Mental Health Commission of Canada

Commission de la santé mentale du Canada

Guidelines for Comprehensive Mental Health Services for Older Adults in Canada

PREPARED BY

Penny MacCourt, PhD, MSW, University of Victoria

Kimberley Wilson, PhD(c), MSW, Canadian Coalition for Seniors' Mental Health

Marie-France Tourigny-Rivard, MD, FRCPC, Chair, Seniors Advisory Committee Mental Health Commission of Canada

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THE *GUIDELINES* ARE INTERACTIVE WITH LINKS TO ADDITIONAL RESOURCES. FIND THEM AT WWW.MHCCSENIORSGUIDELINES.CA

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Sharon Moore PhD

Nona Moscovitz MSW

Penny MacCourt PhD

Kimberley Wilson MSW

PROJECT ADVISORY COMMITTEE

Ken Le Clair MD

David Conn MD

Roger Bland MD

Beth Floyd RN

Nona Moscovitz MSW

Barbara Neuwelt PhD

Sophie Sapergia MSW

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Foreword

Marie-France Tourigny-Rivard, MD, FRCPC, Chair, Seniors Advisory Committee MentalHealth Commission of Canada

Canada's population is currently undergoing a fundamental shift; during the next quarter century, the proportion of Canadians aged over 65 will nearly double as the entire baby boom generation turns 65 (with the first members of that generation born in 1946 turning 65 this year, in 2011). As a result, by 2036 nearly one out of every four Canadians will be a senior, outnumbering children for the first time in history (Statistics Canada, 2010). As in other parts of the world, this trend reflects, at least in part, advancements in health care that have allowed Canadians to live longer and healthier lives than ever before (Butler-Jones, 2010).

At the same time, this demographic shift will have and is already having a significant impact on Canada's health care system, and the mental health care system is arguably particularly vulnerable. In 2006, the Senate of the Parliament of Canada released the final report of its Standing Senate Committee on Social Affairs, Science and Technology's investigation into the state of mental health and mental illness in Canada, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Standing Senate Committee on Social Affairs, Science and Technology, 2006). The report uncovered a mental health care system characterized by fragmentation, lack of availability of necessary services, and widespread stigma experienced by those attempting to access services. Of the more than 2,000 submissions of personal stories from Canadians affected by mental illness, many were from seniors, their family members, and seniors mental health care providers. The report highlighted the effect of ageism in Canadian society, noting that seniors who experience a mental health problem or illness may face a "double whammy" of stigma: the stigma of being older in addition to the stigma of mental illness. Further, it was noted that older adults may experience particularly complex interactions between mental health problems (such as depression or anxiety), cognitive difficulties (such as dementia), and chronic physical illnesses that may be associated with aging, a complexity that is most effectively addressed by specialized geriatric service providers.

As one of the major recommendations of the *Out of the Shadows* report, the Mental Health Commission of Canada (MHCC) was created to support the development of a transformed mental health system for all Canadians across the lifespan. These *"Guidelines for a Comprehensive Mental Health Service System for Older Adults in Canada"* are intended to serve as a guide for seniors mental health service providers, planners, and advocacy groups--those on the forefront of working to address the challenges associated mental illness in later life in the face of a rapidly aging population. The MHCC's Seniors Advisory Committee, which has overseen the development of these *Guidelines*, includes representation from members of this target audience—service providers and members of advocacy organizations—from across Canada. They were inspired by the *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders* (Health and Welfare Canada, 1988), which has served as an important reference document during the

more than two decades since it was published. Further, the development of these *Guidelines* was informed by the experiences of seniors themselves, family caregivers, mental health service providers and planners from across the country who lent their voices in focus groups, and shared planning documents and other information about the services available within their respective jurisdictions.

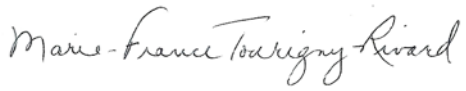
In these pages readers will find recommendations for a model for a comprehensive mental health service system for seniors, informed by current evidence and considered within the context of guiding values and principles important to Canadian seniors (e.g., respect and dignity, self determination, independence and choice for consumers), as well as the concepts of recovery, mental health promotion and mental illness prevention. The model incorporates the broad range and variety of services and approaches required to meet the diverse needs of seniors living with or at risk of developing a mental health problem or illness. Service benchmarks help to provide specific targets to be considered by planners as they look at existing resources, the size of the population to be served, and the contextual factors specific to their province or region (e.g., urban, rural and remote populations).

While it is hoped that planners and providers can utilize the recommendations and model as a reference point in order to identify and address gaps when reviewing and developing services, it is understood that meeting each benchmark or addressing every component of the model will not be possible, given resource constraints faced across jurisdictions. Rather, the recommendations and model are intended to provide guidance that can support incremental changes toward an increasingly accessible and comprehensive range of services and supports, building on existing strengths, partnerships and ongoing planning efforts. It is also hoped that the recommendations in these *Guidelines* will help to facilitate the development of strategies based on collaboration between all partners in care (including family caregivers), both between existing services and in the development of new ones.

I would invite you to view the *Guidelines* online at www.mhccseniorsguidelines.ca where it is available in an electronic version that allows readers to pursue added layers of information (i.e., links to additional literature or websites) that may be of particular interest to them. Further, it is intended that the *Guidelines* will be continually updated as new evidence becomes available.

Thank you for your interest in the *Guidelines for a Comprehensive Mental Health Service System for Older Adults in Canada.* We hope that they serve to support those working to address both the challenges and opportunities that will arise out of our aging population in the coming decades.

Marie-France Tourigny-Rivard, MD, FRCPC,



Chair, Seniors Advisory Committee, Mental Health Commission of Canada

Organization & Overview

The *Guidelines* are organized into four sections. The Introduction provides an overview of the purpose and preparation of the *Guidelines*.

Part I sets the context and explores the key factors that should be considered when planning a mental health service system for older adults. Of particular note are the guiding values and principles that underpin all of the recommendations and content of the *Guidelines*. Part I also includes recommendations about the determinants of mental health, mental health promotion and prevention and early identification of mental health problems.

Part II of the *Guidelines* focuses on the services required to support older adults in later life. This includes a model for mental health services in later life and descriptions of the functions of each resource. Additionally, Part II offers staffing benchmarks for specialized seniors' mental health services and a discussion on how to apply the benchmarks.

And finally, Part III discusses the mechanisms that facilitate a comprehensive mental health service system. This includes recommendations about education, cultural safety, diversity, support for caregivers and service providers, and service delivery models.

Introduction

PURPOSE

These *Guidelines* are intended to support planning, development and implementation of a mental health service system that can respond adequately to the needs of its senior population. They are meant to guide systems planners, government, policy makers, and program managers in planning, developing, and ensuring a comprehensive, integrated, principle-based and evidence-informed approach to meeting the mental health needs of seniors. A comprehensive and integrated mental health system is most likely to be responsive to the varied needs of older persons, be more efficient and reduce both duplication and gaps in services.

They are focused on service systems specific to adults aged 65 and older, recognizing that there will be exceptions to this age cut-off. For example, some individuals in their 50s or early 60s may benefit from a comprehensive geriatric assessment when they age prematurely due to complex, multiple and chronic health problems (as can occur with homelessness), developmental delay or early onset Alzheimer disease. However, specific, age-appropriate services also need to be developed for these younger adults, as their needs cannot be met adequately in the system of care currently available or planned for seniors. Although the *Guidelines* may inform service providers making innovations in their own practice or engaging in creating a better system of care, they are not intended to provide clinical guidance. Further, the recommendations made are congruent with Accreditation Canada Standards for Mental Health.

The comprehensive and integrated model proposed in these *Guidelines* is meant to serve both seniors living with a mental health problem or illness and those at risk of developing one. Further, for the purposes of this document, mental illnesses include Alzheimer's disease and age-related dementias, serious and persistent mental illnesses complicated by aging issues, and mental illnesses that occur for the first time in old age.

Additionally, these *Guidelines* support the development of the Mental Health Commission of Canada's Mental Health Strategy for Canada, and are meant to be consistent with its goals for achieving the best possible mental health and well-being for everyone, as outlined in its 2009 document *Towards Recovery and Wellbeing: A Framework for a Mental Health Strategy for Canada:*

- People of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being.
- Mental health is promoted and mental problems and illness are prevented wherever possible.
- The mental health system responds to the diverse needs of all people in Canada.
- The role of families in promoting well-being and providing care is recognized, and their needs are supported.
- People have equitable and timely access to appropriate and effective programs, treatments, services, and supports that are seamlessly integrated around their needs.
- Actions are informed by best evidence based on multiple sources of knowledge, outcomes are measured, and research is advanced.
- People living with mental health problems and illness are fully included as valued members of society.

The MHCC (2009) goals were developed through a broad consultation with Canadians who have lived experience of mental health problems and illnesses, their families and caregivers, service providers and planners.

DEVELOPMENT OF THE *GUIDELINES*

The development of the *Guidelines* was overseen by representatives from the Mental Health Commission's Seniors Advisory Committee, Science Advisory Committee and Mental Health Commission staff. Between June 2009 and January 2011 the project team engaged stakeholders (older adults with lived experience, caregivers, service providers, program planners, policy makers and educators) from across the country to build an understanding of the changes required to create a comprehensive, transformed mental health system that supports older adults and their caregivers on their journey towards recovery and well-being. In addition to the information gathered from stakeholders, a review of academic literature and government documents (international, national and provincial) was completed. Based on this evidence review, a model was developed to depict an integrated and comprehensive mental health service system for older adults. To ground this service system model in the broader mental health and health systems, supporting evidence was used to create recommendations for decision makers.

To develop the benchmarks, a summary of existing capacity benchmarks for various jurisdictions was produced (based on benchmarks for seniors' mental health services described in Canadian and international planning documents), and reviewed for relevance by key stakeholders across Canada. More information about the methodology used to develop these *Guidelines* and the benchmarks can be found in the online version.

BACKGROUND

The Canadian population is aging as a direct result of the aging of the baby boom generation, and is influenced by increased life expectancy and decreased fertility (Carstairs & Keon, 2009). With the growth of the aging population comes an increasing number of seniors who are at risk for experiencing mental health problems. If left unaddressed, the aging of the population will have far-reaching social, economic and political impacts. These *Guidelines* present an opportunity to address concerns with the current health and mental health system from the perspective of older adults and provides recommendations for moving toward a transformed mental health system that supports older adults in their journey towards recovery and well-being.

MENTAL ILLNESS IN LATER LIFE

As outlined in *Towards Recovery and Wellbeing: A Framework for a Mental Health Strategy for Canada* (Mental Health Commission of Canada, 2009), mental illness does not discriminate; no one across the age span is immune to its effects. It should be noted, however, that there are some unique factors that may contribute to variations of prevalence numbers for those later in life. There are distinct populations living with mental illnesses in later life:

i) those growing older with a recurrent, persistent or chronic mental illness;

ii) those experiencing late onset mental illnesses;

iii) those living with behavioural and psychological symptoms associated with Alzheimer's disease and related dementias; and

iv) those living with chronic medical problems with known correlations with mental illness (for example, Parkinson disease, cerebral vascular disease, chronic obstructive lung disease).

Estimates suggest that, in any given year, about one in every five people living in Canada will experience diagnosable mental health problems or illnesses. These can occur at any time of life, affecting infants, children and youth, adults, and seniors. No one is immune–no matter where they live, what their age, or what they do in life. This means that just about every family in the country will be directly affected, to some degree, by mental illness.

Mental Health Commission of Canada, 2009, p.10

Many older adults live with multiple chronic health conditions (Rotermann, 2005) and therefore medical co-morbidities are more likely in this age group. Many of the common chronic illnesses in later life have known correlations with mental illness. For example, major depression occurs in about 40% of patients who have experienced an acute stroke (Robinson & Spalletta, 2010). Co-morbidities make accurate diagnosis of mental illnesses much more challenging: untangling symptoms of physical illnesses from somatic presentations of mental illnesses such as depression can be difficult and, without proper training and attention, treatable illnesses can, and do, go unnoticed by healthcare providers. In addition, family members or friends who act as caregivers for older adults living with depression or cognitive impairments have been shown to have high rates of distress (Canadian Institute for Health Information [CIHI], 2010a).

PREVALENCE OF MENTAL ILLNESSES IN SENIORS

The most common mental illnesses after age 65 are mood and anxiety disorders, cognitive and mental disorders due to a medical condition (including dementia and delirium), substance misuse (including prescription drugs and alcohol) and psychotic disorders. Family physician data suggest that an increasing number of seniors consult for mental health problems over the course of one year and, proportionally, there is a higher percentage of elderly who consult compared to the younger adult population or children. Although considered common in older adults, none of the following illnesses should be viewed as typical or inevitable consequences of growing older.

As an illness, depression (or clinical depression) usually includes persistent feelings of sadness, hopelessness and/or a loss of interest or pleasure in previously enjoyable activities. It also includes cognitive and physical changes such as trouble with concentration leading to memory problems, disturbed sleep, decreased energy or excessive tiredness, and decreased appetite. These changes are present for at least two weeks (Canadian Coalition for Seniors' Mental Health [CCSMH], 2006a) and are not just due to a "passing mood" or a normal reaction to a sad event. Depression is the most common mental health problem for older adults (CCSMH, 2006a), and substantial depressive symptoms affect an estimated 15% of those living in the community (CCSMH, 2006a). Rates of depression are higher in long term care homes (also called nursing homes) with up to 44% of residents having an established diagnosis of depression or significant (3 or more) depressive symptoms (CIHI, 2010b).

Bipolar disorder, a specific form of mood disorder, is characterized by both manic (hypo-manic) and depressive episodes. While bipolar disorder likely affects less than 1% of older adults, most will have severe recurrent depressive episodes in later life and often require specialized care (CCSMH, 2006a). Bipolar illness most commonly starts earlier in life although there is a subgroup who are diagnosed for the first time after age 65 when the cyclical nature of their depressive illness is more obvious or clear hypo-manic or manic episodes occur.

The most tragic complication of mood disorders is death by suicide. Although research shows that older men have the highest suicide rate in Canada (Mood Disorders Society of Canada [MDSC], 2009), it is widely believed that published suicide rates still underestimate the total number of deaths by suicide for older men and women, due, in part, to the stigma of suicide (CCSMH, 2006b). Currently, men aged 80 and older are the group with the highest suicide rates in Canada (MDSC, 2009).

Anxiety disorders tend to persist in later life and new anxiety symptoms are often part of later onset mood and cognitive disorders. The prevalence of anxiety in community samples ranges from 1.2% to 15% (Bryant, Jackson, & Ames, 2008). Although less researched in the elderly population when compared to depression and dementia, recent research on anxiety in later life is revealing more about its prevalence in older adults, affecting at least 5-10 % of those over age 65 (Bryant et al., 2008). While there are many types of anxiety disorders (obsessive compulsive disorder, panic disorder, post-traumatic stress disorder), generalized anxiety disorder (GAD) remains the most common anxiety disorder (Bryant et. al, 2008). Although poorly defined, age-specific anxiety about falling (also known as post fall syndrome) is a unique and common type of anxiety typical in later life, with estimates of prevalence in community settings as high as 29-54% (Arfken et al., 1994, Tinetti et al, 1994, as cited in Bryant et al., 2008). People aged 65 and older are the group with the highest rate of hospitalizations for anxiety disorders (MDSC, 2009). A significant proportion of seniors with anxiety disorders have been treated with benzodiazepines (tranquilizers) over long periods of time and, as they age, are at increasing risk for cognitive and physical complications (such as memory loss, poor balance, accidents and falls) from these medications. Mental health services often need to assist in the transition to less harmful treatment options for those who have severe and persistent anxiety disorders.

Dementia is a progressive degenerative illness of the brain that includes a number of symptoms, such as loss of memory, impaired judgment and loss of reasoning abilities, as well as changes in mood and behaviour. While there are many types of dementia, including vascular dementia, Lewy Body dementia and frontal-temporal dementia (FTD), Alzheimer's disease is the most common form of dementia, and accounts for 64% of all dementias in Canada (Alzheimer Society of Canada, 2010). The risk for dementia increases with age with rates of 7% at age 60, reaching 20% by age 80 and, at age 85, 33% for men and 46% for women (Alzheimer Society of Canada, 2010). There is an anticipated surge in the numbers of Canadians affected by dementia, particularly when the baby boomers generation ages beyond 75. The Alzheimer Society of Canada (2010) estimates that, "by 2038 the number of Canadians with dementia will increase to 2.3 times the 2008 level to 1.1 million people" (p.17). In the early phases of this illness, the focus tends to be on establishing a proper diagnosis, a process that most often requires the collaboration of neurology, geriatric medicine and mental health services to untangle complex presentations. However, it is the behavioural and psychological symptoms of dementia (BPSD) that are most challenging for the person and for the caregivers, affecting up to 90% of persons with dementia over the course of their illness. Mental health services need to be available particularly to assist in the management of BPSD, which include psychosis, depression, aggression, agitation, and disinhibition (Brodaty, Draper, & Low, 2003). An equally important role for mental health services is differentiating between mild cognitive impairment and early dementia, and between dementia and depression.

Dementia is often complicated by delirium, an acute confusional state, affecting perceptions, attention, orientation, emotions and level of consciousness. People with delirium are disoriented, with an altered level of consciousness and have trouble understanding their environment

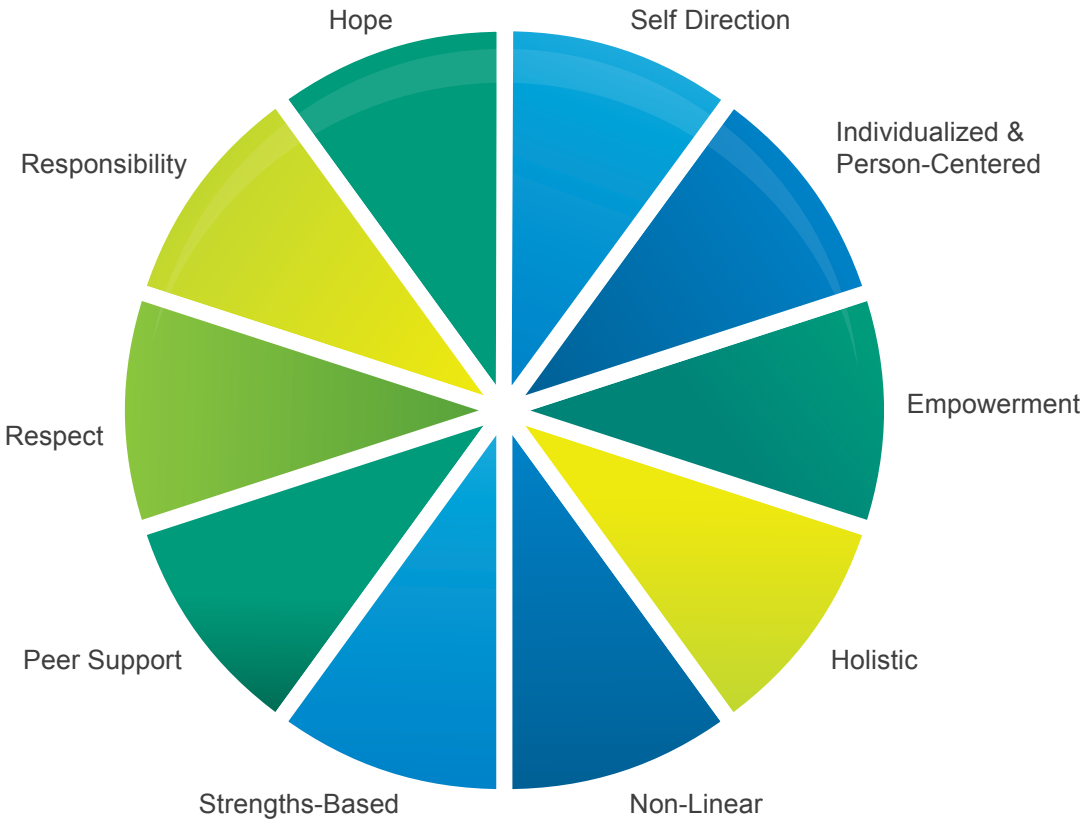
(CCSMH, 2009a). They are often agitated and may experience hallucinations. Unlike depression and dementia, which have gradual onsets, delirium develops very quickly over a period of hours or days. Delirium is often reversible and is typically precipitated by or due to a physical illness or medication (Conn, 2002). Nearly half of seniors admitted to acute care hospitals experience an episode of delirium (CCSMH, 2009a). Whenever delirium occurs, medical services are urgently required to address this life-threatening disorder. Additionally, mental health professionals may be called upon to assist in the management of the agitation and behavioural symptoms associated with delirium.

Substance misuse (most commonly alcohol but also illicit drugs) and complications from the use of medications (prescribed or over-the-counter) are common in later life. Six to ten percent of older adults have problems with alcohol (Seeking Solutions, 2004 as cited in CAMH Healthy Aging Project, 2006). However, given physical changes associated with aging, older adults are much more vulnerable to the negative effects of alcohol on cognition, emotions and physical health in general. Substance misuse often results in acute and longer term cognitive impairment, depression or anxiety, and contributes significantly to falls, accidents and fractures. Mental health services can help develop useful strategies for intervention, in collaboration with addictions, primary care and acute care colleagues and provide opportunities for recovery to those who present with complications from substance misuse.

Older adults also live and age with persistent psychotic disorders, including schizophrenia and delusional disorders. There is also a small percentage of seniors who will experience psychotic disorders for the first time in later life. It is estimated that 40-60% of people with schizophrenia also have alcohol or drug use disorders during their lifetime; nicotine addiction is estimated to be at 90% (Schizophrenia Society of Canada, n.d.). While the overall prevalence of persistent psychotic disorders may appear low (1-2 %), persons affected by these disorders tend to require significant support from and access to mental health services.

Although some of the above illnesses are expected to progress (e.g. dementia), re-occur or continue over time (e.g. mood and anxiety disorders), there are successful treatment options and strategies to promote recovery and wellbeing for all these disorders, despite the fact that for some disorders (such as Alzheimer's disease) there are currently no cures available. Additionally, primary, secondary, and tertiary prevention strategies can be employed to reduce occurrence and severity of symptoms as well as medical complications. A recent CIHI report (2010b) suggests that residents of long term or residential care homes who are diagnosed and treated for depression have better health outcomes than those who are not. Outcome evaluation of geriatric mental health outreach services to LTC homes are also beginning to demonstrate the cost-effectiveness of these services and their potential to reduce hospital admissions (Wiens, Ward & Tourigny-Rivard, 2009).

THE COMPONENTS OF RECOVERY



"Consensus statement on mental health recovery," from Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, US Department of Health and Human Services www.samhsa.org

USING THE RECOVERY PHILOSOPHY IN SENIORS' MENTAL HEALTH

A transformed mental health system will be guided by the philosophy of recovery. At times the seniors' care community has been uncomfortable with the terminology associated with the recovery philosophy. It is vital to ensure that there is an understanding that although the word recovery is often associated with 'cure', the philosophy of recovery and well-being focuses instead on the journey of health and transformation that enables a person living with a mental health problem to live a meaningful life in their community while striving to achieve his/her full potential (US Department of Health and Human Resources, 2006). Although the concept of recovery has been challenged in the dementia community, given the degenerative and progressive nature of dementia, which can at times limit participation, recent literature underscores the symmetry between the recovery philosophy and person-centred philosophies, which are central to dementia care (Hill, Roberts, Wildgoose, & Hahn, 2010). Again, it should be underscored that the concept of recovery is rooted in the importance of choice, hope, respect, empowerment and individualized and person-centred care (Department of Health and Human Resources, 2006) philosophies that are consistent with ideal dementia care. These principles also inform the rest of this Guideline document and have informed the recommendations for a transformed comprehensive service system.

The treatment of mental illness across the life span must take place in the context of a recovery-oriented system. Positive treatment outcomes are achieved for the majority of seniors with mental illnesses, including reduction or elimination of symptoms and improved quality of life, even when dealing with progressive degenerative diseases such as dementia. There is evidence that models emphasizing recovery and well-being are effective among older adults with mental health problems (Age Concern, 2003).

In addition to the adoption of the recovery philosophy, a transformed mental health system includes initiatives focused on mental health promotion and prevention and attends to the determinants of mental health. For those older adults who require mental health services and support, the transformed system will be responsive and adaptive to diverse needs of older adults and will support caregivers as they support their care recipients. The remainder of this document synthesizes evidence from the literature, practice based experience, and lived experience and offers recommendations for a transformed mental health system that responds to both older adults and those who care for them.

Summary of Recommendations

Detailed recommendations and supporting evidence are provided throughout the *Guidelines*. Below is a high-level summary of the overarching key recommendations.

1. Those planning a comprehensive integrated mental health system must understand the diversity amongst seniors, must understand the local context and resources, and must consider the need to modify existing practices and relationships to achieve a transformed system.
2. Policies, programs and services that affect seniors should be assessed with the Seniors Mental Health Policy Lens (MacCourt, 2008) to ensure that they reflect the guiding principles and values outlined in these *Guidelines*. (The Seniors Mental Health Policy Lens, informed by evidence, is an analytical framework for determining the degree to which planned and current policies promote and support the mental health of seniors).
3. Mental health promotion should be embedded in all policies, programs, and services for all older adults (including those with mental illness) and their caregivers, and encompass anti stigma strategies, public awareness, education, and training.
4. Older adults, caregivers, service providers and the public should be informed about the importance of early identification of symptoms of mental illness, prevention strategies and the hope for recovery and well-being.
5. A transformed mental health system is recovery oriented, supports caregivers and provides information to the public and service providers about the journey towards recovery (hope, choice, empowerment) and well-being for older adults living with mental illnesses.

6. The specific components of an integrated mental health service system for older adults may vary according to local context and resources, but all service systems should provide access to the following range of services for the entire senior population: community-based support services, primary care services, general mental health services and specialized seniors mental health services (including specialized community and outreach services to residential care facilities as well as specialized geriatric psychiatry inpatient services). Most importantly, there should be clear mechanisms in place to facilitate collaboration and access between services in order to achieve a comprehensive, efficient system that is integrated and more responsive to the needs of older persons, and focuses on recovery, well-being, and choice for older adults and their caregivers.
7. Benchmarks should be used to review existing services and staffing levels and guide future allocation and deployment of resources, taking into account the size of the population, existing gaps in services and bottlenecks, as well as the priorities of the community.
8. To facilitate a comprehensive mental health service system, cultural safety and diversity must be embedded in structures, programs, policies and services.
9. Caregivers must be considered active partners in the journey towards recovery and well-being, and their roles must be supported and valued in programs, policies and services.
10. Transformation of a mental health service system must include training, education and support for caregivers and health care providers to increase their capacity to respond to the mental health needs of seniors.

PART I: Framing the Context

Key Factors to Consider in Planning a Comprehensive Integrated Mental Health System

These *Guidelines* provide guidance for the development of a comprehensive integrated mental health system and involves all sectors of society: mental health is everybody's business (MHCC, 2009). It is intended to provide the ideal model for meeting the mental health needs of all seniors including those with or at risk of mental illness, and its implementation requires cross-sectoral and multi-sectoral partnerships/collaborations that go beyond/outside the health/mental health care/service system.

Application of the principles and recommendations outlined in the *Guidelines* will be best utilized if local 'experts' use their provincial or regional lens, taking into account the diversity of the seniors' population, and local conditions, capacity and priorities.

» Ensure that planners appreciate the diversity of the seniors they are planning for and are inclusive of marginalized groups, and that communication, accessibility, program design and service delivery are informed by the specific characteristics, strengths and needs of the diverse populations to be served.

The seniors' population is diverse and their needs reflect this diversity. Vulnerability to mental health problems and illnesses vary. Risk factors accumulate throughout life and intersect, resulting in some groups of seniors being at higher risk of mental health problems and illness than others. Diversity amongst seniors must be recognized and considered in communications, accessibility, program design, and service delivery. A comprehensive mental health system that addresses diversity is built upon knowledge and understanding of the specific characteristics of the seniors populations to be served (e.g., culture; literacy; income levels; language; mobility, visual and hearing challenges).

» Ensure that community location and characteristics, existing resources and capacity, local priorities, and how seniors' services are organized are taken into account when planning.

Different provinces (and regions within them) have varying priorities; human resources and services to address seniors' needs and how services are organized differ across the country. These variations, along with overall community capacity and other local conditions will determine what needs to be done, and how, to develop the comprehensive mental health system proposed in these *Guidelines*.

» Address the need for modification of usual practices and relationships to achieve an accessible, integrated, seamless and comprehensive mental health system relevant to local conditions that provides core functions and services.

Working towards ensuring that all components of a comprehensive mental health system are in place may need to be incremental. A comprehensive service system may require creative modification of existing delivery mechanisms, clinical practice or administrative structures. In addition to collaboration and partnerships, new roles and systems may need to be created to ensure core functions and services are provided and to facilitate the coordination necessary to achieve an accessible, seamless and integrated system. If planning is guided by the principles and evidence provided here, the recommendations could be adapted to local situations without loss of their integrity while moving forward.

GUIDING VALUES AND PRINCIPLES

A comprehensive mental health system is underpinned and driven by values and principles shared by Canadians. The following values and principles are intended to guide the development of policies, programs and services that promote and support older adults' mental health as well as programs and services for persons with mental health problems and illnesses. Each of the principles and values can be translated into concrete action.

The Individual Level Principles and Values are grounded in the lived experience of diverse seniors across Canada and in principles and values identified in the National Framework on Aging (Health Canada, Division of Aging and Seniors, 1998). These have been translated into a set of values and principles that inform the Seniors Mental Health Policy Lens (MacCourt, 2008) and were validated by seniors who contributed to the development of the *Guidelines*. The System Level Principles and Values are evidence informed, derived from a review of literature, and from consultations with seniors, their families, service providers, educators, program managers, planners and policy makers across the country. The Individual Level Principles and Values and the System Level Principles and Values must be considered together as they are interrelated in promoting the mental health and well-being of seniors.

INDIVIDUAL LEVEL PRINCIPLES & VALUES

Respect and Dignity

Seniors value being treated with respect, regardless of the situation, and having a sense of self-esteem (e.g., having a sense of self-worth; being accepted as one is, regardless of age, health status, and so on); being appreciated for life accomplishments; being respected for continuing role and contributions to family, friends, community and society; being treated as a worthy human being and a full member of society.

Self Determination, Independence & Choice

Seniors value being in control of their own lives, being able to do as much for themselves as possible and making their own choices (e.g., decisions on daily matters; being responsible, to the extent possible and practical, for things that affect them; having freedom to make decisions about how they will live their lives; having the right to live with risk). Interdependence (enjoying access to a support system) is also important to enable freedom of choice and self-determination. Facilitating an environment in which seniors are provided with the required information, options and supports to make real choices, in keeping with their capacities, can enhance independence and self-determination.

Participation, Relationship and Social Inclusion

Getting involved, staying active and taking part in the community, being consulted and having one's views considered. Being active in all facets of life (socially, economically, politically); having a meaningful role in daily affairs; enjoying what life has to offer; engaging in relationships; participating in available programs and services; and being involved and engaged in activities of daily living (decisions/initiatives in all spheres, not just those specifically oriented to seniors). Social participation and relationships with others are facilitated.

Fairness and Equity

Having seniors' real needs, in all their diversity, considered equally to those of other Canadians e.g., having equitable access (socially, economically, politically) to available resources and services; not being discriminated against on the basis of age; and being treated and dealt with in a way that maximizes inclusion of seniors.

Security

Seniors value financial, physical and psychological security. Having adequate income as one ages and having access to a safe and supportive living environment (e.g., financial security to meet daily needs; physical security (including safe living conditions, sense of protection from crime, etc.); access to family and friends. Knowing that help is available when needed and being able to plan for the future are important to seniors' sense of security.

SYSTEM LEVEL PRINCIPLES & VALUES

Accessible

Seniors have equitable and timely access to appropriate and effective programs, services, treatments and supports. Accessibility is also about removing any social, educational, cultural, economic or physical barriers to programs so that seniors are aware of them and can choose to use them. Information, communication and adaptations appropriate to the seniors likely to be affected by the policy or program will enable seniors to make the most of their abilities and facilitate access.

Person and Relationship Centred

Individualized and person-centred care is embedded in an understanding of the social and economic context in which the older adult lives. Respect for individuals' values and promotion of dignity are fundamental. Policies, programs and services facilitate person and relationship- centred care in all settings through appropriate physical design, and the availability of adequate numbers of trained staff.

Wellness and Recovery Focused

Seniors living with mental health problems and illnesses are empowered and supported in their journey of recovery and wellbeing. In particular, this includes giving purpose to life and enhancing quality of life, fostering hope and strengthening resilience. Policies, programs and services adopt and reflect a recovery orientation that is embedded in the functions required to support people living with mental illness and to prevent illnesses and promote good mental health for all seniors.

Support for Family/Caregivers

Policy, programs and services recognize the role of families and friends in promoting well-being and providing care, and their needs are supported through practical and emotional support and education. Those who are caregivers are recognized as partners in care and valued for their knowledge and experience. See Part III for information/evidence about the need to support caregivers, program examples and recommendations.

Education and Support for Service Providers

Service providers (current and future) are educated about the unique needs of older adults with or at risk of mental illness, and supported in carrying out their roles through access to clinical and ethical consultations, adequate supervision and mentoring, a healthy work environment and availability of sufficient resources (human and otherwise). See Part III for information/evidence about the need to support service providers, program examples and recommendations.

Diversity and Cultural Safety

Consideration of diversity and cultural safety are embedded in programs and practices which are promoted, designed and resourced to ensure inclusiveness. See Part III for information/evidence about diverse seniors' populations, cultural safety and recommendations.

Comprehensive

A comprehensive service system, makes use of a variety of professionals, resources and support personnel, and develops inter-sectoral partnerships, in order to promote and support the mental health of all seniors and to provide a comprehensive range of services in and across settings to prevent and to treat mental health problems and illnesses. See Part II for a description of the range of services required for a comprehensive system.

Integrated Flexible and Seamless

Programs, services, treatment and supports are seamlessly integrated with appropriate information sharing around the needs of seniors and their families/caregivers. The unique needs and strengths of diverse groups are taken into consideration. Coordination of policy and of programs ensures that "every door is the right door" (i.e. that every part of the system can lead anyone to the appropriate service) and that the right service is offered in the right place at the right time. Formal mechanisms to ensure collaboration and effective communication and consultation across sectors and settings are in place.

Mental Health Promotion

Mental health promotion is a process of facilitating the capacity of individuals and communities to take control over their lives and improve their mental health[1]. It seeks to increase self-esteem, coping skills and capacities, and family and community supports, as well as to modify the broader social and economic environments that influence mental health (WHO, 2002a). Mental health promotion strategies are integrated into all components of a comprehensive mental health system for seniors, including into the service system/treatment components.

Evidence Informed

Actions are informed by the best evidence based on multiple sources of knowledge (including experiential), outcomes are measured, and research is advanced. Evidence includes incorporating the lived personal experience of older adults and caregivers, practice based experience and evidence from clinical and population based health research.

1 Mental health is not simply the absence of mental illness. Mental health is distinct from mental illness and each is on a separate continuum. The mental illness continuum has severe illness on one end and no illness on the other, while the mental health continuum, has "flourishing" at one end and "languishing" at the other (Keyes, 2007). Mental health can be promoted and supported (or neglected and undermined) wherever the individual is situated on these continua. A person with a mental illness can have better (flourishing) or worse (languishing) mental health as can a person without a mental illness.

- Ensure that policies, programs and services affecting seniors reflect the core values shared by Canadian seniors and the system values that will support their mental health by applying the Seniors Mental Health Policy Lens (which incorporates these values and principles) to them.
- Ensure that all seniors' and mental health services are designed, delivered, and resourced to support a recovery orientation.

DETERMINANTS OF MENTAL HEALTH IN LATER LIFE

Acknowledgment of the impact of the determinants of mental health through the life course underpins the recommendations made in the *Guidelines*. Although mental health is an individual resource, mental health, mental health problems and mental illness result from, and are affected by a complex interplay of individual characteristics, and cultural, social, economic and family circumstances at both the macro (society) and micro (community and family) levels (Centre for Addiction and Mental Health [CAMH], 2010). The determinants of mental health include social and environmental factors like income, social status, education, physical health, employment, housing, transportation and working conditions, access to appropriate health services, and in the community, building design and the level of social and civic participation . Although responsibility for these issues lies largely outside the mental health and broader health care system, awareness of their impact and collaboration with others to address them does not.

Determinants of mental health are intertwined, affect each other and are cumulative. For example:

- Poverty limits older people's opportunities to join in social activities, follow a healthy diet, to have adequate housing, to meet uninsured health care costs and maintain self-esteem. This may result in poor physical health that then impacts on people's mental and physical health, and their ability to maintain relationships and participate in meaningful activity.
- Physical environments that are physically, economically or psychologically inaccessible interfere with older adults' ability to engage in civic and social activities. This may result in exclusion from the workforce that affects standard of living, security, health and leisure as well as self esteem, social networks and sense of purpose, together impacting on mental health. Age discrimination limits opportunities to participate in activities that would improve physical health, extend social contacts or improve income through employment. Further, the stigma of mental illness compounds age discrimination for seniors with a mental disorder.
- Social isolation, with concomitant risk to mental health, can result when the physical or social environments do not accommodate the challenges of aging or when they devalue seniors. Individual factors that contribute to social exclusion may include low income, low literacy (including health literacy), inadequate English or French skills, and availability of a social support network. Health and physical functioning have also been identified as factors that can support or undermine seniors' ability to access the resources in the social and physical environment.
- Transportation has an impact on the social participation, security, independence and overall health and well-being of older adults (WHO, 2002b) and is key to their (ability to) access their community and its health, social, recreational and civic resources. Housing location, including perceived safety and proximity to family, services and transportation, is a significant determinant of social interaction, which is key to quality of life among seniors (WHO, 2002b; Migita, Yanagi, & Tomura, 2005).
- Addressing the determinants of mental health is not the responsibility of any single sector, and new approaches to policy and program development need to be considered to reflect this reality. Linkages and partnerships with current initiatives across Canada outside the mental health service system, (e.g., Age Friendly Communities, Social Inclusion, Mental Health Promotion, Healthy Aging/Active Aging; Healthy Communities; Healthy Brain Strategies), can be developed, adding value to them while leveraging support for older adults with or at risk of mental health problems.

» Ensure that collaborations and partnerships are in place with seniors, their caregivers and families, all levels of government, health and other ministries and government organizations (e.g., housing, recreation, and transportation), non-government, voluntary and service organizations, as well as the private sector, to address the determinants of mental health.

LIFE COURSE AND DETERMINANTS OF HEALTH

Ill health can be conceptualized as both the consequence and cause of inequalities and exclusion with cumulative impacts over the life course (WHO, 2009). Life course research highlights "the importance of critical points of transition – pre-school, going to school, the move to high school, starting work, redundancy, retirement and bereavement – that influence and are influenced by emotional, cognitive and social development" (WHO, 2009, p. 25). Clear pathways have been identified through which "inequalities from conception, early childhood and through adolescence contribute to poor health in adulthood" (Graham & Power 2004, as cited in WHO, 2009, p.25). A British study found that older adults were about three times more likely to have mental health problems if they had ever experienced a financial crisis than if they had not (29% compared with 9%), and about twice as likely to have mental health problems if they had ever experienced serious illness, injury or assault to themselves (14% compared with 7%), or if they had ever experienced separation or divorce (18% compared with 9%), than if they had not (Mentality, 2004).

» Collaborate with all levels of government, health, and non-health ministries/ government organizations to ensure policies and programs that target earlier life stages recognize the impact of the determinants of mental health in late life.

MENTAL HEALTH PROMOTION

Older adults are a valuable resource to their families and communities with 69% of seniors providing some form assistance to family friends or neighbors; over half of seniors volunteer (British Columbia Ministry of Health, 2005), and in 2001 over 300,000 Canadians 65 or older were in the labour force (Federal, Provincial Territorial Committee of Officials [Seniors], 2006).

Social and civic participation promotes life satisfaction and well-being among older people (Hao, 2008) and supports the development of personal skills. Social participation has been positively associated with better physical and mental health in older adults (Kaskie, Imhof, Cavanaugh, & Culp, 2008). Social and civic engagement has been shown to enhance social support networks, increase ones social status, and reinforce personal knowledge and skills (Hinterlong & Williamson, 2006). Additionally, engaging in social activities and intellectual activities are recommended strategies to promote overall brain health (Alzheimer Society of Canada, 2010).

Through their social and civic participation older adults contribute to the creation of supportive environments and the strengthening of community action, two mental health promotion strategies. Civic engagement is a vital element in the maintenance of healthy, livable communities. Communities with high levels of social capital, indicated by norms of trust, reciprocity, and participation, have advantages for the mental health of individuals, and these characteristics have also been seen as indicators of the mental health or wellbeing of a community (WHO, 2009).

Mental Health promotion aims, through multi-level and multi-sectoral interventions, to reduce the risk factors for poor mental health and to enhance the protective factors (WHO, 2004). Protective factors for positive mental health are those that help to reduce the chances of developing mental health problems and illnesses, aid in maintaining good mental health and assist in developing resilience in the face of adversity (World Health Organization, 2009). Risk factors for poor mental health across the life course are myriad, including a family history of psychiatric disorder, violence, childhood neglect, family breakdown, and unemployment (Mentality, 2004).

Mental health promotion focuses on supporting people's capacity to realize their fullest potential and to cope with major life events (WHO 2004a), allowing them to both draw from, and contribute to, their communities.

> Mental health promotion works through concrete community action in setting priorities, making decisions, planning strategies and implementing them to achieve better mental health. At the heart of this process is the empowerment of communities, and their ownership and control of their own endeavours and destinies,
>
> (Pape & Gallpeault, 2002, p. 19).

» Create partnerships to develop strategies to reduce risk factors and enhance protective factors for positive mental health for all seniors.

Mental health promotion is an avenue for addressing the determinants of mental health and is applicable to all seniors including those living with, or at risk of, mental illness. The World Health Organization (2009) contends that mental health promotion strategies can protect people from mental illness, decrease the incidence of mental illness, improve the mental health of seniors living with mental illness, and challenge the stigma and discrimination associated with mental illness. Mental health promotion aims to reinforce individual, social, environmental and structural factors that protect positive mental health[2], and to address those that increase the risk for poor mental health. Addressing ageism and stigma should be incorporated into these mental health promotion strategies as recent research from Yale University found that those older adults who had internalized negative age stereotypes were more likely to experience a cardiac event than those with positive age stereotypes, suggesting that age stereotypes internalized earlier in life can have a far-reaching effect on health (Levy, Zonderman, Slade, & Ferrucci, 2009).

2 The Public Health Agency of Canada (PHAC) defines positive mental health as "the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity" (http://www.phac-aspc.gc.ca/mh-sm/mhp-psm/faq-eng.php).

In the seminal *Out of the Shadows* report (Standing Senate Committee on Social Affairs, Science and Technology, 2006) recommended that: (1) mental health promotion be integrated into mental health policy and practice and into Canadian public health and social policy more broadly, and (2) mental health promotion initiatives engage communities and respond to their unique strengths and needs. More specifically, the following policy interventions are suggested:

- Provide affordable, supportive and stable housing
- Enhance community supports
- Develop community services that support relationships
- Ensure secure income
- Provide mental health supports for culturally diverse older adults
- Support family caregivers

The World Health Organization (2004a) calls for collective action on policies and programs in government and business sectors including education, labour, justice, transport, environment, housing, and welfare, as well as specific activities in the health field relating to the prevention and treatment of ill-health. This can be accomplished through partnerships to: "build on existing activity in sectors, settings and organizations; create different partnerships for different purposes, at varying levels; and create collaborative action "horizontally" within government departments and organizations, and between those expert in policy, practice, and research" (WHO 2004a, p. 57).

» Develop mental health promotion and illness prevention strategies in partnerships across sectors and government departments and between policy makers, practitioners and researchers.

» Create a knowledge translation strategy and disseminate information about mental health promotion and mental illness prevention in older adults.

The Ottawa Charter for Health Promotion (WHO, 1986) emphasized healthy policy, supportive environments, and control of health issues by people in their everyday settings and continues to provide a guide for the promotion of mental health at the population level . The main strategies are building healthy public policies, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services.

BUILDING HEALTHY PUBLIC POLICIES

The Ottawa Charter (WHO, 1986) recognizes that most societal structures and actions have an effect on health and that all public policies, not only those specific to mental health/illness or seniors, are relevant to mental health promotion .

Currently Healthy Aging and Active Aging policies are being developed across Canada . These policies, (focusing on social isolation, healthy eating, physical activity, tobacco cessation and fall prevention), provide an opportunity for making links to mental health promotion.

» Develop collaboration and partnerships with relevant policy initiatives (e.g., Healthy/Active Aging, Healthy Communities), and the mental health sector, to ensure messaging reaches all seniors including those with, or at risk of, mental health problems, and takes into account cultural, literacy, linguistic diversity and other potential barriers.

» Screen planned and existing programs and policies that affect older adults for unintended negative effects on their mental health, using the Seniors Mental Health Policy Lens.

» Ensure that policies, programs and service delivery, and information about them for clients and the public, reflect positive images of older adults and positive outcomes of mental illness.

» Create a system/work place culture that acknowledges and builds on the strengths of older adults and that does not tolerate ageism.

» Partner with educational institutions and programs to ensure course content incorporate positive images of seniors and demonstrate their value to society.

» Incorporate positive views of older adults, aging and caring for seniors into staff orientation and professional development/continuing studies activities.

» Facilitate development of partnerships and collaborations between local governments, the seniors' mental health sector and other stakeholders outside of health to implement age friendly principles in organizations and communities.

» Ensure that seniors, their family, friends and service providers have the appropriate/necessary information to facilitate seniors' capacity to adopt healthy behaviours.

» Ensure that communities have the infrastructure and services to support seniors' social and civic participation.

» Ensure that health care providers and services are oriented towards mental health promotion and prevention.

» Support public awareness activities to reduce stigmas of age and mental illness.

The Seniors Mental Health Policy Lens Toolkit (MacCourt, 2008) facilitates the capacity of organizations and all levels of government to identify and address any unintended negative impacts of programs and policies on seniors' mental health. Informed by seniors' values and lived experiences, the Seniors Mental Health Policy Lens (SMHPL) can be used to guide the development of programs and policies that promote and support the mental health of diverse seniors, including those with a mental illness.

CREATING SUPPORTIVE ENVIRONMENTS

Older adults are more likely to participate in community life if the social environment is perceived as inclusive, respectful and non-threatening, and if social support is available. Ageism – the prejudice or discrimination against or in favor of any age group (Angus & Reeve, 2006; Butler, 1975) - is a form of discrimination and contributes to the social exclusion of seniors. The New York Academy of Medicine (2009) asserts that ageism, unlike racism and sexism, is widespread, overlooked and accepted in western cultures, including in the workplace, healthcare and media. Additionally, it has been suggested that negative ageist attitudes contribute to elder abuse (Quinn & Zielke, 2005). Seniors living with a mental illness may experience the additional stigma and negative discrimination associated with mental illness. Anti-ageism campaigns directed at seniors and the general public are needed to address these issues. Strategies to reduce stigma and discrimination due to age, mental illness, and other characteristics such as sexual orientation, gender, race and poverty can be built into programs, policies and institutions pertinent to seniors.

Implementation of the Age Friendly Community (AFC) model , can facilitate environments that are supportive of seniors. AFC is built on a life span and active aging platform and on an understanding that the physical and social environment and economic determinants that surround individuals, families and nations, influence active aging. All of these factors, and the interaction between and among them, play an important role in affecting how well individuals age and are included in the characteristic features of an age-friendly city (WHO, 2007).

STRENGTHENING COMMUNITY ACTION

When people come together to work on a common goal through community action, social capital is enhanced, a sense of empowerment is created, and the capacity and resilience of the community is increased. Strengthening community action that involves as many sectors of society as possible and that builds seniors' capacity for positive mental health within the individual, family and friends, community, health sector and societal spheres of influence, is most likely to succeed (WHO, 2007).

The physical and social structures of neighborhoods or communities can protect older adults from the risks of loneliness and social isolation. Action at this level to support well being in older age can also have both a mental health promotion and primary preventive function in relation to those who are vulnerable to mental health problems (WHO, 2007) .

» Develop collaboration/partnership with seniors, their families, appropriate community organizations and interest groups, and levels of government to support and increase neighbourhood/community engagement.

DEVELOPING PERSONAL SKILLS

Information and its dissemination are critical to improving people's understanding of mental health. There is less likelihood that people will seek help where there is a lack of awareness of symptoms of mental illness, cognitive impairment and addictions due to misperceptions that they are part of normal aging, or a belief that symptoms cannot be treated. The concepts of health literacy can be used to guide to mental health literacy and contribute to mental health promotion. To be effective, information, education and the translation of knowledge must be tailored to the diversity of seniors (e.g., language, literacy, culture, vision).

» Develop and disseminate public information to increase mental health literacy, particularly with respect to mental health and aging, including myth-busters and emphasizing the potential for recovery.

At the individual level most approaches to improving the mental health of older people represent the fundamental importance of valued participation, connectedness, support and encouragement (Moodie & Jenkins, 2005). Successful interventions include social support and community empowerment interventions and interventions promoting healthy lifestyle (Jané- Liopis, Hosman & Copeland 2004). Targeted interventions have been successful in improving the mental health of older adults at risk for depression, suicide and other mental health problems. These include brief primary care interventions, such as making patient education about chronic medical conditions a part of routine care for older adults (Hosman & Jane-Llopis, 2005) and screening for hearing loss.

» Ensure that seniors are integrated into decision making structures and systems to effect positive change with seniors as agents in these changes.

» Support voluntary, service and special interest organizations, municipalities (e.g., recreation departments), and other stakeholder groups in engaging seniors in developing programs or initiatives that facilitate the development of healthy behaviours, personal skills, mutual support and social participation.

REORIENTING HEALTH SERVICES

In the public sphere seniors' mental health is typically situated in a biomedical model that emphasizes individual pathology, leading to services and programs that focus on diagnosis and treatment (MacCourt, Tuokko & Tierney, 2002). Relatively little emphasis (or resources) are directed beyond health care to address the mental health determinants or to promote and support seniors' mental health through community programs that for example, reduce social isolation. The Mental Health Commission of Canada (2009) suggests that the mental health system be reoriented towards a recovery model that focuses on strengths and capacities.

» Ensure that health care services are oriented towards mental health promotion and illness prevention.

PREVENTION AND EARLY OF IDENTIFICATION OF MENTAL HEALTH PROBLEMS AND ILLNESSES

PREVENTING MENTAL HEALTH PROBLEMS

Poor mental health can be seen both a cause and a consequence of the experience of social, economic and environmental inequalities. As discussed earlier, mental health promotion strategies to enhance protective factors for positive mental health and reduce risk factors for poor mental health, as well as attention to the determinants of mental health, can contribute to preventing mental health problems and illnesses.

However, socioeconomic inequities between both individuals and between whole communities are increasingly being recognized around the world as important causes of disparities in mental health status (WHO, 2009). Inequalities in health and mental health result from social, economic and geographic influences that are avoidable, unfair and unnecessary. The Victoria Health Promotion Foundation (as cited in WHO, 2004a) describes three dimensions of inequality:

- Inequality of access refers to barriers to the services that support health and wellbeing. It includes barriers created through cost, physically inaccessible services, and through services not being culturally appropriate for all people.
- Inequality of opportunity refers to barriers to the social, geographic and economic resources necessary to achieve and maintain good health such as education, employment, income and a safe place to live.
- Inequality of impacts and outcomes refers to differences in health status between groups (for example in rates of death, illness or self-reported health) (p. 1).

Inequities lead to some populations having greater vulnerability to mental health problems and illnesses than others. Vulnerability results from

> the net result of the interplay among many factors, both individual (including biological) and societal. It can be exacerbated by a range of cultural, demographic, economic, legal and political factors, such as power imbalances within personal relationships and broad social inequalities and limits the extent to which people are capable of making informed decisions about their own health, safety and well-being
>
> (Balfour, 2007, p. 11).

Prevention efforts must recognize and address vulnerable populations (e.g., seniors who are homeless, poor, First Nations) who are at higher risk for mental health problems and illnesses and live with greater barriers to accessing services and supports. Some of these diverse populations are discussed in section III under the section on Diversity.

Given the high co-morbidity among mental disorders and their interrelatedness with physical illnesses and social problems, especially in seniors, the WHO recommends that strategies to prevent mental health problems target clusters of related problems, common determinants, early stages of multi-problem trajectories and populations at multiple risks (WHO, 2004b).

EARLY IDENTIFICATION OF MENTAL ILLNESSES

The focus of mental illness prevention is "the reduction of symptoms and ultimately of mental disorders" (Saxena, Jané-Llopis, & Hosman, 2006, p. 6). Early identification of mental health problems can slow the functional decline associated with some mental illnesses such as dementia, and prevent others, such as delirium. Early identification of depression can reduce its severity and improve the response to treatment and recovery. To this end education of seniors, the general public and of the health and social service providers about the signs and symptoms of mental health problems, and of the need for assessment, is required. Likewise education to dispel myths about aging that attribute, for example, forgetfulness simply to being old, can contribute to preventing mental illness by increasing early detection and intervention. Health care providers should also be aware of common chronic health problems in late life that have correlations with mental health problems, such as heart conditions, cancer etc.

- Provide information about signs and symptoms of mental illness, the importance of early identification, and about the effectiveness of treatments in old age to seniors, their families, organizations serving seniors, the general public, and all levels of service providers.
- Screening for mental health problems should be routine for high-risk older adults, including those who care for people with dementia, seniors with certain chronic illnesses, etc.

Following are prevention strategies that relate to specific mental illnesses experienced by some older adults.

PREVENTING DEPRESSION AND ANXIETY

Aging is not necessarily or catastrophically accompanied by depression and anxiety. Factors that have been most closely linked to depression in later life are physical ill health, pain and disability but it is how they limit seniors' capacity to engage in life rather than the poor health or disability per se that is most important (Godfrey, Townsend, Surr, Boyle, & Brooker 2005). Godfrey and colleagues (2005) have identified the following as significant risk factors in depression: death of an intimate partner, (particularly where there are other long term vulnerability factors such as family and personal history); sudden critical life events (e.g., being victimized, a health crisis); difficulties associated with loss or increasing disability. Additionally, the threat and fear of loss, (related to health or coping) was identified as a risk factor for anxiety. Those who care for people with dementia are also at significant risk for mental health concerns, especially depression, with research from the Alzheimer Disease International community citing figures as high as 40-75% (Schneider, Murray, Banerjee & Mann, 1999).

- Educate all health service providers and community agencies about the importance of supporting mental health and preventing depression through providing rehabilitation, pain management and exercise groups for those experiencing deteriorating mobility and illness.
- Develop partnerships with municipalities, voluntary and other community agencies to provide recreational programs for seniors that open up opportunities for self-expression, relationships, and developing new interests.
- Collaborate with community agencies to provide practical, social and emotional support in coming to terms with and managing life changes (such as cognitive impairment, widowhood), and dealing with financial and other stressors.

Risk and vulnerability factors in depression, physical ill health or disability interact and combine to make it difficult for seniors carry out their daily lives. Where social activities are reduced, relationships may

fade, and opportunities for social participation dwindle, leading to social isolation and depression for some seniors. This suggests that primary preventive strategies are needed to break the downward spiral. Godfrey et al. (2005) suggest that those challenged with mobility and health issues require rehabilitation, pain management and exercise groups; and, that opportunities for self-expression, maintaining and building social relationships, and support to cope with life changes are also needed.

- Consult with and support local government and seniors' organizations in developing local capacity to support older adults' civic and social engagement in their communities and neighborhoods (e.g., New Horizon grants; seniors centres; elder college; age friendly business; transportation), including opportunities for paid and unpaid work.

Godfrey et al. (2005) contend that support and action, in concert with, primary preventive strategies are needed to develop communities that (1) are psychologically and physically safe and easily navigated, (2) provide opportunities for social participation accessible to seniors with diverse interests and challenges, and (3) facilitate seniors capacity as active agents of change and integrate them into decision-making structures and systems.

- Provide information about the importance of early identification of depression, what to watch for, and about the effectiveness of treatments in old age, to seniors, their families, organizations serving seniors, the general public and service providers.
- Educate seniors, their families and the general public about life changes associated with aging including physical changes, widowhood, caregiving and relocation, to encourage planning for the future (e.g., advanced directives).

Many seniors face challenges in accessing appropriate assessment of symptoms of depression and anxiety within primary care, (losing the opportunity for early identification and treatment before symptoms are entrenched), and in accessing mental health specialists for longer standing mental illness (Godfrey et al., 2005).

The Canadian Coalition for Seniors' Mental Health (CCSMH) (2006a) released interdisciplinary evidence based guidelines focused on the *Assessment and Treatment of Depression.* These evidence based *Guidelines* provided the following recommendations for education, prevention and early identification of depression in later life:

- Specialized content in regard to assessment and treatment of depression in older adults should be included as part of the basic education and continuing education programs of all health care professionals.
- Specific training on geriatric mental health issues should be provided for personnel caring for depressed older adults.
- Health care professionals should provide older adults with education regarding the nature of depression, its biological and social aspects, effective coping strategies, and lifestyle changes that will assist their recovery while being mindful of the individual's stresses and strengths.
- Families of depressed older adults should be provided with information regarding the signs and symptoms of depression coping strategies, as well as available treatment options and the benefits of treatment.
- Public education efforts should focus on the prevention of depression and suicide in older adults.
(CCSMH, 2006a, p. 41-42)

PREVENTING SUICIDE

Conwell (2004) reports that there is low awareness that depressive symptoms and suicidal ideation are not normal features of ageing, but rather are indicative of illness that is responsive to treatment.

Older people who are isolated and lack social support are especially vulnerable to suicide in the presence of other risk factors (Conwell, 2004).

There is a dearth of published literature focusing on interventions or treatments that have been specifically directed at the prevention of suicide in older adults. Evidence linking depression and suicide suggest that timely and appropriate treatment of the depressive illness is also likely to prevent suicide. However, many older people who die by suicide have had an active relationship with a primary care provider at the time of death and had clear symptoms of depression which may have been under-estimated or under-treated (CCSMH, 2006b). This understanding has focused attention on the contexts in which older people at risk can be recognized, diagnosed and treated, with early Identification and treatment of depression identified as the most effective way to prevent suicide (CCSMH, 2006b).

Telephone help lines for older adults, when combined with a home visiting service, are a promising strategy for reducing suicide. In Italy, a 71 % drop in suicides was observed among the 18,641 elderly service users compared to a comparable population group, over an 11-year study period (DeLeo, Dello Buono & Dwyer, 2002).

The Canadian Coalition for Seniors' Mental Health also made the following recommendations regarding education and prevention of suicide in older adults:

- Culturally sensitive education and training regarding the assessment and prevention of suicide should be provided to health care professionals in a variety of settings.
- Health care professionals should provide older adults and their families/caregivers with education regarding suicide, stigma, treatment options, and management strategies.
- Provincial and national public awareness and education efforts that focus on suicide prevention, stigma and mental health promotion in older adults are recommended.
  (CCSMH, 2006b, p. 23)

- Provide education to the public and service providers to increase awareness about the myths and realities of depression and suicide in older adults.
- Implement anti-stigma strategies to combat stereotypes of old age and mental illness.
- Ensure that targeted interventions or programs designed to reduce isolation and provide opportunities for social interaction are available to seniors.

- Take measures to address barriers to timely recognition, diagnosis and appropriate treatment of depressive illnesses in older people.
- Educate health care providers about suicide risk factors and the use of screening instruments as part of routine care for older adults at risk.

- Develop partnerships between mental health services and existing help lines and other community services, to ensure that staff has appropriate training in screening for suicide risk and client assessment.

REDUCING SUBSTANCE USE

High-risk alcohol use and hazardous drinking among older adults can be reduced through a brief intervention by a health care provider, and by participation in self-support groups (Health Canada, 2002).

» Develop partnerships with provincial Healthy and Active Aging/Living Departments (which are targeting alcohol abuse, and with Alcoholics Anonymous and other self help groups) to ensure messaging is senior friendly and reaches those at risk of mental health problems.

PREVENTING DEMENTIA

In the 2010 Alzheimer Society of Canada report, The Rising Tide: The Impact of Dementia on Canadian Society the potential impact of dementia in the coming decades was examined, including an extensive review of the literature on strategies to reduce risk for Alzheimer's disease or to slow progression of the disease. They identified the following:

- Eating a healthy diet with an emphasis on a Mediterranean style diet;
- Aerobic exercise;
- An active social life;
- Intellectual activity; and
- Protecting your head (Alzheimer Society of Canada, 2010).

» Ensure that health care providers and the general public are informed about how to avoid head trauma throughout the life span (e.g., bike helmets, falls prevention).

» Ensure health care providers and the public are aware of early signs of vascular disease, how to prevent vascular disease, the importance of treatment, and of the early signs and symptoms of cognitive disorders.

Two strategies seem to have shown stronger evidence of their link to prevention or delay of onset of dementia. The first is the prevention of head traumas earlier in life through highway speed limits, use of crash helmets and seatbelts, drinking and driving laws and vehicle licensing laws; the second deals with vascular disease, an evidence-based risk factor for dementia (Cooper, 2002).

» Ensure, through partnerships with Alzheimer Societies and others that people newly diagnosed with dementia, and their caregivers, have access to peer support, information about the disease and related supports and services, and the opportunity to develop coping skills.

Older adults recently diagnosed with dementia, (and their caregivers), report benefits from (1) groups that provide support and information, and from (2) memory clubs where people with dementia and their care givers share their common experiences with each other, and from (3) support groups for people in the early stage of dementia (Godfrey et al., 2005). Successful groups share common themes: a focus on (1) providing opportunities to share feelings and to have these feelings validated by others who understand what they are going through, and (2) providing information about the condition, how to cope with it, and the types of support and services that are available (Godfrey et al, 2005).

Godfrey et al., (2005) report that relocation may have a negative effect on the functioning and well-being of people with dementia. They report that research indicates that people with dementia in institutional settings who are moved from one unit to another may experience a decline in quality of life. This is understandable given that the hallmark sign of dementia is an inability to learn and retain new information. They also note that individuals who are moved suffer higher mortality and depression rates, but when relocated as part of a resident group to a new unit along with the staff who care for them, there are few or no new adverse effects.

- Policies and programs must take into account the negative impact of relocation on seniors with dementia and when unavoidable, ensure that support is provided.
- Policies, programs and services must be in place to support seniors aging in place as long as they choose to, and are able to, do so.

There is evidence from institutional settings suggesting that individualized care planning and systematic clinical supervision can result in improvements in the mood of people with dementia, and reductions in deterioration in cognitive function and confusion (Edberg et al. 1999). Wells and her colleagues (2000) found that care that is orientated towards the abilities of a person with dementia is beneficial to both the person with dementia and to caregivers. In January 2011 the Alzheimer Society of Canada released "Guidelines for Care: Person Centred Care of People with Dementia Living in Care Homes" that focus on improving the quality of care of people with dementia in care homes through a person-centred philosophy. Additional evidence based resources to support clinical practice for prevention of dementia can be found online with the companion materials at www.mhccseniorsguidelines.ca.

- Individualized person-centred care plans should underpin the care of seniors with dementia.
- Care homes and institutions providing care for older adults with dementia should refer to up-to-date evidence and guidelines on prevention, assessment, and treatment.

PREVENTING DELIRIUM

Although primary prevention of delirium is critical given the associated morbidity and high rates of occurrence, interventions to prevent delirium have not been well evaluated (CCSMH, 2006c). Based on their review of intervention studies and examination of the best evidence available, the CCSMH's National Guidelines for Seniors' Mental Health: Assessment and Treatment of Delirium identified risk factors for delirium in hospitalized older persons and potential system level interventions for the prevention of delirium, as follows:

- Educational interventions directed to hospital staff dealing with delirium and its prevention should be implemented.
- All levels of health care workers should be aware of the components of a mental status assessment and be able to detect and report changes in behaviour, affect and cognition.

PART II: An Integrated Service Model for Mental Health Services in Later Life

The following section considers a range of possible service delivery models, and then proposes an evidence-informed comprehensive model for seniors' mental health services in Canada.

SERVICE DELIVERY MODELS

There are a variety of Canadian and international service delivery models that have been evaluated and shown to support older persons living with mental illnesses . Below is a brief review of innovative models that may be used to support an integrated mental health service system for older adults. Links to additional supporting information can be found in the online version of these *Guidelines*.

MEDICAL HOME MODEL IN PRIMARY CARE

The College of Family Physicians of Canadarecommends the medical home concept be incorporated with the variety of primary care initiatives taking place across Canada to ensure patient-centred care with improved access and better health outcomes. They contend that the model, while suitable for all seniors, is especially suitable for those with complex needs because the medical home acts as the central hub for provision and coordination of medical services.

A medical home is a patient-centred medical care setting where:

1. Patients have a personal family physician who provides and directs their medical care;
2. Care is for the patient as a whole;
3. Care is coordinated, continuous and comprehensive with patients having access to an inter-professional team;
4. There is enhanced access for appointments;
5. The practice includes well-supported information technology, including an electronic medical record;
6. Remuneration supports the model of care; and
7. Quality improvement and patient safety are key objectives. The medical home acts as the central hub for the provision and coordination of the medical care services needed by each of its patients (Canadian College of Family Physicians, 2009 p. 5).

Findings from research reported by the College of Family Physicians of Canada (2009) indicate that the medical home increases access to care, preventative screenings, and improves management of chronic conditions; is associated with better health outcomes; leads to reductions in health disparities in health between socially disadvantaged and advantaged populations; and offers better quality of care, patient experiences, care coordination and access.

More recently, an evaluation of a two-year American pilot study of the medical home found that, compared to patients with other group health clinics, patients in the medical home experienced 29% fewer emergency visits and 6% fewer hospitalizations, and estimated total savings of $10.3 per patient per month. Additionally the results showed improvements in clinician burnout (Reid, Coleman, Johnson, Fishman, Hsu et al., 2010).

MODELS OF CARE FOR SPECIALIZED MENTAL HEALTH SERVICES

Taking into account local conditions and resources, there are a number of ways that mental health services for seniors can be organized and delivered. Evidence to inform decision-making, from an international synthesis report of evaluation studies of different models of psychogeriatric service delivery , carried out for the World Health Organization Health Evidence Network reports the following findings (Draper & Low, 2004, p 4-5):

- There is strong evidence of effectiveness for community multidisciplinary teams
- There is good evidence to support:
  - that case management in the community setting is effective.
  - primary/specialist care collaborations for treatment of later life depression
  - outreach services to residential care
  - integrated post discharge mental health services and treatments to prevent delirium (but effects are modest)
- There is limited evidence to support consultation/liaison for delirium in long-term residential care or medical wards (albeit with modest effects).
- There is lower quality, albeit consistently positive, evidence of the effectiveness of acute hospital care.
- There is weak evidence to support day hospitals, general adult mental health wards, old-age mental health wards, or combined old-age mental health and geriatric wards.
- Integration of acute hospital and community care has been shown to improve outcomes following hospital discharge.
- Specialized seniors mental health services are more effective than geriatric medical and adult mental health services.
- Controlled studies are required to determine whether alternative forms of community or hospital care are as effective.
- Community residences for long-term institutional care appear to offer better quality care than hospitals.
- It is unclear whether there are particular patients who require long term psychogeriatric hospitalization as there is only weak evidence for less-dependent patients.
- No benefit was found from geriatric medical post discharge services.

Mirroring the World Psychiatric Association (WPA) and World Health Organization consensus statement on the organization of care in old-age psychiatry, Draper and Low (2004) reported that the multidisciplinary, comprehensive, integrated service delivery to a defined catchment area is the most widely accepted service delivery model. They recommend that, based on the strongest evidence, (1) community multidisciplinary (geriatric mental health) teams should be developed as a major service-delivery component, and (2) partnerships should be developed with consumers, nongovernmental organizations, primary care providers, social services, long-term residential care providers and other medical services.

The researchers commented that lack of, or limited, evidence does not mean that ineffectiveness has been proven but instead that there are limited studies from which to draw firm conclusions. Therefore, research focusing on the evaluation of clinical services and models of care in Canadian settings would greatly contribute to the international literature and ensure that planners have access to the best data possible when considering incremental investments in mental health services for seniors.

INTEGRATED MODELS OF COMMUNITY CARE

Hollander, Miller, MacAdam, Chappell and Pedlar (2009) proposed an integrated model of care for seniors based on a review of Canadian and American literature. In particular the Veterans Independence Program (VIP) operated through Veterans Affairs Canada was touted as an integrated model of care that offers better health outcomes for older adults. Additional work by Hollander, Chappell, Prince and Shaprio (2007) reviewed the integrated programs based in Quebec [System of Integrated Care for the Older Person (SIPA) and Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA)]. Hallmark features of each model include single entry systems, case management, coordination across and within sectors, and individualized geriatric assessment (Hollander et al., 2007). Incorporating mental health services and building upon the evidence and successes of these models could offer an additional model of care. Links to additional resources can be found in the online version of these *Guidelines*.

A PROPOSED CANADIAN SERVICE MODEL FOR MENTAL HEALTH SERVICE IN LATER LIFE

For older adults who require treatment and support for their mental health problems, having a strong health and social service system that is grounded in the recovery philosophy and guided by principles and values, is an integral part of keeping older adults healthy. The service system dovetails with the broader mental health system (which promotes mental health, prevents mental illness where possible, and attends to the determinants of mental health), which, in turn dovetails with the broader health care system. Implementation of an integrated service system is not just the responsibility of service providers; collaboration with seniors, caregivers, policy makers and others (e.g., all levels of government, voluntary organizations) who can facilitate implementation, is vital to its success. Leveraging the facilitators of a mental health service system will also help to ensure efficiencies and timely access for older adults and their caregivers.

A continuum of care is an integrated system of care that guides people over time through a comprehensive array of health, mental health and social services spanning all levels of intensity of care and is comprised of both services and integrating mechanisms (Evashwick, 1989). The purpose of such a continuum is to meet the needs of seniors and the needs of those caring for them with appropriate integrated services at the time and place where they are needed. The model presented here is based on the concept of a continuum but moves away from the linear concept associated so often with continua; the circular shape places seniors (care recipients) and their networks of informal care at the centre of the system. This model is intended to be holistic and is focused more on required functions and outcomes rather than on systems. The diagram denotes movement in and out of the system at a variety of points, which are individualized according to need and the informed choice of individuals (and their caregivers).

This model is designed to reflect the belief that mental health promotion should permeate and drive all aspects of the continuum, and that services should operate with the philosophy of recovery at their core.

The proposed integrated service model for mental health incorporates the philosophy of recovery and well-being and helps to outline the functions required to support people living with mental illness and to prevent illnesses and promote good mental health for all seniors.

All services should be guided by the values and principles that underpin these *Guidelines*, which allows for flexible interpretation of the recommendations while maintaining their integrity. The centre of the model also reflects the belief that the social determinants of health influence the need for and access to the continuum of services. It also highlights the need for education and support for all participants in the continuum (older adults, family and other informal caregivers as well as health care and other service providers).

Recognizing the vast differences in resources and services across communities in Canada, the model outlines a continuum of services that seniors require, without prescribing how and who should offer them. Although the continuum does not use labels such as primary, secondary and tertiary levels of care, the services that fall under these headings are included in this continuum. For example, primary care typically encompasses consumer self-care and family care, family physicians, and home care, all of which are contained in the top right quadrant of the proposed continuum. The types of services included are based on a continuum of services created by the Ministry of Health and Long-Term Care (MOHLTC) Advisory Committee in Ontario in 2003, modified through our consultations and in recognition that terminology varies across the country.

CORE COMPONENTS OF AN INTEGRATED MENTAL HEALTH SERVICE SYSTEM FOR OLDER ADULTS

The following section describes services required by older adults at risk for, or living with mental illness. In a comprehensive mental health service system for older adults it is recognized that many services will be provided through the usual array of social and health-related services. Recognizing that seniors receive a vast amount of care and support from family and other informal caregivers, formal services must address caregiver support and inclusion of caregivers in decision-making at the individual and system level. Knowing local capacity and resources is crucial and acknowledging gaps in services and functions will help set priorities that can be addressed through incremental policy and service development.

Service components do not make a system of care. In an integrated mental health service system formalized collaborative relationships are required among all components (across and within sectors) with clear mechanisms for accessing each other's programs, services, and skills. Service providers working in front line services for seniors look after the majority of older adults with mental health problems and illnesses living in the community. These service providers must have skills in early identification of mental illnesses in later life, including dementia. While the majority of older adults begin their journey towards recovery and wellbeing with their family physician or other front line service provider, it is important to acknowledge that the front line service system cannot manage all mental health problems alone; collaboration amongst care providers in both the broader health care system and the mental health system is needed. The capacity and confidence of the primary care system to manage older adults with, or at risk, of mental illness, can be increased through access to education and consultation with psychiatric and mental health clinicians.

For a small percentage of older adults with complex and usually multiple health problems, access to specialized geriatric mental health services is required. These specialized services support primary care, general mental health services and geriatric medicine services by providing

An Integrated Model for Mental Health Services in Late Life

GUIDING VALUES & PRINCIPLES

INDIVIDUAL LEVEL

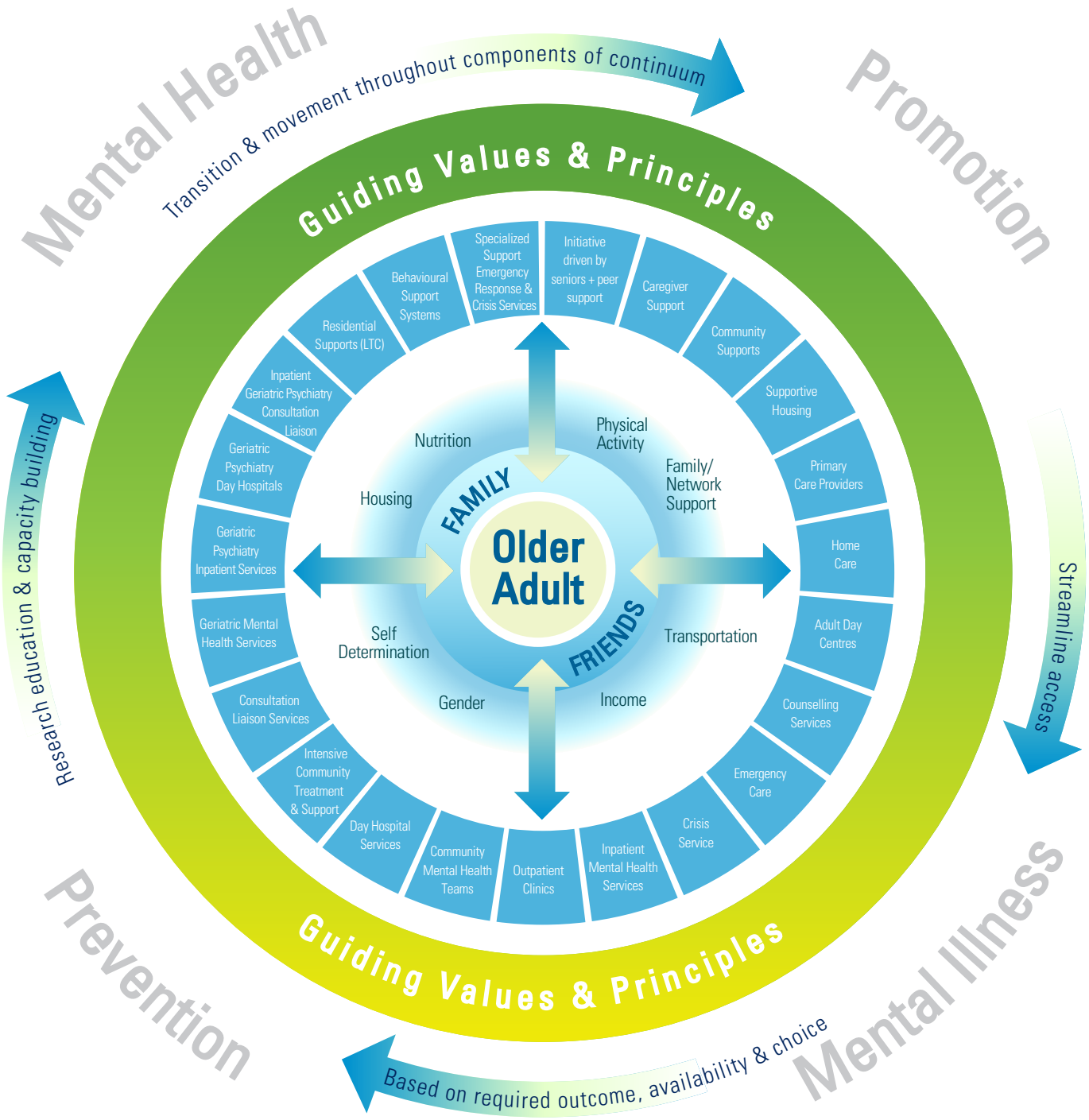
- respect & dignity
- self-determination, indepedence & choice
- participation, relationship & social inclusion
- fairness & equity
- security

SYSTEM LEVEL

- accessibility
- person and relationship centred
- recovery focused
- support for family / caregivers
- education and support for service providers
- diversity and cultural safety
- comprehensive
- integrated, flexible, and seamless
- mental health promotion
- evidence informed

FACILITATORS OF A COMPREHENSIVE SYSTEM

- academic centres
- cultural safety
- diversity
- caregivers as vital partners in care
- support for service providers
- service delivery models
- inter-sectorial partnerships / collaboration
- use of technology
- application of knowledge and evidence


Mental Health
Transition & movement throughout components of continuum
Promotion
Guiding Values & Principles
Specialized Support Emergency Response & Crisis Services
Initiative driven by seniors + peer support
Caregiver Support
Community Supports
Supportive Housing
Primary Care Providers
Home Care
Adult Day Centres
Counselling Services
Emergency Care
Crisis Service
Inpatient Mental Health Services
Outpatient Clinics
Community Mental Health Teams
Day Hospital Services
Intensive Community Treatment & Support
Consultation Liaison Services
Geriatric Mental Health Services
Geriatric Psychiatry Inpatient Services
Geriatric Psychiatry Day Hospitals
Inpatient Geriatric Psychiatry Consultation Liaison
Residential Supports (LTC)
Behavioural Support Systems
Nutrition
Physical Activity
Family/ Network Support
Transportation
Income
Gender
Self Determination
Housing
FAMILY
FRIENDS
Older Adult
Research education & capacity building
Streamline access
Prevention
Guiding Values & Principles
Based on required outcome, availability & choice
Mental Illness

specialized assessment and treatment for seniors who have highly complex illnesses or behaviours. Utilizing consultation and collaborative care approaches, specialized geriatric mental health services help increase the capacity of existing mental health services across various settings, including residential care homes where many seniors with high mental health needs reside, and in rural and remote areas through outreach mechanisms (often facilitated by video technology).

Draper, Brodaty and Low (2006) proposed a tiered model of service delivery for psychogeriatric (i.e., specialized mental health services for seniors) services and underscored the need for prevention interventions for all older adults and to support those living with mental illnesses through treatment and management. Their model also highlights the increased need for intervention based on the level of disturbance, with only a very small percentage of older adults requiring the highest level of care for extreme mental disorders (Draper et al., 2006). Although the proposed model here moves away from the concept of a hierarchy of services, the range of available services go from broad population mental health promotion services and mental illness prevention programs to highly specialized seniors' mental health services, which is reflected in our integrated model. It should also be noted that mental health promotion and mental illness prevention, while not necessarily stand alone services, should be embedded within services at all levels of the system.

Following are brief descriptions of the components needed in a comprehensive mental health system for seniors.

COMMUNITY BASED SERVICES AND PROGRAMS

These services have relevance in all elements of a comprehensive mental health system (primary care, mental health services, and specialized mental health services) and should be tailored and available to support the journey to recovery for older adults and their care providers.

Initiatives Driven by Seniors

Initiatives that are driven by seniors include a variety of programs, models and strategies. Such initiatives are intended to address the health and wellbeing of seniors and focus on improving knowledge, understanding and ability to engage in positive lifestyle choices including self-management (Ontario MOHLTC, 2003). Self help groups made up of seniors who have undergone common challenges such as visual impairment, bereavement, or early diagnosis of dementia are also common. Often under the auspices of an organization they may be led by the affected seniors or by a senior or non-senior facilitator. Their purpose is to promote mental health through sharing experiences and coping strategies and through mutual emotional support. Peer support programs connect seniors who are undergoing challenges with other seniors who have either had a similar experience (e.g., cancer, early stage dementia), or provide general support to individuals. Peer support programs are also important components to allow older adults to manage their own mental health conditions (Kates & Mach, 2007). Specialized seniors mental health services often provide education to peer counselors and to self help groups about normal aging, grief, etc with the goal of facilitating early identification of depression (for example) and referral for assessment and early intervention.

Caregiver Support

Caregiver support services or programs promote the understanding and abilities of families and caregivers whose lives include the realities and myths of the aging process. They support

caregivers in their care-giving roles and may include respite services, education and/or psycho-educational and support groups. Caregiver support services support the mental health of this at-risk population and are most often provided through the primary health care system (e.g., Alzheimer Society support and education) and more specialized mental health services as required (e.g., specialized consultation, personal counselling, education and skill development).

Respite services provide caregivers a break (hours to days) either in their home or by caring for the relative in a long term care facility for short or designated periods of time. These services are provided through the voluntary sector, through the primary care system (e.g., home care services) and through more specialized services (e.g., in complex care facilities or nursing homes).

There are few caregiver support services or programs designed for caregivers of older adults with severe and persistent mental illness and addictions. More research is needed in this important area. Caregiver education and consultation may be provided by seniors' mental health clinicians, peers, or a combination of clinicians and other caregivers. However, there is little data on how to support these caregivers in the longer term. At the very least, clinicians should be encouraged to inquire about the needs of these caregivers as part of the care they provide. See section on caregivers for more information in Part III.

Community Supports

Community supports may include a wide range of programs and services that provide access to a comprehensive range of community services for seniors. Examples may include social recreation programs, visitation services, transportation services, meal services (e.g., Meals on Wheel, Wheels to Meals), and seniors' drop in centres. Community supports are often informed by the local context and may be targeted to meet the needs and build on the strengths of diverse groups. Older adults who display symptoms of mental illness may have difficulty accessing community services due to the associated stigmas. Public education can help to reduce such barriers. Community supports are an important foundation of a mental health service system and staff in these settings should be offered resources and opportunities to improve their mental health literacy, promote mental health, prevent mental illnesses, assist with emerging symptoms, and liaise with front line care providers. Bidirectional referrals and communication between community supports and front line services will contribute to the transformation of the mental health system.

Supportive Housing

Supportive housing is a residential facility that provides 24-hour access to supports and intends to provide a stable, supportive living environment that maximizes the senior's independence. Supportive housing also provides the professional and personal supports necessary to sustain the senior in the environment as long as possible (i.e., age in place) and if necessary facilitate a smooth transition to a more intensive residential environment (Ontario MOHLTC, 2003). Supportive housing is typically for older adults who are functionally able to manage basic activities of daily living (ADLs) and require support with instrumental activities of daily living (IADLs) such as managing medications or preparing meals.

The following sections discuss in further detail the types of clinical services that are required in an integrated mental health service system for older adults. While these *Guidelines* focus on clinical services, it is recognized that older adults value and require services and supports beyond the clinical array, including legal supports, financial supports, and assistance with housing. These supports are vital in supporting older adults in their journey towards recovery and wellbeing. While

these roles are often provided by community organizations, linkages need to be established with clinical services to ensure seamless support and coordination for the older adults. System navigators, discussed further in part III, are also facilitators of these linkages and may be considered a promising practice.

PRIMARY CARE: FRONT LINE SERVICES FOR SENIORS

Primary care services for seniors may include working with family physicians, nurse practitioners, home care nurses, public health nurses, occupational therapists, pharmacists and social workers, home support workers, personal support workers, and volunteers in these settings. This support can be found in a variety of settings such as family health teams, public and community health centres, home support services, seniors' day care, and non-specialized beds in long-term care facilities/nursing homes. These services are commonly the point of entry for mental health care for older adults and open the door to general and specialized mental health services that may be required.

Primary Care Providers

Often, it is the family physician that first sees the individual experiencing mental health problems and begins the process of involving other resources that may be needed to provide care or support for him/her or the family caregivers.

Primary health care providers, including family physicians and hospital primary care clinics, provide preventive, diagnostic and therapeutic mental health services, often in collaboration with mental health services available in private practices or mental health clinics and community based support groups or counseling services. In regions where there are fewer mental health services and supports it is particularly important that family physicians and family health teams have training and education in seniors' mental health and offer special mental health services targeting their needs (e.g. psychotherapy, support groups, etc.). These physicians and family health teams should also have access to shared care and/or consultation with specialized services for more complex cases, utilizing technology as needed to overcome geographical distance barriers.

All primary care providers need to be able to identify symptoms of the various mental illness affecting seniors, including dementia, and assist in the journey to recovery appropriate to their roles/responsibilities, in collaboration with available mental health services.

Home Care

Home based support services for people living with or at risk for mental illnesses, including dementia are offered in the place where an older adult lives. These support services provide assistance with Activities of Daily Living (ADLs, such as bathing and transferring) and with Instrumental Activities of Daily Living (IADLs, such as cooking and shopping). Setting up meals for seniors with visual impairments or prompting those with a dementia to eat their meals are also important tasks that facilitate aging in place. Ongoing assessment and case management is also provided. Home support services are generally designed for those with physical challenges but can also support the mental health of those they serve, help maintain their recovery and well-being, and provide a mental health promotion and respite function for caregivers. Home care staff often assists with the early identification of mental health issues.

In most jurisdictions these services are also provided to physically able older adults with dementia who are unable to plan and execute ADL and IADL activities, and require direction and supervision. Home care staff is in a unique position to provide support and respite to family caregivers and should be supported to do so (through education or clear identification of this function in their job description). Continuity of home support workers and the avoidance of too many different care providers in the home facilitate consistent care and is important in developing trust and positive relationships with older adults and their families. In some jurisdictions older adults with other mental illnesses are not eligible for services if they are deemed "physically capable," even though their illness prevents them from initiating or managing self-care and other life activities. Older adults who smoke heavily or misuse alcohol or other substances also pose significant challenges to home care services in regards to managing health and safety risks for their staff. Their application for services is often denied.

Strong and ongoing collaboration between specialized mental health services and home care services is required to facilitate the provision of mental health services to seniors in their own homes. Education to support early identification and referral to appropriate diagnostic or treatment services, joint care planning, and case consultation, particularly for ethically challenging situations are some of the strategies that may be considered to improve the capacity of home care services to serve seniors with mental illnesses.

Adult Day Centres

Seniors with mental health problems or illnesses may receive services in general adult day centres, with consultation from geriatric mental health outreach teams, or in specialized mental health day centres. Local needs and resources, and client characteristics will determine the range of services available. In many communities, adult day centres are used as a supplementary community resource providing:

- Community outreach, including such activities as health education and promotion, nutrition and bathing programs, blood pressure and podiatry clinics, telephone checking, client advocacy and counseling, caregiver support, including such activities as caregiver support groups, information and education programs.

Adult days centres specific to the cognitive, social and physical needs of adults with dementia are provided in some larger communities.

Counseling Services

Counseling services are usually provided by a registered mental health professional (for example, a psychologist, psychiatric/mental health nurse, social worker or occupational therapist). These professionals have distinct approaches and provide unique services, which can include assessing and diagnosing mental health problems, providing specific forms of psychotherapy or general advice and counseling. Counseling services may be through the public or private sector and may be available to individuals, families and groups.

Emergency Care

Emergency care is provided through hospital emergency departments, and should be used when immediate psychiatric help is required, for example when an older person poses an imminent suicide risk. On average, seniors represent 50% of emergency department presentations (Regional Geriatric Programs of Ontario, 2000). Given the high number of older adults requiring emergency support, many hospitals have collaborated with geriatric medicine services to put

The Day Center is great, I couldn't survive without them. We would be looking at a long-term care facility. You know, it gives me the time to go out and conduct the family business, run the home, without having to worry that he's safe.

Caregiver

in place Geriatric Emergency Management (GEM) nurses. GEM nurses have specialized geriatric training to assist with proper assessment and triage of seniors who present to emergency departments of hospitals. Most GEM training programs include some information on the most common mental health problems of seniors as well as information on mental health services that may be helpful to the patients they see in the emergency room. Some programs have formal linkages with specialized geriatric mental health programs (e.g. Ottawa GEM program) to facilitate education and referrals.

GENERAL MENTAL HEALTH SERVICES

When older adults require mental health support beyond what can be provided by primary care resources, referrals to the mental health system are typically required. General adult mental health services should have the skills and capacity to provide care to older adults, except in complex cases, when specialized geriatric mental health services may be required. For many older adults who have lived with serious mental illness throughout their adulthood, receiving care through general mental health services offers continuity and ongoing management of illness in later life. Services may need to be adapted to seniors by, for example, making home visits, ensuring housing for clients and offices are accessible to those with mobility challenges, adapting information and interventions to accommodate seniors with visual or hearing impairments. Using specialized geriatric mental health services to help build capacity and the knowledge of general mental health services providers will help to build a more integrated and age-friendly mental health service system.

In addition to clinical needs, older adults may also encounter challenging issues that can result from the cumulative effects of living with a long term mental illness (such as accessing and maintaining housing, homelessness, financial and legal issues, employment or activity issues), and losses that often accompany aging (e.g., bereavement, declines in physical functioning). To support recovery, the general mental health service system assists older adults in dealing with these issues and making the linkages to other systems needed to manage.

Crisis Services

Crisis services are an integral component of an integrated mental health system as accessible and coordinated support is required in emergency situations and services must be available to respond 24 hours a day, 7 days a week. Crisis services offer screening for immediate needs, which includes risk assessments (Ontario MOHLTC, 2003). Crisis services also determine next steps for support including working with older adults and their caregivers to determine suitable services and to support with follow up and referrals (Ontario MOHLTC, 2003). Given the high rates of suicide in later life, it is important that crisis service workers receive training and education about normal aging, mental health in later life, age related presentations, and particularly suicide risk assessment and prevention. Services may need to be made age friendly by adapting information, education and interventions to age related issues such as visual and hearing impairments, cognitive processing speed, and mobility challenges.

It is important to note that for older adults, close links to medical evaluation services is required when crises occur because of the very high prevalence of medical and psychiatric co-morbidities. Ideally, the family physician should be involved in all assessments. However, all crisis staff personnel must have knowledge of how presentation of mental health problems in later life differ from that of younger adults, be trained to identify delirium and urgent medical problems that may

contribute to psychiatric emergencies in elderly people and know how to get a proper medical review done quickly. Crisis response services may deflect unnecessary admissions to hospital. However, it is equally important that community and hospitals work together to ensure that inpatient services are available for seniors who present in emergency departments when they require acute care because they cannot be accommodated safely outside the hospital.

Inpatient Mental Health Services

Some seniors may need an inpatient mental health setting when detailed assessment, diagnostic workups, or acute treatment and medication management are required to minimize imminent risk for their safety or the safety of others (Ontario MOHLTC, 2003). Senior-friendly inpatient mental health services collaborate with community partners, ensuring effective discharge plans are coordinated to ensure a smooth transition back to the home setting (including supportive housing and long term care homes). General mental health services are appropriate for the majority of older adults who require an inpatient admission; specialized geriatric inpatient services should be reserved for a small minority of older adults who are experiencing extremely complex or severe mental disorders (Brodaty et al., 2006). In some Canadian settings (e.g. in British Columbia, Ontario, Nova Scotia), a geriatric psychiatrist is available for consultation and liaison with some of the general psychiatry inpatient services, providing support and any education that may be required. Other acute care inpatient services include a geriatric psychiatrist on staff and have dedicated beds for older adults. The inclusion of geriatric psychiatry specialists in acute care inpatient services, either as consultants or on staff likely help minimize the need for specialized geriatric psychiatry inpatient services and may allow seniors to be served closer to home when the specialized geriatric psychiatry inpatient services are located far away, typically in a large urban/university centre.

Outpatient Clinics

Outpatient clinics typically function to provide individual support, ongoing consultation, assessment, and treatment for people who have aged with persistent mental illnesses, by appointment. For older adults living with uncomplicated mental disorders, outpatient clinics are appropriate, although consultation from psychogeriatric teams may be required to manage symptoms associated with later life, such as cognitive impairments (Brodaty et al., 2006).

Community Mental Health Teams

Community Mental Health multidisciplinary teams provide a range of treatment, support and follow-up services to people in the community, including seniors. Clinicians in these services provide ongoing assessment, linkage to other services, emotional and practical support, counseling, advocacy and monitoring. They also assist with ensuring that mental health, health and social services are coordinated.

Day Hospital Services

Day hospital services, although often focused on younger adults, offer more intensive levels of support than outpatient clinics. Day hospital services are typically staffed by multidisciplinary teams and offer a combination of individualized and group support. Day hospital services are usually developed as a strategy to help prevent or shorten psychiatric inpatient admissions. Although there are specialized day hospitals for older adults (usually only in large academic centres), general day hospital services should collaborate with specialized geriatric mental health teams to build capacity to support all adults, including older adults, on their journey towards recovery and wellbeing.

Intensive Community Treatment and Support

Intensive community treatment and support services provide a range of treatment, support and follow-up services to people in the community, including seniors. A multidisciplinary team typically provides these services to people living with severe and persistent mental illnesses. Clinicians in these services provide ongoing assessment, linkage to other services, emotional and practical support and counseling, access to medication, advocacy and monitoring. They also assist with ensuring mental health, health, long-term care services and social services are coordinated (Ontario MOHLTC, 2003). In order for this type of service to meet the needs of seniors with severe and persistent mental illnesses, staff must work in collaboration with primary care physicians and have proper training to help their clients manage the medical problems that are common in this age group. These intensive services have a lower ratio of clients per staff member than any other community treatment service and are reserved for those with the most challenging mental health problems that cannot be managed safely with other, less intensive, services.

Consultation Liaison Services in Hospitals and Complex Continuing Care

Consultation liaison services are generally available in large acute care settings and provide consultation to various inpatient services (e.g. cardiology, orthopedics), seeing patients who may have concurrent mental health problems that complicate their medical care. Treatment is usually provided where the senior is receiving care, although occasionally a transfer to a psychiatric unit may be required. Teams including nurses, social workers or rehabilitation therapists along with physicians may be created to perform the consultation-liaison service. Consultation-liaison services may also include indirect consultation for the purpose of education or development of staff capacity to identify psychiatric illnesses or to manage challenging behaviours. A large proportion of patients seen by consultation-liaison services are elderly and consultation-liaison teams typically have an interest and usually specific training or access to geriatric psychiatry consultants to respond to the needs of all adults, including older adults.

SPECIALIZED SENIORS' MENTAL HEALTH SERVICES[1]

Specialty seniors' mental health services can be conceptualized as a specialty resource that provides collaborative shared care that supports community partners, learning and development, and service improvement. Access to clinical specialized geriatric mental health services is typically only required by a small percentage of older adults; approximately 3% of the whole senior population or 12 to 15% of those seniors diagnosed with a mental illness (BC Ministry of Health Services, 2002). Given that specialized services will see only a small portion of the seniors who have mental illnesses, a significant function of specialized seniors' mental health services is to support front line providers and general mental health services through consultation and knowledge translation, increasing their capacity to respond to the mental health needs of seniors. It is essential that primary care providers and front line services continue to provide ongoing overall medical and supportive care to older adults and that excellent consultation and liaison are maintained between the specialized and general mental health service providers to continue the transfer of best practices into day-to-day care, and to be involved in the system transformation needed to support people with complex disorders. Specialized seniors' mental health services

1 This section is informed by Lamperson (1994), BC Ministry of Health Services (2002) and Ministry of Health and Long-Term Care in Ontario (2003), and by consultations with Canadian stakeholders.

provide this support through shared care, collaborative activities, learning and development and knowledge translation.

Specialized seniors' mental health services should also directly support and offer clinical services to the small percentage of older adults who have complex and severe mental health problems, their families and service providers within community and long term care/nursing home settings.

Specialized Geriatric Mental Health Community and Outreach Services

Sharing some of the characteristics of geriatric medicine outreach teams, geriatric mental health community and outreach teams have specialized training in mental health and geriatric issues. They also work to enhance the capacity of the broader system of services to provide appropriate mental health care to its senior population, particularly in rural and remote regions that must rely primarily on the primary care system. Consultation, education and support are provided to community agencies, family physicians, long-term and residential care homes, and general mental health services (including community mental health teams) and family members, through collaboration and a mental health promotion and illness prevention perspective.

In addition to their consultation role, these teams have a significant treatment and follow-up function, using a shared-care or collaborative care model, for those who have severe, complex and/or persistent illnesses and would otherwise be at high risk of requiring hospital care. While treatment is time-limited (usually a few months), resourcing for these teams need to take into account this important function. The Ministry of Health and Long Term Care of Ontario has published a detailed description of these teams and their functions in its October 6, 2004 document: "Specialized Geriatric Mental Health Outreach Teams Program Policy and Accountability Framework." Specialized Geriatric Mental Health Community and Outreach Services are an essential or core component of the specialized geriatric mental health system (Ontario MOHLTC, 2004). Services are usually provided outside formal offices or clinics, generally in the senior's home (including nursing homes and retirement residences) in order to assess the senior within the context of their social system and obtain information from staff and family members who have regular contact with them and are part of the person's circle of care.

Specialized Geriatric Mental Health Outreach Services assist the primary caregivers to develop care or treatment plans and, through training and education, enhance their capacity to provide the appropriate treatment and support. They also work to enhance the capacity of the broader system of services to provide appropriate care.

The functions of the Specialized Geriatric Mental Health Community and Outreach Services (described in both Ontario's and British Columbia's planning documents) include:

- Assessment (including collection of collateral information),
- Recommendations for care,
- Direct care (treatment, case management, follow up),
- Indirect care, consultation to other care providers,
- Competency assessments or at-risk assessments as required,
- Consultation regarding program development or environmental approaches to care,
- Education and training for service providers, families and other informal caregivers, and
- Research and evaluation.

Teams require the expertise of:

- Physicians, preferably psychiatrists trained in the care of the elderly,[2]
- Nurses and psychiatric nurses,
- Social workers,
- Rehabilitation therapists (occupational therapists, physical therapists),
- Psychologists, and
- Administrative support (secretaries, receptionists).

Depending on local capacity, teams can vary from a basic two-person liaison team to sophisticated teams with 4 or 5 disciplines working in an ideal interdisciplinary format. In a well-resourced community, the foregoing disciplines would form the core mental health outreach team. In small or remote areas the foundation of a geriatric mental health team may be two or more professionals (e.g., a physician and community nurse) working together and liaising with regional specialized geriatric mental health services through tele-health technology.

Other health professionals needed for occasional consultation may include pharmacists, neurologists, geriatricians, and dieticians. Access to lawyers, ethics consultants, nutritionists and staff from the Office of the Guardian and Public Trustee should be available as needed.

It is important to note that the senior's family physician and other community health service professionals must also always be involved. Case management issues (i.e. accountability and responsibility) should be clearly defined among the collaborating professionals.

Indirect Services

Specialized geriatric mental health outreach teams are well positioned to advocate for the needs and choices of their clients and caregivers and can enhance the community care system through the development of linkages with other services, both within and across sectors. Additionally, their expertise with knowledge translation, shared care and collaborative practice is vital for capacity building in an integrated mental healthy system.

Community resources can be enhanced by:

- Establishing and maintaining alliances with the client, family and care providers;
- Using new technologies, such as teleconferencing and video conferencing to maximize outreach;
- Promoting evidence-based practice and research initiatives;
- Engaging in joint programs and educational development; and
- Jointly planning to enhance services, promote coordination and linkages and facilitate evaluation.

2 In Ontario, standards for geriatric mental health services require that a psychiatrist be on the team. In BC, physicians with an interest, or with additional training in geriatric mental health are on the team in addition to, or instead of, a psychiatrist.

Direct Services

The interdisciplinary, multi-dimensional comprehensive assessment provides the basis for a care plan and identifies appropriate treatments and support through reviewing physical, psychological, emotional and social factors contributing to the health problems of the individual, while also identifying functional abilities, environmental factors and resources that are important to maintaining health. The assessment also addresses the provision of support and education for caregivers and other clinicians that are part of the person's circle of care.

The care plan should be developed with the client and caregiver involvement. It describes the client's care requirements, treatment and support needs as well as the rationale for the recommended interventions. The plan should include clear goals and objectives based on client/caregiver informed choices and specify who is responsible for implementation/monitoring. The plan should also include crisis support strategies. It is essential that primary and other services receive regular communication regarding client status to ensure appropriate coordination of care.

In some jurisdictions, specialized geriatric mental health outreach programs may also be called upon to provide Intensive Community Treatment and Support for seniors with severe and persistent mental illnesses or to those who transition out of Provincial Psychiatric Hospitals to be cared for closer to their families. These services are sometimes referred to as "ACT-like services" as the population served has needs similar to those who are served by Assertive Community Teams (ACT) but also have an overlay of age-related complexities. It is important to note that the intensity of these services requires staffing levels much beyond the benchmarked staffing levels described for Geriatric Mental Health Community and Outreach teams.

Outreach programs may not have the resources to carry out all the roles and services described above. However, models of service delivery can be developed with more direct or more indirect care as is appropriate for an individual community. Where other programs provide overlapping services, activities will need to be coordinated and formal linkages between the services established. Local community capacity should determine the most appropriate model - collaboration with local community resources should ensure that all core functions and services are locally available.

Specialized Geriatric Psychiatry Inpatient Services

Geriatric psychiatry inpatient services are also considered to be an essential component of specialized mental health services for seniors. Although only a small number of specialized medium-stay inpatient beds are needed in the system overall (see section on benchmarks) these beds are vital to the overall functioning of the system. Without them, incredible pressure on the front line and general mental health system develops and patients often end up in more costly inpatient services where their needs are not necessarily met (for example an alternate level of care bed in an acute general hospital).

Specialized geriatric psychiatry inpatient services require highly specialized, trained staff and programs to provide care for people whose behaviours or complex disorders are beyond the capacity of general mental health staff and resources. These inpatient services consist of either medium-stay (less than 90 days) or long stay beds and usually receive referrals from acute care mental health inpatient services and geriatric mental health community and outreach teams.

Medium stay beds typically try to operate with an average length of stay of less than 90 days. Patients admitted to medium stay beds have complex needs, may need access to highly specialized treatments such as electroconvulsive therapy and most are able to return home (including their residential care home) (Tourigny-Rivard & Potoczny, 1996). These medium-stay beds are a much needed resource for geriatric mental health outreach teams that provide support to the most complex patients in the community or residential care homes, allowing effective treatment of psychiatric illnesses and stabilization of behaviour problems, which, in turn allow the patient to maintain his/her tenure at home rather than being referred to a continuing or long term care facility. In Canada, medium stay geriatric psychiatry inpatient care can be provided in various settings that have in common access to a specialized geriatric mental health team and "dedicated" geriatric mental health inpatient beds. These include dedicated beds on a geriatric inpatient service or in a geriatric care facility (e.g. at Baycrest in Toronto), dedicated beds on a general psychiatry inpatient service (e.g. Sunnybrook in Toronto or Mount St. Joseph Hospital in Vancouver) or a specific geriatric psychiatry inpatient unit located in a Mental Health Centre (e.g. Royal Ottawa Mental Health Centre).

The average length of stay for longer stay beds, also called rehabilitation beds, can vary from six months to more than a year. This inpatient specialized geriatric psychiatry service address all mental illnesses. Typically, those admitted to specialized geriatric inpatient services have more than one psychiatric illness and several concurrent physical problems and have not responded sufficiently to treatment in a medium stay specialized inpatient service. These rehabilitation beds have typically been located in provincial psychiatric hospitals and serve as a regional or provincial resource.

Geriatric Psychiatry Day Hospitals

Although only available in some of the large academic centres, geriatric psychiatry day hospitals can provide a useful alternative to specialized inpatient care and help maximize the effectiveness of specialized inpatient services, where recently discharged inpatients can continue their journey toward a full recovery. This offers the opportunity for seniors to have access to an ambulatory rehabilitation service when outpatient or community based services cannot provide the full interdisciplinary staffing that they would require for such rehabilitation. This in turns allows more seniors to access the usually very limited specialized inpatient services by shortening the average length of stay on that unit while still providing an opportunity for each patient to achieve their maximum potential for recovery (Tourigny-Rivard & Potoczny, 1996). Centres that offer specialized geriatric psychiatry inpatient care and are located in large centres as a provincial or regional resource should consider the development of a specialized geriatric psychiatry day hospital for its potential to improve access to limited inpatient resources. In some centres, the development of a specialized geriatric mental health component within an already existing geriatric day hospital may be considered.

Inpatient Geriatric Psychiatry Consultation-Liaison Services in Hospitals

In academic centres general mental health consultation-liaison services may include a geriatric psychiatrist who can provide consultation for those older adults who have more complex needs, usually at the request of the general mental health consultation liaison team. Given the small number of geriatric psychiatrists across Canada, this specialized level of consultation will need to continue to be limited to a small proportion of the seniors who require psychiatric consultation while in an acute care hospital.

Consultation-liaison services may also include indirect consultation for the purpose of education or development of staff capacity in regards to the identification or psychiatric illnesses that may present differently in older adults and/or the management of challenging behaviours.

Residential or Long-Term Care Facilities

Residential facilities are often called long-term care (LTC) homes and/or nursing homes. Residential facilities provide 24-hour access to skilled nursing care and support and intend to provide a stable, supportive living environment that maximizes the senior's independence (Ontario MOHLTC, 2003). While most residential facilities are geared towards seniors and their physical care needs, many were not initially developed to support older adults living with mental illnesses or behavioural and psychological symptoms related to dementia. However, currently in Canada, the majority of residents in these facilities have at least one psychiatric or cognitive disorder and, more often, a combination of both in addition to their medical problems. With reductions in the number of geriatric inpatient resources and, in some jurisdiction the closure of provincial psychiatric hospitals, residential facilities have become, de facto, longer-term mental health facilities. Specialized geriatric mental health services need to support the population of residential facilities as most have complex needs. They also need to support the staff of residential facilities in providing care they were not necessarily prepared to provide. There are data available about the impact of specialized geriatric mental health outreach and liaison teams on the rates of admissions from long term and residential care facilities to hospital, demonstrating that a nurse-psychiatrist team decreases significantly the rate of admission to hospital to the very low rate of one admission per 100 LTC beds per year (Wiens et al., 2009).

To better support older adults living with persistent mental illnesses or Behavioural and Psychological Symptoms of Dementia (BPSD) some facilities have developed a longer-term stabilization treatment unit or special units designed for behavioural support. This relatively new type of service is likely to assist those who previously would have accessed care in provincial psychiatric hospitals. It is clear that there will be a growing need for this type of service. An ideal system of care would provide access to such behavioural support units in at least one of the local or regional residential care home, close to or in the patient's own community, allowing families and friends to participate appropriately in the care of their loved ones. These special units, often referred to as behavioural support transition units function to treat and stabilize residents with aggressive behaviours who require periods of acute or more intensive intervention. Intended as a transitional service, these units offer flexible lengths of stays as long as residents continue working towards making progress on their behavioural goals (Coordinated System of Care for Seniors with Behavioural Issues Workgroup, [Southwestern Ontario], 2007). Behavioural support units allow for opportunities to improve resident and staff safety and to reduce emergency department usage.

Behavioural Support Systems

Behavioural Support Systems (BSS) are "integrated networks of people, services and supports, across the continuum of care that provides quality care for those with behaviours associated with complex and challenging mental health, dementia or other neurological conditions" (http://dementiaknowledgebroker.ca/). The Canadian Dementia Resource and Knowledge Exchange (CDRAKE) is leading a Canadian initiative to create guiding principles and recommended components of a behavioural support system. Such a system would dovetail with the integrated mental health system for older adults and both systems would work together to support older adults with cognitive impairments and behavioural symptoms.

Specialized Support for Emergency Response and Crisis Services

The role of specialized services is to support and liaise with general mental health crisis services rather than the provision of direct crisis care. In this role, specialized geriatric mental health services need to be responsive to requests for consultation and education from Adult Mental Health Crisis teams.

- Mental health promotion and mental illness prevention should be embedded in all services across the mental health service system.
- All services components in an integrated mental health service system should be collaborative and work together to support older adults and their caregivers in their journey towards recovery and wellbeing.
- Ensure that there are clear mechanisms between components of the mental health system for accessing each other's programs, services, or skills.
- Community supports, front line services for seniors, general mental health services, and specialized seniors' mental health services are required for an integrated mental health service system for older adults.
- Ensure that primary care providers have the skills in early identification, early intervention and referral of dementia and other mental illnesses.
- At minimum, specialized geriatric mental health services should have a community and outreach capacity (geriatric mental health community and outreach teams), be resourced to support residential (long term) care homes and also have a medium-stay and/or longer stay inpatient service.
- Specialized geriatric mental health services should also be resourced to be able to effectively support a wide range of adult mental health services through timely consultation and education. The provision of direct care in the community (accepting the responsibility for ongoing psychiatric care) requires significant additional resourcing (beyond the resources suggested below for outreach services). For large regional or provincial centres, a specialized geriatric psychiatry day hospital should be considered to ensure that an ambulatory rehabilitation service is available as an alternative to inpatient rehabilitation.

STAFFING BENCHMARKS FOR SPECIALIZED SENIORS MENTAL HEALTH SERVICES

In relation to mental health services for seniors, benchmarks have been described as optimal capacity guidelines to be adjusted to local needs and a reference point for further planning (Lamperson, 1994) and similarly as resource guidelines for specialist mental health services (Mental Health Commission, New Zealand, 1998). More generally in mental health, establishing benchmarks against leaders in the field promotes best practices and continuous service improvements (Bayney, 2005).

The service benchmarks presented in this section are informed by an international cross-jurisdictional review of the capacity benchmarks of publicly funded specialist mental health services for people age 65 and over (Finlayson & Durbin, 2010).

Only 5 jurisdictions with service benchmarks were identified: New South Wales Australia, New Zealand, British Columbia, and two in Ontario. The benchmarks recommended in the two Ontario jurisdictions were limited to outreach services to older adults with mental health needs in the community and without reference to a continuum of care. The full Benchmark Report (Finlayson & Durbin, 2010) summarizes the jurisdictions, their service contexts, and their benchmarks and can be found online with the accompanying materials at www.mhccseniorsguidelines.ca. Below is a brief discussion of the findings of the benchmarks, followed by the proposed Canadian benchmarks.

As indicated in the literature, the number of individuals who are assumed to require and access specialized mental health services at any one time is fairly consistent, ranging from 1.9 to 2.5 % with only British Columbia with a higher estimate of 5% (Finlayson & Durbin, 2010). The core range of services included both community and inpatient services with New Zealand also benchmarking day care places and Australia dedicated residential care beds.

Specialized Geriatric Mental Health Community and Outreach Services (SGMHCOS)

New Zealand and New South Wales' benchmarks for resourcing specialized community and outreach teams were fairly similar, with 10 to 12 Full Time Equivalents (FTEs) health professionals per 10,000 elderly, higher than the proportion recommended in BC and Ontario (5 to 5.5 FTEs) (Finlayson & Durbin, 2010). It should be noted that the New Zealand benchmarks clearly include an intensive community treatment and support function that may be carried out, in part, by Assertive Community Treatment (ACT) teams in Canada, when they admit all adults, including seniors in numbers proportional to the population (Finlayson & Durbin, 2010). In fact, intensive community treatment and support is not included in the description of Specialized Geriatric Mental Health Outreach teams in Canada and the recommendations for staffing of outreach teams in Ontario did not anticipate their potential to provide ACT-like services for seniors who need to transition out of Provincial Psychiatric Hospitals. However, this type of service is being developed in some areas, for example, the Southlake Regional Health Centre Psychogeriatric Assertive Community Treatment Team which has the following goals:

- Lessening or eliminating the debilitating symptoms of mental illness, and to minimize or prevent recurring episodes of illness.
- Meeting the clients basic needs and enhance their quality of life.
- Lessen the family's burden of providing care.
- Decrease the number of hospital visits, emergency visits and crisis service contacts.

- Improve functioning in geriatric social activities. (http://www.southlakeregional.org/mentalhealth.adult.html)

Serving the mixed urban / rural York Region in Ontario their catchment area has approximately 34, 000 older adults (note: exact number difficult to calculate due to blurred catchment areas) (Central Local Health Integration Network, 2008) and their team has 7.2 FTE Health professionals (including 0.2 FTE physician) as well as 2.0 FTEs for management and administrative support. This team provides services to 52 patients, each FTE providing active care to a relatively small number of patients due to the intensity of services required (Paul Cappuccio, personal communication, April 2011).

In comparison, health professionals working as part of specialized geriatric mental health community and outreach teams typically provide services to 40-45 seniors per FTE at any given time and each FTE sees over 100 unique individuals over the course of one year. The services provided are less intensive and time limited, using a shared care or collaborative care approach with primary care services and existing community resources.

Of note, is that both New Zealand and New South Wales specifically dedicate FTEs per 10,000 elderly for the support of residential care homes (1.1 FTE and 5 FTEs respectively), recognizing this as an important role for SGMHCOTs (Finlayson & Durbin, 2010). The Ontario (2004) policy document on Specialized Geriatric Mental Health Teams also mentions this important role without providing specific benchmarks for this function. However, experience in the Champlain region suggests that at least 25% (and up to 40%) of residents of LTC homes should benefit from a comprehensive assessment from the SGMH Outreach team during the course of one year through regular (at least monthly) visits in order to decrease the need for hospital admissions (Wiens et al, 2009). This reflects the fact that residential care homes have become the new mental health facilities for those with persistent mental and behavioural problems in these two countries as well as in various provinces of Canada.

Geriatric Mental Health Inpatient Services

Benchmarks for inpatient services should cover a range of needs, from acute (short-term) admission for crisis management or clarification of diagnosis, to medium-stay admissions where there is enough time to treat most severe illnesses and achieve a good level of recovery, to longer-stay/rehabilitation for those with persistent severe mental illnesses. Access to this range of inpatient services allows the health care system to provide the right level of service in a timely manner.

For acute/short term care (average length of stay [ALOS] of less than 1 month in New South Wales, time limited but unspecified in New Zealand), the number of hospital beds suggested as targets is respectively 2.6 beds per 10,000 elderly (NSW) and 4.5 beds in New Zealand. However, there are no specific targets provided for those who cannot recover sufficiently to return home in such a short period of time. BC suggests 4 to 6 beds for short term assessment and treatment (ALOS 4-6 weeks) but also acknowledges the need for other (longer term) tertiary beds (Finlayson & Durbin, 2010). It should be noted that the recommendations for NSW and NZ are more recent than the initial recommendations in BC and that, in Australia, residential care beds provide an option for longer term treatment in a care setting.

For medium-stay inpatient services, we note that a number of Canadian centres have provided this type of specialized (or tertiary) service (ALOS 6-12 weeks) over the last several years

(Sunnybrook, Baycrest, Royal Ottawa Hospital, Mount St. Joseph Hospital in Vancouver, and others). Based on the experience of the well defined catchment area of Champlain in Ontario, it would appear that 3 to 4 specialized medium stay beds per 10,000 elderly allow for timely access to specialized inpatient care and greatly minimize the need for longer term inpatient admissions in the Provincial Psychiatric Hospital serving this area (Tourigny-Rivard, personal communication) while supporting specialized geriatric mental health community and outreach teams, Residential (Long Term) Care Homes and General Adult Mental Health services as described in the section on specialized services above. This target would be in line with the BC recommendations for 3 tertiary care beds (ALOS 4-6 months) per 10,000 over age 65. This target however assumes that there is a good range of well-coordinated geriatric mental health services, including an option for those who require specialized longer term/rehabilitation care.

For geriatric mental health rehabilitation or longer term inpatient care, there are no clear benchmarks or target recommended in the current literature. However, in Canada, this type of inpatient care has been provided mostly in Provincial Psychiatric Hospitals, often far away from one's family and original community. While there is consensus amongst experts that there is a need for this type of care, there is also agreement that alternative settings should be explored, such as Behavioural Support Units in Long Term Care Homes, as a way to bring this type of care closer to one's home community. Therefore, it may be useful to consider the target provided by Australia for residential care beds outlined below.

Residential Care Beds For Seniors With Persistent Illnesses And Behavioural Problems

Our understanding is that residential care beds recommended in New South Wales provide services similar to those described in Canada as "Behavioural Support Units" and were developed when hospitals that provided longer term psychiatric care closed. It is interesting to note that, in Australia, they recommend 5.1 dedicated residential care beds per 10,000 elderly, which may provide a useful target for jurisdictions that are developing behavioural support units as part of their Behavioural Support System. In British Columbia, the suggested benchmark for Residential Care beds was 10 beds per 10,000 elderly (Lamperson, 1994).

Day Care/Day Treatment Programs

The New Zealand document suggesting benchmarks for services describe Day Care as providing daytime treatment and support for older people with ongoing and disabling mental illnesses outside their home. This may take place in a hospital or community setting. The benchmarks suggested by New Zealand are 4 places per 100,000 total population or 3.8 places per 10,000 elderly.

It is unclear whether these programs include what is described in Canada as Dementia Day Away programs (considered Day Care) or Specialized Geriatric Mental Health Day Hospitals, which offer more intensive treatment, often as a way to prevent or shorten inpatient admissions. The Champlain region of Ontario, which has a Geriatric Mental Health Day Hospital serving the urban population of Ottawa (population 108,000 elderly), currently has 45 places (4.1 places per 10,000 elderly).

Professional Human Resources Benchmarks

The only specific discipline mentioned in the benchmarks is the physician component required to work within the geriatric mental health outreach teams described above (1 FTE per 10,000 elderly). Other health disciplines, which are required as part of SGMHCO teams, are not assigned a specific

benchmark, although most Canadian teams have a preponderance of nurses working within these teams.

Similarly, specific benchmarks for human resources required for geriatric mental health hospital-based services are not available at this time. However, planners will be provided with examples from existing Canadian services on the Mental Health Commission of Canada website, outlining specific services in more detail (e.g. medium stay Inpatient service, Day Hospital service), also describing operational characteristics and referral population for their consideration.

PROPOSED CANADIAN BENCHMARKS

Service	Benchmark per 10,000 elderly	Notes/Description
Seniors' Mental Health Outreach and Community Teams*	5.5 FTE Health professionals	Provides functions outlined in a 2004 Ontario Ministry of Health policy document, including consultation-liaison services to residential (long term) care homes, collaborative/shared care in community settings and capacity building models of care. These teams can only provide time-limited direct care services.
Intensive Community Treatment and Support	5.25 FTE Health professionals	Psychogeriatric Assertive Community Transition Team (as modeled in Ontario) or Assertive Community Treatment for seniors with persistent and severe mental illnesses.
Acute, short-term Inpatient Psychiatric beds	3 Beds	Usually located on a general acute care psychiatric inpatient service, ideally with geriatric psychiatrist consultation/support and average length of stay of approximately 1 month.
Specialized (Medium Stay) Geriatric Psychiatry Inpatient (Hospital) beds for Assessment & Active Treatment *	3.3 Beds	Geriatric psychiatry beds for seniors who require intensive treatment and the expertise of a specialized geriatric team in hospital, with an average length of stay below 90 days.
Residential Mental Health Beds (non-hospital)	7.5 Beds	This is for longer term stabilization & treatment for those with severe & persistent behavioral and psychological symptoms of dementia on a specially designed unit in a long-term care facility.
Specialized Geriatric Psychiatry Inpatient Beds - Long Stay (over 90 days)	**	For example rehabilitation or chronic care beds in a psychiatric hospital (or in other supportive housing) for those with severe and persistent psychotic disorders.

* Core service
** A target of 3 beds/10,000 elderly suggested in previous (BC) benchmarks but this target can be lowered to less than 1/10,000 if Residential Mental Health Beds (described above) are available.

APPLYING THE BENCHMARKS

It is recognized that there are other services from various sectors that complement and support specialty services to an older population, particularly geriatric services and general mental health services. Neither their roles nor those of services that may provide similar functions to specialty services but are funded or administered outside of specialist mental health services were considered in the development of the benchmarks. With this in mind it is imperative to take into account existing local resources and supports when assessing the applicability of the benchmarks to specific service areas and to diverse seniors' populations. As well, local circumstances that can affect applicability of any benchmark or resource guidelines need to be considered, including geography (e.g.. rural vs. urban), cultural composition of the population as well as ongoing changing demographics (such as an increase, not only in the elderly, but particularly in those over age 85 who are likely to have greater health care needs than younger seniors). Local priorities and how local services and supports have evolved, have been organized and funded, are also germane in assessing how the benchmarks can be applied and may affect their distribution.

Canadian planners were surveyed about the feasibility and relevance of the proposed Canadian benchmarks to their jurisdictions of service benchmarks identified above. Results from the survey suggest that the benchmarks are relevant to Canada and although not yet reached according to respondents, they appear to be reasonable service goals to work towards. Some respondents indicated that lower benchmarks could be considered for behavioural support units in LTC or residential care homes and long stay specialized geriatric psychiatry inpatient beds if specialized outreach services are resourced to provide excellent support to long term or residential care homes and there is good access to specialized medium stay geriatric psychiatry beds. According to respondents to our survey, currently there is no jurisdiction in Canada that has the full range of services for a given catchment area or has services that meet the proposed benchmarks. However, most areas have some of the core elements in place that can be strengthened and or complemented with gradual and incremental changes to the system.

- Consider the benchmarks for specialized geriatric mental health services described in these *Guidelines* when allocating resources, taking into account the population size, existing range of available services, gaps and bottlenecks, as well as the priorities of the community.
- Utilize the staffing benchmarks described in these *Guidelines* to evaluate existing relative level of resourcing for specific specialized services and to guide future investments in resources.

PART III: Facilitators of a Comprehensive Mental Health Service System

ACADEMIC CENTRES

» A review of Universities and Colleges current curriculum content and faculty resources should be done periodically to ensure that the mental health needs of seniors is adequately addressed in the preparation of future health professionals and the provision of continuing education programs.

Education is a major enabler in the development of all parts of a comprehensive mental health system. Universities and Colleges play an important role in building capacity for all service sectors, through the curriculum they offer to various future health professionals as well as through the supervised clinical experience they provide in university-affiliated clinical teaching units. Universities also offer opportunities for research, knowledge translation and continuing education for health professionals who have already joined the work force, creating opportunities to improve the care provided to Canadian seniors. Academic centres have a responsibility to ensure that the health professionals they prepare for the work force have a good understanding of mental health issues that commonly affect the elderly since most health professionals participate in the care of seniors during their careers. Therefore, academic centres are expected to take a leadership role in the recruitment and retention of geriatric mental health specialists from various disciplines, to fulfill these academic responsibilities. Keeping in mind the human resources required to staff the services outlined in the above table, colleges and universities need be responsive to the human resources needs for the overall mental health of seniors. Technology is increasingly used to ensure that education is available to professionals who work in rural and remote communities, including the use of tele-health for clinical consultations that serve as "case-based" educational opportunities for primary care providers.

CULTURAL SAFETY

Originating in the 1980s in New Zealand with the Maori people, the concept of cultural safety can assist in policy development, service planning, and practice for diverse and marginalized populations (van Gaalen, Wiebe, Langlois & Costen, 2009). Cultural safety is a term that has been adopted by Canadians, particularly within Aboriginal health. The National Aboriginal Health Organization offers the following description of cultural safety:

> Cultural safety within an Indigenous context means that the educator/ practitioner/professional, whether Indigenous or not, can communicate completely with a patient in that patient's social, political, linguistic, economic, and spiritual realm ... Cultural safety requires that health care providers be respectful of nationality, culture, age, sex, political and religious beliefs, and sexual orientation... Cultural safety involves recognizing the health care provider as bringing his or her own culture and attitudes the relationship
>
> National Aboriginal Health Organization, 2008, as cited in van Gaalen et. al, 2009, p.11

With respect to First Nation seniors, the Alianait Inuit-specific Mental Wellness Task Group (2007) suggests that one strategy for developing a culturally safe and culturally competent mental health system is to engage knowledgeable elders in Canada's First Nations, Inuit, and Métis communities to teach traditional ways and participate in the planning and delivery of mental health services. According to the University of Alberta and Alberta Health and Wellness (2004), a culturally safe and competent mental health system is likely to lead to more use of mental health services by Aboriginal people, greater mental health awareness and reduction of stigma, and an increase in awareness of Aboriginal health and cultural issues by mental health workers and service providers.

The National Aboriginal Health Organization's concept of cultural safety can clearly be applied beyond Aboriginal and Indigenous populations. In fact, this definition of cultural safety is broad enough to be applied to all people, and application of this concept meshes with the concept of person centred care, a key principle underpinning these *Guidelines*.

Achieving cultural safety in practice, policy and system development is a commitment and requires skill and awareness at all levels. The following suggestions for facilitating cultural safety within the mental health system have been offered:

- Employ mental health workers from ethnocultural backgrounds, and train service providers so that awareness of, and responsiveness to, diverse needs and strengths becomes commonplace (Sadavoy, Meier & Ong, 2004; MHCC, 2009).
- Accreditation bodies and provider organizations adopt standards enforcing culturally safe and competent practices (Sadavoy, et al., 2004; MHCC, 2009).
- Actively and meaningfully involve seniors from diverse populations in policy development, implementation, evaluation, and review (Seniors Psychosocial Interest Group, 2004).
- Ensure that service providers have the training required to increase their capacity to become culturally competent in service to Canada's First Nations, Inuit, and Métis elder populations (Province of Alberta, 2004).

It is important to note that achieving cultural safety is a process, often considered a moving target. There is no recipe for implementing culturally safe standards and processes given the individual nature of what is considered 'culturally safe' in mental health care to people with lived experience and their caregivers. As such, ongoing reflection, awareness, and education are vital to moving towards a transformed system with improved cultural safety for all older adults.

DIVERSITY

In Canada the seniors' population is heterogeneous and made up of many different groups (e.g., First Nations, lesbian-gay-bisexual-transgendered [LGBT], employed), each of which has diverse needs, strengths, circumstances, and aspirations. Every province has immigrants, refugees, ethno-cultural and racialized groups, and within these groups intersecting diversities, such as age, sexual orientation and gender, add an additional layer of complexities (MHCC Diversity Task Group, 2009). Variations in education, literacy, competency in official languages, health and income create additional vulnerabilities to marginalization. According to the Public Health Agency of Canada (2003),

> Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services
> http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php, para 30

Although it is estimated that 30 to 60% of persons with a moderate or severe developmental disability have a mental disorder, diagnosis and treatment are difficult given overlapping co-morbid symptoms, communication barriers and a scarcity of expertise in both developmental disability and psychogeriatrics (Dual Diagnosis Task Force of the Public Policy Committee, 1998). The National Advisory Council on Aging (2004) report, Developmental Disability, Mental Health and Illness , identifies a number of factors that contribute to the marginalization of seniors with developmental disabilities:

> The notion and the reality of differences in capacity have often caused them to live parallel lives socially and economically. This means that mainstream information on disease prevention may not be reaching them. This is compounded by the rarity of experts on aging with developmental disabilities and the difficulties of communication – possible factors in preventable or undiagnosed conditions, and lack of access to proper care and other services in the areas of physical or mental health. Social and financial supports are also critical to the continued well-being of seniors with disabilities (p.6).

Investigation may be necessary to identify any inequities specific groups (e.g., developmentally challenged, immigrant, homeless) may experience or special issues and challenges they face that increase their vulnerability and marginalization, with concomitant risk to their mental health. , This is necessary to ensure that information, education, interventions, services, programs and policies are appropriately tailored to the characteristics and needs of specific groups.

LGBT caregivers experience challenges that shape the caregiving experience as well as service provision/utilization. Specifically, LGBT individuals may experience barriers to accessing services because of their own encounters with discrimination or prejudice. Older LGBT adults may be perceived not to have 'families' or support for families, whereas the literature shows this not be the case. Thus, intervention options that include family members (e.g. family support therapies), or religiously based support interventions can be impacted by treatment provider beliefs/stereotypes about LGBT individuals and what would be considered "appropriate" care. As Coon (2004) points out, there may be hesitation for LGBT caregivers to participate in support groups that would involve them self-disclosing their sexual orientation. Further, older LGBT may experience difficulties disclosing or "coming out" that younger individuals would not.

Attending to Canada's many diversities is an ongoing challenge for mental health providers. The *Out of the Shadows report* (Standing Senate Committee on Social Affairs, Science and Technology, 2006), noting the diversity of the senior population, asserts that the Canadian mental health system has failed to recognize the 'uniqueness and diversity of seniors' needs, resulting in barriers accessing services.

- Barriers related to diversity that may be faced by seniors accessing the mental health system include: Limited understanding and capacity to negotiate the current system
- Lack of services that combine ethnocultural, geriatric, and psychiatric care
- Inadequate interpreter services or lack of materials and services in spoken language
- Reluctance to acknowledge mental health problems for fear of stigma (Sadavoy et. al, 2004; Canadian Mental Health Association, Ontario, 2010)

The Seniors Mental Health Policy Lens (MacCourt, 2008) provides a framework for identifying diversity and for considering the needs of diverse seniors populations and can be applied to programs and policies that affect older adults.

» Utilize the Seniors Mental Health Policy Lens to assess whether any seniors affected by a specific program or policy are likely to experience inequities or negative impacts resulting from their memberships in marginalized groups.

In order to reach seniors from diverse cultures, materials and services must be developed and delivered in a culturally sensitive manner (Sadavoy, et al., 2004). A highly promising intervention for Chinese female caregivers demonstrates that interventions can be successfully tailored to accommodate ethnocultural beliefs about dementia. Specifically, Gallagher-Thompson and Coon (2007) provided an in-home behavioural management (IBHM) psychoeducational support program, based on CBT theoretical underpinnings. This intervention was able to show significant effects on caregiver depressive symptoms and caregiver related stress. The decision to modify components of the intervention, such as delivery of the behavioural management in-home versus an external setting, and to adapt the language and communication style (e.g. rephrasing "assertiveness training" to "practicing ways to communicate effectively with those who can assist with caregiving," as well as particular content issues (e.g. the perception that it is shameful for spouses to seek help from adult children), were made by consulting with focus groups of individuals before the implementation of the program.

Value orientation in terms of beliefs about health and illnesses in general, and mental health in specific varies among cultures. Similarly expectations about familial caregiver roles and responsibilities as in filial piety can also vary in ways that impact on how seniors of diverse

ethno-cultural groups and their families access help with behavioural and mental health challenges. Availability of culture appropriate care and culture competent care providers in the mental health realm is critically important to addressing the mental health needs of seniors in a culturally safe way.

Given the many dimension of diversity, examples exhaustively demonstrating its importance is beyond the scope of these *Guidelines*, however more illustrative discussions on this topic can be found with the online version.

CAREGIVERS AS VITAL PARTNERS IN CARE

» Ensure that caregivers are recognized through policy and programs and that they are valued as partners in care.

» Actively involve caregivers and family members of seniors with mental health problems and illnesses in the development of policies and services.

Support for family caregivers is a vital element of a comprehensive integrated mental health system for seniors. Caregivers provide more than 80% of care to seniors, and contribute more than $5 billion of unpaid labour to the health care system (Hollander, Liu, & Chappell, 2009). As the number of seniors grows (to 27% by 2050), so will the need for families to provide care to them (Butler-Jones, 2010). Many caregivers value providing care and experience positive benefits from doing so. Problems arise when the emotional, physical and time demands of caregiving become overwhelming, sometimes resulting in caregiver burn out and facility placement for the care receiver. In spite of their important role caregivers are not adequately supported by health and social services or by public policy. Most public policies that affect caregivers directly or indirectly (e.g., health services, labour) have been developed without taking into account their needs and may have unintentional negative effects on caregivers and their families, compromising their capacity to provide care.

The availability of appropriate services for the persons being cared for, and how they are delivered, affects the ability of caregivers to provide care and their well being. Caregivers of (1) older adults generally (McGee, Tuokko, MacCourt & Donnelly, 2004), (2) of seniors with dementia (Dementia Service Framework Working Group, 2007), and (3) of caregivers/families of seniors with longstanding mental illness other than dementia (MacCourt & Tuokko, 2005), described the challenges they experience in obtaining support as follows:

- There is a lack of appropriate information about, for example the mental illness of the person being cared for, what to expect and how to manage symptoms.
- Although the persons being cared for usually have several illnesses and physical limitations, care and services are fragmented and disconnected.

- The person they are caring for is "assessed to death" as a result of poor communication amongst providers.
- Information about resources is difficult to find as is how to access resources discovered (e.g., complexity of forms, language, print size and unclear eligibility criteria).
- Appropriate services (e.g., transportation, home support, respite, residential care) are seldom available when needed.
- Some services are not affordable for seniors and families with low income.
- Home support services are generally unavailable outside of business hours.
- Services in the community and long-term care beds are often not available when required due to lengthy wait lists even though eligibility criteria have been met. This can precipitate crises and a breakdown in caregiving situations.
- There is little support to help families and caregivers cope with adjusting to, and coping with, the role of caregiving, especially when the person cared for has a severe or chronic mental illness.
- Some seniors' services are not accessible to the persons being cared for if they, for example, smoke, use alcohol or have challenging behaviours.
- The "next available bed" policies in some provinces, (whereby seniors, particularly those waiting placement in hospital, must take the first available residential care bed regardless of cultural or location preferences), creates enormous distress, especially for spouses who are unable to drive or otherwise access transportation to visit.
- It is stressful (e.g., having to direct them, feeling invaded), to have many different people coming into the home to help---continuity of care providers is less distressing..

Caregiving is associated with physical and psychosocial symptoms, (including depression, stress, burden, fatigue, feelings of anger, guilt, grief and loss, frustration, loneliness, isolation, and decreased well-being and life satisfaction) which may place the physical and mental health of the caregiver, and their ability to continue to provide care, at risk (Keating, Fast, Frederick, Cranswick & Perrier, 1999). Those who provide care to chronically ill and elderly persons are vulnerable to elevated levels of stress and depression (WHO, 2004a). It is estimated that 60% of caregivers have a health crisis after 18 months of caregiving (Senior Education Centre, University of Regina, 1995). Caregivers also face "increased financial expenses such as fees for home care services, transportation costs for medical appointments, drug dispensing, technical aids and equipment, and home modification" (Maytree Policy in Focus, 2010, p. 2) that can cause strain.

» Ensure that the way in which services are organized and delivered is flexible, individualized as much as possible, responsive to the concerns and needs of caregivers, and available at the time needed.

» Ensure that there are mechanisms in place to facilitate effective communication between services and service providers involved in the care of individuals.

» Provide continuity of service providers to reduce number of people in the home and to maximize relationship building.

» Provide adequate, timely and flexible information, education, and practical and emotional support to caregivers.

» Ensure there is integration and coordination of information and services across systems for seniors with mental health problems and illnesses.

» Ensure that cultural and location preferences of seniors and their caregivers are respected when placement outside of the home is required.

» Ensure caregivers are provided with the education, practical and emotional support necessary to carry out their role without jeopardizing their own health and mental well-being. Provide financial support for caregivers through mechanisms such as national and provincial taxation systems.

» Ensure all informal or family caregivers have access to psycho-educational and skill-building programs geared to the specific challenges of those for whom they are providing care.

» Create opportunities for peer support for older adults with mental health problems or illnesses and their families to meet with others who have experienced living with mental illness and knowledge about mental health services and supports in Canada.

» Support the mental and physical health and well-being of caregivers, especially older caregivers, early on in the disease process.

Practical support, such as home support services to assist with physical needs of the care receiver and equipment and supplies such as continence pads and mobility aids, can assist caregivers. Respite care, in the home or outside of it, and day programs for the care receiver can reduce some of the burden of care and allow the caregiver to "recharge." Ensuring that services and programs are affordable and readily accessible when needed can also alleviate stress. General education and education and skill development related to specific challenges presented by the care receiver are required to facilitate coping with and managing care effectively. Psychoeducational support groups can alleviate stress associated with caregiving. Sorensen, Pinquart and Duberstein (2002) carried out a meta-analysis to synthesize the effects of 78 controlled caregiver intervention studies for 6 outcome variables, and found psycho-educational interventions for family caregivers of older adults resulted in significant improvements in caregiver burden, depression, subjective well-being and perceived caregiver satisfaction.

Caregivers' needs are not formally acknowledged, assessed or addressed by health and social services in most Canadian jurisdictions and service providers lack evidence-informed tools and resources to do so. Findings from the Sustainable Caregiving Community Project in British Columbia (Antifeau, 2009) have confirmed the importance and significant benefit of assessing and addressing caregiver needs as early as possible and throughout the journey of dementia, in order to sustain an individual with dementia at home for as long as possible.

The Special Senate Committee on Aging (Carstairs & Keon, 2009), recommended a National Caregiver Strategy that would result in the creation of a framework by which all jurisdictions and sectors can meet the needs of an aging population and reflect the compassion that is fundamental to Canadian values (Carstairs & Keon, 2009). The Mental Health Commission of Canada (2009) reinforced this need in their call for support of family caregivers in its strategy framework.

SUPPORT FOR SERVICE PROVIDERS

In order to ensure a seamless system of mental health services is available to older adults, support for service providers should be considered a component of an integrated mental health system for older adults.

Most care of older adults, including those with mental health problems or illnesses, takes place in the community in people's homes, retirement homes, and in independent and assisted living and long term care home settings. Service providers, usually home care workers or nursing aids, often care for seniors with very complex interconnected physical, cognitive and mental health care needs. It is important that these front line workers are able to identify and respond to seniors' mental health and cognitive needs as well as to their physical health needs. , Professional service providers including family physicians also provide frontline care and require similar (but more advanced) knowledge and skills appropriate to their responsibilities.

» Ensure service providers (current and future) who work with older adults have access to education about the unique needs of seniors with or at risk of mental illness, and access to clinical and ethical consultations.

» Ensure service providers have support in carrying out their roles, including adequate supervision and mentoring, a healthy work environment and sufficient resources.

Core competencies/knowledge in the care of older adults required by service providers, have been developed by the National Initiative for the Care of the Elderly (NICE), in collaboration with the Geriatric Education and Recruitment Initiative, in the following areas.

- Medicine as developed by the Canadian Geriatrics Society
- Psychiatry as developed by the Canadian Academy of Geriatric Psychiatry
- Interprofessional as developed by the National Initiative for the Care of the Elderly

In addition to the competencies needed to care for older adults, front line care providers (including family physicians) caring for seniors with mental health problems and illnesses, including substance abuse, require additional knowledge and skills appropriate to their roles:

- Normal aging
- Risk and protective factors for positive mental health
- Geriatric conditions, co-morbidity, pharmacology
- Mental health problems and illness including dementia, substance misuse and addictions
- Behaviour management
- Elder abuse
- Communication and relationship building skills
- Cultural competency
- Recovery orientation
- Skills in team work and collaboration

» Ensure that health care providers and community organizations have the knowledge, skills and time to offer older adults and their families accurate and timely information and education that are specific to the needs of seniors.

» Service providers working with older adults require access to education and clinical consultation appropriate to their roles from specialized mental health clinicians from a variety of disciplines, and a range of services.

Specialized mental health clinicians and services can provide this knowledge through education, mentoring, and consultation about challenging situations. Formal mechanisms built through partnerships amongst the different components of a comprehensive system will ensure that this support is readily accessible in a timely manner. Mechanisms such as video conferencing to rural areas and shared care with family physicians can facilitate broad delivery. Clinical practice guidelines and best practices are also available to inform evidence-based practice (see further information in section III Application of Knowledge and Evidence).

» Service providers throughout the entire continuum of services in a comprehensive mental health system require access to ethical consultation.

The complex situations that some older adults with mental illness including dementia, substance misuse and addictions experience can present service providers with very challenging care issues. The assessment and response to elder abuse, or issues related to right to live at risk for example, often involve consideration of family dynamics, medical or legal assessments and issues, competing rights and resource allocation decisions, to identify just a few of the complexities. Service providers' professional and personal values may be challenged and differing points of view amongst all those involved may be very difficult to resolve. Ethical dilemmas confront all levels of service providers in all settings where care and treatment is provided and can be a significant source of distress for all concerned.

The performance of any health care organization (and the care provided) depends on motivated, knowledgeable, and well-resourced employees (Koehoorn, Lowe, Rondeau, Schellenberg, & Wagar, 2002). The complex nature of interconnected physical, mental, cognitive, spiritual and functional needs of many older adults with a mental illness, challenging behaviours that sometimes occur, and the moral distress that can arise from challenging ethical issues, can together overwhelm the capacity of some service providers. As well, in the face of recessions and restructuring, increased demands within the health care system combined with a shrinking workforce, adequate staffing of services to older adults is problematic.

A recent international survey of registered nurses found that less than half of the respondents reported adequate human resources to meet demands in terms of numbers of RNs or support staff (Aiken et al., 2000, as cited in Koehoorn et al. 2002). Without adequate support and resources, service providers may experience injuries, burn out, presenteeism, absenteeism, or mental health problems such as depression or anxiety. Nurses have among the highest rates in Canada of job absence due to personal illness or injury, psychological distress, and burnout as identified by the Clair Commission in Quebec (Maioni, 2001, as cited in Koerhoorn et al., 2002). In addition to the costs to service providers and those they care for, it is estimated that work-related productivity loss due to depression costs Canadians

$4.5 billion a year (Minister of Public Works and Government Services Canada, 2006). Collaborative research from Canada, Health Canada, and CIHI indicates that nurses with exposure to elements of work stress (high job strain, low supervisor support, low co-worker support, high job insecurity or high physical demands) are more likely to report fair or poor mental health compared to nurse with less exposure (Shields & Wilkins, 2006).

Organizational barriers to optimal care delivery to older adults with mental illnesses have been identified as administrative and institutional financial barriers; lack of collaboration and coordination between service providers; difficulties in implementing new evidenced-based practices; staff shortage and recruitment difficulty; lack of prevention and inefficient screening; and difficulties in implementing staff re-education (Bartels, 2003). Issues related to multidisciplinary teamwork (e.g. hierarchical distribution of expertise, responsibility, leadership, and clinical decisions (Speer & Schneider, 2003) are also germane. Koerhoorn and colleagues (2002) point out that

> The structure, values, cultures and working relationships inherent in an organization contribute to the quality of work. Workplaces that meet workers' needs to participate and make a contribution, provide psychological and economic security, offer opportunities for skill development, and have the right balance of job demands and resources will be more effective and healthier than workplaces lacking these traits (p.16).

» Develop and foster healthy work place environments to attract and retain service providers and to maximize their capacity to provide optimal care to older adults.

» Ensure that mechanisms are in place for service providers to access adequate and appropriate resources to carry out their responsibilities.

» Ensure that supervision or mentoring is available to support service providers in their roles.

The following, from a British review of evidence (Godfrey et al., 2005) summarizes the importance of adequately resourced supportive work environments to the care of older adults with mental illness:

- Individualized, person-centred care requires that care staff have the knowledge and skills to design and implement such care plans.
- Significant improvements in depression and cognitive abilities in the persons with dementia can be gained when facility care staff receives training and ongoing support in developing care plans from a specialist mental health team.
- Care staff who have an empathic understanding of what it may be like to experience dementia, and with the skills to support a broad range of psychosocial needs can have a positive effect on the well-being of people with dementia.
- Care staff need ongoing support, including receiving recognition for their efforts.
- For person-centred care to be effectively implemented, organizations and facilities need to be committed to the approach and supportive of care staff in implementing it.

» Staff caring for older adults must have the sensitivity, knowledge, skills and institutional support to develop and carry out optimal care.

INTERSECTORAL PARTNERSHIPS AND COLLABORATIONS

Collaborations or partnerships between the health care system and other sectors can foster the individual, social and environmental conditions that protect mental health and address those that do not (Herrman, 2001). Communities have the potential to pool resources to offer a wide array of integrated and supportive mental health promotion approaches and activities that can influence the determinants of mental health.

Effective intersectoral collaboration identifies common goals among diverse sectoral partners and then ensures coordinated planning, development and implementation of the related policies, programs and services. Partnerships or collaborations can help assess and improve the efficiency of program operations, and cut or avoid duplication of programmatic costs. Partnerships can also maximize collective competence of the members and the community, develop community ownership and role models for promoting community health, establish credibility within various sectors of the community, and help assure that interventions are accessible and appealing, particularly for isolated and diverse populations. Ultimately, the value of these partnerships will be reflected in the community's enhanced ability to address the multidimensional, interdisciplinary nature of mental health promotion and chronic disease self- management, and to promote holistic and enduring healthy lifestyles of its older adults.

» Partnerships and collaborations between the seniors' mental health sector, government and non-government organizations, special interest groups (e.g., ethnocultural, faith), and voluntary organizations should be formed to build communities that enhance mental health.

In a study of effective partnerships in health promotion and aging supported by the Centers for Disease Control and Prevention, the National Council on the Aging (2004), using criteria for effective health promotion programming established by advisors, identified the following major components of building and sustaining successful partnerships to promote healthy aging:

- Establishing the mutuality of common goals is crucial to focusing and sustaining the partnership.
- Regular forms of communication keep partners on track, updated and feeling part of the process.
- Agreements, whether formal or informal, are needed to clarify member roles and assess program achievements and problems.
- Staff orientation to new programs and partnerships is essential for effective and efficient program operations.
- Recognition of the efforts of partners, staff and volunteers, and sharing of publicity of program successes, is a win-win strategy for maintaining investment in the program while, at the same time, raising public awareness.
- Developing partnerships and trust takes time. Give them time and reap the rewards. (p. 10)

COLLABORATIVE OR SHARED CARE

Multiple mechanisms are required to drive mental health service delivery, particularly given the many capacity and human resource issues faced by service providers and systems. Such mechanisms include using technology to assist with providing care, using inter-sectoral and interdisciplinary collaborative partnerships, system navigation and shared care.

Support for shared care in Canada was solidified during the era of the Canadian Collaborative Mental Health Initiative (CCMHI). The CCMHI was led by 12 national organizations representing community services; consumers, families and caregivers; self- help groups; dietitians; family physicians; nurses; occupational therapists; pharmacists; psychiatrists; psychologists; and social workers and was funded through Health Canada's Primary Health Care Transition Fund (CCMHI, 2006). The goal of the CCMHI was to improve the mental health and well- being of Canadians by increasing collaboration among primary health care and mental health care providers, consumers, families and caregivers, recognizing that primary care providers are often the first point of contact for people with mental health concerns (CCMHI, 2006). As such, the CCMHI focused on improving the mental health and well-being of Canadians by enhancing the relationship and improving collaboration among health care providers, consumers, families, and caregivers; and improving consumer access to health prevention and promotion programs, treatment, and rehabilitation services in a primary health care setting (CCMHI, 2006).

A toolkit was developed by experts in the field to help health care professionals develop a collaborative mental health care practice. A companion toolkit was created focusing specifically on the needs of seniors. The purpose of the toolkit is to assist health care providers to work collaboratively to best meet the unique health care needs of seniors experiencing mental health issues (CCMHI, 2006). See the online version for additional key messages and important elements of the toolkit that can inform those planning and implementing mental health initiatives. Other toolkits can be found at www.ccmhi.ca.

» Implement shared or collaborative care to enhance the relationships and improve collaboration among health care providers, consumers, families, and caregivers.

The Canadian Collaborative Mental Health Initiative (2006) also outlined four key considerations about the ideal characteristics for mental health services for seniors. These included:

1. The recognition that more time is needed for seniors due to complicated presentations, co-morbidities, bio-psychosocial considerations, functional impairments and environmental considerations.
   - Implications for billing, physician recruitment, capacity, and other issues.
2. Understanding that transportation is an important issue for seniors seeking support for mental health problems.
   - Requires 'out of the box' thinking for services including house calls, links with public transportation, and volunteer organizations.
   - Seniors need a unique system of care with case management, interdisciplinary teamwork, and connections to home physical care as well as nursing home care.
   - Supporting movement throughout the various aspects of the continuum supports the principles of independence and recovery.
3. Collaboratives should serve local nursing homes.
   - Seniors in nursing homes often live with mental illnesses that require specialty services and support not found within the skills of the home.

USE OF TECHNOLOGY

Given the complexity of issues that many older adults present, they are likely to require services that cross sectors and that will involve several agencies and service providers (including physicians), over time and often over-lapping. Communication between and among programs, agencies and service providers is imperative for good care, but often lacking. At the same time, confidentiality and privacy of patient information is important, and clear protocols and mechanism must be put in place to ensure the need for information is balanced with rights to privacy.

Technology has the potential for designing and facilitating integration and providing client-level information across providers & patients. Technology (e.g. telepsychiatry, patient consultations via ongoing email exchanges, web-based resource guides, education programs for patients that are viewable on mobile devices) can address some of the barriers to integration and facilitate information sharing and education.

Electronic Charts

The electronic health record (EHR) allows for one collaborative file for each individual, which reduces duplication and enhances overall care management. Used across service components it reduces the need for patients and their families to tell their stories repeatedly, provides up to the moment information to all service providers exactly when needed, and ensures information needed for service delivery is consistent and accurate. Most importantly it enhances patient safety by reducing the chance and incidence of medical errors.

In the United States, Baron, Fabens, Schiffman and Wolf (2005) report that the use of EHR facilitates efficient and accurate collection, storage, analysis, and distribution of data than current manual operations and "helps us to better meet patient expectations, expedites many tedious work processes (such as prescription writing and creation of chart notes), and creates new ways in which we can improve the health of our patients" (p. 222).

» Implement the electronic health record across service components to facilitate accurate sharing of patient information in a timely manner.

Telenursing

Telenursing is a growing specialty for nursing practice in which delivery of nursing services is done over the telephone. It is one of the strategies directed towards reducing the pressures on hospitals, emergency departments, walk-in clinics, physician offices and home health (Hagan, Morin, & Lepine, 2000; Stacey, Hussien, Fisher, Robinson, Joyce & Pong, 2003). In this model of nursing practice, the telephone is the only communication link between the patient and the nurse.

Telepsychiatry

Telepsychiatry activity is widespread throughout Canada and is typically employed to bridge the distance and human resource shortages that are common in rural and remote areas of Canada. A variety of services and service models exist. Evaluation evidence from Ontario indicates that service providers in rural areas receiving case consultation and education through telepsychiatry found it useful to them.

» Utilize tele-psychiatry and tele-nursing to deliver specialized mental health case consultation and education to rural and remote regions.

System Navigation

The social and health care systems are often fragmented and eligibility criteria and processes for the different services may not be clear, together creating barriers to access and to continuity of care for seniors and their families.

A variety of methods have been put in place to address this: one-stop information phone lines or web portals; the concepts of "every door is the right door", of a "single point of entry", and positions created for system navigators. Resources, community size and other factors will determine which approach is implemented.

» Ensure that processes are in place to facilitate seniors' access to services and resources, and that mechanisms are in place for the transition of both the senior and their information.

» Develop a role for system navigators who direct seniors and their families as they move through the health care system.

» Primary health care or home care organizations could take on the role of coordinating system navigation for seniors with mental health problems and illnesses, and their families.

APPLICATION OF KNOWLEDGE AND EVIDENCE

In addition to being a system level principle for an integrated mental health system, evidence must also inform clinical and policy decisions. It is important to note that evidence should include the lived experience of older adults and their caregivers, practice based experience , and evidence from clinical and population based health research. Recent initiatives are advocating for broadened definitions of evidence that help to inform best practices.

Although these *Guidelines* are not intended to provide clinical guidance, a listing of evidence-based clinical guidelines to support the implementation of evidence based service delivery can be found with the companion materials in the online version at www.mhccseniors-guidelines.ca

» Ensure planners, educators and service providers have access to evidence and best and leading practices, the information to support optimal care and services, and the support and resources to implement them.

CONCLUSION

These *Guidelines* are intended to support planning, development and implementation of a mental health service system that can respond to the needs of the Canadian senior population. Applying the guiding values and principles, implementing the key recommendations, and examining a regions' resources based on the model and benchmarks outlined in this document, are key action steps to transforming the mental health system to respond to the needs of seniors. It is the hope of the Seniors Advisory Committee of the Mental Health Commission of Canada that these *Guidelines* will provide guidance while allowing for the many variations in services and policies across the country. Collaboration amongst government sectors and consultation with seniors, caregivers, and health care will strengthen transformation and implementation of the outline recommendations. Again, readers are encouraged to visit the online version of the *Guidelines* at www.mhccseniorsguidelines.ca for additional resources and service exemplars to assist with implementation efforts.

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Mental Health Commission of Canada

Commission de la santé mentale du Canada

Contact Information

Mental Health Commission of Canada

Suite 800, 10301 Southport Lane SW

Calgary, AB T2W 1S7

403-255-5808

mhccseniorsguidelines.ca