

To: Institute Of Neurosciences, Mental Health And Addiction (INMAH)
Response to: Unique Challenges In Mental Health And Addiction Research: The Next Ten Years
Submitted by: British Columbia Psychogeriatric Association, Centre on Aging, University of Victoria, and the
Seniors Psychosocial Interest Group
Contact: Dr. Penny MacCourt, 250-755-6180; pmaccourt@shaw.ca

SINGLE BIGGEST CHALLENGE TO MENTAL HEALTH RESEARCH

The single biggest challenge to mental health research in Canada is the increased prevalence of mental health disorders (including dementia) seen in late life, coupled with the aging population. Our response to this challenge is limited by inadequate recognition and attention to the unique characteristics of older adults and their mental health needs, which inhibits our ability to appropriately plan. This limitation, arising from a combination of biomedicalization of seniors' mental health and ageism, has led to inadequate support for research in seniors mental health. To address these issues we propose that research funds be provided that reflect the proportion of older adults in the general population with (or at risk of) mental health problems, and that support for psychosocial research in particular, be strengthened.

UNDERSTANDING THE CHALLENGE

Increased Prevalence

It is currently estimated that 13% of the population is 65 years of age and older. By 2016, it is estimated that seniors will represent over 16% of the population (Statistics Canada, 2002). It is estimated that 1 in 5 persons aged over 65 years has a mental health disorder, including dementia with behavioural problems, depression, psychosis, bipolar disorders, schizophrenia, anxiety disorder and addictions (Jeste, Alexopoulos, Bartels, Cummings, Gallo, Gottlieb and others (1999). In comparison with other age groups, suicide rates are highest among individuals 65 years of age and older (Bharucha & Satlin, 1997; Schmitz-Scherzer, 1995) and 50% per cent of suicide attempts by the elderly are successful (Gomez & Gomez, 1993). With the growing aging population, come an increased number of seniors who will experience mental health problems, or are at risk of doing so (Sullivan Kessler, Le Clair, Stolee & Whitney, 2004).

Factors Associated With Mental Health Challenges Specific to Late Life

Older adults are a special population which we know relatively little about. This will hinder our ability to create services that support their mental health or prevent mental health problems, and to provide supports and treatments that optimize the mental health of those with mental disorders. Older adults experience unique physical, psychological and social changes that individually and together may challenge their mental health, sometimes resulting in mental illness. Some of the factors associated with mental health challenges in late life unique to older adults are as follows:

- Chronic pain, multiple losses, bereavement, and social isolation are all common among depressed older adults in primary care (Unutzer, 2002).
- Caregiving women, especially those caring for an individual with dementia (Livingston, Manela and Katona, 1996) are at increased risk for depression. Caregivers who receive little social support and who feel burdened and/or lonely are more likely to also experience depression than caregivers with good social support (Clyburn, Stones, Hadjistavropoulos & Tuokko, 2000).
- Multicultural and generational attitudes/values can be a barrier to service, affecting how older adults communicate about their mental health and how issues should be addressed (Unutzer, 2002).
- Ethical and legal issues related to competency, often associated with living at risk, driving, self neglect, elder abuse, etc., require specialized knowledge and skills for assessment and management.
- Substance abuse or misuse and/or developmental disability, have unique social and service dimensions, and can mask or masquerade as mental illness, or occur concurrently (Health Canada, 2002).

- With advancing age, the prevalence of most chronic conditions increases, as does the prevalence of physical problems and dependency (Wilkins & Park, 1996). The prevalence of co-morbid, chronic medical illness can be confounding factors in the presentation of older adults (Blazer, 2000) and can exacerbate or cause depression (Fischer, F., Solberg, L., Rush, W. & Heinrich, R., 2003). Some medications for the treatment of medical conditions can cause or exacerbate psychiatric symptoms (Unutzer, 2002).
- Physiological changes associated with aging need to be taken into account for any pharmacological treatment, including psychiatric (Health Canada, 2002).
- Changes that occur as part of the normal aging process affect psychological and social well-being in some seniors (e.g. retirement; reduction in income level; physical changes; losses, and changes in social support networks) (Lepine & Bouchez, 1998; Samuelsson, Andersson & Hagberg, 1998). Some seniors may become lonely, depressed, or even suicidal (Forbes, 1999; Sokero, Melartin, Ryttsälä, Leskelä, Lestelä-Mielonen & Isometsä, 2005).
- Physical health status is strongly correlated with loneliness (Dugan & Kivett, 1994; Pennix, van Tilburg, Kriegsman-Didi, Boeke & van Eijk, 1999). Loneliness in later life is problematic, as it is closely related to depression, which in turn is closely related to suicide (Rocach, 2000).
- Older adults have expressed that the mental health challenges they face could be better met, if psychosocial approaches such as support groups and social activities, housing, transportation, health care promotion and prevention, wellness and a holistic model of care, were implemented (MacCourt and Tuokko, 2005).
- Psychosocial factors are related to suicide risk; high levels of emotional disturbance; being depressed or anxious; having one or more physical illnesses; a history of stroke; alcohol abuse; being widowed; living alone; fear regarding an inability to influence one's own dying, and a certain weariness of life (Schmitz-Scherzer, 1995; Scocco, Meneghel, Caon, Dello Buono & De Leo, 2001; Sokero, Melartin, Ryttsälä, Leskelä, Lestelä-Mielonen & Isometsä, 2005; Sullivan, Fiellin & O'Connor, 2005).
- Older adults in rural communities have limited access to geriatric mental health specialists and supportive services (e.g., day programs, housing), making collaborations between social and health services and personnel (i.e., social and health) within rural communities and outside of the community important in providing comprehensive care (McGee, Tuokko, MacCourt and Donnelly, 2005).

Together these issues underline (1) the complex intermingling of factors related to older adults' mental health that make them a unique/special population, and (2) the importance of approaches that focus on the individual, their relationships and the social context in which they live, singly and together.

BARRIERS TO ADDRESSING THE CHALLENGE

Biomedicalization of Seniors Mental Health

In that mental health problems in late life usually occur in the context of medical illness, disability and psychosocial impoverishment they are most frequently conceptualized from a holistic biopsychosocial perspective. Currently the emphasis in practice and research has been on the biomedical component of seniors' mental health which focuses on individual pathology (primarily on the diagnosis and treatment of mental illness, on cure and acute care). There has been much less investigation into the broader non-medical interventions and community-based approaches pertinent to seniors' mental health and addictions.

Inadequate Support for Non-Biomedical Research

Research related to the psychosocial component of the biopsychosocial model is often handicapped by the preference of funders for randomised control trial (RCT) methods that may not necessarily be the most appropriate for evaluating such issues as environmental milieu, relational context, quality of life and psychosocial rehabilitation, and by the preference of private industry for biomedical research. There are relatively few researchers who can provide peer review for psychosocial research proposals or can who review papers for publication, further disadvantaging the

field. When research funds are procured they are most frequently short term, and funding is seldom available to facilitate the translation of findings into practice. Without a robust body of research it is difficult to justify psychosocial approaches in practice, hindering our ability to meet the challenge of the aging population with (or at risk of) mental health problems and addictions.

Ageist Attitudes

Ageism is embedded in our social institutions and affects the priority given to seniors' needs (including how they are defined and addressed) by those funding, designing and delivering health and social services. Research suggests that many service providers, including health care professionals are ageist which is reflected in attitudes (e.g. little interest in working with older adults (e.g., therapeutic nihilism) and practice (e.g., fewer referrals for older adults to medical to mental health treatment services). Is it not likely that bodies that fund research and researchers themselves may hold similar ageist attitudes leading to lack of interest in research related to seniors? Is the size of the older population and its anticipated growth, reflected in the proportion of funding for research pertaining to them?

RECOMMENDATIONS TO MEET THE CHALLENGE

1. Increase Support for Aging Research Including Mental Health and Addictions

We recommend funding by INMAH (and other CIHR Institutes) be allocated proportionate to the prevalence of mental health disorders within population groups. For example, given that the prevalence of mental health disorders is approximately 20% in the older population (compared to 1% of younger adults), 20% of the INMAH budget should support research related to older adults' mental health and addictions.

2. Increase Recognition and Support of Psychosocial Research and It's Integration with Biomedical Research

Future RFPs should focus on psychosocial research related to seniors' mental health and addictions. Recognition of the impact of psychosocial factors on seniors' mental health and the importance of integrating these approaches within a more holistic model and concept of wellness, is imperative in meeting the mental health needs of older adults and developing preventative initiatives that will pay dividends down the road and across the lifespan. An increased emphasis on psychosocial factors pertaining to seniors' mental health would support mental health promotion and population health determinants research. The new knowledge developed would radically change the way mental health services are defined, delivered and funded, resulting in a greater emphasis on mental health promotion, prevention and the use of psychosocial approaches, leading the way to a mentally healthier older population. .

3. Implement a Seniors' Psychosocial Research Agenda.

Research Objectives:

Five areas of research have been identified. Because of the complexity of factors influencing seniors' mental health, multidisciplinary (e.g, physicians, occupational therapists, nurses, social workers, psychologists, etc), multi-method (e.g, qualitative, quantitative, individual case studies, small group, etc) research is needed. Research linking epidemiological, etiological, and intervention research that includes psychosocial perspectives is lacking. Integrative research that addresses this need and translational research that promotes the dissemination of research in this area is encouraged.

1. Social Context

The social context is the physical and relational environment in which we live; it has an impact on individuals and is in turn impacted by them. For example, a person who is socially isolated, perhaps because of mobility or transportation issues, may become depressed, which in turn may affect his relationship with his spouse in a negative way. A person with a cognitive impairment may exhibit challenging behaviours that impinge on others because of an over-stimulating or demanding environmental milieu. The National Framework on Aging identifies values that must be incorporated into the social context of older adults' lives (policy, practices, programs, attitudes, relationships etc) in order to support their mental health.

Examples of research areas include studies of:

- The impact of policies (i.e., federal, provincial, municipal, agencies / organizations) on seniors mental health
- Demographic variables and cultural and social factors (e.g., family roles, marriage, ageism, stigma, cultural values) in relation to seniors mental health
- Environmental milieu (e.g., physical design as it effects interaction, social interaction, institutional philosophy) in relation to seniors mental health
- Caregiving and social support as they impact on seniors mental health
- Community development that supports social inclusion and the mental health of older adults

2. Epidemiology and clinical studies of disorders

It is important to develop an understanding of the psychological and social consequences of the underlying aetiology of disorders as they affect people's functioning within a variety of social environments (e.g., living alone, assisted living, long term care facility). The need for such research is particularly pressing if we are to appropriately target interventions and service delivery. Studies encouraged here include those of epidemiology, the psychosocial aspects of diagnosis, lifespan development, and the evolution of psychosocial sequelae across the course of various mental disorders in older adults.

Examples of research areas include studies of:

- Health disparities so as to identify, understand, and target the burden of mental illness and related disability and to improve psychosocial interventions and service utilization among older adults of different ethnic and socio-economic backgrounds.
- Reliability, validity, and predictive value of psychosocial classifications and instruments for older adults.
- Taxonomies of functional outcomes and disabilities in older adults with mental disorders and instruments to measure functional changes following interventions
- Identification of psychosocial risk (e.g., social isolations) and protective factors (e.g., personal coping mechanisms) related to the emergence of mental disorders in later life

3. Age-Associated Events and Critical Transitions

Age-associated events and transitions (such as retirement, widowhood, reduced income, changes in health or function) can impact on mental health and challenge coping abilities. We know little about the various ways individuals cope with transitions, or why some cope better than others. Age-associated events and transitions are associated with the development of some mental illnesses (e.g., bereavement and depression): early intervention could prevent this from occurring. Different cultures, religious groups, genders (including gays, transgendered) may ascribe different meanings to age-associated transitions/events than the main stream (or each other). In our diverse society it is important to identify these understandings and their implications for older adults' mental health.

Examples of research areas include studies of:

- Identification of the impacts of age-associated normative events and critical transitions on seniors mental health
- Identification of personal and social factors that influence the development of mental health disorders arising from the experience of age-associated normative events and critical transitions
- Psychosocial interventions to prevent or ameliorate the onset or recurrence of mental disorders related to normative events and critical transitions

4. Other Intervention Research

In addition to interventions designed to ameliorate the onset or recurrence of mental disorders related to age-associated events and critical transitions, there is a need to examine the broad range of psychosocial interventions and their impact on the mental health of older adults. Interventions are defined here to include preventative treatment, service systems, and rehabilitative interventions.

Examples of research areas include studies of:

- Long-term and short-term psychosocial treatment outcomes for mental disorders including suicide and suicidal behaviours
- Differences among older persons with mental health disorders in compliance, values, intervention preferences, expectations, and service use
- Psychosocial influences (e.g., social relationships, social supports, personality factors, geographic location, culture) and their impact on intervention response
- Psychosocial interventions targeting the early manifestations or behavioural precursors of depression, anxiety, agitation, dementia, other behavioural disorders (e.g., aggression) and suicidality.
- Psychosocial intervention aimed at multiple co-occurring conditions in older adults with or at risk for mental disorders (e.g., substance abuse, elder abuse, co-morbid disease, developmental disorders)

5. Health Service Delivery Research

There are a variety of models that underlie the delivery of services to older adults. Some of these address mental health concerns directly (e.g., mental health services) and some address other areas of concern but have an impact on mental health (e.g., home support). There is little research examining the impact of these services on seniors' mental health in the context of, for example, system costs, organizational structure or host community. Similarly, there is little research examining the adequacy of the implementation of different models of care (e.g., Eden alternative, psychosocial rehabilitation), or comparing these in terms of adequacy of outcomes (e.g., cost, reduction of aberrant behaviours, quality of life).

Examples of research areas include studies of:

- Identification and evaluation of service delivery models that promote seniors' mental health incorporating psychosocial approaches
- Articulation and evaluation of the optimal mental health care team to promote and support mental health (i.e., composition, roles, functioning, implementation of philosophy) in different contexts (e.g., institutions, community, rural).
- Evaluation of the implementation of service delivery models/philosophy of care that incorporates psychosocial approaches.
- The supports (e.g., education, staff to client ratios, specialized consultations) required to recruit and retain care providers who are able to support the mental health of older adults.
- The supports (e.g., education, resources) required to support family caregivers of seniors with mental health disorders.

REFERENCES

- Baldwin, R., Anderson, D., Black, S., Evans, S., Jones, R., Wilson, K et al (2003). Guidelines for the management of late-life depression in primary care. International Journal of Geriatric Psychiatry, 18: 829-838. .
- Banerjee, S. (1998). Needs of special groups: the elderly. International Review of Psychiatry, 10, 130-133.
- Banarjee, S., Shamash, K., MacDonald & Mann, A. (1996). Randomized control trial of effect of intervention by psychogeriatric team on depression in frail elderly people at home. British Medical Journal, 313: 1058-1061.
- Bartels, S. (2004) Caring for the whole person: Integrated health care for older adults with severe mental illness and medical comorbidity. JAGS, 52, 5249-5257.
- Bartels, S., Miles, K. & Dums, A. et al (2003) Factors associated with community mental health service use by older adults with severe mental illness. Journal of Mental Health and Aging, 9: 123-135.
- Bharucha, A.J., & Satlin, A. (1997). Late-life suicide: A review. Harvard Review of Psychiatry, 5 (2), 55-65.
- Blazer, D. (2000). Psychiatry and the older adult. Am.J. Psychiatry, 157, 1915-1924
- British Columbia Ministry of Health (2002) Guidelines for Best Practices in Elderly Mental Health Care in British Columbia, Victoria.
- Brown, G., Bruce, M., Pearson, J., and PROSPECT study Group. (2001). High-risk management guidelines for elderly suicidal patients in primary care settings. International Journal of Geriatric Psychiatry, 16: 593-601.
- Buchanan, D., Farran, C., & Clark, D. (1995). Suicidal thought and self-transcendence in older adults. Journal of Psychosocial Nursing and Mental Health Services, 33 (10), 31-34.
- Callahan, C. (2001). Quality improvement research on late life depression in primary care. Med. Care 39 (8): 772-784.
- Canadian Mental Health Association (2002). Supporting seniors' mental health: A guide for home care staff. CMHA, Toronto.
- Caplan, G, Caplan, R. (1993). Mental health consultation and collaboration. San Francisco (CA): Jossey-Bass Publishers.
- Clyburn, L.D., Stones, M.J., Hadjistavropoulos, T., & Tuokko, H. (2000). Predicting caregiver burden and depression in Alzheimer's disease. Journals of Gerontology Series B - Psychological Sciences and Social Sciences, 55 (1), S2-S13.
- Devons, C.A. (1996). Suicide in the elderly: How to identify and treat patients at risk. Geriatrics, 51 (3), 67-72.
- Donie, J. (2004). The relationship between diabetes and depression: Improving the effectiveness of case management. Lippinkott's Case Management, 9 (4), 177-183.
- Dugan, E., & Kivett, V.R. (1994). The importance of emotional and social isolation to loneliness among very old rural adults. Gerontologist, 34 (3), 340-346.

Dugue, M. (2003). Growing body of health services research paints picture of mental health care system for older adults. Geriatric Psychiatry News, Sept-Oct, 9

Forbes, A. (1996). Caring for older people: Loneliness. British Medical Journal, 313, 352-354.

Fischer, L., Wei, F., Solberg, L., Rush, W. & Heinrich, R. (2003). Treatment of elderly and other older adult patients for depression in primary care. JAGS 51:1554-1562.

Gallo, J & Coyne, J. (2000) The challenge of depression in late life. JAMA, 284,(12) 1570-1572.

Gomez, G.E., & Gomez, E.A. (1993). Depression in the elderly. Journal of Psychological Nursing and Mental Health Services, 31 (5), 28-33.

Health Canada (2002) Best practices: Treatment and rehabilitation for seniors with substance use problems. Minister of Health, Ottawa.

Jeste, D., Alexopoulos, G., Bartels, S., Cummings, J., Gallo, J., Gottlieb, J., et al (1999). Consensus statement on the upcoming crisis in geriatric mental health research agenda for the next two decade. Archives of General Psychiatry, 56: 848-53.

Klinkman, M., Okkes, I. (1998). Mental health problems in primary care: A research agenda. Journal of family Practice, 47:379-384.

Lepine, J.P. & Bouchez, S. (1998). Epidemiology of depression in the elderly. International Clinical Psychopharmacology, 13 (Supplement 5), S7-S12.

Livingston, G., Manela, M., & Katona, C. (1996). Depression and other psychiatric morbidity in carers of elderly people living at home. British Medical Journal, 312, 153-156.

MacCourt, P. & Tuokko, H. (2005). Development of a Seniors' Mental Health Policy Lens: An Analytical Tool to Assess Policies and Programs from a Seniors' Mental Health Perspective. Submitted for publication.

McGee, P., Tuokko, H., MacCourt, P. & Donnelly, M. (2005). Factors affecting the mental health of older adults in rural and urban communities. Canadian Journal of Community Mental Health, In press

Monks, R., Somers, S., Schovaneck, S. & Thompson W. (2004). Psychogeriatric outreach treatment. CPA Bulletin, September, 13-15.

Penninx, B., van-Tilburg, T., Kriegsman-Didi, M., Boeke A., Deeg-Dorly, J. & van-Eijk-Jacques, T. (1999). Social network, social support, and loneliness in older persons with different chronic diseases. Journal of Aging and Health, 11 (2), 151-168.

Prévile M, Boyer R, Hébert R, Bravo G, Seguin M. (2005). Correlates of suicide in the older adult population in Quebec. Suicide and Life Threatening Behavior, 35(1): 91-105.

Rane-Szostak, D., & Herth, K.A. (1995). A new perspective on loneliness in later life. Issues in Mental Health Nursing, 16 (6), 583-592.

Reynolds, C. (2003). Meeting the mental health needs of older adults in primary care: How do we get the job done? Clinical Psychology: Science and Practice, 10, 1029-111.

Rokach, A. (2000). Perceived causes of loneliness in adulthood. Journal of Social Behavior and Personality, 15(1), 67-84.

Salib, E., Rahim, S., El-Nimr, G. & Habeeb, B. (2005). Elderly suicide: an analysis of coroner's inquests into two hundred cases in Cheshire 1989 - 2001. British Medical Science & Law, 45(1): 71-80.

Samuelsson, G., Andersson, L. & Hagberg, B. (1998). Loneliness in relation to social, psychological and medical variables over a 13-year period: a study of the elderly in a Swedish rural district. Journal of Mental Health and Aging, 4(3), 361-378.

Schmitz-Sherzer, R. (1995). Reflections on cultural influences on aging and old-age suicide in Germany. International Psychogeriatrics, 7 (2), 231-238.

Scocco, P., Meneghel, G., Caon, F., Dello Buono, M., & De Leo, D. (2001). Death ideation and its correlates: Survey of an over-65-year-old population. Journal of Nervous and Mental Disease, 189 (4), 210-218.

Sokero, T., Melartin, T., Rytysälä, H., Leskelä, U., Lestelä-Mielonen, P. & Isometsä E. (2005). Prospective study of risk factors for attempted suicide among patients with DSM-IV major depressive disorder. British Journal of Psychiatry 2005; 186: 314-8.

Somers, S. (1998). Community collaborative planning model: Enhanced case management project. Ottawa: Health Transition Fund, Government of Canada.

Stock, R., Reece, D. & Cesario, L. (2004). Developing a comprehensive interdisciplinary senior healthcare practice. J. Am. Geriatrics Society 52:2128-2133.

Sullivan LE, Fiellin DA, & O'Connor PG. (2005). The prevalence and impact of alcohol problems in major depression: A systematic review. American Journal of Medicine, 118(4): 330-41.

Sullivan, M., Kessler, L., LeClair, J., Stolee, P & Whitney, B. (2004). Defining best practices for speciality geriatric mental health outreach services: Lessons for implementing mental health reform. Canadian Journal of Psychiatry, Vol. 49, No. 7, July, 458-66.

Tuokko, H., Donnelly, M., & MacCourt, P. (2001). Meeting the Mental Health Needs of Older British Columbians.

Unutzer, J. (2002) Diagnosis and treatment of older adults with depression in primary care. Biol. Psychiatry, 52: 285-292.

Unutzer, J., Katon, W., Callahan, C., Williams, J., Hunkeler, E. et al (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. JAMA, 288: 2836-2845.

Von Korff, M. & Goldberg, D. (2001) Improving outcomes in depression. British Medical Journal, 323, 948-949.

Waterreus, A., Blanchard, M. & Mann, A. (1994). Community psychiatric nurses for the elderly: well tolerated, few side-effects and effective in the treatment of depression. Journal of Clinical Nursing, 3, 299-306.

Wilkins, K., & Park, E. (1996). Chronic conditions, physical limitations and dependency among seniors living in the community. Health Reports, 8 (3), 7-15.

World Health Organization and World Psychiatric Association.(1998). Organization of care in psychiatry of the elderly-a technical consensus statement. Geneva(Switzerland). Division of Mental Health and Prevention of Substance Abuse, WHO.