Senior Citizens' Secretariat
Newsletter

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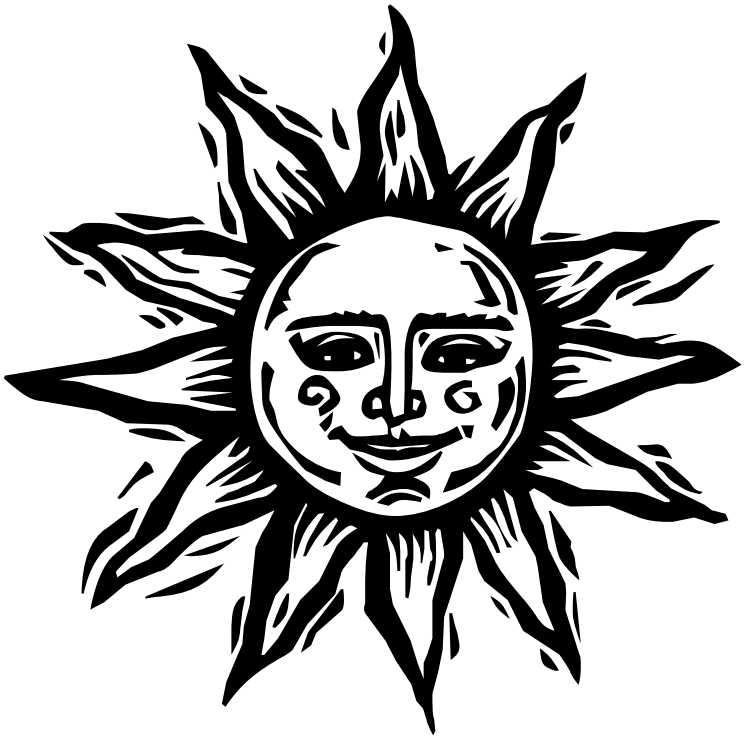
Seniors and Mental Health

"Seniors and Mental Health" has been identified by the four Atlantic provinces as a common area of priority for seniors *and especially for seniors who live in rural areas*. It is recognized that, even when there are programs and resources in place to treat older adults with signs of depression and to provide support to the family of the older adult, there are barriers that impede individuals from accessing mental health services.

Barriers to mental wellness in older adults are found in all communities but rural areas offer extra challenges such as the isolating effects of great distances from services, major centres and even neighbours. Also, transportation in these outlying areas is a major problem. The mental health services that are available tend to be found in cities or major centres. Many seniors do not drive and are dependent for transportation upon a dwindling circle of family and friends. Additionally, the waiting period for assessment and treatment by a specialist is lengthy.

Another major barrier seniors experience is the myth that being old and being sad is somehow normal or acceptable. It is well known that mental health issues carry negative connotations, especially with the elderly who associate them with weakness, madness or a fear they will be institutionalized. Chalifoux et al (1996) also believe that this generation hides or ignores symptoms and so figures are under-reported. Rost et al (1994) echo this in their study of how rural physicians manage depression in rural patients. They suggest that because of the stigma of mental illness in rural areas, depression is



often noted and treated very subtly, but not formally diagnosed, indicating that the rates for rural depression are actually higher than reported.

The Project: Aging Well in Rural Places

These and other barriers are the subject of a project now underway through the Atlantic Health Promotion Research Centre (AHPRC) at Dalhousie University, in partnership with the departments of health in the four Atlantic Provinces. The title of the research project is *Aging Well in Rural Places: Development and Pilot Testing of a Community Based Strategy to Address Depression in Seniors in Atlantic Canada*. The Principal Researcher for the project is Dr. Renee Lyons, Director of the AHPRC.

Goal of the Project

The goal of the project is to design an evidence-based strategy for developing social marketing messages and formats in communities to address problems of depression among rural seniors in Atlantic Canada, in order to improve the mental health and quality of life of this growing segment of the population.

Researchers will work with partners and volunteers in the pilot sites to seek ways for building community capacity and cooperative solutions.

The Process

This is a qualitative and participatory project assisted by seniors in rural areas where focus groups and interviews with key members of the community are helping to explore the issue of depression in rural elderly. In particular, the project is focusing on situational depression in rural seniors, depression arising from stressful life events such as the death of a spouse, chronic illness, multiple losses, the strain of constant caregiving etc. Participants in the focus groups and interviews share known barriers to accessing help for mental problems and some suggestions for making improvements for the future.

With the assistance of LURA Consulting, a local community-based social marketing firm, techniques will be applied to the findings of the project, and will result in strategies for behaviour changes such as, seniors and families actively reaching out for help or learning strategies to prevent depression in the first place. Four pilot study sites are participating: Musquodoboit, NS, Caraquet, NB, the Town of Bonavista, NF and West Prince County, PEI. All participants and researchers are seeking ways to enhance the capacities of communities and to develop project partners to help address the issue.

Secretariat Newsletter

The Secretariat Newsletter is published four times a year by the Senior Citizens' Secretariat and distributed free of charge. We welcome letters, articles and items of interest from you. Please include your name, address and telephone number on all correspondence.

The Senior Citizens' Secretariat was established in 1980 to facilitate the planning and development of services and programs for seniors by coordinating plans, policies and programs presented by the departments of the provincial government. The Secretariat serves as a one door entry to government for seniors, seniors' groups and other provincial bodies concerned with aging issues. The Secretariat develops plans, policies and programs in partnership with other levels of government and agencies responsible for seniors.

The Secretariat's office is located at 1740 Granville Street, 4th floor, P.O. Box 2065, Halifax, NS B3J 2Z1. Tel (902) 424-0065; fax (902) 424-0561; toll-free 1-800-670-0065.

Where are we now?

The project is approximately at the halfway point. The initial data collection is completed and findings have undergone two levels of analysis, initially at the community level by community working groups mostly comprised of seniors and then at the regional level to identify common themes and barriers. Recommendations from the community working groups will help to generate draft community-based social marketing messages and strategies that will be tested in the pilot communities for their potential to create the desired changes in behaviour.

What is next?

After the messages are tested in the pilot communities they will undergo final revisions and be put to use in the pilot communities. Recommendations will be made to the provincial partners and Health Canada for using similar messages and strategies across the Atlantic region and nationally. It is hoped that armed with behaviour-based messaging and newly developed partnerships, rural Atlantic communities will have avenues to improve the mental health outlook and quality of life of their seniors. The project ends in August of 2002.

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2. Rost, K., Humphrey, I., & Kelleher, K. (1994). Physician management preferences and barriers to care for rural patients with depression. *Archives of family medicine*, 3, 409-413. Contact: If you would like more information on this study, please contact Maureen Rogers, Atlantic Research Coordinator, AHPRC/Dal. @ (902) 864-7151.

Submitted by: Maureen Rogers, BN, M.Ed.

The Changing Face of Retirement

According to Statistics Canada, in 1970, 84 per cent of men aged 55 to 64 were in the labor force, but that rate dropped to 60 per cent a quarter century later. For women in the same age group, the rate decreased only slightly.

What's behind these changes? Early retirement programs and incentives are part of the reason Canadians are retiring earlier. In 1987, the minimum age for receiving Canada/Quebec Pension Plan benefits dropped to 60 from 65, and the proportion of Canadians aged 60 to 64 drawing those benefits rose from 20 to 38 per cent between 1987 and 1993. Private pension plans also playa role in this trend.

Retirement, of course, is not always a matter of choice. During Canada's recession a decade ago, 211,000 Canadians retired earlier than they had originally planned. Buyouts, layoffs and forced retirement are also becoming a common reality.

But retirement can no longer be defined simply in terms of age, years of service or pension eligibility. Rather it is a life transition that reflects many factors: gender, occupation, financial status, family circumstances, health, lifestyle, education, the strength and stability of an individual's employment situation, and the economy in general, as well as the interplay of current socio-economic policies and trends.

In a StatsCan study on Canada's Changing Retirement Patterns, about half of retirees reported enjoying life more than the year before they retired. They were especially happy about having more leisure time and time for family. One in five retirees enjoyed life less, giving as reasons poorer health, followed by less social contact and decreased income.

About one-third of retirees believed their financial situation had worsened since retirement. This opinion was more common among younger retirees and those forced into retirement.

There is no one route to retirement. Nor does the journey end once you get there. It is the

beginning of a new life stage. We need to plan for —and beyond—retirement. Today, retirement can provide the opportunity to travel, volunteer, spend time with family and friends or do all the things there never seemed to be time for before. Retirement can mean leaving a job or continuing to work full-time in a second career, part-time, or in a self-employed or freelance position.

With our increased life expectancy (the average Canadian can now expect to live 78 years, compared with 59 in the 19205) many of us will be spending 20 or 30 years in retirement—a significant part of our life, for sure! And as Baby-Boomers (those born between 1946 and 1965) enter their 505, Canadians of retirement age will continue to be a growing force. Travel and leisure industries will boom.

In 1998, Sport Canada reported that golf, considered by many to be the ultimate symbol of the retired life, has replaced hockey as Canada's most popular sport. As well, retirees enjoy activities such as walking, gardening and cycling, and older Canadians are the age group most likely to take time to read.

So as the population gets older and the Baby Boom generation approaches retirement, the needs and lifestyle requirements of retirees will continue to change.

In 1996, 11.2 per cent of Canadians were retired, according to a study by Statistics Canada on Canada's Changing Retirement Patterns. Here are some of the findings of that study:

1. The highest percentage of retirees reside in British Columbia and Ontario (13 and 12 per cent respectively).
2. Fourteen per cent of men and eight per cent of women reported being retired. The majority of women aged 60 or over have never been in the labor force. As more "younger women" now work outside the home, the men versus women retirement ratio is expected to balance out.
3. Two-thirds of retirees (80 per cent of retired men, 45 per cent of the women) were married or living common-law. Ten per cent of retired women were single; almost 40 per cent of them widowed. This is not surprising given that women generally live longer than men and marry "older" men. Seventeen per cent of the men and 44 per cent of the women lived alone.
4. Women retired earlier than men (at age 58.5 compared with 61.4) to spend time with their retired spouses, care for relatives or because of poor health. Men's reasons were often related to their own health or to early retirement packages.
5. Men eligible for registered retirement or pension benefits were more likely to retire before 65. Women with such plans, on average, worked to the age of 60.6 while women without such benefits worked to age 57.4.
6. Part-time and self-employed workers delayed retirement for financial reasons, or because they were already slowing down in preparation for their retirement. Male teachers retired earlier (59.4 years) than men in the service industry (60.8) and in construction and transportation (60.8). Female clerical workers retired earlier (56.8) than women in the primary sector (57.3) or those who were managers and professionals (57.8).
7. Thirteen per cent of retirees returned to work, usually as self-employed, part-time or temporary workers. These "retirees" were more likely to be men, with a higher education and "younger." One-quarter returned to work for financial reasons, one-half for other reasons, such as wanting to keep busy or for the social aspects.

Source: *Good Times: The Canadian Magazine for Successful Retirement*, October 2001.

Managing Hearing Loss

Hearing loss has been called “an invisible impairment” that can dramatically reduce quality of life. Hearing impairment affects one in 10 North Americans, and it is estimated that almost half of the population over 65 suffer from some degree of hearing loss. Health professionals in a variety of disciplines can play a key role in helping their patients/clients with hearing loss to address this common problem.

Types of hearing loss

Hearing loss can be classified in two main categories *conductive* and *sensorineural. Conductive* hearing loss is caused primarily by a mechanical problem in the middle ear or ear canal that disrupts or blocks the conduction of sound. The result is a poor transmission of sound waves via the eardrum, the failure of the ossicular bones to transmit sound, or both. Common causes of conductive hearing loss include excessive wax blocking the ear, fluid in the middle ear and a perforated eardrum.

In most cases of conductive hearing loss, hearing can be restored to some degree, if not completely. This is achieved by removing or repairing the cause of the hearing loss. For example, wax can be removed, infections treated and fluid drained. Even a damaged eardrum can be repaired through a precision surgical procedure using a miniscule skin graft. For severe or complete conductive hearing loss, special bone conduction hearing aids are available, as well as special devices called bone anchored hearing aids {BAHA).

Sensorineural hearing loss results from the reduced ability or failure of the nerve cells to receive transmitted sound. In most cases, sensorineural hearing loss is not reversible and compensatory management strategies are used.

This type of hearing loss is often further broken down into sensory hearing loss (when the inner ear is affected) or neural hearing loss (when the auditory nerve or nerve pathways in the brain are affected).

Sensory hearing loss can be caused by genetic factors (i.e. heredity), exposure to loud and/or constant noise (acoustic trauma), a viral infection, certain drugs or Meniere's disease. Neural hearing loss can result from infections, a brain tumour or other brain or nerve disorders, such as a stroke. In addition, the auditory nerve can be damaged at an early age by childhood diseases, including mumps and rubella (German measles), as well as severe inner ear infections and meningitis.

Presbycusis

The major cause of sensorineural hearing loss, however, is presbycusis, or age-related hearing loss. Presbycusis is a Greek term that literally means “old man's hearing”. It is a common condition affecting as many as 40 per cent of people over 65, and experts report that by age 80 almost everyone will suffer from some degree of hearing loss.

Presbycusis causes gradual, progressive, high frequency hearing loss that tends to affect both ears at the same time. Presbycusis usually begins between the ages of 40 and 50 and becomes slowly and progressively worse over time. It affects men more frequently and severely than women. The speed and extent of this progression varies from person to person.

Presbycusis develops as the middle ear goes through the process of ageing. The eardrum slowly loses its elasticity and the joints of the ossicular bones stiffen. This hampers the sound waves being conveyed from the outer ear to the cochlea. However, it is the age-driven changes in the inner ear that have more impact. A structure in the inner ear called the cochlea is vital to the hearing process. Tiny hairs in the cochlea are responsible for detecting and transmitting sounds to the brain. Presbycusis occurs when these hair cells fail to properly do their job. These hair cells gradually deteriorate over time and become less effective, resulting in an inability to pick up certain higher frequency sounds. As such, it is common for people with presbycusis to ‘hear’ speech but be unable to distinguish sounds in certain ranges (for example, consonants, such as ‘s’ and ‘t’).

Effects of hearing loss

The inability to hear and communicate effectively can have severe psychological effects on an elderly person. The person often feels frustrated, muddled and confused. Self-esteem can suffer, as lack of hearing by an older individual is often mistaken for lack of understanding, or even senility or Alzheimer's disease.

Many elderly who can't hear properly tend to retreat from other people. The end results can be isolation, loneliness and depression, even if the person is surrounded by family and friends.

Other potential dangers include the inability to hear instructions and, as a result, to act inappropriately (e.g. medication mistakes made as a result of not hearing the doctor or pharmacist's comment); and physical hazards (e.g. not hearing approaching traffic when crossing the street).

Presbycusis has no symptoms except the inability to hear. Because hearing loss progresses slowly, people often 'get used' to not hearing as well and automatically compensatory tactics, like standing closer during conversation or turning the radio up louder. In addition, many elderly individuals dismiss hearing loss as a 'something that happens when you get old'. They don't consider it a medical condition, assume nothing can be done and even don't think it is worth mentioning.

"Older individuals are often unaware of, or underestimate, their hearing loss," explains Margaret Cheesman, PhD, Asst. Professor of Audiology at the National Centre for Audiology; University of Western Ontario.

"Many people simply will not accept that they have a hearing problem. And if hearing loss is noticed, it is too often accepted by the person, as well as family members, as an inevitable part of growing old."

Dr. Cheesman also identifies negative perceptions towards this problem. "There is an unfortunate stigma associated with hearing loss that is hard to explain," she comments. "After all, no one would argue about the importance of having their eyes checked regularly as they grow older. But we tend to ignore our hearing."

Another unfortunate misconception is that nothing can be done about age related hearing loss.

Because of these attitudes, it often falls to frontline health professionals, such as visiting nurses, home care professionals and others, to identify the warning signs of presbycusis and initiate intervention (see Table 1).

If the health professional does identify warning signs, they should discuss the situation with the individual and family members, as well as notify the appropriate member of the health care team (e.g. specialist or family physician).

The goal is to have the patient/client's hearing checked by a qualified professional. This professional will be able to determine the type and extent of hearing loss using a number of tests, including an audiogram. The results of these tests will determine the management strategy.

An individual with conductive hearing loss will be referred to a specialist for treatment. However, since sensorineural hearing loss, such as presbycusis, is not reversible, the specialist may recommend strategies to compensate for the loss.

Treatment strategies

Simple strategies for lesser degrees of hearing loss involve simple communications technique, such as:

- Turning down or eliminating all background noise (radios, etc.)
- Getting the person's attention before speaking
- Facing the person when speaking. Speaking one at a time.
- Keeping your face in the light. Speaking slowly and clearly.
- In most cases of presbycusis and other forms of sensorineural hearing loss, however, the recommended management strategy centres on the use of a hearing aid.

Hearing aids essentially work by picking up sounds and amplifying them. These amplified sounds travel through the ear and better stimulate the nerve cells in the cochlea, enabling the person to hear.

Hearing aid design has progressed significantly in the last few years, and today's hearing aids are far removed from the unattractive and even relatively inefficient devices of even a decade ago. For example, problems with whistling and with the device amplifying background noise along with desired sounds they have been significantly reduced. Newer digital hearing aids offer many benefits, including: improved ease of listening, reduction of listening fatigue, minimized distortion and circuit noise and more.

Newer products are also smaller and more cosmetically acceptable.

There are five basic types of hearing aids, and the audiologist will recommend a specific type based on the individual's condition, lifestyle, preferences and other factors.

The most common styles used today are in-the-ear (ITE) and in-the-canal (ITC) hearing aids. In ITE devices, the amplifier electronics are built right into the earmould. ITC hearing aids are smaller than ITE devices and fit into the canal portion of the ear.

Other styles include behind-the-ear (BTE) and body worn hearing aids, as well as completely-in-the-canal (CIC) devices, which are nearly invisible.

If used properly, a modern hearing aid can dramatically improve the hearing of most people with age-related and similar forms of hearing loss. This can make a tremendous difference to the person's ability to communicate, independence and overall quality of life.

Unfortunately many people with hearing loss who can benefit from the use of a hearing aid fail to seek treatment. In this regard, front line health professionals in a variety of disciplines can play an important role in raising awareness and providing accurate education.

World Congress of Gerontology

Dr. Gloria Gutman, President of the Organizing Committee for the International Association on Gerontology (IAG) 17th World Congress of Gerontology, welcomed over 4,000 delegates to the World Congress in Vancouver, BC July 1–6. Against a backdrop of flags from the 62 member countries of IAG, including the first African country, South Africa, Dr. John Gray, Secretary of the Organizing Committee, introduced the dignitaries at the Opening Ceremonies.

Dr. Pierre Soucie, the President of the Canadian Association on Gerontology, welcomed the delegates to Canada on behalf of the CAG, the host society for the Congress. Other dignitaries provided welcoming remarks including a video greeting from the Honourable Alan Rock, Canada's Minister of Health. The Official Opening was declared by the BC Minister of State for Intermediate, Long Term and Home Care, the Honourable Katherine Whittred. The Opening Reception concluded with a dazzling fireworks display celebrating Canada Day.

The Vancouver Convention and Exhibition Centre, with its spectacular architecture, provided excellent facilities for the delegates from over 80 countries. Numbering 4,086 in total, attendance was over four times the average CAG conference and twice as large as the 1997 World Congress that took place in Adelaide, Australia. The major complaint from delegates was that they could not attend more than one session at a time. With over 30 simultaneous sessions there were lots of choices. The size of the Book of Abstracts, with over 3,000 abstracts, illustrated the depth, diversity and scope of the program. In addition to free papers, posters and plenary presentations, the 113 invited symposia were very well attended. The topics and convenors with international reputations, were chosen by the IAG Planning Committee that included the Regional Chairs (Europe, Asia/Oceana, North America, Latin America and the Carribean), the current and past JAG President and the Scientific Program Chair for the 2001 Congress,

Dr. Andrew Wister. Andrew is to be congratulated for this and all other aspects of the program.

A feature of the 17th World Congress was the Continuing Medical Education program. These sessions, organized primarily by Dr. Lynn Beattie, were attended by many non-physicians as well.

Audio tapes and some video tapes were made of the plenary sessions, selected invited symposia and continuing medical education sessions. Tapes of the 80 sessions that were recorded can still be purchased from Kennedy Recordings at: www.kennedyrecordings.com/conf/gerontology.htm

Older Workers Viewed Negatively

Young Canadian workers appear to hold a dim opinion of their older colleagues, a newly released government poll reveals.

The Ipsos-Reid poll, conducted for Human Resources Development Canada (HRDC) earlier this year, suggests that only one-third of all Canadians believe most older workers have attained higher education, and that opinion is strongest among young workers.

Recent statistics obtained from HRDC show about half of workers 55 to 64 years old have obtained post-secondary education, particularly at university or college, compared to 70 per cent of the youngest workers

However, only 27 per cent of those polled between ages 18 and 34 thought most older workers had higher education compared to 42 per cent of 55-plus Canadians.

Mike Colledge, senior vice-president of Ipsos-Reid, said the poll reveals a disconnect in the Canadian population about today's workforce.

"I would imagine that a little bit of self-interest comes into play. There is a little bit of a generation gap," said Colledge.

The gap is particularly noticeable on the question of retaining older workers. Respondents were split on the matter, with 51 per cent saying they believed in making room for the younger generation while 48 per cent thought older workers should be kept employed

Colledge said it is not surprising that the youngest Canadians, between 18 and 34 years old, were the least likely to value older workers, as two-thirds favoured them getting out the way for younger workers. A majority of older Canadians believed older workers are a valuable asset worth keeping around.

A bare majority (51 per cent) of those polled agreed that older workers should be encouraged to remain in the labour force. While only 42 per cent of 18- to 34-year-olds agreed, the number jumped to 58 per cent for those over 55.

A recent C.D. Howe Institute report stated that because of declining birth rates in Canada, the United States and Britain, growth in the working age population will slow and ultimately cease by 2030. That is expected to lead to a dramatic increase in the average age and wages of the workforce.

With the country potentially poised on the edge of a recession, the poll found that two out of three Canadians believed older workers are more likely to be laid off in hard times. This belief is held most strongly by the older segment of the population.

The telephone survey of 1,000 Canadians conducted between March 20 and 25 is considered to accurately represent the opinions of the Country as a whole within 3.1 percentage points, 19 times out of 20.

Source: Jack Aubry, *Ottawa Citizen*, Ottawa. Published: *Calgary Herald*, Thursday 15, 2001.

Presentation to the Standing Senate Committee on Social Affairs

Halifax, November 6, 2001

I am here representing the Valley Caregivers Support Group in rural Nova Scotia. How does one become a caregiver. A family member becomes ill and you become a caregiver. You take on the job without training, without pay and often without support. The job can last weeks, months or years. For me it was 15 years. You live in isolation, lose friends, have little or no social life, ongoing stress becomes a intricate part of your life and if you let care giving become all consuming you can loose your identity. Thousands of Nova Scotians selflessly provide care for family or friends who are mentally or physically challenged, chronically ill, frail or elderly.

By providing care at home these caregivers collectively provide an urgently needed service saving taxpayers millions of dollars.

With an increase number of seniors requiring assistance at home, primary caregivers are a valuable link in the health chain and they need support.

If you neglect the caregiver you will end up with two people who are ill and that becomes a strain on the health care system.

The long hours of emotionally demanding work seems poorly understood and grossly undervalued.

Maxine Barrett

Admission to Nursing Homes

The Valley Caregivers' Support Group has been in existence for seven years, in part to help members cope with the sometimes unbearable stress of caregiving. A major source of this stress for a number of caregivers arises with the decision to place a family member in a nursing home. This decision is usually deferred until well beyond the limit of endurance and when the caregiver and the family member are in a highly vulnerable position. That is the moment when the family must face the cold hard facts about admission to a nursing home facility .The impact of this decision can be overwhelming.

The group, therefore, decided to inquire into the admission policies of other provinces and territories as well as Nova Scotia. We approached Dalhousie University and Assistant Professor Robin Stadnyk of the School of Occupational Therapy undertook to do the research. The project has been expanded to study the impact of the different funding models on families and the member being placed.

Nova Scotia Policies and Practices

Effective April, 2001, all applicants for admission to any licensed nursing home in this province must go through a "single entry access" procedure, *whether or not they pay the full cost of care*. It involves complete disclosure of all income and assets of the applicant, as well as the spouse. Any transfer of property or money to a third party, even a child, within the three years preceding the application, must be disclosed.

Income includes private pensions, Canada Pension, Old Age Security, Guaranteed Supplement, income arising from annuities and any other regularly recurring income. *Assets* include the content of all bank accounts, any property, (excluding the designated residence), RRSPS, GICs, shares, life insurance, boats and any other fixed or liquid asset.

The Government wants total disclosure of your financial affairs with no guarantee of confidentiality. This is to ensure that citizens will fully fund the cost of care in any nursing home to the utmost extent of their ability. For the private payers this does not include medicines, wheel chairs, ambulance fees and numerous other items.

Before any government support is extended, all eligible income and assets, with the exception of the designated residence, much be applied to the cost of care. For married couples, the combined income and assets, excluding the home, are eligible and half of their value must be applied to the cost of care. The impact of such costs on the spouse remaining at home whose income is drastically reduced but whose expenses remain relatively unchanged, is devastating.

This procedure entails the most drastic means testing any citizen will encounter and throughout the process there is no one to advice and direct the caregiver, who finds herself intimidated and humiliated. An exhausted, quilt ridden, emotionally drained and often failing health caregiver is demoralized by the outcome.

You can rent or sell your designated home but all net proceeds *must be applied to your care*, if the title of your home is still in your name. Spouses, can rent or sell the designated home but half of the income *must be applied to the cost of care*. They can transfer the home to another person, as long as they *do not receive value for it*. And since the title is in someone else's name *they can sell the house and the money belongs to them*.

Your have worked hard to acquire your designated home but if you sell it for any reason the government can lay claim to the proceeds with the stroke of a pen. What happened to your dream of leaving a little of your inheritance to your children?

Rates are steadily increasing in nursing homes and some residents have been warned that "all nursing homes will be directly impacted by labour negotiations with Nurses in Nova Scotia."

Evidence that nursing homes may have a different rates for residents who are fully funding their care is indicated in a Department of Health information document, *Nursing Homes/Homes for the Aged: General Information*, Department of Health, March 2001, page 5. Are private paying patients subsidizing Government funded care?

For years caregivers have been trying to shed the name informal caregiver but it is still being used by the Department of Health in their single entry access brochure. There is nothing informal about the 80% care we give day in and day out, sometimes for many years. If they really want to label us it should be the unpaid caregiver.

Policies of other Canadian Provinces and Territories

Families in the Maritime provinces are expected to contribute to the full cost of care and will be means tested for both income and assets as described above for Nova Scotia.

In Newfoundland, the same policy direction exists as in the Maritimes up to a maximum currently set at $2900 per month. In Nova Scotia the cost can exceed $4500 per month. That brings the yearly cost for Nursing Home care to over $50,000.

In Alberta and the Territories residents are not means tested. All person pay an affordable price.

In contrast to the Atlantic provinces, other jurisdictions focus on recovering *only the room and board portion and means testing and only done and income*. The nursing care component is paid for by the province. This is in keeping with the principle of universality in health care of which Canadians boast. Why are senior citizens in the Atlantic provinces being discriminated against? Federal equalization grants are intended to ensure equal health and social services among all provinces. As citizens we are entitle to the same treatment that exists in many other provinces, that is, *paying for room and board and being means tested on just our income*. What a statement these policy directions make about the value that Maritime provinces place on a caregiver's contribution.

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3. *Preliminary Research Report on Nursing Homes across Canada*, February 2001.

Robin Stadnyk, Assistant Professor of the School of Occupational Therapy, Dalhousie University. Maxine Barrett, Valley Caregivers Support Group Box 125, Granville Ferry, Nova Scotia BOS 1KO.

How to give your house and keep it

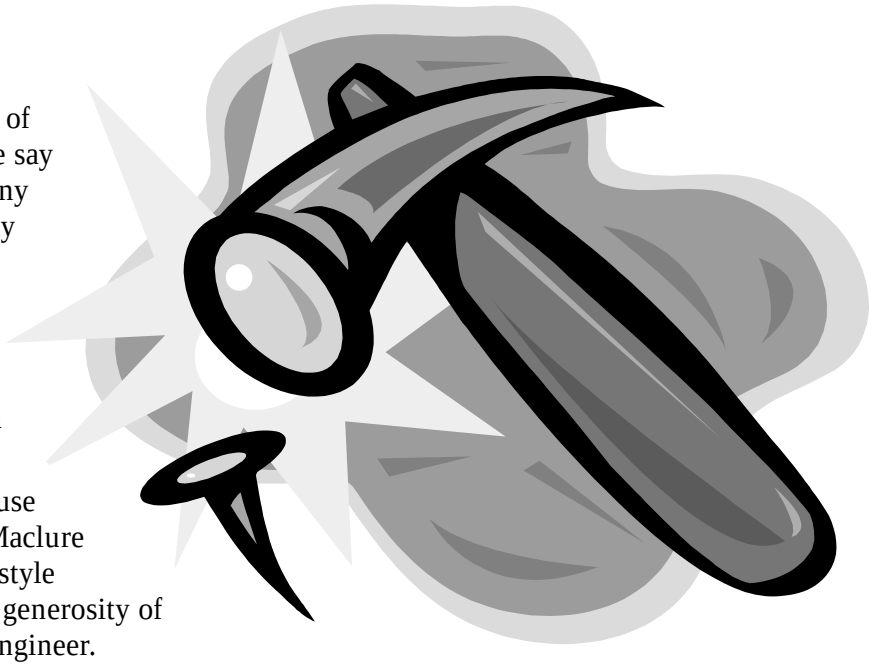
There are two examples in Canada of Houses donated by individuals. We say "individuals" because there are many examples of donations or nominally priced leases by churches.

To put this in simple terms, it is like the member of the oldest profession who was heard to say: "You got it ... you sell it ... and you still got it. What a business!"

A spectacular Oak Bay heritage house designed by the architect Samuel Maclure in his trademark Scottish Baronial style became an Abbeyfield through the generosity of Count Albert De Mezey, a retired engineer.

Ten years ago, Count De Mezey announced in a newspaper article that he wanted to find some use for the house that involved seniors. Needless to say, a number of groups approached him, but Anne Spicer, President of the Abbeyfield Chapter, was able to persuade him to give the house to Abbeyfield. A condition of his gift was that he stay in the house rent-free. This commitment has been honoured, and on November 12 he celebrated his 98th birthday. Through the years Dorothy Youlden and her committee have faced the daunting task of raising money for renovations and repairs, keeping the house at a very high standard.

A recent example of an individual's generosity is in Armstrong, BC. Mr. Peter Unrau gave his house with the condition that he live rent-free and have al1 his living expenses covered. He also insisted on keeping his dog and his pool table. In this, case the house had to undergo extensive renovations and expansion at the back. City Administrator Patti Ferguson and her committee have produced a most attractive residence with deluxe accommodation upstairs for the House Manager. What is interesting about this conversion is that for only three months did Mr. Unrau have to leave the house, which is affectionately referred to as "Pete's Place."



There are many people whose houses have outgrown their needs, yet who do not want to live anywhere else. They find that the effort and expense of upkeep are more than they want to or are able to handle. This model allows the person to continue living in the family home while benefiting others. The conversion process can include close cooperation with the Abbeyfield committee in design and building, and allows him or her to have first choice of a suite in the renovated house.

Source: *Abbeyfield*; Volume 9, Number 3, Fall/Winter, 2001.

Praying Away Stress

A study form the University of Florida and Wayne State University (USA) shows most older adults use prayer more than any other alternative health remedy to help manage the stress in their lives.

In addition, nurse researchers found that prayer is the most frequently reported alternative treatment used by seniors to feel better or maintain health in general.

The study, published in the December issue of the Journal of Holistic Nursing, found that prayer is used more often than other alternative therapies, such as exercise, humour or relaxation techniques.

While prayer was the predominant alternative therapy used by the participants in the study, more than one-third of the respondents reported using other spiritual strategies to feel good or maintain their health as well. Prayer, imagery, music, art therapy, distraction, energy healing, humour, meditation, relaxation and religious counselling were defined as spiritual treatments.

The results of this study illustrate that prayer may help seniors decrease the negative effects of stress in their lives. It also proves useful for further assessment of prayer as a coping and treatment approach.

By Catherine Antoine University of Florida
Magazine Number 2, Volume 1 July 2001
Source: *Intercom: Educating & Advocating for Older People's Rights*, October 2001: Volume 8, No. 7

Bits and Bites

God, Grant me the serenity to accept the things I cannot change,
The courage to change the things I can,
And the wisdom to know the difference.
Living one day at a time, enjoying one moment at a time,
Accepting hardships as the pathways to peace,
Taking the worrisome world as it is, not as I would have it,
Trusting that everything usually turns out all right and probably will again,
That I may be reasonably happy in this life, and supremely happy with Him in the next.

"Worrying helps you some. It seems as if you are doing something when you are worrying." *Lucy Maude Montgomery*

"Be nice to your kids. They choose your nursing home." *Sign in Kingston, Ont.*

Age doesn't always come with wisdom.
It sometimes comes alone.

"To be without some of the things you want is an indispensable part of happiness." *Bertrand Russell*

"It takes a noble man to plant a seed for a tree that will some day give shade to people he may never meet." *David Trueblood*

Before you criticize someone, you should walk a mile in their shoes. That way, when you criticize them, you'll be a mile away and you'll have their shoes.

Books

Living Longer for Dummies

Don't judge this book by its cover—it may be frivolous in tone, but what follows, through sometimes tongue-in-cheek, is serious. Handling a health crisis, dieting and the importance of sex are just a few of the subjects touched upon in this look at longevity.

Author and septuagenarian Dr. Walter Bortz is no dummy. A specialist in internal medicine at the Palo Alto Medical Foundation, he is the past president of the American Geriatrics Society and a past co-chair of the American Medical Association's Task Force on Aging. His previous book, *Dare to Be 100*, is a best-seller. An avid runner, this grandfather of nine has completed 20 marathons. Perhaps he really has found the blueprint for living longer.

Living Longer for Dummies by Walter M. Bortz, M.D. Published by Hungry Minds Inc., 2001. Softcover, 214 pages. $22.99

Source: *Good Times: The Canadian Magazine for Successful Retirement*, January 2002.

All in the Family, Inc.

Insights from the Corporate Boardrooms and Kitchen Tables of Canadian Family Businesses.

Can you mix family and business and make both a success? All 22 families included in this book say you can. "Pride and passion," says author Allan Lynch, are what set family businesses apart from others. Harry Rosen, Alex Tilley and John Sleeman are cases in point. But while blood is thicker than water, being related does not guarantee smooth sailing. "Disasters, divorce and dissident shareholders" have threatened the survival of leading Canadian companies such as Ganong Bros., Terra Footwear and E.D. Smith. From the keys to survival to successful succession, *All in the Family, Inc.* is a must-read for anyone who is or has been involved in a family business.

All in the Family, Inc. by Allan Lynch. Published by Macmillan Canada, Toronto, 2001. Hardcover, 232 pages. $34.99.

Source: *Good Times: The Canadian Magazine for Successful Retirement*, January 2002.

Red Wine for Your Health

Good news! Red wine is good for you! Called the "French paradox theory," studies have shown that wine-drinking countries such as France had lower rates of heart disease and stroke than countries consuming less wine. Why? It has something to do with flavonoids, a naturally-occurring anti-oxidant which helps prevent blood clots and ultimately reduces your risk of heart attack and stroke.

How much can we drink to get all these so-called health benefits? Various studies have recommended from one to five drinks per day—a drink being 3fi ounces. However, age, gender and family heart history should be taken into account.

Red Wine for Your Health, by Andrea Schaffer, published by Key Porter Books Ltd., 2001. Soft cover, 96 pages. $19.95.

Source: *Good Times: The Canadian Magazine for Successful Retirement*, October 2001.

Read all about it

If you're cooking for one or for two, here are some inspiring cookbooks:

- *Healthy Cooking for Two (or Just You)* by Frances Price. Rodale Press, 1995. About $22. (Rodale Press: 1-800-914-9363 to order).
- *Great Food Fast* by Bev Callaghan, RD, & Lynn Roblin, RD. Robert Rose Inc., 2000 About $20
- *Going Solo in the Kitchen* by Jane Doerfer. Random House of Canada, 1998. About $20.
- *Betty Crocker's New Choices for Two.* Betty Crocker, Simon & Schuster, 1995. About $20.

Source: *Good Times: The Canadian Magazine for Successful Retirement*, January 2002.

God, Faith and Health

If you're interested in finding out more about the connection between our spiritual and religious beliefs and their direct relationship with the quality of our health, then you will enjoy this book. Traditional medicine has generally discredited such beliefs because of the lack of evidence-based research. Now, author and scientist Jeff Levin has uncovered some compelling facts linking faith and health.

The studies Levin reviews include a Johns Hopkins University study of more than 100,000 people which concluded: "People attending services on a weekly basis reduced the risk of death the following year by almost 50 per cent." Another study found that "Coronary Care Unit patients who were prayed for by strangers fared better than patients who did not receive prayer."

Levin identifies more than 50 studies in which there is evidence of a reduction in stress, heart disease, high blood pressure, high cholesterol and circulatory diseases for those with a religious affiliation.

God, Faith, and Health, Exploring the Spirituality-Healing Connection, by Jeff Levin, PH.D., published by John Wiley and Sons Inc., May 2001. Hard cover, 272 pages. $36.95

Source: *Good Times: The Canadian Magazine for Successful Retirement*, October 2001.

Sleep Buddy Knee Support Pillow

Prevents aches and pains

How comfortably we sleep at night makes a big difference in the quality of our sleep and how we feel in the morning. If you suffer from lower back stiffness in the morning, pain in your knees and hips or sciatic leg pain, then chances are

you've been told to sleep with a pillow between your knees to prevent these morning aches and pains. But more often than not, as you toss and turn, a pillow between your knees slides away. Well, despair no longer. The Sleep Buddy supports your spine in a natural position, allowing tense muscles to relax. The contoured thigh supports fit around your knees, holding the pillow in position. Front and rear bumpers prevent you from rolling onto your stomach. The pillow is made of polyurethane foam, includes a poly/cotton zippered pillow protector and is 10 by 16 inches. Pleasant dreams!

The Sleep Buddy Support Pillow is available at most back specialty stores or online at www.mybackstore.com. Price is about $26.99 plus $7.99 shipping.

Source: *Good Times: The Canadian Magazine for Successful Retirement*, October 2001.

Seniors and Technology

The Nova Scotia Centre on Aging, Mount Saint Vincent University is pleased to present the recent publication of "Seniors and Technology", Volume 17, in the National Advisory Council on Aging's (NACA) series Writings in Gerontology.

Co-authored with NACA, the volume focuses on the social and ethical implications of increasing levels of automation in everyday technologies in the lives of older adults. While there is real potential for technology to promote seniors' independence and social participation, it is believed that for seniors to benefit fully from technology, the products of technology must be developed and designed in ways that recognize the diversity of seniors and their right to make choices about their use. If technology is to benefit seniors, our society needs to promote receptivity and access by addressing the problems of lack of awareness about the benefits, high costs and attitudinal barriers.

Besides featuring the work of authors and researchers across Canada on this subject, it showcases the national project Everyday Technology and Older Adults: Friends or Foes? currently being coordinated at the Centre and funded by Health Canada's Population Health Fund.

For more information please contact: The Centre on Aging, Mount Saint Vincent University. Phone: (902) 457-6561; Fax: (902) 457-6508.

New Palliative-Care Program

As Government Leader in the Senate, Senator Sharon Carstairs is a member of the federal cabinet. But on March 14, 2001, she was given the additional responsibility of "Minister with Special Responsibility for Palliative Care".

The Senator emphasizes her belief that the greatest need for palliative care is in rural Canada. She cites instances of terminally-ill individuals who must be separated by many miles from their families at a time they need them most.

The Senator's goal is to ensure quality end-of-life care for all Canadians. The need can be expressed statistically: 220,000 Canadians die each year, but it is estimated that only five to ten per cent receive quality, multi-disciplinary, end-of-life care.

Over the past year, a lot has happened on this file. In addition to her appointment as Minister with Special Responsibility for Palliative Care, a palliative-care Secretariat has been established in Ottawa by Health Canada.

Recently, the Ian Anderson Continuing Education Program in End-of-Life Care, at the University of Toronto, developed an educational program that will educate 10,000 primary-care physicians and specialists across Canada over a five-year period to deal with issues surrounding death and dying.

How can the Senator achieve her goal? By following each step in a national strategy based on education, agreed-upon standards, and the co-operation of all those involved in the health field. Senator Carstairs believes she can achieve her goal of ensuring quality end-of-life care.

She is able to report a surprising momentum in the first year of the new federal program. The Canadian Palliative Care Association (CPCA) has also been very active in developing national standards for hospice-palliative care.

CPCA last year took the initiative which led to the formation of the End-of-Life Care Coalition. It includes the Canadian Cancer Society, the

Heart and Stroke Foundation of Canada, the Canadian Breast Cancer Network and the National Advisory Council on Aging, among others.

Their common goal has been succinctly stated: to ensure quality end-of-life care in every province and territory.

A significant portion of palliative care is delivered in large part by dedicated and extensively trained volunteers. Senator Carstairs' quest is for the recruitment and training of another 6,000 of these volunteers in the next five years.

Amazing Computer Memory Research

A team of Halifax scientists is developing a portable computer "cane for the brain" to prop up the fading memory of Alzheimer patients.

The device dubbed My Story will be programmed to help people with the disease recognize friends and relatives.

Doctors and computer scientists even want the handheld computers to be able to do everything from showing lost Alzheimer's patients the way home to reminding them when to buy more milk.

"The computer could beep at you or let you know that now is the time to feed the cat or now is the time to take your pills." said Kenneth Rockwood, a geriatric medicine specialist at the QEII Health Sciences Centre.

Computer experts at Dalhousie University are working with Rockwood to make the computers recognize voices, signatures and even faces.

"We want always to make sure that (the patients are) dealing with the right people—that somebody will not sneak behind them," said Jacob Slonim, Dal's Dean of Computer Science. "You need to worry about privacy and security."

After recognizing a friend or relative, the computer will be able to tell, and even show, an Alzheimer's patient why that person is important in their life.

"So if Uncle Henry's on the phone, for example, and the thing you always remembered about Uncle Henry was the time he took you sailing when you were 12, you can actually have that picture come up (on the computer screen)... said Rockwood, who will discuss the project behind closed doors this week at the Halifax International Invitational Symposium on Defining Treatment Effects in Dementia.

Could prevent outbursts

The computers might even help Alzheimer's patients avoid socially inappropriate behaviour, he said.

"One can imagine circumstances where people are acting up because they're frustrated (due to memory impairment)." Rockwood said.

Depending on the disease's stage, Slonim said the computers which will be able to talk could improve the quality of life for an Alzheimer patient for a decade.

"As the technology is evolving, we can add more and more functionality," such as sensors that alert patients to a full bladder or a dog in need of a walk, he said.

While a prototype will be ready for testing in a year, Rockwood said it will probably be five years before Alzheimer patients get to use the devices. He could not predict how much one will cost. "It would have to be affordable at the end stage," Rockwood said.

Caregiver Coalition Launched

Whether they are referred to as "carers" or "caregivers", every day countless numbers of unpaid individuals provide hours of care and assistance to friends and family members who are sick or dying. Much of the work goes unrecognized. Often it is given at great personal sacrifice to personal health or loss of income. Rarely do governments provide credit. Usually caregivers don't seek any. Frequently caregivers fail to have their own needs cared for.

Things may be about to change. A Canadian Caregiver Coalition was founded earlier this year.

Its mission is to come together with a unified voice, to influence policy, and to promote awareness and action to address the needs of caregivers of all ages across Canada. The Coalition is committed to creating a voice for caregivers within the Canadian context of care and prioritizing caregiving issues in health care policy, education and program development.

The Coalition will highlight advocacy as a timely and crucial need for caregivers who often do not have anyone to speak on their behalf. It aims to fulfill its mission through consultation and advocacy, by promoting relevant research and by networking between organizations, groups and individuals to share information and to promote partnerships.

It publishes a bilingual newsletter, in French and English, two times a year. The fall 200l issue carried a variety of articles on "Respite: A challenge for caregivers, service providers, and policy makers". The next issue will focus on "Home and Community Health".

The Coalition accepts individual and organizational members. Information can be obtained by writing to: 110 Argyle Avenue, Ottawa, Ontario, Canada, K2P 1 B4, or by visiting their website at: www.ccc-ccan.ca.

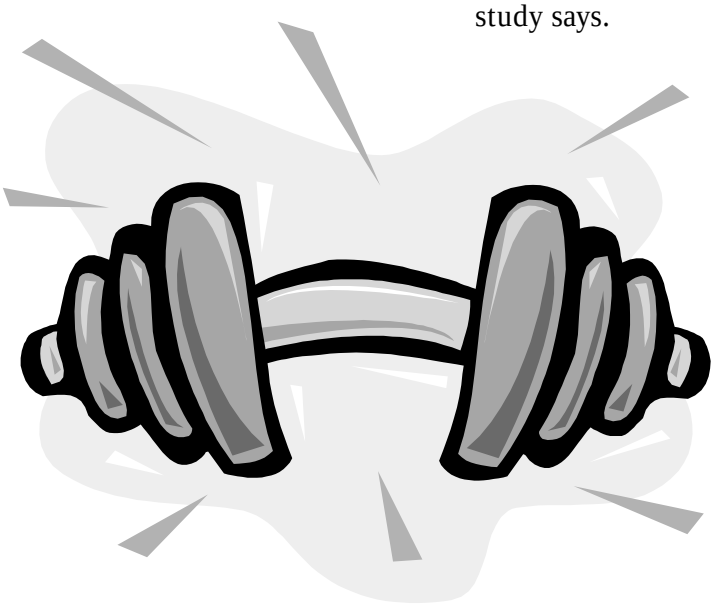
What impact are caregivers having on the Canadian health care system? According to Statistics Canada (1996 GSS Social Survey), over 2.8 million Canadians, 15 years of age and older, provided care to people with physical limitations or long term health problems. The economic value of caregivers is enormous—help given to seniors alone saves the public system over 5 billion dollars per year and is equivalent to the work of 276,509 full-time employees.

Source: *Intercom: Educating & Advocating For Older People's Rights*, Nov. 2001: Vol. 8, No. 8.

Beat 'Daily Living' Aches and Stiffness

Exercise can help older people avert a form of arthritis that can turn ordinary activities such as getting out of bed into a painful—perhaps impossible—chore a study finds.

Those who regularly walked or did weight training were less likely to lose abilities to perform activities of daily living, such as getting out of bed, the study says.



The report is the first to demonstrate that exercise can help people avoid relying on others for help in these ordinary activities, said researcher Brenda Penninx of the Wake Forest University School of Medicine.

Penninx and her colleagues looked at 250 participants ages 60 and older. When the study started, all could perform normal activities, despite osteoarthritis of the knee. Osteoarthritis is characterized by progressive deterioration of cartilage, and affects more than 80 percent of those who reach the age of 70.

The participants were divided into three groups. One walked for 40 minutes three times a week. Another spent the same amount of time on weight training—two sets of 12 repetitions of nine exercises, most of them for the legs. The third did no exercise and served as a comparison group.

Results of the study were published in the Oct. 22 issue of *Archives of Internal Medicine*.

After 18 months, 53 percent of the non-exercise group reported they had lost some or all ability to transfer from a bed to a chair, bathe, use the toilet or dress. In comparison, about 37 percent of exercisers did, and the difference between walking and weight training was so slight that researchers considered the benefits alike.

"I definitely think that people with knee osteoarthritis would benefit from a resistance or aerobic program," Penninx said. "What this study shows is that exercise is beneficial."

And the anti-disability benefits may extend beyond the knee, because 75 percent of the study participants had arthritis elsewhere, Penninx said.

Previous studies have found that exercise reduces pain and improves muscle tone, balance and the ability to do things such as walk, but this is the first to go to the next level and examine prevention of disability.

The study gives a stronger oundation to current medical support for exercise.

"I can't think of anybody I wouldn't put on an individual exercise program," said Dr. Roland Moscowitz, a medical professor at Case Western University. Walking on a treadmill almost always helps, and weight training can help too, provided the person in charge of training knows how to avoid damaging a patient's joints, he said.

Exercise probably is best for people in early stages, before development of joint deformity, extensive cartilage loss and continuing pain, said Dr. Marian Minor of the University of Missouri.

"I'm trying to make a case for prescription of exercise early—not thinking you are going to rescue people later," said Minor, a researcher who was not connected with the Wake Forest study.

From Associated Press (c) iSyndicate
www.ThirdAge.com
Source: *Intercom: Educating & Advocating For Older People's Rights*, Nov. 2001: Vol. 8, No. 8.

WHO Releases New Guidelines to Measure Health

Health indicators have traditionally been based on mortality (i.e. death) rates of populations. All this is about to change.

More than seven years in development, the new World Health Organization (WHO) classification system has been accepted by 191 countries as the international standard to describe and measure health and disability. It is applicable across cultures, age groups and genders. Hence it will soon be possible to reliably compare data on health outcomes of individuals and populations.

Released in mid-November, the International Classification of Functioning, Disability and Health (ICF) changes understanding of disability. No longer is it presented as a problem of a minority group.

According to the WHO, "the ICF takes into account the social aspects of disability and provides a mechanism to document the impact of the social and physical environment on a person's functioning. For instance, when a person with a serious disability finds it difficult to work in a particular building because it does not provide ramps or elevators, the ICF identifies the needed focus of an intervention, i.e. that the building should include those facilities and not that the person be forced out of the job because of an inability to work."

The ICF puts all disease and health conditions on an equal footing.

For further information, contact:
Daniela Bagozzi, Office of the Spokesperson, WHO, Geneva. Telephone: (+41 22) 791-4544
E-mail: bagozzid@who.int.
Website: http://www .who.int/

Source: *Intercom: Educating & Advocating For Older People's Rights*, Nov. 2001: Vol. 8, No. 8.

New Drug Could Prevent Diabetes

Preliminary research suggests that a new drug could stop he progression of type 1 diabetes by halting the destruction of insulin-producing cells.

Experts say that as well as stopping deterioration in people in the early stages of the disease, the drug eventually could also be given to pre-diabetics to prevent the illness, an incurable autoimmune disease that afflicts about 15 million people worldwide.

"Right now this is probably the most exciting thing we have in front of us," said Dr. Jerry Palmer, a professor of medicine at the University of Washington in Seattle who was not connected to the study. He called the results "tantalizing."

In type I diabetes, the immune system goes awry and kills insulin-producing beta cells in the pancreas. It occurs mostly in children and adolescents, but is increasingly being seen in adults. In type 1 diabetes, which accounts for 90 percent of diabetes and is not an autoimmune condition, the beta cells are intact but the body doesn't use insulin properly.

Scientists believe that type I diabetes may be triggered by an infection or other irritant that puts the insulin-producing cells under stress.

The cells secrete a stress chemical, attracting immune system cells patrolling the body. The immune cells mistake the stressed beta cells as foreign invaders and release a poison to kill them.

The experimental drug, developed by Israeli pharmaceutical company Peptor Ltd., contains a substance that prompts the immune cells to release a harmless anti-inflammatory chemical meant to calm inflamed natural tissue instead of a deadly poison meant for an unwelcome stranger.

Similar approaches are being pursued for other autoimmune diseases, such as rheumatoid arthritis.

"This is the first study to show that you can stop beta cell destruction by outside immunization," said one of the investigators, Dr. Itamar Raz, head of the Hadassah Center for Diabetes at Hadassah-Hebrew University Medical School in Jerusalem. "We do know today for the first time that by giving a small amount of antigen we can change the whole characteristic of the immune system and stop that attack.

The study, published in The Lancet medical journal, involved 31 men who had been diagnosed with type I diabetes within the previous six months.

They all got the insulin injections they needed, but in addition, 15 got the drug, DiaPep277, and 16 got a fake injection. The injections were given on the first day of the study, after one month and after six months. They were followed for four more months.

"At the beginning of the study, we think that they had 3 to 7 percent of their beta cells left," Raz said. "At the end of the study, those on placebo had less than 1 percent of their beta cells left. Those on the drug had the same—3 to 7 percent."

By the end, those who were on the drug hardly needed outside insulin, while those on placebo needed an increasing amount as time passed, the study found.

From Associated Press (c) iSyndicate www.ThirdA!e.com

Source: *Intercom: Educating & Advocating For Older People's Rights*, Nov. 2001 - Vol. 8, No. 8

International Conferences

February 2002

Holistic and Creative Choices
February 20–22
Adelaide, Australia
Tel: Pelvin and Associates +61 (08) 8379 8222
E-mail: plevin@camtech.net.au
Website: www.plevin.on.net/hacc /home.htm

Scientific Discovery in Geriatric Psychiatry:
Responding to Clinical Challenges
American Association for Geriatric Psychiatry
February 24–27
Orlando, Florida USA
Tel: (301) 654-7850
E-mail: jschmidt@aagponline.org
Website: www.aagponline.org

April 2002

The Second World Assembly on Ageing
Apri18-12
Madrid, Spain
Website: www.un.org/esa/socdev/ageing

May 2002

Alzheimer's Disease: Update on Research, Treatment and Care
May 2-3
San Diego, California USA
Tel: (858) 622-5850
Fax: (858) 622-1016
E-mail: sjohnson@ucsd.edu

Ageing and Old Age-for Safe and active Life
The Gerontological Society of Serbia
The Sixth Gerontological Congress in Yugoslavia
Address: 11050 Belgrade
Krfska 7, Yugoslavia

EURAG Congress
European Federation of the Elderly (EURAG)
May 20-27
Turin, Italy
Tel: 43-316-814
Fax: 43-316 814 767
E-mail: www.eurag.org

June 2002

Social Development in the Third Millennium
The 30th International Conference on Social Welfare
June 24–28
Rotterdam, The Netherlands
Address: PO Box 19152
3501 DD Utrecht, The Netherlands
Tel: +31 302306510
Fax: +31 302306490
E-mail: icsw2002@nizw.nl
Website: www.nizw.nl/icsw2002

July 2002

8th International Conference on Alzeimer's Disease and Related Disorders
July 19–25
Stockholm, Sweden
Tel: (312) 335-5813
Website: www.alz.org

August 2002

10th World Congress on Pain
International Association for the Study of Pain
August 17–22
San Diego, California, USA
Tel: 206-547-6409
Fax: 206-547-1703
E-rnail:iaspdesk@ juno.com
Website: www.halcyon.corn/iasp

SEPTEMBER 2002

FourFive-Ageing People and Work Life
September 22–24
Tampere, Finland
E-mail: yyhata@uta.fi

OCTOBER 2002

Maturity Matters
IFA's 6th Global Conference on Ageing
October 27–30, 2002
Perth, Australia
Ms. Nic Lanyon, C/- Congress West
Phone: 61 8 9220 1104
Fax: 61 8 9220 1158
E-mail: nicl@fcs.wa.gov.au
Website: http://www.congresswest.com.au/ifa

Annual General Meetings

Federation of Senior Citizens and Pensioners
May 1 and 2 at the Howard Johnsons Motor Inn, Truro. Registration May 1 at 9:00 am–12:00 noon. Meeting begins 1:30 pm, May 1–9:00 am May 2.

Retired Teachers Association of Nova Scotia
May 30th at the Delta Sydney Hotel, Sydney. 10:00 am–12:00 noon.

Gerontology Association of Nova Scotia
May 30th GANS celebrates its 25 years with an anniversary dinner at the Halifax Holiday Inn, don't forget to bring any memorabilia of your own (e.g. clippings, photos) for the "Memories Board." Advanced tickets required. Price $30.

May 31 at the Halifax Holiday Inn: 25th AGM and Educational Conference. “Technology for Successful Aging” showcases exhibitors with information/products/services to enhance the quality of older Nova Scotians and helping professionals in all sectors.

For more information contact Pamela Fancey at 457-6395 or pamela.fancey@msvu.ca

Canadian Pensioners Concerned
April 29th. For more information contact Joan Lay at tel 455-7684; fax 455-1825; e-mail cpc@ns.sympatico.ca

Nova Scotia Government Retired Employees Association
September 23rd at the Holiday Inn Select, Dartmouth.

Offre d’emploi

Le Regroupement des aînés de la Nouvelle-Écosse est à la recherche d’une personne pour assumer la direction de l’association.

Tâches:

- Développer de nouveaux projets et mettre en oeuvre les projets en cours du Le Regroupement des aînés de la Nouvelle-Écosse.
- Établir des contacts avec les personnes, les ministères et les agencies concerns.
- Administrer les affaires quotidiennes de l’association.

Compétences:

- Expérience en egestion de projet, en communication, en planification et en organisation.
- Excellent français oral et écrut.
- Bonne connaissance du milieu acadien et francophone de la Nouvelle-Écosse.
- Intérêt particulier pour la population aînée.
- Connaissance du système informatique.

Entrée en function: le 15 avril 2002
Salaire: selon les competences
Lieu de travail: Dartmouth
Date limite pour postuler: le vendredi 15 mars 2002 12h au Le Regroupement des aînés de la Nouvelle-Écosse
54, rue Queen,
Dartmouth (Nouvelle-Écosse)
B2Y 1G3
Tél: (902) 433-2088, Téléc: (902) 433-0066

Stolen Moments

by Lorna Hillman, Executive Director Family Caregivers' Network Society, Victoria

When family caregivers are asked what they need to carry out their caregiving responsibilities, most often the response is easy access to information and an opportunity to get a break once in awhile. Getting a break or respite means different things to different caregivers. What does respite mean to you?

The term “respite” means a pause or rest from a continuous responsibility or activity and its goal is to enable caregivers to continue with their responsibilities by preventing stress and burn-out.

According to a research study conducted by Dr. Neena Chappell and Dr. Elizabeth Dow,

"Getting a break: The caregiver's point of view", most caregivers receive breaks in ways many of us would not perceive as such. The study indicated that caregivers defined respite as "stolen moments", temporary reprieves from caregiving tasks. This suggests that for many caregivers, respite is minimal. Their days are consumed by eternal vigilance where the care receiver is constantly on their mind, whether concerning health issues, quality of life or co-ordination of services. Caregivers often feel guilty due to periodic and normal feelings of anger and feel that they could be doing more.

Attitudinal change within the health care system is fundamental to providing flexible, accessible and appropriate services that provide family caregivers with opportunities to get a break. Eligibility criteria for services that focus on the care receiver create barriers that prohibit caregivers access to services. If caregivers are part of the assessment for services, it would enable service providers to identify and meet their needs.

The study confirmed that family caregivers and care receivers are minimal users of the community health system. Caregivers access outside services when the care receiver's condition worsens and becomes more complex. Prior to this, the caregiver has been providing care, on average, for about six years.

The research also confirmed that we are a caring society with a strong sense of moral obligation and commitment to our most valued relationships. People will continue to choose to provide care themselves, and the system needs to be organized to support them. Caregivers are essential to the health care system and must be integrated as partners. Providing opportunities for caregivers to get a "stolen moment" is a good place to start.

References

Lorna Hillman and Neena Chappell. (January 2000). *Stolen Moments: Getting a Break When You are a Caregiver*, Public Report. Centre on Aging, University of Victoria: BC.

Source: *A Caring Voice, Canadian Caregiver Coalition Newsletter*, Fall 2001.

Centre on Aging Summer Institute 2002

Interdisciplinary Perspectives in Psychosocial Approaches to Mental Health Challenges in Late Life

June 24–27, 2002

Elderly people with mental health problems are a particularly vulnerable population with unique health care needs. To meet the specialized mental health needs of older adults, a broad range of knowledge and a diverse set of skills are required.

For more information check our website at: http://www.coag.uvic.ca/calendar/index.htm

Senior Support Service

The Cape Breton Regional Police Service, in collaboration with the Cape Breton Council of Senior Citizens and Pensioners, and the Community Employment Innovation Project (CEIP) are developing a support service for seniors.

This program will determine the number of seniors living in the Cape Breton Regional Municipality who require or wish to have telephone contact due to being isolated with no family or neighborly interaction.

If you or someone you know are interested in this program, either to be a volunteer or want to be contacted, you are asked to telephone Constable Brad Burke, Bill Sampson, Cindy MacCharles, Patricia Fewer or Chrissie Bingley.

Constable Brad Burke at (902) 563-5105

Whitney Pier Community Office at

(902) 564-8416

Grand Lake Road Community Office at (902) 563-5340

Recent Publications

1999. “Family Physician's Perspectives on Ovarian Cancer.” *In Cancer Prevention and Contro*l, Vol. 3, No. 1, p. 61–67. (with R. E. Gray, P. Chart, J. C. Carroll, and M. I. Fitch)

2000. “Longterm Care Restructuring in Rural Ontario: Retrieving Community Service User and Provider Narratives,” *Social Science and Medicine*, 50, p. 1037–1045. (with A. E. Joseph)

2001. “Health Diaries for Monitoring Events Following Immunization,” *Canadian Journal of Public Health*, Vo1. 91, No. 6, p. 426–430. (with T.R. Freeman, M. Stewart, and R. Birtwhistle)

Recent Technical Reports: 1998 *Information Aid for Women at Risk of Developing Breast Cancer* (tape and booklet), A Collaborative Project of the Toronto-Sunnybrook Regional Cancer Centre, University of Toronto and the College of Family Physicians of Canada, September. (with Dr. Ellen Warner, Dr. Vivek Goel, Dr. Wendy Meschino, Dr. Lavina Lickley, Dr. June Carroll, Dr. Ruth Heisey, and Elaine Thiel)

1999. *Using Bi/Query, Bi/Analyze and Cube Creator: A how to Manual for Licensed Users of the Provincial Health Planning Database*, for Central West Health Planning Network, October. (with JoAnn Heale)

2000. *Outcome Indicators for Reproductive Health in Central West*, 1994-96, for Central West Health Planning Information Network, March.

Mental Health and Substance Abuse Profile for Adolescents and Young Adults in Central West, 1996/97, Central West Health Planning Information Network, April.

2001. *Evaluating Grade 3 Standardized Testing as a Measure/Indicator of Readiness to Learn*, Central West Health Planning Information Network: Readiness to Learn Project, February .

Monitoring Health System Performance: Diabetes as a Sentinel Condition, Central West Health Planning Information Network, April.

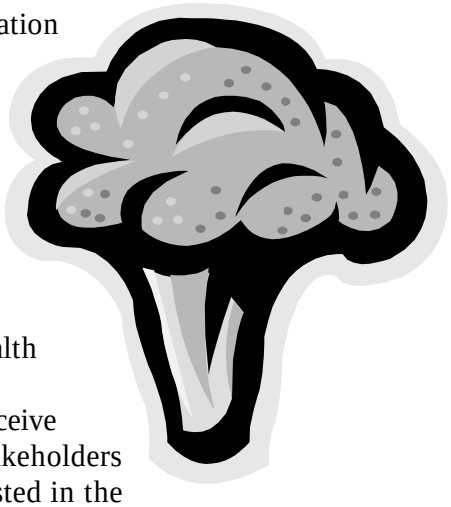
Source: *The Bulletin: The Centre on Aging*, University of Victoria, Fall, 2001: Vol. 9, No. 3

Senior Councils

1. The Seniors Council is the co-ordinating body for all the senior groups in the area. This includes all senior centres, senior clubs, senior housing manor associations and other organizations that are involved with the welfare of seniors. An example of this kind of organization is the Gerontology Association. In the rural areas of the province the seniors council area is the county. In the urban area of Nova Scotia, Halifax, Dartmouth and Sackville each has a Seniors Council. The County of Halifax also has a Seniors Council.
2. Two seniors from each senior group (preferably the president or chairman and another officer) represent their senior group, attend the council meetings, and participate in the business of the council. The business of the council is to hear the concerns of the seniors, try to deal with them at the council level if possible, but if not, to prepare resolutions to present to the appropriate authority; this is the municipal government if it is municipal concern or to the Federation of Senior Citizens and Pensioners of Nova Scotia if it is a provincial matter. The FSCPNS considers the resolution(s) and if appropriate refers it (them) to the Provincial Minister through Senior Citizens' Secretariat, an arm of the Provincial Government dealing with seniors.
3. A purpose of the councils is to promote the general principles of the senior movement: support the dignity of seniors, their health, their welfare and their independence.
4. Councils, since they are composed of senior leaders, can present an example of structure for conducting proper meetings and election of officers, and generally teaching seniors leadership skills by example and in workshops.
5. Councils can bring together all the senior for area wide activities such as ecumenical services, dances, picnics, fairs and senior games. These activities can be cooperative in nature or perhaps competitive to promote a bit of enthusiasm and excitement.

Lucy F. Riley January 16, 2002, Halifax

Consultation on Natural Health Products



The Proposed Regulatory Framework for natural health products was pre-published in the *Canada Gazette*, Part 1, on December 22, 2001. Pre-publication is an important milestone. It marks the beginning of a 90-day public consultation period during which the Health Products and Food Branch's Natural Health Products Directorate (NHPD) hopes to receive feedback from all stakeholders affected by or interested in the Proposed Regulatory Framework for natural health products. It is important to note that pre-publication in the *Canada Gazette*, Part 1, formally brings the process one step closer towards regulation.

The Proposed Regulatory Framework for natural health products, as it appeared in the *Canada Gazette*, Pt. 1, is available on the NHPD website at http://www.hcsc.gc.ca/hpb/onhp/welcome_e.html. NHPD can be reached by e-mail at nhpd_general@hc- sc.gc.ca or by post at the following address: NHPD, A.L. 3709B, Attention: Consultation Feedback, 171 Slater Street, 9th Floor, Ottawa, Ontario, K1A OL3. The telephone and fax numbers are (613) 952-2558 and (613) 946-1615, respectively.

The Natural Health Products Directorate is pleased with the consultation undertaken and the relationships built with stakeholders across the country. The original theme for the consultation was Building Together. The directorate intends to continue "building together" as it works closely with stakeholders over the coming months to develop the necessary guidance documents (policies, directives and guidelines) in support of the regulations.

Source: *Involving You*, Vol. 1, No. 2: Winter 2002, Health Canada.

Contact program to ensure seniors' safety, well-being

Cape Breton Regional Police have instituted a new service aimed at ensuring the safety of local seniors.

The Senior Contact Program will allow police to contact seniors once a week to make sure they are safe and healthy. Similar programs have been initiated in other places in Canada.

An official contract was signed between police and the Cape Breton Council of Senior Citizens and Pensioners.

The program will determine the number of seniors living in industrial Cape Breton who require or wish to have telephone contact due to being isolated or lonely with no family or neighborly contact, as well as any other senior interested in benefiting from this service.

"It's designed for seniors that are isolated," said Const. Brad Burke. "What takes place is, during the week, we'll contact them or a member of their family, and if they're not available, we'll actually send a police car over to their home."

Burke said some seniors in the area are living on their own. Some of them don't have much contact with other people and the program will let the police know if they are OK.

He noted there have been times when police have found seniors sick or injured in their residences and unable to get help. He added there have also been a number of occasions when police have found seniors deceased in their homes.

The program will prepare and implement telephone schedules based on the results of the assessed needs of seniors. In addition, it will provide a variety of activities for seniors to interact with other seniors of various backgrounds.

Designed by the Cape Breton Council of Senior Citizens and Pensioners, the program is expected to begin Jan. 28. It will be run out of the Whitney Pier Police Community Office.

Call 563-5104 or 539-6511 for information on this free service.

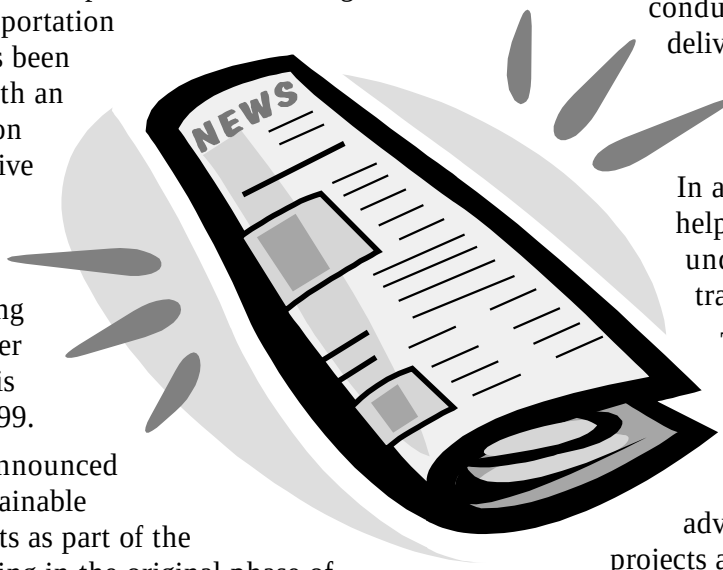
Source: Matt Draper, Cape Breton Post.

News Release

For release January 23, 2002

Fourth round of funding and $2.5 million/ 5 year extension of Moving On Sustainable Transformation (MOST) Program

OTTAWA-Transport Minister David Collenette today announced that Transport Canada's Moving On Sustainable Transportation program (MOST) has been extended to 2007, with an additional $2.5 million to be allocated over five years in response to ongoing demand for the program. The additional funding brings the total to over $3.5 million since this program began in 1999.



Mr. Collenette also announced $167,450 for six sustainable transportation projects as part of the fourth round of funding in the original phase of the program. These projects cover a range of initiatives that will contribute to a more environmentally friendly transportation system.

"Projects funded through MOST over the past two years have successfully delivered concrete results. Extension of this program for another five years demonstrates Transport Canada's ongoing commitment to fostering a sustainable transportation system that is safe, efficient, cost-effective and beneficial for the environment," said Mr. Collenette.

MOST fulfills a commitment made in Transport Canada's first Sustainable Development Strategy, which was tabled in Parliament in 1997. The program was launched with approximately $1 million to be provided to successful project proposals over a period of three and four funding rounds. This funding has been allocated to 26 initiatives aimed at encouraging sustainable transportation. Final approval for funding is subject to meeting the financial and other requirements of the program.

MOST assists organizations such as environmental groups, community associations, academic institutions, and business and professional associations. These groups are conducting projects and delivering concrete results in support of Transport Canada's commitment to sustainable transportation. In addition, the projects are helping to improve the public's understanding of sustainable transportation issues.

Through MOST, Transport Canada is able to manage funding requests in a more transparent and equitable fashion. An advisory committee prioritizes projects and recommends funding allocations. Projects may receive up to a maximum of $100,000 over two years and must receive at least 50 percent of resources from sources other that the Government of Canada.

"Through MOST, the Government of Canada is helping to find ways to meet the transportation needs of Canadians, while helping to protect the environment for present and future generations," added Mr. Collenette.

Funding for the extension of this program was provided for in the December 2001 budget and is therefore built into the current fiscal framework.

Information on MOST, including an applicant's guide and project results, can be found on Transport Canada's web site at http://www.tc.gc.ca/EnvAffairs/MOST/.

Myths

1. There is just one sign language for all countries.

   Just as there is no one spoken language for all countries, there is no one, universal sign language. There are more than 100 sign languages used in the world today. Every sign language reflects its own history, culture and social values, and may have many regional variations.

2. Only a few people have a hearing loss and chances are, I will not be affected.

   The odds are that you or someone close to you has some degree of haring loss. In fact, it has been estimated that one in ten people experience some degree of hearing loss.

3. My child will be limited because of his/her deafness.

   Do not consider your child as sick. He or she is as normal as any other child; the only difference is that he/she cannot hear.

4. All deaf people use sign language.

   Culturally deaf people use sign language. Many people with a hearing loss do not know sign language.

5. All hearing losses are the same.

   The single term "hearing loss" covers a wide range of losses that have very different effects on a person's ability to process sound and, therefore, to understand speech.

6. Deaf people are not sensitive to noise.

   Some types of hearing loss actually accentuate sensitivity to noise. Loud sounds become garbled and uncomfortable. Hearing aid users often find loud sounds, which are greatly magnified by their aids, very unpleasant.

7. Parents lose their deaf children to the deaf community.

   Deaf people who enjoyed a close rapport and good communication, signing or oral, with their parents while growing up tend to remain close to them for the rest of their lives.

8. All deaf and hard of hearing people are good speechreaders.

   Many factors are involved int the success of speachreading. People with a hearing loss are not inherently better speechreaders.

9. People with a cochlear implant have a hole in their head and cannot swim or take a shower.

   People can definitely swim and bathe with their implanted devices. There is no opening in the head at all with modern devices. The implant is completely covered by the skin behind the ear. People need only to remove their extended processor and headpiece before swimming or bathing, just as hearing aid users remove their aids.

Older Surfers

by Cynthia Silver

Every day, the Internet becomes more embedded in our lives. Business, media and government are embracing it as a way to provide services to their clients and the general public. Schools require children and teens to use it as a research tool and libraries and community centres offer access to those without a home connection.

The 2000 General Social Survey (GSS) shows that nearly every teenager used the Net but that use drops quickly with each successive age group. Older Canadians are much less likely to use the Internet than young people, though their numbers are growing: in doing so, many Canadians aged 60 and over may reduce the impact of social isolation following retirement and the onset of age-related health conditions. Older adults are benefiting from access to networked communities through the Internet.

Older people are the fastest growing group of users. Among Canadians aged 60 and over, only 13% (614,000) had used the Internet in 1999. Of those aged 60 and over, men were nearly twice as likely (17%) as women (9%) to use the Net.

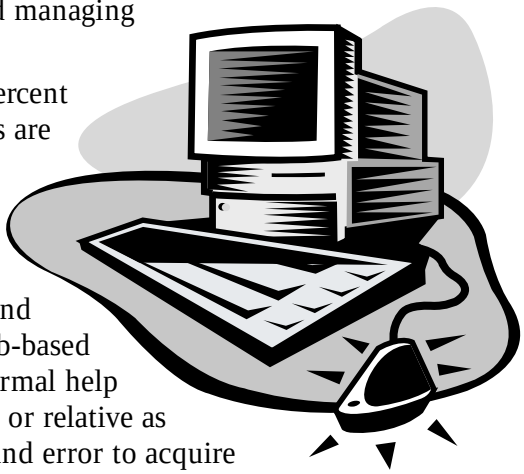
Use grew fastest among those aged 60 and over from 1999 to 2000. Growth was strongest among older women, 43% of whom had started using the Net in the last year compared with 25% of older men. On average, older surfers spent an average of 6 hours per week on the Net, about the same as 45 to 54 year-olds.

Most older users (80%) go online for personal interest or entertainment. Older Canadians primarily searched for online information on goods and services (57% of surfers), news (54%) and health information (38%). Half of older surfers looked for online travel information and 41% looked for information on arts, entertainment or sports. One-third looked for business or economic news.

As people age, they may tend to become socially isolated. A lower income after retirement, declining physical ability and the loss of a spouse are examples of changes that may cause older Canadians to lose touch with people.

However, the Internet seems to be a valuable tool in maintaining contact with others. Nearly all older Internet users (87%) used e-mail and they were sending messages almost as often as younger people: 69% who had used it in the last month did so at least several times a week, as did 76% of those under age 60. Although older people e-mailed their family more often than younger people did, old and young e-mail users were equally likely to stay in touch with friends. And while women have had the traditional role of sustaining family relationships, men were just as likely as women to use e-mail to keep in touch.

Home connections are more popular among older people as they generally have more mobility and transportation problems to deal with, which suggests they have limited access to locations with Internet connections. A home connection offers older adults the opportunity to socialize with others, pursue life-long learning and participate in community activities. It can assist with activities of daily living such as shopping and managing money.



Thirty-five percent of older users are exclusively self-taught. They use manuals, online help and tutorials, Web-based training, informal help from a friend or relative as well as trial and error to acquire computer skills.

The Internet can open the world to older people who may feel isolated and lonely. Many seniors' groups now offer programs to help older adults become familiar with computers and to assist them with Internet access.

Source: *Canadian Social Trends*, Statistics Canada, Winter 2001, No. 63.