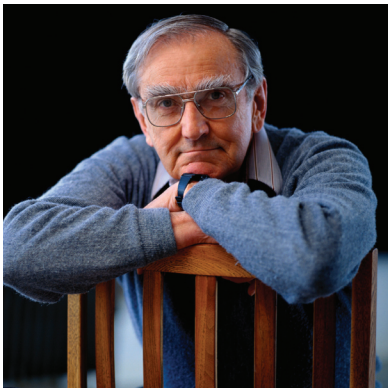
Promoting Seniors' Well-Being:

The Seniors' Mental Health Policy Lens Toolkit



An evidence based practical instrument for developing policy, legislation, programs and services that promote and support the well-being and mental health of all older adults.

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B.C. Psychogeriatric Association

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INTRODUCTION

The World Health Organization has defined **mental health** as a state of **well-being** in which the individual realizes his or her own potential, can cope with the normal stresses of life, can live productively and fruitfully, and is able to make a contribution to her or his own community (WHO, 2002).

Mental health can be promoted and supported (or neglected and undermined) wherever the individual is situated on the continuum. Good mental health enables seniors to realize their fullest potential and to cope with life transitions and major life events, while poor mental health has the opposite effect.

Although mental health is an individual resource, it is influenced by a complex interplay of individual characteristics, and cultural, social, economic and family circumstances at both the macro (society) and micro (community and family) levels (Centre for Addictions and Mental Health, 2007), all of which make up the social context in which seniors live.

Seniors' social context is in part shaped by policy: the guidelines, regulations or parameters that govern social life and determine what resources, services and goods are distributed, and to whom. Policy is relevant to service delivery (e.g., wait lists for long term care facilities), to programs (e.g., eligibility criteria for Home Care services), to organizations (e.g. Health Authority Dementia strategies), and to government legislation, (e.g., Old Age Security), that affect seniors.

Purpose

The **Seniors' Mental Health Policy Lens** has been designed to promote and support the mental health and well-being of all seniors.

- It is a set of questions to identify (or predict) any direct or indirect negative repercussions of policies, programs and services (in place or proposed), on seniors' mental health.
- It supports the development or analysis of any policy or program relevant to seniors, including those that do not directly target either mental health or seniors
- Its' implementation has been evaluated as a best practice in policy design to support seniors' mental health.

Who Should Use the Seniors' Mental Health Policy Lens

The Seniors' Mental Health Policy Lens can be used by policy makers and analysts, program managers, evaluators, service providers, seniors' organizations and advocates, researchers and educators.

When to Use the Seniors' Mental Health Policy Lens

The Seniors' Mental Health Policy Lens can be applied, for a variety of purposes, to policies and programs that directly or indirectly affect seniors.

- To guide the development of new programs and policies
- To review existing policies and programs for potential unintended negative effects
- To identify gaps in current policies and programs for seniors
- To evaluate policies and programs from the perspective of seniors' values and needs
- As a guide to developing a response to an issue or need
- To raise awareness about the mental health challenges that seniors in general, and marginalized seniors in particular, may face.
- To build awareness about the influence of policies and programs on seniors mental health
- To build a shared understanding of seniors' values and concerns, and of factors that can influence their mental health
- To complement quality assurance programs, accreditation processes and program reviews.

Organization of This Toolkit

There are 5 sections in this Toolkit. First, a rationale is provided for why a Seniors' Mental Health Policy Lens is needed. Second, the development of the Seniors' Mental Health Policy Lens and its' evaluation, is described. Third, the Seniors' Mental Health Policy Lens is presented with directions for its' application. Fourth, three appendices provide (1) a guide to interpreting the Seniors' Mental Health Policy Lens questions that incorporates examples of how the Seniors' Mental Health Policy Lens has been applied in a variety of sectors; (2) feedback and tips for applying the Seniors' Mental Health Policy Lens from those who have used it, and (3) an informative discussion of seniors' perspective related to supporting their mental health, and of the values, principles and key concepts that inform the Seniors' Mental Health Policy Lens questions.

I. Rationale for Development of the Seniors' Mental Health Policy Lens

Several concerns have led to the need for a lens to assess policy from a seniors' mental health perspective, each of which can be addressed through the use of the Seniors Mental Health Policy Lens.

Aging Population

Older adults experience unique physical, psychological and social changes that individually and together may challenge their mental health, sometimes resulting in mental illness. It is estimated that 1 in 5 persons aged over 65 years has a mental health disorder (Jeste, Alexopoulos, Bartels, Cummings, Gallo, Gottlieb, et al (1999). Given that the percentage of the population over age aged 65 in Canada is expected to increase from 13% to 22% between 2006 and 2026 (Trucotte & Schellenberg, 2007), there will be an increasing number of seniors who experience mental health problems, or are at risk of doing so (Sullivan, Kessler, LeClair, Stolee, & Whitney (2004).

The Seniors' Mental Health Policy Lens is intended to facilitate social environments (including health services) that promote and support the mental health of older adults, reducing the likelihood of mental health problems occurring.

Lack of Seniors Input into Policy and Programs Affecting Them

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 to: (1) reduce supports that older adults consider important to their well-being, and (2) re-orient services in a way that detracts from good mental health by, for example, limiting access to services (Canadian Mental Health Association, 2002). The Seniors' Mental Health Policy Lens incorporates seniors' values and perspectives about the mental health challenges of aging, identified through this project and others. The Seniors' Mental Health Policy Lens is intended to ensure that policy and programs are assessed against the values and priorities that older adults have identified as important to their mental health.

The Seniors' Mental Health Policy Lens is intended to give voice to seniors, highlight seniors' strengths, support their social inclusion and promote their mental health.

Marginalization and Stigmatization

Negative stereotyping of older adults fosters and promotes age discrimination and perpetuates ageist attitudes. Ageism may affect the priority given to seniors' needs (including how they are defined and addressed) by those funding, designing and delivering health and social services (Estes, 2001).

Seniors who are part of marginalized groups may experience over-lapping stigma. For example, a senior who is gay and First Nations may experience homophobia and racism along with ageism. Additionally, there is a significant stigma attached to mental health problem and illness that can further contribute to poor mental health. This stigma is apparent in the inequitable allocation of medical and non-medical resources for older adults with mental illness and addictions in comparison to other illnesses such as diabetes and cancer.

If biases in policies are unrecognized, this can lead to inadequate planning and design of legislation, programs, services and interventions, costly in both human and economic terms.

The Seniors' Mental Health Policy Lens is intended to identify biases in policy that may lead to negative impacts on the mental health of older adults, including those who are members of marginalized groups.

Biomedical Framing of Seniors' Mental Health

Current policy (and funding) related to seniors' mental health is typically situated within a biomedical model which emphasizes individual pathology and leads to services and programs that focus primarily on the diagnosis and treatment of illness (MacCourt, Tuokko and Tierney, 2002). Although the needs for many seniors are chronic and often related to disability or deficits in their social support system or environment, there is a narrow focus on cure and acute care. Relatively little emphasis (or money) has been put into non-medical interventions or community-based services to promote or support seniors' mental health, such as programs to reduce social isolation or to support caregivers. The newly formed Mental Health Commission of Canada (2008) advocates taking a comprehensive approach to mental health and mental illness – one that encompasses re-orienting the mental health system towards a recovery model rooted in person-centred care, respect for

individuals' rights, and that focuses on strengths and capacities. By applying the Seniors' Mental Health Policy Lens to policies and programs related to health (e.g. discharge policies for acute care; home support services), the non-biomedical factors that contribute to the mental health of older adults are highlighted and can be addressed.

The Seniors' Mental Health Policy Lens is intended to facilitate a paradigm shift in the way health and social services are defined, delivered, and funded that will result in increased emphasis on recovery, mental health promotion and on the prevention of mental health problems.

II. Development and Evaluation of the Seniors' Mental Health Policy Lens

Development of the Seniors' Mental Health Policy Lens

The Seniors' Mental Health Policy Lens was developed as part of a national project, *Psychosocial Approaches to the Mental Health Challenges of Late Life*, awarded to the British Columbia Psychogeriatric Association by the Population Health Fund (MacCourt and Tuokko, 2005).

The Seniors' Mental Health Policy Lens was designed to reflect the values and perspectives of older adults and to facilitate their inclusion in policy design and analysis. To gather this information twelve focus groups were conducted with older adults across Canada (in English, French and Chinese). Participants were asked to identify what they considered the challenges of aging to their well-being and mental health, how they meet these challenges and what is helpful or unhelpful to them. In addition, findings from other pertinent Canadian studies of older adults were examined for seniors' perspectives about the factors influencing their emotional well-being/mental health. The development of the Seniors' Mental Health Policy Lens also took into consideration: the population health determinants, principles of mental health promotion and of healthy aging policy, and the values and core principles embedded in the *Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities* (B.C. Ministry of Health, 2002), the *National Framework for Aging: A Policy Guide* (Health Canada, 1998), and the Framework for a Mental Health Strategy for Canada (Mental Health Commission of Canada, 2008). Each of these components is discussed in Appendix 3.

Evaluation of the Seniors' Mental Health Policy Lens

The implementation of the Seniors' Mental Health Policy Lens has been evaluated at 15 sites across sectors (i.e., in government, seniors' organizations, health care, education and programs for older adults) throughout Canada. The pilot studies have demonstrated that the Seniors' Mental Health Policy Lens is a practical, relevant and useful tool for designing policies, identifying gaps in existing policy, educating future health professionals, guiding the development of new programs, and evaluating service delivery, from the perspective of seniors' values. Participants found it valuable that the Seniors' Mental Health Policy Lens is principle-based which allowed them to interpret its' questions in relation to their context, while retaining the integrity of the tool. It was noted that use of the Seniors' Mental Health Policy Lens prompted the inclusion of seniors and their advocates in designing and reviewing programs and policies that affect them. The Seniors' Mental Health Policy Lens is designed as a process tool and has proven valuable in helping stakeholders, with varied perspectives and interests related to older adults' well-being, to find common ground so that they can work together effectively. The process of applying the Seniors' Mental Health Policy Lens has been reported to develop awareness about the factors that influence seniors' well-being and mental

health. Participants who used the Seniors' Mental Health Policy Lens in health care settings found that it fit well with practices they already undertake (e.g., quality assurance programs, accreditation) making it relatively easy to integrate into their work. Educators found that the Seniors' Mental Health Policy Lens provided their students (future health professionals) with a critical lens for examining issues related to seniors' well-being.

The experiences of the pilot sites in promoting and implementing the Seniors' Mental Health Policy Lens has been used to re-develop the Seniors' Mental Health Policy Lens as a best practice in program and policy design. Feedback from the pilot groups about the strengths and weaknesses of the Seniors' Mental Health Policy Lens has been incorporated into this Seniors' Mental Health Policy Lens Toolkit which was then presented at a number of conferences, where further feedback was received. Next, a symposium was held to share experiences about applying the Seniors' Mental Health Policy Lens and to identify the benefits and challenges of doing so. This information was then used to refine the Seniors' Mental Health Policy Lens and to design materials to support the implementation of the Seniors' Mental Health Policy Lens in diverse settings and for different purposes, all found in this Toolkit. Examples of how the Seniors' Mental Health Policy Lens has been applied are incorporated into the *Guide to the Application of the Seniors' Mental Health Policy Lens* section of this Toolkit (Appendix 1). Appendix 2 provides feedback and tips for applying the Seniors' Mental Health Policy Lens from those who have used it.

III. SENIORS' MENTAL HEALTH POLICY LENS (SMHPL)

INSTRUCTIONS

You may refer to the *Guide to the Application of the Seniors Mental Health Policy Lens* (Appendix 1) for explanations of the questions and examples of how others have applied them.

PREPARATION

Describe the Policy/Program

Review the purpose and objective of the policy/program to which the SMHPL is being applied.

_____

_____

_____

Consider the Seniors' Populations Affected by the Policy/Program

Who are the senior populations likely to be most affected by the policy/program/practice? (Think about those who are seniors today as well as those who will be seniors in the future).

_____

_____

_____

Think about these seniors as you respond to each of the SMHPL questions

APPLY THE SENIORS MENTAL HEALTH POLICY LENS

Beside each question in the SMHPL check Yes, No, or Not Sure, NA (Not Applicable), according to what you believe your policy reflects.

Be sure to keep notes as you go about areas where you require more information and your plans for obtaining it.

I Process Factors

1. Seniors' Involvement

❑ How are seniors, seniors' advocates and seniors organizations involved in the design/review of the policy/program?

Seniors' Involvement	Yes	No	Not Sure	N/A
Are mechanisms in place for seniors to be consulted and actively involved in the design, implementation, and evaluation of policies and programs that affect them?				

❑ Who needs to be involved?

Notes

2. Collaboration

❑ Are key organizations/Ministries, interest groups or individuals involved?

Stakeholder Involvement	Yes	No	Not Sure	N/A
Does the policy/program emphasize partnership and collaboration with key stakeholders?				
Are relevant organizations (government and non-government, voluntary, private) and Ministries engaged?				

❑ Who else needs to be involved?

Notes

II Assessing Policy/Program Content

1. Diversity and Marginalization

- ❑ Assess whether any seniors are likely to experience inequities or negative impacts resulting from their memberships in marginalized groups

Does this policy/program avoid negative effects for seniors who are:	**Yes**	**No**	**Not Sure**	**N/A**
Gay, lesbian or transgendered				
Members of an ethnocultural, linguistic, religious,				
and/or racial minority				
Women				
Men				
Low-income				
Mentally ill				
Cognitively impaired				
First Nations				
Physically disabled (e.g., mobility, vision, hearing)				
Chronically ill				
Institutionalized				
Developmentally disabled				
Experiencing addictions				
Immigrants (as seniors)				
Employed (paid or volunteer)				
Over age 85				
Other				

Notes

2. Transition and Challenges

- ❑ Consider whether the seniors likely to be affected by the policy/program are impacted by any of the transitions or challenges below. If so, consider whether the potential negative effects are taken into account/addressed.

Does the policy/program address any potential negative impacts that the following experiences may have on seniors' mental health?	**Yes**	**No**	**Not Sure**	**N/A**
Bereavement				
Relocation				
Isolation (social or geographic)				
Decline in health, sensorium, or physical or cognitive functioning				
Family status (single, childless)				
Inadequate social support networks (weak, dysfunctional)				
Inadequate social environment (e.g., deprived, unsafe, conflicted)				
Caregiving				
Living situation (homeless, alone, long-term care institution, hospital)				
Experiencing ageism				
Other				

Notes

3. Accessibility

- ❑ Does the policy/program remove any handicaps and make appropriate adaptations to accommodate needs and to enable participation.?

	Yes	**No**	**Not Sure**	**N/A**
Is accessibility facilitated by sufficient staff/volunteers?				
Is eligibility and other relevant information about access presented clearly and simply?				
Is pertinent information readily available that is appropriate to the seniors affected? (Taking into account literacy, health literacy, vision/hearing impairments, language, culture)				
Are any physical barriers removed for seniors with impairments (mobility, visual, hearing)				
Is it affordable?				
Are sufficient resources likely to be available in a timely manner?				
Is transportation readily available?				

Notes

4. Participation and Relationships

❑ Does the policy/program promote and support seniors' relationships and their social participation?

Does the policy/program	Yes	No	Not Sure	N/A
Remove any barriers (e.g. financial, technological, institutional, attitudinal, etc.) to seniors' social and civic participation?				
Facilitate access to seniors' social network of family and friends?				
Facilitate access to seniors' community (e.g. cultural; geographic and spiritual)?				
Promote/support a sense of belonging/mattering?				

Notes

5. Self-Determination and Independence

❑ Does the policy/program/practice promote and support seniors' self-determination and independence?

Does the policy/program	Yes	No	Not Sure	N/A
Provide opportunities to make choices?				
Provide support (information, time, encouragement, resources) to facilitate choices and informed decision making?				
Promote coping skills/strengths?				
Build on the capacity of seniors to adjust to different circumstances?				
Enable seniors to make the most of their abilities? (Compensate for mobility issues, sensory changes, etc)				
Provide a full continuum of options when offering choices and to inform decisions?				
Promote resiliency?				
Promote recovery and hope?				

Notes

6. Respect and Dignity

❑ Does the policy/program reflect respect for seniors and support their dignity?

Does the policy/program	Yes	No	Not Sure	N/A
Promote seniors' self- esteem?				
Support seniors' dignity?				
Respect privacy and confidentiality?				
Demonstrate respect for seniors?				
Acknowledge the uniqueness of each individual?				
Portray seniors positively?				

Notes

7. Fairness and Equity

❑ Is the policy/program fair to seniors in the context of the public good?

Is the policy/program fair?	Yes	No	Not Sure	N/A
Are the procedures and criteria inherent in the policy fair and reasonable?				
Does it consider individual versus collective needs?				

Notes

8. Security

❑ Does the policy/program facilitate seniors' psychological, physical and economic security?

Does the policy/program	Yes	No	Not Sure	N/A
Provide the security of being able to plan for future (for appropriate care, housing, services and end of life).				
Provide a sense of safety?				
Facilitate psychological security?				
Reduce the risks of crime, disease or injury?				
Facilitate physical security?				
Facilitate economic security?				

Notes

9. Protection and Risk Management

- ❑ Does the policy/program provide seniors with the security of knowing that when needed, assistance is available?

Does the policy/program	Yes	No	Not Sure	N/A
Facilitate appropriate interventions to protect seniors when warranted?				
Provide for the timely and effective management and communication of risks?				
Provide for the reduction of risks to seniors' health, security and well-being?				
Ensure that the least intrusive measure (given the risks) is taken?				
Ensure that the preferences of seniors are taken into account as much as possible?				
Respect and protect seniors' legal rights?				

Notes

10. Evidence-Informed

- ❑ Is the policy/program informed by evidence?

Does the policy/program	Yes	No	Not Sure	N/A
Is it based on current evidence and/or best practices?				
Can it be evaluated for process and outcome?				

Notes

III CREATING AN ACTION PLAN

1. Summate the columns - How are we doing? Where can we improve?

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 changes that will yet increase the number of "Yes" responses.

NO>YES? This is an opportunity for reflection about the policy/program. Examine the policy/program for content and overall intent. It appears that what is important to seniors may not be fully addressed. It would be useful to ask seniors and their advocates to provide imput.

NOT SURE> Either YES or NO You need to gather more information before proceeding with your policy/program. This will ensure it more comprehensive and holistic.

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

2. Review your notes and your discussions. Note strengths of the policy/program:

_____

_____

_____

_____

3. Identify the individual areas that require improvement 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. Set target dates.

Issues Identified	Actions/Information Needed	Who needs to be involved	Target date

4. Make a Recommendation

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

Recommendation	**Yes**	**No**
Accepted		
Accepted as revised		
Need more information to decide from whom, where		
Needs revision		

5. Revise the policy, and re-apply the lens, starting at the beginning. Repeat until the (revised) policy is recommended for acceptance.

APPENDIX 1

A Guide to the Application of the Seniors' Mental Health Policy Lens

Following are explanations for each section of the Seniors' Mental Health Policy Lens (SMHPL). In order to illustrate the diverse range and broad scope to which the SMHPL is relevant, examples are provided that are drawn from the application of the SMHPL in a variety of settings, for different purposes and by a mix of users. The examples are in italics.

Preparation

Policy Description

Review the purpose and objective of the policy/program to which the SMHPL is being applied. In some instances specific sections of the SMHPL may need to be given more or less weight in reviewing section scores and in making recommendations. The SMHPL questions are structured so this can be done without compromising its' integrity.

The SMHPL was implemented to design a community nutrition program intended to maximize seniors' independence by ensuring they can get proper food without moving into an institutional environment. In this instance, as the goal was independence, the closest attention was paid to the Independence questions/scores.

Consider the Seniors' Population Affected by the Policy/Program

Before applying the SMHPL, having current knowledge about the population of seniors who are most likely to be affected by the policy is important. **(This could be seniors today and/or those who will be seniors in the future.)** This will ensure that the policy will be appropriate to those at whom it is directed. Think about these seniors as you consider each of the SMHPL questions.

I Process Factors

Although the SMHPL questions are presented as a checklist they are intended to stimulate thinking and support discussion. The implementation of the SMHPL is most valuable when done in collaboration with those affected.

Involving seniors and other relevant stakeholders can add considerable value by:

- ensuring consideration of the perspectives of all stakeholders affected, especially seniors
- developing an understanding of each other's perspectives
- finding common ground
- facilitating a sense of ownership of any changes/initiatives that result
- establishing credibility within various sectors of the community
- helping to ensure that the results are accessible and appealing to those affected.

1. Seniors' Involvement

Seniors involvement in decisions affecting them is a central tenet of the SMHPL. They have a wealth of experience to share and are experts in their own lives. Their input is required to ensure that programs and services affecting seniors are informed by seniors and reflect their values.

❑ How are seniors, seniors' advocates and seniors' organizations involved in applying the SMHPL

Seniors' Involvement	Yes	No	Not Sure	N/A
Are seniors affected by the policy/program involved in the policy analysis/creation?				
Are seniors' organizations and advocacy groups involved/consulted?				
Are mechanisms in place for seniors to be consulted and actively involved in the design, implementation, and evaluation of policies and programs that affect them?				

A coordinator for a municipal leisure centre used the SMHPL to review their programs and determined that they needed to improve accessibility for older adults, particularly those isolated by transportation needs. To strategize how to address accessibility she invited seniors' organizations, local businesses, voluntary organizations and the city transit corporation to assist. This resulted in a variety of novel services and subsidies to suit individual needs. Seniors were then involved in evaluating the new approaches.

2. Collaboration

Given the complexity of interwoven factors that can affect seniors' mental health and well being (e.g., social isolation, transportation, low income), seniors' organizations, seniors' advocates, various levels of government, Ministries and non-governmental organization may all need to be involved in policy development or analysis.

❑ Are key organizations/Ministries, interest groups or individuals involved?

Stakeholder Involvement	Yes	No	Not Sure	N/A
Has the policy been developed in collaboration with stakeholders who will be affected?				
Does the policy/program emphasize partnership and collaboration?				
Are relevant organizations (government and non-government, voluntary, private) and Ministries engaged?				

In one province the Ministry of Health applied the SMHPL to drafts of their Chronic Pain and Chronic Disease Prevention and Management Strategies which set out broad key directions and strategies to guide policy, program / services development, funding, and multi-sectoral collaboration. Their experience with the SMHPL led them to re-consider the representativeness of their Advisory Groups, (adding seniors' organizations and community agencies), and to make some significant changes to content. They also added the SMHPL to the provincial implementation plan as an action item for strategies related to older adults.

II Assessing Policy/Program Content

1. Diversity and Marginalization

The seniors' population is heterogeneous and made up of many different groups, some of which are marginalized and vulnerable, and each of which has diverse needs, circumstances, and aspirations. Often seniors belong to more than one group. (This and the transition section also incorporates some of the determinants of health—see Appendix 2 for more information.)

- if the policy/program/practice applies to all seniors a review of how the determinants of health and normative events and transitions affect seniors generally, and of seniors' perspectives about the mental health challenges of aging, should be carried out. (See Appendix 2, Conceptual Framework).

- if the population of seniors affected is composed of, for example First Nations seniors, seniors who have a mental illness or other vulnerable groups, additional research may be necessary to determine what inequities they may experience or special issues and challenges they face.

❑ Assess whether any seniors are likely to experience inequities or negative impacts resulting from their memberships in marginalized groups.

Does this policy/program avoid negative effects for seniors who are:	**Yes**	**No**	**Not Sure**	**N/A**
Gay, lesbian or transgendered				
Members of an ethnocultural, linguistic, religious, and/or racial minority				
Women				
Men				
Low-income				
Mentally ill				
Cognitively impaired				
First Nations				
Physically disabled (e.g., mobility, vision, hearing)				
Chronically ill				
Institutionalized				
Developmentally disabled				
Experiencing addictions				
Immigrants (as seniors)				
Employed (paid or volunteer)				
Other				

The SMHPL was used to frame research about the needs of caregivers of older adults with persistent mental illness and addictions. Caregivers and service providers reported that older adults with addictions faced significant stigma, often were poor, suffering from chronic health problems, and faced discrimination in accessing seniors services, health care services and housing. Caregivers and service providers were tainted with the stigma of mental illness and addictions as well.

The findings from the research were presented to the health authorities involved with recommendation for addressing the inequities.

Mental health is influenced by interacting personal, environmental and societal factors –the determinants of health (i.e., gender, income and social status, quality of social support networks, personal health practices and coping skills, adequacy of the physical and social environments and access to health services), that accumulate as individuals go through life.

The SMHP was applied by a First Nations organization to frame the development of a program to promote healthy aging. It was recognized that First Nations people have a higher prevalence of diabetes, lower income, and often impoverished physical environments when compared to other Canadians. The uniqueness and importance of First Nations' cultural practices (including food preferences, respect for elders, oral traditions) and spiritual practices were recognized. All of these factors were taken into account to design a mental/health promotion program that built on seniors' strengths and reduced barriers to participation.

2. Transitional Challenges

Age related normative events, critical transitions and other events may pose increased challenges to some seniors' mental health. The SMHPL can be used to raise awareness about this and to target services to these seniors. For example:

- A woman living in a rural area and caring for her husband with dementia at home is vulnerable to negative changes in health (physical and mental) and social isolation, both of which may be compounded by limited respite and other resources. If she also has a low income she will not be able to purchase services privately.
- A man who has lost his wife and with distant relationships with his children (or no children) may become socially isolated and at risk for suicide.

❑ Consider whether the seniors likely to be affected by the policy/program are impacted by any of the challenges below. If so, consider whether the potential negative effects are taken into account/addressed.

Does the policy/program address any potential negative impacts that the following experiences may have on seniors' mental heath?	Yes	No	Not Sure	N/A
Bereavement				
Relocation				
Isolation (social or geographic)				
Poor health status				
Significant impairments in hearing and/or vision				
Family status (single, childless)				
Inadequate social support networks (weak, dysfunctional)				
Inadequate social environment (e.g., derived, unsafe, conflicted)				
Caregiving				
Living situation (homeless, alone, long-term care institution, hospital)				
Experiencing ageism				
Other				

The discharge policies of a general hospital were reviewed with the SMHPL after a recently bereaved elderly man, treated for cardiovascular problems, was discharged to his farm where he lived alone and committed suicide. It was found that this seniors' social situation was not taken into account at discharge. This resulted in a policy that seniors with risk factors (above) would not be discharged without social work involvement to develop a plan for a supported discharge.

3. Accessibility

Accessibility is about removing any social, cultural, economic or physical barriers to programs so that seniors are aware of them and can choose to use them. Information, communication and adaptations appropriate to the seniors likely to be affected by the policy/program will enable seniors to make the most of their abilities and facilitate access.

- Brainstorm ways that the policy/program might unintentionally impede seniors' access—be creative.

One group recognized that their voice messaging system discouraged some seniors from contacting their program; so they removed it. Another group realized that where they were advertising their program was not reaching many of the seniors eligible for their service. Poor lighting in a leisure centre was recognized as a barrier to seniors with low vision.

❑ Does the policy/program remove any handicaps and make appropriate adaptations to accommodate needs and to enable participation?

	Yes	No	Not Sure	N/A
Is accessibility facilitated by sufficient staff/volunteers?				
Is eligibility and other relevant information about access presented clearly and simply?				
Is pertinent information readily available that is appropriate to the seniors affected? (Taking into account literacy, health literacy, vision/hearing impairments, language, culture)				
Are any physical barriers removed for seniors with impairments (mobility, visual, hearing)				
Is it affordable?				
Are sufficient resources likely to be available in a timely manner?				
Is transportation readily available?				

A seniors' centre, concerned about a lack of participants, applied the SMHPL to their program. They discovered that information about the program (provided in pamphlets) was not reaching many of the seniors in the community who were members of ethnocultural minorities, had low levels of literacy or low vision. They addressed these issues by providing information in different languages and in large print. They also worked with ethnocultural groups to ensure their promotional materials, food and activities were culturally appropriate, and to promote the program to their communities. Together these activities increased participation in their centre.

Use of the SMHPL has guided a rural municipality to recognize the risk of social isolation and related mental/health risks that resulted from lack of affordable and appropriate transportation compounded by geographic location and weather. This resulted in a multi-stakeholder meeting that developed a grant program for innovative solutions to transportation issues.

4. Participation and Relationships

Seniors value getting involved and 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, and in decisions/initiatives in all spheres, not just those specifically oriented to seniors).

- ❑ Does the policy/program promote and support seniors' relationships and their social participation?

Does the policy/program	Yes	No	Not Sure	N/A
Remove any barriers (e.g. financial, technological, institutional, attitudinal, etc.) to seniors' social and civic participation?				
Facilitate access to seniors' social network of family and friends?				
Facilitate access to seniors' community (e.g. cultural; geographic)?				
Promote seniors' inclusion in society?				
Reduce loneliness, and/or social and spiritual isolation?				
Promote/support a sense of belonging/mattering?				

A seniors centre that implemented the SMHPL discovered that their physical environment (e.g., poor lighting, noise) and lack of reception for new members, inadvertently impeded some seniors (with visual or hearing deficits, and others who felt uncomfortable/shy), from becoming involved at the centre. They made appropriate changes to their space and recruited volunteers to greet new members. The seniors centre has also initiated family teas and a service to read mail and write letters.

5. Self-determination and Independence

Seniors value being in control of their own lives, being able to do as much for themselves as possible and making their own choices (e.g., decisions on daily matters; being responsible, to the extent possible and practical, for things that affect them; having freedom to make decisions about how they will live their lives). Interdependence (enjoying access to a support system) is also important to enable freedom of choice and self determination. Facilitating an environment in which seniors are provided with the required information, options and supports to make real choices can enhance independence and self-determination.

- ❑ Does the policy/program/practice promote and support seniors' self-determination and Independence?

Does the policy/program	Yes	No	Not Sure	N/A
Provide opportunities to make choices?				
Provide seniors with information and time to enable them to make informed choices about the risks they are willing to take and live with?				
Provide support (encouragement, resources) to facilitate decision making?				
Promote coping skills/strengths?				
Build on the capacity of seniors and adjust to different circumstances?				
Enable seniors to make the most of their abilities? (Compensate for mobility issues, sensory changes, etc)				
Promote and support options and informed choices for seniors in all aspects of their lives? (Consider whether a full continuum of options is available)				
Promote resiliency?				
Does it promote recovery and hope?				

Using the SMHPL to review a geriatric mental health service led to discussion of how health professionals, although well intended, "prescribe" what is appropriate care and treatment. This led to incorporating questions about coping skills and strengths into the assessment and the care plan.

6. Respect and Dignity

Seniors value 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 roles and contributions to family, friends, community and society; being treated as a worthy human being and a full member of society.

❑ Does the policy/program reflect respect for seniors and support their dignity?

Does the policy/program	Yes	No	Not Sure	N/A
Promote seniors' self- esteem?				
Support seniors' dignity?				
Respect privacy and confidentiality?				
Demonstrate respect for seniors?				
Acknowledge the uniqueness of each individual?				
Portray seniors' positively?				
Respect the values of seniors?				

A complex care facility used the SMHPL to frame a training program for staff that focussed on respect for person-hood, how to identify/promote residents' strengths and coping patterns, and building relationships.

The BC Ministry of Health has undertaken two initiatives that reflect the values and principles embedded in the SMHPL. Officials have worked with seniors' organizations and other partners to find ways to showcase seniors in the 2010 Olympic and Paralympic Winter Games. This initiative is intended to increase awareness that seniors are encouraged and supported to volunteer, leading to associated health benefits that result from enhanced social integration and a greater sense of value in society. The Premier's Council on Aging (made up of seniors) is another example of facilitating seniors' involvement and input into policies and programs affecting them.

In a review of the care of older adults in a general hospital the SMHPL revealed a number of practices that compromised seniors' dignity, such as: sharing rooms with people of the opposite sex; staff talking over seniors, calling them by their first name without asking, and not responding quickly to toileting needs. A policy was created to address these issues.

7. Fairness and Equity

Seniors value fairness and equity. They would like their needs considered equally to those of other Canadians (e.g., having equitable access socially, economically and politically to available resources and services; not being discriminated against on the basis of age; and being treated and dealt with in a way that maximizes their inclusion in society).

- ❑ Is the policy/program fair to seniors in the context of the public good?

Does the policy/program	Yes	No	Not Sure	N/A
Is the policy/program fair to those affected by it?				
Are the procedures and criteria inherent in the policy fair and reasonable?				
Does it consider individual versus collective needs?				
Does it take into account the full costs and benefits of supporting the aspirations of seniors?				

Seniors by and large would like to remain in their own homes as long as possible but may be challenged by such factors as low income, physical and cognitive limitations, and challenges in accessing the community. By being able to remain in their homes seniors are more likely to remain involved with their social support network and in their communities; both protective factors for mental health. The SMHPL was used to review federal programs directed at seniors and found three federal policies/programs (HASI, RRAP-Disabilities Program and Veterans Independence Program) that supported seniors' preferences to remain at home.

In a review of nursing home policies it was noted that there was no policy in place to balance the needs of older adults with disturbing and challenging behaviours, with the negative impacts of their behaviours on the mental health of other residents. There was pressure on the nursing home to discharge the challenging residents. An evidence based clinical practice guideline was implemented to ensure that "least intrusive" interventions (e.g., modify the social and physical environment) were implemented prior to consideration of relocation. At the same time, measures were put in place for the ongoing assessment of disturbance to other residents and staff, and were factored into the decision making.

8. Security

Seniors value a sense of security which can be accomplished by 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 emotional and practical support.

A senior who lives in a deteriorating urban environment may feel too unsafe to venture outside of the home, increasing the risk of social isolation. Seniors who may have experienced discrimination (e.g., racism, homophobia) or who are frail and/or have impaired mobility may feel especially threatened.

❑ Does the policy/program facilitate seniors' psychological, physical and economic security?

Does the policy/program	**Yes**	**No**	**Not Sure**	**N/A**
Provide the security of being able to plan for future (appropriate housing and services, death).				
Provide a sense of safety?				
Facilitate a sense of belonging?				
Reduce the risks of crime, disease or injury?				
Facilitate physical security?				
Facilitate economic security?				

A seniors' advocacy group recognized that the way seniors were being portrayed in the media and by politicians (i.e., as robbing the young through their pensions, as a health care burden, as "bed blockers"), was ageist and stigmatizing. Using the SMHPL as a guide they developed a strategy to involve seniors in a campaign to educate advertisers, government and their elected representatives about the impact of negative stereotypes on seniors' mental health and well being.

9. Protection and Risk Management

Although self-determination is important to seniors so is the security of knowing that when needed, assistance is available.

- ❑ Does the policy/program provide seniors with the security of knowing that when needed, assistance is available?.

Does the policy/program	Yes	No	Not Sure	N/A
Facilitate appropriate interventions to protect seniors when warranted?				
Provide for the timely and effective management and communication of risks?				
Provide for the reduction of risks to seniors' health, security and well-being?				
Ensure that the least intrusive measure is taken? (given the risks)				
Ensure that the preferences of seniors are taken into account as much as possible?				
Respect and protect seniors' legal rights?				

A seniors' mental health service applied the SMHPL to their eligibility, intake and referral policies. They found that their waitlist practice and the time lag for making the initial assessment and communicating the results to other health care professionals was too lengthy and contributed to increased risks to some clients as interventions/ resources were delayed. They streamlined their processes, developed a professional intake, triage and crisis response, and developed a proposal for additional staff.

10. Evidence-Informed

Policies and programs should be informed by pertinent legal and regulatory frameworks, standards, guidelines, "best" or leading practices and research evidence. The Seniors Mental Health Policy Lens is only one form of analysis by which a policy is assessed–other sources of information and tools of analysis and reviews should also be considered when applying the Seniors Mental Health Policy Lens and in analyzing results.

- ❑ Is the policy/program informed by evidence?

	Yes	No	Not Sure	N/A
Is it based on current evidence and/or best practice?				
Can it be evaluated for process & outcome?				

In a review of policies related to tenancy in supportive housing it was found that provincial Landlord Tenant policies and residential care standards did not apply, leaving a policy vacuum around the issue of evictions.

A Home Support agency applied the SMHPL to an examination of admission and exit criteria for supportive housing. They determined that they needed to first review the legal requirements related to supportive housing and then to factor them into their policy analysis.

APPENDIX 2

Support for Using the Seniors Mental Health Policy Lens

1. Strengths of the Seniors Mental Health Policy Lens (SMHPL)

The following strengths of the SMHPL were identified by those who have used the SMHPL.

- It is person/client centered
- It is wellness focused
- It provides a holistic view of programs and policies: physical, mental, social, spiritual.
- It is simple to use.
- It can be used as a quick screen by individuals.
- The information about the values and key concepts that make up the SMHPL provides an education in itself.
- It portrays seniors positively. Semantic presentation has a strong impact on how seniors are positioned/portrayed and policy is interpreted
- The SMHPL is a process tool. It is non-threatening and opens up conversations.
- The SMHPL provides opportunity to reflect in systematic way
- It can facilitate integration of differing perspectives of multiple stakeholders
- The SMHPL can provide consistency and rigor in examining policy from different perspectives, and help to establish common ground. For example it can facilitate discussion between advocacy groups and policy analysts about policies that affect seniors.
- It can provide diverse stakeholders with a common frame of reference and context to guide discussion (e.g. l for a Resident-Family Council and Management meeting to set common goals and to evaluate them).
- The SMHPL provides concrete support to discussion about abstract and value based goals/ philosophies
- Scope is adjustable. Can be applied region/health authority, municipality, province, countrywide, as well as to a single agency, policy, program
- It can be used at any stage of planning, developing, reviewing or evaluating a policy or program.
- Fits with other ‘‘routine’’ processes/can be integrated into —accreditation, evaluation, quality assurance, self-directed care.
- Accountability can be increased when different groups are using the same frame of reference.
- Using the SMHPL adds transparency to the policy making process and makes goals, potential impacts, etc. more comparable.
- The SMHPL can be used for strategy development, when services are being re-organized, or at other points where shifts are happening in the way things are usually done.

- The SMHPL can be used to review how well standard policies and procedures further, for example, person or client-centred care/services.
- Can be used to evaluate progress.
- Provides an accountability mechanism to ensure that we did something when a need was identified.
- Emphasizes capacity building and consultation to the health care system providing care to the elderly.

2. Examples of How the SMHPL Has Been Applied

Examples of how the SMHPL has been applied, illustrating its' range and scope, have been integrated into the Guide, Appendix 1. As well, power point presentations, listed below, about some of the examples can be viewed on the Seniors Mental Health website:

http://www.seniorsmentalhealth.ca/Best%20Practices.htm

- To develop a proposal for a provincial Continuing Care Challenging Behaviors Assessment Service
- To critique and provide input into draft provincial strategies
- As a framework to guide development of an Elder Abuse Lens that examines policy from the perspective of preventing and detecting elder abuse
- To guide development of policies for legal services for seniors
- Review of services in a non-profit advocacy centre for seniors
- To facilitate community development by assessing community services for seniors (housing, home support, mental health) for inclusion of a seniors' mental health perspective
- To incorporate seniors' mental health into a grant application to fund seniors programs
- As an educational tool in post secondary programs
- To assess the potential impact of a provincial First Available Bed policy on seniors mental health (i.e., When a first placement choice is not available an individual is required to accept an alternative placement until the desired choice becomes available)
- To review a local heat wave preparedness plan to the meet the needs of the community
- To guide development of a seniors wellness program
- To review program development
- To guide/frame the development of a new re-organized and integrated regional geriatric mental health best practice system.
- To guide the redesign a regional geriatric mental health with a focus on shifting from inpatient to community-based services and to a biopsychosocial model of care.
- As a catalyst for discussion and development so that clinicians and managers can share their perspective about program design.

3. Tips for Using the Seniors' Mental Health Policy Lens

The following are tips for applying the SMHPL, provided by those who have used it.

Planning the Application of the SMHPL

- When deciding who to involve in the process, think broadly but also be strategic—the process is an opportunity to influence key people and to develop new partnerships
- Application of the SMHPL stretches thinking but takes time—plan for this
- Consider and plan the amount of time that will be needed to apply the SMHPL to larger multi-sectoral policies. You will need time to organize and conduct focus groups, and consultations, and for other tasks (e.g., research) identified during the writing/review of the drafts.
- Obtain the commitment of leaders before implementing the SMHPL – if during the process of applying the SMHPL there are too many layers of bureaucracy that need to be involved the intent may be lost.

Applying the SMHPL

- Knowing about the seniors who are/will be affected by the program/policy is key to being able to apply the SMHPL effectively.
- Stop for a moment and think about any biases you may bring to the table/process.
- It is essential that the facilitator be able to establish a trusting environment for individuals to be able to disclose their views.
- Discussion about how to interpret the SMHPL questions can create a good opportunity for developing an understanding of each other's perspectives
- Use the SMHPL questions to create a context that dampens personal/individual agendas by keeping the focus on the seniors who will be affected by the policy/program.
- Encourage stakeholders to frame their input points and perspectives in relation to how they will further meet the needs of the population.
- Use the process to reinforce that all seniors are entitled to a standard of care that maximizes participation and enhances quality of life regardless of impairment or limitation
- In applying the SMHPL be sure to identify and document what is being done right so that the process does not seem negative or over-whelming.

After Applying the SMHPL

- Think about the Not Applicable responses and consider whether they really indicate that you need to know more about the population and the setting. If information is missing, obtain it.
- Follow up on Not Sure responses by obtaining the necessary information so that you can answer Yes or No.
- Develop action plans with time lines and identified responsibilities for each section of the SMHPL not adequately addressed

- Recognize that to address issues raised by applying the SMHPL may require appropriate staffing, education, environment etc. Build advocating for this into the over-all process—make it an action item
- Develop procedures/communication plans to accompany follow up
- Design an accountability mechanism to ensure that something is done when a need is identified
- The results of the application of the SMHPL need to be communicated to seniors who will be affected, and to other stakeholders in an appropriate manner to each group.
- The SMHPL takes the perspective of an "ideal world" and as some gaps identified may seem too large and expensive to address. The ideal world discussion helps to make the analysis as deep broad as possible, which is good. In the next step, recommendations and action plans can be made that take into account different funding and resource limitations identified. What is learned can be kept ready for when opportunities arise in the future.
- Take every opportunity to introduce the SMHPL as an action item for strategies related to older adults.

APPENDIX 3

Key Values, Principles and Concepts

In this section background information about the values, principles and concepts that underpin the SMHP Toolkit is provided.

I. Values and Principles

The SMHPL reflects the values of seniors. Seniors' values and their perspectives related to the mental health challenges of aging have been derived from a number of Canadian studies in which seniors shared their views.

Challenges To Mental Health Identified By Seniors

In the Psychosocial Approaches to the Mental Health Challenges of Late Life (Health Canada, 2004) project described earlier, older adults across Canada identified the following challenges to mental health: seeing yourself deteriorate; maintaining self esteem; having no real role to play in society; not being needed; loss of status; family dysfunction; loneliness; 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; no suitable resources, and feeling invisible in youth oriented society.

In 1997, the National Indian and Inuit Community Health Representative Organization (NIICHRO) and the Canadian Ethnocultural Coalition (CEC) held dialogues with aboriginal and ethnocultural older adults, to learn about the factors they felt affected their well being (Ship, 1997). The researchers reported that participants identified challenges to their well-being and mental health 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.

Factors That Support Mental Health Identified by Seniors

In the Psychosocial Approaches to the Mental Health Challenges of Late Life (2004) project participants identified the following as important to maintaining good mental health: information with which to make informed decisions about their futures; opportunity for choice; enough income to meet basic needs, including for medications, transportation and social participation; practical help that supports living in own homes (e.g.: yard work, repairs); knowing that assistance can be acquired when needed, and a sense of belonging. In 2002, the Canadian Mental Health Association project "Seniors' Mental Health and Home Care" conducted focus groups with older adults, family caregivers and home care providers, at several locations in Canada. Participants identified a diverse range of factors that they believed influence the mental health of older adults. 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, and 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), and the role of the formal care provider and flexibility of service provision. Participants in the NICHRO and CEC (Ship, 1997) project also identified what they believe are the essential elements for ageing well. These included: physical, mental-emotional, social and spiritual well-being; the 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, and accessible and affordable transportation.

Principles For Promoting and Supporting Seniors' Mental Health

The positive and negative influences on their mental health identified by seniors are captured in the core principles identified in the Principles of the National Framework on Aging: A Policy Guide (Health Canada, 1998), developed by the Federal/Provincial/Territorial Ministers Responsible for Seniors through an extensive consultation with seniors, policy analysts, and other key stakeholders. The project incorporated the needs, values and concerns expressed by seniors, resulting in a set of core principles required for programs and policies that promote older adults' quality of life and well being - dignity, independence, participation, fairness and security. These core principles reflect seniors' shared values and 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 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; and 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; and 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.

Principle and Values of Seniors Mental Health Care

The values and core principles embedded in the Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities (B.C. Ministry of Health, 2002) underpin the SMHPL questions. These values and principles were identified through consultation with older adults, family caregivers, volunteers, specialists in seniors' mental health, policy makers, program planners and managers, and organizations interested in elderly persons with (or at risk of) mental health problems. They are fundamental in guiding the development of services for older adults with mental health problems and their families.

Principles of Care

The principles that should guide the care of seniors with mental health problems are:

- Client and Family Centred
- Goal Oriented
- Accessible and Flexible
- Comprehensive Care
- Specific Services
- Accountable

Values and Beliefs

The values and beliefs underlying the principles of seniors' mental health 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 and of control and choice with their life; optimal use of their mental abilities; achievement of their own goals (both personal and collective); 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 older adults with mental health problems and towards a biopsychosocial model of care.

- 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.

Approaches to Support Seniors' Mental Health

In a British Columbia study, Meeting the Mental Health Needs of Older British Columbians (Tuokko, Donnelly and MacCourt, 2001), a wide range of psychosocial factors that support older adults' mental health were identified: regular mental activity; cognitive stimulation and interaction; socialization, activity 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.

II. Core Concepts of The SMHPL

The conceptual framework that informs the development of the SMHPL draws upon a review of population health determinants related to late adulthood, resilience, principles of mental health promotion, healthy aging public policy, and a recovery orientation to mental health care, each of which will be discussed below.

1. Population Health Determinants and Late Adulthood

Population Health Perspective

A population health perspective (Health Canada, 2002) has been incorporated into the development of the SMHPL questions to ensure that 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" is the product of complex interactions among individual characteristics, the physical environment, and social and economic factors. A population health approach assesses health status and health status inequities of the population as a whole (as well as groups within it), as characterized by geography, age, gender, culture or other defining features, over the lifespan.

The benefits of a population health approach extend beyond improved population health outcomes to include a sustainable and integrated health system, increased national growth and productivity, and strengthened social cohesion and citizen engagement (Public Health Agency of Canada, 2007).

Determinants of Health

The determinants of health (Health Canada, 2002) include:

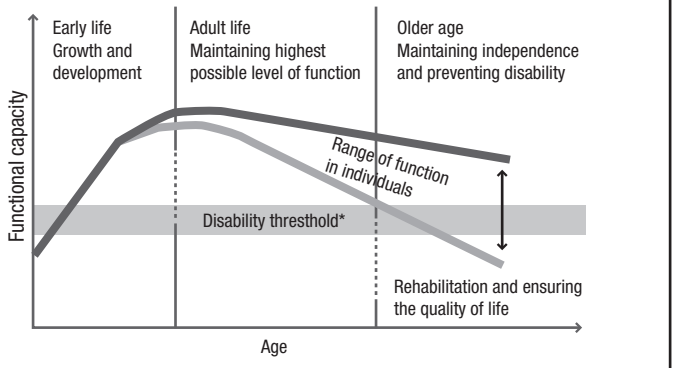
- Biology and Genetic Endowment - the basic biology of the human body is a primary determinant of health. Genetic endowment may predispose some individuals to particular diseases or health problems.
- Gender - Gender refers to the variety of roles, attitudes, behaviours, values and influences that society 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 individual seniors, for subgroups within the seniors population, and for the population of seniors as a whole.

Life Course Perspective

The determinants of health need to be understood from a life course perspective which recognizes that older persons are not a homogeneous group and that individual diversity increases with age. This is illustrated by the World Health Organization (2002) in the following Figure, which shows that functional capacity increases in childhood to peak in early adulthood and eventually decline. The rate of decline is largely determined by factors related to lifestyle behaviours, as well as external social, environmental and economic factors. From an individual and societal perspective, it is important to remember that the speed of decline can be influenced and may be reversible at any age through individual and public policy measures, such as promoting an age-friendly living environment (WHO, 2002).

Figure 2. Maintaining functional capacity over the life course



Source: *Active Aging: A Policy Framework, WHO, 2002*

The Impact of Determinants in Late Adulthood

A life course perspective recognizes that at each stage of life individuals experience life events and transitions that occur as part of the normal aging process, and will affect individuals differently. Most transitions throughout the life course include a major shift in social expectations and changes to identity, role, relationships, abilities and patterns of behaviour. Following, 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.

In late life, mental health problems (including mental disorders) usually occur in the context of medical illness, disability and psychosocial impoverishment. Physical changes (e.g., changes in vision and hearing, loss of muscle mass and bone density, increased risk for fractures, and brain atrophy) are common in the elderly (Connell, 1999). Cognitive changes, such as memory loss or slowed thinking, may also occur. There are also several health conditions (such as stroke, heart disease, chronic obstructive pulmonary disease, arthritis, and cancer) that are associated with late life. Age, disability, and chronic health conditions are interrelated (Andrews, 2001). Physical changes and chronic health conditions can have substantial impact on the psychological and social wellbeing of older adults by, for example, reducing opportunities for social engagement and relationships and their associated benefits.

Life events or transitions that can occur as part of the normal aging process, may disrupt or threaten to change an individual's normal routine and activities, and consequently can affect an individual's mental health. Pressures from the environment that affect the majority of seniors include: retirement; changes in income level; and changes in social support networks (including caring for another individual, and coping with the death of a spouse and peers). For some, this may result in the development of a mental illness for the first time in late life.

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). Retirement for most will signal a change in roles within the household, the family, and the community in general. Older adults with inadequate incomes and poor health, and who must adjust to concomitant stresses, such as the death of a spouse, are likely to have a very difficult time adjusting to retirement (Gall, Evans and Howard, 1997). Many older adults with a life-long mental illness have not developed long work histories and are unlikely to go through retirement -- they are also unlikely to have adequate incomes.

Seniors generally have lower incomes than younger individuals (Statistics Canada, 2002). Being unattached (either through death or divorce) may make women particularly vulnerable to poverty (Hungerford, 2001). Older adults who cannot afford non-insured items that may be required due to age related changes (e.g., medications, glasses, hearing aids, dental work, mobility aids, transportation, and home help) could be at risk for poor health (including mental health) and social isolation. Many older adults with mental illnesses in earlier life stages may have relied on very low incomes (e.g., disability and social assistance) all their lives. The cumulative effects of poverty are likely to marginalize them in terms of housing, nutrition, access to non-medical needs and social participation.

Some older adults will need to leave their homes due to physical, cognitive and/or social changes. The degree to which relocation challenges mental health will depend on the viability of personal coping strategies, the degree to which the senior feels s/he has control over the move, and the discrepancy between home and the new location. Cooke (2005), in a review of literature, found that relocation to nursing homes entails some degree of risk but that the risk can be reduced by careful pre-relocation planning, adequate post-relocation support, minimized social disruption, and, the move offers improved quality of life and a higher standard of care.

Older adults may become 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. In the case of dementia, family caregivers provide about 80% of the care received (Guberman, 1999) with spouses the primary caregivers for approximately 37% of community dwelling individuals with dementia (Canadian Study of Health and Aging Working Group, 1994). These caregivers manifest considerable stress and clinical depression, have an increased number of illnesses and make greater use of health care resources than caregivers of those with a physical illness/disability (Livingston, Manela and Katona, 1996). In addition to experiencing physical and mental health conditions related to providing care, spousal caregivers are likely to be seniors themselves and may experience their own age-associated health conditions.

The preceding events may negatively affect seniors' mental health by increasing social isolation, loneliness, depression, and suicidal thoughts and may impact each other, depending on the availability of appropriate individual and social resources when needed. 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). Loneliness in later life is problematic, as it is closely related to depression, which in turn is closely related to suicide (Rane-Szostak and 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 and Dugan, 1990; Forbes, 1996). Physical health status is strongly correlated with loneliness (e.g. Dugan and Kivett, 1994). Anxious individuals tend to be at risk for loneliness (Fees, Martin and Poon, 1999; Long and Martin, 2000).

Clinically significant depression affects about 10% of seniors in the general community, and of these, approximately 25% experience severe depression (Wattis, 1996). Amongst seniors depression occurs more frequently in the old-old and more frequently in older women than in older men (Ostbye, Steenhuis, Walton and Cairney, 2000). Other risk factors include: being widowed or single, experiencing stressful life events (including physical illness and abuse), and having poor social support (Lepine and Bouchez, 1998).

In comparison with other age groups, suicide rates are highest among individuals 65 years of age and older (Bharucha and Satlin, 1997). 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 (Scocco, Meneghel, Caon, Dello Buono and De Leo, 2001). Tadros and Salib (1999) note that social isolation and physical impairment seem to be important risk factors for suicide in the elderly. Schmitz-Scherzer (1995) notes 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 elderly people.

Resilience

How well seniors are able to cope with or adapt to normative transitions is related to their resilience, a dynamic process that results from multiple protective factors that include: psychological resources/ personality characteristics such as perceived control and self-efficacy; socio-demographic resources such as education, income, and occupational status; and, social-relational resources such as social support and social networks (Ryff, Singer, Love & Essex, 1998). Seniors who are already isolated and have reduced incomes, for example, are likely to have more difficulty in coping with changes in health status and decline in function than seniors who have social support and a good income. The principles of mental health promotion, healthy aging and healthy public policy can all contribute to facilitating resilience.

2. Principles of Mental Health Promotion

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" (Hamilton & Bhatti, 1996). Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections, and personal dignity.

Mental health promotion builds individual and community capacity by enhancing people's own innate ability to achieve and maintain good mental health, and by creating supportive environments that reduce barriers to good mental health. As an approach to wellness, it focuses on the positive aspects of mental health such as assets and strengths rather than focusing on deficits and needs, and it emphasizes the value inherent in good mental health. It aims to achieve wellness for the entire population by addressing the determinants of mental health by applying the health promotion strategies of the Ottawa Charter. It relies on the collaboration of all sectors of society with meaningful participation of those most affected–individuals, families and communities–and by intervening and taking action at each of these levels to build capacity, including the structural or policy level (Jané-Llopis, Barry, Hosman, & Patel, 2005).

Mental health promotion can:

- Improve physical health & well-being
- Prevent or reduce the risk of some mental health problems
- Improve mental health services and the quality of life for people experiencing mental health problems
- Strengthen community capacity to support social inclusion
- Increase mental health literacy

Strategies to Promote Mental Health[1]

Although seniors are diverse as a population, there are some general themes for promoting mental health, most of which represent the fundamental importance of valued participation, connectedness, support and encouragement (Moodie & Jenkins, 2005).

Because seniors have the wisdom, skills and the time to make contributions to society, volunteering is an intervention that can enhance individual well-being and build community capacity at the same time (Keleher & Armstrong, 2005). While physical exercise is important for all ages in enhancing mental health, exercise interventions that encourage regular physical activity in supportive, age-friendly environments are effective for helping older adults to manage physical ailments and reduce the risk of depression (Keleher & Armstrong, 2005; Hosman & Jané-Llopis). Interventions that support people with hearing loss or visual impairments can promote independence, and interventions such as community befriending programmes can provide social support, thus reducing loneliness and depression. Evidence shows that friendship is important for well-being, particularly for older women. Meaningful friendships provide companionship and support, and help maintain a sense of self through difficult times (Hosman & Jané-Llopis, 2005).

[1] This section is summarized from Evidence Review: Mental Health Promotion (2007), prepared by K. Balfour of Balfour Consulting, for the BC MOH.

3. Healthy Aging Public Policy

Public policy plays an important role in creating the social milieu in which older adults live, and therefore can impact on their mental health. For example, Pharmacare policies that do not pay the full amount for medications related to chronic illnesses can create a significant stressor for older adults with low incomes and compromise their mental health. Likewise lack of adequate, affordable and appropriate transportation systems to access health and social resources can block access to needed resources.

Healthy aging policy[2], promoted by the 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 mental health promotion principles. The goal of healthy aging is to optimize the well-being of all Canadians as they age, including those who are frail, disabled, and in need of care (Healthy Aging and Wellness Working Group of the F/P/T Committee of Officials: Seniors, 2006). While concern for individual health is maintained, the major thrust of healthy public policy moves well beyond conventional promotion and prevention strategies, and well beyond the health care system, to develop healthy policies in all sectors of life. This approach provides a template for policy makers who wish to promote social environments that support healthy aging.

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 of seniors in health-promoting policy initiatives;
- ecological perspective, which places humans in a broad context of the physical and social world.

Promoting healthy aging can support resilience and reduce the likelihood of normative transitions negatively affecting seniors. For example, seniors who are socially connected to their communities when they are widowed are more likely to be able to adapt to widow-hood than those who are isolated. Preparing seniors for transitions such as relocation, or providing support groups for widows and caregivers, are both likely to promote seniors' resilience. Similarly, age-friendly communities can facilitate seniors' capacity to remain socially connected in spite of declines in function such as mobility, by addressing transportation needs.

[2] Healthy aging is a multidimensional concept, encompassing the avoidance of disease and disability, maintenance of high physical and cognitive function, sustained engagement in social and productive activities (Rowe & Kahn, 1997), and positive spirituality (Crowther, Parker, Achenbaum, Larimore, & Koenig, 2002).

4. Recovery Orientation to Seniors' Mental Health Care

The Mental Health Commission of Canada is committed to encouraging the adoption of a recovery orientation in order to improve the health and social outcomes of people living with mental health problems and illnesses (Mental Health Commission of Canada, 2008).

Recovery is understood as an individual journey of healing that enables people living with mental health problems and illnesses to lead meaningful and productive lives in the community, while striving to achieve their full potential despite any limitations imposed by their condition. Family, friends, health care and other providers of services and supports are partners in this journey of recovery.

The key components of recovery are:

- *Finding and maintaining hope* – believing in oneself; having a sense of being able to accomplish things; being optimistic about the future.
- *Re-establishing a positive identity* – finding a new identity which incorporates illness, but retains a core, positive sense of self.
- *Building a meaningful life* – making sense of illness; finding a meaning in life, despite illness; being engaged in life.
- *Taking responsibility and control* – feeling in control of illness and in control of life.

CONCLUSION

To conclude, in order to promote, support, maintain and/or improve the well-being and mental health of older adults the values and principles discussed must be integrated into the interventions, services, programs, policies and social structures that affect older adults. The use of the Seniors Mental Health Policy Lens can facilitate this process.

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Promoting Seniors' Well-Being:

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