



Canadian Mental Health Association, ONTARIO

**Mental Health and Addictions Issues for
Older Adults:
Opening the Doors to a Strategic Framework**

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Mental Health and Addictions Issues for Older Adults: Opening the Doors to a Strategic Framework

PREAMBLE:

The Canadian Mental Health Association (CMHA), Ontario is a not-for-profit, charitable organization whose vision is “mentally healthy people in a healthy society.” As a core responsibility, CMHA, Ontario develops and provides public policy advice that promotes mental health and improves the lives of people living with mental illness.

We applaud the efforts of the Ministry of Health and Long-Term Care (MOHLTC) in the development of their discussion paper, *“Every Door is the Right Door”* and in the directions they are taking to develop a 10-year strategy for mental health and addictions.

With this paper we hope to concentrate attention on older adults with mental health and addictions issues and underscore the necessity for a framework that is specifically focused on this group. The aging population in Ontario, the increasing prevalence of mental ill-health in this demographic and the associated human, health and social costs provide compelling reasons to establish a framework that prevents mental ill health, provides for early identification and early intervention if illness presents, and supports seniors so they can live in their homes, in communities of their choice.

INTRODUCTION

In 2008, adults over the age of 65 constituted 13.5 per cent of the total population in Ontario or 1.7 million people; by 2036 that figure is expected to rise to approximately 23.2 per cent or 4.1 million¹ Of these, it is estimated that the prevalence of mental health problems ranges anywhere from 17 to 30 per cent or higher, depending on what diagnoses are included in the analysis² For example, if sub-clinical depression and anxiety are added, estimates rise to 40 percent of older adults.

In total that means that between 289,000 and 680,000 older adults are affected by mental health problems in Ontario (Ontario Ministry of Finance 2009). Mental ill health has a significant impact on our economy, health care expenditures, use of high-demand acute care beds and, of particular importance, our social fabric. The moral, economic and familial impacts of mental ill health for so many older adults make a compelling argument for government action.

A FRAMEWORK FOR SENIORS' MENTAL HEALTH AND ADDICTIONS

This report will focus on services and supports needed for older adults at risk/or living with mental health problems. We also know from the literature that in many instances, addiction-related concerns are a concurrent factor. The specific groups addressed in this report include:

- Those growing older with long-standing or recurrent mental health issues;
- Those whose mental health problems, including depression and the dementias, which are primarily related to biological aging or circumstances associated with later life;
- Those older adults dealing with concurrent disorders.

Mental Health Disorders in Older Adults (Appendix A)

- Depression
- Suicide
- Anxiety Disorders
- Dementia
- Delusional Disorders
- Delirium
- Paraphrenia, late onset psychotic disorders
- Concurrent Disorders

Currently there are a lack of adequate mental health services and community supports for older adults. Instead of a mental health system, where *“Every Door is the Right Door,”* we find that many doors are closed to the needs of older people, and the gaps in service outweigh the opportunities for access. It is indeed an injustice to rationalize these gaps on the basis that mental health problems are a natural by-product of aging. Research shows that many so-called aspects of “normal aging” (such as depression) are preventable and treatable³.

While some supports do exist in the form of psychogeriatric services and acute and special long-term care beds, these focus primarily on the needs of those with dementia or serious mental illness. ***To address the needs of all older adults, a framework must be developed that includes a continuum of education, care and support that will enable people living in the community to live their lives to the fullest in spite of the challenges of mental illness and/or addictions.***

OPENING THE DOORS

In July 2009, the Ontario Ministry of Health and Long-Term Care (MOHLTC) released a discussion paper, *“Every Door is the Right Door.”* Using the directions laid out in their paper as a template for discussion, we offer our insights and strategies into a senior’s framework for mental health and addictions.

Core Elements of a Senior’s Framework

- √ Community-based care
- √ Collaboration across all sectors to deliver a social model of care
- √ Recovery-based approach that involves the client and family (where desired by the client)
- √ Client and family/carer involvement in system planning, implementation and evaluation

DIRECTION #1: ACT EARLY

Prevention, early identification and early intervention are key strategies in an effective mental health system for seniors.

a) Prevention

The consequences of loss, sorrow and grief as a result of life events affect many older adults, causing ongoing negative mental health consequences. Anxiety, depression and perhaps substance abuse are just some of the mental health problems that arise as people navigate these transitions in later life. Prevention strategies can mitigate these effects from becoming permanent mental health issues.

i. Peer Social and Education Networks

Research has shown that psychosocial interventions such as peer social networks and facilitated education programs help seniors to build on their strengths, optimize their wellness and play an important role in preventing age-onset depression. Support for these community-based social networks is required to ensure broader availability for these important services.

The Seniors Speakers Bureau (SSB), funded by Canadian Pensioners' Concerned (Ontario Division), is a good example of such a network. The SSB provides educational sessions on aging and depression by seniors with lived experience to other seniors.

Another example is the "Connecting Seniors of Canada" (CSC), sponsored by the Institute for Life Course and Aging, University of Toronto. CSC facilitates research, educates and trains senior volunteers and professionals to develop and implement community-based wellness programs. CSC empowers older adults through their participation in four basic programs: "A Time for Me" (personal growth); "Senior Peer Helper Training" (training for one-one-one helpers); "Growing Further" (an unstructured interim personal growth program); and "Co-leader Training" (seniors as volunteer facilitators). By bringing older adults together in groups facilitated by professionals and/or trained senior volunteers, they learn to nurture their inherent creative abilities, adapt to changes, take control of their lives and address the challenges of aging (deaths of family and friends, moving, retirement, reduced energy).

The federal "New Horizons for Seniors" program encourages seniors to play an important role in their communities by encouraging them to contribute their skills, experience and wisdom in support of social well-being in their communities. Through these activities, the program promotes the ongoing involvement of seniors in their communities and reduces their risk of social isolation.

ii. Primary Care

The importance of accessible and responsive primary care is essential in the prevention of mental health problems in older adults. With the advent of Family Health Teams (FHT) in Ontario, come new opportunities to prevent the incidence and impact of mental illness related to aging and loss. Home visits to the frail elderly, nurse practitioners for community-based primary care and expanded community-based supports to enable seniors to live at home are all excellent strategies for creating environments conducive to good mental health and should be expanded across the province.

A collaboration between the Waterloo Wellington Community Care Access Centre and the Guelph Family Health Team provides in-home primary care to frail, isolated seniors in the City of Guelph. Nurse practitioners provide community-based primary care with physician consultation through the FHT. Senior residents are referred to community-based supports to enable them to live as independently as possible in the home of their choice. Examples such as this provide effective, cooperative and integrated service delivery models that could be excellent foundations for extension to our seniors in need.

b) Early Identification and Early Intervention

There is growing statistical evidence that the incidence of mental illness is increasing in older adults. In spite of that, there is reluctance for people to self-identify or for family members or peers to mention someone who is suspected of having mental health problems because of perceptions that this is an unavoidable part of normal aging. This makes early identification and intervention extremely difficult.

Part of this reluctance is due to social stigma about ageism. To combat this, seniors-specific education is needed to decrease societal stigma, self-stigma and benign ignorance about the differences between normal aging and signs of mental illness. Resource materials for seniors' groups, seniors' centres, conferences and workshops would be valuable aids to increasing awareness about ageism and discrimination. Examples of organizations already providing materials that are seniors-specific include: the Mood Disorders Association of Ontario; the Canadian Mental Health Association; the Centre for Addiction and Mental Health; the Alzheimer Society of Ontario and Community Care Access Centres.

Educational support is not only needed for seniors, it is also required for all service providers involved with seniors, be that in mental health or in other parts of the public sector such as social services, housing, transportation and justice. Psychogeriatric Resource Consultants and members of the Geriatric Mental Health Outreach Teams can provide that type of education.

Finally, public education on the topic of ageism is needed to reach out to family members who might inadvertently be discriminating against their own loved one by ignoring early signs of mental illness with rolling eyes, a shrug of the shoulders and “oh, he’s just getting old.” CMHA York Region, for example, as part of its geriatric mental health program provides education and group support for seniors presenting with concurrent disorders and related dementias, their family members and informal caregivers.

Screening and risk assessments by primary care practitioners are invaluable in early detection of mental illness and treatment, particularly for depression. For that reason, primary care professionals should have support and access to training that enables them to recognize, address and diagnose the full range of mental illnesses and addictions and differentiate them from the signs of normal aging. In addition, primary care practitioners must have access to other expertise for consult, rapid referral and educational support. A recent study shows that only 9% of physicians routinely question or screen outpatients for depression⁴. This presents a huge opportunity for improvements in early detection and intervention.

If screening indicates that early signs of mental illness are presenting, then the involvement of the multi-disciplinary primary care team should take place, involving professionals such as a geriatric nurse, pharmacist, dietician and occupational and physical therapists. There are currently innovative models in Ontario that not only include the primary care team at this stage, but also involve a home care coordinator and specialist services such as a geriatrician, neuropsychologist and bereavement counselor⁵. The Canadian Collaborative Mental Health Initiative Toolkit project is another example that proposed a broad framework for seniors that spanned many disciplines and services⁶.

First Link is an example of a partnership program between primary health care professionals and the Alzheimer Society to ensure that individuals and families dealing with dementia receive support and information throughout the course of the disease. First Link partners include family physicians, geriatric specialists, pharmacists and social service workers. This type of program bears further consideration as an expanded model for **all** seniors’ mental illnesses and addictions because it embodies the values of community action through collaborative relationships, early intervention and support for self-management.

In addition to the screening, risk assessments and support provided by primary care practitioners, there is also a sense among older adults and service providers involved in our focus groups that older adults themselves, seniors’ centres and seniors’ service providers could play a role in early detection. To make this happen, education and resources as well as collaboration with mental health services and other community service providers would be required.

An interesting collaboration that provides a model for self-screening initiatives took place in Windsor, Ontario in October 2008. The event was sponsored by the Canadian Mental Health Association, Windsor Essex County Branch in conjunction with the Centres for Seniors in Windsor and held at the Sandwich Community Health Centre. In recognition of Mental Illness Awareness Week the public was invited to play “Feel Good Bingo,” an entertaining game that taught older adults about the signs, symptoms and treatment options for depression and anxiety.

Another example of an early identification program for older adults was the “Early Identification of Cognitive Impairment and Mental Health Issues for Community-living Chinese Seniors” project undertaken by Yee Hong Centre for Geriatric Care and the Wellness Centre of Mount Sinai Hospital. Thirty-five volunteers were recruited for a prospective study to screen vulnerable Chinese seniors for dementia and depression and track their subsequent help-seeking behaviors.

The project concluded that “Targeted screening can enhance early detection of mental health or cognitive problems in ethnic elders; systematic face-to-face discussion of screening results and implication appeared to increase the rate of help-seeking; and the project supported the need for and the feasibility of mental health/cognitive screening for at-risk community dwelling ethnic elders ⁷.”

Of special interest, is a program undertaken on a community-wide basis by the New York City Department for the Aging (DFTA) in partnership with the City Department of Health and Mental Hygiene and the Mental Health Association of New York⁸. A large scale Geriatric Screening Initiative was introduced to identify depressed seniors and increase access to treatment in high-risk areas of the city. The Geriatric Screening Initiative provided information and training to seniors about depression, raised primary care doctors’ awareness of depression in seniors, identified seniors at risk of depression using a standardized screening tool, referred seniors at risk for depression to their health care providers and evaluated the proposed model for replication in other communities. Senior centres were the primary venue for the education, screening and referral services. DFTA-funded community-based case managers provided screening and referral services to homebound clients and DFTA coordinated all aspects of program implementation and project evaluation.

During the two years of the program, 51 senior centers and seven case management agencies collaborated in this endeavor. Training involved 265 staff from senior centers and case management agencies. The project team educated 1,262 seniors in English, Spanish, Chinese and Korean. The project identified 135 senior center participants who were at-risk for depression and were referred to their physician. Additionally, the project screened 611 homebound clients, 55 of whom were found to be at risk for depression.

Undoubtedly, there are many opportunities to consider psychosocial approaches and interventions on an individual, group, community and policy level as Ontario moves towards a 10-year strategy for mental health and addictions.

Key Strategies for Acting Early:

Prevention:

- ✓ Support for community-based social support and education networks by seniors, for seniors
- ✓ Expand Family Health Team services to include home visits, nurse practitioners focused on frail elderly
- ✓ Expand community-based supports to enable seniors to continue to live at home

Early Identification and Intervention:

- ✓ Education for the public, specifically seniors, their families and service providers on ageism, discrimination and normal aging vs. mental health problems
- ✓ Targeted education for seniors on self-screening for mental illness
- ✓ Targeted community screening and early identification
- ✓ Primary care screening and assessment
- ✓ Multi-disciplinary team support at primary care level and by specialists if early signs of disease are detected

DIRECTION #2: MEET PEOPLE ON THEIR OWN TERMS

In this section, we interpret the concept to mean “Meeting people on their own terms, in their own place, in their own way, in culturally safe and culturally competent ways.” Research has proven that treatment is more effective, clinical outcomes are more positive and client satisfaction in the experience is much greater, when the treatment approach is recovery-based and person-centred. This is equally true when we talk about an effective approach to seniors’ mental health.

Mental health service delivery must not only be oriented to recovery, but must involve seniors with lived experience, their families or carers in the planning, implementation, monitoring and evaluation of system and service change. If the changes do not make a positive impact on the people being served, then service is not person-centred but service-centred; meaningful change must be defined and determined with input from those who have the lived experience.

a) Addictions and Concurrent Disorders

There are very few services focused on senior-specific addiction and/or concurrent disorders. This is particularly problematic given the fact that seniors with depression are four times more likely to have alcohol-related problems than those who are not depressed (Spencer, 2003). In addition, those who are addicted to over-the-counter and prescribed medications cannot access services when required.

Examples of seniors-specific addictions programs include:

Ottawa: Centretown Community Health Centre - Lifestyle Enrichment for Senior Adults (LESA)

LESA offers free, bilingual in-home counseling and group support for senior adults experiencing problems related to the use of alcohol and other psychoactive drugs, problem gambling and aging. There is a focus on lifestyle change and overall improvement in health.

Toronto: Community Outreach Programs in Addictions (COPA)

COPA is a Toronto-based organization committed to helping adults 55 years and over who struggle with addictions that impact their daily lives. Programs include outreach; harm reduction; referrals and case management; support groups; assistance for family, partners, and friends; and education and training for other professionals and organizations that work with older adults. COPA now also has a worker directly linked to long-term care homes in the Greater Toronto Area.

Guelph: Homewood Health Centre

Homewood provides residential treatment for patients 55 years and older that require treatment for addictions. Treatment is based on a medical/disease model that provides detox, stabilization and personalized program design. The catchment area is limited to Wellington and Dufferin Counties

There are a few adult addiction services which have specialized seniors' programming. These include:

- The City of Hamilton Alcohol, Drug and Gambling Program which has an assessment/referral service for seniors 55+ and an outpatient counseling service for those 23 to 99 years of age;
- The Elliot Lake Family Life Centre, Senior Assessment Program;
- The Peel Addiction Assessment and Referral Centre (PAARC) Addiction Service which provides an Older Persons Assessment Program, offering initial assessment and treatment;
- The St. Joseph's Care Group – Sister Margaret Smith Centre in Thunder Bay offers assessment, community treatment and residential services for older adults.

Most gambling treatment services in Ontario list their age ranges as inclusive of older adults. COPA, LESA, PAARC, and the Sister Margaret Smith Centre described above include gambling treatment programs to some extent. Additionally, the Sault Area Hospital's Addiction Treatment Clinic has both an Older Adult Problem Gambling Assessment Program and an Older Adult Problem Gambling Program.

b) Ethno-Cultural Needs of Seniors

Meeting people on their own terms also requires an approach that is culturally safe and culturally competent. At present, a lack of English coupled with social isolation contribute to mental health problems in older adults of different ethnic backgrounds and add to the challenges in providing them with support. There is an absence of formal ethno-specific seniors' mental health services. This gap leaves a large number of elderly people in Ontario stranded on islands of linguistic and social solitude. Some faith-based organizations, community centres and associations attempt to cover the gap through programming but more funding is required to ensure that the needs of these seniors are met.

The Wellness Centre, a Mount Sinai Hospital community program in partnership with Hong Fook Mental Health Association and the Yee Hong Centre for Geriatric Care in Toronto, is the realization of an innovative model of care which addresses the mental health needs of ethno-cultural seniors by combining traditional Chinese and Western approaches to wellness. This centre is designed to meet the needs of the Chinese community for more efficient and timely access

to the mental health system by providing information, assessment and treatment in a comfortable and accepting environment. With a focus on early identification of serious mental disorders, this centre offers an array of culturally and linguistically appropriate programs including education, health promotion, and traditional and Western health care that serve as an interface to more individualized mental health services. Clinical services include psychogeriatric assessment, treatment (pharmacotherapy and psychotherapy), psychoeducation, counseling to caregivers and family, outreach, shared care, and referrals. The Wellness programs include health and fitness, reflexology, and stress management.

c) Social Determinants of Mental Health and a “Whole of Government” Approach

Good mental health requires that the social determinants of health including affordable and appropriate housing in their own community, adequate income, education, social networks and transportation, are present. This necessitates a cross-sectoral approach at all levels, from government ministries to grass roots service delivery to ensure that the bio-psychosocial factors of mental health are balanced and available to seniors. Service by silo cannot be the way of the future. Cross-ministerial coordination and partnerships are the keys to real system transformation.

In keeping with the “whole of government” approach, it would be advantageous to apply a “Seniors’ Mental Health Lens”⁹ to all government policies to assess the impact of any policy on mental health and older adults. Applicable not only to the MOHLTC but to all Ministries, this lens would ensure that policy development that would benefit one area of public service would not inadvertently be counterproductive to seniors’ mental health and addictions.

Key Strategies for Meeting People on their Own Terms:

- √ Adopt a recovery-based service culture
- √ Involve people with lived experience in all aspects of system and service change
- √ Establish additional centres/services for seniors with concurrent disorders
- √ Support development of ethno-specific mental health services for seniors in the community
- √ Cross-sectoral involvement of all relevant ministries to ensure that the complete biopsychosocial needs of older adults with mental illness are met
- √ Apply a “Seniors’ Mental Health Lens” to all government policies

DIRECTION #3: TRANSFORM THE SYSTEM

Instead of a seamless system of integrated components offering comprehensive, effective, efficient, proactive and population-based services, there exists a minimal patchwork of supports. Each component struggles to provide the best service it can, yet without a cohesive structure, seniors who need mental health and addictions support find themselves shut out from the help they need. The consequences of the lack of alternatives are tremendous in terms of unmet need, extended waiting lists, escalating costs, overutilization of medication and human suffering.

a) Helping Older Adults with Mental Illness and/or Addictions Remain at Home

i. Community Support Services

Most people, when given a choice, would prefer to remain in their own communities, in their own homes rather than be institutionalized. Older adults with mental health problems are no different. Supports and services that enable them to do so, in a safe, effective and holistic manner are extremely important elements in a mental health system that embraces the needs of seniors.

In 2008, the Toronto Central LHIN developed a list of existing community support services. Given the inconsistencies and difficulties in obtaining information about services not funded by MOHLTC and /or not typically considered within the realm of mental health or seniors' services, the list was limited to the following types of services. Even so, the list is illustrative of a portion of the array of community health and addiction services required to help older adults remain at home:

- Intervention and assistance services/non-intensive case management
- Support and counseling
- Adult day programs (both for frail elderly and people with dementia)
- Recreational programs
- Meals on wheels/congregate dining
- Friendly visiting
- Transportation
- Volunteer services
- Caregiver support services
- Respite services
- Peer support services
- Home support services

Examples of effective seniors' mental health programs can be found in Fort Frances and the Windsor branch of the Canadian Mental Health Association. In other parts of the province, new programs are being introduced and may provide excellent models for implementation elsewhere. For instance, the Canadian

Mental Health Association, York Region has a Geriatric Mental Health Program aimed at building partnerships and enhancing opportunities for developing resources and support networks for seniors with serious mental illness and other health related challenges. The program offers health assessment and counseling, service coordination and referral, mental health care and treatment, and time-limited personal care support.

ii. Specialized Case Management

To support older adults in the least restrictive, most natural environment possible to achieve good quality of life, specialized case management for seniors is an ideal approach. This type of service is comprehensive, intensive and frequent, linking specialized psychogeriatric, addiction and community support services. Case Managers support the client and caregivers, in managing health symptoms, providing mental health and physical health information, assist with goal setting and day-to-day management of tasks.

The Full Circle Program at Community Care East York is an intensive mental health case management service for adults 60 years of age and older who are experiencing changes in behaviour related to the aging process while coping with mental health issues. Working in partnership with Woodgreen Community Services and Toronto East General Hospital, the Full Circle philosophy focuses on recovery, health and wellness. Trained professionals help clients manage mental health symptoms, provide mental and general health information, assist with goal setting and management of day-to-day tasks and provide support to families and/or caregivers. Services are offered in diverse languages including Cantonese and Mandarin.

COTA Health's Geriatric Mental Health (GMH) Case Management service provides individualized support to clients living with age-related dementia and clients over age 65 living with a serious mental illness. This service is available in Etobicoke, North York and downtown Toronto. GMH Case Management services are committed to being flexible and responsive to the unique needs and desires of each client.

Geriatric Psychiatry Community Services of Ottawa (GPCSO) Case Management Service serves clients over the age of 65 with mental health problems or those suffering from dementia complicated by behavioural and psychological symptoms. They also provide service to individuals under the age of 65 with a diagnosis of Alzheimer's, dementia or frontal temporal dementias complicated by behavioural or psychological symptoms. The client must be a resident of the Ottawa area and referred by a physician (exceptions are made on a case by case basis). GSPCSO provides individualized assessment and treatment in the client's home including retirement homes. Counseling, support and education are offered to caregivers. Staff include geriatric psychiatrists, nurses, social workers and occupational therapists and a psychogeriatric resource consultant. The

average length of stay is anywhere from one day to several years.

As with virtually every aspect of seniors' mental health in Ontario, different models and interpretations of Specialized Case Management have been used in different communities, with differing resources and capacities in programs across the province. It is generally considered that these are among the most valuable services supporting seniors with mental health and addiction issues, enabling them to remain in their own homes. In spite of that, capacity and access are major concerns and waiting lists for existing services are often long.

iii. Geriatric Mental Health Outreach Teams (GMHOTS)

GMHOTS have been identified as a major resource for transforming the mental health and addictions system for older adults¹⁰. By providing an interdisciplinary approach to assessment, consultation, treatment and education, GMHOTS have been extremely effective in helping seniors with serious mental illness remain at home.

Though limited, research on the effectiveness of specialty geriatric mental health outreach teams has identified reduced rates of placement both for older persons living alone and for those in care¹¹. Outreach services have demonstrated a reduction in psychiatric hospitalization by as much as 60 per cent and a decrease in psychiatric disability in the home. In addition, Banerjee and others reported that interdisciplinary geriatric teams improved health among 58 per cent of the patients treated compared with improvement in only 25 per cent of those treated by standard family practice¹².

Examples of GMHOTS include:

North Bay Northeast Mental Health Centre

The Seniors' Mental Health Outreach Program is a component of North Bay's Regional Consultation Service. It provides assessment and recommendations to individuals in their home communities through locally based nurse clinicians, with psychiatric support from the base team in North Bay. Specialized assessments from occupational therapy, social work and recreation therapy are available on request. Clinicians are located in North Bay, Cochrane, Iroquois Falls, Kapuskasing, Huntsville, New Liskeard, Elliot Lake and Little Current.

Niagara Geriatric Mental Health Outreach Team

This team provides a continuum of specialty mental health services including clinical assessment and intervention, education and community development. It provides clinical outreach services in the place of residence (eg. own home, long-term care facility, supportive housing, retirement home) to seniors with mental health problems who can not or

will not seek traditional services. Service is delivered by a multi-disciplinary team including geriatric psychiatry, nursing, social work, psychology, occupational therapy and partnering staff from the Alzheimer Society, Canadian Mental Health Association and the local Community Care Access Centre.

Sunnybrook Health Sciences Centre:

Sunnybrook's Community Psychiatric Services for the Elderly (CPSE) encompass a full range of services, usually in the place of residence, which include assessment, review of the complete psychosocial, cognitive and functional status at home; treatment plans and counseling for seniors and their families. CPSE also manages the psychiatric disorders of their clients, offers outpatient geriatric psychiatric services, and makes referrals to community and support agencies. In addition, this service consults and liaises with other facilities and provides education programs to community groups and healthcare professionals.

The expansion of these types of valuable resources is greatly needed and it is recommended that consistent mandates, increased service capacity and enhanced staffing be available across the province.

iv. Outpatient Programs

Outpatient programs (hospital-based) vary widely in mandate and function across the province. These programs enable access to services while helping people remain in their homes. There are many excellent examples of programs that could be replicated across the province to provide better opportunities for seniors who are able to travel to hospital for services. Some of these include:

Baycrest Day Hospital for Depression:

This multi-disciplinary out-patient service is for seniors in the community who suffer from depressive illness; physician referral is required. Treatment consists of individual and group therapy, and medication. Emphasis is placed on treatment of depression and learning new coping skills. Prior to discharge, the Day Hospital social worker will work with both the patient and the family to ensure that community supports and resources are in place.

Centre for Addiction and Mental Health (CAMH) Outpatient Services:

The objectives of these services are: to maintain clients in the community for as long as possible; to provide specialized geriatric mental health consultation services to community partners; and to assist in-patient units by providing continuity of care to clients upon discharge.

Service is offered through a series of clinics, including:

- Psychogeriatric Assessment, Consultation and Education clinics (PACE): Inter-professional outpatient teams provide assessment, consultation and education services to the community. There are currently three PACE clinics (Pace Central/East, Pace West and Pace Peel).
- Late-Life Mood Disorder Clinic: The late-life mood disorder clinic is a part of the PACE clinics and provides psychiatric consultation for patients/clients who have had long standing mood disorders and are now over age 60, as well as individuals who develop a mood disorder after the age of 60. The clinic has a particular interest in older persons with difficult to treat mood disorders.
- Late-Life Schizophrenia Clinic (LLS): Provides psychiatric consultation and treatment when needed for: patients who have had schizophrenia or a related disorder since an early age and are now age 60 or above; and patients who develop a psychotic disorder late in life.

Knowledge sharing of these types of programs coupled with funding to support wider and more consistent delivery would be an excellent adjunct in an array of approaches aimed at helping older adults with mental illness to remain at home.

b) Avoiding Emergency Visits and Hospital Admissions

Even if all of the proposed community services for older adults were in place, there will still be times when problems could escalate and an individual will require acute care. Hospital emergency departments become the destination of last resort, however busy Emergency Rooms tend to further agitate a senior who may already be confused and aggressive. Furthermore, a senior suffering from an acute episode in an emergency department, waiting for admission to a mental health bed, becomes a resource-intensive patient as his agitation becomes a source of concern for staff. For both patient and hospital staff, it is best to avoid this situation in advance rather than deal with it escalating within the confines of the ER.

For these reasons, it is suggested that crisis-avoidance be the first step. Currently, some jurisdictions benefit from Assertive Community Treatment Teams (ACTT). This model has proven to be effective for supporting people with mental illness and avoiding emergency trips, however their mandate does not consistently extend to people over 65 years of age. Variations occur from one ACTT to another with providers making their own determination of the upper age limit, primarily because of funding considerations. It is recommended that the

province establish a mandate for all ACTT services to include people over 65 years of age and provide funding to support this.

In spite of the efforts of ACTTs, some clients can enter into crisis. To manage these episodes effectively and still avoid an ER visit, it is recommended that province-wide 24/7 crisis services for seniors with mental health and addictions issues be established. These services would provide immediate attention, assess client needs and provide short-term intervention. They would link clients to community support services as well as specialized psychogeriatric services in order to help them post-crisis and assist them to stay safely at home after an acute episode.

Finally, if an emergency visit is required, the availability of Geriatric Emergency Management (GEM) nurses in the emergency department has been shown to be effective. The specialized attention and interventions of these professionals both during and after the hospital visit can decrease the negative effects of dislocation and assist in re-integration to the community after discharge. Currently most GEM nurses work during the day, Monday through Friday; it is recommended that this important service be available on a 24/7 basis.

c) Long-Term Care and Seniors' Mental Health

While the major focus of this report is not on long-term care facilities, it is important to briefly touch on their role, capacity and services for seniors with mental health issues. The Canadian Coalition on Seniors' Mental Health estimates that 80 per cent to 90 per cent of residents have some form of mental disorder and that depression is present in approximately 50 per cent of residents¹³. According to the Ontario Long-Term Care Association (OLTCA) almost a quarter of residents who have depression, show signs of worsening over a three month period¹⁴.

Staff are ill-equipped for the most part to adequately manage these challenges. There is a tremendous need to strengthen the capacity, knowledge and skills of the workforce in long-term care settings to better manage residents' behaviours in a sensitive and timely fashion. The implementation of Psychogeriatric Resource Consultants has been helpful with regards to staff training however there is more that needs to be done.

The alignment of Geriatric Mental Health Outreach Teams (GMHOTs) to long-term care facilities has been helpful in the Toronto region. By teaching long-term care staff how to tap into seniors' mental health expertise outside the facility they have opened up support networks that were previously unknown or under utilized. Similar support models would be helpful beyond the Toronto area to ensure equitable service provision for residents who live outside of the GTA.

Data from the OLTCa also show that almost half of the homes in their study reported the need to call police for assistance with residents and almost the same percentage required the use of a Form 1 or associated psychiatric leave¹⁵. This has prompted the OLTCa to question whether long-term care facilities are the appropriate places for older adults with mental health issues both from the perspective of care for those who suffer from the problem and for the safety of other residents. A thoughtful review of the future role of long-term care facilities and residents with acute mental health conditions is required to ensure appropriate treatment is available to these individuals and to safeguard the well-being of other residents.

Key Strategies for Transforming the System:

Helping Older Adults to Remain at Home

- ✓ Recognition and support for community support services
- ✓ Specialized case management
- ✓ Formal relationships between psychogeriatric services, home and community care services
- ✓ Expand Geriatric Mental Health Outreach Teams across the province
- ✓ Increase the availability of Outpatient Mental Health Clinics for seniors
- ✓ Support the role of primary care practitioners

Avoiding ER visits and Hospital Admissions

- ✓ Establish a policy that expands ACTT service limits beyond 65 years of age
- ✓ Establish crisis response service for seniors with mental health issues
- ✓ Ensure every ER has a GEM nurse available for in-hospital service and post-discharge follow-up on a 24/7 basis

Long-Term Care

- ✓ Additional training for staff to better manage mental health problems in residents
- ✓ Expand use of GMHOTS for long-term care staff support beyond Toronto region
- ✓ Review the role of long-term care facilities and residents in acute mental distress

DIRECTION #4: STRENGTHEN THE WORKFORCE

Training the workforce to enhance knowledge, decrease discrimination and increase and share best practices are essential elements for strengthening the mental health and addictions workforce.

a) Training

Mental health service providers have identified the need to enhance their skills in a number of areas; they seek training to improve their abilities and offer improved service to their clients¹⁶. There are a number of options that would be beneficial in creating an environment based on best practice and ongoing quality enhancement.

As a first step, it would be beneficial to enhance undergraduate professional curriculae to include issues related to aging, geriatrics and mental health. In addition, there needs to be more specialized academic training opportunities in gerontology and mental health. Furthermore, and in keeping with the vital role of primary care, build on physician training strategies that are aimed at medical students, family medicine residents and practicing family physicians to increase knowledge capacity in diagnosis, treatment and support of seniors with mental illness.

One such initiative, funded by the Ontario MOHLTC and the Ontario Senior Secretariat, was the “Alzheimer Disease and Related Dementias: Physician Training Strategy.” This \$2 million grant was awarded to the Ontario College of Family Physicians to develop an education program for medical students, family medicine residents and practicing family physicians. The program covered: diagnosis and treatment of Alzheimer Disease and related dementias; the impact of the disease on the person, his/her family and caregivers; information on accessing available resources; and directions on developing, maintaining and communicating an advanced care plan.

With so much of the mental health workforce in the community, it would be advantageous to enhance support to services that expand the skills and knowledge of these staff. Training should include topics such as the:

- Differentiation of the signs of normal aging from signs of mental ill health;
- Understanding the process and expectations around aging and chronic mental illness;
- Early identification of mental health problems/addictions;
- Managing disruptive behaviours;
- Shifting the culture of service delivery to one of recovery rather than control;

- Effective interventions and access to resources for helping depressed or suicidal seniors;
- Anti-stigma and ageism discrimination;
- Helping older people overcome the barriers to seeking help.

There are a number of excellent community-based organizations that provide this type of training, offering custom-designed education for personal support workers and their organizations. The Ontario Community Support Association (OCSA) through its Capacity Builders training service is one example. Another is COPA (Community Outreach to Persons with Addictions), which provides offsite and telephone consultations, along with education and training for professionals and organizations that work with older adults.

CAMH offers training related to its publication “Responding to Older Adults with Substance Use, Mental Health and Gambling Challenges” in two versions – one for front-line staff and volunteers and one for supervisory and professional staff.

Some local mental health providers provide training for service providers as well. The CMHA, York Region provides presentations and workshops on a variety of topics such as geriatric mental health, chronic disease management, concurrent disorders, medications and side-effects for front-line staff from the mental health, addictions and seniors sector as part of its geriatric mental health program.

Across the province, Psychogeriatric Resource Consultants and members of geriatric mental health outreach teams offer differing degrees of education on many aspects of seniors’ mental health, though the emphasis in many cases is on dementia education, and much is focused on the long-term care environment. Two of the PACE program clinics associated with CAMH in Toronto have Psychogeriatric Resources Consultants who provide case-based education to long-term care homes and some community agencies.

Over the past few years, related networks including NICE (Network for Issues in the Care of the Elderly), SHRTN (Seniors Health Research and Transfer Network), and CCSMH (Canadian Coalition for Seniors Mental Health) have created knowledge exchange opportunities providing information, webinars and other online educational opportunities.

Additional resources and training to assist the workforce could be expanded through the use of local mental health providers, specialized centres, Psychogeriatric Resource Consultants and GMHOTs.

b) Best Practice

There is widespread desire for implementing best practice for seniors as it relates to mental health and addictions. Work has begun in jurisdictions throughout

Canada but much more work is required to ensure that services are effective and efficient. This will require the government of Ontario to provide the leadership to incentivize best practice models while balancing those concepts with the realities of specific communities and locales. Best practice in one environment cannot and should not be replicated without regard to the resources, attitudes and cultural context in another.

Key Strategies for Strengthening the Workforce:

Training:

- √ Enhance undergraduate training in all health and social service programs in aging, geriatrics and mental health
- √ Offer more specialized academic training opportunities in gerontology and mental health
- √ Build on physician training strategies aimed at medical students, family medicine residents and practicing family physicians to increase knowledge around older adults and mental illness
- √ Support community-based education for workforce in aspects of seniors' mental health problems ranging from normal aging, anti-ageism, early identification, treatment and support

Best Practices:

- √ Establish a mandate in Ontario for best practices, building on the work done in other jurisdictions while adapting them to suit local context

DIRECTION #5: STOP STIGMA

Ontario's MOHLTC has recognized the need to identify and stop stigma and end discriminatory behaviours. Stigma and discrimination can exist amongst the public, service providers, families and consumers themselves.

a) The Public

Discrimination often starts with a lack of self-awareness about personal attitudes and behaviours. In general, people do not intentionally discriminate against older people, including those with mental health problems; however lack of intent does not mean a lack of discrimination. Social media campaigns and education are needed to increase awareness of stigmatizing attitudes around ageism and to decrease societal biases towards older people with mental health issues.

b) Providers

The stigma against aging and the resulting discriminatory behaviours towards older adults with mental illness is a serious concern in the mental health workforce. While recognition of the problem is an important first step, targeted education is essential in overcoming the plural dilemma of ageism and mental illness in seniors. Enhancing workforce knowledge in the understanding that many mental health problems in older adults are preventable and/or treatable and not "just an irreversible consequence of old age" is necessary if providers are to adopt a recovery-based service approach.

It is important to observe that the stigmatizing attitudes of ageism and discrimination against older adults with mental illness exist beyond the mental health workforce. At any point in the public service, be that housing, employment, social assistance, justice or any other portfolio, unconscious discrimination can pose barriers to the provision of optimal assistance. There is a need for basic understanding of seniors' mental health for service providers who will work with older adults. This could be achieved through training to heighten awareness of latent attitudes and facts surrounding seniors, normal aging and mental illness.

c) Self-Stigma

One of the most tragic consequences of societal and provider discrimination is the development of self-stigma in those suffering from mental health and addictions issues. Self-stigma prevents people from self-identifying when they are experiencing difficulties, asking for help and maintaining their engagement in services. Their own built-in biases against mental illness and their fear of being stigmatized by others not only create barriers to treatment, but induce feelings of guilt, shame and self-loathing.

Addressing the public and provider recommendations listed previously will help in decreasing the tendency for older adults to self-stigmatize but it would also be beneficial to provide educational opportunities by seniors, for seniors, to teach about the distinctions between normal aging and the onset of mental health issues. This type of education should also be provided to the family and carers of older adults because they are key to overcoming the personal effects of discrimination and the development of self-stigma.

In addition, resource materials such as those provided by Community Care Access Centres (CCAC), the CMHA, Ontario and CAMH could be funded so that they are more broadly available in any community location where seniors are likely to frequent.

Finally, the internet has become a tremendous resource for many people seeking information however credible sites are mixed in with sources of dubious credentials. The province needs to support and improve access to reliable, on-line information to combat misconceptions about ageism, normal aging and mental health problems. Good examples include the:

- Canadian Mental Health Association, Ontario (www.ontario.cmha.ca),
- Centre for Addiction and Mental Health (www.camh.net)
- Ontario Psychogeriatric Association (www.opga.on.ca)
- Canadian Coalition on Seniors' Mental Health (www.ccsmh.ca)
- Alcohol and Aging (www.agingincanada.ca)
- B.C. Partners for Mental Health and Addictions Information (www.heretohelp.bc.ca/publications/factsheets/seniors)

Key Strategies for Stopping Stigma:

- ✓ Public awareness campaigns
- ✓ Service provider training to decrease stigmatizing attitudes for mental health workforce as well as other public service sectors
- ✓ Community-based training by seniors, for seniors and their caregivers, on normal aging, the effects of ageism discrimination, early signs of mental health problems
- ✓ Support for printed resource materials
- ✓ Support for credible, web-based information on aging and mental health

DIRECTIONS # 6 & #7: CREATING HEALTHY COMMUNITIES AND BUILDING COMMUNITY RESILIENCE TO MENTAL ILLNESS AND ADDICTIONS

The approach to preventing mental illness and supporting older people with mental health issues does not start or stop within the formal jurisdiction of mental health services. The social determinants of health are broadly accepted as being relevant to physical health as well as mental health. Measures that are taken to foster the overall population health of a community must include factors that nourish social inclusion, affordable housing, adequate income, good transportation and opportunities for recreation and exercise.

a) Whole of Government

In order for this to occur, a “whole of government” approach is required to ensure that a cross-sectoral approach supports the biopsychosocial needs of seniors. Similarly, this coordinated approach must take place for planning, implementation and evaluation of service delivery at the regional and local levels. The MOHLTC should assume leadership responsibility for establishing this multi-level, multi-sectoral approach in partnership with other Ministries such as Community and Social Services, Education and Housing.

b) Housing

Adequate and affordable housing for seniors with mental illness is a prerequisite for successful community living. Thus, the availability of assisted living or supportive housing linked to community services for older adults with mental illness is necessary to enable them to live in communities of their choice. Supportive housing could also relieve some of the backlog of alternate level care patients who are waiting for a long-term care bed but could actually manage alone provided there was housing and services in place to assist them¹⁷.

The services provided by LOFT Community Services in the Greater Toronto area are a noteworthy example of supportive housing for seniors with mental health and addiction issues. LOFT services for seniors help more than 400 vulnerable, at-risk and frail older adults to continue or regain the ability to live independently and maintain a sense of community. All seniors, whether in a high support program or not, receive a daily visit from LOFT staff who help them manage the complex challenges they live with including limited financial resources, absence of family support, cultural isolation (for first generation Canadians), poor physical health and mental health and addiction issues. LOFT helps them find permanent housing, access to services for crisis and emergency intervention, and personal and social support.

In addition to supportive housing, there has been exploration of the benefits of service support hubs that would offer assistance to at-risk seniors living in a specified geographic community. The support hubs would be operated from a

centrally located supportive housing service provider. This type of home support could be provided to those living in congregate situations, traditional seniors' or supportive housing buildings, or in seniors' private homes located in the geographic community. Services should include daily visits from staff who help older adults manage challenges such as limited income, no family support, cultural isolation, poor physical health, mental health and addictions issues. They would also assist seniors with mental health issues in transition from acute care back to the community.

For example, since 2008, the Central LHIN has funded Crosslinks Seniors Housing and Support Services to respond to the needs of a largely under-served population of at-risk seniors living in the Jane and Finch area of Toronto. Crosslinks offers practical support for daily living for clients with mental and physical health and addiction challenges, social isolation, abuse and abandonment. The program offers acceptance, support and community building in a non-judgmental environment.

It is an innovative partnership between LOFT Community Services, Toronto Community Housing Corporation (TCHC) and Downsview Services to Seniors, with each partner contributing resources and expertise. The program is based in a large TCHC apartment building in the Jane and Finch area, and in the past, has served resident seniors. Now, community support teams have taken the program's services to an additional group of seniors living in nearby buildings. Expansion funding for this program has just been approved and it is expected that the program's capacity will double in the coming year.

c) Transitional Services

In addition to supportive housing, there is a need for transitional services that provide interim stay beds for patients who are discharged from acute psychogeriatric care back to the community. Transitional services should include support in regaining an independent life style, getting access to community supports and finding permanent, lower-cost supportive housing.

The partnership between LOFT and CAMH on the Stepping Stone Project (SSP) provides an excellent model of transitional services. SSP has 12 transition beds located at the John Gibson House (a LOFT housing site) for psychogeriatric patients aged 60 years and older, with a maximum length of stay of six months. The main objective of SSP is to provide clients with the services and support required to enable them to regain their independence and make the transition to permanent, supportive housing in the community after discharge from CAMH or an acute care hospital.

LOFT provides 24-hour supportive housing services. In addition, a transitional housing worker is assigned to each client and s/he is responsible for ongoing ADL skills, recreational and goals assessments, linking with community supports,

and developing a plan of support towards recovery. Together, the worker and client are working towards the transition into lower level supportive housing options. CAMH provides the psychogeriatric, occupational therapy and nursing resources, as well as clinical follow-up services. CAMH's PACE team will support the client's transitions post discharge from John Gibson House as they move into the community.

c) Community Services

Support services that enable seniors to live at home contribute to the mental health and well-being of these individuals and prevent the onset of mental illness resulting from poor nutrition, social isolation, lack of stimulation and difficulties in managing activities of daily living. Services that provide peer support, caregiver support and social opportunities are vital in sustaining good mental health. We applaud the resources that have been provided to these services and encourage further support to build and expand their availability.

Several disease-specific organizations including the Arthritis Society, the Osteoporosis Society of Ontario and the Stroke Recovery Association Ontario offer support groups to mitigate the depression that can so often accompany these chronic conditions. Community Outreach Programs and Addictions (COPA) provides group support for those involved with older adults with addiction problems. Widows and widowers groups have been run in seniors' centre and community centres for many years, and many ethno-specific seniors organizations offer social groups which, in fact, act as support groups for those new to Ontario or struggling with issues of aging as immigrants. The Mood Disorders Association of Ontario (MDAO) runs groups for older adults affected by depression and other mood disorders.

Caregiver's specific needs are now being addressed through a number of psychosocial approaches including day and overnight respite programs offered in community and seniors' centres. Many Alzheimer Society branches and related organizations offer both caregiver support groups and individual peer support. Veterans Affairs Canada has developed a manual and training program called "Care for the Caregiver" which has been designed to support caregivers providing emotional, physical and financial assistance to their elderly, family members. The program helps the caregivers to develop new skills, consider different approaches to caregiving, deal with their feelings and be mindful of their own health needs.

Community Care Access Centres (CCAC) assist older adults to live in their homes. Currently, however, the appropriate policy mandate for CCACs and other community mental health resources is unclear with respect to seniors and mental illness. Government needs to define and fund a consistent mandate for seniors' mental health and addictions that builds on the strengths and capacities of the community mental health services sector in cooperation with CCACs.

d) Transportation:

Transportation to services is a particular concern for seniors due to problems relating to physical ability or financial hardship. This creates barriers to service for those living in their own homes or in long-term care facilities. Affordable transportation that ensures accessibility is a requirement if mental health services are to be available to seniors.

Key Strategies for Communities and Mental Health for Seniors:

Whole of government approach:

- √ Cross-sectoral involvement, led by the MOHLTC care, to address the health and social factors of mental well-being

Housing:

- √ Expand available supportive housing for seniors with mental illness
- √ Extend services linked to supportive housing into the community to prevent at-risk seniors from becoming homeless
- √ Establish transitional services to facilitate re-integration of seniors with mental illness from hospital back to the community

Community Services:

- √ Expand community services for seniors with mental illness and/or addictions to assist them in living at home
- √ Encourage support groups for older adults with mental illness and for their caregivers
- √ Support families and other caregivers
- √ Define and fund the role of CCACs in caring for older adults with mental ill health at home

Transportation:

- √ Affordable, available transportation is necessary to enable seniors to access mental health services as well as social and recreational activities

Conclusion:

In 2008, adults over the age of 65 constituted 13.5 per cent of the total population in Ontario or 1.7 million people. Mental health problems affected anywhere from 17 to 30 per cent of these individuals. That means between 289,000 to 680,000 seniors suffer from disorders such as depression, anxiety, dementia, delusions, delirium, paraphrenia and/or concurrent issues in this province.

By 2036, adults over the age of 65 years will constitute 23.2 per cent of the population in Ontario or 4.1 million people; potentially the number of seniors with some kind of mental illness could reach 1.23 million. This has staggering consequences to families, our social fabric, health care costs and our economy.

The financial, societal and moral imperatives of implementing mental health and addictions reform for seniors are clear. Action must be taken in ways that enable older adults to reside in the community, living their lives to the fullest in spite of the challenges of mental health and/or addictions.

The Canadian Mental Health Association (CMHA), Ontario recommends that a specific seniors' framework be included as part of the mental health and addictions reform in this province. We believe that the core elements in a seniors' framework should include:

- Community-based care;
- Collaboration across all sectors to deliver a social model of care;
- Recovery-based approach that involves the client and family (where desired by the client);
- Client and family/carer involvement in system planning, implementation and evaluation.

CMHA, Ontario appreciates the opportunity to contribute to the discussion on the Ministry of Health and Long-Term Care's discussion paper, "*Every Door is the Right Door.*" Within the context of the seven directions outlined in that paper, this report has provided strategies tailored specifically to the needs of older adults and identified approaches that have proven to be effective.

Having said that, it is important to note that future initiatives must be developed within the context of the locale in which services are delivered. While strategic elements should be evident in reform, actual delivery of services should reflect the resources, attitudes and culture of the specific environment. A cookie cutter approach to implementation is not a panacea for effective reform.

Instead of a mental health system, where "*Every Door is the Right Door,*" we find that many doors are closed to the needs of older people. CMHA, Ontario hopes that this report will open those doors and facilitate reform leading to a mental health and addictions framework for seniors.

Appendix A

Mental Health Disorders of Older Adults and Seniors

Depression:

The prevalence of seniors with depressive symptoms is reported to be 10 per cent to 15 per cent in Canada¹⁸. Many seniors' service providers and many older adults themselves believe this statistic to under-represent the situation. Some of this may be due to the practice of reporting only what is assessed as "clinically significant" depression as opposed to what older adults experience as a seriously disabling condition.

Even if only 10 per cent to 15 per cent of older adults are dealing with the effects of serious depression, this accounts for 225,000 older adults in Ontario in need of services and supports for this treatable condition.

The CMHA points out that depression in seniors is one of the most common mental health problems affecting seniors, but is often underdiagnosed¹⁹. As with other age groups, there are significant differences in prevalence rates of depression between older women and men, with women experiencing almost twice the rate (14.1 per cent) than that reported for men (7.3 per cent)²⁰. Recent immigrants are at particular risk due to increased social isolation²¹.

Diagnosing depression in older adults is complicated. Age-onset depression can be related to many factors including family history, physical health, financial insecurity, substance abuse, loss of a partner, living alone, or social isolation. Unlike depression in younger people, depression in seniors is often exhibited as anxiety, agitation and complaints of physical and memory disorders. Its diagnosis requires skill, time and resources that are not always readily available.

Suicide:

Untreated depression and lack of social supports are considered major risk factors for suicide among seniors²². Suicide is often considered one extreme indicator of depression. The 1996 Statistics Canada Census Data rank suicide as 10th in the list of causes of death. In Canada, suicide is five times more likely in people over 60 than in younger age groups.

Across the country, mortality rates due to suicide are highest among men over the age of 80 (more than 27 per 100,000)²³. Approximately 1000 older adults are admitted to Canadian hospitals each year as a consequence of intentional self-harm, while it is unknown how many experience self-harm without hospitalization²⁴.

Suicide rates among women showed three peaks: in the late teens (15-19 years), in middle age (45-59 years) and among older seniors (80-84 years); rates among

men start to increase among 70-74 year olds and are highest among men 80 years of age and over. With increasing age, the disparity increases dramatically such that men 65 to 69 of age are twice as likely as women in the same age group to commit suicide and men 85+ are 22 times more likely to end their own lives²⁵.

These statistics do not account for the deaths by self-harm which are not officially recorded. On these occasions, it has happened that fewer questions are asked by the attending physician and to avoid embarrassment to the family, the cause of death of the older person is listed as heart failure. As well, the rate of 'passive suicide' among older adults may not be recorded. In these circumstances, the older adult may have expressed a desire to 'get it over with' and refuse food, medications or medical procedures which could sustain their lives.

Dementia:

Dementia describes the symptoms associated with non-treatable, irreversible, progressive illnesses that affect the brain. Alzheimer's disease, the most common form of dementia, is a progressive, degenerative disease of the brain, which causes thinking and memory to become seriously impaired. After Alzheimer's disease, Vascular Dementia (VaD) is the second leading cause of dementia²⁶.

Over time there has been some discussion as to whether or not dementia should be classified as a mental illness. We have included dementia in this paper because there are common issues that affect both older adults with dementia and those with other mental illnesses or concurrent disorders.

The prevalence of dementia is anticipated to escalate over the coming decades. Most Ontarians with dementia today are supported outside of institutions, in their homes, or by their families. Care partners of people with dementia report stress levels three times greater than those caring for persons with other chronic diseases and depression is nearly twice as common²⁷.

Some other interesting facts:

- More than 180,000 people in Ontario have dementia and in less than 25 years, the number will double²⁸
- Dementia is the leading cause of disability in Ontarians over 60, causing more years lived with disability than stroke, cardiovascular disease and all forms of cancer²⁹
- Persons with dementia use one third of Alternate Level of Care bed-days. Dementia is highly correlated with hip fractures and persons with dementia occupy over 60 per cent of our long-term homes³⁰
- The risk of developing dementia increases with age. Dementia is found in 2 per cent of Canadians 65 to 74 years of age, 11 per cent of

Canadians 75 to 84 years of age and 35 per cent of Canadians 85 years and over³¹

- Conditions such as delirium, depression, vitamin B12 deficiency, thyroid disease, and others are often confused with dementia or co-exist with it³²
- Depression coexists with dementia in 35-40 per cent of cases³³
-

Delirium:

Delirium is generally a reversible mental health disorder but can have serious implications if not diagnosed and treated. It is usually precipitated by a physical illness or drug use. Prevalence rates in the community are difficult to determine since most estimates are based on patients admitted to hospitals. Further, delirium is often missed because behavioural changes resulting from delirium are assumed to be part of a dementia syndrome and are not given suitable attention. Although prevalence rates are difficult to establish, delirium is potentially very serious and can result in death.

- It is estimated that 13 per cent of all hospitalized older adults develop delirium³⁴
- Delirium has been described as the most common and potentially reversible lethal mental health disorder of old age
- Although delirium is considered a medical emergency, it is poorly recognized as such, even in acute care settings. Many conditions that would be relatively innocuous in a younger, healthier person (e.g., infections of any sort, urinary retention, constipation, fecal impaction) can result in a delirium in elderly persons.
- Recognizing the potential for delirium and demonstrating the effectiveness of intervention is the focus of a study reported in the *New England Journal of Medicine* (Inouye et al, 1999). This study found that directing focused delirium intervention protocols to hospitalized older patients significantly reduced the number and duration of delirium episodes.

Anxiety Disorders:

Anxiety disorders are often left out of the discussion of seniors' mental health and yet many older adults deal with the debilitating effects of anxiety-related symptoms for the first time in their later years. Both health providers and older adults themselves often dismiss anxiety symptoms as 'worrying too much'. In fact, up to one in four adults experience an anxiety disorder sometime in their lifetime, which may include phobias, or panic, obsessive-compulsive, or post-traumatic stress disorders³⁵. Almost 20 per cent of people over age 65 have had an anxiety disorder in the past six months. Anxiety disorders are the most common mental health problems in women; among men, they are second only to substance use disorders³⁶.

Concurrent Disorders:

While little research has yet focused on concurrent disorders specifically in older adults, substance use in this population is of great concern and there are certainly relationships with mental illness for many seniors. Alcohol is the most common substance misused by older adults and alcoholism is often hidden, denied, or unrecognized. Substance abuse among seniors may also involve prescription or non-prescription (over-the-counter) drugs.

Since aging tends to slow the body's metabolic rate, seniors may experience new reactions to substances they have been using for years. Generally, they require less of a substance than when they were younger to feel the same effects. As a result, alcohol "abuse" is estimated to affect between 5 per cent and 11 per cent of seniors³⁷. Men over 65 years of age tend to drink alcohol more frequently than women over 65 years of age and one third of older adults with drinking problems begin misusing alcohol after they reach old age³⁸.

Between 40 per cent and 70 per cent of the people who seek help for a primary substance use concern at the Centre for Addiction and Mental Health in Toronto also have a co-occurring mental health disorder³⁹ and though statistics are difficult to find it is estimated that rates among older adults are likely similar.

Older adults take up to 40 per cent of all medications prescribed in Canada⁴⁰. Substance misuse may be as significant as substance abuse as some seniors forget to take their medications, or share medications with others. Some may also "self-medicate" – try to treat their medical conditions on their own by taking more or less of a medication than prescribed, or by taking medications not prescribed. An estimated 50 per cent of prescriptions are not taken properly and up to 20 per cent of hospitalizations of people over 50 are due to problems with medications⁴¹. What seniors often are not aware of is that over 150 medications commonly prescribed to older adults can cause problems if taken with alcohol.

Older people who are depressed are three to four times more likely to have alcohol related problems than are older people who are not depressed. Between 15 and 30 per cent of people with major late-life depression have alcohol problems⁴².

While there has been little research on concurrent disorders among older adults in Ontario specifically, problem gambling in that demographic has been studied extensively. A major study was conducted in 2004 by the Responsible Gambling Council, "Gambling and Problem Gambling among Older Adults in Ontario." The study was intended to determine the characteristics and prevalence of gambling and problem gambling among older Ontario adults, examine factors related to problem gambling, and discuss the implications of these findings for addressing gambling problems among older adults. Overall, a majority of older adults (73.5 per cent) had participated in some type of gambling activity in the past 12 months. The study found that "The importance of the economic cost of gambling

to respondents is reflected in the finding that winning money (33.9 per cent) was the most common benefit attributed to gambling, followed by excitement or fun (30.7 per cent), and the opportunity to socialize (20.9 per cent). Interestingly, a significant proportion (29.0 per cent) also indicated no benefit to gambling. While economics appears to play a significant role in shaping participation, gambling also appears to serve an important social function, particularly as respondents age and become more isolated (e.g. widowed). Of note, is the fact that depression is common in older adults with alcohol and/or gambling problems. The addiction can sometimes be a way of fighting depression, or the addiction can lead to or worsen an existing depression⁴³.

Paraphrenia / Late-onset psychotic disorders:

In the past, most of the research into schizophrenia focused on younger adults. This was partly due to the fact that few people suffering from schizophrenia lived into older age, falling victim to suicide or lifestyle issues associated with this devastating disease. With better treatments and supports, more people with schizophrenia are living longer and although few statistics are available to describe this population there is now an increase in the attention being given to older schizophrenic patients, including those with a late onset of the disorder⁴⁴.

Schizophrenia can be diagnosed after the age of 45, although this is very uncommon. Delusional disorder and psychotic (delusional) depression are more likely to have onset during middle age and old age than during early adulthood.

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