Transcript for Paths to Wellness for older persons: body, mind, spirit

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Muriel Howden:

Hello, everyone and welcome to Path to Wellness for Older Persons: Body, Mind, Spirit.

This is the last Webinar of the Vibrant Voice series for this year.

My name is Muriel Howden.

I am the Executive Assistant and Senior Outreach Advisor for RTOERO.

I will be moderating today's session and providing active offer for any participants who wish to ask questions or have information relayed in French.

Throughout the Webinar feel free to use the Q and A box to submit your questions for our guest speakers.

[content repeated in French]

As we begin the Webinar today, we would like to pair our respect to the Indigenous lands that connect us across Canada.

And then our board chair, Rich Prophet, will introduce today's guest speakers.

I am speaking to you today from the traditional territory of many nations, including the Mississauga of the Credit, the Anishinabe, the Chippewa, Haudenosaunee and the Wendat Peoples, which is now home to many diverse First Nations, Inuit and Métis peoples.

We acknowledge, recognize and honour the ancestral traditional territories on which we live and work and the contributions of all Indigenous Peoples to our communities and our nation.

[content repeated in French]

Thank you, Miigwech.

Rich?

And Rich is going to come to introduce our wonderful two guest speakers.

Rich Prophet:

And it basically says that I cannot start my videos...

There, it comes on now.

Yes.

Hello.

My name is Rich Prophet.

I'm the Chair of the Board at RTOERO.

Thank you for joining us today.

RTOERO is a bilingual, trusted voice on healthy, active living in the retirement journey.

We work with our members and partners to advocate for critical policy improvements to address urgent needs now and create a more secure and compassionate future for everyone.

Our three key advocacy issues are senior strategies, geriatric health care and environmental stewardship.

The focus for today's session, as Muriel mentioned, is pathways, Paths to Wellness for Older Persons: Body, Mind, Spirit.

It is on a geriatric health care and senior strategy.

I am pleased to introduce our first panelist, who is no stranger to our members and older adults in British Columbia and across Canada.

Isobel Mackenzie is a senior advocate for the province of British Columbia.

Over the last two decades, she has worked in various aspects of care to support older adults.

She has served on a number of national and provincial boards and commissions and was instrumental in pioneering a new model of dementia care that is now a national best practice.

Our second panelist is Dr. Keri-Leigh Cassidy.

She is a national leader in positivism in health care and an expert in cognitive behavioural therapy.

Dr. Cassidy is a professor of psychiatry and the Clinical Academic Director of Dalhousie's Geriatric Psychiatry Program at the Nova Scotia Health Authority.

Dr. Cassidy also founded the foundation of Health, a national nonprofit association that supports behavioural change to promote brain health and resilience.

I will now turn it over to our moderator, Muriel Howden, to start the Webinar.

Muriel.

Muriel Howden:

Thank you very much Rich.

Before we begin, I just would like to remind everyone to submit your questions in English or French using the Q and A box at the bottom of your screen.

Our two panelists will address as many questions as we can at the end of the presentation.

[content repeated in French]

So let's begin with Isobel Mackenzie.

Isobel, the floor is yours.

Isobel Mackenzie:

Thank you very much, Muriel.

A Bonjour and Hello to everybody on the Webinar.

I am speaking to you from Victoria, British Columbia, which is the traditional lands of the Songhees and Esquimalt First Nations of our country.

So I'm just going to start with a share screen here, get that up and running.

And I am going to get somebody to give me a thumbs up that they see my Slideshow.

Brilliant.

Thank you.

So I'm just going to start by giving you a little bit of a context of the picture of seniors in British Columbia because it really looks very similar to the national average.

And as we know, the national average is usually determined by what happens in Ontario because Ontario so overwhelms the rest of Canada.

So, while these numbers are B.C. numbers, you can expect that they look very similar for Ontario.

And I know that some of the members of theAssociation live in different provinces.

Most provinces look similar.

Alberta has a slightly younger population, and the Maritimes has a slightly older population.

But, for the most part, the order of magnitude is the same.

So the first thing about seniors is that when we look at 65 plus, where are people living?

Over nine out of ten people over 65 live independently.

They might live in a condominium or a townhouse, but it's their own home.

Even at the age of 85, which is when we start to see some significant shifts, we find that more than seven out of ten seniors are still living completely independently at age 85 plus.

About 10% are living in what we might call retirement homes or assisted living, or sometimes it's called seniors independent living, where you have your own apartment, but some common dining and activities.

And about 10%, pardon me about 15% of people 85 and over live in what we would call a nursing home or a long term care home or residential care facility.

So I think we can take great comfort to know that for the most part, most of us will live the entirety of our life in our own home.

And that while it is possible that we might want to move to congregate setting or need a nursing home, in all probability, it's less likely than not that that will be required.

Income, however, can be a challenge.

So the median income for a senior in BC, and this is a little bit higher than the national average.

So median, as you know, half is over.

Half is under.

Just under $30,000 a year, depending on where you live in the country and what the expenses are, that can be more challenging.

Certainly in big cities like Toronto, Vancouver, Montreal, it's going to be much more challenging.

But we do know that while there are some income supports, certainly for seniors who don't have workplace pensions like public servants have, it is and can be very challenging.

And the choices that you have as you age might be a bit different.

Looking at the healthcare status also gives us a little bit of good news and hope and inspiration for the future.

So this is looking at BC's population and looking at our diagnostic codes through our physician billing system.

So it's a fairly robust, accurate data system.

One of the things to notice is that under 65, the prevalence of dementia is almost imperceptible.

It can happen... early onset dementia certainly does occur.

It's possible, but it's not very probable.

It's very rare that we would see the onset of dementia under the age of 65.

When we look at over 65 the prevalence in the entire population over 65 is 6%.

So that still means 94% don't have a diagnosis of a dementia.

But what's interesting is when we look at the 65 to 84 age group, actually, that number drops to 3% and then rises significantly at 85 plus to 20%.

But 80% of people 85 and over do not have a diagnosis of dementia.

So again, yes, it is possible.

The probability of developing dementia does rise with age.

It is a neurological degenerative disease for which we don't have a cure.

But there are management tools, but most people will live the entirety of their life not only in their own home, but, as I like to joke, they'll keep all their marbles or most of them, however few or many they may be for most of their life, as well.

So that's an important thing to think about, as we're planning for a future.

Even when we look at high complexity chronic conditions.

So this category would capture people who have more than one thing.

So hypertension in and of itself is not placing you in high complexity chronic conditions.

But if you had hypertension and diabetes or hypertension and COPD or renal chronic kidney disease, these would place you in the high complex chronic condition.

So under 65, we're a healthy population.

65 plus have high complexity chronic conditions.

A little bit less than that in our 65 to 84 group, but pretty much doubles at the age of 85 to 35% of our population.

But again, that means the majority, have high complexity chronic conditions.

Most people actually are quite healthy in their later years as well.

And again, we see this in long term care, where 4% of the population 65 plus live in long term care, actually drops to 2% at 65 to 84, and then at 85 plus rises to 15%.

So again, some context for understanding the importance of the whole theme of your session around healthy aging and the paths for wellness, that really is very hopeful.

Now, that is not to say that people will not require long-term care and health care services as they age.

Some will, absolutely.

And the challenge is you can't really predict accurately who is going to require those.

What we do know is that for the most part, while, by the time you're age 85 or 90, your income doesn't actually determine whether you have better health.

It does determine the options you have available to you.

And that's where I think looking and planning and having a plan for the resources that are needed is important.

Now, you also wanted to learn a little bit about this office and the role of advocacy.

So the Office of the Seniors Advocate was created in 2014, and it's based on legislation called the Seniors Advocate Act, which was passed in BC, actually the year before the office was formed.

So this is a statutory office created by government.

And in the legislation governing this office, we have a mandate to monitor and analyze senior services and issues.

We make recommendations to government and service providers to address systemic issues.

It's not a regulatory body.

We don't have a regulatory function.

Our powers and authority really extend to compelling information from providers, compelling data and the ability to report directly to the public.

We can't actually make the government do anything or make a service provider do anything other than provide us with the information.

On an annual basis we get about 13,000 calls and just under a website that gets just under 100,000 visits a year.

So obviously, an interest out there.

In BC, when we're looking at Ontario, we always multiply by three, and that would be the proportionality for the application to Ontario.

So in terms of the effectiveness of the office and what can this office do?

And these are just a little bit of a catch all of some of the headlines.

The main, I think, power of offices like this in this office in particular, has been the power to empower the public, particularly seniors, with the information, with the data that it is.

Our job is not to defend what governments are doing.

To some extent we will explain what they are doing, but we can identify the gaps, and we can put out the information that, if you can capture the public's imagination on the issues impacting seniors, you will see that the political will to address those issues will follow.

So if we look in British Columbia, this office started reporting on our hours of care that were delivered in long term care, which led to the recognition we weren't delivering the hours of care that we had a policy to deliver, which led to a commitment to increase those hours of care.

And we have effectively reached that milestone now.

And we've seen that in other areas as well.

When we talked about in the income area, a senior supplement in British Columbia that is for our lowest income seniors that hadn't changed in 27 years.

And in the most recent budget, we saw a doubling of that amount.

Again bringing the attention to the public of these issues and then the public are who is going to push the politicians and the political will to make the changes.

So I think there is value to offices like this.

I think there's value to regulatory regimes, as well.

But just within the realm of advocacy, I think there is a tremendous amount of value, and it would be my hope that we would see similar offices to this in provinces across the country.

That hasn't happened to date.

Newfoundland does have an Office of the Seniors Advocate, but they're a small province.

And so it may be a little under resourced.

And New Brunswick has one that shares common administration with the Office of Children's Representative or the Children's Advocate as well.

The challenge from a federal perspective is that most issues affecting seniors are under provincial jurisdiction.

The only thing under federal jurisdiction are the income supports of CPP, OAS and GIS.

And so while a federal senior's advocate might be effective, really it is the provincial level where you see the levers, if you will, that need to be pulled in order to see real changes in the lives of seniors.

So, there is the contact information for my office.

The website is there lots of information, and you can call my office and get a live voice answering your call and we'll hopefully direct you into the right space.

So I will stop sharing at that point and turn it back over to you, Muriel.

Muriel Howden:

Thank you.

Isobel Mackenzie, thank you so much for this great presentation.

Just a reminder we will take the questions after.

So we will now be welcoming Dr. Keri-Leigh Cassidy for her presentation.

Dr. Cassidy:

Thank you, Muriel. Thank you so much for the opportunity to speak to this important group.

And I'm speaking to you, as was mentioned from Nova Scotia, which is the territory of the Migma people.

I also wanted just to commend the organizers for the diversity of perspectives, geographical diversity here, from one side of the country to the other.

And also the theme from policy and advocacy at a structural level to this talk, which is also very much about empowering people, but in a slightly different way, in a less of the top down, more the bottom up kind of way, which is,

What can we do as individuals in our own lives?

And the theme here is how to thrive in retirement.

So I find with my own work that it's helpful in working one on one with people or even just thinking about it for myself to stop and have a bit of self reflection.

So if we're going to think about how to thrive in our retirement phase, it helps to stop and think about, What are my expectations, my hopes, my fears, and to put those out on the table.

So for some people thinking ahead, it tends to be the fantasy of what it will be when we finally don't have to be cracking a whip at work all the time and that we'll have this ability to kind of start the party.

Can't wait.

The clock is ticking down.

Some people are very eager for this next chapter.

Another possible fantasy would be escapism.

We finally get to go to the Caribbean for any length of time we want or some other way of really relaxing and de-stressing and that this is what retirement means to us.

Likewise, there can be a lot of worries and fears about this future unknown phase, whether it's impending or you're already in it, that it could be really boring and dull sitting at home, twiddling your thumbs with nothing to do.

And an anxiety about what it means to suddenly have all this unstructured time.

Or it can be a real fear of becoming lonely or isolated or even possibly depressed in the face of such a big change in lifestyle and cut off from friends and colleagues.

So, when people actually experience the retirement, it can be a combination of these things.

But let's face it, the current context to reflect on is extremely stressful around the entire globe.

So when we reflect on our life, it has to be put in the context of current reality.

So no matter what your hopes, fantasies or fears might have been, it's all entwined now with the impact of an epidemic that has changed everybody's lives in countless ways, limiting us, restricting us, forcing us to behave in completely new ways socially, from a health perspective.

And also a reality of our current times is the broader global environment, political and natural.

I don't know about you, but I find this fall to be rather warm out in Nova Scotia.

And we have right now the Global Summit on Climate Change.

So, at a global level, there's stress, but at a personal level, the reality of one's day to day life can include the care of an aging parent.

So you're dealing with one's own aging, but also family members who may become more frail, need our help.

We may have adult children who are going through their own life stresses, problems, maybe divorce, conflict, what's happening for the grandchildren or their children, your dear grandchildren, and how you may help or be part of that, entwined with that.

And then concerns for yourself.

The chronic conditions Isobel referred to do increase with age, and so there may be new health issues that you have or maybe coming around the corner that are a source of stress.

So in this context, with our fantasies, our fears and our realities, what does it really mean to thrive?

Which is the title of this talk.

If you look at the definition of what it means to thrive, it is to progress toward or realize a goal despite our because of circumstances.

In other words, we don't have to have perfect conditions in order to thrive.

In fact, the resilience research would say that one doesn't have resilience unless it's in the face of struggle and conflict.

So it is a precondition to the development of resilience.

And so to progress towards a goal even though we have these conflicts, these fears, it is really possible.

The question is, are we armed with the right knowledge, tools and support to thrive... to make the most of this next phase in our lives?

And how would you know?

So the Fountain of Health is trying to empower people with the right knowledge, tools and supports.

And it's a project that I've been involved with, if you go back a slide there Muriel, for about ten years now.

It's a knowledge translation project that is a nonprofit offering training and tools to support people's well-being at any stage and phase at the level of the individual, organizations like yours, and clinicians who are doing this frontline work.

So we don't have policy, but we offer tools and training.

You can find this information on our website, which is fountainofhealth.ca

Obviously it's a play on the fountain of youth.

But who needs youth when you can have good health?

Right?

So you can register for workshops.

The Optimal Aging workshop is a four week virtual workshop, if you're interested.

And also there's an app, which is a web based app that you can use if you have the Internet and an email account.

So there's no going to a store downloading.

It is usable on any device.

It's called the Wellnessapp.ca

What you'll find on the website in the next few months is a new learning centre where we will be making it even easier to register and log in for the various courses and training that's offered here.

The T.H.R.I.V.E. model of wellbeing involves six key domains that I'll get into in a minute.

And before I do, I wanted to acknowledge others in the team.

Just so you know, this kind of work isn't done in isolation.

Clearly, I have a large community of professionals involved in this work.

You can see the different organizations who are partners in the leadership team.

And I just want to draw your attention to Dr. Erica Frank, who is Canada's research Chair on preventative medicine.

And so she's a member of this group.

Okay.

Yes.

So we have three people highlighted here.

Dr. Dilip Jeste, on the left there, is the founding father of what's called Positive Psychiatry and a mentor of mine.

Dr. Michael Vallis next in the top left is a behavioural psychologist who founded the Behaviour Change Institute.

And then

Dr. Erica Frank

below him is the Canada's Research

Chair of Preventative Medicine.

So together we're doing this work to try to get the message out across Canada.

So when we think about what does it mean to thrive, it's worth thinking about this illness-wellness continuum.

That basically the idea of waiting for a disease to strike us before we begin to consider how to promote our wellbeing is often the way we go.

But it may not be the best path.

Many of us will sit in what you could call a comfort zone.

Well, there's no problem here so I'll just keep going.

And yet there are some places in some countries and some venues where there's even lower levels of chronic disease in the older population.

So, while we do very well, is Isobel mentioned, like the majority of people are aging in a healthy state, it is possible to further reduce that burden of disease in a population overall.

And when you look at whether the specific ingredients to help with that, of course, social determinants of health, a lot of things are environmental, make a difference.

But there are things at an individual level that people can do that protects health.

And so moving out of a comfort zone and becoming more proactive, as an individual or within a community, to optimize health is something that is possible and something that I would encourage you to be thinking about.

Why bother?

So why would we work on these things?

It turns out that only about 25% of human longevity is accounted for by inherited family genes.

In other words, there's a huge amount of our health that is determined at an individual level by what's called epigenetic factors.

And that is, things that happen after our birth, after the things we're born with.

And so, of course, environment is a big one.

But so is our own personal lifestyle, and even our outlook.

Fascinating work on how longevity and optimism go hand in hand.

And I wanted to take a minute to tell you about this concept in neuroscience called brain neuroplasticity.

It has become a little better known, but it's really a brand new idea.

And that is, that it is possible for the brain to continue to rewire, to continue to set down new neurons and reshape itself throughout our entire lives, even into old age.

And as a group of teachers, this should very much resonate that we talk about lifelong learning.

Well, it happens at a cellular level.

The ability to shape our own minds through our activities is what the focus is in the T.H.R.I.V.E. Model.

These are high impact activities and habits that shape our minds and shape our bodies in a way that protects us against chronic disease developing or making it more difficult to cope with.

That is our thinking habits; physical health habits like physical activity and our nutrition; our relationship habits, the way and the quality with which we connect to others; our interests, and our ability to continue to challenge our mind with absorbing pastimes and challenges.

This one is a key in the T.H.R.I.V.E. Model.

It is matching our values, what we think is most meaningful with us, with the things we spend our time on.

And doing it in a way that allows us to actually accomplish them.

And our emotional habits.

How do we de-stress when the stress levels go high?

How do we use our awareness of our emotions to acknowledge them, and whether we're getting into actually mental illness to recognize that and to seek help appropriately.

These are all really key.

And then en francais.

[content repeated in French]

The science of well-being could be translated then into these actions.

And this is what I find very exciting and why I've been doing this for ten years.

And it's regardless of socioeconomic.

It is independent of cultural affiliation.

Obviously they need to be translated into opportunity and access and a sense of community, but actually often disenfranchised communities do this better in some ways.

They will connect with each other.

They will be generous in their social engagement.

They will have a lot of compassion for one another, show kindness.

But when people think about what makes people happy, it turns out to be a lot of things that is accessible to anyone.

Money does not buy happiness.

Opportunity actually often buys misery.

When you think about the things that actually show in science to improve people's wellbeing, it is time affluence.

Time affluence, which anyone moving into retirement is going to have, I hope.

It is the ability to be idle while also at other times than being engaged in interesting, absorbing activity that gives us mental flow without distraction and interruption nonstop.

It is thinking about others.

Showing compassion not only to others, but also to ourselves.

Having gratitude for whatever it is we have.

And when you think when I think about in the Mi'kmaq community, there's the teaching of the elders of basic principles which really have to do with virtues.

There's a lot of overlap in those teachings and what science is telling us promotes our wellbeing.

Good citizenship.

So, self-esteem, unfortunately, in our culture, we tend to overemphasize self-esteem at the expense of community, at the expense of what you would call self compassion.

So if we are too invested in what we "quote" accomplish and some social expectations of success, the minute we falter, we can be really hard on ourselves.

We can be highly critical and feel ashamed, and that leads us not to even share our hardest moments or admit them to even ourselves or to others.

So what helps us thrive is actually the ability to speak in a compassionate way to ourselves in our hardest moments.

I wanted to give you a couple of anecdotes that lets you know that physicians are also in need of this work.

And I'm working with colleagues in projects to bring this to the physician audience.

So here's an example of a colleague who has been using the T.H.R.I.V.E. approach, and he posted it on social media.

So Dr. Chris Frank set the goal to do a wheelie on his bicycle.

And he had been hoping to do this since he was six and he decided it was going to happen before he turned 60.

So he did manage and he says, Fountain of Health rocks.

I set this goal and it has improved my quality of life.

What did Dr. Frank do?

Here are the three steps.

Step one is that self reflection, which we talked about earlier.

Where am I now in these T.H.R.I.V.E. domains?

Second is to set a goal, and it's not just any goal.

It's a micro goal.

The third is to write it down and track the progress at least over a few weeks.

It sounds very basic, but to do it is a different matter.

What's so important about the tiny goal is that it sets us up for success.

And when we have success, what happens is called the cognitive ripple effect.

So this tiny little drop of water hits the water.

And what happens from there is the cognitive effect.

And that is, instead of feeling helpless, the thoughts change to ones of self efficacy.

I can do this.

That was fun.

I think I'll repeat it.

It over time becomes a new behavioural habit, and our identity shifts from being a couch potato let's say to somebody who is invested in their personal physical health.

And that is the magic of the tiny goal.

What's beautiful about it and exciting is that no goal is actually too small.

As long as it's moving in the right direction, towards improved self-care, improved health.

That something that you think you could enjoy and stick with over some time.

That's what makes the difference in long term health outcomes.

Just like an airplane, if it shifts the degree of its trajectory by one degree at take off, in a couple of minutes it won't have any impact.

But over a few hours, they could land in a very different city or even country.

Does this work?

I'm happy to say yes, it does.

We've tested this in over 2000 clinicians who are trained to use this approach with their patients.

And in over 1,500 subjects, we have had our outcomes that showed, I think it's on the next slide, that over 80% of people at least partially meet that goal within four weeks.

But better than that, they have improved health attitudes and increased self reported wellbeing.

And that's what we were hoping for.

So I invite you to learn more about the science of wellbeing and behaviour change through the Fountain of Health website, through the Optimal Aging four-week workshop, or through trying out the wellness app.

And, as I mentioned, we're trying to put together a better interface for the public on these tools and how to access them through the learning centre.

So stay tuned.

Yes and

I hope we can have further discussion about this.

About what does this mean for you personally?

What would purposeful retirement be for you at a personal level and at a broader sense, in your own families and communities?

How could you bring this knowledge to help you?

Muriel Howden:

Wow.

So first of all, a very big thank you to Isobel Mackenzie and Dr. Keri-Leigh Cassidy.

Incredible presentations.

So we're now entering the question and answer phase of our session.

I see that we have actually a lot of questions that have come in.

So this is great.

I will send them to Dr. Keri-Leigh Cassidy or Isobel Mackenzie.

And of course, if one of you wants to add, please don't hesitate.

[content repeated in French]

So I'm going to start with the first question.

I think this one actually came during your presentation, Isobel.

So I think this one would be probably for you.

I know you were talking about this.

What causes the percentage drop in the age group from 65 to 84?

Isobel Mackenzie:

Two things.

First of all, the denominator is much larger for the 65 to 84 group, so the proportion drops even though an absolute number may be larger.

And in order of magnitude, it's about 800,000 people in the 65 to 84, compared to about 120,000 in the 85 plus.

So that's part of it.

But I think the other part of it, and that was behind showing the age stratification over 65 is really to understand that for a good part of our life in retirement or as a senior defined as 65 and older, we're actually very healthy.

And that it's really when we start to get into our mid 80s that you're starting to see these issues.

And even then you're not seeing them as predominantly as the images or the preconceived notion would have us believe.

I think the very important message, and it's reinforced by what Dr. Cassidy was saying, is that when you look at where we are in our health from age 65 until we die, most of us for most of those years are pretty healthy.

And we need to think about that and the kinds of things we can engage in that can help us, as Dr. Cassidy has said, increase those number of years and push off the years of disability for want of a better term that we may experience in our final months or years of life.

So really, it's a reflection of the fact that most of us, when we're seniors are pretty healthy, just like most of us are living in our own homes.

Muriel Howden:

Thank you, Isobel.

And actually, the next question is for you, but maybe Dr. Keri-Leigh Cassidy will want to add to it.

I think it's really a continuation to what you just said.

The question for Mallory is, To what extent might these numbers reflect a lack of diagnosis for senior 85 plus due to the thinking that dementia and high complexity conditions are simply natural at that age?

On the high complexity, chronic conditions, it's not an under reporting if you've gone to a physician for that condition.

So these are based on diagnostic codes.

On the dementia front there's always this debate, right?

Every illness and disease is undiagnosed until it's diagnosed.

So every disease where we're giving prevalence is, by definition, under reporting, because there's people who have not yet been diagnosed.

I think the issue is by the time a person's activities of daily living have been impacted by a dementia, they are diagnosed.

So are there people out there with undiagnosed dementia?

Absolutely.

But it's at a stage in their life where the impact is mild enough that they haven't gone to their physician or gone to the emergency department or the hospital and had this formal diagnosis made.

This is a lot about stereotypes and ageism.

Seniors can be as guilty of it as everybody else.

And one of the stereotypes is that you're going to lose your mind.

And we really have to think about this because it links to capacity, and our ability to make decisions for ourselves, and the willingness of others, particularly governments, to step in and decide that they should be making the decisions for us.

And we saw that in spades during the pandemic, particularly around visit restrictions and long-term care.

So we need to be very, very careful.

The brain, like the body, slows as we age, but it doesn't seize, right?

The difference is, we can see the body still functions, albeit maybe a little slower at 85.

We don't see the mind as it's working, and it's slower, but it's going to get there.

And so we project onto older adults, particularly those as they get into their 80s, our need to step in when really, if we just give time and space, just like they'll get across the street, it might take they'll get to the conclusion that they need to get to, it just might take them 90 seconds instead of 60 seconds.

Muriel Howden:

It's such a good point.

It's really so much to change in the mindset as well.

Dr. Keri-Leigh Cassidy, did you have anything to add to this?

Dr. Cassidy:

Yeah, no, I would just echo some of what Isobel has said and just maybe elaborate a bit more is that ageism and stereotypes about aging is a very big issue for us in our culture.

And it can foreclose our own future through kind of a self-determined destiny.

So, in other words, there's research showing that our own outlook about aging has an impact on health outcomes.

Without getting too much into that science, it's one of those areas that I find really fascinating.

And I've reflected a lot about this in a bunch of ways.

One is that society, culture, medicine included, hasn't caught up with the greatest success story of modern medicine; that in the last 100 years our life expectancy has nearly doubled from 50 to 86 or more in a very short period of time of human history.

So, up until 100 years ago, 50 was an advanced age.

And now we have this whole other almost a whole other lifetime ahead of us at that midpoint that we haven't quite figured out what it means.

And medicine is very much at fault too, for pathologizing aging as a gradual deterioration of our faculties and our physical health to the point of death.

But that is not the human experience, by and large.

Often people are discovering all kinds of things about their potential.

And we see every day because of the sheer numbers of people who are much older in their 70s, in their 80s.

Look at the Queen of England or her husband, who are thriving well into a very, very late stage of life.

To know that this medical model is very limited.

And so I think it's really important that we help society and ourselves break that down and to be tapping into our human potential, which is why I'm so interested in positivism in medicine, because it's sorely lacking.

Muriel Howden:

Thank you very much.

Thank you.

So, Isobel, I'll send the next one to you.

Although again, I think Keri-Leigh may have to add, as well.

This question came in French.

So let me read it in French first, and then I'll read it in English.

So the question is

[Content in French]

So apart from long-term care residences, is the idea of senior living communities a good one?

Isobel Mackenzie:

For some people, it is.

I think the biggest takeaway is people will want to live differently in retirement just as they want to live differently before retirement, right?

Some people want to live in the country.

Some people want to live an urban life.

Some people want the lock it and leave it convenience of a condo.

Some people like to putter in a garden.

We don't fundamentally change who we are.

So, social engagement is absolutely important.

But what constitutes social engagement is different for different people.

Some people, you know, a daily interaction, for some, a weekly interaction.

For some, it's minute by minute interaction.

Different people will have different thresholds for what is required to keep them engaged.

So communities with many people will absolutely work for some people.

There will be others who will say not for me.

And I think it's our job to just respect that people's capacity to make a decision about where they want to live and who they want to live with stays with most of us for a very long time.

And we just need to respect what people choose.

Muriel Howden:

Keri-Leigh?

Dr. Cassidy:

Yes, some have referred to institutional living as like apartheid of Western culture.

But this assumption that older people only want to be with other older people, is clearly not true for everybody.

Now, of course, there's pragmatics involved that once somebody needs nursing care level of care on a day to day basis, there are just some pragmatics that make it necessary.

But clearly, as Isobel points out, what would be ideal is that people could shape their own future and have a wide variety of choices about what that might look like.

Muriel Howden:

Thank you.

I'll stay with you,

Keri-Leigh, for the next question from Mona.

And of course, Isobel, please feel free to add to it.

But the question is,

How do you meet the needs of the various ethnic communities?

Dr. Cassidy:

Yeah, I touched on that a bit here, and I think the limitations of the work that I'm involved with is that it isn't embedded within Health Canada or the Public Health agency or some other major effort to enter into as many communities as possible.

The method by which it would be ideal would be to start with dialogue about what's important in any given community.

What's their response, and then a co-creation of how best to translate the science and these approaches in that particular community.

But I touched on the fact that a lot of the basic principles about what makes for well-being is cross cutting and therefore would be really relevant.

And in many communities where there's less affluence or less opportunities, people will already have a lot of these aspects that promote well-being embedded in the fabric of the community.

But certainly there are going to be community-specific issues and challenges related to social determinants of health, access, opportunity, poverty and so on, that would have to be addressed.

Muriel Howden:

Right.

Thank you.

Thank you, very much.

So I'll send probably the next one to Isobel Mackenzie.

And then actually for the following question, I will call the chair of the board Rich Prophet and our CEO Jim Grieve, to help us with this one.

But I'm going to go to Phil's question.

I need to tell you, Phil is actually writing to us from England.

I just want to say we're welcoming our participants from all over the world and all continents, and we're delighted about this.

So, Isobel, here's the question.

So social isolation is a real threat to vulnerable seniors.

The heat dome in the summer 2021 resulted in hundreds of deaths of vulnerable seniors in Vancouver alone.

Is there some type of programming or registration possible to identify vulnerable seniors living without family or without community support?

Isobel Mackenzie:

The short answer is yes.

And I think that that is a piece of work we're doing here in British Columbia right now where we saw during a four day heat Dome, the consequences of I think it was about 800 deaths and 70 some percent of them were people over the age of 65.

We're finding that the biggest risk factor was living alone.

It may even be an exclusive risk factor.

In other words, every case was a person living alone.

We're still getting that data and then looking at other factors.

So living in an apartment, did that enhance?

But one of the things is living alone is a risk factor for a whole host of things.

So the heat Dome and heat exhaustion and not understanding what's happening until it's too late is but one example.

But falls, if you live alone and you fall, you can be unable to call for help and be undiscovered for several days.

Medication errors.

There's just a whole host of things that tell us living alone without any connection is the risk.

Right?

So it is around how do we get on a more daily basis, the kinds of connections that will provide that sense of security.

And. you know the persons in England where, of course, the best thing to come out

of England was the road to Scotland.

But other than that, it was over in the UK where about I think it was three or four years ago they had this Minister of loneliness established, right.

And it caused a great cacophony of media sound.

You sort of sit back and you go, wait a minute the government's going to tell us we all have to play with each other.

At the end of the day, government doesn't solve this.

We solve this.

This is about us as individuals, and it's about whether the person is 90 or 20 and it is about this shift we've made when you think about it.

All this automation that's made all these things easier have disconnected us from everybody.

We don't talk to the checkout girl at the grocery counter anymore because we scan our own groceries.

We don't talk to the bank teller anymore because we do our banking online.

The list goes on.

We don't go into the post office to get the stamp anymore because we don't mail anything, right.

And at every one of these benefits of more time, we've removed ourselves from interactions with people and that's I think those chickens have come home to roost and more so for older people who are more likely to live alone.

So at the age of 65, I can't remember it's something like 20% of people live alone.

But by the time you're 85, that more than doubles.

And as you keep going, it's going to increase.

Generally, it's the death of the spouse.

And at that point in life, those interactions that we had in our daily activities of life, we need those.

And we've got to think about unintended consequences of some of our modern approaches to things.

Muriel Howden:

That's right.

Thank you.

Thank you, Isobel.

So, Keri, I will send the next question to you.

I will start with you, but I will also call the chair of the board Rich Prophet and our CEO Jim Grieve, who may have to add to this.

So let's start with you, Dr. Cassidy.

At the simplest levels, how may everyone fight ageism?

Dr. Cassidy:

So the simplest is, of course, to start with things you have direct influence over at a personal level.

There's lots of other, more complicated things.

But if I try to be true to your question and Isobel referred to this, too, is there's a body of literature.

It's called the stereotype embodiment theory, but to say that in simple terms, it's basically ageism directed at ourselves.

So because of the negative cultural stereotypes of what it means to grow older in general, we'll think of somebody who's older as anybody who's at least 15 or rather than ourselves.

So if and when we start to see signs that represent this stereotype, a grey hair or a new health condition or trouble with vision or whatever it is and new problems that remind us about the stereotype, it can have a very negative effect on our self esteem and sort of negative self views about aging.

So Becca Leevy, out at Yale University, studied the effect of negative self views about aging and found that people who had a more positive outlook lived seven and a half years longer than those with a negative outlook.

This is twice as long as the benefit of not smoking or being physically active.

Loneliness similarly, has a very big impact.

So that's what Isobel was talking about.

That's why there was a Minister of loneliness established because the health impact was finally recognized.

So valuing ourselves, having compassion with ourselves for any changes that we might be experiencing and going through.

Is it a very important first step?

It makes us more likely to empathize with those who are further along in that process and also by empathizing with ourselves, we're better able to take actions rather than to feel helpless, depressed or disengaged.

Muriel Howden:

Thank you and Rich?

Rich Prophet:

Thanks, Muriel.

Following along with some of the concepts that Dr. Cassidy mentioned, loneliness and social isolation.

Very Interestingly, RTOERO foundation started on October the 6th, a program entitled Chime In.

And this is where any member can join from across Canada every Wednesday from one to two, and they discuss various topics.

I know I've been involved in three of the sessions and very simple concepts.

Last week we discussed what types of music people like.

I know I was in chat rooms with people from Kamloops, people from Algonquin, people from Toronto, people from Ottawa, various groups.

But every week people are involved in this, and they've indicated that they are lonely and that's why they're involved there.

They enjoy the opportunity to interact.

That's one thing.

Education, I think Allison said it's up to us to decide what has to be done.

And very Interestingly in one of the upcoming editions of Renaissance is a balanced life and what we have to address is as the two speakers said, it's not just the physical exercises that we have to address.

It's the mental components that we must address, because if you don't address the mental concept, then stress comes into play.

And the greater the stress, obviously, the greater the problems that are with respect to that.

As I said, education, I've noticed in Dr. Cassidy's list of groupings that it was one was the International Longevity Centre, and that is where RTOERO has become involved with the UN Convention for Older Adults.

That's what we're advocating very much so with respect to that.

And lastly, I just want to say the education we know we need a cultural change.

Unfortunately, in some cultures, the Indigenous culture, those who are aged are highly regarded, but in our culture.

Oh, well, Rich, you're doing not too bad for a guy that's 75 years old.

Well, that's a very negative concept.

And we have to change that idea.

And that is called education with respect to that.

Jim.

Jim Grieve:

Well, thank you very much.

And Dr.Cassidy and Isobel, you're doing a superb job in stimulating the conversation here.

But the issue here is fighting ageism.

That's the question.

How do you fight ageism?

Rich has given you some really terrific ideas about what RTOERO is trying to do with and for our members and seniors across Canada.

I'm a little hoarse today because I'm going to talk about personal commitments to fighting ageism.

And that is the 10,000 steps today, the nutrition that you've got to keep as much as you possibly can.

The engagement, the entertainment.

I'm a little hoarse today because I finally, after two years was able to get back and sing with my band last night, so I need to get my voice back in shape here.

It's family connections for two years during this pandemic, it's not good enough to see grandchildren and children by Zoom.

It's not enough.

In the last few months being able to have them here and in the backyard and share a meal.

So so important.

These are the things that keep me young and keep me really engaged.

I don't even think about the number of the birthday.

I think more about what can I do to sustain friendships and sustain that connection with family and look after my body as well as much as I possibly can.

I don't worry about these well deserved grey hairs because I earned them every one of them.

And ageism is just a place.

I think it's just that you were surrounded by ageist issues, but you only have to pay attention to them if you really must, because as we learned earlier in the week, we had

a lovely webinar from Candy Palmater, who was speaking about the experience of the Indigenous experience in Canada.

And she said, you've got to understand that you first have to love yourself and that you have to be available to the others.

You're a terrific person.

Look in the mirror every day.

And I think that whole mindfulness notion of being centered is so so important.

And our Renaissance magazine, which has won numerous awards, features issues on exercise and nutrition and mindfulness and all of those things that fight the issue that we're talking about here, which is ageism.

Muriel Howden:

Amazing.

Thank you so much.

Thank you.

Rich Prophet.

Thank you, Jim Grieve.

I'm going to move.

Time is going way too fast.

So I'm going to move to our last few questions because we are, believe it or not, down to probably 10-12 minutes.

The next question is for Doctor Cassidy, but I think the next couple ones I'm going to send to you, Isobel Mackenzie.

So the next one for you, Keri-Leigh, is are there any studies linking screen time exposure to world news and decline in wellbeing?

Dr. Cassidy:

That's a good question.

I'm not up on exactly that specific niche, but what I can say is that we do know that our thoughts have a big impact on our wellbeing.

And so anything that stimulates our thoughts towards worry and catastrophe will have a negative impact.

So it's important.

I know there's been general advice put out there that it's important to basically have a bit of a media diet, so choose very carefully like healthy nutrition, choose very carefully the sources of information, limit the time spent there.

Decide just how much of a portion you need to feel informed.

Try not to do that right before you go to sleep at night.

And anything that sets off your nervous system.

So it's very individual, I suppose in a way, anything that sets off the nervous system to the stress response that then leads to an interference with sleep at night will have a negative health effect.

And there's no doubt that we've been super saturated in a lot of very distressing news.

The realities of the situation has affected all of us.

And so the consumption of that media is a really important aspect to day to day wellbeing, and making very selective choices there.

Muriel Howden:

Very nice.

Thank you, Keri-Leigh .

Anything to add to this, Isobel, or I'm sending you possibly the last questions because the time is moving fast, and I know, Keri-Leigh, you'll have lots to say on this.

So here's for you Isobel to start the question from Garth.

It's a personal comments and question, but the truth is, it's obviously touching so many people.

I'm 86 years old and I have had a very happy and positive 30 year retirement.

My major issue is dealing with the loss of my wife of 62 years of wonderful marriage.

This type of loss will affect all couples.

I do not believe you can prepare for grieving and the resulting feeling of loss.

Do you have any advice?

Isobel Mackenzie:

Well, he's right.

There's nothing that can prepare you for it in reality and in reality it's going to happen.

Everybody out there who's married and living with their spouse, one spouse will previously see the other in all probability.

I do think it's harder when you're older.

I think that losing a spouse at a young age 45 or 50 is tragic, in another way, a life cut short.

But for the spouse that remains, they're active and engaged.

They're probably in the workforce.

They're focused.

When you're older what has happened to a greater extent is that your spouse has become your social network and that the loss of that can be profound for many.

I think recognizing it is important.

I think understanding the importance of a peer relationship who can most empathize somebody who has also experienced it and having those networks and finding a way to link into those networks, whether it be the loss of a spouse through death or whether the loss of a spouse through

Alzheimer's or dementia, that's another kind of loss that spouses can experience as well.

Talking to people who shared that experience is, we believe the most therapeutic for many.

Again, not all, but more than somebody who hasn't experienced it but has theories on it.

Muriel Howden:

Right.

Thank you, Isobel.

Before we welcome Jim Grieve again for final remarks, Dr. Keri-Leigh, did you want to add anything?

Dr. Cassidy:

My sincere condolences.

That kind of a loss at any age and stage is so very difficult and requires a great deal of strength to endure.

A lot of self compassion and really being able to speak to yourself the way you would your most loved person as you deal with that loss can help provide some soothing and solice and also just to flag that in the context of that kind of loss, people can start to develop signs and symptoms of depression, which is a clinical condition.

So if in that state, after a month or two, if there are those features, it would be being sad all the time, most of the time for two weeks in a row with loss of appetite and general loss of interest or self esteem, those are things that are worth seeking direct help around.

Jim Grieve:

It's such a pleasure to hear you both speak.

We view ourselves as RTOERO as kind of seniors advocates

extraordinaire across the country.

We certainly believe in that sort of fountain of health as well.

And in many cases where we're dealing with social isolation.

We've been proactive for years in this organization and having what we call in each of our districts a goodwill representative or several.

These are people who take the time to either call or visit the senior seniors among us among our membership just to check on them, but also to have that conversation.

I remember someone saying at one point this is a representative saying I went for my five minute visit to drop off of poinsettia in the holiday season and stayed 3 hours and more than anything, that social isolation, that connection with another person is so vital and so missing.

And the whole notion of can we find a way to bring that kind of inter age groupings together so that we have young children and older adults very close together because there's a fountain of youth, also from that wonderful source of the early years.

Honestly, Isobel, thank you so much for today.

And Dr. Keri-Leigh Cassidy amazing.

I mean, we could go another hour as Muriel said.

Sadly this is the end of our 2021 Vibrant Voices series.

We are gearing up for 2022, which comes around the corner in a couple of months.

I hope that you'll continue.

There's been over 350 people involved in this one today.

At least that's the number I saw and we've recorded this, so it's going to be posted on the website and that's on Vibrantvoices.ca it'll take a couple of weeks because we make sure that it's AOD compliant and that it is bilingual and available to you very shortly.

So we're working on our Webinar series for 2022.

We'll keep everyone informed about what's coming.

We're looking for your ideas, too.

Are there people you'd like to hear more from in this case or in addition to?

So stay tuned.

Thanks for joining us again today and again thank you to Isobel and to Keri-Leigh for just a phenomenal opportunity to engage our members.

Take care and enjoy the rest of your day.

Thank you.

Thank you so much.