



Seniors Mental Health Policy Lens

An Instrument for developing policy, legislation, programs and services that promote and support the mental health of older adults.

Prepared by:
Penny MacCourt, PhD
pmaccourt@shaw.ca

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The Seniors Mental Health Policy Lens is one component of the "Psychosocial Approaches to the Mental Health Challenges of Late Life" awarded to the British Columbia Psychogeriatric Association by Health Canada Population Health Fund
www.seniorsmentalhealth.ca

PREFACE

The Seniors Mental Health Policy Lens (SMHPL) was developed as part of a national project “Psychosocial Approaches to the Mental Health Challenges of Late Life” awarded to the BC Psychogeriatric Association by Health Canada, Population Health Fund.

The goal of the project was to develop the capacity of communities across Canada, through a comprehensive integrated cross-sectoral approach, to use psychosocial approaches to promote seniors' mental health, and to prevent and/or address mental health problems. In order to meet this goal the project intended to: (1) find out from seniors how they successfully cope with critical transitions; (2) find out from seniors key elements in programs and services that are helpful to them; (3) identify promising psychosocial approaches and models that promote seniors' mental health or prevent or address mental health problems; (4) develop a seniors mental health policy lens with which to assess the effect of policies and programs on seniors' mental health; (5) develop useful community resources based on the findings and experiences of the project.

The SMHPL was developed in consultation with a wide variety of practitioners, policy makers and researchers interested and active in the field of older adults' mental health from across Canada. Feedback on the original drafts was received from all over Canada from professionals from many different disciplines, and integrated into this final document.

A form to evaluate the SMHPL can be found at the end of this document - please complete and email to Dr. MacCourt at pmaccourt@shaw.ca or send by fax to (250) 756-2139.

Copies of the SMHPL can be down loaded, and information about the project “Psychosocial Approaches to the Mental Health Challenges of Late Life” can be found on the project web site www.seniorsmentalhealth.ca or by contacting Dr. Penny MacCourt at pmaccourt@shaw.ca

Disclaimer: The views expressed herein do not necessarily represent the official policies of Health Canada.

EXECUTIVE SUMMARY

The Seniors Mental health Policy Lens (SMHPL) is an analytical tool, that has been developed to identify (or predict) the direct or indirect repercussions of policies, programs and services (in place or proposed) on the mental health of all older adults.

It was developed as part of a national project, "Psychosocial Approaches to the Mental Health Challenges of Late Life", awarded to the BC Psychogeriatric Association by Health Canada, Population Health Fund.

The SMHPL was developed in consultation with a wide variety of practitioners, policy makers and researchers interested and active in the field of older adults' mental health from across Canada. It incorporates Canadian seniors' perspectives about the factors influencing their mental health, and reflects the values of older adults.

The SMHPL is designed to promote social environments, including health services, that are supportive of older adults' mental health. It provides a method for identifying the negative effects of current and planned policies, programs, and practices on seniors' mental health. It is intended as an aid to help ensure that the way mental health services are defined, delivered, and funded will result in a greater emphasis on mental health promotion, and on the prevention of mental health problems.

This document includes a rationale for the SMHPL, the conceptual framework for its' development, and the basis for the questions that are used for the analysis.

This document states who the intended users are, and how they can apply and implement this lens. A blank set of questions and a working example of the policy's use is included. It is intended that this document will fully prepare the reader to use the SMHPL.

SENIORS MENTAL HEALTH POLICY LENS

Introduction

The seniors' mental health policy lens (SMHPL) is a conceptual framework that has been developed as a guide to identify (or predict) the direct or indirect negative repercussions of policies, programs and services (in place or proposed) on the mental health of all older adults.

The SMHPL was developed as part of a national project, "Psychosocial Approaches to the Mental Health Challenges of Late Life", awarded to the BC Psychogeriatric Association by Health Canada, Population Health Fund. The SMHPL was developed in consultation with a wide variety of practitioners, policy makers and researchers interested and active in the field of older adults' mental health from across Canada. It incorporates Canadian seniors' perspectives about the factors influencing their mental health, and reflects the values of older adults.

This document begins with a definition of terms. The purpose of the SMHPL and a rationale for why it is needed, are provided. Next, the SMHPL and how to implement it is presented. An example showing how the SMHPL can be applied is demonstrated in Appendix I. The values and principles identified through a literature review, and through research conducted with older adults, form the basis for the SMHPL and are presented in Appendix II.

Definition of Terms

Mental health is a broad concept that suggests a continuum from wellness through illness. Mental health can be promoted and supported (or not) wherever the individual is situated on the continuum. Mental health is conceptualized as an individual resource, but one that is affected by the social context in which the individual lives.

Policy is defined as guidelines, regulations, parameters or rules that govern social life and determine how resources, services and goods are distributed and to whom. Policy occurs at the legislative level (e.g., Old Age Security), within programs (e.g., admission criteria for home support services), and in service delivery (e.g., staff rotation in long term care facilities).

The Seniors Mental Health Policy Lens (SMHPL) is an analytical framework that allows the user to assess government policies, program policies and service delivery policies that pertain to older adults. The SMHPL is a set of questions for focussing on the possible negative impacts of particular measures on older adults' mental health.

The **biomedical model** (in relation to mental health) focuses on individual pathology and leads to the organization of services and programs that focus primarily on the diagnosis and treatment of mental illness.

Psychosocial refers to the non-biomedical component of the biopsychosocial model. It includes a focus on individual, group, and community factors that impact on mental health.

The **social model** of care in relation to mental health is holistic and focuses on the individual and the social context, separately and together. It incorporates all components of the biopsychosocial model and leads to the organizations of services and programs that promote and support mental health, and prevent and treat mental illness, through individual, group and community interventions.

Purpose of the SMHPL

The SMHPL is designed to strengthen the capacity of government and non-government organizations to promote social environments, including health services, that are supportive of older adults' mental health. It provides a method for identifying the negative effects of current and planned policies, programs and practices on seniors' mental health, thus allowing for their amelioration. The use of the SMHPL will result in a greater emphasis on mental health promotion and the prevention of mental health problems, which in turn will affect how mental health services are funded, designed and delivered.

Rationale for the SMHPL

The need to assess policy from a seniors' mental health perspective has arisen from a number of concerns, as follows, each of which can be addressed through the use of the SMHPL:

- The prevalence of mental health problems affecting elderly people in Canada is between 17% and 30% (Health & Welfare Canada, 1991). With the growing aging population, come an increased number of seniors who experience mental health problems, or are at risk of doing so.

The use of the SMHPL facilitates social environments that support the mental health of older adults, reducing the likelihood of mental health problems occurring.

- Much of the policy that shapes the lives of older adults, directly or indirectly, has been developed without the input of older adults, and often without reference to their particular needs. The resulting policies are unlikely to reflect the priorities and values of older adults. Seniors' mental health has become marginalized as decisions are made (1) to reduce the very supports that seniors consider important to the promotion of their mental health, and (2) to re-orient services in a way that detracts from good mental health by, for example, limiting access to services (Anderson & Parent, 2002).

The SMHPL incorporates the values and priorities that older adults' have identified as important to their mental health, and against which policy can be assessed.

- Ageism affects the priority given to seniors' needs (including how they are defined and addressed) by those funding, designing and delivering health and social services. If ageist biases in policies are unrecognized this can lead to inadequate planning and design of policies, legislation, programs, services and interventions. This can be costly in both human and economic terms (Rogers, 1993). It can also result in unintended and undesirable outcomes for older adults and society as a whole.

The SMHPL is designed to identify biases in policy that may lead to negative impacts on the mental health of older adults.

- Current policy related to seniors mental health is typically situated within a biomedical model. The biomedical model of mental health focuses on individual pathology and leads to the organization of services and programs that focus primarily on the diagnosis and treatment of mental illness. There is a narrow focus on cure and acute care, yet for many seniors, the needs are chronic and often related to disability or deficits in their social support system or environment. The biomedical paradigm has led to the neglect of the development of broader non-medical interventions and community-based services required to support seniors' mental health. Often services that meet psychosocial needs (e.g., transportation, or health promotion and prevention) are cut in times of financial restraint (Tuokko et. al., 2001).

The SMHPL focuses on the individual and the social context, separately and together, in relation to the mental health of older adults. Its' use fosters a social model of care which emphasizes the psychosocial component of the biopsychosocial model.

Development of the SMHPL Questions

The SMHPL is made up of a set of ten questions that are (1) intended to raise users' awareness about the factors that impact on the mental health of older adults, and (2) guide their analyses of policies from a seniors' mental health perspective. The SMHPL questions are based on the principles of the population health determinants (Health Canada, 2002), mental health promotion (Health Canada, 1996) and healthy aging policy (Marshall, 1994). They draw upon the values and core principles embedded in the "Guidelines for Best Practices in Elderly Mental Health Care" (B.C. Ministry of Health, 2002) and the "National Framework for Aging: A Policy Guide" (Health Canada, 1998). The SMHPL also incorporates Canadian seniors' perspectives about the factors influencing their mental health, and reflects the values of older adults. (For a full discussion of each of these, see Appendices).

The Seniors Mental Health Policy Lens Questions

- Has the policy been developed in collaboration with those who will be most affected?
- Does the policy address the diverse needs, circumstances, and aspirations of vulnerable sub-groups within the seniors' population? Are any negative effects from this policy likely to be magnified for any of these groups?
- Does the policy acknowledge the multiple determinants of health?
- Does the policy consider accessibility?
- Does the policy support seniors' social participation and relationships?
- Does the policy support seniors' independence and self-determination?
- Does the policy support seniors' dignity?

- Is the policy fair? Does it take into account the full costs and benefits of supporting the aspirations of seniors?
- Does the policy/program support seniors' sense of security?
- Is consideration given to the cumulative impacts on later life of policies/programs targeted at earlier life stages?

Who Should Use The SMHPL?

The SMHPL can be used by policy makers, program managers, designers, evaluators, clinicians and seniors' advocacy groups. It can be used by those who create policy, and by those who wish to critique policy from a seniors' mental health perspective.

Application of the SMHPL

The SMHPL is intended to promote analysis and discussion of policy decisions under consideration, and to facilitate assessment of the impact of current policies and programs on senior's mental health. The SMHPL can be used as a quick screen of policies, as a critique of policies and programs, to guide research and evaluation studies of program impact, or to develop a policy response to an issue or need. It can be used to evaluate the mental health implications of policies that specifically target older adults (e.g., long term care eligibility criteria), and those that do not (e.g., hospital discharge policies).

The SMHPL can be used for policy analysis, and to clarify the implications of program activities in government and non-government sectors on older adults' mental health. For example, what are the potential negative impacts on older adults' mental health, of:

- Lack of accessible and affordable transportation?
- Elimination of cleaning services to older adults receiving home support?
- Mandatory driving assessments for individuals over age 85?

The SMHPL is educative and can be used to assess policies not specifically targeting seniors for unintended ageist biases that may lead to negative impacts on the mental health of older adults. For example, what are the potential negative impacts on older adults' mental health, of:

- Multiple step voice mail systems used to access programs?
- Requirement for Do Not Resuscitate orders (DNRs) for long term care facility residents?

The SMHPL can be used to assess the potential negative implications of health care system policies (e.g.: organization, funding criteria, staffing issues) on the mental health of older adults. For example, what are the potential negative impacts on older adults' mental health, of:

- Biweekly staff rotations in long term care facilities?
- Staff without specialized training in geriatrics or psychogeriatrics in hospital emergency departments?
- Quotas on number of older adults admitted to general psychiatric beds in hospitals?

Implementation of the SMHPL Questions

By answering the SMHPL questions the user is prompted to consider how a policy may affect both the mental health of older adults in general and of specific groups with special needs in particular. By using the SMHPL users are able to identify unintended negative effects of a policy on the mental health of older adults. If no negative effects are noted the policy is accepted. Where it is unclear whether negative effects exist or not, the need for additional information is noted and potential sources for obtaining this information recorded. Where negative effects are revealed, the user identifies actions that could correct/offsets these. The findings are summarized, any necessary actions undertaken, and the policy revised accordingly. The SMHPL is then reapplied to the policy in a reiterative manner until the unintended negative effects have been adequately addressed.

CONCLUSION

Mental health is affected by a wide array of interacting individual and social factors. Policies, from legislative to organizational, play an important role in creating the social milieu in which older adults live, and can have inadvertent negative effects on their mental health. The SMHPL, based on the values of older adults, provides a lens through which these negative effects can be illuminated, by those who make policy and for those who wish to critique it. Once visible, strategies to avoid or address the negative effects can be designed. The use of the SMHPL therefore can facilitate the development of policies, programs and services that promote and support the mental health of older adults and prevent mental health problems.

Example of the SMHPL applied

In the next section, Appendix I, a guide to using the SMHPL worksheet is provided, with an example.

APPENDIX I

How to use the SENIORS MENTAL HEALTH POLICY LENS Worksheet

The SMHPL worksheets are provided to assist you in using the SMHPL questions effectively.

The questions are not program specific nor all inclusive and you may need to design additional questions for your specific task. Some questions may not apply to your situation. Initial discussion should address the addition of new questions.

The SMHPL is not simply a checklist; it is intended to support discussion and assessment of a policy in terms of potential impact, positive and negative, on seniors' mental health.

1. Begin by providing a brief description of the policy being reviewed or developed.
2. Beside each question, Check **Yes, No, Not Sure, or NA (Not Applicable)**, according to what you believe your policy reflects.
3. Summate the checks in the four columns, and analyze the results using the following criteria:

YES > NO? You are well on your way to a positive policy/program. But look for some ways it could be improved. Go back and determine if there are any policy changes that will yet increase the number of "Yes" responses.

NO > YES? Your policy/program should be re-examined for content and overall intent. Many needs, wants, and concerns of seniors are not being met. A good source of input is from seniors themselves - ask them.

NOT SURE > Either YES or NO
You need to gather more information before proceeding with your policy/program. Your policy is not comprehensive or not holistic.

NOT APPLIC > Either YES or NO
Go back and critically examine your policy. Are there this many categories that do not apply to your policy or program? Or does much of the policy/program not apply to the needs, wants, and concerns of those it is intended to be written for?

To the above add a summary of your discussions.

4. Answer yes or no to whether the policy should be accepted, or accepted as revised, and whether there is a need for more information, or if revision is required.

If the policy is not accepted, identify the individual areas that require revisions and ways that potential negative effects could be addressed or off-set. Note who needs to be involved to address this process, and what information needs to be gathered.

5. Revise the policy, and re-apply the lens, starting with 1., above.
6. Starting with question 5 above, repeat until the (revised) policy is recommended for acceptance.

EXAMPLE using Seniors Mental Policy Health Lens

The following example illustrates how the SMHPL can be utilized.

ISSUE: Management of a Polish-Canadian Long Term Care facility wants to implement a new meal service policy. The intent is to control costs, minimize staffing and structure the system for ease of management. Management has asked for input from dietary and kitchen staff.

After the initial draft, the policy was analyzed with the SMHPL. The results, with commentary in italics, follows

Policy Description

Residents’ meals are to be served only in the dining room and at set times. Table seating will be assigned by units.

1. Process Factors

PROCESS	Yes	No	Not Sure	N/A
a. Has the policy been developed in collaboration with those who will be most affected?		✓		
b. Does the policy/program emphasize partnership and collaboration?		✓		
c. Are seniors/organizations consulted? Involved?		✓		
d. Are other relevant organizations/ sectors/Ministries engaged?		✓		

Residents Council and family representatives need to be involved. Nursing and activity staff need to be consulted.

2. Diversity:

i - Does the policy/program recognize/address the diverse needs, circumstances, and aspirations of marginalized/vulnerable sub-groups within the seniors' population?

RECOGNIZE DIVERSITY?	Yes	No	Not Sure	N/A
		✓		

Same policy is applied to all regardless of any individual circumstances.

ii - Does this policy/program avoid negative impacts on the following groups?

AVOIDS NEGATIVE EFFECTS FOR:	Yes	No	Not Sure	N/A
Gays and lesbians	✓			
Ethnocultural minorities	✓			
Women			✓	
Caregivers			✓	
Poor	✓			
Oldest old			✓	
Mentally ill			✓	
Cognitively impaired			✓	
Aboriginal	✓			
Disable			✓	
Chronically ill			✓	
Religious minorities	✓			
Long term care residents		✓		
Developmentally delayed			✓	

All long term care residents will experience impact of any negative effects. Most residents are women and in the oldest-old age category so any negative effects magnified for them. Caregivers who visit may find it difficult to work around a rigid schedule, increasing their stress. Individuals with significant mental, cognitive, and/or physical impairments are likely to need approaches that are individualized to the ups and downs of their immediate circumstances in order to support their coping skills, independence and self-esteem. Rigid schedule and place for meals will not facilitate this.

Will need to talk to some these individual to see what they think about proposed policy. Also need to talk to staff responsible for getting residents to dining room at set times. Can it be done without rushing residents?

3. Determinants of Health

Does the policy/program acknowledge the multiple determinants of health?

Specifically will negative effects be avoided on:

AVOIDS NEGATIVE EFFECTS ON:	Yes	No	Not Sure	N/A
Physical health			✓	
Social support networks		✓		
Social environments			✓	
Safety				✓
Income status				✓
Personal health practices and coping skills			✓	
Access to appropriate health care				✓
Sense of physical security				✓

The policy, in that it does not take into account the diverse social needs of older adults, may stress some adults with its' insistence on congregate meals. In order to get to meals on time some residents may need more help than they currently have, thus undermining their current coping skills. Will there be increased use of wheelchairs to transport residents to the dining room rather than taking the time to assist with walking or to allow them to walk alone? The social environment may be negatively impacted by focus on scheduling rather than residents. The rigid table seating may not take into account personal compatibility; not being able to eat with whom one chooses may undermine social support systems. Caregivers whose schedules mean they visit at mealtime may find it less possible to visit.

4. Does the policy/program consider accessibility?

CONSIDER ACCESSIBILITY?	Yes	No	Not Sure	N/A
a. Is pertinent information readily available?	✓			
b. Is it affordable?	✓			
c. Are sufficient resources likely to be available in a timely manner?	✓			
d. Is transportation readily available?				✓

Is there sufficient staff available to assist residents to meals on time?

5. Does the policy/program promote/support seniors' social participation and /or relationships?

PROMOTES PARTICIPATION AND/OR RELATIONSHIPS?	Yes	No	Not Sure	N/A
a. Within their social network of family and friends?		✓		
b. Within the community?			✓	
c. Does it promote seniors' inclusion in society?				✓
d. Does the policy/program reduce loneliness, and/or social and spiritual isolation?			✓	
e. Does it promote/support a sense of belonging/mattering?		✓		

This policy promotes eating together but may ignore particular relationships and , social support systems that residents have formed within the facility, thus in fact reducing their sense of community. (There is no reason to believe that the planned seating will lead to relationships or build community (given the lack of attention to individual needs, interests, etc). The whole approach treats residents as interchangeable units which can promote feelings of alienation.

6. Does the policy support seniors' independence, self-determination?

SUPPORT INDEPENDENCE?	Yes	No	Not Sure	N/A
a. Does it provide opportunities to make choices?		✓		
b. Is information, encouragement and support provided to facilitate choice?		✓		
c. Does it promote coping skills?		✓		
d. Does the policy/program reduce loneliness, and/or social and spiritual isolation?			✓	
e. Does it build on the capacity of seniors and adjust to different circumstances?		✓		

Policy does not support independence. May increase need for help getting ready for, and to, meals, thus undermining coping skills. No choices undermine independence. Individuals are not able to adapt where, when and with whom they eat to their energy levels, mood and or emotional or social needs. Erodes autonomy.

7. Does the policy/program support seniors' dignity?

SUPPORT DIGNITY?	Yes	No	Not Sure	N/A
a. Does it promote self-esteem?		✓		
b. Is it respectful of seniors' privacy?			✓	
c. Does it acknowledge the uniqueness of each individual?		✓		
d. Does it consider individual versus collective needs?		✓		

Self-esteem will be eroded by non-individualized approach. People who prefer to eat alone (due to drooling for example) will be forced into public eye.

8. Is the policy/program fair?

IS IT FAIR?	Yes	No	Not Sure	N/A
		✓		

Does not take into account individual needs.

Does it take into account the full costs and benefits of supporting the aspirations of seniors?

Please write in response where space is provided.

a. What are the benefits to seniors if policy is carried out?

Some residents may benefit from a rigid structure—won't have to think or plan. Eating only in the dining room may create a social opportunity. For those who are able to walk, going to the dining room 3 times per day will provide them with exercise.

b. What are the costs to seniors if policy is carried out?

Change imposed without consultation and to meet institutional needs implies that residents are not important which undermines morale, sense of being valued part of a community. Some residents may prefer to eat alone. People may not want to eat at the set times. People may feel devalued by an approach that doesn't take into account individual differences, preferences. May deter some visitors. Some residents may refuse to go to the dining room—this could affect their nutrition.

9. Does the policy/program support seniors' sense of security?

SUPPORT A SENSE OF SECURITY?	Yes	No	Not Sure	N/A
a. Economic security✓				✓
b. Physical security				
c. Opportunity to plan for future e.g., death; appropriate housing and services			✓	
d. Sense of belonging			✓	

Residents may feel that any kind of change can be made without consultation (e.g., room changes, bath days, facility transfers), and their sense of belonging, having a say, to plan, is compromised.

10. Is consideration given to the cumulative impacts on later life of policies/programs targeted at earlier life stages?

Please write in response where space is provided.

(Not applicable here.)

Summate the columns

- YES > NO? You are well on your way to a positive policy/program. But look for some ways it could be improved. Go back and determine if there are any policy changes that will yet increase the number of "Yes" responses.
- NO > YES? Your policy/program should be re-examined for content and overall intent. Many needs, wants, and concerns of seniors are not being met. A good source of input is from seniors themselves - ask them.
- NOT SURE > Either YES OR NO
You need to gather more information before proceeding with your policy/program. Your policy is not comprehensive or not holistic.
- NOT APPLIC > Either YES OR NO
Go back and critically examine your policy. Are there this many categories that do not apply to your policy or program? Or does much of the policy/program not apply to the needs, wants, and concerns of those it is intended to be written for?

Add Summary of Discussions

Recommendation

RECOMMENDATION?	Yes	No
Accepted		✓
Accepted as revised		
Need more information to decide from whom, where	✓	
Needs revision	✓	

1. Negative implications identified:

- 1 – Seniors nor their family members have been asked for their opinions about the policy changes that will ultimately affect them. This will seem disrespectful to some residents and may anger them. Seniors are not given the opportunity to make choices about their meal times, where they eat or with whom – this is disempowering. Seniors are not being treated as individuals with unique needs. Institutional needs are over-riding resident involvement. A sense of alienation may lead to depression.
- 2 – Extra help some residents may need to get to dining room on time may erode independence and personal coping skills. Residents with mental illness or cognitive impairments in particular may need individualized approaches re meal times and socialization depending on the day – they may decompensate if they must adjust to rigid schedules, rather than having schedules adapted to their immediate needs. Could lead to agitation and aggression towards staff.
- 3 – If residents do not like the new policy they may refuse to follow it and miss meals. Not only might this affect their nutritional status but it may lead to social withdrawal and depression.
- 4 – The net results of these negative implications may be to communicate to residents and their families that the views and preferences of older people do not matter to the facility, and can be ignored with impunity. This may have a negative effect on residents’ self-esteem and morale. Any sense of community is undermined by this approach.

2. Suggested remedies:

- 1 – Strategies need to be developed to find out what residents and their families feel about the proposed changes to meal service policies.
- 2 – Alternative ways of addressing management needs that allow residents to have some choice in when and where they eat, and that respects individuality, need to be generated.

3. Partnerships, collaborators required:

Residents and their families need to be involved in creating the meal service policies. The Resident Council should be involved. Nursing and activity staff also need to be consulted.

Results and Commentary

Assessment of Results

Management has found that they have nearly twice as many NO responses, as Yes. In addition there are nearly an equal number of NOT SURE responses. Even NOT APPLICABLE scored higher than YES, and the question arises as to whether the policy addresses the needs of the residents. Management decides that there is sufficient indication to re-examine the content and overall intent of the policy.

Missing Information is Gathered Through Consultations

I – Representatives of the Residents Council and family representatives sit down with management, and the following needs, wants, and desires are made known.

1. Meals should be served at various times, to suit individual mealtime habits.
2. Mealtime is an opportunity to interact with people. It is a social event that is as important as the meal itself. Always seating people at the same chairs, or even at the same tables, may be easy to “manage”, but it removes the opportunity for people to mix and to keep “in touch”.
3. Residents have preferences about whom they sit with. They point out that just because they all live in the facility it does not mean they are interchangeable.
4. Residents don’t always want to eat with one another.
5. Residents would like to be able to invite family and friends to meals on occasion.
6. Residents overwhelmingly want traditional Polish meals to be offered.
7. Residents are also concerned with costs. They suggested that the menu be offered on a cost recovery basis for family and friends.

II – Nursing and activity staff are consulted and raise the following concerns:

1. Trying to get everyone to the dining room at set times means more will have to be done for residents, that some residents will be rushed. This will increase dependency and may agitate some residents, possibly increasing aggression.
2. Activity staff will have to finish and start activities more rigidly
3. Some residents are incompatible with each other and should not be seated together.
4. Planned table seating does not take into account differences in social and cognitive functioning, nor how these factors will contribute to, or detract for socialization at tables.

Negative Implications Are Addressed

Management considered these points, and tried to implement what was feasible, in the following manner:

1. Rigid table seating was abolished.
2. As space and scheduling permitted, residents could invite friends and/or relatives, with a minimum of one-day ahead booking, larger numbers requiring more lead time. Meals would be charged on a cost recovery basis.
3. Continental breakfasts were to be tried as an alternative to rigid breakfast time. (Staffing concerns made it impractical to offer flexible mealtimes at other times of the day).
4. Traditional Polish cuisine was added to the menu, where dietary concerns could still be met.
5. Collaboration with residents would be on-going to evaluate and amend the policy.

Policy is Redrafted to Reflect the Above and Reassessed with SMHPL.

When the redrafted meal service policy is analysed using the SMHPL, management has found that they have quadrupled the number of YES responses, practically eliminating the NO and the NOT SURE responses. NOT APPLICABLE responses have increased, so management reviews this and is satisfied that these generic categories are indeed not applicable to this particular policy.

Management has been able to meet the original goals of controlling costs and minimizing staff. Dietary needs are still being met. Management feels confident that this policy will have the support of the majority of residents. This, in itself, will make this policy easier to implement although more difficult to manage. This is viewed as acceptable. The overall well-being and mental health of the residents will be supported through the revised meal service policy.

Recommendation is Made

RECOMMENDATION?	Yes	No
Accepted		
Accepted as revised	✓	
Need more information to decide from whom, where		✓
Needs revision		✓

SENIORS MENTAL HEALTH POLICY LENS WORKSHEET

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NO > YES? Your policy/program should be re-examined for content and overall intent. Many needs, wants, and concerns of seniors are not being met. A good source of input is from seniors themselves - ask them.

NOT SURE > Either YES or NO
You need to gather more information before proceeding with your policy/program. Your policy is not comprehensive nor holistic.

NOT APPLIC > Either YES or NO
Go back and critically examine your policy. Are there this many categories that do not apply to your policy or program? Or does much of the policy/program not apply to the needs, wants, and concerns of those it is intended to be written for?

To the above add a summary of your discussions.

4. Answer yes or no to whether the policy should be accepted, or accepted as revised, and whether there is a need for more information, or if revision is required.

If the policy is not accepted, identify the individual areas that require revisions and ways that potential negative effects could be addressed or off-set. Note who needs to be involved to address this process, and what information needs to be gathered.

5. Revise the policy, and re-apply the lens, starting with 1., above.
6. Starting with question 5 above, repeat until the (revised) policy is recommended for acceptance.

POLICY DESCRIPTION

1. Process Factors

PROCESS	Yes	No	Not Sure	N/A
a. Has the policy been developed in collaboration with those who will be most affected?				
b. Does the policy/program emphasize partnership and collaboration?				
c. Are seniors/organizations consulted? Involved?				
d. Are other relevant organizations/sectors/Ministries engaged?				

NOTES:

2. Diversity

Does the policy/program recognize/address the diverse needs, circumstances, and aspirations of marginalized/vulnerable sub-groups within the seniors' population?

RECOGNIZE DIVERSITY?	Yes	No	Not Sure	N/A

Does this policy/program avoid negative impacts on the following groups?

AVOIDS NEGATIVE EFFECTS FOR:	Yes	No	Not Sure	N/A
Gays and lesbians				
Ethnocultural minorities				
Women				
Caregivers				
Poor				

Oldest old				
Mentally ill				
Cognitively impaired				
Aboriginal				
Disabled				
Chronically ill				
Religious minorities				
Long term care residents				
Developmentally delayed				

NOTES:

3. Determinants of Health

Does the policy/program acknowledge the multiple determinants of health?
Specifically will negative effects be avoided on:

AVOIDS NEGATIVE EFFECTS ON:	Yes	No	Not Sure	N/A
Physical health				
Social support networks				
Social environments				
Safety				
Income status				
Personal health practices and coping skills				
Access to appropriate health care				
Sense of physical security				

NOTES:

4. Does the policy/program consider accessibility?

CONSIDER ACCESSIBILITY?	Yes	No	Not Sure	N/A
a. Is pertinent information readily available?				
b. Is it affordable?				
c. Are sufficient resources likely to be available in a timely manner?				
d. Is transportation readily available?				

NOTES:

5. Does the policy/program promote/support seniors' social participation and /or relationships?

PROMOTES PARTICIPATION AND/OR RELATIONSHIPS?	Yes	No	Not Sure	N/A
a. Within their social network of family and friends?				
b. Within the community?				
c. Does it promote seniors' inclusion in society?				
d. Does the policy/program reduce loneliness, and/or social and spiritual isolation?				
e. Does it promote/support a sense of belonging/mattering?				

NOTES:

6. Does the policy support seniors' independence, self-determination?

SUPPORT INDEPENDENCE?	Yes	No	Not Sure	N/A
a. Does it provide opportunities to make choices?				
b. Is information, encouragement and support provided to facilitate choice?				
c. Does it promote coping skills?				
d. Does the policy/program reduce loneliness, and/or social and spiritual isolation?				
e. Does it build on the capacity of seniors and adjust to different circumstances?				

NOTES:

7. Does the policy/program support seniors' dignity?

SUPPORT DIGNITY?	Yes	No	Not Sure	N/A
a. Does it promote self-esteem?				
b. Is it respectful of seniors' privacy?				
c. Does it acknowledge the uniqueness of each individual?				
d. Does it consider individual versus collective needs?				

NOTES:

8. Is the policy/program fair? Does it take into account the full costs and benefits of supporting the aspirations of seniors?

What are the benefits to seniors if policy is carried out?

What are the costs to seniors if policy is carried out?

9. Does the policy/program support seniors' sense of security?

SUPPORT A SENSE OF SECURITY?	Yes	No	Not Sure	N/A
a. Economic security				
b. Physical security				
c. Opportunity to plan for future e.g., death; appropriate housing and services				
d. Sense of belonging				

NOTES:

10. Is consideration given to the cumulative impacts on later life of policies/programs targeted at earlier life stages?

Please write in response below.

Summate the columns

- YES > NO? You are well on your way to a positive policy/program. But look for some ways it could be improved. Go back and determine if there are any policy changes that will yet increase the number of "Yes" responses.
- NO > YES? Your policy/program should be re-examined for content and overall intent. Many needs, wants, and concerns of seniors are not being met. A good source of input is from seniors themselves - ask them.
- NOT SURE > Either YES OR NO
You need to gather more information before proceeding with your policy/program. Your policy is not comprehensive or not holistic.
- NOT APPLIC > Either YES OR NO
Go back and critically examine your policy. Are there this many categories that do not apply to your policy or program? Or does much of the policy/program not apply to the needs, wants, and concerns of those it is intended to be written for?

Add Summary of Discussions

Recommendation

RECOMMENDATION?	Yes	No
Accepted✓		
Accepted as revised		
Need more information to decide from whom, where		
Needs revision		

1. Negative implications identified:

2. Suggested remedies:

3. Partnerships, collaborators required:

APPENDIX II

CONCEPTUAL FRAMEWORK FOR DEVELOPMENT OF THE POLICY QUESTIONS

The Seniors Mental Health Policy Lens draws upon population health (Health Canada 2002), mental health promotion (Health Canada, 1996) and healthy aging policy perspectives and principles (Marshall, 1994). It draws upon the values and core principles embedded in the "Guidelines for Best Practices in Elderly Mental Health Care" (B.C. Ministry of Health, 2002), in the "National Framework for Aging: A Policy Guide" (Health Canada, 1998) and on seniors' perspectives about factors influencing their mental health.

In this section theoretical literature that underpins the development of the SMHPL is examined in terms of its' application to the mental health of older adults.

Population Health Determinants

Incorporation of the population health perspective into the SMHPL ensures that the both individual and social factors, singly and in combination, that impact older adults' mental health are taken into account.

From a population health perspective, "health" involves more than the absence of illness. It is the product of complex interactions among individual characteristics, the physical environment, and social and economic factors. Health Canada (2002) has noted that these determinants of health include:

- **Biology and Genetic Endowment** - the basic biology of the human body is a primary determinant of health. Genetic endowment may predispose some individuals to particular diseases or health problems.
- **Gender** - Gender refers to the variety of roles, attitudes, behaviours, values and influences that society differentially attributes to men and women. Many health issues may occur because of gender-biased roles or social status.
- **Education** - Education may: improve one's ability to gain access to information and services that potentially keep an individual healthy; provide people with the skills they need to identify and solve problems; increase choices and opportunities; and increase job satisfaction, job security, and financial security. Good health is associated with higher education.
- **Physical Environment** - the physical environment includes both the natural environment (air, water, land) as well as human environments (which include housing, community safety, transportation). Good health is associated with quality natural and human environments.
- **Employment and Working Conditions** - Unemployment and underemployment are associated with poorer health. Individuals with more control over their work circumstances are healthier than those involved in more stressful work.

- **Income and Social Status** - Health is directly related to income and social status. People with higher incomes are healthier than those with lower incomes, and individuals with higher socio-economic status are healthier than those with lower status.
- **Social Support Networks** - Support from families, friends, and communities is associated with better health.
- **Social Environments** - Supportive societies (those that are stable, recognize diversity, and promote safety, good working relationships and cohesiveness) can reduce or eliminate many potential risks to good health.
- **Culture** - Culture and ethnicity are products of personal history and social, political, geographic, and economic factors. They affect how people view health and illness, link with the health system, access health information, participate in health promotion programs and make life-style choices.
- **Healthy Child Development** - Prenatal and early childhood experiences can have a substantial effect on subsequent health, well-being, coping skills, and competence.
- **Personal Health Practices and Coping Skills** - Personal health practices refer to behaviours individuals choose to do or not do in their daily lives. Coping skills refer to the internal resources individuals have to manage situations or problems, and to deal with outside influences and pressures. Good health practices and strong coping skills are associated with better health.
- **Health Services** - Health services that are designed to prevent disease, restore health and function, and maintain and promote health contribute to population health.

While each of these determinants of health is important in its own right, it is the combined influences of the various factors that determine health status for individuals, for subgroups within a population, and for the population as a whole.

In the next section, the implication of the determinants of health for older adults' are explored by applying them to the critical transitions and normative events that may occur in late adulthood.

Social Determinants and the Psychological and Social Well-Being of Seniors

There are several changes that occur as part of the normal aging process. These events affect the majority of seniors and include: retirement; changes in income level; physical changes; and changes in social support networks. Seniors may respond to these events in many different ways.

Retirement

Retirement may be seen as either a positive or negative event, depending on the circumstances surrounding the formal withdrawal from the labour force (Pitt, 1998). For some, retirement may be seen as an opportunity to actively engage in a number of activities, which may have received little attention while an individual was working. For others, retirement may signal a reduction in income, a decrease in

social contact, a loss of a support system and/or a conscious awareness of one's age and mortality.

Retirement is not a static event, and instead can be conceptualized as a number of phases that individuals may go through. The timing and sequencing depends on such circumstances as the reason for retirement and age at retirement (Atchley, 1976). Older adults with inadequate incomes and poor health, must adjust to concomitant stresses, such as the death of a spouse, have the most difficult time adjusting to retirement (Stull & Hanch, 1984).

Retirement will affect both the individual and his or her spouse or partner. If the spouse/partner has never worked or has not worked for a long time, retirement may signal a change in roles within the household, the family, and the community in general. For example, a wife who has never worked may find it difficult to have her husband assist her with household chores if she is used to doing them by herself. In contrast, if the spouse/partner remains in the workforce (a situation which may be more common in the future as more women are in the workforce), the retiree may experience increased loneliness.

Changes in Income Level

Seniors generally have lower incomes than younger individuals (Statistics Canada, 2002). In general, senior men have higher incomes than senior women. Lewis (1997) has suggested that this may be the result of historical patterns of economic dependence on men and sporadic low wage or non-existent employment histories for women (Lewis, 1997). Being unattached (either through death or divorce) may make women particularly vulnerable to poverty (Hungerford, 2001; Lewis, 1997; Statistics Canada, 2002). Lewis (1997) noted that women's improving educational and work opportunities may result in improved financial circumstances for future generations of older women (but see Whall, 1990).

Physical Changes

Physical changes (such as changes in vision and hearing, loss of muscle mass and bone density, and increased risk for fractures) are common in the elderly (Connell, 1999; Pitt, 1998). There are also several health conditions (such as stroke, heart disease, chronic obstructive pulmonary disease, falls, arthritis, and cancer) that are associated with the senior years. Memory loss may also occur, although most seniors do not develop dementia. The extent to which age, disability, and chronic health conditions are interrelated is controversial (Andrews, 2001). There is some evidence that the prevalence of disability is declining in successive cohorts of older individuals (Andrews, 2001; Khaw, 1999).

Physical changes and chronic health conditions can have substantial impact on the psychological and social well-being of older adults. Health problems may make it difficult to get out and about. In turn, there may be a concomitant reduction in social contact and an increase in mental health problems. For example, Ahto, Isoaho, Puolijoki, Laippala, Romo, and Kivela, (1997) found that depression was more common in men with coronary heart disease compared to male controls, but was not related to the presence or absence of coronary heart disease in women.

Sullivan (1997) has suggested that subjective perceptions of well-being may be more tightly linked with morale than objective health. Several studies have provided

support for this view. For example, Moore (1992) found that more health problems were associated with lower education, lower income, less health knowledge, and poorer health practices as well as lower perceived health status and lower self-efficacy. In contrast, older adults who felt they were healthy and self-sufficient had fewer health problems, greater knowledge of health issues, and better health practices. More recently, Hogan, Fung, and Ebly (1999) examined how health status changed over a five year period in a group of 108 community-dwelling seniors 85 years of age and older. They found that, even though over two-thirds of the participants indicated they had experienced a decline in their functional abilities, approximately 79% felt that their health had stayed the same or improved over the five year period (see also Ebly, Hogan, & Fung, 1996; Hogan, Ebly, & Fung, 1999).

Changes in Social Support Networks

Caregiving

Many older adults may be caregivers to others at some point during their senior years. Some may provide care to individuals with cognitive impairment, while others may provide care to the physically frail.

Livingston, Manela, and Katona (1996) examined the mental health of a representative community sample of caregivers of individuals with a physical disability, depression, or dementia. They found that being a caregiver for an older individual is not in itself a risk factor for mental health problems. Depression was least likely to occur in caregivers of individuals with physical limitations. In contrast, depression was common in caregivers of individuals with a psychiatric disorder, and was most common for women providing care to someone with dementia.

Knowledge regarding the impact of providing care to an individual with dementia is important since it is estimated that dementia affects 8% of individuals 65 years of age and older and that the number of individuals affected continues to increase (Canadian Study of Health and Aging Working Group, 1994a, 2000). It is also known that the prevalence of dementia increases from an estimated rate of 2.4% in individuals 65 to 74 years of age to an estimated rate of 34.5% in individuals 85 years of age and older (Canadian Study of Health and Aging Working Group, 1994a). Spouses are the primary caregivers for approximately 37% of community dwelling individuals with dementia; daughters are the primary caregivers for an additional 29% (Canadian Study of Health and Aging Working Group, 1994b).

These findings suggest that the presence of dementia can have several important consequences for elderly persons. First, the physical, psychological and social declines seen in individuals with dementia can have a significant impact on caregivers. For example, Clyburn, Stones, Hadjistavropoulos, & Tuokko (2000) found that caregivers experience greater burden when the individual with dementia has a relatively high number of disturbing behaviours and when caregivers receive little informal support from others. Bergman-Evans (1994) noted that spousal caregivers are particularly at risk for loneliness and decreased social support regardless of whether the individual with dementia remains at home or is institutionalized. Caregivers who are feeling burdened and/or lonely are more likely to also experience depression compared to those who have good social support (Bergman-Evans, 1994; Clyburn et al., 2000; Ross, Rosenthal & Dawson, 1997).

Second, spouses of older individuals with dementia are likely to be seniors themselves. As well, children (that is, daughters, sons, daughters-in-law, and sons-in-law) of the old-old with dementia may also be seniors. Both groups of caregivers may experience their own age-associated health conditions, in addition to experiencing physical and mental health conditions because of providing care.

Third, as the population continues to age, it is conceivable that non-cognitively impaired old-old parents will be faced with providing care to cognitively impaired young-old children. This may present a whole new set of issues regarding caregiving for individuals with dementia.

Fourth, depression is not uncommon in individuals with dementia. This may have an impact both on the nature of, and response to, programs and interventions designed for this group. Furthermore, individuals with dementia may not respond to pharmacological treatment of depression in the same way as non-cognitively impaired seniors.

Spousal Bereavement

Spousal bereavement is often an important cause of medical and psychiatric morbidity. Bennett (1997), for example, examined changes in mental and physical health, morale, and social functioning in elderly women over an 8-year period. Women who were widowed during the course of the study were compared with never-married and still-married controls. Bennett noted that the sample as a whole showed age-related declines in both physical and mental health and widows showed additional declines in mental health compared to women in the control groups.

Symptoms of complicated grief (such as searching, preoccupation with thoughts of the deceased, and lack of acceptance of the death) are frequently observed in older bereaved spouses (Rozenzweig, Prigerson, Miller, & Reynolds, 1997). These symptoms appear to be distinct from depressive symptoms (Prigerson, Frank, Kasl, Reynolds, Anderson, Zubenko, Houck, George, & Kupfer, 1995). Prigerson et al. (1995) noted that symptoms of complicated grief were associated with impairments in global functioning, mood, and self-esteem 18 months after the death of a spouse.

Depression (along with suicide) and anxiety frequently occur in conjunction with spousal bereavement (Rozenzweig, et al., 1997). In a study of older men, Byrne and Raphael (1997) found that widowers reported more state anxiety (which was related to intensity of grief) and general psychological distress over the first 13 months following the death of their spouses, compared to married controls. Widowers also reported more thoughts of death and suicide than married men. However, the two groups did not differ with respect to loneliness or depression.

Social Isolation

Widowed women are at risk for social isolation (Whall, 1990). Kramarow (1995; see also Wolf, 1995) has noted that the proportion of elderly widows living alone has continued to rise over the last 100 years, although no single factor appears to be responsible for the increase. Macunovich, Easterlin, Schaeffer and Crimmins (1995; see also Wolf, 1995) have suggested that the trend may be affected by kin availability. They noted that the trend is also affected by age: at the time of the study, the proportion of young-old widows living alone was declining, while that of

the old-old was increasing. The authors suggest, however, that the trend will be reversed in the future; that is, that the proportion of young-old living alone will increase while the proportion of old-old living alone will decrease.

Additional Challenges to the Psychological and Social Well-Being of Older Adults **Loneliness**

Loneliness has been defined as "an unwelcome feeling of lack or loss of companionship, or feeling that one is alone and not liking it" (Forbes, 1996, p. 352). While often confused with social isolation, loneliness cannot be considered the direct result of social circumstances. A situation resulting in loneliness for one person may be a source of contented aloneness for someone else (Forbes, 1996).

Loneliness in later life is problematic, as it is closely related to depression, which in turn is closely related to suicide (see for example, Mullins & Dugan, 1990; Rane-Szostak & Herth, 1995). Determinants of loneliness include: age, gender, health status, economic condition, a need for affection and security, a desire to be part of a social network, and the existence of friends (Mullins & Dugan, 1990; see also Forbes, 1999). Loneliness may be less prevalent in rural areas where a sense of community exists than in more densely populated areas (Forbes, 1999).

Loneliness may affect about 10% of seniors (Forbes, 1999). It appears to increase with age (Tijhuis, de Jong-Gierveld, Feskens, & Kromhout, 1999). In a study involving 1725 individuals 75 years of age and older, Holmen, Ericsson, Andersson, and Winblad (1992) found that 35% of the participants experienced loneliness (see also Rokach, 2000). They noted that there was a gradual increase up to the age of 90, after which a levelling was found. Loneliness is more common in women than men (Holmen, et al., 1992).

Physical health status is strongly correlated with loneliness (e.g. Dugan & Kivett, 1994). However, the predictive direction is not clear. For example, Fees, Martin and Poon (1999; see also Holmen et al., 1992) reported that individuals who felt lonely also reported having reduced physical health. Loneliness may also occur more frequently with some health conditions than with others. For example, Penninx, Van Tilburg, Kriegsman, Boeke, Deeg, and Van Eijk (1999) reported greater loneliness in individuals with lung disease or arthritis. Anxious individuals tend to be at risk for loneliness (Fees et al., 1999; Long & Martin, 2000). Loneliness may also be higher in individuals with reduced cognitive functioning (Holmen et al., 1992).

Given Wu and Pollard's (1998) finding that emotional support appears to be the greatest unmet need for unmarried, childless seniors, it might be expected that loneliness would be more common in seniors who were single (either never married, or not currently married) or who were childless. Widowed men and women report higher levels of loneliness and depression than married individuals (Koropecj-Cox, 1998; see also Holmen et al., 1992). However, perceptions of well-being in never married, childless men and women are indistinguishable from those of their married peers. Similarly, individuals with and without children (regardless of marital status) do not appear to differ (e.g. Holmen et al., 1992; Koropecj-Cox, 1998; Mullins & Dugan, 1990). Loneliness may be determined more by the absence of friendship support rather than being single per se (e.g. Dykstra, 1995; Mullis & Mushel, 1992).

Rokach (1996) suggested that loneliness might be reduced by improving functional status and socialization. Rane-Szostak and Herth (1995), however, have suggested that the emphasis should be on strategies used by older adults who are not lonely (even though they may have experienced decreased physical function and/or socialization), in order to understand how loneliness may be avoided in others.

Depression

There is a belief that depression is common in older adults, but the evidence is inconsistent and contradictory. Gomez and Gomez (1993) noted prevalence rates of 1% to 29%. More recently, Macdonald (1997) cited a prevalence rate of 15% for seniors in the general community and 25% in general practice patients. Wattis (1996) noted that clinically significant depression affected about 10% of seniors in the general community, and that of these, approximately 25% experienced severe depression. The National Advisory Council on Aging (1997) cited a prevalence rate of 5%. The different rates may reflect different definitions of depression (Gomez & Gomez, 1993).

In older persons, mild or situational depression (that is depression which occurs in response to physical or social losses) occurs more frequently than major depression (Tannock & Katona, 1995; Wattis, 1996). Nevertheless, the directional nature of the association between loss and depression is not always clear (Macdonald, 1997; Pitt, 1998). Depression occurs more frequently in the old-old (for a review, see Tannock & Katona, 1995). Depression occurs more frequently in older women than in older men (Ostbye, Steenhuis, Walton & Cairney, 2000). Other risk factors include: being widowed or single, experiencing stressful life events (including physical illness), and having poor social support (Lupine & Boucher, 1998).

Despite the frequency with which it occurs, depression is often overlooked in older adults, in part, because the signs and symptoms of depression in the elderly are different from those in younger individuals. For example, depression in older individuals commonly presents as a series of physical problems such as changes in sleep patterns, decline in appetite, weight loss, regular variation in mood, constipation, and repeated minor aches and pains (Gomez & Gomez, 1993; Macdonald, 1997; Wattis, 1996). Symptom overlap among depression, anxiety and many chronic conditions may make diagnosis difficult (Montano, 1999). In addition, depressive symptoms may be viewed by the older individual, family members, and physicians as a natural part of the aging process and thus may remain unrecognized and/or untreated (e.g. Gomez & Gomez, 1993). It is essential to both recognize and treat depression in the elderly, however, as it is associated with both increased morbidity and mortality (Gomez & Gomez, 1993; Wattis, 1996).

Suicide

In comparison with other age groups, suicide rates are highest among individuals 65 years of age and older (Bharucha & Satlin, 1997; Buchanana, Farran, & Clark, 1995; Devons, 1996; Schmitz-Scherzer, 1995).

Risk factors for suicide in the elderly may be fundamentally different from those for younger individuals (Tadros & Salib, 1999). Men may be at greater risk for suicide than women (Devons, 1996; Li, 1995; Wattis, 1996). White men may be at even greater risk (Gomez & Gomez, 1993). Additional risk factors include: high levels of

emotional disturbance; being depressed or anxious; having one or more physical illnesses; a history of stroke; being widowed; and living alone (Conwell, Rotenberg & Caine, 1990; Rich, Warstadt, Nemiroff, Fowler, & Young, 1991; Scocco, Meneghel, Caon, Dello Buono & De Leo, 2001). Tadros and Salib (1999) note that while social isolation and physical impairment seem to be important risk factors for suicide in the elderly, they may be more important for younger individuals. Schmitz-Scherzer (1995) noted that uncertainty and fear regarding an inability to influence one's own dying and a certain weariness of life may also be risk factors for the elderly.

Within the older population itself, suicidal thoughts may be relatively common. For example, in a recent study of 611 community-dwelling adults 65 years of age and older, Scocco, et al. (2001) found that 17% of participants responded affirmatively to at least one question on suicidality. This finding is of major importance since 50% of suicide attempts by the elderly are successful (compared to 13% of suicide attempts in individuals under 50 years of age; Gomez & Gomez, 1993). Successful suicides occur most often early in depression (Gomez & Gomez, 1993).

Tadros and Salib (1999) noted that attempts to reduce suicide in the elderly will need to be different from those used with younger individuals. Older individuals are less likely to indicate their intent, and more likely to express profound hopelessness (Gomez & Gomez, 1993).

Principles of Health Promotion and Mental Health Promotion

The principles of health promotion and of mental health promotion form an important component of the conceptual framework for the SMHPL, in that they underline a dual focus on facilitating community and individual capacity building.

Health Promotion is a process that enables individuals to take control over and improve their health (Hamilton & Bhatti, 1996). It emphasizes the concepts of lifestyle, risk, and preventive health behaviour (Power, French, Connelly, George, Hawes, Hinton, Klee, Robinson, Senior, Timms, & Warner, 1999; see also Heidrich, 1998). The concept of health promotion encompasses five basic strategies:

- Building health public policy - to ensure that policy developed by all sectors contributes to health promoting conditions.
- Creating supportive environments - that recognize the changing nature of physical, social, economic, cultural, and spiritual aspects of society and ensure positive impacts on the health of people.
- Strengthening community action - to ensure that communities have the capacity to set priorities and make decisions on issues that influence their health.
- Developing personal skills - to enable individuals to gain the knowledge and skills necessary to meet life's challenges and contribute to society.
- Reorienting health services - to create systems that focus on the needs of the whole individual and which involve partnerships among providers and users of services.

Mental Health Promotion is “the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental Health Promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections, and personal dignity, (Health Canada, 1996).

Although there is a large body of literature both on health promotion and on the prevention of mental illness, there is relatively little literature on mental health promotion, either in the general population or in the elderly. This likely reflects the fact that physical health and mental health have generally been addressed separately in programs, policies, and professions (Driscoll, 1998).

There is growing evidence, however, that physical and psychosocial well-being are interrelated (e.g. Andrews, 2001; Heathcote, 2000; Miller, 1991). Thus, some studies of health promotion have included psychological and/or social measures (such as emotional well-being, life satisfaction, and perceived health status) as well as measures of physical well-being (e.g., Bagwell & Bush, 1999; Hogan, Fung, & Ebly, 1999; Slaninka & Galbraith, 1998). In these cases, mental health promotion appears to be considered part of general health promotion, but the mental health components have not necessarily been “teased out”.

Healthy Aging Policy

"Healthy aging policy", promoted by WHO (World Health Organization) and the Health Promotion Directorate of Health and Welfare Canada, provides a framework for policy makers, that builds upon population health and health promotion frameworks. While concern for individual health is maintained (eg: disease prevention; illness and treatment; promotion of healthy lifestyles, etc), the major thrust of healthy public policy moves well beyond conventional health promotion and prevention strategies, and well beyond the health care system, to develop healthy policies in all sectors of life. This approach provides a clear template for policy makers who wish to promote social environments that support seniors' mental health, and the major principles have been integrated into the SMHPL.

The healthy aging policy approach incorporates the following four principles:

- multisectoral – health will be enhanced through developments in all sectors (e.g.: the economy, nutrition, housing, the environment and education);
- equity – principles of fairness should guide efforts to promote health;
- broad participation
- ecological perspective, which places humans in a broad context of the physical and social world.

Based on an understanding that health status is primarily environmentally determined, policy-makers are led to examine the health effects of all policies that have an impact on the social or physical environment (Marshall, 1994).

Marshall (1994), has identified a number of policy implications for aging that arise out of a healthy public policy approach, as follows:

- "Policy initiatives should include, and perhaps focus on, the well elderly. The importance of medical and health professionals for health policy is circumscribed.
- Environmental and ecological theories of aging, grounded in the work of Kurt Lewin and related theorists assume great importance. Adaptation, in the ecological approach, rests on attaining a "fit" between person and environment. Policy initiatives should focus on changing the environment rather than the person.
- Policy initiatives to enhance the health of the elderly should focus on income security, housing, and other social determinants, rather than specifically (only) on health and medical matters.
- Health promotion/disease prevention goals should be set for people of all ages in a life-span context, and specifically for the aged.
- In keeping with the emphasis in healthy public policy of encouraging active participation, older people should be included in health-promoting policy initiatives.
- The ecological tenets of healthy public policy, applied in the social realm, imply that the "problems" of the aged should not be viewed in isolation from the problems of the society as a whole.
- Notwithstanding the previous point, equity considerations should lead to resources allocated on "equality" grounds, in order to redress systematic or institutionally based deprivations. For example, compensation should be directed to the aged because they are systematically excluded from full labour force participation.
- Socially relevant policies in a wide variety of fields should be examined in light of their health effects (broadly defined) on the older adults. For example, urban design and transportation should take into account the special needs of a less mobile or frail older population, thereby providing an environmental fit which facilitates greater opportunities for independence." (Marshall, 1994, p234).

The principles of healthy aging public policy, as elaborated by Marshall, address the determinants of health and utilizes principles of health promotion, but takes them well outside of narrow health/health care parameters or responsibility and into the larger society. This underlines the necessity of multisectoral collaborative approaches that cross conventional systems/sector boundaries to promote and support seniors' mental health.

Principle and Values of Psychogeriatric Care

The British Columbia Psychogeriatric Association (a provincial non-profit multidisciplinary organization) developed principle and guiding values for the care of older adults with mental health problems, as a basis for "Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities", (B.C. Ministry of Health, 2002). This was accomplished through consultation with elderly persons,

family caregivers, volunteers, psychogeriatric specialists, policy makers, program planners and managers, and organizations interested in elderly persons with (or at risk of) mental health problems. These principles and values underlie the SMHPL and are fundamental in guiding the development of services for older adults with mental health problems and their families

Principles of Care

The principles are that care to older adults with mental health problems should be:

- Client and family Centred (Client and family directed where possible but always client-centered)
- Goal Oriented
- Accessible and Flexible
- Comprehensive Care
- Specific Services
- Accountable

Values and Beliefs

The values and beliefs underlying the principles of psychogeriatric care were articulated as follows:

- Mental health is defined as: “The capacity of individuals to interact with each other and their environment in ways that enhance or promote:
 - their sense of well-being
 - their sense of control and choice with their life
 - optimal use of their mental abilities
 - achievement of their own goals (both personal and collective) and
 - their quality of life.” (Anderson and Parent, 2002, adapted from Health and Welfare Canada, 1988)
- The principles of psychosocial rehabilitation form the philosophical foundation for best practices in mental health. These principles emphasize the importance of older adults’ involvement in personal care and life goals as well as the need for treatment and supports that help older adults manage their symptoms and builds on their strengths.
- Promoting and achieving quality of life is a major goal.
- A major shift should be made across the continuum of care away from a bio-medical model approach in caring for psychogeriatric clients and towards a biopsychosocial model of care. A biopsychosocial model moves the focus from individual pathology alone to a consideration of the whole person within the context of his/her social environment..

- An interdisciplinary team approach that utilizes a variety of skills in a collaborative manner is important in meeting the broad needs of clients.
- Supportive or assistive environments must be provided as required.
- A culture of caring across the continuum of care that acknowledges the need for a meaningful life (rather than just living) and that recognizes people's relational needs should be fostered. A culture of caring would prevent the alienation, anomie and despair that many elderly persons feel and would promote optimal mental health.

To summarize, the values, principles and beliefs drawn from the theoretical literature, that underpin the development of the SMHPL, have been described.

Seniors Perspectives on Aging and Mental Health

In this section studies and projects that have identified factors that support the mental health of older adults, from their perspectives, are reviewed. The findings have been incorporated into the SMHPL questions.

National Framework on Aging Principles

The Federal/Provincial/Territorial Ministers Responsible for Seniors, through an extensive consultation with seniors, policy analysts, and other interested stakeholders, developed a policy guide for reviewing policies and programs for seniors, titled "Principles of the National Framework on Aging: a Policy Guide". Their work incorporates the principles of population health and health promotion, as well as the needs, values and concerns, as expressed by seniors. The following core principles, reflecting seniors' shared values, are meant to guide government and non government organizations, planners and decision makers in designing and reviewing policies and programs that promote seniors' quality of life and well-being (Health Canada, 1998).

• Dignity

being treated with respect, regardless of the situation, and having a sense of self-esteem e.g., having a sense of self-worth

- being accepted as one is, regardless of age, health status, etc.
- being appreciated for life accomplishments
- being respected for continuing role and contributions to family, friends, community and society
- being treated as a worthy human being and a full member of society

• **Independence**

being in control of one's life, being able to do as much for oneself as possible and making one's own choices e.g., decisions on daily matters

- being responsible, to the extent possible and practical, for things that affect one
- having freedom to make decisions about how one will live one's life
- enjoying access to a support system that enables freedom of choice and self-determination.

• **Participation**

getting involved, staying active and taking part in the community, being consulted and having one's views considered by government e.g., being active in all facets of life (socially, economically, politically)

- having a meaningful role in daily affairs; enjoying what life has to offer
- participating in available programs and services being involved and engaged in activities of daily living (decisions/initiatives in all spheres, not just those specifically oriented to seniors)

• **Fairness**

having seniors' real needs, in all their diversity, considered equally to those of other Canadians e.g., having equitable access (socially, economically, politically) to available resources and services

- not being discriminated against on the basis of age
- being treated and dealt with in a way that maximizes inclusion of seniors

• **Security**

having adequate income as one ages and having access to a safe and supportive living environment e.g., financial security to meet daily needs

- physical security (including living conditions, sense of protection from crime, etc.)
- access to family and friends; sense of close personal and social bonds; and support

These principles are echoed in more concrete terms in the factors identified by seniors as important to their mental health in several Canadian projects described below. The range of factors identified illustrates that seniors see their mental health as grounded in a social and economic environment/context, and in their relations to others. The factors identified are congruent with both the principles of the National Framework, above, and the determinants of health.

Seniors Perspectives on Mental Health: Canadian Studies

Meeting the Mental Health Needs of older British Columbians (2001)

Participants in "Meeting the Mental Health Needs of Older British Columbians" (Tuokko et. al. 2001) identified a wide range of psychosocial needs relevant to seniors' mental health: regular mental activity that provides reality orientation, mental exercises, cognitive stimulation and interaction; individual, family and group counselling and support; socialization, activation and companionship; an appropriate and life-enhancing psychosocial milieu; information, assistance and support during times of transition; sense of empowerment, purpose and self-worth with an opportunity to contribute to society if desired; and respect and dignity. In this same study participants expressed a need to broaden the scope of mental health care to include, and give greater recognition to, the importance of psychosocial needs such as support groups and social activities, housing, transportation, health care promotion and prevention, wellness, and a more holistic model of care.

NIICHRO and CEC (1997)

In 1997, the National Indian and Inuit Community Health Representative Organization (NIICHRO) and the Canadian Ethnocultural Coalition (CEC) held dialogues with aboriginal and ethnocultural seniors, to learn about the factors these seniors felt affected their well being (Ship, 1997).

The seniors identified challenges to their well-being and mental health such as: cultural disruption; ageism, sexism and racism; poor physical health; poverty; unhealthy living conditions and environment; and social isolation. They stated that language barriers, cultural differences, minority status and limited services accentuate the problems they experience. Unwanted social isolation and spiritual isolation were also identified as challenges to mental health. They stated that social isolation can occur as a result of: lack of information about programs and services; lack of home care and home supports; lack of supportive services; weak family/social and community networks; lack of participation in recreational, social and community activities. Participants felt that spiritual isolation can occur as a result of: inability to observe religious and spiritual practices as a result of lack of access and opportunity; loss of meaning and purpose in life; loss of sense of connectedness and belonging to something larger than oneself.

Participants in the NICHRO and CEC project also identified what they believe are the essential elements for ageing well. These included:

- Physical, mental-emotional, social and spiritual well-being
- Empowerment (ability to decide about one's own life).
- Awareness and access to information about existing programs and services.
- Easy access to medical, social and other support services.
- Ageing in place, with respect and with dignity, for as long as possible (independent and interdependent lives).
- A supportive social environment

- Continued community involvement and participation.
- Financial security.
- Adequate and supportive housing.
- Accessible and affordable transportation

Seniors' Mental Health and Home Care (2002)

In a Canadian Mental Health Association project "Seniors' Mental Health and Home Care" (2002) focus groups were conducted with seniors, family caregivers and home care providers, at several locations in Canada about their mental health. A diverse range of factors that influence the mental health of seniors were identified. The leading factors that were reported to strongly influence positive mental health included:

- independence and control over one's life,
- a sense of dignity and purpose, physical health,
- social interaction,
- spirituality,
- coping with losses
- life experience of the individual.

A number of broader situational factors that contribute to mental health were also identified. These included:

- quality of the home environment,
- sense of security and personal safety,
- the extent of one's caregiving role,
- financial security,
- transportation,
- timely and easy access to services (including services that are culturally and linguistically appropriate),
- the role of the formal care provider and flexibility of service provision

Psychosocial Approaches to the Mental Health Challenges of Late Life (2004)

In a national project carried out by the BC Psychogeriatric Association and funded by Health Canada (Psychosocial Approaches to the Mental Health Challenges of Late Life), seniors in several Canadian centres (rural, urban and northern) were asked what they thought were the most significant challenges to their mental health. In addition to some of the factors identified in the previous projects, these seniors identified the following:

- seeing yourself deteriorate but accepting yourself
- maintaining self esteem
- having no real role to play in society/not being needed
- loss of status
- not being able to pull your weight
- not being able to do things you used to
- having to depend on others
- loss of spouse
- loss of home
- inability to get to resources, or no suitable resources
- feeling invisible in youth oriented society.

Seniors identified the following as important to maintaining good mental health; information on which to make informed decisions about their futures

- opportunity for choice
- enough income to meet basic needs, including for medications, transportation, social participation
- practical help that supports living in own homes (e.g.: yard work, repairs)
- knowing that help/assistance can be acquired when needed
- a sense of belonging/mattering.

Through the foregoing studies older adults have identified the values that are important to them. They have also provided their perspectives on factors that challenge and factors that support, their mental health. All together their perspectives underline the importance of recognizing that approaches that focus on the individual, their relationships and the social context in which they live, singly and together, are important in supporting the mental health of older adults. It is noteworthy also that the perspectives of older adults reinforce the relevance of the population health determinants, health promotion strategies, and healthy aging public policy, discussed earlier, to promoting the mental health of older adults.

CONCLUSION

The elements derived from the literature review and those identified by older adults as important to their mental health, must be integrated into the interventions, services, programs, policies and social structures, in order to promote, support, maintain and/or improve the mental health of older adults. The use of the SMHPL can facilitate this process.

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EVALUATION OF SENIORS MENTAL HEALTH POLICY LENS

The purpose of this questionnaire is to evaluate the Seniors Mental Health Policy Lens (SMHPL). The aim of the SMHPL is to provide a way of examining current policy, or developing new policy (at the federal, provincial, municipal, or agency levels) to ensure there are not unintended negative impacts on seniors' mental health. We want to make sure we are developing relevant and appropriate materials: please help by completing and returning this questionnaire. It will take 5 minutes. For each question, read the statement, then circle the number that reflects your response, where 1 means you "strongly disagree" with the statement, and 5 means you "strongly agree" with the statement. In every case, 5 is a more positive rating. Circle NR if you feel unable to respond to a question. Comments are welcome. Please return the sheet by fax (250-756-2139), or by email to pmaccourt@shaw.ca. Thank you.

The SMHPL is :

1. **A good summary;** The background paper identifies the key factors/issues related to supporting seniors' mental health, and provides a good rationale for development and use of the SMHPL.

1	2	3	4	5	NR
Strongly disagree				Strongly agree	

2. **Educative/Informative;** the background paper provides solid and useful information.

1	2	3	4	5	NR
Strongly disagree				Strongly agree	

3. **Relevant;** it is helpful in identifying potential negative effects of policy and/or in creating policy supportive of seniors' mental health.

1	2	3	4	5	NR
Strongly disagree				Strongly agree	

4. **Useful;** it will be useful in your work

1	2	3	4	5	NR
Strongly disagree				Strongly agree	

5. **Clearly structured;** the guidelines and worksheet are well organized and provide clear direction

1	2	3	4	5	NR
Strongly disagree				Strongly agree	

6. **User-friendly;** All components are written/presented in a way that many different people can understand and use.

1	2	3	4	5	NR
Strongly disagree				Strongly agree	

