

# *The Mental Health Needs of an Aging Population*

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for the



CANADIAN MENTAL  
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L'ASSOCIATION CANADIENNE  
POUR LA SANTÉ MENTALE

Introduction

The aging populations of Canada and Newfoundland and Labrador have pushed healthy aging towards the fore of the issues facing both the federal and the provincial governments. While the mean age nationwide is on the rise, the population of this province is aging faster than anywhere else. Nationally, the overall decline in fertility rates following the enormous “Baby Boomer” generation means the country’s largest demographic will soon be senior citizens. Newfoundland and Labrador in particular has the added problem of out-migration. Often seeking broader economic horizons, younger people entering the workforce are either forced or choose to leave the province. The end result is a wider gap between the number of young adults and Boomers. From 1990 to 2005, the percentage of people in the province older than 50 has risen from 21 percent to 34 percent. Also, the percentage of people older than 80 has doubled in that time (Seniors Resource Centre Association of Newfoundland and Labrador, 2005). The Economics and Statistics Branch of the Newfoundland and Labrador Department of Finance estimates that by 2026, 27 percent of the population will be over the age of 65, up from 13.7 percent in 2006 (NL Department of Health and Community Services, 2006). Canada-wide, it is estimated that seniors will account for 18 percent of the population by 2021 (CCSMH Guidelines for Seniors’ Mental Health, 2006).

Unfortunately, the inherently ageist nature of society has often left senior citizens on the fringe of decision-making, even with regards to their own physical and mental wellbeing. The result is health policies that do not reflect the needs and desires of seniors. Penny MacCourt of the B.C. Psychogeriatric Association believes policies related to seniors’ mental health are too often situated within the biomedical model, meaning a narrow focus on acute care. Instead, MacCourt feels that there must be a wider range of non-medical interventions and community-based services given that the needs of many

seniors are often related to disability and/or weakened social support systems (MacCourt, 2004).

### Mental disorders affecting the elderly

There is a common misconception that all forms of mental disorder are most prevalent among seniors and that they are normally concomitant with aging. In truth, only dementia, Alzheimer's disease, and delirium are most common among older people. The documented rate of depression among community-dwelling seniors, for instance, is somewhere between 2 and 4 percent, similar to the Canadian national average of 4 to 5 percent. Keeping with general trends, a study of Edmonton seniors found that the prevalence rate of depression for women (14.1 percent) was double that of men (7.3 percent). The Mood Disorders Society of Canada also claims that depression among seniors is twice as prevalent among women (2006). It should also be noted that prevalence rates for depression are significantly higher among seniors in long-term care (LTC) facilities and/or with chronic medical conditions. Between 15 and 25 percent of nursing home residents suffer from major depression, while another 25 percent have symptoms of mild depression, most of whom are likely to develop major depression over time (Conn, 2002).

Depression is generally more difficult to pinpoint among the elderly. This is primarily because seniors are usually not wont to discuss their depressive symptoms. Furthermore, many seniors are not of the opinion that mental health problems constitute medical problems. Many fear the stigma of mental illness and worry that their friends and neighbours will think differently of them. Men, in particular, are less likely to report depressive symptoms (Murray et al., 2006). Also, diagnosis can be complicated by the

presence of some form of cognitive disorder (Conn, 2002; Mood Disorders Society of Canada, 2006).

Studies have determined the rate of schizophrenia in nursing homes to be approximately 2.4 percent. Psychosis in nursing homes ranges from 12 to 21 percent depending on the criteria used. One study concluded that 21 percent of newly admitted nursing home residents suffered from delusions. Shockingly, given these figures, there is a general lack of psychiatric services available at LTCs (Conn, 2002).

### Common determinants of mental health among seniors

A number of social and psychological determinants make seniors more apt for mental illness. These may include inevitable physical changes, retirement and its accompanying decrease in income, the loss of a spouse, social isolation, and loneliness. These factors can contribute to the onset of late-life major and minor depression, suicidal ideation, and can exacerbate cognitive disorders such as Alzheimer's disease and dementia.

Because physical health and mental health are so often intertwined, the physical changes experienced by the elderly can create stress and uncertainty which can in turn cause mental illness. These changes can range from the reduction of sensitivities (e.g., hearing loss, reduced vision, etc.) to conditions affecting mobility and/or cognition (e.g., heart disease, stroke, arthritis, etc.). These physical health problems may make it difficult for seniors to leave their residences and interact with family and friends (Stride Magazine, 2004).

Though retirement is generally regarded as a positive, relaxing experience, for some it might be the source of a great deal of worry and confusion about the future. While some see it as a time to pursue some of the goals they were not able to when they

were working, others are hampered by the reduction in income and the lack of social interaction. Also, the changes in daily routine caused by retirement have the potential to create friction within the household. Elderly men generally draw more income than do women. It has been suggested that this is due to historical dependence on men and sporadic or non-existent employment histories for women (MacCourt, 2004). As a result, older women tend to draw less from pensions than do men. Not surprisingly, single or widowed elderly women typically face the most economic pressure. Fortunately, it is likely that the increasingly educated population of future seniors will mean a reduction in poverty among the elderly. Also, future seniors will have had access to better nutrition and medicare (Pushkar & Arbuckle, 2002).

Another important factor of seniors' mental health is social isolation, which can be closely related to the implications of physical health changes and retirement. Though isolation is not necessarily tantamount to loneliness, the two tend to go hand-in-hand. Hall and Havens (2002) define social isolation as being separated from one's environment to the point of having few meaningful relationships. However, social isolation can result from personal choice and can often be referred to as solitude rather than loneliness. Seniors who have recently suffered a loss of some kind, be it the loss of a spouse, the loss of physical capability, or the loss of employment, are typically at an increased risk of developing some form of mental illness (Conn, 2002).

There are a number of indications that isolation may be taking the form of loneliness for a senior. For example, a widowed senior might say he/she misses their spouse, or that they are unsatisfied with their level of social contact. Though no definitive measure of the prevalence of loneliness among seniors has been established, experts agree that women who are widowed or live alone are at the highest risk. Because women

have a higher life expectancy than do men, they tend to outlive their spouses and may be forced to live alone without the support of friends or family. However, men tend to have a harder time coping with the loss of their spouse, likely because they are less prepared and have smaller social support networks than do women. Loneliness may lead to the worsening of mental health or negatively influence the body's immune system, leaving it susceptible to many forms of illness (Hall & Havens, 2002).

Though a number of late-life factors can influence the onset of loneliness, an earlier history of adjustment problems or a lack of social support over the course of one's lifetime are often at play (Pushkar & Arbuckle, 2002). With regards to home care, some seniors often do not want to make such a drastic change. Understandably, some seniors are suspicious of a stranger in their homes and suspect the caregiver of taking advantage. However, home caregivers can offer services and social contact that the senior might not otherwise have access to. They can aid with chores, pick up groceries, or offer a means of transportation. Often, caregivers and seniors become very close friends (Spencer, 2002).

As previously mentioned, LTC facilities typically offer very little in the way of geriatric psychology. Too often, care takes a "one-size-fits-all" format. In reality, the resources, demographics, and needs of a community must all be considered in developing and improving primary, secondary, and tertiary levels of care. By far the most important is the primary level. At this level, general practitioners, family physicians, and home support workers provide preventive, diagnostic, and therapeutic services (MacCourt et al., 2002).

### Government response

In Newfoundland and Labrador, the government's *Healthy Aging for All in the 21<sup>st</sup> Century* initiative has the ultimate goal of establishing a provincial healthy aging

framework. In March 2006, the government released a seniors profile examining the shifting demographics and a discussion paper proposing areas of focus for the framework. Over the spring, 18 public consultations were held throughout the province encouraging individuals to comment on the broad strokes of the government's discussion paper. To tackle the issue directly, a Division of Aging and Seniors has recently been established within the province's Department of Health and Community Services. The government has also established a ministerial Council for Aging and Seniors, chaired by the Minister of Health and Community Services (NL Department of Health and Community Services, 2006).

There has also been significant activity at the federal level. In May 2006, the Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby, released *Out of the Shadows at Last*, a series of findings and recommendations concerning mental health, illness, and addiction. Of particular interest was the detailed chapter devoted to issues surrounding the mental wellbeing of seniors. Understandably, most of the committee's energy was spent addressing the need for adequate community and recovery-based alternatives to institutionalization for seniors with mental illness. The committee cited the fact that 20 percent of Canadian seniors have some form of mental illness. This number falls within the one stated in 1991 by Health & Welfare Canada between 17 and 30 percent of elderly people in Canada had a mental illness (MacCourt, 2004). As well, the committee noted the fact that 80 to 90 percent of seniors in nursing homes are afflicted with a mental illness or cognitive impairment. Alzheimer's Disease, by far most common among seniors, affects one in 13 people over the age of 65 and one in three people over the age of 85. Through months of consultations and data gathering, the committee concluded that there is a "provider-

driven model” currently in place limiting the effectiveness of the Canadian mental health sector. Due to mental health services being largely limited to hospitals and mental health-specific facilities, seniors with mental illnesses are often granted mere ten-minute visits. Unfortunately, there is still a tendency in the health care system to see seniors as “bed-blockers” and placement problems. The committee also identified the practice of “warehousing” seniors with mental illnesses. Rather than focusing on recovery, the committee is of the belief that the system too often chooses to put seniors with mental illnesses out of sight (Canadian Senate Committee on Social Affairs, Science and Technology, 2006).

The committee recommends that a Mental Health Transition Fund be created to channel funding for changes in the mental health sector from the federal government to the provincial and territorial governments over a ten-year period on a per capita basis. The committee suggests that a Canadian Mental Health Commission oversee this fund. The funding would assure that those with mental illnesses receive equal treatment to those with physical illnesses. Also, it would see to it that a wider range of affordable and supportive housing units be made available to seniors with mental illnesses. Overall, the committee feels that seniors with mental illnesses should be transferred from acute care to LTC facilities whenever possible.

In the last 30 years, the breakdown of seniors admitted into LTC facilities has changed markedly. Today, unlike in the past, when the majority of LTC residents were simply physically frail, anywhere from 75 to 85 percent of residents have some form of cognitive or mental health disorder. The committee found that the mental health sector has not yet adequately adjusted to this new reality. It suggests that a new focus be placed on developing and upgrading skills among staff pertaining to the treatment of mental

illnesses. Also, the committee believes there has been far too little enhancement of on-site mental health and support services, a result of which can be overmedication and chemical restraint.

The committee recommends that measures be put in place to ensure that aged couples can continue to live together or at least in close proximity. The committee believes seniors with mental illnesses living with a spouse or other caregiver deserve to receive the same services received by those who live alone (Canadian Senate Committee on Social Affairs, Science and Technology, 2006). The nature of mental illness can place a great deal of stress on spouses/caregivers and can have negative effects on their relationships. The 1994 Canadian Study of Health and Aging found that spouses are the primary caregivers for approximately 37 percent of community dwelling seniors with dementia, while daughters are the primary caregivers approximately 29 percent of the time (MacCourt, 2004). There are approximately 4.5 million caregivers in Canada caring for chronically or terminally ill loved ones. Aside from the mental costs of such work, there are enormous economic variables. It is estimated that in Canada informal caregivers' financial contributions total approximately \$100 million a week. Quite often, caregivers must adjust their own budgets or borrow money accordingly. It is estimated that the work provided by informal caregivers saves the health care system over \$5 billion a year and is equivalent to that of 276,509 full-time employees (Henderson, 2002).

### Canadian Coalition for Seniors Mental Health

The Canadian Coalition for Seniors Mental Health (CCSMH) worked closely with the Senate committee in developing *Out of the Shadows at Last* and recently released national guidelines pertaining to delirium, depression, suicide, and LTC facilities. In its LTC guideline, it cited a study concluding that between 15 and 25 percent of seniors in

LTC facilities have symptoms of major depression, while another 25 percent have symptoms of moderate depression. In most cases, this moderate depression will likely develop into significant depression over time. The mortality rate of seniors with depression is 1.5 to 3 times higher than those without depression. In view of this, the CCSMH recommends that psychological assessments, guided by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), be done of residents immediately after admission, with continued monitoring and evaluation over the course of time. Protocol for these assessments would include a physical exam and follow-up, and consideration of treatment history and response. The assessment would also consider social factors pertaining to mental health. These include changes in family situation, new stressors, and the availability (or lack thereof) of meaningful activities/positive experiences.

Unfortunately, treatment of depression among the elderly is often complicated by the presence of other co-morbid conditions, in particular some form of delirium. Late-life depression may be addressed by psychotherapeutic or pharmacological treatment. However, caregivers must ensure that the inevitable side effects of pharmacological care do not exacerbate the already existing medical problems of seniors. That said, a number of psychotherapeutic therapies have demonstrated effectiveness for combating late-life depression. These include behavioural therapy, cognitive behavioural therapy, brief dynamic therapy, and reminiscence therapy. The CCSMH also reports that seniors tend to prefer psychological to pharmacological care whenever possible. A number of studies have observed that the side effects of antidepressants are more pronounced among seniors. A possible explanation for this could be the fact that the liver metabolizes antidepressants. With age, changes occur in hepatic metabolism and this could increase the likelihood of side effects. The CCSMH feels that the aging population should bring

along with it a more educated health care sector in terms of gerontology (CCSMH Guidelines for Seniors Mental Health, 2006).

## Suicide

The CCSMH also considered the unfortunate reality of suicide among seniors. In 2002, 430 Canadian seniors, 361 of whom were men, died as a result of intentional self-harm. In 1997, the suicide rate among Canadian seniors was nearly double that of the nation as a whole. A 2001 study of 611 seniors found that 17 percent answered affirmatively to at least one question pertaining to suicide. A study done in 1991 revealed that 38 percent of seniors who committed suicide discussed their suicidal ideation with a health care professional (CCSMH Guidelines, 2006).

Interestingly, one study found that 66 percent of those who had completed suicide had visited their doctor within the last month of their life, though they did not necessarily make mention of suicidal ideation (Conn, 2002). This suggests that physicians are not being active enough in identifying latent depressive symptoms. It has been found that approximately half of suicide attempts by seniors are successful. This is particularly alarming given the fact that only 13 percent of suicide attempts are successful among people under the age of 50 (MacCourt, 2004). In light of these statistics, the aging population will likely bring with it a significantly increased suicide rate. The CCSMH believes suicide can be addressed through much the same means as depression. Mental health services must be able to provide individualized care and, where possible, meaningful activities for seniors. Perhaps not surprisingly, few clinical measures exist for the assessment of late-life depression and suicidal ideation (CCSMH Guidelines, 2006). In England, there is early evidence that the publication of strategies to prevent suicides has had a positive effect. The suggestions include multi-agency cooperation, identifying

knowledge gaps, and lowering risks and access to means of suicide (Ilfie & Manthorpe, 2005).

### Recommendations to the CMHA

The mental health of seniors has too long often been regarded lightly or even dismissed entirely. Given the growing population of seniors in the country and the province and the inevitable increase in late-life mental illness that will accompany it, a new outlook is needed at all levels of the health care system. In particular, an inclusive, community-based system of recovery dedicated to assuring the social relevance of mentally ill seniors and the reduction of stigma is the key. Without such a framework in place, the system will inevitably leave mentally ill seniors socially isolated. Of paramount importance is the continued spread of knowledge concerning mental health in the caregiving sectors. The alarming rate of suicide among seniors, particularly men, is perhaps the strongest indication of the need for a broader base of education in the health care system with regards to geriatric psychology. The provincial and federal government initiatives are encouraging, if not yet fully realized, developments. Certainly, more of the governments' energy and resources must be directed towards developing and refining systems to address the mental health concerns of seniors.

The Canadian Mental Health Association can provide substantial leadership in the realm of seniors' mental health. Most importantly, there should be a strong voice advocating the ongoing development of programs, educational and otherwise, dedicated to reducing the stigma so often associated with seniors and mental illness. Sadly, neglect and labelling still regularly permeate the health care system. Too often seniors seeking medical care, particularly those with a mental illness, are seen as bed-blockers rather than normal patients. Similarly, LTC facilities typically offer very little hope of any kind of

recovery. Health care professionals, LTC staff, caregivers, and friends and family must ensure that seniors with mental illnesses remain relevant members of their communities and traditional social networks. Where possible, those with late-life mental illness must be able to contribute to their own wellbeing by making choices and offering opinions. The key to achieving this is through education. Workers at all levels of the health care system must have a good understanding of the possible implications of inadequate treatment. Inarguably, never has the wellbeing of seniors been more of a pressing issue. The unflinching advocacy of the Canadian Mental Health Association in would be an immeasurably important element in the ongoing development of provincial and federal government endeavours related to seniors' mental health.

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