

crosscurrents

SUMMER 2008
VOL 11 NO 4

The Journal of Addiction and Mental Health

Older Adults Adding life to years



IT'S NEVER TOO LATE

Reaching out to older adults with substance use issues

GENERATION TO GENERATION

When aboriginal elders speak, youth listen

GAMBLING ON THE GOLDEN YEARS

So much to lose, so little to gain

THE AGING PSYCHIATRIST

Why older is better

Intimate partner violence

Ethnoracial communities
take action

The nature of nurture

What epigenetics means for
prevention and treatment



camh

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

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Cherry Blossoms, Kate Wheeler, watercolour on paper, 17" x 21"

Kate Wheeler (1910–2004) took part in the Creative Activities Expression Program of the Society for the Arts in Dementia Care in Vancouver, BC. She was inspired by the cherry tree that grew in the courtyard of the care facility where she lived.

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Centre de toxicomanie et de santé mentale

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Issued four times a year.

Annual subscriptions are \$16.00 in Ontario (\$8.03 for Ontario students, seniors, patients, clients, consumers and family members), \$26.70 in Canada and \$36.95 in the U.S. and internationally (includes shipping and handling and taxes).

Published by the Program Development Department
CENTRE FOR ADDICTION AND MENTAL HEALTH
A PAHO/WHO Collaborating Centre
Affiliated with the University of Toronto

Summer 2008
Vol. 11 No. 4
ISSN: 1481-3122

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Older adults constitute the fastest growing population group in North America. More older people means more older people at risk for and experiencing mental health and substance use problems – and more families and communities affected. Yet mental health and addiction among older adults is one of the most under-researched and misunderstood areas of health care, swept aside by stigma and ageism – our attitude that older adults have nothing left to contribute and that poor health is a natural part of aging. But, in the words of gerontology writer Harry Moody, old age brings with it an “abundance of life.” Indeed, human development doesn’t stop at 65 or 80 or 90; it lasts a lifetime.

The stories in this issue show that prevention and treatment can make a big difference; it is never too late, even for a population we dismiss as set in its ways or not worth attending to. Dr. Benoit Mulsant, a world-renowned gerontologist, introduces the issue, asking “Why should we care about older adults?” Elizabeth Scott reports on the valuable role of community outreach in

meeting the needs of older adults with substance use issues. Astrid Van Den Broek writes about the intersection between grief, loneliness and gambling among older adults. Anne Ptaszniak discusses the often-overlooked needs of older LGBT adults. The Q&A column examines prescription medication use, misuse and abuse.

This issue also examines the positive side of aging. Older adults carry with them years of experience. Psychiatrist Mary Seeman tells us why older psychiatrists are better. We also profile a program that promotes creative expression among people with dementia. Lesley Young discusses the traditional role of aboriginal elders, who are respected for their knowledge and wisdom and can teach us all that older adults have a valued and productive role to play in society. Ruth von Fuchs, president of the Right to Die Society of Canada, and psychiatrist Dr. Isaac Sakinofsky present two sides of the debate around rational suicide, a topic that relates not only to older adults, but to us all.

Enjoy this stimulating issue of *Cross-*



Currents. Send us your comments and ideas. Write a letter to the editor expressing your thoughts on our stories. It is your input that furthers the dialogue around mental health and addiction issues.

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a view from CAMH

The focus of this issue on older adults coincides with an increased emphasis within our own academic health sciences centre on understanding and treatment for this segment of our population.

CAMH provides Ontario’s largest geriatric mental health and addiction program, with 48 inpatient beds, five outpatient clinics and 10 ongoing research initiatives – including the use of rapid transcranial magnetic stimulation and the role of brain imaging, taking advantage of CAMH’s positron emission tomography scanner (the only such research tool consecrated exclusively for mental health and addictions research in North America). Additionally, ongoing studies are examining cognition in older adults with schizophrenia and bipolar disorder and treatment interventions for these individuals. The program’s education activities have increased substantially with medical students, residents, research fellows and advanced students from the other mental health disciplines. Patient

safety initiatives have focussed on preventing falls, as well as medication errors in older adults, who often take multiple drugs.

Among CAMH’s inpatients over age 60, 46 per cent have a documented concurrent disorder; this aspect, as well as a focus on late-life schizophrenia and bipolar disorder, provide unique emphases for this program. Additionally, 43 per cent of the inpatients are immigrants to Canada in the last 10 to 15 years, reflecting the reality of 21st-century Toronto. Similarly, over 80 per cent of the staff are either born or trained outside of Canada. Because most older adults with mental health and addiction problems live beyond the walls of our hospital, CAMH provides clinical outreach to 26 Toronto long-term care facilities and educational outreach to more than 80 of them.

Patients and families are represented on its program advisory committee, where in addition

to clinical, academic and policy concerns, issues such as the “triple whammy” of stigma related to mental illness, addictions and ageism are considered.

The Mental Health Commission of Canada, launched in September 2007, has placed particular emphasis on older adults through its Seniors Advisory Committee. A number of initiatives at a national level, supported through the Mental Health Commission, will help to raise awareness, change attitudes, increase knowledge, improve care and enhance the quality of life of older adults living with a mental illness. We owe it to them.

David S. Goldbloom, MD, FRCPC

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The art of dementia: Program encourages creativity and connection

ASTRID VAN DEN BROEK

At age 93, Kate had moderate dementia. Lifting her arms to paint was difficult, but she made the effort to participate in the Creative Activities Expression Program. Her drawings were plain, mainly lines of pencil, felt pen and watercolours, but the stories that accompanied the drawings said so much more. They were stories about making it through the Depression, or overcoming various difficulties in life. She also depicted simple, peaceful scenes, such as the cherry tree that grew in the courtyard of her care facility in Vancouver, and which graces the cover of this issue. Kate's family encouraged her in her artistic quest, seeing the spark it ignited. Kate joined a pottery class, taking a taxi there and back, eager not to miss any of her activities.

The spark ignited in Kate began as the motivating force behind the establishment of the Vancouver-based Society for Arts in Dementia Care, which runs the creative expression program. "Creative expression brings people with dementia alive – they express their emotions, abilities, spirituality, culture, who they are – allowing them to live life to the fullest," says Dalia Gottlieb-Tanaka, the Society's founder. "Creative expression also helps them connect to others and feel heard and valued."

The idea for the Society came to Gottlieb-Tanaka four years ago through her work with older adults with dementia and later on as a PhD student at the University of British Columbia. Today, the Society serves as an educational resource for people working in long-term

care facilities who are interested in doing creative expression activities with residents. The Society also curates exhibits of the artwork and promotes awareness around creativity and dementia through an annual conference and workshops. The idea has expanded beyond the Canadian border, with an Australian chapter of the Society opening in Perth in 2006.

"Creative expression brings people with dementia alive – they express their emotions, abilities, spirituality, culture, who they are – allowing them to live life to the fullest"

Indeed, the Society is all about expanding – expanding opportunities for people with dementia to communicate and express themselves. "In some ways, relationships are changing through dementia, so creative expression can help families find ways to reconnect," says Dr. Rémi Quirion, scientific director at the Douglas Hospital Research Centre in Montreal. "You can see the person on a piece of paper or in music or through another creative medium."

Hilary Lee, chair of the Australian chapter of the Society, recalls Ella*, an Italian immigrant with dementia who also showed signs of depression and withdrawal. She joined a tapestry group through which she produced a touching tapestry – a snapshot of her wedding day in Italy, dancing with her husband. Working on the tapestry, Ella would sing spontaneously and signs of her previous personality would emerge. To Ella's family, it was a glimpse of the Ella they knew and the tapestry inspired lively discussion.

Creative expression can also offer glimpses of newly discovered life-enriching skills. "We have found that there remains a lot of capacity for the brain to reorganize itself, even in very late life," says Quirion. "There are various ways to influence that capacity – drug treatment, nutrition, exercise, education and also art."

In order to better develop that capacity, the Society is also contributing to the growing body of research around arts-based activity programming for people with dementia. Along with Dr. Peter Graf, a psychology professor at the University of British Columbia and a member of the Society's advisory board, the Society and its Australian partner have developed an assessment tool to gauge the effects of participating in creative programs. The tool explores various areas in which individuals may best express themselves. "One is by means of memory. Another is spoken language – is there a change in language as a result of being involved in creative expression?" says Graf. "Body language and facial expressions are also used. Is there a change in attention?"

The ultimate goal is to help determine the best way to forge a creative connection and enhance the quality of life of people with dementia such as Kate and Ella. Another former participant, Sylvia, expressed it best: "You have given me freedom and it tastes so good. ■"

For more information about the Society, visit www.cccd-society.org.

*not her real name



Dalia Gottlieb-Tanaka

Kate sits in a window of her care facility, painting the cherry tree that graces the cover of this issue.

The nature of nurture: Epigenetics challenges belief that DNA is destiny

AVRIL ROBERTS

For too long there has existed a dichotomy between nature and nurture. We see the genetic code as a fixed blueprint – DNA as destiny. But the growing field of epigenetics is yielding new insights into the interplay between nature and nurture and providing clues about how environment and experience may in fact alter that seemingly rigid blueprint.

Our genetic code, the actual sequential structure of our DNA, remains intact, but the expression of individual genes in that sequence can be permanently altered by environmental influences, explains Dr. Moshe Szyf, a pioneer in the field of epigenetics. Once triggered, a group of molecules called a methyl group attaches itself to the control centre of the gene, permanently switching on or off the manufacture of proteins essential to the working of every cell in the body.

It is this expression of the genes – essentially, how genes “behave” – that may be affected by environmental and lifestyle factors such as diet, exposure to toxins, social interactions, nurturing and other life experiences that can change the way our genes behave and affect our health and behaviour. It may explain why one identical twin develops schizophrenia and the other does not.

In a recent landmark study, Szyf, who is a professor of pharmacology and therapeutics at McGill University in Montreal, and a team of researchers found that child abuse is associated with chemical changes in the brain. The study, published in a 2008 issue of the journal *Public Library of Science*, compared the brains of people who had experienced child abuse and died by suicide with the brains of people who had not died by suicide and had no history of abuse. The abused people’s brains showed differences in methylation, which switches on or silences genes and is susceptible to environmental factors. “When methyl groups are added to the wrong place, they can cause disease,” says Szyf. “They can silence critical genes that we need for life or mental function.”

In demonstrating this susceptibility to environmental factors, this latest research

complements a landmark 2004 study in which Szyf and Dr. Michael Meaney, a neuroscientist at Montreal’s Douglas Hospital, demonstrated that nurturing can alter brain chemistry and personality. Mother rats that licked their babies had offspring that grew up to be relaxed and more sociable than those whose mothers neglected them. The mothers’ grooming switched on a gene that suppressed the production of the stress hormone cortisol in the babies.

At the Krembil Family Epigenetic Laboratory at the Centre for Addiction and Mental Health (CAMH) in Toronto, senior scientist Dr. Arturas Petronis and his team are working to identify disease-specific epigenetic changes. In the first epigenome-wide investigation in psychiatric research, the team has discovered epigenetic changes in the brains of people with schizophrenia and bipolar disorder. The changes were noted on genes involved in neuro-transmission – the exchange of chemical messages within the brain, brain development and other processes linked to disease origins.

According to Petronis, these epigenetic changes may help explain some of the complexities of schizophrenia and other psychiatric disorders. “If we shift the emphasis from looking for variations in the DNA sequence to looking at epigenetic misregulation, then we can explain not only inherited predisposition to disease, as the traditional genetic paradigm can, but also phenomena such as discordance of identical twins, gender differences in susceptibility to disease and fluctuations in disease course.”

Such findings may lead to new diagnostic approaches and individualized treatment. According to Szyf, “although we cannot change the genetics, we can change the epigenetics,” through drugs, for example. In 2006, Szyf and Meaney showed that certain compounds could reverse the epigenetic changes in the stressed-out rats.

Similarly, reversing harmful epigenetic patterns in humans could open the door to new therapies for mental illness and addiction. “The challenge is to tailor drugs in such a way that their effects will be

positive,” says Szyf.

At the Krembil laboratory, which is the only lab in North America dedicated to psychiatric epigenetics, Petronis sees in epigenetics a potential for personalized medicine, disease prevention and even a cure. He says that if schizophrenia were found to have, say, 25 different epigenetic causes, and in a certain individual you identified problems 2, 7 and 21, treatments may be developed that are tailored to that individual’s needs.

“Right now we’re treating symptoms,” says Petronis. “We block dopamine receptors not because they initiate the disease process but because we know it’s one of the problems downstream. However, if we knew what the primary epigenetic problems were in schizophrenia, we could think about developing a strategy that would cure the disease.” Petronis’ team is working to identify more epigenetic changes in schizophrenia that could be targets for drug therapies.

Lifestyle changes offer another avenue for correcting epigenetic missteps. “We know certain diets can change the way genes are marked by DNA methylation, but we need to better understand what would be the optimal diet to protect our epigenome and to maintain healthy gene expression programming throughout life,” says Szyf.

Even how we behave towards one another could affect treatment or prevention strategies. Szyf suggests that, as with child abuse, behaviours such as bullying might cause physical damage to the epigenome (which controls the differential expression of genes in specific cells), so we need to be more sensitive and responsible in our social interactions. This is particularly critical because research shows that epigenetic changes, whether beneficial or harmful, can be passed on to future generations.

The upshot is that, after nearly three decades of being considered somewhat of a fringe pursuit, epigenetics research is moving closer to centre stage, as it hints at answers to some of the medical mysteries discovered through traditional genetics. ■

Ethnoracial communities take action against intimate partner violence

AVRIL ROBERTS

The launch of a community development project that will train immigrant and refugee women as leaders within various ethnoracial communities promises to deliver culturally appropriate responses to intimate partner violence (IPV) against women. The Community Leadership and Action Project, spearheaded by Springtide Resources in Toronto, formerly Education Wife Assault, grew out of awareness that immigrant and refugee women face many stressors that increase their risk of abuse; yet they are less likely than Canadian-born women to contact social services agencies for help.

"We're moving towards changing people's attitudes and actions," says Angie Rupra, co-ordinator of the Immigrant and Refugee Women Connecting for Change program at Springtide. "A community devel-

opment approach is more effective because community members understand the needs of their community better than we do, as an organization. They are able to manoeuvre within their community to see more concrete results." The three-year project, funded by Status of Women Canada, will run until 2011 and will train about 10 women.

Language is important, given that in some cultures, such as that of Sri Lankan Tamils, there is no word for domestic violence, says Dr. Robin Mason, a research scientist with the Violence and Health Research Program at the Women's College Research Institute in Toronto who has interviewed Tamil women about their understanding of IPV. However, Mason's work has made it clear that Tamil women understand the concept, mentioning abusive behaviours such as threats of deportation, tight control over spending, sexual abuse, daily beating and "hurting the mind."

Social and cultural values and expectations of the community can pose another challenge. Mason notes that within many communities marriage is considered an unbreakable covenant. One Tamil woman

status. Under immigrant sponsorship agreements, women are often socially and financially dependent on their partner, who sponsored them. Abusive partners often exercise control by threatening deportation and removal of children from the home or by misinforming women about their rights under Canadian law. Refugee women fear deportation if their partner is convicted of domestic assault, and women who have overstayed a temporary visitor's visa and have no legal status in Canada are more likely to hide abuse than seek help from hospitals, police or the courts. In fact, many newcomer women discover that calling the police does not necessarily have the desired effect: They expect police intervention to be a deterrent to abuse, not result in removal of the abuser, who may be the family's only breadwinner.

Efforts to reach immigrant and refugee women through mainstream public awareness campaigns are

often off the mark. "We go for the harder impact – the woman with the black eye, the naked woman covered in bruises," says Mason. "But when communities are asked to frame it for themselves, they frame it in different ways." They often prefer images of the desired goal – happy, healthy families – rather than graphic depictions of abuse.

Such action is important because IPV interventions have historically neglected the experiences and needs of Canada's ethnic minorities, a steadily growing population. Yet the stresses of living in a new country, including isolation and limited educational and job opportunities, contribute to the risk for intimate partner violence.

Despite this risk, immigrant and refugee women face various barriers to support. "Women would rather contact a social services organization or ethno-specific agency that has the language capacity to assist them," says Fatima Filippi, executive director of Rexdale Women's Centre, a Toronto agency with a 30-year history of providing settlement and support services to immigrant and refugee women in 18 languages.

explained, "We cannot separate, even in an abusive situation. We cannot seek help for problems, but we have to live this forever and only at the time of death, only then, can we be separated."

Mason also found a lot of negativity related to the terms "help-seeking" and "advice" because they imply breaking up families or separating couples, so outside help should be sought only if the woman plans on separating. However, in arranged marriages, the stigma of separation and divorce can ripple outwards to affect the marital prospects of children and other family members.

Interestingly, young Tamil women told Mason that arranged marriages can be a protective factor against IPV because one's parents assume partial responsibility. If a partner is abusive, it is easier to tell parents what is going on and get help from them, whereas, in a love match, the woman is on her own.

For many women, the greatest barrier to help-seeking is immigration

Intimate partner violence interventions have historically neglected the experiences and needs of Canada's ethnic minorities. Yet the stresses of living in a new country, including isolation and limited educational and job opportunities, contribute to the risk for intimate partner violence

When immigrant and refugee women do seek help, services may be unfamiliar or may not meet their needs. "The concept of a shelter might be foreign because, back home, things may have been handled in a more community-based way, with the woman going to the home of a friend," says Rupra at Springtide. "And the idea of counselling might not resonate because these are formalized services, a North American way of doing things."

As a result, agencies that serve immigrant and refugee women are developing creative, non-threatening ways to reach women who might not otherwise come forward and to change community responses to abuse. As Mason asks, "Are we creating an atmosphere where it's safe for women to talk about this issue?"

Springtide offers a peer education program where immigrant and refugee women are trained to facilitate community workshops with such titles as: Living with Others;

Me, Myself and I; and Settlement:

Dealing with Family Changes. "We know from experience that if we put 'domestic violence' or 'woman abuse' in the title, women are hesitant to come," says Rupra. "We found that this approach gets women out of the house and talking about issues."

Rexdale Women's Centre, which operates out of 13 different locations, offers women a violence prevention and crisis intervention program that includes one-on-one counselling in their own language and two types of support groups – one

for women who simply want information, another for those who self-identify as victims of violence and want support in moving on.

The agency made a significant change more than a decade ago, after a woman stood up during a presentation and announced, "We're not perpetrating the violence against ourselves. It's the men who are perpetrating it against us, so what is being done to work with men?" As a result, Rexdale signed on to Ontario's Partner Assault Response (PAR) program, a court-mandated psycho-educational program for assaultive men.

The agency now weaves the issue of violence against women into all of its programs. English as a second language classes (attended by women and a few men) feature presentations on women's rights and violence against women. Following one session, a man accused the instructor of counselling on how to break up families. Days later, another man brought his adult daughter to the agency and told workers, "She's being abused. I don't think that's right."

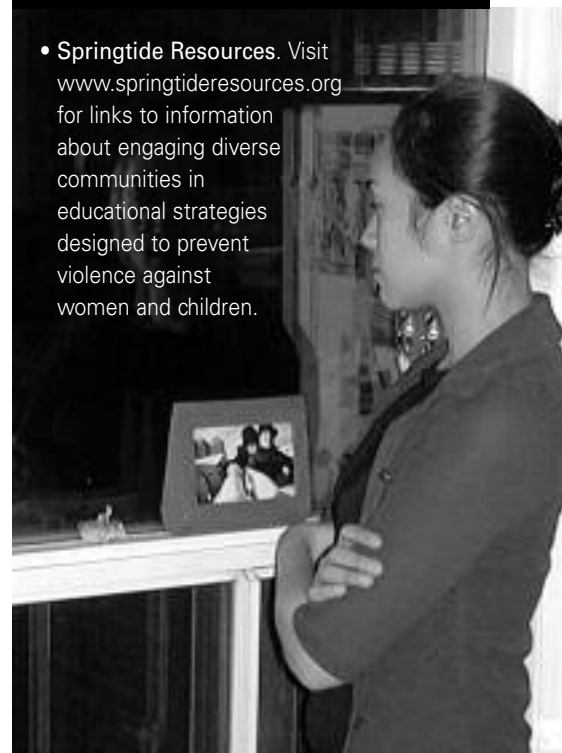
Filippi notes that the agency also plays a role in bridging the language and culture gaps when clients interact with police, legal clinics, housing authorities and the medical system. "We help people understand that there are cultural issues that are very strong within certain communities and ensure they work with and respect that."

The agency is also increasing its presence in the community in a non-threatening way. It hosts a Christmas gift-wrapping counter at the local mall and sets up a table on parent/teacher school nights and at community fairs. Through a program funded by the federal government, a full-time worker from the agency is stationed at the neighbourhood library, establishing a presence for the agency.

"Given the complex issues facing immigrant and refugee women who experience IPV, health professionals must be willing to learn about the specific meanings of IPV within a woman's cultural context," says Mason. "They must respect the woman's expertise and be able to work collaboratively with her and others to determine appropriate actions." ■

RESOURCES FOR REACHING OUT

- **Centre for Addiction and Mental Health.** Visit www.camh.net to order *Working with Immigrant Women: Issues and Strategies for Mental Health Professionals*.
- **Faith Trust Institute.** www.faithtrustinstitute.org. This U.S.-based multi-faith feminist organization looks at sexual and domestic violence issues and how these issues intersect with religion.
- **Ontario Council of Agencies Serving Immigrants.** Visit www.ocasi.org to access two documents: *Training Manual – Prevention of Domestic Violence against Immigrant and Refugee Women: Prevention through Intervention Training and Resource Manual – Family Violence against Immigrant and Refugee Women: Community Development Strategies*.
- **Society of Obstetricians and Gynaecologists of Canada.** Visit www.sogc.org and do a keyword search to access the *SOGC Clinical Practice Guidelines: Intimate Partner Violence Consensus Statement*.
- **Springtide Resources.** Visit www.springtideresources.org for links to information about engaging diverse communities in educational strategies designed to prevent violence against women and children.





Bipolar disorder affects work more than depression

A recent study from the University of Toronto suggests that, while any mood disorder negatively affects workplace function, the negative impact of bipolar disorder on workplace function greatly exceeds that resulting from major depressive disorder. Researchers examined survey data on 20,747 currently employed individuals from the 2002 Canadian Community Health Survey: Mental Health and Well-Being. They found that individuals with either bipolar I disorder or major depressive disorder had significantly lower incomes than those without a mood disorder. However, those with bipolar disorder were at the greatest disadvantage, earning an average of \$32,000 a year, nearly \$5,000 less than those with major depressive disorder, who averaged \$36,800 a year. Those without a mood disorder had average annual incomes of \$40,200. Individuals with bipolar disorder were 60 per cent more likely than those with major depressive disorder to have reported a disability day in the previous two weeks and 40 per cent less likely to report good job security. The authors conclude that, while the overall cost to society of major depressive disorder is greater due to the higher prevalence of that disorder, their study shows that bipolar disorder is a more costly disorder at the individual level. Screening and intervention programs for people with bipolar disorder may therefore be more cost effective than comparable programs for people with major depressive disorder.

Chronic Diseases in Canada, 2008, v. 28(3): 84–91. Roger S. McIntyre et al., Department of Psychiatry and Pharmacology, University of Toronto, Toronto, Ontario.

Genetic component of fears changes during youth

The genetic component of common fears changes considerably during an individual's passage through childhood and adolescence, according to new research from the Virginia Commonwealth School of Medicine in Richmond, Virginia. A sample of 2,490 Swedish twins and their parents was questioned regarding the intensity of the twins' situational fears, animal fears and blood/injury fears between age 8 and 20. It turned out that some genetic risk factors influenced the intensity of fears at age 8 and 9 and then became less influential as the children aged, while new genetic risk factors "came on line" in adolescence and early adulthood. In addition, the influence of the children's shared environment on their fears decreased and that of each child's unique environment increased during adolescence. This reflects the fact that the role of the home environment typically declines during adolescence as children spend progressively less time with family and more time with friends. According to the authors, these results support a "developmentally dynamic" hypothesis predicting that the influence of genetic factors on our fears will vary over time. This can result from both genetic innovation, whereby new genes become active over time, and genetic attenuation, whereby the influence of some genes declines with the passage of time. The authors explain that this genetic dynamism may have evolved in response to the reality that threats posing the greatest risk to a young child are not necessarily the same as those that most threaten an adolescent or adult.

Archives of General Psychiatry, April 2008, v. 65: 421–429. Kenneth S. Kendler et al., Virginia Institute for Psychiatric and Behavioral Genetics, Virginia Commonwealth University Medical School, Richmond, Virginia.

Counselling by pediatric providers and peers reduces teen smoking

Counselling by pediatric care providers and peer counsellors can be effective in preventing adolescents from taking up smoking and getting those who are already smokers to quit, according to a new study from the University of Massachusetts Medical School in Worcester, Massachusetts. Over the course of twelve months, researchers followed 2711 smoking or non-smoking patients between the ages of 13 and 17 who visited one of eight Massachusetts pediatric primary care clinics. Participants were randomly assigned to either usual care or an intervention that consisted of a brief counselling visit with a pediatric care provider followed by counselling from peer counsellors aged 21 to 25 years during the initial six months. Compared with those given usual care, non-smokers who received counselling from both physicians and peers were 2.2 times as likely to have remained abstinent at six months and 1.6 times as likely to have done so at twelve months. Among smokers, those given the combination of provider and peer counselling were 1.6 times as likely as those given usual care to have quit at six months, but there was no difference between the two groups at 12 months. Smokers who paid more frequent visits to their doctors were more likely to have quit at the six and twelve month follow-ups. Encouraged by these results, the authors suggest that extending peer counselling beyond the initial six months might improve rates of abstinence among smokers at 12 months.

Pediatrics, April 2008, v. 121, online, doi: 10.1542/peds.2007-1029. Lori Pbert et al., Division of Preventive and Behavioral Medicine, University of Massachusetts Medical School, Worcester, Massachusetts.



Methamphetamine causes long-lasting physiological changes

Methamphetamine use results in long-lasting physiological changes to the brain that leave former users vulnerable to relapse, according to research from the University of Washington in Seattle. Researchers gave mice large doses over 10 days and compared them with mice treated with saline. Methamphetamine use resulted in long-lasting depression of communication between the cortex and the striatum, a process mediated by the neurotransmitter glutamate. This depression lasted more than four months (a mouse's average lifespan is two years) and was reversed when methamphetamine was readministered. The immediate result was an increase in the release of dopamine. This led to a reduction in the release of glutamate by the cortex. Paradoxically, after withdrawal of methamphetamine, another dose was required to restore normal glutamate levels. The reason has to do with neurons in the striatum known as interneurons, which produce the neurotransmitter acetylcholine and have two types of dopamine receptors: D1 receptors promote the release of acetylcholine and D2 receptors inhibit release. During initial administration of methamphetamine, increase in dopamine levels stimulates D2 receptors. The resulting decrease in acetylcholine inhibits the release of glutamate. Once physiological changes associated with addiction have set in, dopamine increases stimulate D1 receptors. This promotes the release of glutamate and reverses the depression of communication between the cortex and striatum. The authors indicate that these results shed light on physiological changes in the brain that affect craving and relapse in people with substance dependence.

American Journal of Psychiatry, December 2007, v. 164: 1832–1841. David Silbersweig et al., Weill Medical College of Cornell University, New York, New York.

Most adolescents with depression respond to treatment

The large majority of adolescents undergoing treatment for depression will ultimately achieve a sustained improvement in their symptoms, even if they do not respond in the first months of treatment, according to a study from the Oregon Research Institute in Eugene, Oregon. Researchers followed 242 adolescents with major depressive disorder enrolled in the Treatment for Adolescents with Depression Study. Participants were assigned to receive fluoxetine, cognitive behavioural therapy (CBT), a combination of both or placebo for 12 weeks. This initial acute phase was followed by a six-week continuation phase and a subsequent 18-week maintenance phase. During the continuation and maintenance phases, medication dosage and frequency of CBT therapy sessions were adjusted according to participants' initial responses. By week 12, 61 per cent of all participants had achieved a sustained response, defined as two consecutive Clinical Global Impression Improvement scores indicating substantial improvement. Specific rates of sustained response at week 12 were 42 per cent for the CBT group, 68 per cent for the fluoxetine group and 71 per cent for those given a combination of the two therapies. By the end of the study at week 36, rates of sustained response had increased to 75 per cent for the CBT group, 83 per cent for the fluoxetine group and 88 per cent for those given combination therapy. These findings emphasize the importance of continuing treatment even when the initial response is not encouraging. A one year follow-up study is in the offing that will address recurrence rates among the adolescents after the end of treatment.

Archives of General Psychiatry, April 2008, v. 65: 447–455. Paul Rohde et al., Oregon Research Institute, Eugene, Oregon.



Binge drinking more common than alcohol dependence in impaired driving

Binge drinkers are more likely to be responsible for alcohol impaired driving than people with alcohol dependence, say researchers with the U.S. Centers for Disease Control and Prevention in Atlanta, Georgia. The researchers analyzed results from the 2006 Behavioral Risk Factor Surveillance System survey, looking at data with respect to alcohol consumption and self-reported impaired driving among 157,914 U.S. adults who were current drinkers. For the purposes of this study, binge drinking was defined as the consumption of four or more drinks per occasion among women and five or more drinks per occasion among men. Heavy drinking was defined as the consumption of an average of more than one drink a day among women and more than two drinks among men. The researchers found that 84 per cent of those who drove while alcohol impaired were binge drinkers. Binge drinkers who were also heavy drinkers were 20 times more likely than those who were neither binge drinkers nor heavy drinkers to drive while impaired. Impaired driving was also eight times as likely among binge drinkers who were not heavy drinkers and four times as likely among heavy drinkers who did not binge drink, compared with those who were neither binge drinkers nor heavy drinkers. These results suggest that the majority of impaired drivers are not alcohol dependent, and are therefore likely to be responsive to alcohol control policies and counselling by health care providers.

Alcoholism: Clinical and Experimental Research, April 2008, v. 32: 639–644. Nicole T. Flowers et al., Division of Adult and Community Health, Centers for Disease Control and Prevention, Atlanta, Georgia.

Alzheimer's survival rates vary with race and ethnicity

Survival rates among people with Alzheimer's disease vary considerably according to race and ethnicity, suggests research from the University of California, San Francisco. Researchers used data on 30,916 individuals with Alzheimer's gathered from more than 30 Alzheimer's disease centres (ADCs) across the United States. The sample, whose average age was 78, survived an average of five years after their first visit to an ADC. The mortality rate for African Americans was 85 per cent of the rate for Caucasians, while the rate for Latin Americans was 57 per cent of the rate for Caucasians. The risk of mortality among Asian Americans and Aboriginals was comparable with the risk for Caucasians. Autopsies showed that neuropathology did not account for these differences. The authors speculate that the advantage seen in African Americans and Latin Americans may be due to differences in living environment and in levels of comorbid illness. For instance, the lower rate of nursing home placement among African Americans and Latin Americans may give them an advantage since nursing home placement is known to be associated with increased mortality. If the reasons for the differences in survival rates seen in this study can be determined, treatments could be developed in the future to improve survival rates for all people with Alzheimer's.

Neurology, April 1, 2008, v. 70: 1163–1170. Kala M. Mehta et al., Division of Geriatrics, University of California, San Francisco, California.

Our grandparents, our parents, ourselves ...

Why care about mental health and addiction in later life?

BY DR. BENOIT Mulsant

ADDRESSING ADDICTION AND MENTAL HEALTH PROBLEMS IN LATE life is a demographic imperative and a clinical possibility. Canada is one of the youngest developed countries, but its aging population is growing. In 2011, the baby boomers will start to turn 65. As a result, the proportion and number of adults 65 and older are increasing more rapidly than those of all other age groups. Older adults will comprise 20 per cent of the population by 2026 and 25 per cent by 2041, compared to 12 per cent in 2001. The fastest population growth is occurring among the oldest: Canadians who are 85 and older are expected to number 1.6 million in 2041 (representing four per cent of the overall population), compared to 430,000 in 1981. This is due in large part to the increase in life expectancy, expected to reach 81 for men and 86 for women in 2041.

As the proportion of older adults doubles and their number almost triples, the healthcare system will experience an unprecedented influx of older adults with substance use and mental health problems. Most will also have various age-related co-morbidities, making their care more complex but also more necessary.

While most older adults live independently in the community, free of behavioural, psychological or cognitive problems, a substantial minority face significant challenges associated with addiction or mental health problems. For instance, five per cent of community-dwelling adults 65 and older suffer from a dementia (Alzheimer's disease in most cases) and a similar proportion experience clinical depression. However, due to the inseparability of physical and mental health in old age, the proportions of older adults with depression or dementia increase dramatically in care settings. Prevalence is about 10 per cent in outpatient primary care clinics and general hospitals and 25 to 50 per cent in long-term care homes.

Fortunately, major advances over the past three decades have led to a dramatic increase in knowledge. Clinicians can now diagnose, treat and, in some cases, prevent mental health problems in late life. We now know that when left untreated, late-life depression is associated with suffering, low quality of life, disability and increased mortality due to comorbid physical illness or suicide. In North America, older white men constitute the demographic group most at risk for completed suicide. We also know that almost none of these suicides are the result of a rational decision to die with dignity. Rather, they are caused by depression, alcohol misuse or a combination of both.

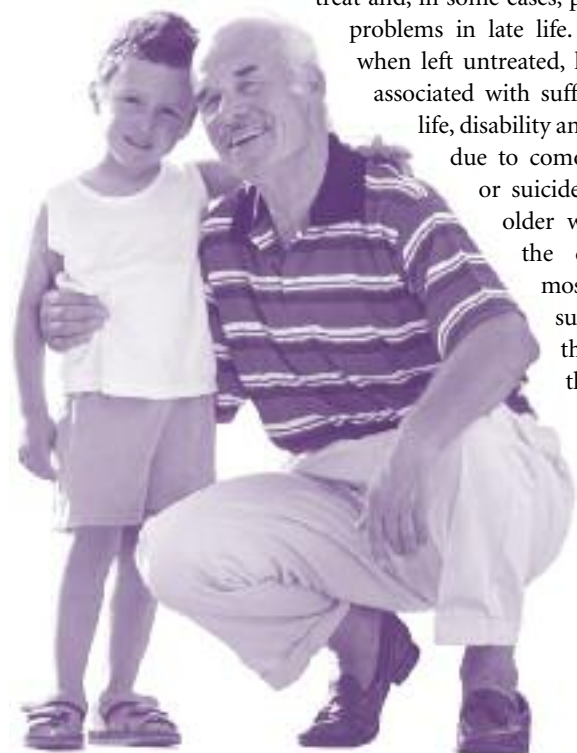
Suicidality associated with late-life depression can resolve completely when the depression is treated adequately. We have learned from more than 100 scientific studies that late-life depression can be treated at least as effectively as depression occurring earlier in life with antidepressant medications, standardized psychotherapies and electroconvulsive therapy. This is true even among the oldest olds, those in their 80's and 90's.

Some recent studies are also demonstrating that depression can even be prevented in selected groups of older adults at high risk for depression, such as those suffering from stroke or macular degeneration. Similarly, other mental disorders occurring in late life such as schizophrenia, anxiety disorders, alcohol abuse or cognitive impairment and behavioural disturbances associated with dementias can be treated effectively. Like most common physical ailments afflicting older adults – hypertension, diabetes, heart failure – these mental disorders cannot be “cured,” but their symptoms can be alleviated and the associated morbidity and disability can be prevented.

Unfortunately, despite these advances, data show that many physicians are unlikely to recognize and diagnose addiction and mental health problems in older adults. Older adults presenting to their primary care providers complaining of depressive symptoms are half as likely as younger adults to receive a diagnosis of depression. More than half of older adults in the early stages of Alzheimer's disease are not diagnosed. When diagnosed with depression or dementia, most older patients do not receive treatment, or when they are treated, it is typically inadequate. When a “happily married” 40-year-old woman who has “nothing to be depressed about” reports to her physician that she feels miserable and is crying all the time, she will be promptly started on an antidepressant or referred for counselling. When the same complaints are reported by a frail widow in her 70's, her physician will typically think “I would also be depressed in her situation.” Her depressive symptoms, having been “explained away,” will remain untreated. She will continue to suffer for weeks or months unless she kills herself, or more often, lets nature follow its course and lets herself die by neglecting her physical needs. Why is this older person less deserving of treatment than a young adult? Why is her depression less deserving of treatment than a hip fracture? If she had fallen down a flight of stairs and broken her hip, the orthopedic surgeon would not have ignored her because her fracture “made sense.”

Older adults battling with mental health problems or addiction face a double stigma. Contemporary Western society is obsessed with youth and health. It fears, or at best ignores, mental illness and aging. This has to change. Why should we care? Today, these older persons are our grandparents, our parents, our aunts and uncles. In 20 to 40 years they will be us. ■

Dr. Benoit H. Mulsant is physician-in-chief of the Centre for Addiction and Mental Health in Toronto, as well as clinical director of its Geriatric Mental Health Program. He is also a vice-chair of the Department of Psychiatry at the University of Toronto.



It's never too late

Reaching out to give older adults hope

BY ELIZABETH SCOTT

IT'S A BRILLIANTLY SUNNY APRIL DAY IN TORONTO AND I'M ON MY WAY to spend the day with Teresa Morski, a community service provider with Community Outreach Programs in Addictions (COPA) in Toronto, an agency that serves older adults with substance use and mental health issues.

Today Teresa and I are venturing into the community to see five clients, a typical day. "By seeing them at home we get a better picture of what's really going on and how to help," says Teresa. Almost all of her clients, like herself, are Polish immigrants, a cultural diversity that adds a further level of complexity to her clients' situations. "For many immigrants, health and addiction are related to their adjustment to a new country," she says, as we start the day.

Most of Teresa's clients have been in Canada for many years. When they arrived, long hours, poor wages, working two or three jobs to support themselves and family back in Poland consumed all of their time and energy. Sadly, when finally able to sponsor family to come to Canada, for many, "it was too late; they didn't want to come," says Teresa.

Teresa herself fled Poland 22 years ago – a nursing degree in hand and husband by her side. During her seven years at COPA, her language skills and cultural heritage have proven valuable in reaching out to older adults in Toronto's Polish community. Her roster of Polish and Ukrainian clients – most of whom do not speak English – has grown from four to 32, in addition to three Canadian-born clients.

In their loneliness and loss of meaningful reasons to make life alone in Canada work, many of Teresa's clients started to drink, which lead to job loss, financial hardship, homelessness and an almost inexorable downward spiral of bad circumstances and hard luck.

Today, most of Teresa's clients struggle with depression, isolation and alcohol and prescription drug misuse. "In addition to supporting them around these issues, we help with housing, finances, welfare, disability support" – the fundamentals that give clients some stability, says Teresa. Her connection with clients helps boost their self-esteem by providing an all-important ongoing relationship.

Teresa's first client, Joanne, one of her Canadian-born clients,

lives in supportive housing in Toronto's west end. On our way, Teresa explains that Joanne is a heavy smoker and that she has been trying to get her out of her small apartment – which she hasn't left in months – to attend a nearby day program. The winter weather has made it difficult. Teresa is concerned because Joanne's breathing is getting worse, although she is pleased that Joanne has stopped drinking.

Inside the sparse but tidy apartment, Joanne sits on her sofa under a blanket, crossword in hand, TV on. She is extremely thin and weak, having recently experienced a fall. Teresa wants to ensure that Joanne's progress continues, so after some friendly repartee, she observes, "Your appetite isn't good right now." "No, it's OK. I'm eating," Joanne replies, slightly defensive.

The two women talk a little about nutrition; then Teresa moves to her next concern: "We talked about Sistering [the day program]. Now we have nice weather and we can go out. Remember I promised you that?" But Joanne is concerned: "How am I going to get off the chesterfield?" she asks. "It hurts to move."

As with all of Teresa's clients, dealing with Joanne's immediate physical concerns is top priority. "It's easier to work on the addiction when we know everything medically is OK," says Teresa. For Joanne, this means arranging a myriad of appointments – from Wheel Trans, a public transportation service for people with disabilities, to a dietitian, a dentist and Joanne's family doctor.

"I'm glad you don't drink anymore," Teresa continues, shifting topics. "We will give you more information about relapse prevention, we'll work on that. Do you have cravings for alcohol?" "No," Joanne replies. Teresa also wants Joanne to cut down on smoking. "She's trying to make a saint out of me already!" laughs Joanne.

It's almost 11 a.m. and after our goodbyes, we head off to visit Mieczyslaw, who lives on another floor in the same building. An occupational therapist is assessing him for home safety but Mieczyslaw doesn't speak English, so Teresa is going to translate.

Depending on need, Teresa sees most clients once or twice a week. I'm beginning to grasp that Teresa's energy is spent on being tuned into each client's physical and emotional reality and the pace at

which change for the better may be possible. In addition to being their counsellor, Teresa becomes their advocate and friend. “They don’t know where to find resources, where to go. They’re afraid to ask the wrong questions,” she says.

On the elevator to Mieczyslaw’s, Teresa tells me she has worked with him for about six months, through referral by the building superintendent. It turns out that Mieczyslaw almost lost his apartment. The drinking and noise – sometimes there were as many as four people in his bachelor apartment at one time – disturbed other tenants, the rent was always late and Mieczyslaw was uncooperative. Initially, Mieczyslaw didn’t have a telephone, so Teresa would leave notes on his door saying she’d been there for an appointment when he didn’t show. When he was in, he was drinking. “He was unable to communicate at all,” says Teresa, “but recently I have seen improvement. I have many clients in this building, so he never knows when I might show up.” Mieczyslaw’s rent is now paid directly to the superintendent by his disability support program and the disturbances have stopped; a phone has been installed and Mieczyslaw is seeing his family physician regularly.

Inside Mieczyslaw’s tiny apartment, a large dining table consumes most of the space and there’s a flimsy rollaway bed by the window. “No drink, one month. Nothing!” Mieczyslaw announces as he moves with the help of crutches to sit at the table. “You do speak English!” Teresa cajoles, and he smiles at us, continuing the discussion in Polish.

“Counselling, employing the stages of change to help clients, is a big part of this job,” Teresa tells me later. That’s how she encouraged Mieczyslaw to stop using alcohol. But identifying the reason for drinking can be difficult: “People may drink because of isolation and depression, but they may also become depressed and isolated because they drink,” she says.

Today, Teresa is concerned about Mieczyslaw’s physical health; a bad knee, the result of a long-ago construction accident, requires surgery to relieve the pain, but due to Mieczyslaw’s past drinking he can’t have the operation. However, through regular meetings and counselling, Teresa hopes he will continue to abstain, making the operation possible.

By the end of the OT’s visit, requisitions are drawn up for a new mattress to help Mieczyslaw sleep better and several assistive devices: “If he had a wheelchair he could go to Alcoholics Anonymous,” says Teresa. He could also do more for himself, like grocery shopping or joining friends at a seniors centre. Teresa explains that encouraging clients to participate in activities leads to more involvement in the

Mieczyslaw’s story shows how easy it is for older adults to lose faith in life, to grow increasingly isolated and use alcohol or other substances to try to feel better

community, which means making new friends, which in turn reduces isolation and opportunities to drink and can ease depression.

Mieczyslaw’s story shows how easy it is for older adults to lose faith in life, to grow increasingly isolated and use alcohol or other substances to try to feel better. “It’s a problem, that he’s lonely, separated from family. His wife and three children live in Poland but they don’t have any relationship anymore,” says Teresa.

But in Canada for 16 years, alone with so many grievous challenges, Mieczyslaw has turned his life around with the help of regular contact with Teresa. As we leave, his gratitude is touchingly palpable.



Health Canada

MENTAL HEALTH AND ADDICTION RESOURCES

Agingincanada.ca. Dedicated to alcohol issues that affect older adults

Best Practices: Treatment and Rehabilitation for Seniors with Substance Use Problems. Found through a keyword search on the Health Canada website. www.hc-sc.gc.ca

Canadian Coalition for Seniors Mental Health. www.ccsmh.ca

Community Outreach Programs in Addictions. www.copa.ca

Get Connected! Linking Older Adults with Medication, Alcohol and Mental Health Resources.
www.samhsa.gov/Aging/docs/GetConnectedToolkit

Older Adult Consumer Mental Health Alliance. Washington, DC-based advocacy and education association.
www.oacmha.com/OACMHA.htm

Older Persons' Mental Health and Addictions Network of Ontario. www.opmhan.ca

Partners Seeking Solutions with Seniors. Winnipeg, Manitoba-based organization that educates healthcare providers and older adults about alcohol and medication use: www.solutionsforseniors.cimnet.ca

He stands and kisses both of our hands, a Polish gesture of respect.

But turning life around can be met with barriers like stigma and ageism. In order to reach older adults in a less intimidating way, COPA does not require clients to acknowledge their substance use issues before COPA will help. As relationships with clients

build, opportunities to address issues and offer support multiply.

Our next visit is with Czeslow, a palliative care client who lives in a high-rise apartment in a different part of town. Czeslow came to Teresa through one of her clients who brought him to Teresa’s west-end satellite office. In Canada for 12 years, Czeslow lived in a small basement apartment when he met Teresa and couldn’t make it up the stairs on his own. Teresa discovered that Czeslow had been on a waiting list for subsidized housing for 14 years – that was in November. By December, Teresa had found a more suitable apartment for him with a view of Lake Ontario.

Concerned about his appearance, Teresa immediately suggested Czeslow visit his family doctor. That led to the diagnosis of stomach cancer, which is now spreading. Czeslow has grown very weak and spends most of his days sitting in an uncomfortable, heavy plastic wheelchair. Teresa's first order of business today is to check whether a new wheelchair, ordered recently by an OT, has been delivered.

As we arrive, two of Czeslow's male friends take their leave. Cable TV included in Czeslow's rent means he can watch Polish TV and it's now tuned into a Polish game show. The new wheelchair indeed arrived and Teresa and Czeslow enthusiastically discuss in Polish the improved comfort it provides.

Teresa draws me into the discussion and expresses concern about Czeslow's medications, of which there are many. The risk of misuse is high. "Sometimes clients get confused and accidentally overdose because they may have more than one prescription for the same medication from different doctors," Teresa says. "In that case, we try to contact the pharmacy to explain the situation," which is what Teresa plans to do. She will also ask the pharmacist to arrange for a 'blister pack' to organize Czeslow's many medications.

We wrap up with Czeslow and head out to visit Teresa's last two clients. Andrzej, who lives in Czeslow's building, was referred to Teresa by a local hospital alcohol withdrawal management unit. Andrzej voluntarily admitted himself to the unit, but he still struggles with alcohol.

In Canada for about 18 years, he married a Canadian – Andrzej speaks English – but his wife left him and he lost his job due to an accident. The previous week he had been in serious crisis – suicidal, ready to end his life due to overwhelming sadness and despair. "He's very depressed with lack of motivation in life because he can't work now. We referred him to a psychiatrist to be sure his depression is addressed," says Teresa. After receiving a somber message from Andrzej, Teresa accompanied him to an emergency ward, but he was discharged a few hours after Teresa left. Today I see him struggle to maintain a sense of dignity in the face of receiving financial support: "That's not good money, I want to work," he says, visibly disconcerted.

As we sit at Andrzej's kitchen table, Teresa has some news she hopes will encourage him: A nearby residential treatment program has an opening and has scheduled an assessment for the next day; Andrzej just needs to ensure he is alcohol-free for the 72 hours before he is admitted. Andrzej smiles but hesitates: He wants Teresa to accompany him to the assessment. I watch Teresa struggle to assess Andrzej's mood and to make allowances for his need for support and to encourage him to go on his own. In the end, she decides to rearrange her schedule so she can accompany him.

Teresa's last client of the day, Irena, lives in yet another high-rise building. When we arrive, Irena is visibly upset, although Teresa doesn't know why. Irena has Lou Gehrig's disease and a stomach hernia that requires special attention, but the appointment is cut short at Irena's request, with her agreeing to a follow-up call. Teresa has never seen Irena so distressed before. "She needs more help," she says under her breath, her concern palpable as we drive back to her office.

As our day together comes to an end, I'm struck by an overall sense of the tenuousness of each clients' health and the importance of Teresa's support as she helps clients deal with so many vital issues. I'm also awestruck by how much has been accomplished in just a few hours. "We do what we can to improve the quality of life of older

adults," Teresa says. While time and life's difficulties may have imposed their inexorable effects on her clients, it is not without hope that Teresa works to improve upon what little her clients have. ■

FAST FACTS ABOUT ALCOHOL AND OLDER ADULTS

The physiological changes associated with age result in lower tolerance for alcohol and increase its toxic effects.

Alcohol problems in later life are commonly accompanied by medical problems, which can either be caused by or worsened by the substance use.

Older adults' sensitivity to alcohol may be heightened by medical conditions such as diabetes, hypertension or dementia, or by medication.

Over 150 medications prescribed to older adults interact with alcohol. For some, alcohol increases or decreases the effectiveness of the medication. For others, the medication intensifies the effect of the alcohol. Prescription sedatives can be lethal when combined with alcohol.

Alcohol use can exacerbate depression. The risk of suicide is 50–70% higher in people who are alcohol dependent than in the general population.

ALCOHOL USE PROBLEMS IN LATER LIFE: SEE THE SIGNS

Mental

memory difficulties after having a drink
trouble finishing sentences
being unsure of oneself
irritability, sadness, depression
trouble concentrating
forgetting to pay bills

Physical

loss of co-ordination (walking unsteadily, frequent falls)
digestion problems such as gastric reflux
poor nutrition
weight loss
changes in sleeping habits
unexplained bruises (especially at furniture level)
jaundice or anemia (yellow skin colour)
swollen abdomen
not bathing or keeping clean
acne rosacea (bulbous nose, red rash on face)

Social

difficulty staying in touch with family or friends
lack of interest in usual activities
desire to remain alone much of the time
socializing only with drinking buddies

Adapted from Improving Our Response to Older Adults with Substance Use, Mental Health and Gambling Problems: A Guide for Supervisors, Managers and Clinical Staff, 2008, CAMH Healthy Aging Project.

The aging psychiatrist

Why older is better

BY DR. MARY V. SEEMAN

MANY THINGS HAPPEN TO PSYCHIATRISTS AS WE AGE. WE become more experienced, more skilled at what we do. But at the same time, the field evolves and leaves us further and further behind. Add to this the inevitable numbing of our senses, our ever-dwindling supply of neurons, plus the stubborn determination to keep on doing what one has always done, and we have the aging psychiatrist: seasoned, yes, better for wear, but stuck in her ways and still insisting that “evidence” means the evidence of her own eyes. (Evidence-based medicine means the results of methodologically correct large-scale trials).

I began working with patients in 1960. But if *I* needed to talk to someone, would I choose a young psychiatrist or an old one? Probably an old one.

I'd prefer an older psychiatrist because I wouldn't want to be grilled about symptoms. Younger psychiatrists feel obligated to make a DSM diagnosis at first meeting because that is how they have been trained. Older psychiatrists prefer to talk and get to know the patient. Diagnosis is of secondary importance and is only really required for officialdom. Being diagnosed is like being given a label, a numbered tattoo instead of a nuanced portrait. The young, of course, have a point. Diagnoses are hard to make once you know a person well because there is too much that does not fit into categories. The only time to make a diagnosis with certainty is during that first hour when data points are few. I was amazed when, on retirement, I referred my clients to others and could not, with any confidence, assign a diagnostic label to individuals I had been following for years. Yet in a one-shot consultation, diagnoses seem so straightforward.

The second reason why I would choose an older therapist is because I think he or she would be more understanding of my foibles, less prone to judgement. I could be wrong, but I think that part of being seasoned is that you accept the human condition and don't jump up in amazement when someone tells you they have been secretly in love with their wife's sister for 50 years, or that they snort cocaine before performing heart surgery. I prefer the equanimity of someone who has seen it all.

The third reason I would choose an older person is because I don't want to hear “I know how hard that must be for you” repeated 10 times in the course of an hour. I don't want any stock phrase, for that matter, especially not the word “OK”: “How do you feel?” “Terrible.” “OK.” “How old is your mother?” “She died a month ago.” “OK.” “Are you having trouble sleeping?” “Yes.” “OK.” “Ever thought of suicide?” “Yes.” “OK.”

Older psychiatrists may not hear well, so I may have to speak up, but I can count on their listening skills being hyper acute. Their sight may be relatively poor, but I know they won't lose sight of the issues I bring to them. Their hearts may be hypertrophied and irregular, but that's what I am looking for – a big heart that beats along with mine. Gait may be slow and balance precarious duty when they walk you to the office, but I know they'll be fast on the uptake and stand firm and unswayable in the face of social pressures and passing fads.



Having lived through troubles of their own, older therapists tend to be more strength-based: “You hear voices? That's all right. Voices can serve a lot of good purposes. They're a comfort when you're lonely.” “You see imaginary shapes? That's nothing to worry about. The world needs visionaries.” “You can't stand people? I know exactly what you mean. Solitude is a wonderful thing.” “You're skeptical about other people's intentions? I know what you mean. It's smart to be cautious.”

Aging brings with it what social gerontologist Lars Tornstam calls *gerotranscendence*. It's experienced as a curious redefinition of time and space that allows for stronger connections with past and future generations and the acquisition of what we refer to as wisdom. Death is no longer fearsome, and so life is no longer frightening. Instead of fearing life, the elderly imbue it with renewed mystery and subtlety. Transcending one's own petty concerns means caring genuinely more for others. Material goods lose their meaning entirely. Ambition seems like a foolish game. Competitiveness goes. There's often a return to the exuberance and self-confidence of youth. Anything seems possible (a paradox because very little is). Superficial relationships hold no interest and being alone with your thoughts takes on a whole new appeal. Social norms are less constricting and the world becomes a richer place. Right and wrong don't differentiate quite as sharply as they once did, and forgiveness is easier.

All this translates into becoming a better therapist. In this sense, psychiatry is a smart professional choice. There aren't many disciplines where your skills actually sharpen in your later years. But that could be fantasy. The pianist Artur Schnabel not only re-wed (and to a young wife!) at age 80; it has been said that, astoundingly, he surpassed himself on the concert stage. The truth is he played fewer pieces, practised each one more often and slowed down before a fast bit to give the illusion that he could still pick up the tempo, which, unfortunately, he no longer could. ■

Dr. Mary Seeman, was inaugural Tapscott Professor and chair of schizophrenia studies at the Centre for Addiction and Mental Health in Toronto. She is a professor emerita, University of Toronto.

Generation to generation

When aboriginal elders speak, youth listen

BY LESLEY YOUNG

ONE DAY RECENTLY, AN ABORIGINAL ELDER TOOK A GROUP OF foster children on a medicine walk through the lush cedar forests of Duncan, British Columbia. Along the way, the elder pointed out plants that could be used as medicine. One six-year-old foster child later put the advice to use: After hurting her ankle playing, she wrapped it in the healing ferns she had learned about and pulled her sock up over it all on her own.

This day-long excursion and the lessons it taught are an example of the valuable role that aboriginal elders can play in ensuring that the future of youth includes a strong link to the cultural knowledge and traditions that will ground them in their identity as aboriginal peoples. At Surrounded by Cedars, an aboriginal child and family welfare agency in Victoria, BC, and the host of the medicine walk, elders provide a crucial cultural component to social services.

Shelly Johnson, chief executive officer of the agency, relies on the unique perspective of the Elders' Advisory Committee, of which many members themselves had difficult childhoods, including the experience of the residential schools, where they were forcibly removed from their families. "Many have also fought long battles with addiction and mental health issues," says Johnson. "They have a lot of patience and compassion and an absolute determination to make things different for this generation and those after them."

"Elder" is a title that refers to members of aboriginal communities – usually older, but not always – who are respected and honoured for their spirituality, wisdom, life experience and teachings. When it comes to services for children and youth with mental health and substance use issues, elders play various roles, from helping to develop policy to providing hands-on guidance and support. At Surrounded by Cedars, for example, elders played a key role in defining the vision and mission of the organization and insisted that for the organization to be truly helpful, all staff should be aboriginal.

Elders are also directly involved with youth, participating in cultural and social programs such as crafts, traditional drumming and nature walks. Surrounded by Cedars' annual back to school picnic, a fundraiser to ensure aboriginal children have school supplies, provides an opportunity for elders to get one-on-one time with kids.

These events provide opportunities for elders to pass along aboriginal traditions and with that, a sense of belonging, says Midewiwin chief and elder Jim Dumont, who is a board member of the Nimkee NupiGawagan, a youth solvent abuse treatment centre in Muncey, Ontario. "At Nimkee, connecting youth with their indigenous identity is essential to the healing process," says Dumont. "Once they are connected to their culture, they are connected to their spirit and spirituality. Elders are key to this process."

Connecting kids with their culture includes passing along aboriginal teachings, such as the "Seven Gifts" (or life values). Dumont says the gift of kindness is especially pertinent to troubled youth. According to aboriginal culture, animals and humans were born predisposed to care about one another; however, many aboriginal children do not experience this growing up, says Dumont.

Knowing that elders are available and willing to listen goes a long way to finding that meaning and value in life, says Freda Shaughnessy, a Kwakwaka'wakw elder on Surrounded by Cedars' advisory council and an elder at the Victoria Youth Custody Centre. "When they move from the reserve to the city, we lose kids; they are no long-grounded." She says it helps them just to talk to elders – she will take the bus through town to touch base with aboriginal youth on the streets. Shaughnessy is an example of how older generations, who are not necessarily "elders" in the official sense (although she is), are highly regarded and often play a significant role in raising children. She raised her grandchildren and is now raising her great grandson. "You have to share what you've got, otherwise it gets lost," she says. Shaughnessy takes her grandson to aboriginal ceremonies that include singing, clapping, storytelling and drumming. She sees how much young people enjoy the cultural programs. "When we take kids, even non-native kids, to sweat lodges, they love it."

The respect and honour bestowed upon aboriginal elders can serve as an example to mainstream society, which often views older adults as a burden, says Johnson. Dumont agrees: "In dominant society, when you reach a certain age you're put out to pasture. Native people are in danger of mimicking that," he says. "The way native people respect, honour and include older generations and uphold the importance of elders is something everyone can learn from." ■

Elder Alex Nelson and a child at the local Winter Feast hosted by Surrounded by Cedars. Nelson plays "Grandpa Cedar Claus," welcoming each child into the Cedar Big House.



Shelly Johnson

Gambling on the golden years

So much to lose, so little to gain

BY ASTRID VAN DEN BROEK

ESTHER, A SINGLE MOTHER, TRUDGED HER WAY THROUGH A MODEST-paying job all of her working life. By retirement, she had built up an impressive \$50,000 in life savings. But after Esther's daughter moved two provinces away to start a new job and Esther started her retirement, life suddenly began to look a little empty. After being introduced to gambling by a friend who played regularly, before she knew it, she was hooked. By the time she realized that she had developed a serious gambling problem, that \$50,000 was long lost to slots and lottery tickets. To this day, she cries at the thought that she won't even be able to pay for her own funeral.

Statistics show that gambling participation declines with age, but as this composite case illustrates, problem gambling has particularly serious consequences for older adults, and with the rapidly expanding aging population, gambling problems may also be growing. "Gambling has become a new pastime for seniors, and the government spends large amounts of money on promoting gambling in order to generate revenue," says Kim Gosnell, chair of the Ontario Resource Group on Problem Gambling and Older Adults. "There is increased access to gambling and more social acceptance and disposable time and money, which results in a larger number of seniors gambling today compared to 15 years ago."

A 2004 report published by the Responsible Gambling Council (RGC) found that among Ontarians 60 years and older, 74 per cent had participated in some type of gambling activity in the past year, with the most popular activity being lotteries. About two per cent were identified as having a moderate to severe gambling problem.

Dr. Gary Nixon, an associate professor in the School of Health Sciences at the University of Lethbridge in Alberta, sees this trend across Canada: "It's a growing issue because the baby boomer generation is growing older and we're seeing the advent of casinos and an increase in the amount of leisure time older adults have," he says.

With that increased leisure time comes increased risk. The effects of problem gambling can be much more devastating at this stage of life than at others, says Lisa Pont, a problem gambling counsellor at

the Centre for Addiction and Mental Health in Toronto. Older adults are more vulnerable than other age groups, given their greater dependence on fixed incomes and more limited ability to recoup gambling losses. A 2008 study published in the *Journal of Gambling Issues* reports that certain categories of older people, including those without a partner and those with a disability, are more likely to draw on their savings to fund gambling activities more than they can afford to lose. That's the case whether it's a trip to the casino or something as seemingly innocuous as buying a lottery ticket.

But calls to help lines show that older adults can't afford the lure of fast cash. In the one-year span beginning in October 2006, the Ontario Problem Gambling Helpline received 209 calls from men and 209 calls from women between age 55 and 64. The helpline received 109 calls from women and 103 from men over age 65. However, research shows that the large majority of older adults with problem gambling do not consider themselves to have a problem and lack observable signs associated with problem gambling. The most common indicators of problem gambling included gambling more than one intended and feeling guilty about gambling.

Older adults may experience unique issues tied to gambling. The RGC study found that the most common benefit attributed to gambling was winning money, but gambling also appeared to serve an important social function. Older adults are more likely to have suffered losses – be it spouses or jobs or children in the home – which makes them more vulnerable to start gambling as a way to deal with that loss, grief and loneliness, particularly because alternative resources and activities for older adults are limited, says Pont. "If these older adults have chronic health issues or increased fatigue, their options for socializing are that much more limited," she adds.

Staving off isolation and loneliness is something the gambling industry does well, offering convenient casino shuttle bus service, meal discounts for seniors and other perks. "Transportation is taken care of, you're indoors in a relatively safe environment, sitting down; you're not alone," says Pont. In fact, notes Pont, some clients she

HOW TO TALK WITH OLDER ADULTS ABOUT GAMBLING

If you think an older adult may have a gambling problem, a few questions may help to identify the problem. Encourage the person to talk about their gambling, without asking whether they have a problem. Start by asking:

- What do you do for fun?
- Do you ever play bingo or the lottery?
- Do you ever go to the casino or racetrack?

If the person says they gamble regularly and are willing to talk about it, ask:

- What do you like about going to the casino (or playing bingo, the lottery, etc.)?
- Is there anything you don't like about it?

How older adults answer these questions may suggest that they spend more than they feel they should, or that they wish they could stop but need to win first. You can then mention that gambling can cause problems for many people and that some counsellors specialize in helping people with gambling-related problems. If the person shows interest, arrange to connect them with a qualified gambling counsellor.

Adapted from *Responding to Older Adults with Substance Use, Mental Health and Gambling Challenges*, 2006, CAMH Healthy Aging Project.



works with who suffer from chronic disease or chronic fatigue feel a sense of “no pain” or “no fatigue” once they’re in the casino.

In Ontario, recognition of the unique problem of gambling among older adults led to the development of the Ontario Resource Group, which involves nine sites, including the Sister Margaret Smith Centre in Thunder Bay, where Gosnell is a member of the Problem Gambling team. The partners are funded by the Ministry of Health and Long-Term Care to provide problem gambling services to older adults and work together to develop resources and prevention and awareness information specific to older adults.

Such services are badly needed because social isolation means that gambling problems often go unnoticed or untreated, according to a 2000 study from the Alberta Alcohol and Drug Abuse Commission. The study found that older adults often do not know where to go for information about gambling or where to access help and support.

Gosnell identifies other barriers to help, including transportation issues, mental health issues like depression, poor physical health that affects mobility and acute chronic conditions such as arthritis and cultural or religious beliefs about money. Stigma also exists among older adults, many of whom grew up during a time when mental health and addiction issues were more taboo than they are today.

Reaching these older adults may require creative approaches and flexibility. “That may mean doing home visits rather than office visits for treatment and support in order to overcome some of the barriers,” says Gosnell. “It is also important to be aware of other issues that may accompany problem gambling, such as issues with alcohol. And older adults with gambling problems are at higher risk for suicide, so services need to screen for suicidal thoughts,” notes Deb Kostyk, a seniors and gambling prevention and education consultant with the Addictions Foundation of Manitoba in Winnipeg.

“It’s easier with a young healthy person with some resources to develop a plan to get them into a job development program or get them back to the gym,” says Pont. “It can be more challenging when someone’s ‘winding down’ in their lives than when they’re starting up.”

At the Sister Margaret Smith Centre, the Older Adult Programs is one of only three programs in Ontario that provide specialized treatment services to older adults (the other two are the Sault Area Hospital in Sault Ste. Marie and Lifestyle Enrichment For Senior Adults in Ottawa). The program offers assessment and counselling, therapeutic groups and continuing care to help clients maintain the changes they’ve made. Prevention activities include initiatives such as



OLDER ADULTS AND GAMBLING RESOURCES

- The St. Joseph's Care Group in Thunder Bay, Ontario, offers valuable resources for healthcare professionals. Information about the **Ontario Resource Group on Problem Gambling and Older Adults (55+)** can be found at www.mha.sjcg.net. Choose Gambling and follow the Older Adults sidebar link. Scroll down to access the Network Providers brochure under Ontario Resource Group.
- **Betting on Older Adults: A Problem Gambling Prevention Clinical Manual for Service Providers** published by the Ontario Resource Group can be accessed through the St. Joseph's Care Group website above. You can also find **Gamble Scramble**, a series of puzzles that provide prevention and awareness information about gambling.
- www.problemgambling.ca – an online community supported by the **Centre for Addiction and Mental Health** in Toronto.
- **Addictions Foundation of Manitoba.** www.afm.mb.ca. An older adults and gambling resource will soon be available.

Gamble Scramble, a series of gambling awareness games produced in collaboration with Addiction Services Kenora and the Addictions Foundation of Manitoba.

A key component of treatment involves looking at the bigger picture of the client's life to get a sense of what is missing, says Pont. “Clinicians need to look at the areas of aloneness in that person's life,” she says. “Are they socially connected? Do they feel there are places where they have meaning in their lives? Do they feel like they are contributing anywhere in their lives? Are they still connected to something or somebody?”

Given the connection between grief, loss and gambling, Pont and her colleagues are working on establishing a grief and loss group through CAMH to give older adults with gambling issues a healthy alternative for working through their losses. “Having opportunities for older people to talk to one another works; it can be powerful,” says Pont. “Educating physicians and clinicians who work in other areas with older people on how to spot gambling problems and how to have those conversations is also key.”

Pont, Gosnell and others would like to see more awareness around the issue of older adults and gambling because all signs indicate that it's not a problem that will go away on its own. “The older you get, the more losses you're likely to have had – spouses, losses of identity related to work and parenting,” says Pont. “You've been active and when you're retired and the kids are gone, you think, ‘Now what?’ For some, it's gambling.” ■

Over the rainbow

Meeting the needs of older LGBT adults

BY ANNE PTASZNIK

DURING THE LATE 1960S AND 70S, CHRIS MORRISSEY FELT SO ALONE in her conflicted feelings about her sexual orientation that she sometimes felt suicidal. Yet the therapist she saw for more than four years never once indicated that it would be OK to talk about this issue. Morrissey, now 65, is the programs manager for the Generations Project, which provides resources and support for lesbian, gay, bisexual and transgender (LGBT) older adults in Vancouver, British Columbia, so they do not have to endure the silence she faced.

This silence pervades health services for all age groups, where clinicians often don't ask, or may treat gender identity and sexual orientation as irrelevant, forcing clients to essentially hide their identity or to not seek help in the first place. Yet sexuality and sexual orientation remain important parts of who people are as they age.

Gens Hellquist, executive director of the Canadian Rainbow Health Coalition in Saskatoon, Saskatchewan, says that it is difficult to determine what percentage of older adults are LGBT, due to fears of disclosure and varying definitions of sexual orientation; but he estimates the number to be around 10 per cent.

What we do know is that with the aging of the general population, the unique needs of older LGBT adults cannot be ignored. Yet in a 2006 McGill School of Social Work national study of the needs of LGBT older adults and their caregivers and service providers, most service providers indicated that they had no clients they could identify as lesbian or gay. They also reported that they were not trained to deal with LGBT issues. Results also showed that service providers lacked awareness that ignoring issues of identity and sexuality limits the ability to support older LGBT adults.

Similarly, a 2002 study in the *Journal of Gay and Lesbian Social Services* advocated that substance use treatment must address social and psychological factors related to sexual orientation, including "coming out," societal and internalized homophobia and family and support systems. Yet 40 to 50 per cent of substance abuse counsellors received no formal training about these issues.

But addressing these issues is crucial. Older LGBT adults may have faced a lifetime of discrimination or secrecy. Dick Moore, manager of the Older LGBT Programme at the 519 Community Centre in

Toronto, says that many older LGBT adults grew up in a time when being gay or lesbian was considered a mental disorder. While some became involved in the gay liberation movement, others grew up when the only way to cope was to pass as straight.

As a result of this history and ongoing discrimination, Moore says some older people simply will not seek help unless they are in crisis. But this isolation can affect mental health. A 2001 *Aging and Mental Health* study of 416 lesbian, gay and bisexual adults aged 60 to 91 found less suicidal ideation among older adults who were open about their sexual orientation. Some researchers have found that the "coming out" experience of older adults can help them cope with some of the stresses of aging, what researcher Douglas Kimmel has referred to as "crisis competence."

Morrissey says that there are more visible LGBT practitioners working in services today and services for specific groups within the LGBT demographic. Her program offers a weekly Golden Oldies group for older LGBT adults with drug and other alcohol problems in partnership with gay and lesbian addiction counsellors from the local community health centre.

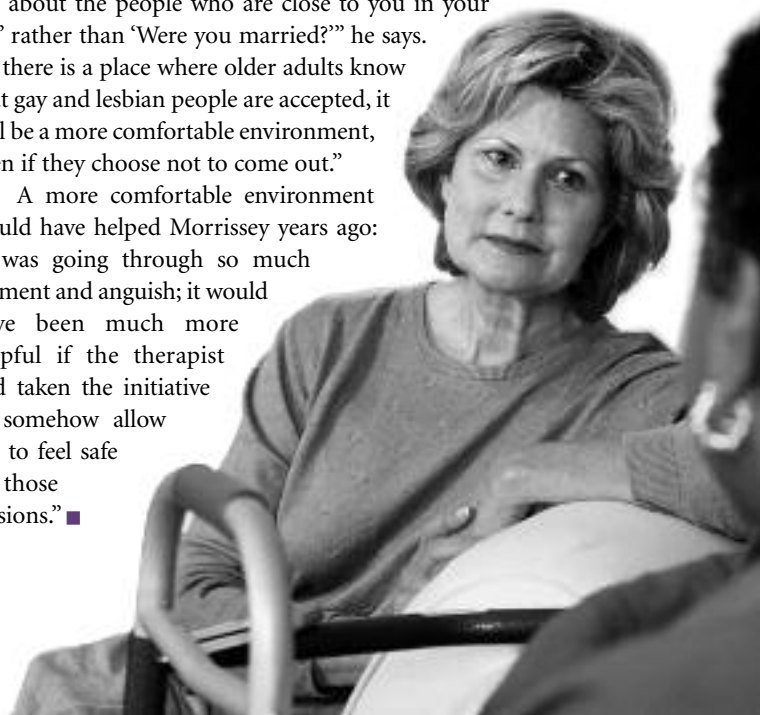
Angela Johnston, a master's candidate in gerontology at Vancouver's Simon Fraser University who is studying the needs of the older LGBT community, says that it is difficult to recommend one overarching strategy for health care professionals for more appropriate care because there is a lot of diversity within the LGBT community. Some older adults she interviewed for her research were open about their sexuality, while others were not out in all areas of their lives. Johnston says that counsellors need to ask clients what they need and want and should assess how their sexual orientation influences them because its influence may vary. Key to providing appropriate care is to visibly demonstrate openness to serving LGBT communities.

Moore agrees, adding that professionals need to be aware of heterosexism, even in language. "It provides a whole different opening for a conversation if you use the word 'partner' or ask 'Could you tell me about the people who are close to you in your life' rather than 'Were you married?'" he says. "If there is a place where older adults know that gay and lesbian people are accepted, it will be a more comfortable environment, even if they choose not to come out."

A more comfortable environment would have helped Morrissey years ago: "I was going through so much torment and anguish; it would have been much more helpful if the therapist had taken the initiative to somehow allow me to feel safe in those sessions." ■

TOOLS FOR WORKING WITH OLDER LGBT ADULTS

Asking the Right Questions 2. This clinical manual is available on the Centre for Addiction and Mental Health website at www.camh.net. **Canadian Rainbow Health Coalition.** www.rainbowhealth.ca. The Seniors link features reports on the needs of older LGBT adults, including a report from the 519 Community Centre in Toronto. **Generations Project.** www.lgbtcentrevancouver.com **Lesbian and Gay Aging Issues Network.** www.asaging.org/networks/index.cfm?cg=LGAIN. A constituent group of the American Society on Aging. **GLBT Health Access Project: Community Standards of Practice.** www.glbthealth.org/CommunityStandardsOfPractice.htm. This U.S. project provides guidelines for increasing quality of care for the LGBT population.



Common questions about prescription pain medication

BY ANGELA PIRISI

What proportion of older adults uses pain medication?

Although adults aged 65 and older make up approximately 13 per cent of the population in Canada, they consume 20 to 40 per cent of all prescription drugs and 25 per cent of all over-the-counter drugs, according to the Public Health Agency of Canada. A report by Partners Seeking Solutions with Seniors in Winnipeg, Manitoba, found that older adults fill an average of 15 prescriptions a year and often take up to 10 different medications at one time. About 60 per cent of community-dwelling older adults use pain medications regularly, according to Dr. David Lussier, director of the Geriatric Pain Clinic at the McGill University Health Centre in Montreal, Quebec. About five per cent use opioids [narcotic painkillers]. The most common pain medications used by older persons are non-opioid analgesics like acetaminophen.

What is the difference between medication use, misuse and abuse?

“Medication use has to be viewed on a continuum,” says Estela Torres, an older adult outreach counsellor with Richmond Addiction Services in British Columbia. “Use is taking medication for a specific purpose, usually with a time limit (for benzodiazepines; opioids and other classes may be long term). With misuse, medication is used beyond the intended recommended time period and to address other problems than it was prescribed for, such as using sleeping pills and tranquilizers as mood enhancers or painkillers as sedatives. If it continues, the body develops tolerance to the drug, which signals abuse.”

What prescription and non-prescription drugs carry greater risk of misuse and addiction?

Torres says that alcohol, benzodiazepines and nicotine tend to be the three most commonly abused substances in older seniors, while younger seniors tend to abuse illicit drugs more, such as crack, cocaine and marijuana. As the baby boomer generation ages, the number of cases among older people is expected to rise, given a more liberal attitude towards such drugs.

Older adults are much less likely to misuse opioids, says Dr. Roman Jovey, physician director of the Addiction and Concurrent Disorders Program at Credit Valley Hospital in Mississauga, Ontario. “Older patients are less likely to develop opioid tolerance but are more sensitive to opioid side-effects, such as constipation.”

What are common reasons for medication misuse and abuse among older adults?

Misuse is much more common than abuse, says Lussier. “Misuse is most often accidental, due to inadequate understanding of the proper dosing,” he says. Risk factors for misuse are taking several medications, lack of information on how to use the medications, functional impairments like decreased vision and cognitive deficits. As for abuse, “even though it is rare, pain medication abuse is possible in older adults, and is more frequent in those with a history of substance abuse,” says Lussier.

Depression, loneliness, chronic pain and boredom may also lie

behind abuse, says Torres. Moreover, “some older adults were raised with the belief that pills offer solutions for everything and they look up to a doctor to fix things,” she adds.

What concurrent conditions may accompany pain?

“Many patients with chronic pain often have concurrent mental health conditions, such as anxiety or depression,” says Jovey. Impaired quality of life, secondary to the pain, may be evident as depression, anxiety, sleep disruption, appetite disturbance and weight loss, cognitive impairment and limitations in daily activity performance, according to the International Association for the Study of Pain.

Some older adults use alcohol to self-medicate, to nullify emotions or physical pain, explains Torres. Nurses and outreach workers should consider that medication misuse or abuse could signify that older adults are using pain medication to deal with these secondary problems. Effective pain management can help to treat these secondary symptoms, according to guidelines from the American Geriatrics Society. “Sometimes, treating pain will help depression, and treating depression can make pain treatment more effective,” says Jovey. “Some physicians like to treat both at once, and others treat one, then the other. I try to treat the pain first, then the depression.”

Why might some older adults be overprescribed or underprescribed?

For pain, older adults are much more likely to be underprescribed than overprescribed due to the common belief that pain is a normal part of aging, fear of addiction and side-effects and underreporting of pain by older adults. “Overprescribing is most often related to a physician’s lack of knowledge about pain management in older adults and the use of inappropriate medications,” says Lussier. “For example, if a person suffers from anxiety related to chronic pain, it is better to treat the pain than to prescribe benzodiazepines. Or if the person with chronic pain has depression, an antidepressant will be more useful than increasing opioid doses. Likewise, neuropathic pain will often require an adjuvant analgesic such as an anticonvulsant or antidepressant rather than increasing opioid doses.”

What does support for older adults with prescription medication misuse or abuse involve?

“You have to look at the whole picture to see if there is a problem,” says Torres, who does home visits. “Signs of benzodiazepine abuse include frequent falls, bruises, abdominal discomfort, disturbed sleep patterns, confusion and memory and cognitive impairment. Clues about alcohol abuse include money troubles, weight loss, tremors, diarrhea, vomiting, an unkempt appearance, a chaotic home setting and frequent admission to hospital for injury.”

“Young seniors may self-refer because of growing awareness,” says Torres. “For others, we refer them to a case manager. We use a two-pronged approach that includes psychosocial and medical components. The psychosocial part consists of support, education and exploring coping skills. The medical side, handled by a doctor on staff, includes a tapering schedule that involves reducing medications by very small amounts.” ■

Anxiety – Yours and mine

Although it's called *A Brief History of Anxiety*, Patricia Pearson's book tackles the subject in an encyclopedic way. She draws creatively on the work of historians, philosophers, anthropologists, theologians and poets – and her own experiences as an investigative journalist, crime reporter and fiction writer – to depict anxiety through the ages. Along with 40 million adult Americans in any given year, Pearson suffers from what Keats described as “wakeful anguish.”

Pearson is generous in exposing her own struggles within a more widespread, collective anxiety in Western culture. Her writing is often lyrical, so much so that we can feel her inner turmoil. Pearson's sensibility, her acute sensitivity to fear and the uncertain – elements of the world that we all live with and that make life excruciating when we live them too acutely – is what makes this book so successful. She captures the angst and silence that often greet us in the throes of anxiety, when depression and anxiety collude. Despite her success as a professional writer, she also lives with “a pervading sense of doom.”

A Brief History of Anxiety (Yours and Mine) is an ambitious work. While not only looking at our experiences of anxiety historically, Pearson also describes her family's legacy of anxiety, her own “nervous breakdown” following a difficult breakup, her stint as a TV crime reporter in New York, anxiety in childhood, the prevalence of

anxiety across cultures, anxiety in the workplace and the use of antidepressants to treat anxiety. But at times the book takes on too much.

This is no more true than in the chapter on antidepressants. Pearson draws from leading “activist psychiatrists” – David Healy, Joseph Glenmullen and Peter Breggin – and from online consumer chat groups to speak about the often underreported effects of antidepressant withdrawal. She speculates about the potentially devastating side-effects of these medications, including a possible risk of diabetes. But is there research to back up these claims?

For the anxious readers among us, Pearson's cautionary notes on antidepressants may only leave us, well, more anxious. While I think we all know about possible withdrawal effects, particularly with certain types of antidepressants, the severity of withdrawal symptoms merits greater exposure, as does a discussion of how to discern when someone is experiencing withdrawal effects and when they are experiencing a return of the symptoms the drug was intended to treat.

Pearson writes that “[a]nxiety is treatable with pills, and is no longer respected as a meaningful signifier of a culture caught and flailing in arrested development.” But can't both be true? Can't we take antidepressants to treat anxiety, while recognizing that our culture is contributing to our demise? My greatest difficulty with this section is not

what Pearson has written, but what she has omitted. Psychotropic drugs have transformed many people's lives, enabling them to hold down jobs, maintain relationships and enjoy simple pleasures, such as being able to concentrate on a good novel. For many people, life is so tormented that they are willing to risk reduced sexual pleasure, weight gain, a dulling of mood and the uncertain potential long-term effects of these drugs to make life bearable. These drugs may also prevent some individuals from sinking into a depression that can lead to suicide. Ultimately, people need to make their own decisions about what amount of pain is tolerable and how best to combat it. The disquieting truth about antidepressants is that we simply don't know for sure what amount or type is best or for how long.

While this grey area of antidepressant use is absent, the book succeeds wholeheartedly and compassionately in depicting other shades of grey as we struggle to live amidst life's uncertainties – a recommended read for people with anxiety, those trying to escape its ravages and the professionals working hard to treat it. ■

A Brief History of Anxiety (Yours and Mine). Patricia Pearson. Random House, Toronto, 2008, 208 pp., \$29.95.

Diana Ballon is an editor at the Centre for Addiction and Mental Health in Toronto.

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SHEILA LACROIX

Healthy aging

Federal government resources

For an indepth overview of health aging, see the report *Healthy Aging in Canada: A New Vision, A Vital Investment – From Evidence to Action* on Health Canada's website or by doing a Google search. The report outlines three “key mechanisms” for building longer, healthier lives: supportive environments, mutual aid and self-care. The key areas are social connectedness, physical activity, healthy eating, falls prevention and tobacco control. Discussion of each area examines current knowledge, promising practices and future directions. For more government resources visit Health Canada (www.hc-sc.gc.ca, choose Seniors and Aging from the A–Z Index) and the Public Health Agency of Canada (www.phac-aspc.gc.ca, choose Seniors from the menu).

Mental health promotion resources

Coming soon to the Centre for Addiction and Mental Health (CAMH) website (www.camh.net) is *Best Practice Guidelines for Mental Health Promotion Programs: Older Adults 55+*. This is the second in a series of mental health promotion e-guides developed by CAMH, the Centre for Health Promotion at the University of Toronto and Toronto Public Health.

For the publicBoth the Canadian Mental Health Association (CMHA) and the U.S. Geriatric Mental Health Foundation (GMHF) provide tips and guidelines for the aging public. At CMHA (www.cmha.ca), under Your Mental Health, select Aging and Mental Health. On the GMHF website (www.gmhfonline.org/gmhf/), see the Consumer/Patient Information section for fact sheets on topics including *Healthy Aging: Keeping Mentally Fit as You Age*, *Substance Abuse and Misuse Among Older Adults* and *Depression Recovery Toolkit*.

Rational suicide and the older adult

On our own terms

RUTH VON FUCHS

Editorials do not necessarily reflect the views of CAMH.

We welcome submissions from our readers.

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Some things – a meal or a symphony – have a beginning, a middle and an end. Life too can be seen like this.

After an appetizer and an entrée and a dessert we usually feel full, and are disinclined to eat any more. After youth and middle age and elderhood some people feel content, and are disinclined to live any more.

And just as a typical symphony proceeds through a series of movements, introducing and developing a theme and then resolving in a finale, life may proceed through a number of phases and then arrive at a stage where it feels completed.

Not everyone is lucky enough to have a life that fits in with either of these similes. But those who do come to view their life as a finished work may ask why they are not allowed to take their bouquet of roses and leave the stage gracefully.

Part of their difficulty stems from competing life-metaphors that are widespread among their fellow citizens who are not yet old. These younger people often experience life as a river that rushes endlessly onward, a force to which any kind of blockage or stopping is antithetical. A second analogy is also common, especially during tough times when we might consider opting out: Life is felt to be an obligation, a kind of indentured servitude resulting from some implicit contract with the universe.

Together these two images propel us through youth and middle age, the periods during which we might make a few copies of our genes. But once we are past the optimal time for reproduction, new sensations often begin, as Nature starts signalling us that we are off the hook.

One such feeling is the fullness or contentment I have already mentioned. Another results from what economists call “the law of diminishing returns.” My Economics 101 professor illustrated it by reference to the process of eating an ice-cream cone: The first lick is heavenly, the second is delicious, the third is pretty yummy, the fourth is quite pleasant and so on, until lick number 17, which is not very exciting at all.

When people who are having these

experiences become clients of professionals who are not yet having such experiences, misunderstanding can result. The ready-to-leave people may be seen as abnormal. Indeed they are abnormal, in the purely statistical sense; not only are they a minority within the population as a whole, they may well be a minority even within the population of senior citizens – many elderly people have had a life so hard and unfulfilling that they never let go of the rushing-river or indentured-servitude metaphors.

But being statistically abnormal may not mean being in need of treatment. It may simply mean being exceptional.

The satisfied people can be exceptional in another way too: Their contentment often enables them to be more realistic. They can be fully aware and accepting of the fact that they and all other animate entities have been “designed” to wear out and go away to make room for the new homes of their genes.

Such people are quite likely to love some of those new homes, as I love my 26-year-old nephew. I am not at all disturbed by the idea of freeing up resources in order to help him have as good a life as I have had. At 67, I am starting to get a few hints from my body, and when the hinting finally turns to shouting I plan to heed it.

But there may be a problem. Currently, self-initiated exiting – by the helium method, for instance – requires not only certain physical abilities but also certain mental abilities, such as the ability to concentrate on a particular sequence of actions. I have always been a rather distractible person, likely because of what is called a low threshold of perception (perceptiveness can be overdone, it seems). Suppose this tendency increases as I age and I get worried that it may compromise my ability to self-deliver, worried enough that I consult a mental health professional in case there is some pharmaceutical remedy.

If I reveal why I am concerned about being able to concentrate, will my suicidal ideation automatically trigger a standard course of treatment for depression?

Or will the therapist’s mind contain



some new ideas, such as “rational suicide”? Will he or she protect me from myself only to the extent of helping me avoid doing something that would be seen as a mistake not just by other people but by myself, if I lived to evaluate it? Will there be gentle probing to see if my feeling of completeness has intensified rather suddenly and rather recently, perhaps in the wake of an event such as the death of my husband? Even if it has, will professional concern be leavened with openness and respect, so that I hear something like this:

“You probably know why I have been asking you these questions. And I sense that you too are starting to wonder if it might be wise to wait a while. It so happens that there is something you could do during the waiting time that would embody the prudence we both desire, and that might also help to alleviate your ‘presenting symptom.’ Difficulty with concentration is a common feature of depression, and experience has shown that antidepressant X is particularly effective against this facet of the disease. Would you like to make a trial of this drug? A month or two would likely be enough time to let you see if it made a change for the better, in any way. What do you say?”

Ruth von Fuchs is president and secretary of the Right to Die Society of Canada.

Rational suicide and the older adult

A humane experiment gone adrift

DR. ISAAC SAKINOFSKY

By choosing the metaphor of ending life after finishing a good meal, Ruth von Fuchs would beguile us into believing that requesting physician-assisted suicide (PAS) is a serene, natural process, like ordering an after-dinner coffee. As a suicide student for half a century, I know suicide is never so tranquil and measured a process; rather, it stems from deep despair, anguish and perhaps also chagrin, over a personal predicament that embodies severe mental or physical suffering or incapacitation. Although ageing brings susceptibility to debilitating or terminal physical illness, an intolerable predicament can arise at any age and it would be discriminatory to focus on the elderly when discussing PAS (which von Fuchs broaches, but does not term as such).

PAS involves taking one's own life with the help of a doctor who plays no direct role other than supplying the lethal agents. It is legally practised in the Netherlands and Oregon. In Oregon it is applicable to competent adults with terminal illness if the diagnosis and prognosis are confirmed by two physicians and judgement is unimpaired by psychiatric disorder. It is noteworthy that Oregon does not require an applicant to be suffering, whereas unbearable suffering is a precondition in the Netherlands. Every case must be carried out in consultation, performed with due care and reported to the authorities.

Peggy Battin, a Utah philosophy professor, recently examined data from these two localities to determine whether certain vulnerable groups were being targeted. There was no evidence of increased risk for the elderly, women, minors, the uninsured, undereducated, poor, physically disabled, chronically ill, psychiatrically ill or racial and ethnic minorities. In only one vulnerable group, HIV/AIDS, was the proportion excessive.

The case with HIV/AIDS illustrates the fear element driving many applicants to seek PAS or euthanasia (where the doctor personally administers the lethal agents). In Amsterdam, of 131 gay men with AIDS who died before 1995, 22 per cent died by euthanasia or PAS. The advent of clinically

effective drug cocktails may since have significantly reduced such requests. This example also serves as a backdrop for the arguments of Herbert Hendin, a respected US psychiatrist strongly opposed to PAS and euthanasia. Hendin quotes the case of a young professional he calls Tim, who first saw him after being diagnosed with myelocytic leukemia, a disease with a 25 per cent chance of survival. Tim was understandably fearful and preoccupied with suicide and wanted the doctor to support his decision. "Once Tim and I could talk about the possibility or likelihood of his dying – what separation from his family and the destruction of his body meant to him – his desperation subsided. He accepted medical treatment, complained relatively little about the unpleasant side-effects and used the remaining months of his life to become closer to his wife and parents. Two days before he died he talked of what he would have missed without the opportunity for a loving parting."

Hendin is concerned that what began as a humane experiment has gone adrift, and is now not humane at all because patients are not getting proper treatment. Instead of alleviating the patient's terror behind the PAS request, physicians are merely confirming the patient's decision-making competence and have become their patient's willing executioners. Virtually every guideline set up by the Dutch, says Hendin, has been corrupted with time. About 1,000 cases a year are life-ending acts without explicit requests or consent from the patients. Of the total annual mortality of 136,000 in 2005, 0.1 per cent were by PAS, but 1.7 per cent by voluntary active euthanasia and 0.4 per cent by involuntary active euthanasia. Frequently, cases are neither documented nor reported, and no colleague consults in the decision-making or examines the patient.

Hendin's worst fears that legally sanctioning PAS would lead to a "slippery slope" have been realized in the Netherlands, where the practice now encompasses the chronically ill or psychologically distressed without physical illness. More patients die from voluntary and non-voluntary euthanasia than PAS. He quotes such egregious cases



as that of a man given a choice by his wife between euthanasia and admission to a chronic facility. He chose euthanasia, and the doctor, although aware of the coercion, obliged. One Dutch study reported that more requests for euthanasia come from families than from patients themselves.

A major factor in the Netherlands has been neglect of palliative and hospice care. In the Netherlands, Hendin argues, Dutch physicians turn to euthanasia when they feel helpless and do not know what else to do. The Dutch government now acknowledges the country's deficiencies in palliative care and is creating centres for such care. There is also a grassroots movement by palliative care physicians to educate all Dutch physicians in the care of terminally ill patients.

The right to die movement followed a change in societal values, which were based on the sanctity and value of life. With the shift towards autonomy came the protection of people's rights to self-determination. Such rights should certainly be supported to the extent that they do not impinge upon others' rights and are exercised responsibly. It is all too easy to cast oneself into the character of God and override the tentative but true wishes of others, as Ann Wickett, wife of Derek Humphry, founder of the Hemlock Society, alleges that he did (she called him "a killer"), and as some Dutch physicians appear to have done. In the matter of PAS we should tread very carefully.

Dr. Isaac Sakinofsky is head of the High Risk Consultation Clinic at the Centre for Addiction and Mental Health in Toronto.

CANADA

49th Annual Institute on Addiction Studies

July 13–17, Barrie, Ontario
Contact: Linda Hood, Box 322,
Virgil, ON L0S 1T0
toll-free telephone 1 866 278-3568
toll-free fax 1 888 898-8033
e-mail info@addictionstudies.ca
www.addictionstudies.ca

Canadian Academy of Geriatric Psychiatry Annual Scientific Meeting / Canadian Coalition for Seniors' Mental Health Conference

September 3–4, Vancouver, British Columbia
Contact: CAGP, 55 St. Clair Ave. W., Ste. 255,
Toronto, ON M4V 2Y7
tel 416 921-5443
e-mail info@cagp.ca
www.cagp.ca/en/conferences.cfm

58th Annual Meeting of the Canadian Psychiatric Association

September 4–7, Vancouver, British Columbia
Contact: CPA, 141 Laurier St. W., Ste. 701,
Ottawa, ON K1P 5J3
tel 613 234-2815
fax 613 234-9857
e-mail conference@cpa-apc.org
www.cpa-apc.org

Canadian Academy of Child and Adolescent Psychiatry 28th Annual Conference

September 7–9, Vancouver, British Columbia
Contact: CACAP, 141 Laurier Ave. W.,
Ste. 701, Ottawa ON K1P 5J3
tel 613 288-0408
fax 613 234-9857
e-mail elizabeth.waite@cacap-acpea.org
www.cacap-acpea.org/

9th Annual Fetal Alcohol Canadian Expertise Research Roundtable

September 9, Montreal, Quebec
Contact: Motherisk Program, Hospital for
Sick Children, 555 University Ave., Toronto,
ON M5G 1X8
tel 416 813-8084
fax 416 813-7904
e-mail susan.santiago@sickkids.ca
www.motherisk.org

New Perspectives Conference on Addiction

September 11–13, Nanaimo, British Columbia
Contact: Bonnie Bartlett or Lis Muike
tel 250 751-0111
toll-free 1 800 683-0111
e-mail marketing@edgewood.ca
www.edgewood.ca

2008 International Conference on Special Needs Offenders

September 14–17, Niagara Falls, Ontario
Contact: Town Events Management, 209
Scarboro Cres., Toronto, ON M1M 2J6
tel 416 694-9713
fax 416 694-9726
e-mail info@towneventsmangement.com
www.specialneeds offenders.org

Psychosocial Rehabilitation Canada National Conference: "Breaking Through the Barriers to Recovery"

September 17–19, Winnipeg, Manitoba
Contact: PSR, Fay Kraynyk, 799 Pritchard
Farm Rd., East St. Paul, MB R2E 1J1
fax 204 482-3203
e-mail pheonixsociety@accesscom.ca
www.psrrpscana.ca

5th International Council of Nurses International Nurse Practitioner/Advanced Practice Nursing Network Conference

September 17–20, Toronto, Ontario
Contact: International Conference Services
Ltd., 1177 West Hastings St., Ste. 2101,
Vancouver, BC V6E 2K3
tel 604 681 2153
fax 604 681 1049
e-mail inapn2008@meet-ics.com
www.meet-ics.com/inapn2008/

Canadian Conference on Suicide Prevention: Suicide and Addiction

October 26–29, Quebec City, Quebec
Contact: Hélène Pigeon, Agora Event Planners,
50, St-Charles, P.O. Box 26740, Beaconsfield,
QC, H9W 6G7
tel 514 695-1624
tel 514 695-1624
e-mail congresaqps2008@aqps.info
www.congresaqps2008.info

20th Annual Conference of the Canadian Society of Addiction Medicine

October 30–November 1, Vancouver,
British Columbia
Contact: CSAM, 375 West 5th Ave., Ste. 201,
Vancouver, BC V5Y 1J6
tel 604 484-3244
fax 604 874-4378
e-mail admin@csam.org
www.csam.org/annual.htm

Building Equitable Partnerships Symposium 2008

November 5–7, Toronto, Ontario
Contact: Mary Austin, CAMH, 33 Russell St.,
Toronto, ON M5S 2S1
e-mail Mary_Austin@camh.net
www.camh.net/News_events/CAMH_Events/
/bep_symposium_2008.html

UNITED STATES

Obsessive Compulsive Foundation 15th Annual Conference

August 1–3, Boston, Massachusetts
Contact: OCF, P.O. Box 961029, Boston, MA
02196
tel 617 973-5801
fax 617 973-5803
e-mail conferences@ocfoundation.org
http://conferences.ocfoundation.org/

116th Annual Convention of the American Psychological Association

August 14–17, Boston, Massachusetts
Contact: APA, 750 First St. N.E., Washington,
DC 20002-4242
tel 202 336-6020
e-mail convention@apa.org
www.apa.org

3rd National Conference on Women, Addiction, and Recovery

September 15–17, Tampa, Florida
www.fadaa.org/women/index.asp

National Council on Alcoholism and Drug Dependence National Conference

October 22–25, Kansas City, Missouri
Contact: NCADD, 244 East 58th St., 4th floor,
New York, NY 10022
tel 212 269-7797
fax 212 269-7510
e-mail national@ncadd.org
www.ncadd.org/affiliates/conferencematerials/
/2008-Save_Date.pdf

American Public Health Association 136th Annual Meeting

October 25–29, San Diego, California
Contact: APHA, 800 I Street, N.W.,
Washington, DC 20001
tel 202 777-2478
e-mail annualmeeting@apha.org
www.apha.org/meetings

ABROAD

19th World Congress of Social Work

August 16–19, Salvador de Bahia, Brazil
Contact: INTERLINK Consultoria and Eventos
tel 5571 3336-5644
e-mail secretariat@socialwork2008.com
www.ifsw.org/en/p38000308.html

World Forum Against Drugs

September 8–10, Stockholm, Sweden
Contact: Andreas Ericsson, Ragvaldsgatan
14, SE-118 46 Stockholm, Sweden
tel 46 8 644 21 74
e-mail andreas@wfad08.org
www.wfad08.org

5th World Conference on the Promotion of Mental Health and Prevention of Mental and Behavioral Disorders

September 10–12, Melbourne, Australia
Contact: Think Business Events, P.O. Box 415,
Ascot Vale, VIC 3032, Australia
tel 61 3 9370 1265
fax 61 3 8610 2170
e-mail info@margins2mainstream.com
www.margins2mainstream.com

2008 Global Conference on Methamphetamine: Science, Strategy, and Response

September 15–16, Prague, Czech Republic
Contact: Luciano Colonna
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fax 44 0 208 987 6021
e-mail luciano.colonna@globalmeth.com
www.globalmethconference.com/

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Publications Mail Agreement Number /
Envoi de publications – convention de vente n°

40005034

ISSN 1481-3122



9 771481 312005

