Mental Health Commission of Canada
Commission de la santé mentale du Canada

Transforming Health Care, Social Care and Community Landscapes to Optimize the Mental Health of Older Adults in Canada

Taking the pulse of older adults, caregivers, health care providers, researchers, educators, and policy makers

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Introduction

The purpose of this report

The overarching aim of this work is to inform, inspire, and engage collaborative efforts to advance the mental health of older adults in Canada. We hope this report will help (1) elevate the voice of older adults (i.e., people over age 60 years) and other key partners, (2) build a foundation of evidence-informed principles, values, and strategies, and (3) stimulate collaborative actions from coast to coast to coast to foster conditions and environments that optimize the mental health and healthy aging outcomes and experiences of older adults.

How do we understand mental health

Mental health falls along a continuum that extends *across* mental *wellness* (i.e., presence of positive mental health), mental health *concerns* (i.e., diminished cognitive and/or emotional capacity that interferes with the enjoyment of life), and mental *illness* (i.e., mental health disorders that interfere with day-to-day functioning) and is *interconnected* with physical, emotional, cognitive, social, and environmental health.[1] This definition promotes a view of mental health (similar to that of physical health) that recognizes and considers its complex and dynamic nature across situations and circumstances.[2] It supports the notion that *all* people experience mental health and, depending on physiological and life scenarios, these experiences may fluctuate across the continuum from wellness to illness, and back.[3]

Mental health and older adults

The health and wellness of older adults is of increasing concern internationally.[1] Studies show that many older adults experience health-care, and social care circumstances that negatively impact their overall health (i.e., physical, mental, social, environmental, spiritual).[4] These circumstances can shorten their lives unnecessarily and reduce the quality of ageing.[5] Mental health is an important facet of overall health that must be supported to help older adults (as individuals and as a population) achieve healthy aging.[6] Good mental health helps people maintain health and wellness and provides them with a solid foundation to successfully deal with the adverse events and circumstances associated with ageing. In contrast, poor mental health often leads to poor health and wellness and can hinder a persons' ability to age well.[7] Although good mental health is a necessary ingredient for achieving positive overall health, the mental health of older adults is often neglected.[8] Studies show that older adults do not receive the same level and degree of

mental health support (i.e., mental health promotion and mental illness prevention and treatment) as younger individuals.[9] This is true for both older adults who live in the community as well as those who live in residential care facilities, and other formal health care settings.[10]

To some extent this is due to the complexity of the health scenarios that come with age (e.g., multiple chronic illnesses that make it difficult to detect, diagnose, and manage interrelated mental health concerns and illnesses).[1] However, the neglect of the mental health needs of older adults is also a result of many layers of stigma and discrimination in both community and health-care environments.[11] Age-related stigma encompasses the attitudes and behaviours of younger people that systematically disregard the values, goals, and capabilities of older adults on the basis of their age.[12] Older adults who experience poor mental health and/or who belong to equity-deserving groups face higher degrees of stigma and discrimination as a result of their mental health status health.[13] As a consequence, older adults experience greater difficulties in accessing opportunities that are good for their mental health (e.g., non-stigmatizing attitudes; appropriate, good-quality mental health care; health-promoting interactions) in community and health-care environments.[14] This leads to an unnecessarily high prevalence of mental health concerns and illnesses in this population (e.g., heightened prevalence of depression, anxiety, addictions, social isolation, and loneliness)[5]. Poor mental health can take a toll on the everyday lives of older adults and caregivers (i.e., unpaid family members and friends who operate in a care role).[15] It also takes a toll on communities and health systems.[16] Conversely, when older adults have access to community and health-care environments that promote good mental health, their overall health and quality of aging improves.[2]

Although the current landscape does not sufficiently support the mental health of older adults, actions can be taken to help.[3] We can take steps to improve community and health-care environments so they better meet the requirements of older adults.[17,18] We can reset policy, practice, research, training and education, and knowledge mobilization directions to combat the inequities that lead to poor mental health and aging experiences.[1,3] To promote population-level healthy aging and extend the impact of health-care dollars, it is critical that we begin to put change strategies in place soon. Yet, to be successful, these changes must be done in a meaningful and informed way.[19] A deeper understanding of the experiences, perspectives, and ideas of older adults, caregivers, health-care providers (i.e., health and social care professionals), and other key partners (i.e., researchers, educators, policy makers, knowledge mobilizers) can provide a solid foundation upon which to initiate strategic action.

Why do we need to hear from older adults, caregivers, health-care providers, and other key partners

It is important to understand and learn from the experiences and perspectives of older adults, caregivers, health-care providers, and other key partners on what could help to optimize the mental health of all older adults in Canada. Perspectives are more than simply opinions. Perspectives are built on real experiences and reflect the values that are important to people. Perspectives on mental health tell us not only about what people have experienced with respect to their mental health but also about how people's lives have been impacted by these experiences and the personal meanings they have derived from them. Likewise, the perspectives of health-care providers on this subject are based on their lived experience of dealing with the challenges that are part and parcel of delivering mental health care to older adults. This type of lived experience and on-the-ground knowledge is often not widely accessible within the broader literature, but it is necessary to help us move forward in the right direction. We hope this report will bring to light important lived-experience and on-the-ground knowledge to help us better understand how to transform community and health landscapes in Canada to optimize the mental health of older adults.

The need for collaborative action

The goal of improving conditions and environments such that they promote good mental health and enhance healthy aging for all older adults in Canada is beyond the scope of one organization, group, sector, or system. We will need to work together. Real changes in mental health outcomes and experiences will not be realized without strategic planning and action by the many organizations and groups for which this population is a priority (e.g., long-term care [LTC], home and community care, specialized geriatric mental health services) as well as those that provide care and support to the general population (e.g., primary care, acute care, and rehabilitative care). Specific and corresponding operational plans (with accompanying timelines and benchmarks) must be developed by (and aligned across) organizations and groups that represent different sectors (e.g., health, community and social care services, public and private sector organizations and groups), layers (e.g., primary, secondary, tertiary), types (e.g., early intervention, outpatient, residential/inpatient), disciplines (e.g., nursing, medicine, physiotherapy, occupational therapy), and domains (e.g., physical, mental, social, and environmental). Organizations and groups from coast to coast to coast are encouraged to use this report to build collective initiatives that advance the mental health of older adults across the country.

What you will learn about in this report

This report highlights the findings of a study conducted for the Mental Health Commission of Canada (MHCC) to take the pulse of older adults, caregivers, health-care providers, and other key partners on the mental health of older adults in Canada. The study aimed to

- identify population-level trends (in and across partner groups) that highlight important experiences, perspectives, and opinions about the mental health of older adults in Canada
- understand the mental health experiences and inequalities faced by older adults and reveal how they become shaped by forces at play within the broader community and health-care landscapes
- pinpoint key priority areas and related strategies for moving forward.

The remainder of this report contains:

- the methods used to conduct the study
- the study findings (survey and qualitative study)
- discussion (points of connection across study findings)
- implications
- next steps.

Methods

Framework

A conceptual framework guided the data collection (e.g., types of questions asked) and analysis (e.g., the interpretation of responses) processes. We created the framework in an earlier stage of this project on the basis of an extensive review of the literature. It incorporates and extends the action areas identified in the United Nations Decade of Healthy Ageing (referred to herein as simply the Decade): ageism, age-friendly environments, integrated care, and LTC.[20]

- **Ageism:** Ageism refers to socially constructed and discriminatory ways of thinking about and acting toward older adults that foster inequitable social, economic, political, educational, and psychological outcomes. Ageism may be exhibited toward any older adult, but sometimes it is exhibited specifically toward those experiencing mental health concerns and illnesses.
- **Age-friendly environments**: In an age-friendly environment, the policies, services, and structures that comprise the physical and social environment are designed to help older adults "age actively." Environments that are set up to help older adults live safely, enjoy good health, and stay involved can bolster and sustain their overall mental health and wellness.
- **Integrated care**: With respect to mental health, integrated care involves the integration and coordination of mental health services and supports across the continuum of care to fill service-delivery gaps, improve access to quality care, and enhance overall health outcomes for older adults.
- **Long-term care (LTC)**: We define LTC as consisting of a continuum of services and supports that range from in-home assisted living services to long-term care facilities. These provide a range of supports (e.g., in-home assisted living services, retirement homes, aging-in-place options, LTC facilities) to meet individuals' marginal or more intensive needs for assistance in health and daily living. A seamless spectrum of LTC services and supports (with associated funding) is required to close precarious gaps in the care and support available to older adults who experience or who are at risk of mental health conditions or illnesses.

Our framework[3] contextualizes the action areas of the Decade (above) with a specific focus on the mental health of older adults. This framework assumes that efforts are required in and across community and health-care domains to optimize the mental health of older

adults in support of healthy aging. A publication describing the framework in greater detail can be found here [Framework].

Study design

To take the pulse of older adults, caregivers, health-care providers, and other key partners regarding the mental health of older adults in Canada, we conducted a rapid, pragmatic mixed-methods study. The study consisted of two parts. First, we carried out a pan-Canadian survey of the perspectives of older adults, caregivers, health-care providers, and other key partners. Next, we conducted a qualitative study that consisted of a series of in-depth interviews and focus groups with key informants and representatives from equity-deserving groups. This study was approved by the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

Pan-Canadian survey

An online survey was developed by the project team in collaboration with the Older Adult Advisory Committee. The survey was distributed to the MHCC's network of contacts, who were encouraged to also share the survey broadly with their own networks and contacts. Additionally, social media was used as a means of recruitment. Target participants for the survey were older adults, caregivers, health-care providers, researchers, and individuals working in the policy sector. This was a voluntary and open survey. Anyone with a link could access and complete the survey questions. Before completing the survey, participants were asked to view a letter of information and provide consent to participate in the study. Participants who consented were given access to the online survey. The survey took approximately 15 minutes to complete. All questions were optional, with the exception of the first survey question, which required participants to indicate their role (e.g., older adult, caregiver). The different types of participants were shown different survey questions, although there were some commonalities among the question sets. Survey data were collected between January 16, 2024, and February 13, 2024. Summary statistics were calculated for demographic data and quantitative data. The responses to open-ended questions were analyzed using content analysis.

Although, as stated, anyone with a link could access and complete the survey questions, there are several limitations with regard to survey representativeness that should be noted, particularly for the older adult respondents. Firstly, to access the survey, individuals required access to both a technological device and the internet. They would have also required the necessary digital literacy to complete the survey. Secondly, those with serious mental illness may have experienced challenges in completing the survey or an

unwillingness to participate. Lastly, the employed recruitment strategies were more likely to reach independent, community-dwelling older adults, compared with those in long-term or residential care.

This report contains highlights from the survey data. Findings from the complete data set are available upon request by emailing mhccinfo@mentalhealthcommission.ca.

Qualitative study

A purposeful selection process was used to identify and recruit individuals who were either older adults with relevant lived and/or living experience, and/or professionals working in an area that could impact the mental health of older adults (i.e., key informants) for interviews and focus groups. Participation was voluntary and participants were informed that they could decline to participate in any aspect of the study without penalty.

Seven key informant interviews were conducted in January – February 2024, with individuals who had field-based expertise in one or more of the four action areas identified in the Decade. One-on-one in-depth interviews were carried out with key informants who had knowledge and experience related to the mental health and wellness of older adults in Canada in one of the four action areas of the Decade. The interviews took approximately 60 minutes. A semi-structured interview guide was used to direct the interview. An example of a question that was asked is "*From your standpoint, what opportunities exist that could positively impact older adult mental health and wellness in Canada*?" Three focus groups were conducted with older adults from equity-deserving groups. The focus groups took approximately 90 minutes. A semi-structured interview guide was used to guide the discussion. An example of a question that was asked is "*Can you describe any challenges you have in promoting and maintaining positive mental health and wellness*?"

Study component	No.	Description of participants
Key informant interviews	7	Field-based expertise related to integrated care (specialized geriatric mental health and specialized geriatric medicine); age-friendly communities and LTC supports in the community; equity-deserving groups, stigma, and discrimination; holistic integrated care
Focus groups	3	Caregivers of persons living with dementia; LTC resident council members; older adults experiencing low income

The interviews and focus groups were conducted either in person or online (using Zoom webinar software). For analysis purposes, the interviews and focus groups were digitally recorded. The data were analyzed using an iterative interpretative analysis procedure.

The analysis involved coding (and interpreting) content into themes that corresponded to the area of research inquiry. A final *synthesis* was conducted to explicate interconnections between and across the experiences and perspectives of individuals and groups. The preliminary findings were reviewed by participants and validated before being finalized for this report.

Findings

In this section we first present the findings of the pan-Canadian survey and the qualitative study separately. Points of interconnection between the two sets of findings are then summarized.

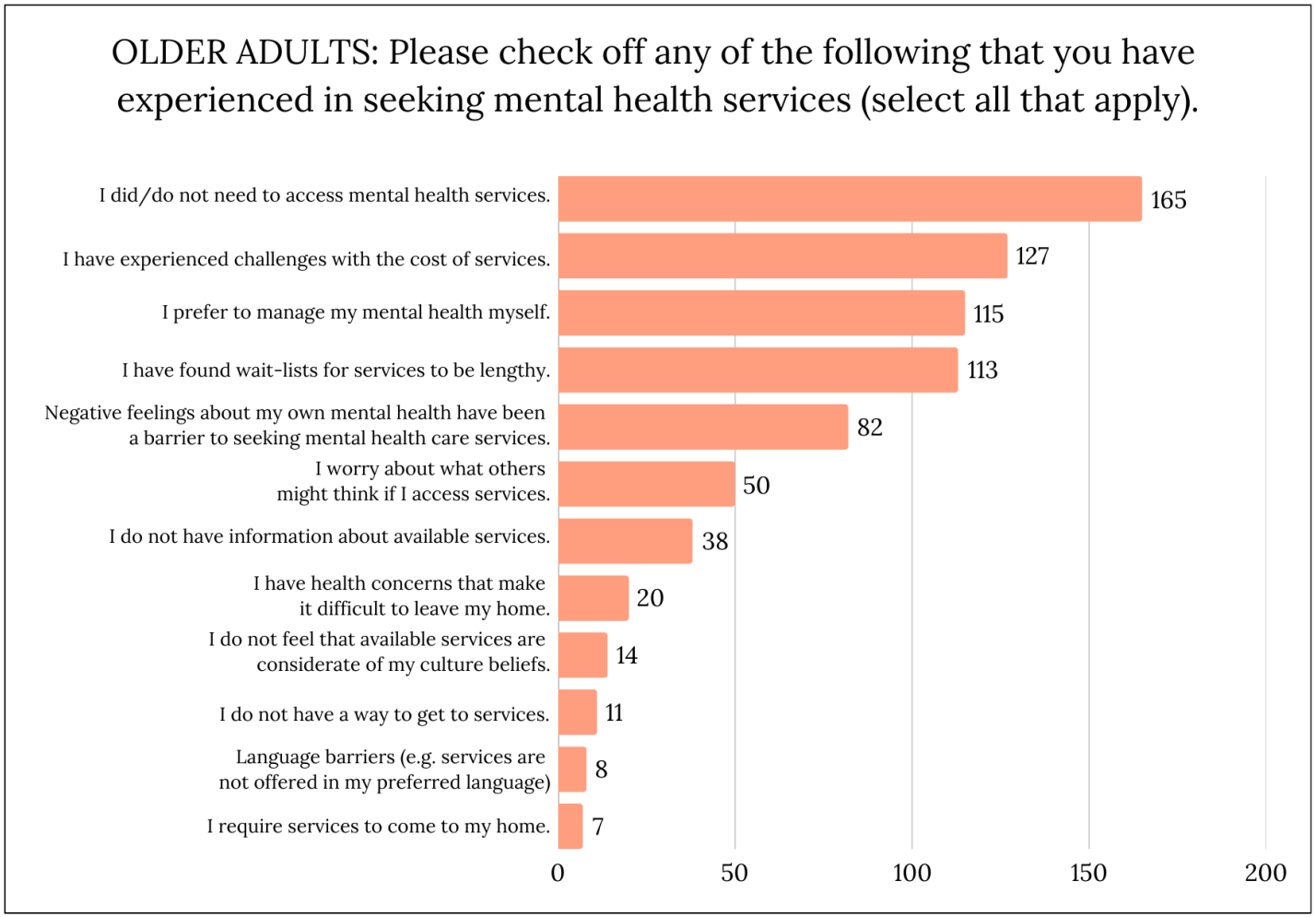
Pan-Canadian Survey of Older Adult Mental Health

Survey results: Older adults' responses

The older adults who responded to this survey were predominantly cis-gender women (75%). Seventy-eight per cent of the participants were between 51 and 70 years of age. Most participants were heterosexual and white. A detailed demographic breakdown of the participants in the survey is found in Appendix 1.
Given the survey length and quantity of data collected, selected results are available in this report. Full survey data analysis is available upon request.

Highlights

- In total, 71.6% of older adults rated their mental health and well-being as good or better.
- The most common approaches to supporting mental health and well-being identified by participants were:
    - connecting with friends/family
    - eating well
    - getting enough rest/sleep.
- Over two-thirds of older adults surveyed (67.5%) had experienced concerns with their mental health and well-being.
- Less than one-third (29.3%) had been diagnosed with a mental illness.
- Over one-third (34.8%) had used mental health services in the last year.
- Psychologists were the most commonly accessed service.
- Overall, older adults were satisfied with the care they received.

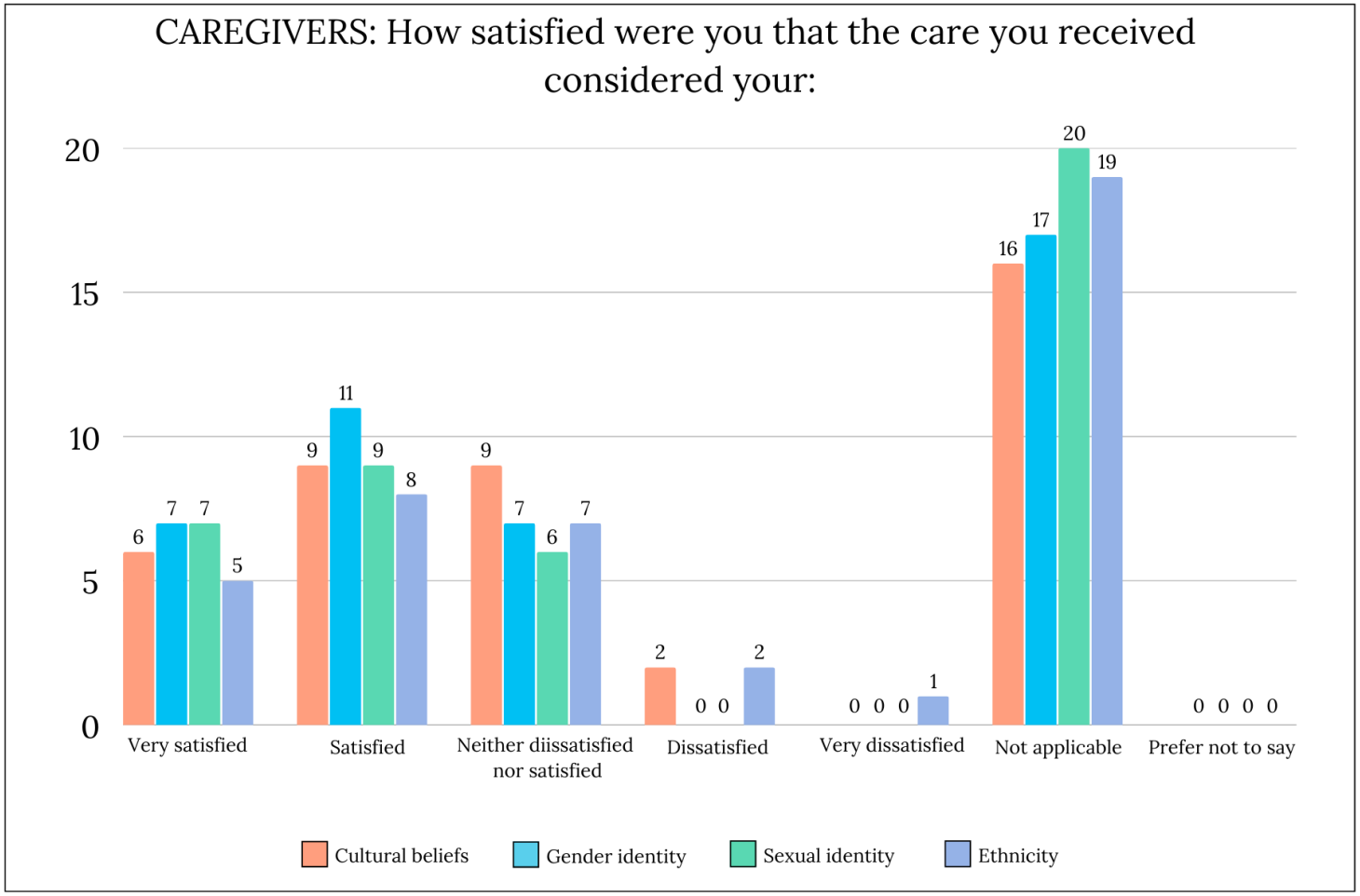

OLDER ADULTS: Please check off any of the following that you have experienced in seeking mental health services (select all that apply).
I did/do not need to access mental health services.
165
I have experienced challenges with the cost of services.
127
I prefer to manage my mental health myself.
115
I have found wait-lists for services to be lengthy.
113
Negative feelings about my own mental health have been a barrier to seeking mental health care services.
82
I worry about what others might think if I access services.
50
I do not have information about available services.
38
I have health concerns that make it difficult to leave my home.
20
I do not feel that available services are considerate of my culture beliefs.
14
I do not have a way to get to services.
11
Language barriers (e.g. services are not offered in my preferred language)
8
I require services to come to my home.
7
0
50
100
150
200

Survey results: Caregivers' responses regarding their own mental health and well-being

Nearly all caregiver participants were cis-gender women (93%). Most caregiver participants were between 51 and 70 years of age. Caregiver participants included a mix of caregivers who cared for individuals living in LTC, in the community with assistance, and independently in the community. A detailed demographic breakdown of participants is found in Appendix 1. Given the survey length and quantity of data collected, selected results are available in this report. Full survey data analysis is available upon request.

Highlights

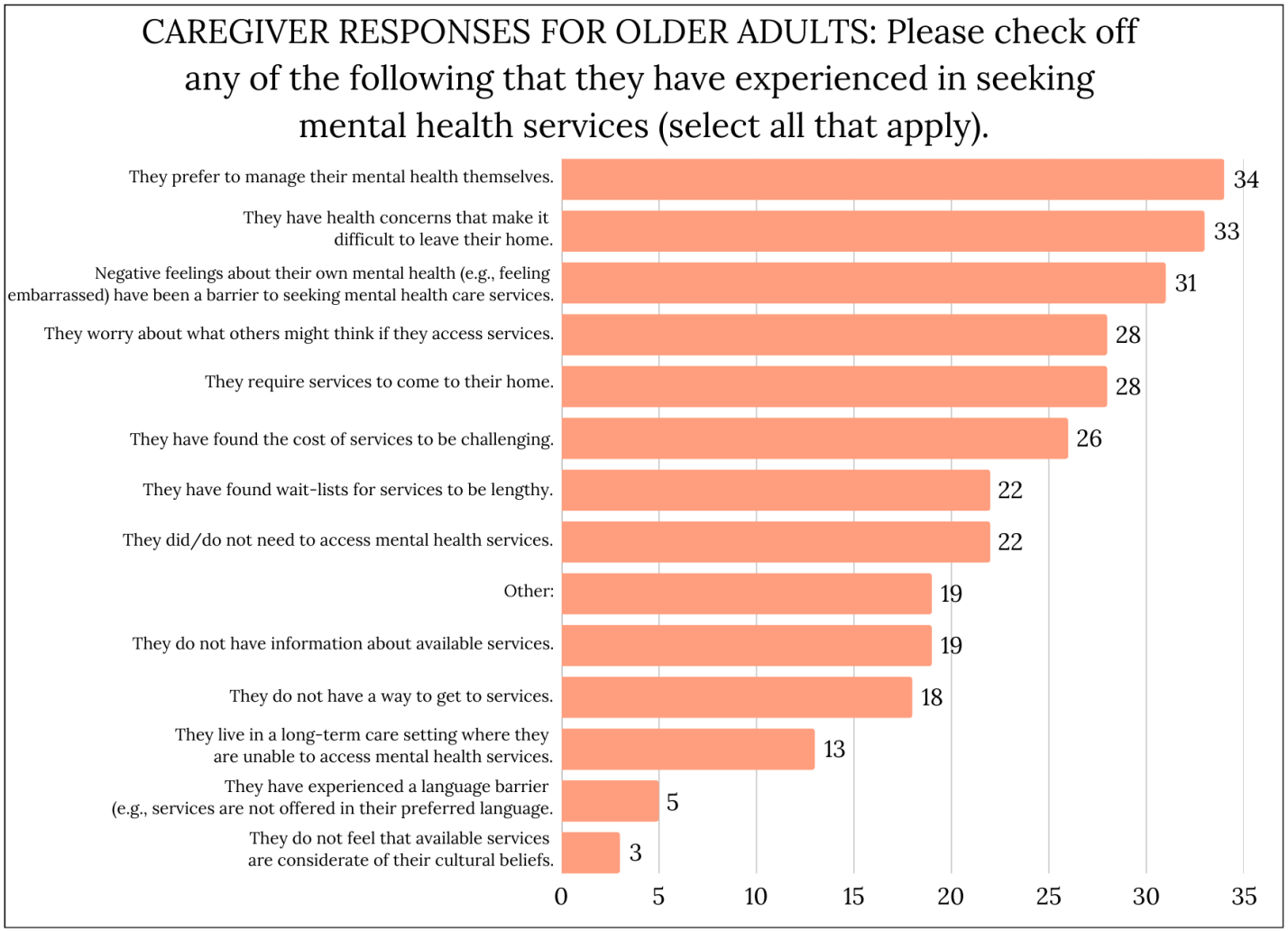
- In total, 83.5% of caregivers reported that being a caregiver has negatively impacted their mental health and well-being.
- The most common approaches caregivers used to support their mental health and well-being were
- exercising
- being outdoors
- eating well.
- Approximately half (52.6%) of caregivers rated their mental health and well-being as good or better.
- The most commonly accessed service among caregivers was primary care providers.


CAREGIVERS: How satisfied were you that the care you received considered your:
20
15
10
5
0
6 7 7 5
9 11 9 8
9 7 6 7
2 0 0 2
0 0 0 1
16 17 20 19
0 0 0 0
Very satisfied
Satisfied
Neither diissatisfied nor satisfied
Dissatisfied
Very dissatisfied
Not applicable
Prefer not to say
Cultural beliefs
Gender identity
Sexual identity
Ethnicity

Survey results: Caregivers' responses regarding the mental health and well-being of the older adults for whom they provide care

Highlights

- 74.8% of caregivers rated the mental health of the person for whom they care as fair or lower
- The most common approaches the older adults for whom the caregivers provided care used to support their mental health and well-being were
    - connecting with friends/family
    - medication
    - getting enough rest/sleep.
- Caregivers reported that primary care services were the services that the person for whom they provided care accessed most often for their mental health and well-being concerns.
- A large proportion of caregivers reported that the person for whom they provided care had experienced concerns with their mental health and well-being as an older adult; a smaller proportion indicated that the person had received a diagnosis.

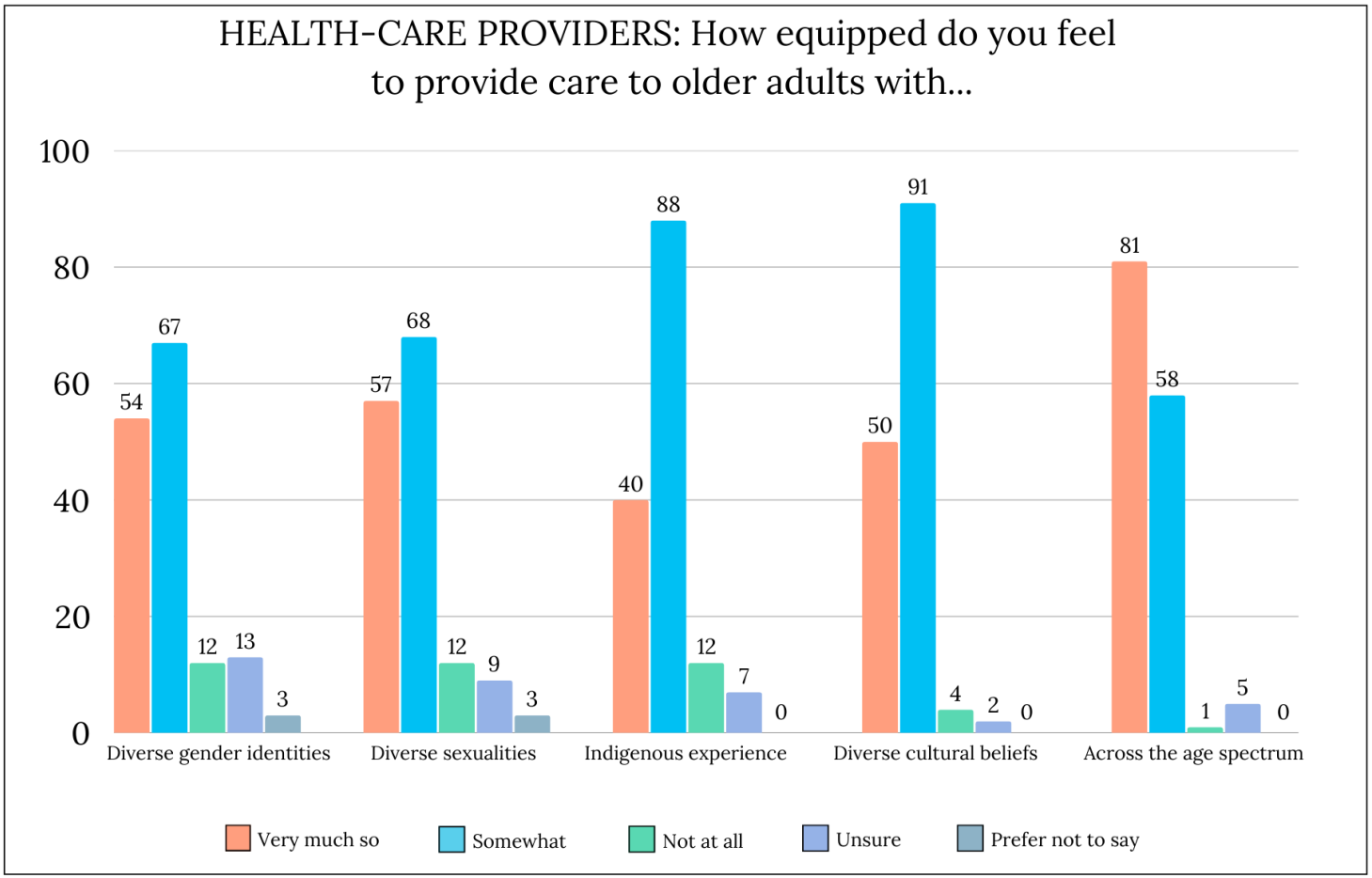

CAREGIVER RESPONSES FOR OLDER ADULTS: Please check off any of the following that they have experienced in seeking mental health services (select all that apply).
They prefer to manage their mental health themselves.
34
They have health concerns that make it difficult to leave their home.
33
Negative feelings about their own mental health (e.g., feeling embarrassed) have been a barrier to seeking mental health care services.
31
They worry about what others might think if they access services.
28
They require services to come to their home.
28
They have found the cost of services to be challenging.
26
They have found wait-lists for services to be lengthy.
22
They did/do not need to access mental health services.
22
Other:
19
They do not have information about available services.
19
They do not have a way to get to services.
18
They live in a long-term care setting where they are unable to access mental health services.
13
They have experienced a language barrier (e.g., services are not offered in their preferred language.
5
They do not feel that available services are considerate of their cultural beliefs.
3
0
5
10
15
20
25
30
35

Survey results: Health-care providers

Most health-care provider participants identified as white and practised in Ontario. Fifty per cent of health-care participants practised in large urban centres, with the remaining participants fairly evenly split between small and medium population centres. A detailed demographic breakdown of participants is found in Appendix 1. Given the survey length and quantity of data collected, selected results are available in this report. Full survey data analysis is available upon request.

Highlights

- There was variation in health-care providers' ratings of their mental health and well-being, with the majority rating their mental health and well-being in the last month as good or fair.
- More than half of the providers reported that their work environment has negatively impacted their mental health and well-being.
- Overall, health-care providers reported having the capacity to act in each of the four action areas of the UN Decade of Healthy Aging (ageism, age-friendly environments, integrated care, and LTC).
- In each of the four Decade areas, education and training was the top or second choice when providers were asked what would improve their capacity to act in each of these areas.
- Training was selected as the top option in terms of what would improve their ability to involve older adults and caregivers in their care.


HEALTH-CARE PROVIDERS: How equipped do you feel to provide care to older adults with...
100
80
60
40
20
0
54
67
12
13
3
57
68
12
9
3
40
88
12
7
0
50
91
4
2
0
81
58
1
5
0
Diverse gender identities
Diverse sexualities
Indigenous experience
Diverse cultural beliefs
Across the age spectrum
Very much so
Somewhat
Not at all
Unsure
Prefer not to say

Survey results: Researchers

The sample size of researchers was too small for analysis; however, the survey data for this group are reported in the following tables. Similarly, the demographic data for the researcher respondents were too limited for analysis, but a detailed demographic breakdown of participants is found in Appendix 1. Given the survey length and quantity of data collected, selected results are available in this report. Full survey data analysis is available upon request.

In which of the following topic areas do you feel your research may have the most impact?	Number of respondents
Age-friendly environments (enable healthy aging and allow all people, irrespective of their level of physical or mental capacity, to continue to do the things they value and live dignified lives)	1
Integrated care (services delivered to meet the person's needs, coordinated between different health-care providers)	1
Ageism (stereotyping [how we think], prejudice [how we feel], and discrimination [how we act] toward people on the basis of their age)	1
Long-term care (long-term support and assistance to ensure people can maintain their functional ability, enjoy basic human rights, and live with dignity)	1
No answer	3

To what extent does your research involve a focus on older adult mental health?	Number of respondents
Primary focus of research	2
Not a primary focus but involved in some older adult mental health research	1
No answer	4

Which of the following could improve your capacity to conduct better quality research on older adult mental health?	Number of respondents
Greater funding for older adult mental health research	2
Increased collaboration between research centres and teams working in this field of research	2
Education/training on engagement of older adults in research	2
Identification of older adults' mental health priorities	1
Increased collaboration between public and private sector research	1
Simplified research ethics board processes	1
Other	1

In what research steps do you engage older adults?	Number of respondents
Research priority setting	1
Research question development	1
Study design	2
Outcome selection	1
Design of data collection instruments	2
Data collection	2
Data analysis	2
Knowledge translation activities	1
Funding applications	0

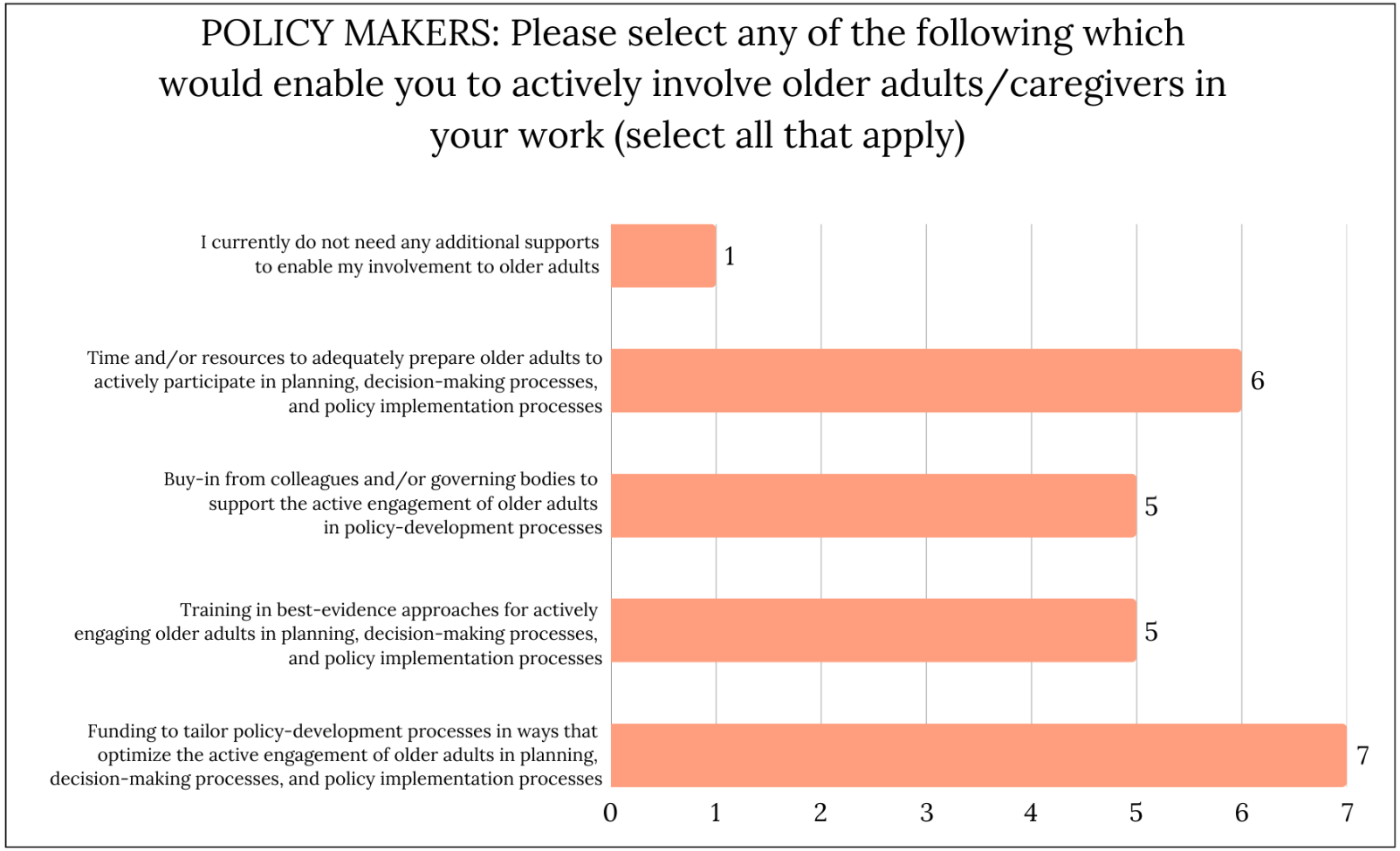
I do not actively engage older adults in the research process	0
Other	0

In your experience, which factor(s) have supported older adults' engagement in your work?	Number of respondents
Funding to cover their active inclusion in research activities (i.e., honorariums, travel and accommodation reimbursements, conference fees, training programs)	1
Training in best-evidence approaches for actively engaging older adults in research activities	2
Training in best-evidence approaches for actively engaging older adults in research activities	1
Time and/or resources to train older adults to actively participate in research design, data collection, data analysis, and dissemination processes	2

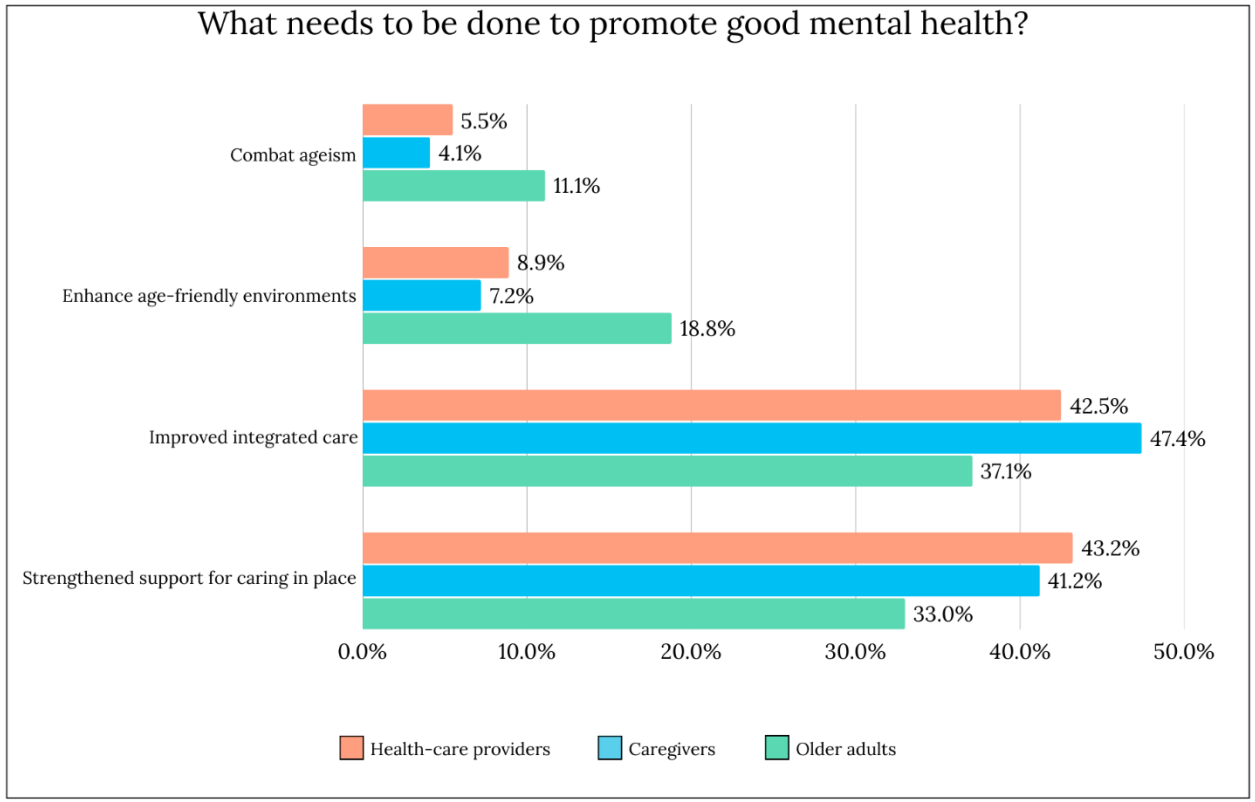
Survey results: Policy makers

The sample size of policy makers was too small for analysis; however, the survey data for this group of respondents are reported in the following tables. Similarly, the demographic data for this group were too limited for analysis, but a detailed demographic breakdown of participants is found in Appendix 1. Given the survey length and quantity of data collected, selected results are available in this report. Full survey data analysis is available upon request.

Does your work in the policy sector relate to any of the following topic areas? (select all that apply)	Number of respondents
Age-friendly environments	6
Integrated care	7
Ageism	6
Long-term care	3
Other	1


POLICY MAKERS: Please select any of the following which would enable you to actively involve older adults/caregivers in your work (select all that apply)
I currently do not need any additional supports to enable my involvement to older adults
1
Time and/or resources to adequately prepare older adults to actively participate in planning, decision-making processes, and policy implementation processes
6
Buy-in from colleagues and/or governing bodies to support the active engagement of older adults in policy-development processes
5
Training in best-evidence approaches for actively engaging older adults in planning, decision-making processes, and policy implementation processes
5
Funding to tailor policy-development processes in ways that optimize the active engagement of older adults in planning, decision-making processes, and policy implementation processes
7
0
1
2
3
4
5
6
7

Survey participants were asked a common question across participant types. The chart and table below provided a comparison of their responses. Data from researchers and policy makers are not included in the chart because of the low number of responses to this question from these groups.



Survey results: Open-ended questions

What needs to be done to promote good mental health?	*Why is this an important area for action?*	
	Caregivers	*Older adults*
Strengthened support for caring in place	*Strengthened support for caring in place is important because action in this area can..* • better enable ageing in place of choice • help improve continuity of care, which would better support caregivers to keep loved ones at home • help older adults continue to live meaningfully in their homes and communities • offer a variety of affordable supports (both formal and informal) in the community that support the social determinants of health • help prevent /mitigate social isolation and loneliness • decrease caregiver burden • improve social inclusion / participation / motivation • help delay or avoid institutional placement • help people recover from acute care stays without needing LTC	*Strengthened support for caring in place is important because action in this area can....* • improve access to mental health supports in the community • help bridge the gap while people are waiting for referrals to specialized services • help provide better navigation supports (where to find appropriate resources, get referrals) • provide the types of supports that currently aren't available/affordable (e.g., light housekeeping; help with shopping/cooking; transportation options; self-care options) • help people stay in their own home and community longer • contribute to sense of well-being, self-worth, and positive mental health • help people maintain their independence • help people age in place in rural areas

What needs to be done to promote good mental health?	*Why is this an important area for action?*	
	• enable earlier detection/management of mental health concerns and illnesses • bridge the time between onset of need for LTC and availability of LTC placement • help those who cannot afford private pay options	• help those who don't qualify for the supports that are available but who also don't have the financial means to absorb the cost of private services/supports • give more options for care to come to the person (rather than the person needing to go to the care) • avoid or delay "leaving home," which is highly detrimental to people's mental health / wellness • be a part of a system of client-centric care continuum that ages with the individual • make supports for aging in place easily available and easily accessible
Improved integrated care	*Improved integrated care is important because action in this area can…* • decrease repetitive assessments • reduce preventable emergency department visits • make better connections between hospital and community care • foster better care transitions	*Improve integrated care is important because action in this area can….* • improve access to comprehensive services • improve integration of health / mental health / social care services • provide robust mental health care embedded in public health (e.g., family doctor / public health unit) • help make the system "user friendly"

What needs to be done to promote good mental health?	*Why is this an important area for action?*	
	• improve access to mental health care in all care environments (e.g., LTC, transitional care) • provide access to an array of professionals (e.g., social workers) • improve access to trained professionals who can appropriately respond to the situation/circumstance (e.g., dementia) • address physical as well as mental and social health issues • ensure more professionals understand different communication styles (improves quality and timeliness and overall effectiveness of care) • make links to social care services, community programs, and peer supports (not just medical services) • remove the need for families to act as "middle man" doing all the coordination	• help agencies work together better • help tailor appropriate supports for older adults from equity-deserving groups • help cut back on overprescribing (by making other types of support available/accessible)
Enhance age-friendly environments	*Enhancing age-friendly environments is important because action in this area can…*	*Enhancing age-friendly environments is important because action in this area can…* • encourage older adults to remain/become active and be

What needs to be done to promote good mental health?	*Why is this an important area for action?*	
	• enhance the awareness, skills, and capacities of the community at large (e.g., police) • improve senior-friendly transportation options • improve walkablility/mobility • improve access to nearby outdoor spaces (nature, parks) • help make more community options for leisure and recreation affordable • enable older adults to flourish • help combat ageism	engaged, which improves overall mental health and wellness • enhance social and physical participation • decrease isolation and loneliness • involve older adults in the planning and design of age-friendly environments • help older people get out of the house, be active, and contribute • promote programming and costs tailored to seniors • give opportunities for social interactions to strengthen a sense of belonging • give opportunities for intergenerational connections • increase the number of safe (and accessible) spaces for older adults to live, recreate, and work • improve access to affordable leisure and recreational programs • promote senior-friendly transportation options
Combat ageism	*Combating ageism is important because action in this area can…*	*Combating ageism is important because action in this area can…*

What needs to be done to promote good mental health?	*Why is this an important area for action?*	
	• reduce the number of people who feel mental health challenges are a result of "just old age" • improve management and treatment of mental health concerns and illnesses • help improve access to needed (appropriate) services/supports • help address/alleviate self-stigma	• address stigma as an underlying barrier to all four action areas (stigma must be addressed to move forward in the other areas) • help society understand that mental health concerns and illnesses in older adults can and should be treated (stop expecting older adults to "just handle it") • create a better understanding and acceptance of the life course • reverse the ageism that is the root cause of poor mental health (e.g., poor care, lack of opportunities, barriers to finding help, youth-centric planning) • encourage older adults to seek help • promote the value of older adults and what they can contribute

Qualitative Study

Although the interviews and focus groups were conducted with the intention of highlighting specific challenges and opportunities *within* each of the four action areas of the Decade, what emerged were in fact very distinct *patterns across* these action areas.

The findings are presented in three parts: the bigger picture, current challenges, and strategic areas for change.

The bigger picture

Participants were asked to share experiences (lived or field-based) and perspectives that shed light on the broader situation of older adults' mental health and wellness in Canada. The following key themes arose out of the analysis of the data.

The definition of mental health needs to recognize its complex and dynamic nature, including its role in healthy aging

Mental health falls along a continuum that extends *across* mental *wellness* (i.e., presence of positive mental wellness), mental health *concerns* (i.e., diminished cognitive, emotional capacity that interferes with enjoyment of life), and mental *illness* (i.e., mental health disorders that interfere with day-to-day functioning) and is *interconnected* with physical, emotional, cognitive, social, and environmental health. In other words, overall mental health includes not only concerns and illnesses but also wellness. This definition promotes a view of mental health that recognizes and considers its complex and dynamic nature. It supports the notion that *all* people experience mental health, and depending on their physiological and life circumstances, their mental health experiences can fluctuate across the continuum from wellness to illness and back. Mental health is further considered to be a critical element that intertwines and interconnects physical, emotional, cognitive, social, and environmental health. Maintaining good mental health is therefore a critical determinant of healthy aging.

All older adults are at risk of experiencing mental health concerns and illnesses

Physiological and neurological changes that occur as we age (e.g., changes in blood circulation, blood sugar levels, hormone balance, and neurotransmission pathways) place all older adults at risk of experiencing mental health concerns. Common mental health concerns that adults may face as they age include feelings of depression, anxiety, low motivation, and social isolation and loneliness. If not well managed and treated, mental

health concerns can quickly evolve into mental illnesses (e.g., major depression, generalized anxiety disorder) that can cause further deterioration in individuals' quality of life and can lead to suicidality and premature mortality. Many older adults also face life circumstances (e.g., loss of a loved one, social isolation, mobility and functional impairments) that expose them to additional mental health harms and further deplete the resources they need for day-to-day coping and overall functioning.

Some older adults are living with mental health concerns and/or illnesses that have been present in their lives since they were young. These conditions tend to change in presentation as people age. These individuals may now need new coping techniques and interventions to cope with their mental health concerns and illnesses. Other common mental health concerns that arise as people age are related to cognitive changes and the possible progression of these changes toward dementia or major neurocognitive disorder. These neurological conditions can bring with them significant changes in mood (e.g. depression, anxiety) and behaviour (e.g., agitation, paranoia) that may require behavioural care and therapeutic interventions. Finally, older family members and friends who provide care to people who are experiencing mental health concerns and illnesses are another cohort of older adults who may require assistance from mental health services for their own needs.

It is possible for all older adults to experience improvements in their overall mental health and achieve levels of mental wellness that promote healthy aging

Older adults live in various states of mental health that are either optimal (mental wellness) or recoverable (mental health concerns and illnesses) in the sense that people can be moved along the continuum (via informal and formal therapeutic interventions) to bring them closer to an optimal state of mental health. It is plausible for all older adults to achieve degrees of mental wellness even while dealing with mental health concerns and/or illnesses. As people age, they can be supported to preserve their mental wellness, mitigate mental health concerns, and/or receive treatment for mental illnesses as part of a broader strategy to promote healthy aging. This requires a wholistic approach to services and supports that incorporates intertwined mental health promotion and mental illness prevention, management, and treatment strategies. The aim of mental health promotion and mental illness prevention (e.g., media campaigns, health education, information hubs) is to spread awareness and help individuals gain and exercise control over their mental health as well as the environments that contribute to and/or detract from their overall mental wellness. Therapeutic interventions like mindfulness training and cognitive behavioural therapy can help older adults self-manage their mental health concerns. Older adults who are experiencing a mental illness can also benefit from other therapeutic interventions (e.g., medications; brain stimulation such as electroconvulsive therapy) just as

much as younger adults. Receiving treatment can help these older adults to function well and enjoy a good quality of life. In summary, it is clearly possible for *all older adults* to experience improvements in their overall mental health.

From a population health perspective there are three distinct clusters of older adults who are living with or at risk of mental health concerns and illnesses

A variety of health and socio-economic circumstances impact where and how older adults access mental health care and support. It is now more common for older adults to continue to live in the community well into their 80s and 90s. Many live in the community independently and may not require or receive any support. This first cluster may make use of available programs and services in the community (e.g., private house cleaning, snow removal, handyman services) that enable them to live independently. The second cluster, also living in the community, is composed of those who because of physical, mental, or cognitive challenges rely more heavily on informal supports (e.g., family, friends, neighbours) and formal care services (e.g., government-funded home care) to help them continue to live in the community. Of these individuals, some are eligible to receive publicly funded community care services on the basis of their income. Individuals who are ineligible for these services because their income is higher than the maximum threshold may or may not have the financial means to pay for private services to help them continue to live in the community. A third cohort lives in institutional care settings (e.g., residential and LTC facilities) because they need more intensive supports for activities of daily living, as well as nursing and medical care services.
Patterns regarding access to mental health supports and therapeutic interventions differ in and across these three clusters. It is understood that these clusters are often interconnected and that people will move in and out of these clusters over the course of their aging journey. Thus, the types of mental health services and levels of support that an older adult can easily access vary with respect to which population cluster they are a part of at a given time. Patterns among those who can (and cannot) access the full spectrum of mental health services and supports (prevention, management, treatment) are determined not only by individuals' population cluster but also by their socio-economic determinants of health. The patterns of inequitable access to the full range of mental health supports (described below) also reflect patterns of inequality with respect to healthy aging.
Prevention-oriented mental health supports (e.g., mindfulness training, psychotherapy, resilience training) are often not considered “medically necessary” and are therefore not covered by most provincial and territorial health insurance plans. With few exceptions, they are also not provided as part of standard primary care practice, nor are they government funded when accessed outside of hospital-based services. When they are, these supports are often time limited and subject to long wait lists.

Older adults who live in the community with adequate financial means can purchase these types of mental health supports (to prevent and/or manage mental health concerns) in a timely fashion and for an appropriate duration. They can also pay for other services and supports (e.g., yoga classes, housekeeping, personal support workers) that help them function independently and autonomously. These resources can help them to continue to live in the community and support their overall mental health. However, older adults with adequate financial resources may still experience barriers in accessing services to address their mental health concerns and illnesses because of the current shortage of primary care and specialized geriatric mental health services in many provinces and territories across Canada. Older adults are most likely to first seek help for mental health concerns from their primary care practitioner. Consequently, the primary care sector is well positioned to provide the first stage of prevention for mental health issues. When the numbers of primary care providers are depleted, a sizeable care gap emerges for older adults who live in the community, even if they have the resources to access support for their social determinants of health.

Older adults who live in the community without adequate financial means to purchase private supports may be eligible to receive publicly funded home care services. Home care services usually provide personal nursing care and light home management. While the personal contacts and physical support provided by home care staff can play an important role in supporting the mental health of their clients (e.g., decreasing loneliness, providing reassurance and encouragement during difficult times), specific prevention- or treatment-oriented mental health services are usually not part of publicly funded home care services, nor are other home maintenance services that older adults rely on to continue to live in the community, such as grass cutting or snow removal. Without financial means, these older adults are unlikely to access prevention-oriented mental health supports. If they develop mental health concerns or illnesses, these older adults may be referred by their primary care physician for formal mental health outreach supports, if they are available in their community (many rural and remote areas do not have mental health outreach teams or supports). The wait lists for these outreach services are long, and individuals' mental health concerns may advance before they are able to access them. When mental health problems and illnesses advance to the point that they can no longer be managed in the community by primary care physicians and home care services, these individuals often need to move into LTC facilities or be admitted to hospital.

Finally, **older adults who reside in residential care facilities** need access to 24-hour medical and nursing care. A large proportion of the residents of LTC facilities live with either a neurocognitive disorder (estimates are more than 60% in Canadian homes) or symptoms of a mental illness such as anxiety and depression. In some jurisdictions, there are specialized mental health services connected to LTC homes to support LTC staff in the

care of older adults who are experiencing behavioural and psychological symptoms of dementia, require treatment adjustments for recurrent or ongoing mental illness, or have a new mental health problem or illness (such as depression or anxiety) that needs to be evaluated. However, even in homes with access to mental health outreach support, it is difficult to implement treatment beyond pharmaceutical interventions because of the lack of resources for non-pharmacological therapies. Geriatric mental health outreach teams and services are not available in many rural areas. Many provinces and territories have extremely limited outreach services into LTC, and in some there are none at all. Even in Ontario, where outreach services into LTC are available, some LTC homes may not have them. Older adults who reside in LTC facilities, even if they have financial means, are often not able to access mental health supports to prevent, manage, or treat their mental health concerns or illnesses because these services are not provided in their LTC home and there may be physical barriers to accessing services outside the LTC home (community mental health clinics or inaccessible private practitioner office). The physical and social environments of LTC facilities are not designed and resourced with mental health promotion in mind. Reforming LTC environments to facilitate mental health promotion would probably have a significant impact on residents, their families, and staff.

A population health and prevention approach to mental health for older adults would mean ensuring equitable access to mental health services and supports for prevention, management, and treatment across all three clusters. This would be a necessary step to promote equitable access to the determinants of healthy aging for the whole population.

When consistently present across settings and situations, the following elements can strengthen and reinforce positive mental health experiences and optimize mental health outcomes for older adults

Conversations with older adults and key informants indicate that the following key values and principles ought to be prioritized in community and health-care environments.

- **Autonomy** refers to the opportunity for individuals to put in place courses of action that reflect their personal values, interests, and goals. When older adults are given choices and enabled to make decisions, they can exercise control over aspects of their lives that are important to them. There are many different types of autonomy, including personal, cultural, functional, administrative, and legislative. Having autonomy can foster a sense of independence, self-direction, competency, and self-respect.[4]

- **Choice** is essential to autonomy. What people need to flourish is highly individualized. To support their mental health, older adults require the ability to

exercise meaningful choices across all life domains (e.g., health, work, cultural, spiritual, lifestyle). Diversity in the choices available to older adults can help them access social interactions, services, and environments that align with their values, goals, and capacities across a range of life domains. The ability to exercise a broad range of options supports self-determination and self-direction.[6]

- A **sense of meaning** is fostered when activities, interactions, and environments hold personal significance. When the activities individuals engage in, the people they interact with, and the environments they occupy align with their interests, values, and beliefs, they take on or have personal significance. By engaging in activities and making choices that are meaningful, older adults are able to define themselves as individuals and express the ways in which they are unique.[21]

- **Connections** make it possible to be in relationship with others. Older adults benefit from opportunities to access and nurture connections with family, friends, neighbours, same-age peers, and intergenerational peers. These connections are important for fostering shared experiences and a sense of belonging. Connections can also generate valuable opportunities for information and communication exchange. Connections that are organic, mutual, and reciprocal can bring about feelings of perceived value and support.[22]

- The experience of "**being in community**" with others builds on but goes beyond connection. A sense of community arises when connections take on relational depth. This depth emerges as a result of sharing space with others in ways that invite mutual interdependence and emotional connection. A sense of community can help older adults develop trust and a sense of safety.[23]

- **Engagement** stems from working collaboratively with others toward a common goal. It involves giving one's time, support, care, and/or money to a cause. Engaging environments provide opportunities for older adults to join with others in an intentional process to learn, contribute, and grow. Opportunities for engagement help to build feelings of contribution, value, productivity, and being "active and engaged" in life.[24]

- **Occupation** (meaningful activity) gives people the opportunity to actively create meaning in their lives. Older adults want to feel as though they are still learning and growing and to experience an overall sense of purpose. Occupation is a way to continue to create and shape one's life. Doing activities that align with their interests and goals can provide older adults with a sense of purpose and self-direction.[25]

- Opportunities to **contribute** their time, knowledge, and/or resources enable older adults to share parts of themselves with others and with their communities. When older adults are invited to contribute, they have the chance to learn new skills, to meet new people, to become connected with others, and to "give back."[26]

- **Stimulation** sparks interest and incites motivation. People can be stimulated in a variety of ways including emotionally, intellectually, sensorily, socially, creatively, and spiritually. When older adults feel stimulated in their everyday lives they can acquire a sense of joy and fulfillment.[27]

- **Feeling valued** by others can reinforce connections and personal meaning for older adults. When older adults feel valued by others they gain a sense of confidence and self-respect. There are a variety of ways to show older adults they are valued including offering acknowledgement, empathy, compassion, and recognition.[28]

- Opportunities for **reciprocal exchange** (mutually beneficial interactions) with peers and other groups can create opportunities for mutual action, resource sharing, and influence. Opportunities for reciprocal exchange can take the form of peer support and community volunteer initiatives. Reciprocal exchange helps older adults build relationships, gain influence, build trust, and access valued resources.[29]

- **Equity** refers to fairness and justice in processes and results that enable older adults to access valued resources. For older adults, equity often requires differential treatment and resource distribution to ensure a level playing field in and across all environments.[8]

- A **holistic** (i.e., physical, mental, social) and **whole systems** (i.e., community, health care) approach supports healthy aging across settings and across the lifespan.[30] Older adults require access to services, supports, and opportunities that enable them to nurture and find balance across the physical, psychological, emotional, spiritual, and environmental domains.

Current challenges

The challenges that hinder older adults (as a population) from optimizing their mental health in pursuit of healthy aging cut across action areas and population clusters.

Access to appropriate and integrated mental health services for older adults is both limited and inconsistent across the continuum of care

Consistent access to quality mental health care across the continuum of care (i.e., among health-care providers and within, between, and across professions, organizations and systems) is essential to optimize the mental health of older adults as a population. Unfortunately, access to specialized (or seniors focused) mental health services and supports within primary care, acute care, home care, LTC, and other care environments is currently limited and inconsistent. This is often influenced by geography (urban, rural, and remote communities), the presence or absence of clinical and administrative leadership among mental health providers, and allocation of funding that is proportional (or not) to the mental health needs of older adults by health care planners. Mental health services and support are not currently a consistent and integrated component of the care provided to older adults. Sufficient knowledge and skills to detect, address, and/or make appropriate referrals for mental health concerns and illnesses are not readily available in all care environments. There is limited awareness across the continuum of care of the unique mental health needs and distinctive presentation of mental health concerns and illnesses in older adults. There is equally insufficient availability of specialized geriatric mental health services to adequately manage the number of referrals from services across the continuum of care and allow for efficient care and care integration. Mental health services planning at the local, regional, and provincial/territorial levels often does not take into account the size or specific needs of the jurisdiction's elderly population, because it is assumed that the mental health needs of older adults are the same as those of the general adult population. Geriatric services planning usually focuses on evaluation and consultative services and does not consider or underestimates the mental health needs of its population, in particular the need for specific mental health resources for those who need a period of treatment (not just an evaluation).

Disconnected community and health infrastructures (e.g., workforce, information systems, agencies) create gaps that negatively impact detection, prevention, and help-seeking for mental health concerns and illnesses

Continuous access to mental health resources, approaches, and interventions in and across health-care, social care and community-at-large environments is required to promote population-level mental health for older adults. However, disconnected community, social-service, and health-care planning and funding sources make it difficult for older adults to access information, resources, and supports to prevent mental health concerns and seek help early. For instance, few community-based navigation supports exist to help older adults and family members identify where and how to access appropriate services and supports to prevent or address mental health concerns and illnesses (of both an acute and chronic nature). An insufficient number of services and supports are specifically designed and funded to help older adults avoid and/or manage mental health concerns and illnesses

while aging in place. There is an equally distinct lack of connection between community resources that could play a role in preventing or assist with the management of mental health concerns and health-care and social support agencies. Community resources (e.g., volunteer supports) could potentially be tapped to help spread and extend the reach of mental health information and prevention strategies into the community more broadly.

Imbalances exist between the focus on mental health treatment and the focus on mental health promotion (prevention and self-management)

A population health strategy that optimizes the mental health and wellness of older adults should have a balanced focus on prevention, management, and treatment services.

That being said, across the continuum of care, some treatment services, such as those that rely mostly on pharmacological interventions, are more available than services that can support the self-management of mental health concerns (e.g., psychological counselling, mindfulness interventions, peer supports) and prevention strategies (e.g., healthy active lifestyle programs, social prescribing). For older adults living in the community, services and supports that focus on primary mental health (and mental illness) prevention (e.g., physical activity and leisure programs) often require unsubsidized, out-of-pocket payments that create inequitable access. This imbalance is also highlighted in the types of care available in many primary care, acute care, home care, residential care, and even tertiary care settings where limited resources are used mostly for diagnostic consultation and short-term interventions (often focused on pharmacotherapy) rather than more time-intensive interventions such as psychotherapy. These mental health services therefore do not offer the range of prevention services that are needed for an effective public health strategy. Beyond resource constraints, there is some indication that ageist attitudes may contribute to a lack of emphasis on health promotion and prevention strategies. More attention is required on the part of system planners to ensure a balanced approach to mental health promotion and mental illness prevention, management, and treatment across the continuum of care.

Community and health-care settings do not reflect the principles, values, and characteristics that foster mental health friendly environments for older adults

How older adults are seen and treated within community and health-care environments can significantly impact their capacity when it comes to preventing and managing mental health concerns and illnesses. To optimize the mental health of older adults these environments must consider and respond to the goals, values, and capacities of older adults in their planning and resource allocation. Universal design principles and approaches that optimize the mental health of older adults are absent (as a standard of

planning) across the array of community settings and contexts. For example, community transportation systems are not designed with the goals and capacities of older adults in mind. This often leads to older adults spending more time in their home and less time accessing community resources that promote mental health (e.g., nature parks, social events). Universal design principles and approaches that optimize the mental health of older adults are also absent (as a standard of care) across the array of health and social care settings and contexts. For example, emergency departments (and their care approach) are not designed to accommodate the mobility, cognitive, and communication capacities of older adults.

The options available to older adults to help them prevent, manage, and treat mental health concerns and illnesses are not responsive to the diversity of this population

To foster population-level healthy aging, all older adults must have equitable access to mental health services and supports. This means considering and being responsive to the ethnocultural, linguistic, and socio-economic diversity of older adults. Older adults from equity-deserving groups, in particular, have difficulty accessing services and supports to help them prevent, manage, and/or treat mental health concerns/illnesses that align with their values, goals, and capacities. For instance, older adults who are not fluent in English have greater difficulty accessing mental health services and supports in their language. Mental health interventions are also often not designed in ways that consider and respond to culturally specific values and attitudes regarding mental health. In general, the mental health workforce lacks the ethnocultural and linguistic diversity needed to respond (as a system) to the needs of many older adults. Similarly, older adults who experience low income may have difficulty accessing transportation to access formal mental health services.

Promising novel and innovative mental health interventions and strategies lack sufficient supporting evidence and scale-up

Traditional models of care are not designed to prevent and address complex and interrelated mental health concerns and illnesses as they present in the older adult population. There is a lack of innovative care initiatives that enable the integration of collaborative specialty geriatric mental health knowledge, practice, and resources across the continuum of care. These models can spread and extend access to appropriate mental health care across the continuum of care. Although several promising models have been developed through grassroots initiatives and pilot projects, there has been limited investment in identifying, evaluating, and scaling up (e.g., regionally, provincially/territorially, nationally) these care strategies. These include models that integrate mental health knowledge, practice, and resources into LTC and other health-care

environments to help staff in those sectors and settings identify, address, and manage the mental health concerns and illnesses of older adults (e.g., the behavioural and psychosocial symptoms of dementia). It is equally important to incorporate standard and robust evaluation strategies to generate sufficient evidence of the overall effectiveness of these models for older adults, caregivers, staff, organizations, and systems.

Strategic areas for change

The discussions with participants surfaced eight opportunities for change. These eight areas of opportunity represent the elements of a broader strategic direction to guide policy, practice, research, and knowledge mobilization efforts across the four action areas of the Decade (ageism, age-friendly communities, integrated care, and LTC) and across population clusters. The eight elements of the strategy for change are described below. Some promising exemplars (noted by participants) are listed under each element. These lists are not intended to be a comprehensive but rather to offer a sampling of potential actions for change.

Mental health literacy and anti-discrimination initiatives across the lifespan

Mental health literacy initiatives aim to build knowledge, beliefs, and abilities so people can prevent, recognize, and manage their own mental health challenges and/or illnesses and support others (often family members) who have mental health challenges and/or illnesses. Community-wide initiatives can create a common language and normalize mental health conversations among people of all ages and circumstances, leading to greater empathy and astuteness about mental health matters among the health-care workforce and the general public. To foster a realistic view of mental health and its dynamic presence in all our lives, mental health must be presented as an internal state of equilibrium that fluctuates across mental wellness, mental health concerns, and mental illness. A life-course lens is essential for building an accurate understanding of shifts in mental health indicators, determinants, and appropriate supports as people age. Perhaps most importantly, these initiatives can produce a critical mass of individuals from across diverse backgrounds who, as they age, are better prepared to maintain their mental health and address concerns as they arise. Moreover, throughout their lifetime, they will be better positioned to operate as change champions across health and community settings. Such initiatives can foster the development of age-friendly environments that support mental health (in places of work and leisure, including in health and social care services), combat ageism, and prepare future health and social care professionals to participate in integrated care teams.

Some promising exemplars noted by participants:

- Community awareness campaigns with a mental health literacy focus
- Mental health literacy and anti-discrimination programming in primary, secondary, and post-secondary education curricula
- Educational programming that includes positive experiences and interactions with older adults and elders in primary, secondary, and post-secondary schools
- Fountain of Health (Thrive Learning Centre)

Interprofessional gerontological mental health education and training

The goal of interprofessional education (IPE) is to equip health-care and social care students and practitioners with knowledge, skills, and attitudes that enable them to initiate and engage in collaborative practice. Collaborative practice occurs when practitioners work together to solve common problems and complex issues to improve interrelated (physical, mental, social, and environmental) health outcomes. IPE programs can help break down the health-care siloes that currently hinder older adults from accessing appropriate mental health care across settings (e.g., primary care, acute care, LTC, tertiary care). An important component of IPE ought to be basic gerontological education for all health-care providers who may come into contact with older adults. This includes a wide range of health workers, including physicians, nurses, social workers, rehabilitation therapists, personal support workers, dentists, pharmacists, and first responders. IPE in which basic gerontological education and training is embedded can help prepare the health-care and social care workforce to operate interprofessionally to address the mental health needs of older adults and their families. This will ensure that no matter where they seek help, older adults will be able to access appropriate and quality mental health knowledge, care, and approaches. In addition to a solid basis of government-funded basic education for all practitioners, government-funded specialized training in geriatric mental health ought to be provided to those who will be interacting with older adults on a regular basis (e.g., physicians and other practitioners who work in primary care, palliative care, emergency medicine, complex care, and LTC environments). Advanced training would ensure that these practitioners (no matter their discipline, position, or setting) can contribute to comprehensive person-centred care, offer care in welcoming age-friendly environments, and advocate for the development of mental health services to facilitate integrated care.

Some promising exemplars noted by participants:

- Interprofessional team-based geriatric education and training, including continuing education and professional development activities, as an embedded part of post-professional training programs
- Geriatric mental health teams that organize and provide educational opportunities to support and augment the capacity of all care providers

Systems-level infrastructure that encourages the delivery of quality mental health care focused on the needs of older adults across the continuum of care

Levers can be built into the systems-level infrastructure to ensure that health-care and social care practitioners who work in hospital and community settings use older person-centred approaches that support the mental health of older adults (e.g., communications and interactions that are person-centred, align with the goals, values and capacities of older adults and evidence-based), Accreditation, licensing, and certification are formal requirements (levers) by which organizations and practitioners must abide to ensure their services comply with specific quality standards. Accreditation requirements can encourage organizations to provide access to services and care that promote optimal mental health for older adults. Given that universities and colleges are responsible for preparing future health professionals to provide excellent mental health care to older adults, courses and clinical experiences directly related to this responsibility must be part of the curriculum. Accreditation and peer reviews of educational programs and institutions have an important role in ensuring that the future workforce is adequately prepared to respond to the needs of the growing population of older adults. Licensing and certification requirements can also ensure that practitioners have the appropriate types and levels of training to promote mental wellness and appropriately identify and address mental health concerns and illnesses in older adults. All of the above oversight mechanisms can ensure that older adults are able to access quality person-centred mental health care in and across all settings (integrated care), including LTC settings. It is important that the indicators used to assess compliance align with the values, goals, and capacities of older adults. This is particularly important in hospital and LTC settings when older adults may focus more on quality-of-life indicators and less on traditional improvement metrics.

Some promising exemplars noted by participants:

- Canadian Gerontological Nursing Standards of Practice and Competences
- Accreditation organizations working in collaboration with older adults to develop specific accreditation standards related to seniors' mental health

Mental health promotion

Mental health promotion involves building the personal capacity (e.g., knowledge, skills) of individuals and populations to ensure that people are able to exercise control over their environments and make choices that contribute positively to their mental health. This means providing services that strengthen the capacity of older adults to play a key role in preserving their mental wellness and preventing and/or self-managing mental health concerns and illnesses. Prevention and self-management interventions are important components of a health promotion approach. Psychosocial interventions and access to self-management tools are essential. Psychosocial interventions include activities and techniques that build behavioural, cognitive, emotional, interpersonal, and social skills to improve overall functioning and well-being. Self-management tools help older adults to actively identify challenges and solve problems associated with their mental health. This set of services has the potential to support the independence, autonomy, and overall mental health of older adults.

Some promising exemplars noted by participants:

- Fountain of Health (Thrive Learning Centre)
- Smart Aging Program

Partnerships between care organizations and the community-at-large

There is a need to establish collaborative partnerships (and connected infrastructures) between care organizations (health-care and social-care services) and non-clinical entities that exist in the community-at-large (non-profits, private businesses, municipal programs). By fostering care/community partnerships we can begin to address the support gaps that prevent older adults from accessing appropriate, consistent, and continuous mental health services and supports in and across these environments. These partnerships bring diverse people, organizations and systems together across care and community environments to leverage resources and build bridges to boost mental health equity and address the social determinants of mental health in and across these settings. These partnerships are best formed through a community development approach in which representatives from diverse backgrounds come together to generate solutions and take collective action. For example, a working partnership between local family health teams, specialized geriatric services, seniors' associations, not-for-profit community-based associations such as the Alzheimer Society, and local businesses like the YMCA, can produce innovative solutions that break-down access barriers and improve population-level mental health for older adults. It is important to note that interventions developed as a result of care/community partnerships ought to incorporate inclusive design principles.

Some promising exemplars noted by participants:

- Community-based navigation hubs that provide access to information, resources, and connections to both informal and formal supports that help with the prevention, management, and treatment of mental health concerns and illnesses
- Alternative aging-in-place options (including built and social environments) that promote optimal mental health and incorporate easy access to services and supports to help manage and treat mental health concerns and illnesses
- Alternative long-term residential care options (including built and social environments) that promote optimal mental health and incorporate easy access to services and supports that help manage and treat mental health concerns and illnesses

Services and supports that integrate mental health knowledge, practice, and resources across the continuum of care

Innovative integrated care interventions must be established to create service pathways that infuse specialized geriatric mental health knowledge, resources, and practices across sectors (health, community and social care services, public- and private-sector organizations and groups), layers (primary, secondary, tertiary), types (early intervention, outpatient, residential/inpatient), disciplines (nursing, medicine, physiotherapy), and domains (physical, mental, social, and environmental). Models of integrated service delivery have the potential to build capacity at multiple levels (inter-individual, interdisciplinary, inter-organizational, inter-system) to enable the whole-system approach required to ensure equitable mental health outcomes for older adults. Models of integrated care are structured (and funded) in a way that enables service providers from diverse care settings (e.g., primary care, acute care, home care, LTC, specialty geriatric mental health care) to co-plan, co-coordinate, and co-deliver care. Important systems-level structures are required to support these models including regional whole-system planning and advisory committees focused on older adults' mental health, shared intersectoral funding envelopes for joint initiatives, and regional whole-system integrated electronic medical record systems. As well, program-level processes are needed that make it possible for providers from different care settings to come together (in person or virtually) to engage in collaborative knowledge building, problem identification, and solution finding (e.g., circle of care teams, lunch and learn sessions, cross-training initiatives). Finally, these models must be evaluated for both their effectiveness in improving integrated (mental and physical) health and social outcomes and their ability to foster knowledge, practice, and resource sharing across the continuum of care.

Some promising exemplars noted by participants:

- Behavioural Supports Ontario
- Geriatric mental health emergency management programs
- Psychogeriatric resource consultants
- Six Nations Health Services
- Regional mental health seniors advisory committees comprised of planners, accreditors, inter-agency administrators, intersectoral providers, older adults, family members, researchers, educators, and community leaders

Scale-up of evidence-informed interventions that optimize the mental health of older adults

There is a need to scale up best evidence interventions that can optimize the mental health of older adults (regionally, provincially/territorially, and nationally). It is important to determine which interventions ought to be scaled and how to ensure they will be effective at scale. Intervention-level research is needed to establish the evidence base to support the implementation and scale-up of interventions (across the four action areas of the Decade) with the potential to have a broad impact on the mental health of older adults as a population. Evaluations of pilot projects must incorporate quality and feasibility benchmarks that are continuously refined with data from real-world delivery. Promising interventions must be scaled up and investments made to support continuous evaluation that is aligned with appropriate care quality and outcome indicators.

Some promising exemplars noted by participants:

- Community-wide mental health promotion initiatives
- Age and mental health friendly communities
- Age and dementia friendly communication training initiatives
- Service delivery models that help to integrate speciality geriatric mental health knowledge, practice, and resources across the continuum of care (primary care, acute care, LTC)

Technologies to improve the spread and reach of mental health services and supports

Digital technologies can enhance access to existing mental health services and contribute to novel interventions. Technology can open new frontiers in mental health promotion and mental illness prevention, maintenance and self-care, early intervention, and treatment. Digital technologies can also help improve mental health data collection across settings and sectors. Mobile devices such as cellphones, smartphones, and tablets can enable new

(and more efficient and effective) ways to spread the reach of mental health services and supports. For example, built-in sensors on devices can be used to collect information on the behaviour and emotional wellness patterns of older adults and flag when intervention is required. Technologies can also give older adults easy and more immediate access to self-management tools, counselling between appointments, and ways to reach out for help. Moreover, technologies (e.g., smartphones and tablets) can help older adults stay connected to family and friends. Moving forward, industry regulations will be needed along with evaluative information about the effectiveness of technologies on mental health service delivery and care outcomes. A key priority will be to invest in resources that support universal access to technology and digital literacy skills for older adults.

Some promising exemplars noted by participants:

- Virtual LTC supports that can be accessed by LTC providers or caregivers who are caring for older adults with complex and chronic care needs who reside at home
- Mobile apps that promote mental health literacy
- Regional inter-agency and intersectoral health record systems

Discussion

This report contains the findings of a pan-Canadian survey and qualitative study conducted between September 2023 and March 2024. The survey was conducted with older adults, caregivers, health-care professionals, researchers, and policy makers from across Canada. Survey responses help identify population-level trends (in and across stakeholder groups) that highlight important experiences, perspectives, and opinions about the mental health of older adults in Canada. The qualitative study was conducted with key informants in the field (in each priority area of the Decade) and older adults who belong to equity-deserving groups. The findings of this study provide a deeper understanding of the mental health experiences and inequalities faced by older adults and reveal how they are shaped by forces at play within the broader community and health-care landscape. Finally, the interviews with key informants and older adults identified key priority areas and related strategies to begin a new way forward.

Points of Connection

Here we examine the findings more closely to highlight patterns of interconnections that arose across data sources, the action areas of the Decade, and population clusters.

Across quantitative and qualitative findings

There were several points of connection among the survey findings, qualitative study findings, and strategic areas for change.

Mental health literacy and anti-discrimination initiatives across the lifespan	
Findings (survey and qualitative)	Strategy
Over half of older adult respondents reported that they experienced mental health and well-being concerns. Many older adults reported that they had experienced age-based stigma and discrimination when seeking help for mental health concerns and illnesses. Many older adults and caregivers reported that a fear of stigma (both self and perceived) were reasons why they may avoid seeking help for mental health issues. Community and health-care settings do not reflect the principles, values, and characteristics that foster mental health friendly environments for older adults.	Community-wide initiatives can create a common language and normalize mental health conversations among people of all ages and circumstances, leading to greater empathy and astuteness about mental health matters among the general public and the general workforce, including health-care workers.
Mental health literacy and anti-discrimination initiatives across the lifespan can help improve self-detection of mental health concerns and illnesses and combat the age- and mental health-based stigmas that contribute to low levels of help-seeking among older adults and caregivers.	

Interprofessional gerontological mental health education and training	
Findings (survey and qualitative)	Strategy
A majority of health-care professionals reported that they did not feel well equipped to provide care to older adults experiencing mental health concerns and illnesses. Education and training was consistently identified as an important factor that could enhance the capacity of health-care professionals to act in each of the four areas of the Decade. Community and health-care settings do not reflect the principles, values, and characteristics that foster mental health friendly environments for older adults.	Interprofessional education (IPE) that embeds a basic gerontological education and training can help prepare the health-care and social care workforce to operate interprofessionally to address the mental health needs of older adults and their families. This will ensure that no matter where they seek help, older adults will be able to access appropriate and quality mental health knowledge, care, and approaches.
A focus on training and education will help to ensure that all professionals across the continuum of care possess the knowledge, skills, and confidence to work together to make appropriate care and referral decisions for older adults.	

Systems-level infrastructure that encourages the delivery of quality mental health care and older person centred care across the continuum of care	
Findings (survey and qualitative)	Strategy
Although over half of older adult respondents reported that they experienced mental health and well-being concerns, less than half reported making use of mental health services and supports in the last year. A majority of older adults indicated that they were unable to receive mental health services as part of LTC. Access to appropriate mental health services for older adults is both limited and inconsistent across the continuum of care.	Systems-level levers such as accreditation, licensing, and certification can ensure that practitioners who work in health-care and social care settings and people who work in community programs and organizations available to the public use standard approaches that support the mental health and wellness of older adults. Accreditation requirements, for instance, encourage organizations to provide easily accessible and appropriately resourced services and care that promote optimal mental health for older adults.
Systems-level levers help promote consistency and uniformity in the types of mental health services available across the continuum of care and in how they are delivered. These levers ensure that older adults are able to access appropriate and quality mental health supports, no matter which "door" they walk through.	

Mental health promotion	
Findings (survey and qualitative)	Strategy
More than half of health-care providers reported that their work environment had negatively impacted their mental health and well-being. Over half of older adults reported that they experienced mental health and well-being concerns. A total of 83.5% of caregivers indicated that being a caregiver had negatively impacted their mental health and well-being. Imbalances exist between the focus on mental health treatment and the focus on mental health promotion (prevention and self-management).	Mental health promotion strategies focus on strengthening the capacity of older adults (as individuals and as a population) to play a key role in preserving their mental wellness and preventing and/or self-managing mental health concerns and illnesses. Psychosocial interventions and access to self-management tools are essential for supporting the independence, autonomy, and overall mental health of older adults.
A mental health promotion focus gives older adults and caregivers the tools they need to identify, prevent, and begin the process of self-managing mental health concerns in the early stages. By providing better access to psychosocial interventions and self-management tools (in both community and health-care settings) we can help prevent or mitigate more serious mental health harms for a significant number of older adults, caregivers, and mental health-care workers.	

Care / Community Partnerships	
Findings (survey and qualitative)	Strategy
Older adults indicated that they preferred to connect with family and friends as a way to maintain their overall well-being. A majority of policy makers agreed that "improved frameworks and accompanying policies that focus on ageism" are needed. The majority of older adults, caregivers, and health-care providers agreed that "strengthening support for caring in place" is a priority for supporting the mental health of older adults. Disconnected care / community infrastructures (e.g., funding and governance structures, communication systems, human resources) across health-care, social-care and community systems, create significant service delivery and support gaps that negatively impact mental illness detection, prevention, and help-seeking.	Care / Community partnership initiatives bring people, organizations and systems together from a variety of environments including formal health-care services, social-care services and programs and organizations available to the community-at-large. These partnerships bring people, organizations and systems together in an effort to leverage resources and build bridges across diverse sectors. The innovative outcomes achieved via care / community partnerships can improve mental health equity and address the social determinants of mental health for older adults as a population. A community development approach is ideal for bringing partners together, generating solutions and initiating collective action around local issues and support gaps.
There are many ways that community environments impact the mental health of older adults (either positively or negatively). Efforts to build interconnected care / community infrastructures (e.g., shared funding, shared policies, integrated communication systems, integrated workforce) can improve population-level mental health and wellness outcomes for older adults and caregivers.	

Services and supports that integrate mental health knowledge, practice, and resources across the continuum of care	
Findings (survey and qualitative)	Strategy
Less than 30% of caregivers were satisfied with the collaboration between health-care providers involved in their mental health care and the care of their loved one. Many caregivers had themselves been diagnosed with a mental health concern or illness and had made use of mental health services in the past year. A majority of older adults, caregivers, and health-care professionals agreed that an important priority for supporting older adult mental health is "improving integrated care." Access to integrated mental health services for older adults is both limited and inconsistent across the continuum of care.	Models of integrated care are structured (and funded) in a way that enables service providers from diverse care settings (e.g., primary care, acute care, home care, LTC, specialty geriatric mental health care) to co-plan, co-coordinate, and co-deliver care. Program-level processes are needed that make it possible for providers from different care settings to come together (in person or virtually) to engage in collaborative knowledge building, problem identification, and solution finding (e.g., circle of care teams, lunch and learn sessions, cross-training initiatives).
Models of integrated care bring diverse professionals, services, and organizations (in and across community and health-care settings) together to help shape and implement care plans that can addresses complex and interrelated physical, mental, and social health issues, not only for older adults but also for caregivers. Integrated care does not occur spontaneously. Models are needed that provide the structure, resources, and opportunities for the integration of knowledge, practice, and resources to occur. To achieve this, providers and organizations must be supported to invest the necessary time and resources to plan and implement these models.	

Scale-up of evidence-informed interventions that optimize the mental health of older adults	
Findings (survey and qualitative)	Strategy
Researcher respondents agreed that "integrated mental health care models and their impact on older adult mental health" ought to be a priority research area. Promising novel and innovative mental health interventions and strategies lack sufficient supporting evidence and scale-up.	It is important to determine which interventions ought to be scaled up and how to ensure they will be effective at scale. Intervention-level research is needed to establish the evidence base to support the implementation and scale-up of interventions (across the four action areas of the Decade) with the potential to have a broad impact on the mental health of older adults as a population.
Traditional models of care are not designed to prevent and address complex and interrelated mental health concerns and illnesses as they present in the older adult population. New models of care are needed that can demonstrate effectiveness (using appropriate indicators) and that can be scaled up so they are available regionally and nationally.	

Technologies to improve the spread and reach of mental health services and supports	
Findings (survey and qualitative)	Strategy
A majority of health-care professionals reported that they experienced barriers (i.e., training and education) that limited their ability to involve older adults and caregivers in care planning. A majority of policy makers agreed that "funding to tailor policy-development processes in ways that optimize the active engagement of older adults in planning, decision-making, and policy implementation processes" is important for helping them actively involve older adults and caregivers in their work. The options available to older adults to help them prevent, manage, and treat mental health concerns and illnesses are not responsive to the diversity of this population.	Technology can open new frontiers in mental health promotion and mental illness prevention, maintenance and self-care, early intervention, and treatment. Digital technologies can also help improve mental health data collection across settings and sectors. Mobile devices such as cellphones, smartphones, and tablets can enable new (and more efficient and effective) ways to spread the reach of mental health services and supports.
To foster population-level healthy aging, all older adults must have equitable access to mental health services and supports. This means considering and being responsive to the ethnocultural, linguistic, and socio-economic diversity of older adults. Digital technologies can enhance access to existing mental health services and promote innovative service delivery to accommodate diverse (linguistic, ethnocultural, and socio-economic) needs and preferences.	

Implications

The findings reflected in this report build on and extend the literature review we conducted on mental health in older adults at an earlier stage in the project.[3]

Our findings:

- shed light on the current experiences, perspectives, and needs of older adults, caregivers, and health-care providers in Canada
- pinpoint the values and principles that older adults and caregivers believe ought to be present in community and health-care environments
- spotlight inequities tied to socio-economic, residential, and health factors that give some older adults much poorer access to mental health services and supports than others
- identify current challenges that must be resolved to achieve population-level positive mental health experiences and outcomes for older adults
- highlight a range of strategies that can be used by different groups (older adults, caregivers, health-care providers, policy makers, researchers, educators, knowledge mobilizers, and others) and rolled out at regional, provincial/territorial, and national levels to optimize mental health experiences and outcomes for older adults in Canada.

Next Steps

The intention of this report is to identify key areas where change is needed and to invite the active input of people and organizations across heath-care, social care services, and community-at-large settings to take up efforts at the regional, provincial/territorial, and national levels (aligned with their mandates and missions) that optimize the mental health of older adults in Canada. There are things we can all do to help improve the mental health of this population. Although health care in Canda falls under provincial/territorial jurisdiction, the findings in this report can be used to implement courses of action that optimize the mental health of older adults at multiple levels of governance. It will be important to identify and facilitate connections between people, groups, and organizations (across community and health domains) to lead and action the changes that must take place in and across the four action areas of the Decade. This will require the combined efforts of many diverse change champions including older adults, caregivers, health-care providers and administrators, system planners, educators, accreditors, researchers, and knowledge mobilizers. It is our hope that in the coming months and years, people, organizations and systems that are in a position to lead will come together to collectively steer the changes that must take place. For this to happen, coordinated efforts will be needed to facilitate connections and leverage resources from coast to coast. Moreover, to push forward with new directions for older adults' mental health, leadership mechanisms (e.g., a national-level steering committee) must be developed to stimulate and oversee change efforts in and across the policy, practice, research, education and training, and knowledge mobilization arenas.

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Appendix

Participant Demographics

Category	Response option	Older adults	Caregivers	Health-care providers	Researchers	Policy makers
Age, years	18-30	–	3	6	0	0
	31-40	–	4	21	1	0
	41-50	–	19	36	1	3
	51-60	136	40	55	0	3
	61-70	174	21	22	0	0
	71-80	68	5	2	0	2
	81-90	12	0	1	0	0
	91-100	1	0	0	0	1
	Prefer not to say	1	2	2	0	0
Gender	Cisgender woman	282	84	114	1	6
	Cisgender man	82	3	3	1	2
	Nonbinary	2	0	2	0	0
	Transgender woman	0	0	0	0	0
	Transgender man	0	0	1	0	0
	Transgender person	0	0	0	0	0
	Two spirit person	0	1	1	0	0
	Don't know	1	0	0	0	0
	Prefer not to say	7	2	6	0	1
Sexual identity	Asexual	38	5	–	–	–
	Bisexual	11	3	–	–	–
	Gay	10	0	–	–	–
	Heterosexual	299	76	–	–	–
	Lesbian	3	1	–	–	–

Category	Response option	Older adults	Caregivers	Health-care providers	Researchers	Policy makers
	Pansexual	1	0	–	–	–
	Prefer not to say	13	4	–	–	–
	Queer	3	0	–	–	–
	Two spirit person	0	2	–	–	–
	Don't know	1	0	–	–	–
I consider myself to be...	Black	11	1	3	0	0
	East Asian	3	0	8	0	0
	First Nations	4	1	5	0	1
	Inuit	1	0	0	0	0
	Latin American	4	3	0	1	0
	Métis	4	2	2	0	0
	Middle Eastern	1	0	0	1	0
	South Asian	3	3	4	1	0
	Southeast Asian	2	0	2	0	0
	White	327	79	111	0	8
	Other	29	3	9	0	0
	Prefer not to say	10	3	7	0	0
Military service	Yes	29	5	–	–	–
	No	359	85	–	–	–
	Unsure	1	2	–	–	–
	Prefer not to say	4	2	–	–	–
Type of military service	Canadian Armed Forces regular or reserve force, currently serving	2	0	–	–	–

Category	Response option	Older adults	Caregivers	Health-care providers	Researchers	Policy makers
	Canadian Armed Forces regular or reserve force, past service (veteran)	18	3	–	–	–
	Royal Canadian Mounted Police, past service (veteran)	3	0	–	–	–
	Other country military	2	0	–	–	–
	Prefer not to say	1	0	–	–	–
Household annual income	$10, 000 or under	2	0	–	–	–
	$10,001 - $25,000	18	0	–	–	–
	$25,001 - $50,000	37	3	–	–	–
	$50,001 - $75,000	63	5	–	–	–
	$75,001 - $100,000	80	19	–	–	–
	$100,001 or over	118	44	–	–	–
	Don't know	2	1	–	–	–
	Prefer not to say	65	17	–	–	–
Province or territory of residence	Alberta	49	15	8	0	0
	British Columbia	43	5	29	0	0
	Manitoba	25	9	6	0	1
	New Brunswick	5	3	2	0	2
	Newfoundland and Labrador	9	0	4	0	0
	Northwest Territories	0	0	0	0	0
	Nova Scotia	58	6	9	0	1
	Nunavut	0	0	1	0	1
	Ontario	180	43	80	2	3
	Prince Edward Island	1	2	0	0	0
	Quebec	13	5	1	0	0

Category	Response option	Older adults	Caregivers	Health-care providers	Researchers	Policy makers
	Saskatchewan	2	1	2	0	0
	Yukon	2	0	1	0	0
	Prefer not to say	1	1	0	0	0
Description of area where respondent lives	Small population centre (population between 1,000 and 29,999)	104	21	32	0	1
	Medium population centre (population between 30,000 and 99,999)	68	11	38	0	1
	Large urban population centre (population of 100,000 or over)	206	55	72	2	6
	Unsure	3	2	1	0	0
	Prefer not to say	5	1	1	0	0
Newcomer to Canada	Yes	0	0	–	–	–
	No	386	89	–	–	–
	Prefer not to say	3	1	–	–	–
Current living situation	Lives in the community with assistance (e.g., home care, community care, care partner)	5	–	–	–	–
	Lives independently in the community	376	–	–	–	–
	Other	6	–	–	–	–
	Prefer not to say	1	–	–	–	–
	Lives in an assisted living residential facility or LTC facility	–	19	–	–	–

Category	Response option	Older adults	Caregivers	Health-care providers	Researchers	Policy makers
Current living situation of person caregiver cares for	Lives in the community with assistance (e.g., home care, community care, care partner)	–	21	–	–	–
	Lives independently in the community	–	42	–	–	–
	Other	–	6	–	–	–
	Prefer not to say	–	2	–	–	–

Mental Health Commission of Canada

Commission de la santé mentale du Canada

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