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BC Pages

Newsletter of the B.C. Psychogeriatric Association

President's Report

I hope everyone had a wonderful winter break—where I am on Vancouver Island the emphasis was really on winter, with tons of snow!!

The Board has set an ambitious agenda this year, and we are slowly chipping away at it.

Many of you will remember, and have contributed to, the Seniors Mental Health Policy Lens (SMHPL) project sponsored by the BCPGA. We have received additional funding from the Public Health Agency of Canada to integrate other critical lenses (e.g., gender, disability, etc) with the SMHPL in order to create a web-based resource of information and perspectives on recognizing and addressing the mental health challenges seniors face from ageism and the problems experienced by members of other marginalized groups (e.g., mental illness, low income, First Nations, etc). Even more exciting, the Mental Health Commission of Canada has directed all their Advisory Groups (e.g., Caregivers, Workplace) to use the SMHPL when developing their work plans. This will support a life span perspective whereby programs and policies put into place will have to consider the needs of current and future seniors.

Speaking of the Mental Health Commission of Canada I would suggest that you take a look at their website http://www.mentalhealthcommission.ca/english/pages/default.aspx to get a sense of the work that is being planned.

The Mental Health Commission of Canada is a non-profit organization created to focus national attention on mental health issues and to work to improve the health and social outcomes of people living with mental illness.

The Commission, while funded by the Government of Canada, is a national body, not a federal one. It has been endorsed by all levels of government, although the Commission operates at arm's length from them. The Commission is currently working on four key initiatives:

1. A national strategy
2. An anti-stigma campaign
3. Homelessness research demonstration project
4. A knowledge exchange centre

A Seniors Advisory Group ensures that seniors are front and centre in the planning. BCPGA made a presentation to the Senate Commission on Mental Health that led to the creation of the Mental Health Commission of Canada. As I have been appointed to the Seniors Advisory Group, we will continue to promote and work towards promoting and supporting seniors' mental health at the Mental Health Commission table.

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Many of you are aware of the challenges that older adults face in receiving, and we face in delivering, the right care at the right time at the right place. Earlier in the year we put out a call for people to share their concerns, to which a number of people responded. Our thought was to collect these and to present them to the Ministry of Health. Since then Kim Carter, the Ombudsman, has initiated an investigation that will consider a variety of seniors' care services including home support, assisted living, and residential or long-term care. The investigation will look at issues such as the standards of care and how they are established, monitored and enforced, and on decision-making processes, including the adequacy of information provided, how decisions are communicated and how concerns about decisions are reviewed. If you go to http://www.ombud.gov.bc.ca/seniors/Seniors_Care_Questionnaire.htm you will find a *seniors input form,* designed to provide seniors, their families and those involved in providing support to seniors with an opportunity to provide input directly into the Ombudsman's investigation. Please encourage your colleagues, clients and their families to submit their concerns. The BCPGA Board is meeting with the Ombudsman and her team in January to discuss our concerns and how we can contribute to the Ombudsman's investigation.

Another opportunity to advocate for better care for seniors and others with disabilities is to join the BC Health Coalition's letter writing campaign. BC Health Coalition is calling on all British Columbians to stand up for seniors' and people with disabilities by sending a letter to Premier Campbell demanding that the provincial government act now to provide quality, accessible health care and to improve necessary services such as home support and long-term residential care You can find more information at http://www.bchealthcoalition.ca. The BCPGA has endorsed the BC Health Coalition campaign on seniors' health.

Our 2009 conference *The Heart of Psychogeriatric Care* taking place in Richmond BC will be a wonderful opportunity to come together as a community to share our successes, challenges and ideas, to address issues of concern and to see old friends and make new ones. Dr. Elisabeth Drance will be our keynote after-dinner speaker on April 30th— I cannot think of anyone who lives the idea of putting heart into Psychogeriatric care better than she does. Another keynote speaker is the Ombudsman, Kim Carter, who will tell the results of the investigation into seniors' care and point the way forward. A really exciting component of the 2009 conference is a play about older drivers, presented by Dr. Holly Tuokko and her team, designed to inform and affect attitudes towards this important issue. Not only will we be entertained, but we will have the opportunity to contribute to research on driving! Finally, be sure to note that we are holding a pre-conference workshop specifically for direct-care staff (home support workers, residential care aides, etc.), that focuses on recognizing and addressing depression and on self-care. Brochures detailing all the conference events will be forthcoming very soon, and we are counting on all our members to disperse these conference and pre-conference brochures as widely as possible.

I'm looking forward to seeing everyone at the Conference!

Penny MacCourt
President

CONFERENCE TRAVEL AWARDS FOR STUDENTS

Are you a BC based graduate student or researcher who plans to present a paper or poster at a conference?

As part of its mandate to develop research capacity, facilitate mentoring, knowledge exchange and synthesis in the area of aging health, BCNAR is offering Travel Awards for BC-based graduate students and researchers who are actively engaged in research on aging, and who plan to present a paper or poster at a conference. Applications are due the 1st of January, April, July, and October.

For general information and application form see our Funding Web-page http://www.bcnar.ca/

The British Columbia Psychogeriatric Association (BCPGA) is a professional, multi-disciplinary, non-profit interest group.

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ADVOCACY REPORT

Focus on Depression

The BCPGA continues to advocate for better services on the whole range of challenges for seniors with mental health problems, their families and caregivers. This year the Board has chosen a special focus on depression. Depression is a very significant issue and can occur with dementia and other conditions BCPGA is concerned about.

Members are encouraged in their own spheres of influence to advocate for improved services and approaches for people affected by depression. Please send suggestions on how the Board can pursue the Depression Focus to jegray@shaw.ca.

The Board is exploring strategies that are hopefully achievable within about a year. These include:

1. Develop an **overview** of our Depression Focus for the website. It would be 1 or 2 pages to establish why this is a major issue, the sub-issues and what needs to be done about them.

2. Examine the **Ministry of Health Depression Strategy** and take action. The Strategy, developed in 2002, includes a section on the elderly. Possible options include: advocating for a full guideline on the elderly and depression (like they have on post-partum); calling for or doing an assessment of whether the 2002 recommendations regarding seniors have been implemented.

3. Develop a document on depression **in acute care.**

4. For **Anxiety and Depression Screening Day,** work with the organizers to help focus on seniors as part of that program.

5. The **BC Mental Health Planning Council,** which has members from the Health Authorities and Ministry of Health, does not have a committee on seniors' mental health, although there is a committee on dementia. A seniors' mental health committee could be helpful for the range of issues including depression. This idea is being explored.

6. **Canadian Coalition on Seniors Mental Health Guidelines.** The CCSMH has a series of excellent guidelines on depression and suicide. If we could facilitate the "knowledge transfer" of this information to practitioners and caregivers in BC, we would have made great progress on our Depression Focus. BCPGA could post these or link them on our website, address them in the newsletter and highlight them at the conference. Any suggestions as to how these guidelines could be incorporated into practice in BC would be appreciated.

John Gray and Elisabeth Antifeau
Co-Chairs
Advocacy Committee

Canadian Centre for Elder Law: Current Projects

The Canadian Centre for Elder Law (CCEL) is the national non-profit charitable organization which works to improve the lives of older adults in their relationship with the law. Its goal is to be the best in elder law reform and outreach relating to elder law and elder rights issues. The CCEL produces legal reports, scholarly articles, public legal education materials, the peer-reviewed Canadian Journal of Elder Law workshops, and annually, organizes the Canadian Conference on Elder Law. The CCEL is a division of the British Columbia Law Institute.

Currently, two CCEL projects of interest are the Aging with Challenges project and a paper providing *A Comparative Analysis of Adult Guardianship Laws in BC, New Zealand and Ontario*.

The Aging with Challenges project explores the challenges faced by persons aging with physical and mental disabilities. It explores the experience of aging with congenital and early-onset physical and mental disabilities, and examines the particular barriers facing adults who are aging with these challenges, whether attitudinal, legal, or economic.

Because of recent advances in medical technologies and rehabilitative therapies, persons who often did not survive into middle age because of complications related to their disability are now experiencing a significant increase in life expectancy. For the first time in history, children with severe congenital and early-onset disabilities are living well into middle and late life. For example, as of 2001 there were more than 120,000 Canadians aged 15 and over with developmental disabilities, and more than 55,000 of them were aged 45 and over.

These groups constitute a new category of older adults aging *with* physical or mental disability. It is a cohort defined by individuals who develop physical or mental disabilities at birth, in youth, or early adult years as opposed to persons who first acquire disabilities in their later years. Although not large yet, this population's increased longevity has already created new and unexpected challenges for many Canadians. Persons with cerebral palsy, spina bifida, multiple sclerosis, post-polio syndrome, Down's Syndrome, and other physical and mental disabilities are living well beyond former medical estimates, and surviving well into later-life. While the cumulative effect of aging with long-term physical or mental disabilities is not yet known, it is already clear that aging with a disability over the lifecourse creates significant biological, social, and societal challenges.

Although persons aging with early-onset physical disabilities share some challenges in common with those who acquire disabilities later in life, there are significant physiological distinctions. For example, adults aging with early-onset disabilities are prone to additional complications that accelerate the aging process by an average of 20-25 years. Persons living with life-long physical and mental disabilities also tend to experience compound health problems at a younger age, and encounter unexpected physiological deficits in later years.

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NEWS FROM THE REGIONS	The Kootenays

Of the money raised from the Silent Auction at the 2008 Conference in Cranbrook, $259 was donated to the Therapeutic Activation for Seniors (TAPS) program. With Randy Grahn in the picture below is Jill Fehr who manages the program, including driving the bus to pick up seniors. After this photo was taken, she was headed out to pick up some senior guests for Christmas dinner, which is made right on-site in their facility.

TAPS is a non-government funded program surviving on donations and small fees from program users. In many cases the fees are waived when seniors cannot afford them. This is one of the few surviving TAPS programs originally funded and run out of health care facilities, but abandoned as part of the current government's reorganization of services.

The seniors in this program are older, reasonably well, but isolated and thus lack a support circle. Few of them drive, and most live alone. The program provides companionship, meals, outings, and purpose. The program participants make craft items for sale to help raise funds, and they often have activities at the Center as a group. Jill has many anecdotes of seniors who recovered and thrived after getting involved in the program. Mental, spiritual and physical health all responded to belonging and feeling cared for and supported.

The facility is located in an old school portable donated for the seniors use. It needs constant upkeep, which falls on the shoulders of volunteers. The bus was owned by the Interior Health Authority who donated it to the program. It also is now maintained by volunteers. When it needed tires, one of the local shops had some good tires they installed for free.

When Randy made a sheepish comment about the size of the donation from the Silent Auction, he was reassured that it was a significant donation for them. The rest of the Auction funds were donated to the East Kootenay Foundation for Health to be used to support seniors' programs in the rest of the region.

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Not surprisingly, these physiological challenges eventually translate into social and economic disadvantages. Adults with disabilities are considerably less likely than those without disabilities to participate in the labour force, and are also more likely to be poor and have inadequate or unaffordable housing. Of those individuals who are employed, the majority of them will earn significantly less income than adults without disabilities. Even pension entitlements and tax credits do little to assist those whose physiological age exceeds chronological standards, or whose disability-type eludes compensation. Why these disadvantages persist and how they impact adults aging with disabilities is of particular concern, given that Canada's older adult population is predicted to double over the next two decades. Although Canada does have legislative protections in place to guard against disability discrimination (most notably, the Canadian *Charter of Rights and Freedoms*), there is as yet no single piece of unifying legislation directly aimed at removing these barriers. While provincial frameworks may be an equally advantageous alternative, only Ontario has enacted stand-alone disability rights legislation to date. Whether or not the country could benefit from enacting national disability rights legislation remains to be seen. In the interim, however, the need for further research and analysis in this area is abundantly clear.

The *Comparative Analysis of Adult Guardianship Laws in BC, New Zealand and Ontario* paper discusses the legislative and practical schemes in BC and other jurisdictions, notably New Zealand and Ontario. It considers key issues that are essential to meaningful reform in BC. The paper has been prepared in connection with the Aging with Challenges Project. The CCEL gratefully acknowledges funding from the Law. More information about The Canadian Centre for Elder Law, the Aging with Challenges project and the guardianship law paper are on CCEL's website: www.ccels.ca/ .

Laura Watts, National Director
Canadian Centre for Elder Law

Applied Theatre Performance on Older Driver Safety To Be Performed at the BCPGA Conference in May 2009!

Researchers from the University of Victoria have developed a play addressing older driver safety. The play explores the highly complex social issues involved in older driver safety and reflects research findings from the existing literature and focus groups conducted with seniors and others with a direct vested interested in decision-making about older driver safety on Vancouver Island. Driving, for many older adults, is associated with independence, personal identity and self-esteem; driving cessation, whether voluntary or involuntary, may result in reduced mobility, increased isolation, and declines in physical and mental health. Yet, health care practitioners and policy makers are asked to identify unfit drivers and raise this potentially sensitive issue with those in their care. Funds for the play's development were provided by the Social Sciences and Humanities Research Council (SSHRC). Funds to support the performance of the play at the BCPGA conference in May 2009 were provided by the Institute on Aging of the Canadian Institutes of Health Research (CIHR).

Links & Leads

Current CCSMH Projects: Assessment & Treatment of Depression

With funding from the Public Health Agency of Canada, Population Health Fund, CCSMH was able to continue to disseminate all four of the CCSMH National Guidelines for Seniors' Mental Health. The CCSMH is also beginning to implement recommendations from each of the national guidelines. In 2007/2008, pilot projects were launched in a variety of settings across Canada to disseminate information and implement recommendations from the guidelines. Exciting work on these projects is still underway. Bookmark their website (www.ccsmh.ca/en/default.cfm) and visit it frequently for updates or contact them for more information.

1. Tool on Depression: Assessment and Treatment for Older Adults
Based on the CCSMH National Guidelines: Assessment & Treatment of Depression, tools for primary physicians were developed in partnership with the National Initiative for the Care of the Elderly (NICE).

Pocket Brochure for Clinicians [96 KB pdf]
One-page Summary for Clinicians [205 KB pdf]
Power Point Presentation for Teaching [coming…]

The brochure has been distributed to a variety of family health teams and physician groups. Lunch and Learn sessions for residents and staff of two health teams have also been launched to promote the use of these assessment tools to our target groups.

2. Tele-education Session on Depression and Suicide in the Elderly
This session was developed in cooperation with the Nova Scotia Seniors' Mental Health Network. Their pre-existing provincial education materials were modified to reflect recommendations from the CCSMH National Guidelines: Assessment & Treatment of Depression and Suicide Risk and Prevention of Suicide. April 2, 2008, Dr. Mark Bosma presented this interactive, case-based tutorial which was video-conferenced to hospital-based mental health programs in all nine districts in the province.
Depression in the Elderly: CCSMH National Guidelines-informed Interactive, Case-Based Tutorial [495 KB PPS]

3. Face-to-face knowledge transfer sessions
Train-the-trainer sessions are being conducted by members of the Standards Committee of the Nova Scotia Seniors' Mental Health Network using the Depression in the Elderly: CCSMH National Guidelines-informed Interactive, Case-Based Tutorial. The goal of these presentations is to transfer knowledge and information from the tele-education sessions to other colleagues in the districts and to increase awareness and use of the CCSMH guideline recommendations in local practice.

MEMBER PROFILE

Elaine Unsworth

As if raising five children weren't challenging enough, Elaine Unsworth decided at the age of 35 to become a nurse. She attended UBC for both the under-graduate and graduate programs in nursing and is now a Clinical Nurse Specialist (CNS) in Elder Care. About a year ago she started working as a CNS with the Geriatric Psychiatry Consultation Team in Acute Care at Mt. St. Joseph Hospital (MSJ) in Vancouver. MSJ is a vital part of Providence Health Care – a community hospital in a big city – and has 200 acute care beds, including the only Acute Care Geriatric Psychiatry unit in Vancouver. General Surgery, General Medicine, Geriatric Medicine, and an ICU complement the other in-patient beds.

Elaine believes that one of the benefits of working in a smaller hospital is that the staff know each other and when clinical issues are raised, resources can be shared to address patient needs. "As well, being part of the large health care system of Providence Health," she says, "we have a variety of resources available to us to ensure that we provide quality care. In my case, I became aware of difficulties staff were having managing challenging behaviours of older adult in-patients in the acute care medical and surgical units. Although the availability of a psychiatrist at all times had provided great support to all staff (nursing and physicians included), point of care staff were not always clear about how to support patients with challenging behaviours related to delirium and/or dementia, or exhibiting depressive symptoms. I agreed to offer nursing support to staff and join the Geriatric Psychiatry Consultation Team as a Clinical Nurse Specialist. The consultation service is available from 0800 to 1700 hours Monday to Friday and a psychiatrist on call is available after hours."

Elaine follows all patients referred through the system and supports the staff on a regular (at least daily) basis. She sees many patients with delirium, depression, and/or dementia (and sometimes all three). Because MSJ caters to many older adults, issues around decision-making, competency, and end of life care are frequent. The point of care staff often request assistance in determining when to give prns, what type of prn to give, and what interventions are appropriate to increase comfort and decrease physical and chemical restraint. This gives only a glimpse of the type of support Elaine provides for staff who are actually doing all the work. "I am privileged," she says, "to have a wonderful job, working with very dedicated staff."

Elaine also enjoys life outside work. "As a mother of five (and wife of one), life has been busy, but the children are really no longer children and Rick and I are having a great time with our own interests. I love knitting, quilting, and Canucks Hockey! I am also active in my church as a council member. Nursing is the best thing I ever did (apart from family), and I am thankful every day that I can get up and go to spend my day doing something I love."

End of Life in Long-Term Care from the Perspectives Care Aides

By: Shelly Waskiewich, BA
Master's Student, University of Victoria

It is estimated that 253,000 Canadians over the age of 65 have Alzheimer's disease and by 2031 it will affect more than one-half million Canadians (Canadian Study of Health and Aging, 1994). Often the level of care required to keep people with dementia (PWD) in their own homes becomes too much for family members, resulting in a move into a long-term care (LTC) facility. Approximately 87% of people in LTC facilities have a cognitive impairment or dementia (Graham, Rockwood, Beattie, Eastwood, Gauthier, et al., 1997). Further, Canada is facing a rapid increase in the number of people dying in LTC facilities. Therefore, staff are providing care to an increasing number of residents who are dying, both with and without dementia.

In part, due to these significant demographic changes, Abbey, Froggatt, Parker, and Abbey (2006) state, "the context within which LTC for older people is provided is changing" (p. 57). Older adults are currently admitted to LTC in more advanced stages of their illnesses and their care needs are changing (Wowchuk, McClement, & Bond, 2006). The traditional focus of LTC, on "doing everything to keep people alive" (Abbey, Froggatt, Parker, & Abbey, 2006, p. 59) and maintaining the maximum level of functioning and independence possible (Wetle, Shield, Teno, Miller, & Welch, 2005; Wowchuk, McClement, & Bond, 2006), may no longer pertain for some. Staff provide palliative care in LTC environments, yet a philosophical shift from providing a functioning/independence focus of care to a palliative approach to care has been limited.

As individuals near death, their care needs change; this may require "more intense resources, including more aggressive pain and symptom management and emotional support" (Rice, Coleman, Fish, Levy, & Kutner, 2004, p. 669). Palliative care in LTC overall has been described as 'suboptimal' (Kaaslainen, Brazil, Ploeg, & Martin, 2007) and research in the United States (US) has shown that the end-of-life (EOL) care provided in this setting is inadequate (Kayser-Jones, Schell, Lyons, Kris, Chan, et al., 2003). For example, Keyser-Jones et al. (2003) found that residents were not receiving basic care, "such as bathing, oral hygiene, [and] adequate food and fluids" at the end of their lives (p. 76). For PWD there are also special considerations when they are dying, as they are no longer able to verbally communicate feelings or discomfort (Moss, Braunschweig, & Rubinstein, 2002). As a result, their symptoms are generally under-recognized by staff and, consequently, under-treated (Harris, 2007).

Many staff in LTC typically do not receive specialized training in palliative care (Raudonis, Kyba, & Kinsey, 2002) and the large majority of care is provided by resident care aides (RCAs). Resident care aides have traditionally been given little training to care for this complex population (Ersek, Kraybill, & Hansberry, 1999), and care aide staff receive limited education around how to communicate with someone who is terminally ill, despite the fact that they are the primary contact for both residents and family members (Kayser-Jones, 2002). Resident care aides may work in an environment with inadequate staffing, lack of supervision (Kayser-Jones, Schell, Lyons, Kris, Chan et al., 2003), high turnover, low morale (Quadagno & Stahl, 2003), and where there is a heavy workload (Kayser-Jones, 2002). These issues only add to the challenges that staff face with providing care to residents with complex and diverse care needs.

Dr. Stajduhar (my co-supervisor) is currently co-leading a research project examining the quality of palliative care in selected inpatient health care settings, including extended care (LTC). Data from that study indicates that family members express dissatisfaction with a number of issues. However, the study has not examined staff's perspective on providing care in these settings. The majority of research in EOL care in LTC is conducted in the US[1], and RCAs perspectives are typically absent from studies. Therefore, the population of focus for my thesis will be on RCAs because they provide care on a 24-hour basis, have extensive experience providing direct care to residents, and consequently, contribute to the quality of EOL care provided in LTC. Their perspective will provide an understanding of the contextual factors affecting quality of EOL care in LTC. This information, in turn, can be used to inform the development of strategies to improve the quality of EOL care as it can direct change that works in the context of where this care is provided.

I will begin data collection in January 2009 and I look forward to sharing my results in future newsletters or conferences.

[1] For research on end-of-life care in Canadian long-term care facilities, see the work by Dr. Kevin Brazil (McMaster University).

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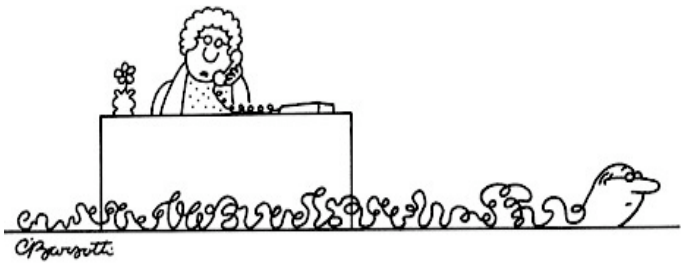
Research News

Ginkgo biloba for prevention of dementia: a randomized controlled trial

JAMA. 2008; 300(19):2253-62 (ISSN: 1538-3598)

DeKosky ST; Williamson JD; Fitzpatrick AL; Kronmal RA; Ives DG; Saxton JA; Lopez OL; Burke G; Carlson MC; Fried LP; Kul ler LH; Robbins JA; Tracy RP; Woolard NF; Dunn L; Snitz BE; Nahin RL; Furberg CD; University of Pittsburgh, Pittsburgh, Pennsylvania, USA. dekosky@virginia.edu

CONTEXT: Ginkgo biloba is widely used for its potential effects on memory and cognition. To date, adequately powered clinical trials testing the effect of G. biloba on dementia incidence are lacking. OBJECTIVE: To determine effectiveness of G. biloba vs placebo in reducing the incidence of all-cause dementia and Alzheimer disease (AD) in elderly individuals with normal cognition and those with mild cognitive impairment (MCI). DESIGN, SETTING, AND PARTICIPANTS: Randomized, double-blind, placebo-controlled clinical trial conducted in 5 academic medical centers in the United States between 2000 and 2008 with a median follow-up of 6.1 years. Three thousand sixty-nine community volunteers aged 75 years or older with normal cognition (n = 2587) or MCI (n = 482) at study entry were assessed every 6 months for incident dementia. INTERVENTION: Twice-daily dose of 120-mg extract of G. biloba (n = 1545) or placebo (n = 1524). MAIN OUTCOME MEASURES: Incident dementia and AD determined by expert panel consensus. RESULTS: Five hundred twenty-three individuals developed dementia (246 receiving placebo and 277 receiving G. biloba) with 92% of the dementia cases classified as possible or probable AD, or AD with evidence of vascular disease of the brain. Rates of dropout and loss to follow-up were low (6.3%), and the adverse effect profiles were similar for both groups. The overall dementia rate was 3.3 per 100 person-years in participants assigned to G. biloba and 2.9 per 100 person-years in the placebo group. The hazard ratio (HR) for G. biloba compared with placebo for all-cause dementia was 1.12 (95% confidence interval [CI], 0.94-1.33; P = .21) and for AD, 1.16 (95% CI, 0.97-1.39; P = .11). G. biloba also had no effect on the rate of progression to dementia in participants with MCI (HR, 1.13; 95% CI, 0.85-1.50; P = .39). CONCLUSIONS: In this study, G. biloba at 120 mg twice a day was not effective in reducing either the overall incidence rate of dementia or AD incidence in elderly individuals with normal cognition or those with MCI. Trial Registration clinicaltrials.gov Identifier: NCT00010803.



"It's your husband, Mrs. Thompson. He's come unravelled again."

Membership News

Dear BCPGA Members:

Since the last BC Pages newsletter, we have welcomed five new members. The membership now stands at 115 individuals who have paid dues for 2008-2009. This figure includes 51 new members and 64 members renewed from 2007-2008.

Of particular note is that there are presently twelve student members of the BCPGA, more than ever in the organization's history. The Board is committed to encouraging student membership, as we are certain that students will bring new enthusiasm and inspiration to the BCPGA. Students interested in becoming (more!) involved in the BCPGA should feel free to contact me at bcpga@yahoo.ca.

We also recognize that a crucial way to reach students is to promote the value of BCPGA student membership to existing members who have regular interaction with students. As many of you are in a position to speak with students about the BCPGA, we hope that you will consider publicizing the benefits (and discounted student rate) of BCPGA membership to those you teach, mentor and support. If you know students who may be interested in becoming a BCPGA member, please do not hesitate to put them in touch with me and I would be happy to answer any questions.

We are continuing to acknowledge the contributions and accomplishments of the BCPGA membership by profiling individual members in the BC Pages newsletter. In this edition, be sure to check out the feature on one of the BCPGA Board members, Elaine Unsworth. Thank you very much to Betsy Lockhart and Maia Kennedy for their continued assistance in preparing member profiles.

At the meeting in September, the BCPGA Board decided to move toward distributing BC Pages electronically through the membership email distribution list. However, we recognize that some members would prefer to continue receiving a hard copy of the newsletter. Therefore, we intend to give members the additional option of continuing to receive a copy of BC Pages by mail. More information will follow early in 2009.

This is the last edition of BC Pages before the current membership year ends on March 31, 2009. Watch for an electronic copy of the membership renewal form in your inbox early next year. We look forward to welcoming you all back in the new year.

Anthony Kupferschmidt
Membership Chair & Treasurer
bcpga@yahoo.ca

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You only need two tools in life: WD-40 and duct tape. If it doesn't move and should, use the WD-40. If it shouldn't move and does, use the duct tape.
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The Heart of Psychogeriatric Care

2009 British Columbia Psychogeriatric Association (BCPGA)
12th Annual CONFERENCE
April 30, May 1 & 2, 2009

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This conference supports and acknowledges the many dedicated individuals who are

The Heart of Psychogeriatric Care.

Keynote Speaker: Dr. Elisabeth Drance

Session Topics:
Depression: Assessment and Non-pharmacological Approaches
Substance Abuse and Seniors
Culturally Competent Care
Making the Inter-Rai Data Work for You
Medical Management of Depression: Medication and ECT
Cognitive Behaviour Therapy: Changeways for Seniors
Supporting Caregivers through Case Management
Recreation Research, Dementia and Meaningful Activity
Communication and Ethics: A Panel Presentation
Adult Guardianship Update
Moral Distress, Compassion Overload: How Can We Look After Ourselves?

***This year research about older drivers will be presented as a play. ***

The Pre-Conference Workshop is back by popular demand:
April 30, 2009 from 0800-1600
This pre-conference workshop is geared towards care aid, home support and other direct care staff providing meaningful activities and social interactions for older adults across the continuum of community, acute and residential care.