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MENTAL HEALTH OF SENIORS

WHY FOCUS ON SENIORS?

Seniors constituted 14.8% of the population in Canada in 2011 and this proportion has increased over the past five years. Further growth in percentage of the population made up of seniors is expected, given that those between the ages of 60 and 64 years showed the fastest increase, as cohort, between 2006 and 2011 (29.1%). In part this growth is due to below replacement fertility levels and increased life expectancy. The mean life expectancy at birth for the 2010 cohort was 83 years for females and 79 years for males. Seniors are an increasingly diverse group in ethnicity and language. For example, 28% of seniors are foreign born. We need to value people who are elderly in our society.

WHAT IS THE PREVALENCE OF MENTAL DISORDERS AMONG SENIORS?

The good news is that the vast majority of seniors remain psychologically healthy and are resilient to life trauma. Nevertheless, excluding those with dementia, about one in five seniors lives with some form of mental disorder and the prevalence increases with age (33% in those 95 years old). According to the Canadian Coalition on Seniors Mental Health (2006), about 15% of community dwelling seniors report significant symptoms of depression. Significantly higher rates of depression occur among medical inpatients, nursing home residents and home care recipients. In 2011, approximately 7.9% of seniors lived in collective dwellings, such as residences for senior citizens or health care and related facilities, with the proportion increasing with age.

Unfortunately, it appears that depression is often under-reported and under-detected and hence untreated, especially among ethnic minorities. Triggers for depression include the death of a loved one, a move to a smaller place or a nursing home and negative life events, such as separation or divorce or a financial crisis. Among other significant conditions, anxiety (5%-10%), alcohol related disorders (6%-10%), psychosis (1%-2%), and dementia (which affects 7% of Canadians and almost half over age 90) are prominent. When a mental health condition becomes very serious and cannot be treated in a community setting, hospitalization may be required. Among seniors hospitalized for mental illness the breakdown of diagnoses is as follows: Organic Disorders – 56%; Mood Disorders – 16%; Schizophrenic and Psychotic Disorders – 14%; Substance Related Disorders – 7%; Anxiety Disorders – 3%; Unknown Disorders – 2%; Other Mental Health Disorders – 1%.

In a large scale sample of nearly 50,000 seniors living in residential care facilities (such as long-term care, nursing or personal care homes) in five Canadian jurisdictions, nearly half (44%) had a diagnosis and/or symptoms of depression and more than half had dementia. Seniors who had symptoms of depression but no diagnosis were similar on measures of physical health, functional status and quality of life to those with both symptoms and the corresponding diagnosis, but the former group were not treated for their symptoms.

In the study cited above, more than half of the participants in residential care facilities (all ages) had dementia. Rates of dementia increase with age, with an incidence rate in the general population of about 20%. There is a gender differential, with rates of 33% for men and 46% for women at age 85. The proportion of the population with Alzheimer's disease and other forms of dementia is expected to double within the next 30 years to 1.1 million or nearly 3% of Canadians, in part due to the changing demographics cited above. A large scale study revealed that 20% of seniors in publicly funded long-term and home care facilities had a diagnosis of Alzheimer's disease and/or other forms of dementia. Although the preference among seniors is for aging at home, this can sometimes be difficult for those with dementia due to the need to manage challenging behaviours and medical instability.

The suicide rates of seniors, especially among men, are another source of concern. Suicide attempts among seniors are significantly more lethal as compared with those in the general population. It has been estimated that 1 in 4 attempts results in death as compared with 1 in 100-200 attempts in the general population. Early interventions are crucial. Risk factors are alcohol use/dependence, dementia (for men), depression severity and diminished cognitive performance. Marriage is a protective factor for men, but not women, as are positive social relationships for both men and women.

Unfortunately, the complexity of the mental health status of many seniors is exacerbated by the presence of comorbidities. Of those hospitalized for mental illness, 87% had one or more comorbidities such as hypertension, diabetes, dementia, heart disease and hypothyroidism. On average, these individuals had more than 5 concurrent conditions.

Compounding the problem of the high incidence of mental health problems among seniors is a reluctance to seek help. Fewer than half (42%) of older adults with a DSM-IV diagnosis reported using health services. Many of these individuals did not perceive a need for

professional help. Other impediments to help seeking include the double stigma of ageism and mental illness, both of which contribute to social isolation. Although public attitudes to mental illness have improved, there are still discriminatory perceptions about those with a mental disorder.

WHO ARE THE CAREGIVERS?

It has been estimated that there are more than two million informal caregivers in Canada, many of whom are seniors themselves. Most typically, the caregiver is a spouse or son or daughter. Twenty-three percent of working individuals spend seven hours per week caring for an older dependent. A conservative estimate of their economic contribution was $25 billion. Although many find the experience of caregiving to be very fulfilling, it can also be challenging and detrimental to their health, particularly when the caregiver is also challenged. Caregivers report the need for more support, especially in the areas of help with personal care (e.g., dressing, bathing), emotional support, more coordinated care, medical care at home, assistive devices to aid mobility, a consultant to discuss care, help with upkeep of the home and faster access to medical care. A great many caregivers experience considerable distress – more than 50% in situations where the recipient of their ministrations is physically or verbally abusive and/or displays depressive symptoms. The level of their distress is correlated with the number of hours of informal care provided, as well as with the level of client impairment. Client spouses were at highest risk of distress (25%).

RECOMMENDATIONS

The following recommendations could be implemented by individuals, various levels of government and other agencies to the benefit of seniors.

- A focus on healthy aging. How can the aging experience be enriched such that the debilitating effects of mental disorders and dementia are prevented or minimized? A variety of strategies have been researched and proven beneficial to seniors, including: exercise, avoidance of high levels of stress; use of a computer, playing games, participating in social activities, practicing a craft, reading, maintaining or improving self-esteem, engaging in cognitively demanding activities; continuing to engage in activities which provide enjoyment and maintaining a positive mind set.
- Education for caregivers. Caregivers often are ill-equipped and need access to information and resources which will enable them to plan an appropriate care program and to implement effective practices. Particularly important is accurate information about available ancillary resources and how to access them.
- Support for caregivers. Clearly some mechanisms must be put into place to provide respite time for caregivers. Informal caregivers are often at risk. Their problems can be compounded by unwillingness to leave loved ones alone, lack of transportation and reluctance to engage with friends and relatives, Further, consideration could be given to providing financial recognition of the contribution of home caregivers to the economy.
- Assessing needs and monitoring progress. Implementation of common standards and procedures would allow for comparability in assessment of clinical status, performance and quality of care across jurisdictions as well as across settings and care providers.

- Greater access to care. Responding to the demographic data in a realistic manner through the establishment of additional facilities for seniors based on best practices is needed. For example, more adult day care programs and in-home support are needed.
- Raising professional awareness. Training of health care professionals, especially those who provide primary care, to screen for depression and other mental disorders among seniors, particularly during times of loss or dramatic life changes.
- Adopting s life span perspective. Recognizing that advanced years represent a normal life phase, just as childhood, adolescence, adulthood do, might defuse the consequences of "ageism" which creates social exclusion and reluctance of seniors to seek professional care when needed.
- More specialized care. Greater access to mental health treatment programs that are specifically focused on seniors. These would provide a broader range of options beyond usual reliance on pharmaceutical solutions. We need healthcare professionals trained in geriatrics, accessible and affordable transportation, affordable respite care, etc.

ADDITIONAL REFERENCE MATERIAL

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