Seniors and the Mental Health Care System in Canada

One in five Canadians will experience mental illness during a one-year period, either directly, or as family members, neighbours or care providers.[1] There has been, and continues to be an increase in the number of senior citizens living in Canada. The number of seniors is expected to increase to five million by 2011, which means that about one out of every seven citizens will be a senior. This temporary shift in the population pyramid will have "an enormous impact initially on labour markets, pensions, and the health care sector, and eventually – in the 2030s – long term care."[2] It is important to remember that seniors are not a homogeneous group. They encompass a broad range of ages, and their mental health needs vary within these age groups from youngest to oldest. The delivery of mental health services and the underlying research to support it, must take this diversity into account.

The mental health system has failed to recognize the uniqueness and diversity of seniors' needs. Part of this failing is due to the provider-driven structure/institutionally-driven philosophy of the mental health system. It is generally structured to primarily suit the needs of individual and institutional service providers, rather than the needs of clients. Secondly, existing services and supports for individuals with mental illness and addiction are fragmented among many separate agencies and many access points. This can make the system hard to navigate. Services tend to be delivered in an uncoordinated fashion through multiple providers.

Another cause of systemic failure may be the lack of knowledge exchange among researchers in gerontology, and also between providers of specialist care to seniors and other mental health and addiction care providers.[3] Differences among professionals and 'turf protection' can create barriers to communication. Lack of a common language between home care and mental health organizations may cause unnecessary difficulties in communications. There needs to be a willingness and clear protocols for information sharing among health professionals in different sectors, and with the consumer and family, with respect for privacy and personal preference.[4]

Collaboration between home care and mental health sectors in areas of training for management and front-line workers, and for coordination with existing health, community services and non-governmental organizations is required as part of the mandate of the First Minister's Ten Year Action Plan (2004) for short-term acute community mental health care. However, a two week provision of case management and crisis response is an unrealistic timeframe when dealing with people having long-term chronic illness who experience periods of acute distress. The Ten Year Action Plan is based on a national vision of improved access and quality of services. Unfortunately, this plan has overlooked commitments to comprehensively improve mental health treatment, follow-up services, prevention strategies, and to address mental health promotion.

Without a concerted commitment in this area, the human and financial costs of mental illness and poor mental health will only increase, and our health care system will continue to falter.[5]

Canada is the only Western industrialized country that does not have a national strategy on mental health.

Compensation models and payment systems continue to inhibit interdisciplinary collaboration, as does the instability of funding for mental health services. In so far as the mental health and addiction system is not a real system, but rather a complex array of services, the federal government must show leadership not only in the re-assessment of transfer payments to provinces but also in developing a comprehensive policy framework.

The First Ministers agree to provide "first dollar coverage" although this is not to be confused with *full-dollar coverage.* In insurance literature, "first dollar coverage" means that there is no deductible limit that the individual must pay, either through private insurance or out of pocket. As a result, "first dollar coverage" can mean full public funding with no deductibles or public funding with no deductibles but with user charges/ co-payments. "Full dollar coverage" of home care services would mean publicly funded coverage for any services and supplies in the home that would have been provided if the person were hospitalized.[6]

Policies on payment can vary significantly even within the same province. In Ontario, for example, one Community Care Access Centre (CCAC) may pay for medical supplies for a client while the adjacent CCAC may have policies that require the client to pay for these supplies out-of-pocket.[7]

Home care services fall outside the legislative framework of the Canada Health Act. However, professional home care services (nursing, social work, etc.) are publicly funded in every province and territory in Canada. Paraprofessional services such as personal care, housekeeping, and meal preparation may or may not be covered by government programs. As a result, clients requiring these services may have to pay for them in part or in full.[8]

Per capita provincial and territorial home care spending has increased significantly over the past decade. While home care spending still only represents 4.3 percent of the total provincial and territorial government health expenditures compared to 44 percent for hospital care, home care spending increased from a level of $36 per capita in 1990-91 to $88 per capita in 2000-01. Of the overall home care expenditures, 73.9 percent is expended providing services to seniors who are 65 and older.[9]

It is estimated that 2.1 percent of Canadians use home care services (1998-99 data). Seniors are nearly three times as likely to receive home care as persons aged 18 to 64, with the highest use by seniors who are 75 or older. Older women are twice as likely to receive home care as their male counterparts.[10]

The FDA has determined that the use of atypical antipsychotic medications for treating behavioural disorders in elderly patients with dementia is associated with increased mortality. The deaths were primarily due either to heart-related events, such as heart failure and

sudden death, or to infections such as pneumonia. Atypical antipsychotics are **not approved** for treating behavioural disorders in patients with dementia.[11] In Canada, regulations may differ.

Analysis:

Research indicates that between 85 and 90 percent of all care is unpaid, even when hospital and other institutional care are included in the calculations. Home care often involves assistance with Regular household tasks, or 'Instrumental Activities of Daily Living' (IADL). When people become ill, are released early from hospital, have more long-term disabilities or simply become more frail as they age, they require help with cooking, shopping, cleaning, laundry and home maintenance. Although most of this work is done without pay, many people do not have anyone available or able to take on this unpaid work. Research carried out in British Columbia shows that paid assistance in these areas can mean the difference not only between staying at home and entering a facility, but also between life and death.[12]

Respondents noted that difficulty with recruiting and retaining home care staff affects home care's capacity to provide trained personnel and to support the development of connections with clients. Continuity of care suffers, and there is no sense of investment in, or attachment to, the person. The lack of continuity of staff has a negative effect on mental health needs as it also impinges on people's sense of security and safety.[13]

Respondents spoke of the difficulty maintaining their dignity, privacy and feeling of being treated with respect when many strangers come through their home. The stress of having to explain everything to a new person frequently is also detrimental to good mental health. As a member of a caregiver organization commented: "What is required is the same familiar face to look forward to. Different faces can be very invasive."[14]

Regarding the revised Charter Principles developed with consumer, family and caregiver input, (CCMHI, May 2005) it is noted that key barriers to implementation of the Principles include a bias towards the medical model of mental illness rather than a population health approach, and inequitable access to mental health services due to current funding models (services are often not available in the public system or they are too costly for many consumers.[15]

If an agreement is reached to use some medication, it must be remembered that it takes longer for seniors to process a drug, i.e. at the age of 70, the kidneys usually have only 50 percent efficiency, relative to kidneys at age 40. The liver also loses efficiency in later life. This means that a half standard or a one-third standard dose is a sensible approach. And it should never be assumed that a client will not understand an explanation of the benefits, risks/adverse reactions and side effects of a drug. It is advisable to consult the Beers list, (developed by Dr. Mark H. Beers) - a compilation of drugs and drug classes found to increase the risk of adverse events in older adults. Frequently, older adults are more sensitive to medications or their side-effects.[16]

In regards to dementia, a possible alternative may be the use of short-term zuclopenthixol acetate (Clopixol Acuphase) or long-acting zuclopenthixol decanoate (Clopixol.) This medication may offer low sedative and hypotensive effects. However, the side-effect profile is similar to the piperazine group of phenothiazines. In short, some patients may benefit and some may find the drug intolerable. Note that difficulty titrating the dose may lead to extrapyramidal symptoms (EPS). On the average, zuclopenthixol appears to offer lower adverse effects than related thioxanthenes such as flupenthixol and thiothixene.[17] It is important to keep in mind that what appears to be "dementia" may simply be a side-effect of being on various medications and/or the result of poor nutrition, insomnia or acute distress.

In closing, it is well worth remembering that aging, in and of itself, is not an illness. Nor is it something to apologize for. We are born, we live our lives, and we die. It is a process that happens to all of us. Those of us who are still young may look upon the elderly as an inconvenience, or even a nuisance, at times. We may believe that the elderly have already used up their potential and no longer offer society what younger people can. To think this way is a big mistake. Quite often, experience and wisdom will go further than youthful assumptions and inexperience. And one day, you will also arrive and will be glad that you know other people.

Recommendations:

1. Federal, provincial and territorial governments will need to work together to build momentum for the implementation of short term (2 week) home care, and also to make long-term plans for the implementation of services to address the needs of persons with severe and chronic mental illness in their home and community. The federal government must ensure that it has the capacity to work with the Council of Ministers of Health on mental health initiatives, and support an interdepartmental mental health committee that comprises representatives from the federal programs with mental health responsibilities to coordinate their efforts, resources, and to share identified best practices with provinces and territories.[18]

2. Diversity issues, such as age, gender, language, cultural identity, sexual orientation, religion and lifestyles must be addressed for both consumers and caregivers in every area of planning and delivery of mental health home care.

3. To ensure that clients are active participants in the planning and delivery of their care, policies must reflect a client-centered model and support the integration of the model into clinical and home support services by front line staff. To enhance communication with, and accountability to, the community, policies should encourage the recruitment and participation of seniors and family caregivers not only in the governance structure of home care organizations and/or advisory groups, but also in ongoing care planning and identification required supports.[19]

4. Money from the Mental Health Transition Fund should be made available to the provinces and territories for initiatives designed to facilitate seniors with a mental illness living in the community. These initiatives could include, amongst other things, the provision of:

- home visits by appropriately compensated mental health service providers;
- a range of practical and social support services delivered in their homes to seniors living with mental illness;
- a level of support to seniors living with mental illness that is, at a minimum, equivalent to the level of support available to seniors with physical ailments, regardless of where they reside;
- a more widely available supply of affordable and supportive housing units for seniors living with mental illness.[20]

5. Seniors with a mental illness who are living with family caregivers should be eligible for all of the health and support services that would be available to them if they lived alone in their own home.[21]

6. Efforts should be made to shift seniors with a mental illness from acute care to long-term care facilities, or other appropriate housing, where it is clinically appropriate to do so, by making alternatives to hospitalization more widely available, and that staffing competencies in long-term care facilities be reviewed and adjusted, through the introduction of appropriate training programs, to ensure that the devolution of responsibility for patients living with a mental illness from acute care facilities to long-term care facilities is done in a way that ensures on-site availability of clinically appropriate mental health services.[22]

7. That a range of institutionally based services for seniors living with a mental illness be integrated (e.g. supported housing units and long-term care facilities) by locating them adjacent to each other, to make the transition(s) between different institutional settings efficient and safe, and, that every effort be made to facilitate aged couples being able to continue to live together, or in close proximity to one another, regardless of the level of services and supports they each may require.[23]

8. To ensure that home care staff have adequate knowledge of the factors affecting mental health, training in mental health issues should be made explicit in staff development plans and be incorporated into continuing education curricula.[24]

9. To ensure that continuity of care is maintained, operational policies and structures must maximize staff retention (e.g., salary and benefits policies) and encourage and support staff in developing and sustaining relationships with clients (e.g. scheduling policies).[25]

10. The development of a national program could potentially lead to the development of standards for recruitment, training and certification of both advocates and rights advisors. Both would require formal training and certification and eventually both would be seen as professions within the mental health sector. National standards would ensure that every individual with a mental illness would have the same access to information, support and assistance in both knowing and exercising their rights. In a fair, equitable and just society nothing less should be expected.[26]

11. That copies of the Beers List of medications to be used with caution in geriatric patients be made available to seniors, their families and caregivers.

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