprehensive network for this population. We are also working in concert with a broad range of local agencies to address the issue of elder abuse in our community."

Elder Abuse

The following is an edited extract from the CMHA, Ontario Division's approved Position Paper Respecting Mental Health Issues in the Abuse of Older Adults.

We take for granted our right to freedom from harm. Yet every year in Canada at least 4% of Canadian seniors living in private dwellings are abused by family members or other intimates. This translates into approximately 98,000 older adults across the country. Unfortunately, this abuse does not happen solely at home. Institutional abuse of older adults, including mistreatment perpetrated by staff, other patients, or visitors in nursing homes and other care facilities also occurs. A 1998 study of 31 nursing homes found that 36% of nursing home staff had witnessed the physical abuse of an older adult in the preceding year and that 81% had witnessed psychological abuse.

The proportion of the population who are 65 years of age and older is growing. This means that the number of older persons who experience abuse will in all likelihood also rise in the years to come. Clearly, there is a great need for us to recognize and address the abuse of older persons in our society.

In the Fall of 1996, a Task Force on Psychogeriatric Issues was struck by the CMHA, Ontario Division's Public Policy Committee to further study the issues surrounding older persons with mental health problems. One of the policy recommendations with respect to psychogeriatrics was the need to examine the issues surrounding elder abuse together with societal views on aging – the deep and profound prejudice against the elderly, which has been identified as one cause of the abuse of older adults and a factor in the creation of situations in which abuse is more likely to occur. In response to this recommendation, a Task Force on Elder Abuse was struck in the Fall of 1997.

The abuse of older adults is a very complex issue and there are no simple explanations regarding who is abused, who perpetrates abuse and why it happens. There is no one reason for its occurrence and situations and motives vary widely. Abuse can also be systemic, not just individual and/or institutional.

As an organization we must prepare ourselves and others in the mental health field to deal with the systemic mental health implications involved in the abuse of older persons. The Elder Abuse Task Force identified three overriding systemic concerns in relation to mental health and elder abuse. Of particular importance is the common and pervasive belief that abusers are mentally ill. This borders on stigma and as such can be very damaging to consumer/survivors generally, and to consumer/survivors/family caregivers and their older family members in particular. A second concern highlights the complexity of understanding and delineating symptoms of abuse and symptoms of mental illness. The symptoms used to indicate abuse are also symptoms indicative of a mental health problem. The insensitive labelling of abuse may damage essential caregiving relationships. Individuals who have been abused require mental health support and the system needs to recognize that the prevention of mental health problems also requires prevention in regards to the abuse of older adults. Finally, efforts to address ageism and how this form of prejudice influences health/mental health and social policies are critical.

DEFINING ELDER ABUSE

The abuse of an older adult is "any action or lack of action by a person in a position of trust – a friend, family member, neighbour or paid caregiver – which causes harm to an older adult."

This abuse includes:

Physical Abuse
Psychological Abuse
Financial Abuse
Sexual Abuse
Medication Abuse
Violation of Civil/Human Rights
Neglect *(which can be active, as in intentional withholding of basic necessities and care, or passive, not providing the basic necessities and care because of a lack of experience, information or ability.)*

PREVALENCE OF THE ABUSE OF OLDER ADULTS

The best available Canadian data on the prevalence of abuse of older adults are derived from two studies. Podnieks, Pillemer, Nicholson, Shillington, & Frizzel (1990) conducted a telephone survey of 2,000 persons over the age of 65 from all parts of Canada. This was the first national study to document the amount and nature of abuse of older adults. The second study, conducted by Pittaway & Gallagher (1995) examined case histories from agencies as a source

Elder Abuse

Continued from page 17

of information on the prevalence of abuse. The results of the national telephone survey led the researchers involved to conclude that "at least 4% of Canadian seniors living in private dwellings had recently been abused by family members or other intimates of the victim".

There are presently no formal provincial statistics available, however some indications of the extent of the problem in Ontario do exist. A study conducted for the Ontario College of Nurses found that 10% of nurses and nursing aides interviewed had witnessed a fellow staff member hitting or shoving clients at some time during their career and 30% had witnessed nursing staff being rough with clients (Ontario College of Nurses, 1994).

The fact that the proportion of the population who are 65 years of age and older is growing means that the number of older persons who experience abuse will in all likelihood also rise in the years to come.

Like older persons in general, persons with disabilities as a group are at higher risk for abuse. It has been estimated that people with disabilities are four to ten times more likely to experience abuse, neglect, or exploitation than other adults (Adults with Vulnerability, 1997). It has also been estimated that 75% of persons who experience abuse have at least one major mental or physical impairment (Pringle, 1997).

Persons with disabilities and older adults may be at increased risk of abuse for some of the same reasons. For example, both groups may have a limited ability to fend off or escape assault; both may have a communication or cognitive impairment that makes it difficult to inform others about abuse; and both may be subject to discriminatory attitudes which lead perpetrators of abuse to believe they are less worthy or deserving of respect. Given these factors, older persons with mental health problems are at an even greater risk of abuse than other adults and older persons without mental health problems, two groups who themselves are at increased risk.

Based on the description of the issues involved in the abuse of older adults, the following recommendations are particularly important for the CMHA, Ontario Division, and for use in advocacy efforts aimed at this unique population and problem. In keeping with our focus, emphasis has been placed on recommendations centred on the abuse of older adults with mental health problems, the abuse of older persons by those with mental health problems and the role of mental health service providers and the mental health system in addressing these abuse issues. It is hoped that these recommendations will enable those involved to examine the issues and provide a vehicle through which policy discussion can continue.

1. The CMHA, Ontario Division should advocate for a more positive portrayal of older adults that includes sensitivity training for staff and volunteers working in the mental health and long-term care systems around the effects of institutionalization, ageism, the identification of abuse and the resources available to assist in situations of abuse.

2. The CMHA, Ontario Division should advocate to the Ministry of Health that more resources, particularly in terms of staffing, be provided in order to identify and prevent the abuse of older adults in both the institutional and community sectors. This includes advocating for resources to serve not only older persons with mental health problems who have been abused and caregivers with mental health problems that have abused an older adult but both older family caregivers and service providers in the mental health system who have been abused.

3. The CMHA, Ontario Division should advocate to the Ministry of Health for the creation of standardized protocols and procedures specifically dealing with situations of suspected abuse of older adults with mental health problems and older family caregivers with mental health problems that will decrease or eliminate the barriers affecting intervention including disclosure, identification and reporting.

4. The CMHA, Ontario Division should advocate for the development of self-help supports, including natural and informal networks in the mental health system for those who experience abuse or have perpetrated abuse and wish to deal with issues in a peer support context.

5. The CMHA, Ontario Division should advocate to the Ministry of Health and the Ministry of Community and Social Services for the co-ordination of services and supports to persons who are abused and for the identification of a single point of access to information regarding available resources, e.g. Community Care Access Centres, to be established.

6. The CMHA, Ontario Division should advocate to the Ministry of Health for the development of co-ordinated multi-disciplinary teams and the identification of existing specialized services as resources for other agencies.

7. The CMHA, Ontario Division should advocate for more Canadian-based research on the abuse of older adults in order to develop a better understanding regarding what people experience as abuse and to effectively establish "best practice" standards and program models.

Alzheimer Strategy for Ontario

The CMHA, Ontario Division supports Ontario's Strategy for Alzheimer Disease and related Dementias and congratulates the government on the development of a strategy which recognizes both how widespread Alzheimer Disease will become as the population ages, and the tremendous toll that the disease will take on persons who will experience it and those who will provide care to them. The CMHA is pleased to note that the Plan of Action is one focused not only on the facilities that provide care to persons with Alzheimer Disease, but also on the local Alzheimer Societies that provide support to persons with Alzheimer Disease and their family caregivers in the community. This recognizes the different aspects of the support continuum that must be in place to serve those with Alzheimer Disease and their families. The Action Plan acknowledges the need for specialized training of staff; a program for training family physicians in order to enhance early detection and diagnosis; increased public awareness, information and education; planning for appropriate safe and secure environments; respite services for caregivers; research on caregiver needs; the development of provincial policy on advance directives; psychogeriatric consulting resources, coordinated specialized diagnosis and support and an intergenerational volunteer initiative to encourage high school students to volunteer in a long-term care facility or program.

CALENDAR

January 22, 2000

Psychoanalysis and Religion. Institute for Advancement of Self-Psychology. Emmanuel College, U of T.
For information: (416) 690 4796.

January 26

Working Women's Multiple Roles and Psychological Distress: The Influence of Gender Role Socialization. Taryn Tang. Women's Mental Health Interest Group, Department of Psychiatry, U of T. 4-5 p.m. CAMH - Clarke site, Toronto.
For information: (416) 979 6922.

February 23

Women and Psychopharmacology, Dr. Myroslava Romach. (Details see Jan. 26 above)

February 23 & 24

Suicide Intervention Workshop. Sponsored by CMHA Waterloo Region and Wellington-Dufferin Branches. 8:30-4:30. $25.
For information: Sue at 1-877-727-2642.

March 3

Women and Psychosis Conference. CAMH-Clarke site.
For information: (410) 979 4747 ext. 2481

March 31

"2000 A.D. - Preserving Human Dignity". Sponsored by Alzheimer Society and Toronto Rehab. Institute. All day. $125. St. Lawrence Centre, Toronto. For information: (416) 597 4494 ext. 3693.

April 9-15

National Volunteer Week

April 14

Gala Art Auction to benefit CMHA Lambton County Branch. Ramada Hotel Convention Centre, Sarnia. Over 130 pieces of art will be auctioned! For information: (519) 337 5411.

May 30 & 31

Suicide Intervention Workshop. Sponsored by CMHA Waterloo Region and Wellington-Dufferin Branches. 8:30-4:30. $25. For information: call Sue at 1-877-727-2642.

June 4-7

Recovery in the Millennium. Annual Addiction Studies Conference. University of Western Ontario, London. Sponsored by Westover Treatment Centre and Alcohol & Drug Recovery of Ontario. For information: adrao@kwigs.net.

June 12-14

Psychology after the Year 2000. International Conference - Israel. Email: conference@psy.haifa.ac.il.

Networking in Mental Health & Addiction

Exploring Innovation and Emerging Trends

The demand for increasingly effective mental health and addiction systems is clear.

Although lack of adequate funding and supportive legislation continue to challenge these systems, there are hundreds of exciting and effective solutions across Ontario. And there are hundreds, even thousands of individuals who are pushing the boundaries of current knowledge and providing innovative services and programs.

Networking in Mental Health and Addiction: Exploring Innovation and Emerging Trends is a key educational opportunity for people in the mental health and addictions fields to examine leading edge research, programs, and services, translating the latest breakthroughs and knowledge into improved services.

Date: June 22-23, 2000
Place: Fanshawe College, London, Ontario
Conference Registration information will be available in early March.

For further information or to receive Conference information, please contact Allen Flaming at (416) 977-5580 or by email aflaming@ontario.cmha.ca or Lianne McKay at (416) 535-8501 ext. 4253 or by email Lianne_McKay@camh.net

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Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

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CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
Ontario Division/Division de l'Ontario
180 Dundas Street West, Suite 2301
Toronto, Ontario
M5G 1Z8