THE CANADIAN ACADEMY OF GERIATRIC PSYCHIATRY
AND
CANADIAN COALITION FOR SENIORS MENTAL HEALTH

Submission to
The Standing Committee on Social Affairs, Science and Technology

Mental Health and Mental Illness
Seniors Roundtable
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Presented by Dr. David Conn
Psychiatrist-in-Chief, Baycrest Centre for Geriatric Care,
Associate Professor, Dept. of Psychiatry, University of Toronto,
President, Canadian Academy of Geriatric Psychiatry,
Co-Chair, Canadian Coalition for Seniors' Mental Health.
Tel: 416-785-2456 e-mail: dconn@baycrest.org

EXECUTIVE SUMMARY

With the rapid growth of the aging population there will be an unprecedented increase in mental illness with an equally unprecedented demand on the systems current capacity to address seniors mental health needs. Mental health and behavioural problems associated with senior's mental illness are not a natural part of aging and much can be done to prevent deterioration, restore health and maintain or enhance quality of life.

In addition to the full range of mental illnesses which affect the general population, seniors are at very high risk of suffering from dementia or delirium. Certain groups of seniors have a very high prevalence of mental illness e.g. those living in long term care facilities and those suffering from chronic physical conditions. Assessing and treating seniors with mental illness presents unusual challenges for health care professionals and caregivers. Symptoms of mental disorders experienced by older adults may differ from those experienced by younger people, which can make accurate diagnosis and treatment difficult. Ageism and stigma are also serious problems facing this population group. Effective and timely assessment and treatment can prevent unnecessary disability and premature mortality, reduce caregiver burden and greatly improve quality of life. Unfortunately the incidence of suicide among men 80 years of age or older is the highest of all age groups.

Current service delivery models do not reflect the complex and ever changing mental health needs of seniors. The lack of coordination and integration between service modalities further compound effective approaches to assessment, treatment and prevention. Furthermore, lack of resources and problems with recruitment and retention of service providers also compounds service delivery issues.

Consistent with maintaining good mental health, is the need to provide a coordinated range of supports to informal caregivers of seniors with mental health problems. The economic value provided by family caregivers is enormous. Supports to family caregivers are limited, usually insufficient and mostly geared to the needs of the ill family member, not to the needs of the caregiver.

A series of recommendations following this section address a variety of issues related to seniors' mental illness including public education, staff education, enhanced research, human resource reviews, guidelines and best practices and support to caregivers

RECOMMENDATIONS

The Canadian Coalition for Seniors Mental Health (CCSMH) and the Canadian Academy of Geriatric Psychiatry (CAGP) would like to propose a number of recommendations related to seniors' mental health. We would like to see these recommendations included in a National Action Plan for mental health and mental illness as proposed by the Canadian Psychiatric Association and the Canadian Alliance for Mental Illness and Mental Health.

Public Education/Awareness

1. Provide Federal funding for the development of a public education campaign (in collaboration with multiple stakeholders e.g. CCSMH, CAGP, others) to increase awareness of mental health concerns in seniors. Include certain key messages such as mental illness does not have to be a natural part of aging and that treatment is highly effective. Included in this campaign should be the development and dissemination of education tools focusing on "warning signs" for dementia/cognitive impairment, depression and anxiety disorders. Funding should include targeted monies for an outcome evaluation study

Education

1. Support educational strategies for the purpose of prevention, early assessment and effective interventions. This can be done through collaboration of the Federal government, Canadian Council on Health Service Accreditation and other key stakeholders. The standards of excellence defined within the accreditation guidelines should include specific number of hours and type of education for all staff in long term care and home care agencies. We recommend that accreditation should require demonstration that all staff has participated in appropriate educational programs that include information related to identification and management of seniors' mental health problems.

Research

1. A workshop should be supported by the Federal Government and coordinated by key stakeholders (CCSMH, CAGP, others) to establish seniors' mental health research priorities. The results of the workshop should lay the foundation for targeted funding for research in geriatric mental health. This should be supported through Canadian Institute for Health Research (CIHR) and Canadian Health Services Research Foundation (CHSRF) to enhance the funding available for basic, clinical and health systems research.
2. Encourage the Canadian Institute for Health Information in collaboration with the provinces and territories to create a working group to collect data specifically related to seniors' mental health in both community based and long term care settings.

Human Resources

3. Support a national health human resources strategy that includes issues specific to seniors' mental health. This could be done through partnership with Human Resource Development Canada and other key stakeholders. The strategy should address supply, distribution, recruitment and retention strategies, remuneration/benefits and credentialing. This strategy should also include an inventory of current human resources; development of an objective assessment of current and future needs; and gap analysis.

Systems of Care

4. The Federal/Provincial/Territorial Committee on Seniors should collaborate with the CCSMH and CAGP to sponsor a national "*Best Practices*" conference with themes that includes policy, education, environment, assessment and treatment, public education and health promotion, research and human resource retention and recruitment.
5. Create a national committee to develop guidelines on Assessment, Treatment and Service Delivery Models in collaboration with service providers, professional organizations, regulatory bodies and consumers. Funding should be made available to support the development, dissemination, implementation and evaluation of these guidelines.
6. Provide financial support for Geriatric Tele-health initiatives, which provide mental health consultation and education to rural and remote areas of the country.

Caregivers

7. Provide family caregivers with the necessary supports to successfully provide care including sources of relevant and meaningful mental health information and contact information for local support services such as respite and home care.
8. Provide tax credits or tax breaks to reflect actual costs for out of pocket expenses incurred by caregivers.
9. Continue to review and make change to employment insurance, pension plans and labour codes to accommodate caregivers' needs to take time off work when necessary without risking job loss.

BACKGROUND

The following section details the facts related to the increasing seniors population and the mental health problems they face.

Growth in Population of Canada's Seniors

According to Health Canada by 2021 seniors (age 65+) will account for 18% of the Canadian population representing a total of 6.7 million people. By 2041 seniors will account for 22.6% of the population[1]. Furthermore, by 2021, there will be 20% more seniors in the population than children under the age of 15 and by 2026 this proportion will rise to 38%[2]. The impact of seniors' population growth will place unprecedented demand on all sectors including specialized mental health services for seniors.

Depression

Current data on seniors living in the community indicates that between 2% to 4% suffer from serious clinical depression. However, if all persons with depressive symptoms are included, the rate rises to between 10% and 15%[3]. It is estimated that by 2021 there will be 1 million Canadian seniors with depressive symptoms. The incidence of depression in seniors in long term care settings is three to four times higher than the general population. Studies suggest that between 15% and 25% of nursing home residents have symptoms of major depression and another 25% have depressive symptoms of lesser severity. The incidence of new depression in long term care settings has been estimated to be 12% to 14% per year, with about half these cases meeting criteria for major depression[2].

Psychosis

The prevalence of schizophrenia in the general population is estimated to be 1% for all age groups, whereas the prevalence of psychosis in nursing home residents range from 12% to 21% depending on how psychotic symptoms are measured[2]. Psychotic symptoms among seniors are frequently associated with dementia or delirium and a number of physical conditions can also give rise to psychotic symptoms. Psychosis is frequently associated with behavioural disorders which increases caregiving burden.

Suicide

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[1] Health Canada, Division of Aging and Seniors; " A Quick Portrait of Canadian Seniors" www.hc-sc.gc.ca/seniors-aines/pubs/vignette/vig01_e.htm

[2] Statistics Canada, www.statscan.ca; population projections for the years 2021 and 2026

[3] Conn, D.K., "An Overview of Common Mental disorders Among Seniors." in Writings in Gerontology – Mental Health and Aging. National Advisory Council on Aging, Government of Canada, 2002

Suicide is another indicator of mental illness and the incidence among men 80 years of age and over is the highest of all age groups (31 per 100,000)[4] . Seniors face many challenges. They experience the loss of relationships through the death and chronic illness of their friends and life partners. They may also experience loss of their physical and mental abilities. Symptoms of depression may not be recognized and treated appropriately. In addition, being constantly faced with their own mortality, seniors might choose death on their own terms. Research indicates that a very high proportion of people who kill themselves have a history of mental illness, such as depression, bipolar disorder, schizophrenia or personality disorder. Of these, depression is the most common.

Dementia/Cognitive Impairment

Current figures indicate that 364,000 Canadians over 65 have Alzheimer's disease or a related dementia[5]. Dementia affects approximately 8% of all people aged 65 and over; and almost 35% of persons aged 85 and over. It is estimated that about 20% of day centre clients and more than 50% of residents of long-term care facilities suffer from some form of dementia. It is also estimated that the number of Canadians with dementia will rise to 592,000 by 2021. By 2031, over 750,000 Canadians will have Alzheimer disease and related dementias[5].

Behavioural disturbances associated with dementia are common and are often the reason why families have decided on institutionalization[6]. Behavioural symptoms associated with Alzheimer's Disease and related dementias include verbal, physical and sexual aggression, agitation and insomnia. While behavioral symptoms have received less attention than cognitive symptoms, they have serious ramifications: patient and caregiver distress, premature institutionalization, and significant compromise of the quality of life of patients and their families. Alzheimer's disease complicated by behavioral symptoms appears to place patients at risk for abuse by caregivers[7].

Mental Disorders in Long Term Care Settings

According to Statistics Canada, 38% of all women aged 85 years and over and 24% of similarly aged men live in an institution[8]. Based on a May 2000 report, prepared for the FPT Advisory Committee on Health Services the number of long term care beds in Canada will increase between 61% to 170% by 2041 depending on population growth and assumptions on community care availability. This translates into between 127,000 to 297,000 more long term care beds that will be required[9]. Recent studies suggest that the prevalence rates of all mental disorders among nursing home residents are between 80% and 90% [10]. By 2041 there could be between 164,000 to 338,000 residents in long term care facilities with mental disorders.

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[4] Centre for Chronic Disease Prevention and Control, Health Canada, "A Report on Mental Illnesses in Canada. Ottawa, Canada 2002.

[5] Canadian Study of Health and Aging Working Group: study methods and prevalence of dementia. *Can Med Assoc J* 1994; 150: 899-913.

[6] Brodaty,H.,Low,L.F. Aggression in the elderly. J Clinical Psychiatry 2003;64 Suppl 4:36-43

[7] Mental Health, Report of the Surgeon General 1999, "Chapter 5 - Older Adults and Mental Health". http://www.surgeongeneral.gov/library/mentalhealth/toc.html#chapter5

[8] Statistics Canada: http://www.hc-sc.gc.ca/seniors-aines/pubs/factoides/en/no12.htm

[9] KMPG Consulting, May 2000; "Canadian Continuing Care Scenarios 1999 -2041" prepared for the FPT Advisory Committee on Health Services

[10] Conn, D.K., "Seniors Living in long-term Care Facilities" in Writings in Gerontology – Mental Health and Aging. National Advisory Council on Aging, Government of Canada, 2002

Furthermore, a study of long term care facilities in Ontario revealed that 88% of nursing homes received five or less hours per month of care by a psychiatrist for their whole institution and almost 40% of nursing homes receive no direct psychiatric consultation[11]. The need for an appropriate range of mental health services for seniors in long-term care settings substantially outweighs the system's current capacity to provide these much-needed services.

Caregiving

Family or unpaid caregivers provide care for family members and friends and provide the majority of long term care in Canada. The economic value provided by family caregivers is enormous. It is estimated that informal caregivers save the public system over $5 billion per year and is equivalent to the work of over 276,000 full time employees[12].

The burden of caregiving historically falls upon women. Over 70% of informal caregivers are women, mostly wives and daughters and 30% of informal caregivers in the community are employed[13]. According to a 1999 Health Canada study employees juggling work and family cost Canadian employers at least $2.7 billion a year in lost time and employees miss 19.8 million days of work each year due to work family problems[14]. Furthermore many caregivers are seniors themselves who are coping with their own aging issues. In fact 36% of informal caregivers in the community are over the age of 70[12].

The caregiver role is highly demanding. Caregivers of older people have higher than average rates of depression. Studies show that caregivers experience a sense of burden and an estimated 46 percent are clinically depressed. Up to half of the primary caregivers caring for someone with Alzheimer's develop significant psychological distress[15]. Supports to family caregivers are limited, usually insufficient and mostly geared to the needs of the ill family member, not to the needs of the caregiver.

ISSUES AFFECTING DIAGNOSIS, TREATMENT AND SERVICE DELIVERY

Mental illness in older adults is not inevitable and can be treated. There are however, a number of barriers that may hinder effective diagnosis and treatment.

Ageism:

Many people mistakenly believe that health problems like depression or cognitive impairment are normal in older people and that no effective treatments are available. It may be argued that expenditures in health care target acute care, while the parts of the system seniors need most, such as community-based and long term care, do not get adequate funding.

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[11] Conn DK, Lee V, Steingart A, et al. Psychiatric services: a survey of nursing homes and homes for the aged in Ontario. Can J Psychiatry 1992, 37:525-30

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[12] Stephenson, M., Sawyer, E., (2002). Continuing the Care: The Issues and Challenges of Long Term Care. CHA Press Ottawa, ON

[13] Statistics Canada: http://www.hc-sc.gc.ca/seniors-aines/pubs/factoides/en/no12.htm

[14] Duxbury, Linda, PhD, Chris Higgins, PhD, and Karen Johnson, PhD. "An Examination of the implications and Costs of Work-Life Conflict in Canada." Final report submitted to Health Canada.

[15] American Association of Geriatric Psychiatry, www.aagpgpa.org; "geriatrics and mental health -the facts"

Stigma

Some seniors believe that mental health disorders and treatment are shameful, represent a personal failure, or will lead to a loss of autonomy. They may deny having mental health problems or refuse treatment from mental health care providers. Family members may not want to acknowledge mental health problems in their parents which may further prevent access to available resources. For example depression may be seen as a natural consequence of ageing, loss and physical illness and may not be diagnosed or treated.

Problems Associated with Diagnosis and Treatment

Mental disorders experienced by older adults may differ from those experienced by younger people, which can make accurate diagnosis and treatment difficult. Depression is often under-diagnosed and under-treated because it is confused with or masked by other problems, or because the observed symptoms are considered to be part of the normal aging process. Unlike in younger adults, depression in seniors is more often expressed by anxiety, agitation, and complaints of physical and memory disorders. For example, an older person who is depressed may be more likely to report physical symptoms such as insomnia or aches and pains rather than feelings of sadness or worthlessness[16]. In addition seniors typically have co-morbidities which complicate issues of assessment and treatment. Health care providers without specialized training in seniors' mental health may not be able to effectively diagnose or treat seniors' problems.

One study found that only 11% of depressed patients in primary care received adequate antidepressant treatment, while 34% received inadequate treatment and 55% received no treatment[17]. Considerable experience and expertise are needed to make the proper diagnosis. Studies suggest that the consequences of unrecognized and untreated depression in seniors may include excessive use of health care services, increased length of stay during hospitalization, decreased treatment compliance and increased morbidity and mortality[3]. Untreated depression causes unnecessary suffering and diminished quality of life and can cause significant negative effects on physical health. Studies suggest that depression is associated with increased mortality rates in long term care with a relative risk of between 1.5 and 3, as compared to non-depressed patients[9].

Cognitive disorders also constitute a common health problem among seniors that can be difficult to diagnose. The diagnosis of dementia can be complicated because there are other disorders that coexist with, or have similar features to Alzheimer's disease. For example delirium is a common condition in older adult patients and can be confused with dementia. Some reversible disorders such as vitamin B-12 deficiency and thyroid disease have similar features to dementia. Patients with severe depression can present with significant cognitive impairment, which is often reversible with the treatment of the depression. A study in the United Kingdom found that general practitioners recognized only 58% of patients with dementia[18]. A similar study in the US found that only 3.2% of patients with mild cognitive impairment were recognized by general practitioners and

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[16] Administration on Aging, Department of Health and Human Services; "Older Adults and Mental Health" Fact Sheet. www.aoa.dhhs.gov/may2002/factsheets/older-adults-and-mental-health.html

[17] Mental Health, Report of the Surgeon General 1999, "Chapter 5 - Older Adults and Mental Health". http://www.surgeongeneral.gov/library/mentalhealth/toc.html#chapter5

[18] O'Connor, D.W., Pollitt, P.A., Hyde, J.B., Brook, C.P., Reiss, B. B., Roth, M. (1988). Do general practitioners miss dementia in elderly patients? *British Medical Journal*, 297, 1107 -1110

only 23.5% of those with moderate to severe dementia were identified as having a dementia syndrome[19]. Effective and timely diagnosis can allow for the use of effective therapies which can slow the progress of Alzheimer's disease, reduce excess disability caused by depression and anxiety, and allow for patients with treatable conditions to regain their quality of life and prevent or delay long term care placement.

Seniors are commonly frail, have coexisting health conditions and are frequently on multiple medications. As a result, seniors are particularly vulnerable to the adverse effects of medications. In addition, sub-optimal or inappropriate use of psychotropic medications has frequently been raised as an important concern. The development of federal legislation in the United States which provides regulations regarding mental health care in long term care facilities was prompted by concerns regarding sub-optimal or inappropriate use of medications in this population.

Service Delivery

There are vast discrepancies in the availability of mental health services between different regions of the country, with very limited availability in rural areas and smaller cities. In most regions, services that do exist are poorly coordinated and do not have the capability of serving multiple multicultural communities. In addition services are often not well coordinated nor reflective of the evolving needs of elderly with complex problems. The need for developing an accessible and viable coordinated system has been underscored by many policy papers including recent deliberations of the European Union.

Several fundamental principles have been delineated with respect to the delivery of mental health services to seniors including comprehensiveness, defining the target population, community outreach, availability and flexibility and support for caregivers[20]. Optimal services are generally provided by a multidisciplinary group of mental healthcare workers. Community outreach is an essential component of geriatric care, as many seniors are reluctant or unable to leave their homes. Telehealth allows specialized assessment to reach remote areas.

RECRUITMENT AND RETENTION OF PHYSICIANS AND OTHER PROFESSIONALS

At the National Symposium on Gaps in Mental Health Services for Seniors in Long-Term Care (April 2002), human resource shortages were identified by professional and non-professional participants as one of the most important problems in the provision of mental health services in long-term care (LTC).

For example, there are currently 529 long-term care facilities in Ontario alone, with 61,000 beds. To meet the increased long term care bed needs in the short-term, there will be an additional 20,000 beds added in Ontario by the year 2004. There will be redevelopment of 16,000 existing beds to meet current design standards. Given the building boom in the long-term care facility sector, there is surprisingly little information about human resource needs in LTC facilities in Canada. It is recognized that mental health services are not consistently provided to this population group.

[19] Callahan, C.M., Hendrie, H.C., Nienaber, N.A., Tierney, W.M. (1995). Documentation and evaluation of cognitive impairment in elderly primary care patients. *Journal of American Geriatrics Society*, 44, 1205-1209

[20] Shulman,K. (1991). Regionalization of psychiatric services for the elderly. Can. J. Psychiatry. 36:3-8.

The majority of primary care medical services for physical and mental health in long-term care facilities in Canada are provided by family physicians. There is limited involvement by psychiatrists, general internists and geriatricians. Despite the large increase in the number of beds available in long-term care facilities, the number of physicians needed to meet the increased demand has not been clarified.

It is very difficult to estimate the number of family physicians working in LTC and the number of physicians working as Medical Directors of a facility. Most provincial medical associations do not have distinct sections representing this group of physicians. Organizations of medical directors are provincial rather than national and most provinces do not have such groups. Existing organizations do not have listings of family doctors currently providing care. No studies examining the provision of medical care in LTC in Canada were found in the literature.

At this point, the experience of Canadian family physicians in LTC care is not understood. The CCSMH has undertaken a pilot study of Ontario Family Physicians working in long term care settings to determine the opportunities and barriers to long term care practice. Once this study is completed further national studies targeting physicians and nurses should also be supported.