

**AN ASSESSMENT OF THE NEEDS OF SENIORS
AFFECTED BY MENTAL ILLNESS AND/OR ADDICTIONS
IN BRANTFORD AND BRANT COUNTY**

PROJECT REPORT

Prepared for the Brant Mental Health and Addictions Network

by

SHERCON ASSOCIATES INC.

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July 16, 2008

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1.0 INTRODUCTION

1.1 Background and Purpose

This research project was commissioned by the Brant Mental Health and Addictions Network and funded by St. Joseph's Healthcare Hamilton, Brant Geriatric Mental Health Outreach Program. The study focused on the needs of seniors with mental health and/or addictions issues and their families/caregivers in Brantford and Brant County. It had three objectives:

1. To estimate the number of seniors living with mental illness in Brantford and Brant County and numbers affected with co-occurring dementia or addictions.
2. To identify the needs of the target population in Brantford and Brant County in order to age successfully at home, avoiding unnecessary or premature institutionalization.
3. To help to prioritize those needs to ensure better planning of local services and more effective allocation of resources.

A Request for Proposals for researchers was issued in March 2008. The project was carried out by Shercon Associates Inc. of Oakville under the direction of a Needs Assessment Planning Group consisting of Network representatives from the Geriatric Mental Health Outreach Program, Brant CMHA, the HNHB Community Care Access Centre, the Alzheimer Society of Brant, St. Leonard's Community Services and McMaster University. Work began with a start-up teleconference on March 25, 2008 and a draft project report was issued on June 26, 2008.

1.2 Study Methodology

The study was designed to "triangulate" information obtained from three key constituencies - users of services, providers of services and policy makers/funders. The data collection stage therefore utilized several different qualitative and quantitative research methodologies to generate needs assessment data.

- An information review including salient literature, relevant reports, documents and similar studies in other jurisdictions. A list of references and other resources appears in Appendix A.
- A review of website information, directories, agency literature, MOHLTC funding allocations and other service data to construct a profile of services currently existing in Brant County for seniors affected by mental illness and addictions.
- Semi-structured key informant interviews with nine community professionals and government officials in a position to have a high-level overview of addictions and mental health services in Brant as well as provincially and nationally. The interviews were carried out by telephone by the lead consultant. Topics included broad views of the current services system, trends and issues and suggested future priorities.

- A comprehensive six-page provider questionnaire. Questionnaires were distributed by the Network with responses routed directly back to the consultant by mail, fax or through an on-line web template. Twenty-four responses were received from a cross-section of health and social services agencies, service providers and other key community organizations. The survey questions addressed awareness of current services, perceptions of service effectiveness, gaps between demand and supply, priorities for service enhancement, potential service duplication, perceived barriers to service and suggestions for service improvement.
- A demographic analysis to produce a statistical profile of Brant County with particular emphasis on variables related to population trends, age groups and population health. The analysis drew on 2001 and available 2006 census data. The demographic information was combined with data on mental health and addictions occurrences to produce an estimate of the number of seniors living with mental illness in Brant County and numbers affected with co-occurring dementia or addictions. Five and ten year projections were also drawn from the data.
- Telephone interviews with 15 members of the target population representing a cross-section of issues and circumstances. Respondents were first approached by the appropriate agencies to obtain informed consent prior to being contacted by the consultant. Questions addressed clients' met and unmet needs and their experiences in seeking help.

Information from the data collection phase was compiled, summarized and analysed in preparation for interpretation and reporting. Fixed choice responses from the provider questionnaire were tabulated using an Excel spreadsheet and open-ended information from the questionnaires and interviews was transcribed and content analysed. Data sets were turned over to the client at the conclusion of the project.

The project consultant reviewed preliminary study findings with the Needs Assessment Planning Group at a meeting held on June 9, 2008. Some additional data was then gathered and a full draft report was submitted to the committee on June 26, 2008. The group met on July 2, 2008 to review the draft report and this final report was prepared reflecting their input.

The consultant will remain on-call to the Planning Group for three months to respond to questions and provide advice re: interpretation and implementation of the findings.

2.3 Assessment of Data Quality

Great care was taken throughout the data collection and analysis steps to ensure the information gathered was objective, reliable and valid. A number of factors related to the data collection stage of the project suggest that there is a good level of data quality:

- The demographic analysis utilized the most current population data available and reputable sources of occurrence information.

- The provider survey response was small but representative, covering a good cross section of agencies, providers and organizations and including the major players in mental health and addictions in Brantford and Brant County. In some cases the questionnaires submitted by organizations represented a composite of input from several staff members.
- Information gathered from the interviews with members of the target group identified consistent themes across individuals and situations.
- Information from the key informants corroborated data from other parts of the study.
- The review of the preliminary findings with members of the Planning Group suggested that the data had good “face validity” in that it was consistent with their own experiences and perceptions. There were few anomalies in the findings.

There are also some limitations in the study. The demographic information may under represent the actual incidence of mental health and addictions issues in the senior’s population due to underreporting. Also, the data on the target group is restricted to seniors already receiving services. It did not prove possible to gather information first hand from “hard to serve” seniors due to problems in identifying, locating and accessing this group. Information about their needs had to be obtained indirectly through anecdotal accounts from key informants.

These limitations should be taken into account, but in sum, the data quality appears acceptable and the findings can be interpreted with a reasonable level of confidence.

Dr. David Sheridan
SHERCON ASSOCIATES INC.
Principal Investigator

July 16, 2008

2.0 DISCUSSION OF FINDINGS

2.1 Demographic Factors

The significant demographic trends related to seniors mental health and addictions issues in Brantford and Brant County are discussed in this section. Detailed statistical tables and charts appear in Appendix B.

2.1.1 Population Growth

Between 2001 and 2006 the population of the Brant CMA (Census Metropolitan Area for Brantford and Brant County) increased by 5.5% or 6,521 people. Growth was higher in Brant County (8.7%) vs. Brantford (4.4%). There has been significant residential development in Paris and St. George that explains the higher growth in Brant County. Overall the growth of the Brant CMA is below the provincial average of 6.6% growth.

Population growth in the senior's age group (age 65+) reflects the general pattern of the overall population. The senior's population in Brantford grew by 4.9% and in Brant County by 11.8%.

Growth is most significant in the oldest age group – 85 years and over. In Brantford this population grew by 19.1% and in Brant County by 12.6%. However, these growth rates are much less than the provincial level of 27.1%.

The 2006 census marks the last census before the impact of the post World War II baby boom (1945 - early 1960's). Individuals born in 1945 will turn 65 in 2010, just prior to the next census in 2011. The age group 60-64 is projected to increase from 6,095 to 8,500 (Brant CMA) or 40%.

The growth of the over age 65 group will have a significant impact on Brant during the next 25 years. Between 2007 and 2031 the population of the age 65 and over group will increase from 18,690 people to almost 39,200. This represents 13.6% of the population in 2007 and 22.8% of the population in 2031.

(See Appendix B, Figure 1)

2.1.2 Seniors with Mental Health and Addictions Issues

Quantifying mental illness among seniors depends on how mental illness is defined. If age related dementia and delirium, less severe mental illness and substance abuse are included the rate of mental illness among seniors ranges from 17% to 30%. Therefore, by 2010 between 3,400 and 6,000 seniors in Brantford and Brant County will have a mental illness. These rates are for seniors living in the community and not in long-term care residences. By 2020 between 4,800 and 8,400 seniors in the community will have a definable mental illness. (See Appendix B, Figure 2)

Seniors have the same rate of severe mental illness as the general population if age related illnesses such as Alzheimer Disease are not counted. This rate is approximately 2%. By 2010 almost 397 seniors in Brantford and Brant County will be living in the community with a severe mental illness such as schizophrenia, bi-polar illness or severe depression. By 2020 this will increase to approximately 559. While the actual number of individuals may appear small, they use a disproportionate amount of healthcare and community services. (See Appendix B, Figure 3)

Anxiety is a major problem for seniors with between 10% and 20% exhibiting diagnosable anxiety disorders. By 2010 between 2,000 and 4,000 seniors in Brantford and Brant County will have an anxiety disorder. By 2020 this will increase to between 2,800 and 5,600. Anxiety is closely linked to issues of aging such as spousal loss, isolation, financial issues and general health decline. (See Appendix B, Figure 4)

Depression is commonly categorized as major and minor depression. Among seniors major depression is identified in 1.2% while minor depression is identified in 11.2% of seniors. These frequencies are for seniors living in the community. For seniors living in long-term care homes the incidence of depression is between 30% and 40% (National Council on Aging, 1999). There are eight long-term care homes in Brantford and Brant County representative of a total of 390 total beds.

In Brantford and Brant County by 2010 just over 238 seniors will have a major depressive disorder while 2,221 seniors will have a minor depressive disorder. By 2020 336 seniors will have a major depressive disorder and almost 3,133 will have a minor depressive disorder. (See Appendix B, Figure 5). Similar to anxiety, depression is closely linked to common issues of aging. Depression is approximately twice as common in women as it is in men (Newmann, 1998). Unrecognized and untreated depression among seniors is suggested to result in excessive use of health care services, increased length of stay during hospitalization, decreased treatment compliance, and increased risk of medical illness and suicide. (Conn, 2002)

2.1.3 Seniors and Addictions

Alcohol is the most common addiction among seniors. It is estimated that between 5% and 11% of seniors abuse alcohol. In Brantford and Brant County this means that by 2010 between 1,000 and 2,200 seniors will have an alcohol addiction. By 2020 this will increase to 1,400 to 3,100 seniors. It should be noted that older men exhibit alcohol abuse issues almost twice as frequently as women. Additionally it is estimated that one third of seniors with alcohol abuse issues have developed their addiction after becoming a senior. (See Appendix B, Figure 6).

While there are undoubtedly seniors with other addictions to illegal substances, incidence rates are relatively low (but may be increasing). It is reported that abuse (purposely or by accident) of prescription drugs and over-the-counter medicine is a significant issue but it is difficult to accurately measure this. Gambling addictions are also a factor but are not reported here due to lack of available data.

2.1.4 Seniors with Dementia

Between 2005 and 2030 the number of seniors in Brantford and Brant County with dementia will increase by almost 90% from just fewer than 1,800 to almost 3,400. This rapid increase is directly related to the aging post World War II baby boom generation and the increasing life span of individuals in general. First, existence of a “baby boom” generation will simply mean that there are more seniors in general. Just as this generation has done all their lives, their disproportionate numbers will place increased demands on health care and social services similar to the increased demand they placed on the school systems when they were younger. Second, increasing life spans mean that there will be more seniors reaching the oldest age groups (90+) where the incidence of dementia is highest (52%). (Appendix B, Figure 7)

It is estimated that 40% of seniors with dementia have a co-occurring depressive disorder. In Brantford and Brant County this translates into approximately 620 individuals with dementia in 2005 also suffering from depression. By 2031 this number will increase to almost 1,500 individuals. These individuals are particularly hard to treat due to communication difficulties and other issues associated with dementia. (See Appendix B, Figure 8)

2.1.5 Seniors and Chronic Disease

Seniors are affected not only by mental illness and addictions but also chronic diseases. Chronic diseases are those involving a long course in their development or their symptoms (e.g. coronary heart disease, stroke, COPD, depression, lung cancer, diabetes, hypertension, dyslipidemia, osteoarthritis etc). A Canadian study (Fortin et al, 2005) confirms the increasing prevalence of multimorbidity with age in both men and women. More than 80% of older adults greater than 65 years of age had four or more chronic health problems. Chronic diseases cause medical, social and psychological problems that limit the activities of elderly people in the community and decrease their quality of life. While not all chronic diseases are life threatening, they are a substantial burden on the health and economic status of individuals, their families, and the community as a whole. It is suggested that a health care delivery system serving seniors needs to recognize care of chronic disease, and should emphasize continuing care aimed at improving functions, postponing deterioration and disability, and preventing complications.

2.2 Available Services

Ministry of Health and Long Term Care (MOHLTC) funded mental health and addictions organizations available to seniors in Brantford and Brant County appear in Table 1 below.

TABLE 1 - MOHLTC Funded Programs

<p>Brant Assertive Community Treatment (ACT) Team, St. Joseph's Healthcare Brant Community Healthcare System Brant Geriatric Mental Health Outreach Program, St. Joseph's Healthcare Brantford Vocational Training Association Canadian Mental Health Association, Brant County Branch St. Leonards Community Services, Addictions Services St. Leonards Community Services, Crisis Support</p>

While these programs are directly funded through the HNHB LHIN as designated mental health and addictions programs, numerous other organizations and providers service this target group in Brant County and many of these are represented in the provider survey discussed in the next section.

The "Four Quadrant Model" (Concurrent Disorders Policy Framework, 2005) is widely used to give addictions and mental health service providers a common framework for planning. Four quadrants are drawn based on severity of addictions and severity of mental illness of clients served. In May 2008 the member agencies of the Brant Mental Health and Addiction Network worked through a collaborative mapping exercise using the model.

Severity of Addiction	High	Quadrant III	Quadrant IV
	Low	Quadrant I	Quadrant II
		Low	High
	Severity of Mental Illness		

Forty separate mental health and addictions programs serving Brant clients of all ages were mapped to quadrants and it was found that the largest number of programs were in Quadrant II (Low addiction severity/high severity of mental illness) and the fewest number of programs appeared in Quadrant III (high addictions severity/low severity of mental illness). There were a relatively low number of Quadrant IV programs (high addictions severity/high mental illness severity). The exercise examined programs for all age groups, but it does reveal a need for more specialized integrated programs for individuals with concurrent disorders.

2.3 Perceptions of Service Providers

This section reviews the principal findings from the survey of 24 service providers in Brantford and Brant County. The questionnaire and detailed frequencies appear in Appendix C.

2.3.1 Respondent Profile

Twenty-four organizations and service providers in Brantford and Brant County responded to the survey, broken down as follows:

- 9 health and social services agencies
- 3 faith based organizations
- 2 mental health agencies
- 2 long-term care homes
- 2 independent service providers
- 1 psychiatrist
- 1 addictions agency
- 1 developmental services agency
- 1 hospital
- 1 retirement home
- 1 other organization

Close to half of the services provided by the respondents were targeted to seniors, although the percentage ranged from 0 to 100%. Referral sources included self-referred, families, health care professionals and other agencies. The age groups addressed and the services provided by the respondents appear in Table 2:

TABLE 2 - Services Provided and Age Groups Addressed

	Children 15 and under	Youth 16 to 18	Adults 19 to 59	Seniors 60+
Addictions services	2	3	5	4
Mental health services	4	7	9	11
Other services/supports	8	8	14	14

Figures represent number of responding agencies providing a service

2.3.2 Perceived Service Gaps

Respondents were presented with an alphabetical list of services and supports for seniors with mental health and/or addictions issues and asked to indicate the five services they felt were currently experiencing the greatest system pressure in terms of gaps between demand and supply. Findings appear in Table 3 on Page 12.

TABLE 3 - Perceived Service Gaps

		Mental Health #	Addictions #
Information and Prevention	Health promotion and prevention initiatives	5	4
	Information and referral	5	6
	Public education	3	4
	Column Percent →	12%	16%
Diagnosis and Treatment	Assessment	5	2
	Counselling and psychotherapy	6	4
	Family physicians	15	11
	General psychiatric services	6	3
	Geriatric psychiatric services	7	5
	Mental health in-patient care	7	-
	Residential treatment	-	8
	Service coordination and monitoring	7	4
	Withdrawal management	-	7
	Column Percent →	48%	51%
Community Support	Adult day programs	6	4
	Client advocacy	2	1
	Court supports	2	1
	Crisis intervention	9	4
	Family/caregiver supports	7	3
	Linking to services and supports	7	4
	One-to-one and/or group therapy	3	4
	Peer support and self-help initiatives	4	3
	Social and recreational programs	4	5
	Column Percent →	40%	33%

Figures represent number of respondents identifying item as a service gap

Identified gaps were greatest in the area of diagnosis and treatment in both the mental health and addictions sectors. Gaps in information and prevention services were greater in addictions, and gaps in community supports were greater in the mental health field.

Specific services seen by at least one-third of the respondents to be experiencing system pressure in terms of supply/demand gaps are listed below in order of mention.

- Family physicians (mental health and addictions)
- Crisis intervention (mental health)
- Residential treatment (addictions)
- Geriatric psychiatric services (mental health)
- Mental health inpatient care
- Service coordination and monitoring (mental health)
- Withdrawal management (addictions)
- Family/caregiver supports (mental health)
- Linking to services and supports (mental health)

2.3.3 Perceived Service Effectiveness

Respondents were asked to rate the overall effectiveness of various aspects of the system of services and supports for seniors with mental health or addictions issues in Brantford and Brant County. Results appear in Table 4 and reveal low ratings in the “poor” to “fair” range.

TABLE 4 - Perceived Service Effectiveness

	Rating
Having a positive impact on clients	2.3
Ensuring individuals receive services in a timely fashion	2.1
Coordination across programs and practitioners in the health care sector	2.1
Ensuring individuals receive the right services	2.0
Responding to the unique needs of seniors	2.0
Identifying and responding to community needs	1.9
Coordination across sectors	1.7
Providing flexibility and choice to clients	1.7
Overall Average:	2.0

Average ratings on a four-point scale where 4=excellent; 3=good; 2=fair and 1=poor

The highest rated item was having a positive impact on clients. Coordination across sectors and providing flexibility and choice to clients received the lowest ratings. Reasons for low ratings pertained to limited options, lack of service awareness, lack of physicians, poor coordination and transportation issues.

2.3.4 Service Priorities

Respondents were asked to (hypothetically) allocate \$1,000 in new funding to the various services and supports for seniors with mental health and or addictions issues in their community. Findings appear in Table 5 on Page 14.

An examination of Table 5 reveals that the main service priorities identified by the service providers, in descending order, were the following:

- Family physicians (the top priority)
- Family/caregiver supports
- Geriatric psychiatric services
- Crisis intervention
- Links to services and supports
- Adult day programs

These tend to parallel the service gaps identified in Table 3.

TABLE 5 - Service Priorities

		Amount \$
Information and Prevention 7%	Health promotion and prevention initiatives	24
	Information and referral	32
	Public education	16
Diagnosis and Treatment 51%	Assessment	56
	Counselling and psychotherapy	53
	Family physicians	209
	General psychiatric services	26
	Geriatric psychiatric services	84
	Mental health in-patient care	14
	Residential treatment	0
	Service coordination and monitoring	37
	Withdrawal management	8
	<i>Table 5 continued on next page</i>	
Community Support 40%	Adult day programs	71
	Client advocacy	8
	Court supports	5
	Crisis intervention	82
	Family/caregiver supports	95
	Linking to services and supports	72
	One-to-one and/or group therapy	16
	Peer support and self-help initiatives	34
	Social and recreational programs	42
2%	Other	16
	Total	\$1,000

Figures represent hypothetical funding dollars allocated by respondents

2.3.5 Obstacles and Barriers

Respondents were asked to review a list of potential obstacles and barriers to individual seniors with mental health and/or addictions issues accessing services and indicate the extent to which they were a problem in their community. Findings appear in Table 6 on Page 15 and reveal that transportation, lack of awareness of services and stigma are the greatest obstacles to seniors accessing mental health and addictions services in Brant and Brant County.

TABLE 6 - Obstacles and Barriers

	<i>Not a problem at all</i>	<i>Not too much of a problem</i>	<i>Somewhat of a problem</i>	<i>A large problem</i>
Lack of awareness of services	0	1	8	8
Transportation	0	3	7	9
Stigma re: accessing MH and addictions services	2	1	7	8
Long wait lists/wait times	0	2	11	5
Financial cost or out of pocket expenses	0	2	10	5
Physical mobility	0	3	11	5
Prohibitive admission criteria	0	4	10	3
Hours that supports or services are available	1	3	12	0
Geographic location of services	1	5	10	2
Language or cultural differences	2	5	10	2

Figures represent numbers of responses

2.3.6 Ratings of Local Service Agencies

Respondents were asked to rate how well specific agencies (members of the Brant Mental Health and Addictions Network) were doing in meeting the needs of seniors with mental health or addictions issues. Ratings appear on the next page:

TABLE 7 - Ratings of Local Agencies

	Rating (out of 5)	Don't know
Brant Community Healthcare System - MH Services	*	11 respondents
Brant Geriatric Mental Health Outreach System	*	8 respondents
Brantford Vocational Training System	*	17 respondents
Canadian Mental health Association, Brant County Branch	*	7 respondents
St. Leonard's Community Services - Addictions Services	*	10 respondents
St. Leonard's Community Services - Crisis Support	*	10 respondents
Average Rating - all agencies	3.4	

Ratings are out of 5 where 5=high and 1=low.

* Agency-specific ratings provided to individual organizations for consideration and feedback

The respondents gave mid-range to high ratings of the local agencies providing mental health and addictions services to seniors. However, what is noteworthy is the large number of respondents unable to give ratings and selecting the “don’t know” category, suggesting that the need for information about programs and services is widespread, cutting across service providers as well as individuals accessing services.

2.4 Experiences of Members of Target Group

This section discusses the findings from the telephone interviews with 5 caregivers and 10 individuals from the target population representing a cross-section of issues and circumstances. The group consisted of family members and individuals diagnosed with depression, anxiety disorders and in some cases, dementia. One respondent disclosed an addictions issue (alcohol). Ages of the individuals interviewed directly ranged from 60 to 75 years. Ages of individuals represented through caregiver interviews ranged from 63 to 88 years. The interviewees appear to be well served by a wide range of services including hospital, family physicians, psychiatrists, CMHA, geriatric outreach, vocational rehab, counsellors, pharmacists and group homes. Family history was a major factor in the respondent group with several reporting that they had other family members with mental health issues.

2.4.1 Accessing Services

Several interviewees stated they did not get services as “early as they should have”, due to stigma and denial of the need for assistance. Often they were “pushed” to seek help by family members. Their initial awareness of services available was low.

Primary health care providers, including some family physicians, were seen to be not adequately aware of mental health issues and services. One interviewee stated: “It took us three to four years to get help - no one knew how to handle it”. However, once individuals did receive services they felt they were “lucky” - but believed there are many other individuals with similar problems who were not being helped.

Significantly, when asked “what else would help you” most interviewees were not able to identify any additional services that would assist them.

2.4.2 Experience with Services

Those individuals and family members who had received services tended to be satisfied and felt the services made a difference. Psychiatry services were particularly well rated, but individuals would like more time with their psychiatrists and pointed to the need for more psychiatrists, nurses and other healthcare specialists. Several also identified a desire for more “relaxed clinics” dealing with depression vs. formalized settings. There was also an apparent preference for individual programming as many of the interviewees alluded to individual difficulties with group programs.

Family members reported some difficulties in getting individuals to utilize the right services. Respite care for persons with dementia was a case in point, where it frequently was not used due to the disruption and adjustment problems involved.

2.4.3 System Issues

Transportation was mentioned as a problem by several respondents. Interviewees also reported experiencing some stigma and lack of understanding on the part of the public as well as some service providers. Several described their own personal and financial difficulties occurring as a result of their condition.

Several individuals expressed some concerns about getting their future needs met as their condition deteriorated and their eligibility for funding (such as ODSP) changed.

As previously mentioned in Section 1.3 (Assessment of Data Quality) it was not possible to gather information first hand from “hard to serve” seniors due to problems in identifying, locating and accessing this group. However, key informants and several members of the target group did offer some anecdotal accounts of seniors with mental health and/or addictions issues not receiving services. In one instance, a woman with dementia and (undiagnosed) mental health issues was reported to be living alone under unsafe and unhealthy conditions, but resisting any attempts by neighbours and the local church to provide assistance. Other cases involved seniors defaulting on rent due to alcohol and gambling addictions.

2.5 **Views of Key Informants**

The nine “key informants” who participated in semi-structured telephone interviews with the consultant included three geriatric psychiatrists, one geriatrician, a senior LHIN official, agency and association executives, a municipal official and a church minister actively involved in the community.

Key points raised in the interviews included the following:

- System strengths in Brantford and Brant County included existing specialized geriatric services, outreach, an emphasis on recovery, experienced and stable service providers, and collaboration among health and social service agencies.
- A major system weakness was the lack of awareness/connections between family physicians and adult psychiatrists, geriatricians and geriatric psychiatrists. A need was identified for improved linkages, joint planning and shared models of care.
- Other system shortcomings were the need for more resources across the system, lack of a critical mass of specialized care, urban/rural equity and access issues and the need for improved utilization of existing programs.

- Priority needs were identified in specialized care, rural services, transportation and provider education.
- Some key informants referred to the lack of a high-level coordinated system for addressing mental health - with mental health, dementia and seniors issues being prioritized and addressed separately by funders and planners.
- Future trends included an increase in self referrals and service uptake by new seniors with different attitudes, multicultural groups and stigmatism re: addictions issues, increasing complexity of patients, increasing difficulties re: recruitment of specialized health care providers and more addictions issues as baby boomers become seniors.

Overall, the key informants called for systems solutions across sectors, single point accountability, education and the need for capacity building involving the whole population rather than treating seniors as a specialized group.

3.0 CONCLUSIONS

The needs of the target group can be addressed under three areas - service gaps, process issues and system barriers. Conclusions in this section are based on “triangulated” findings that emerged across the various data sources, including the demographics, key informant interviews, provider survey and target group interviews.

3.1 Service Needs

Family physicians, specialized care (physician and non-physician providers trained in mental health and addictions) and family/caregiver supports are the major service needs for seniors with mental health and addictions issues in Brantford and Brant County. These should be considered as priorities in future planning and funding requests.

3.2 Process Issues

A number of process-related issues should also be addressed, including:

- The need for improved linkages, communication and follow-up between and among service providers, especially family physicians, geriatricians and psychiatrists
- Inadequate knowledge and understanding of mental health and addictions issues and services by service providers
- Difficulties with transition between sectors, such as the move of seniors from the community to the long-term care system

Future planning should place a priority on provider education, system coordination and opportunities for increased linkages and collaboration among providers.

3.3 System Barriers

There are major obstacles that interfere with senior’s accessing mental health and addictions services in a timely and effective manner. These include:

- Transportation
- Stigma related to mental health and addictions on the part of the public and in some cases, service providers
- Denial on the part of many seniors, preventing or delaying access to services
- Low knowledge by seniors about how to locate and access services and supports

Future planning should place a priority on improved transportation, public education and aggressive outreach to seniors in the community.

Findings from this study will be used to inform planning by local service agencies and will be incorporated into the Master Aging Plan for Brantford and Brant County currently being carried out under a grant from the Trillium Foundation.

Appendix A - LIST OF SOURCES

British Columbia Ministry of Health Services, Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities. February 2002.

Canadian Coalition for Seniors' Mental Health, National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Depression, 2006.

Canadian Mental Health Association, Brant County Branch, Family Evaluation Survey Report. March 2006.

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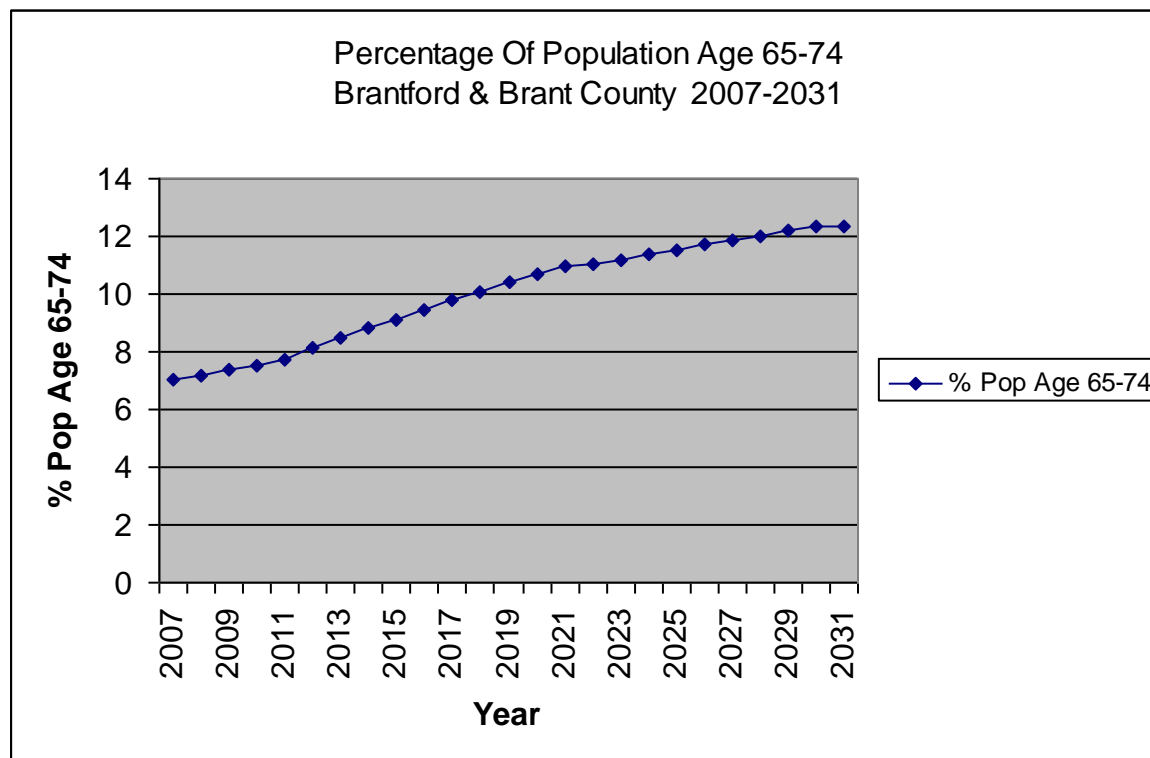
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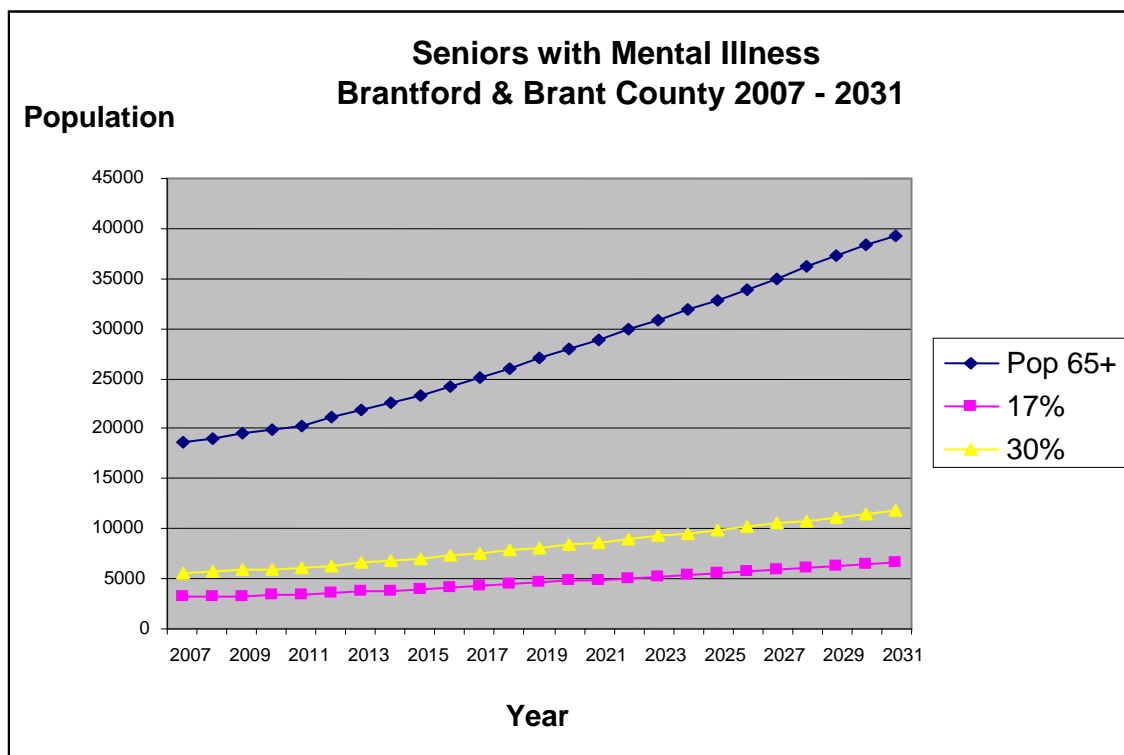
APPENDIX B
Demographic Graphs and Charts

FIGURE 1 - Population Projections

Brantford & Brant County Population Growth 2007-2031				
	2007		2031	
	Population	% of Pop.	Population	% of Pop.
Age 65-74	9530	7.0	21270	12.4
Age 75-84	6820	5.0	13710	8.0
Age 85+	2340	1.7	4220	2.5
Age 65+	18690	13.7	39200	22.8
Total Population	135940		171980	
	Growth 2007-2031		Average Annual Growth 2007-2031	
65-74	123.2		5.1	
75-84	101.0		4.2	
85+	80.3		3.3	
Age 65+	109.7		4.6	
Total Population	26.5		1.1	

Sources: Statistics Canada estimates, 2007, and projections of Ontario Ministry of Finance.

FIGURE 2 - Seniors with Mental Illness



Note: Includes age related mental illness (delirium & dementia), substance abuse and less severe mental illness. Range is 17% to 30%

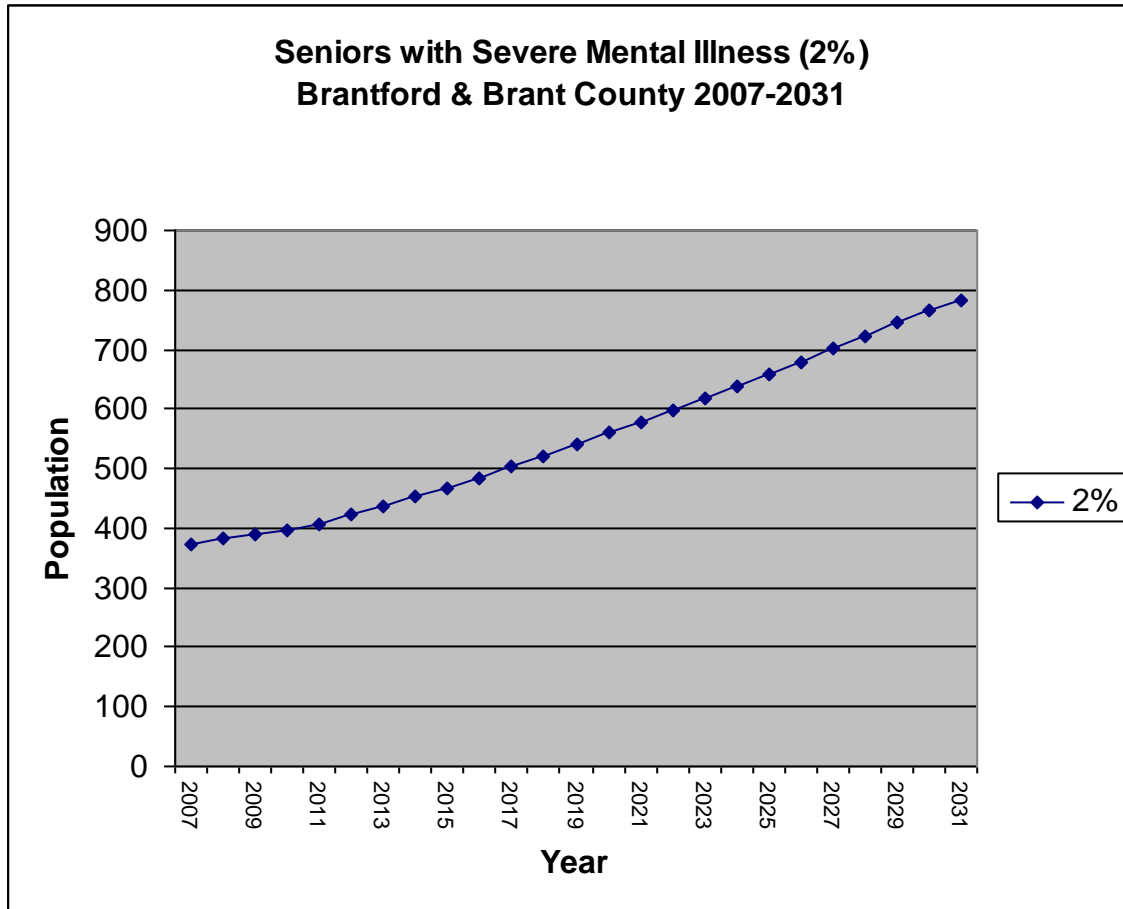
**Seniors with Mental Illness in Brantford and Brant County
Range 17% to 30%**

Year	pop 65+	17%	30%
2007	18690	3177.3	5607
2008	19060	3240.2	5718
2009	19460	3308.2	5838
2010	19830	3371.1	5949
2011	20290	3449.3	6087
2012	21080	3583.6	6324
2013	21910	3724.7	6573
2014	22650	3850.5	6795
2015	23380	3974.6	7014
2016	24230	4119.1	7269
2017	25120	4270.4	7536
2018	26050	4428.5	7815
2019	27010	4591.7	8103
2020	27970	4754.9	8391
2021	28900	4913	8670
2022	29890	5081.3	8967

2023	30910	5254.7	9273
2024	31890	5421.3	9567
2025	32870	5587.9	9861
2026	33970	5774.9	10191
2027	35040	5956.8	10512
2028	36130	6142.1	10839
2029	37300	6341	11190
2030	38340	6517.8	11502
2031	39200	6664	11760

Source: Elderly Mental Health Care Working Group (2002). Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities. Vancouver, British Columbia: British Columbia Ministry of Health Services

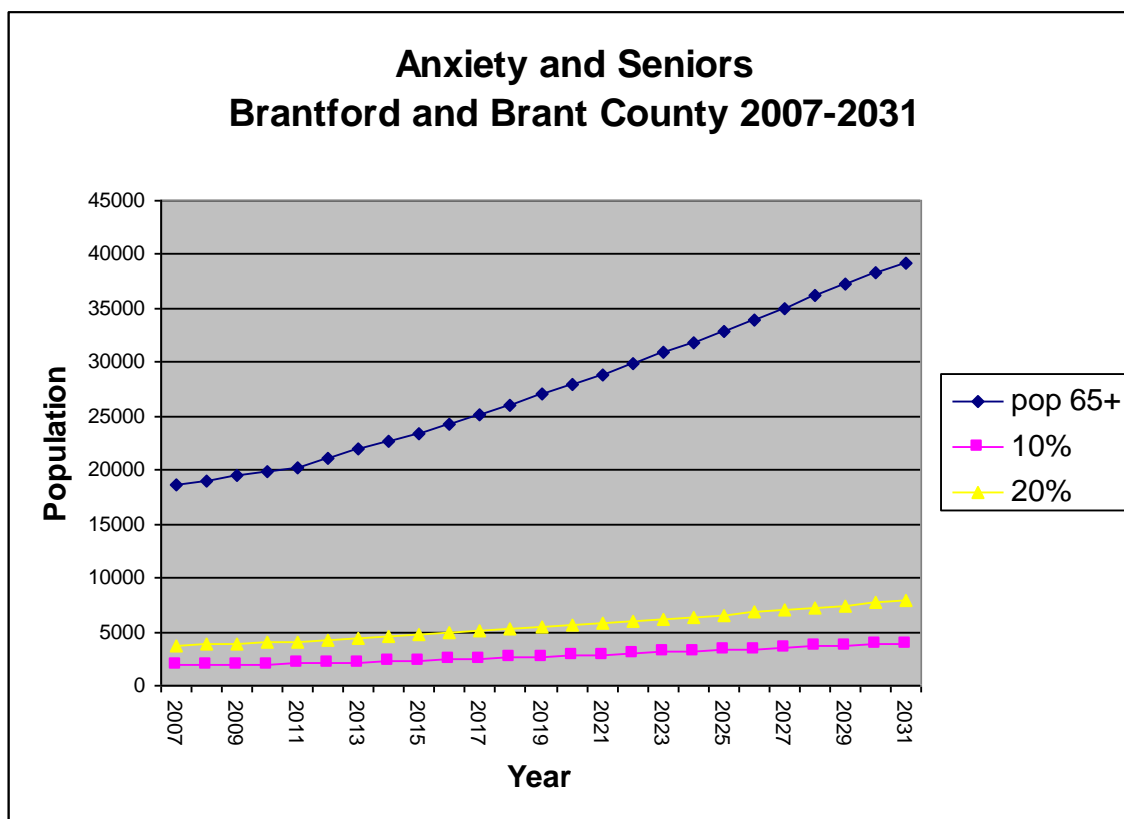
FIGURE 3 - Seniors with Severe Mental Illness



Seniors with Serious Mental Illness					
Year	65+	2%	Year	65+	2%
2007	18690	374	2019	27010	540
2008	19060	381	2020	27970	559
2009	19460	389	2021	28900	578
2010	19830	397	2022	29890	598
2011	20290	406	2023	30910	618
2012	21080	422	2024	31890	638
2013	21910	438	2025	32870	657
2014	22650	453	2026	33970	679
2015	23380	468	2027	35040	701
2016	24230	485	2028	36130	723
2017	25120	502	2029	37300	746
2018	26050	521	2030	38340	767
			2031	39200	784

Source: Conn, D. K. (2002). An Overview of Common Mental Disorders among Seniors. Writings in Gerontology, No .18, 19-32, National Advisory Council on Aging.

FIGURE 4 - Anxiety and Seniors

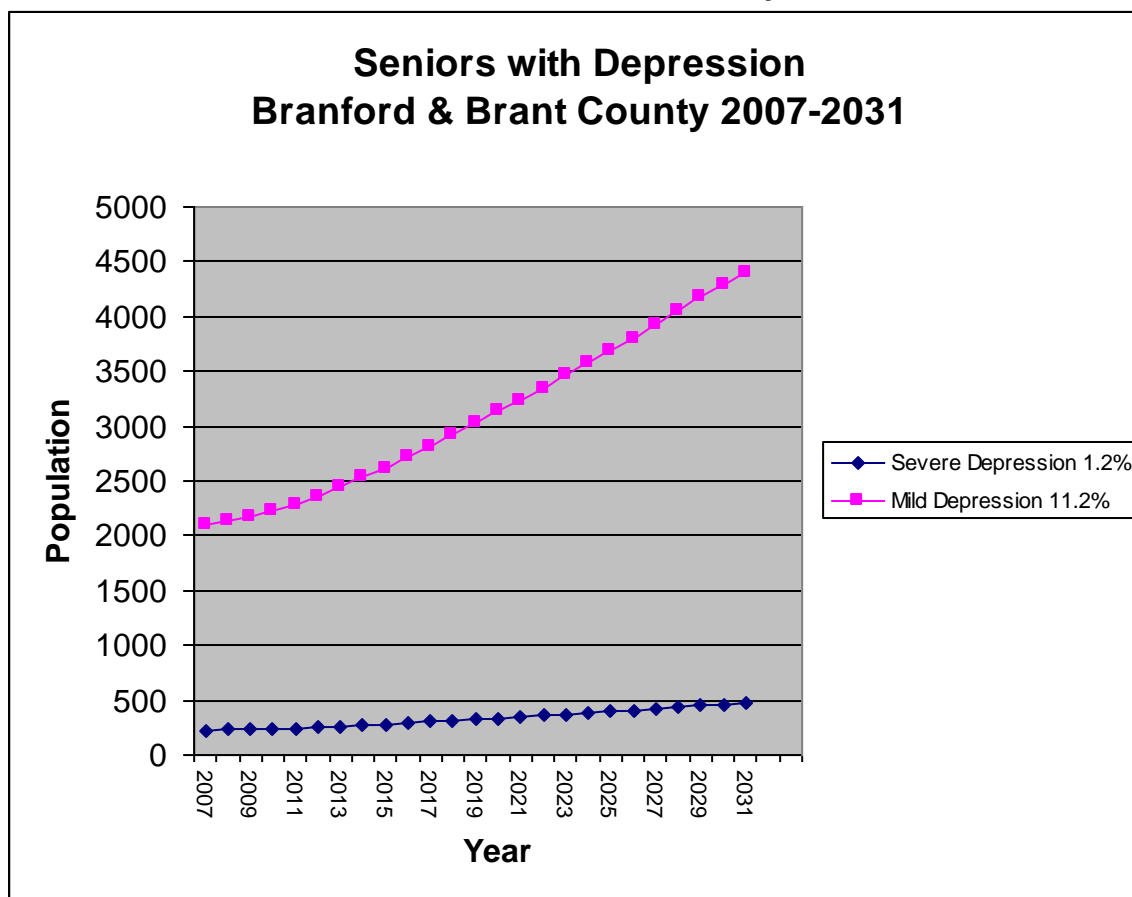


Anxiety			
Year	pop 65+	10%	20%
2007	18690	1869	3738
2008	19060	1906	3812
2009	19460	1946	3892
2010	19830	1983	3966
2011	20290	2029	4058
2012	21080	2108	4216
2013	21910	2191	4382
2014	22650	2265	4530
2015	23380	2338	4676
2016	24230	2423	4846
2017	25120	2512	5024
2018	26050	2605	5210

2019	27010	2701	5402
2020	27970	2797	5594
2021	28900	2890	5780
2022	29890	2989	5978
2023	30910	3091	6182
2024	31890	3189	6378
2025	32870	3287	6574
2026	33970	3397	6794
2027	35040	3504	7008
2028	36130	3613	7226
2029	37300	3730	7460
2030	38340	3834	7668
2031	39200	3920	7840

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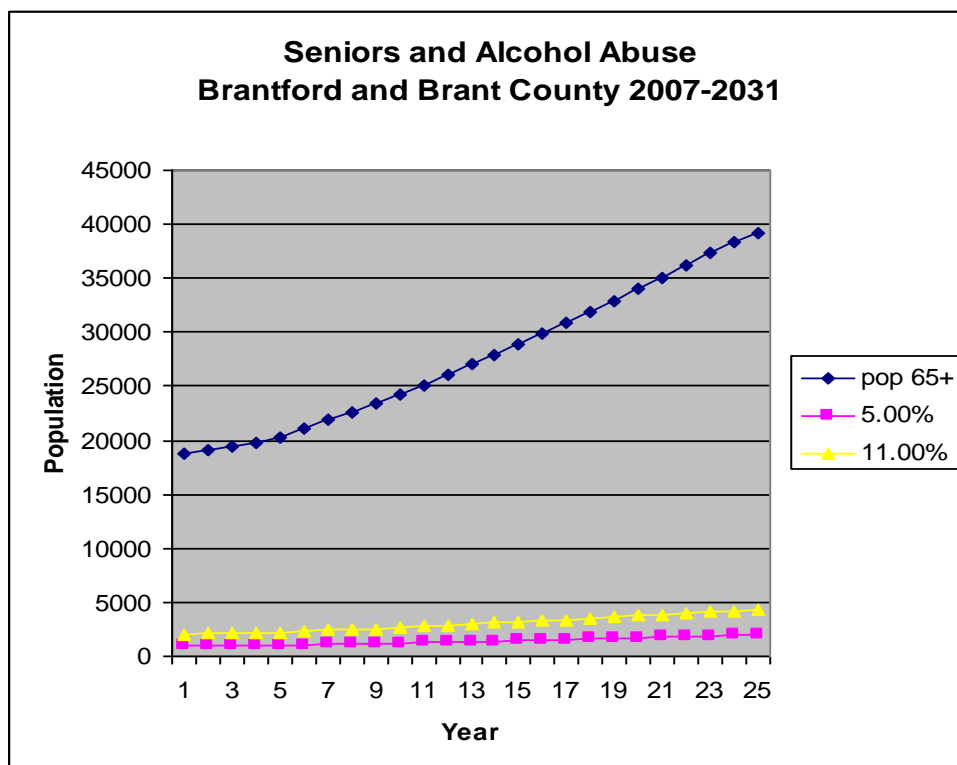
FIGURE 5 - Seniors with Depression



Year	Pop 65+	1.20%	11.20%	Year	Pop 65+	1.20%	11.20%
2007	18690	224	2093	2020	27970	336	3133
2008	19060	229	2135	2021	28900	347	3237
2009	19460	234	2180	2022	29890	359	3348
2010	19830	238	2221	2023	30910	371	3462
2011	20290	243	2272	2024	31890	383	3572
2012	21080	253	2361	2025	32870	394	3681
2013	21910	263	2454	2026	33970	408	3805
2014	22650	272	2537	2027	35040	420	3924
2015	23380	281	2619	2028	36130	434	4047
2016	24230	291	2714	2029	37300	448	4178
2017	25120	301	2813	2030	38340	460	4294
2018	26050	313	2918	2031	39200	470	4390
2019	27010	324	3025				

Source: Newman, S.C.; Bland, R.C.; Ron, H.T. (1998). "The prevalence of Mental Disorders in the Elderly in Edmonton: A Community Survey Using GMS-AGECAT. *Canadian Journal of Psychiatry*, 43(9).

FIGURE 6- Seniors and Alcohol Abuse

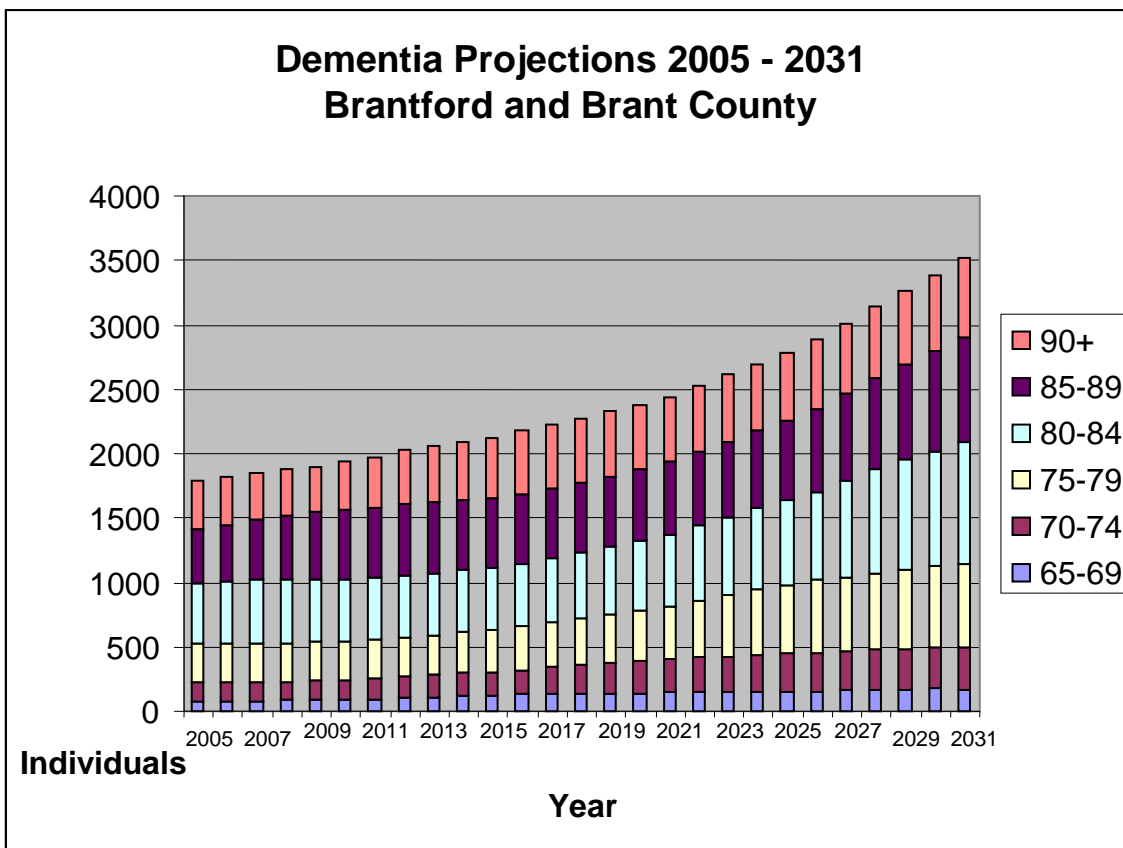


Alcohol Abuse			
Year	pop 65+	5.00%	11.00%
2007	18690	935	2056
2008	19060	953	2097
2009	19460	973	2141
2010	19830	992	2181
2011	20290	1015	2232
2012	21080	1054	2319
2013	21910	1096	2410
2014	22650	1133	2492
2015	23380	1169	2572
2016	24230	1212	2665
2017	25120	1256	2763
2018	26050	1303	2866

2019	27010	1351	2971
2020	27970	1399	3077
2021	28900	1445	3179
2022	29890	1495	3288
2023	30910	1546	3400
2024	31890	1595	3508
2025	32870	1644	3616
2026	33970	1699	3737
2027	35040	1752	3854
2028	36130	1807	3974
2029	37300	1865	4103
2030	38340	1917	4217
2031	39200	1960	4312

Source: McEwen, K.L. et al. (1991). Mental Health Problems among Canada's Seniors: Demographic and Epidemiologic Considerations. Ottawa, Ontario: Health and Welfare Canada

FIGURE 7 - Seniors with Dementia



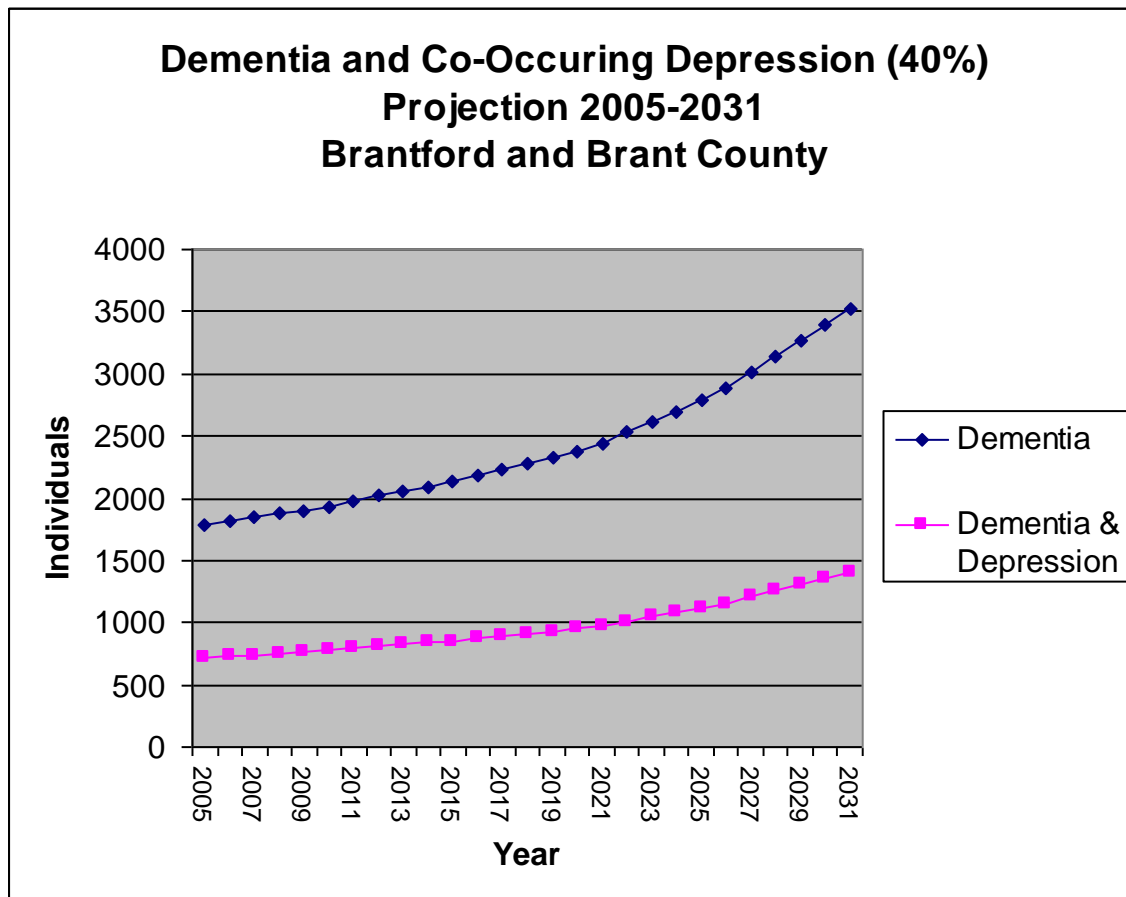
Brantford and Brant County Dementia Projections 2005-2031							
Age Groups							
Year	65-69	70-74	75-79	80-84	85-89	90+	Total
Incidence	1.52%	3.36%	7.94%	16.24%	28.36%	51.78%	
2005	74	145	301	479	414	378	1791
2006	77	145	299	487	439	367	1815
2007	79	144	298	500	462	362	1846
2008	83	147	295	502	490	357	1874
2009	87	151	297	490	519	352	1895
2010	90	154	301	482	530	378	1935
2011	93	159	301	481	541	398	1974
2012	102	165	301	482	555	419	2025
2013	109	173	307	477	558	435	2059
2014	115	180	316	482	547	455	2095
2015	121	186	322	489	538	471	2128
2016	128	194	334	492	541	486	2176
2017	130	212	347	494	547	502	2231
2018	132	227	363	505	544	507	2279
2019	136	240	379	520	550	502	2327
2020	141	252	394	531	558	502	2379
2021	143	266	410	552	564	507	2442
2022	146	270	448	575	572	518	2529

2023	149	275	483	604	584	518	2612
2024	150	284	509	632	604	518	2696
2025	153	293	535	658	621	528	2787
2026	157	299	563	687	643	533	2882
2027	160	306	572	754	674	549	3015
2028	164	312	585	812	714	559	3146
2029	169	317	605	857	748	574	3271
2030	173	322	626	901	778	590	3391
2031	171	332	639	950	816	616	3524

Source: Hopkins et. al, 2005

Percentage Increase	
2005-2010	8.00%
2005-2015	18.80%
2005-2020	32.83%
2005-2025	55.61%
2005-2030	89.34%

FIGURE 8 - Dementia and Depression



Source:

Source: Friedman E.A. and Stark stein, S.E.: Treatment of Depression in Patients with Dementia” Epidemiology, Path physiology and Treatment.

APPENDIX C
BRANT MENTAL HEALTH AND ADDICTIONS NETWORK
Survey of Service Providers and Community Organizations

The Brant Mental Health and Addictions Network is conducting an assessment of the needs of seniors (older adults over the age of 60 years) living in Brantford or Brant County affected by mental illness with or without co-occurring dementia or addictions issues. The primary focus of the study is on seniors who live in the community. Study findings will be used to inform system, community and program planning and support other initiatives such as the Aging at Home Strategy and the Brant Master Aging Plan.

Please complete and return this questionnaire to the address on Page 6 no later than 5:00 p.m. Friday, May 23, 2008. **You may also complete this questionnaire on-line** by going to www.shercon.ca, clicking on "Surveys", and following the instructions.

If you are unsure, or don't know the answer to a particular question, simply leave that item blank. It is not necessary to answer all the questions.

1. Please provide the following background information:

Name of Agency or Service Provider **24 respondents**

Type of Organization: *Check all that apply*

<p>2 Mental health agency</p> <p>1 Addictions agency</p> <p>1 Developmental services agency</p> <p>9 Other health and social services agency</p> <p>3 Independent service provider such as a physician, therapist, etc.</p> <p>1 Other</p>	<p>3 Faith based organization</p> <p>1 Hospital</p> <p>1 Retirement Home</p> <p>2 Long-term care facility</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------

Estimated percentage of your services that are targeted to seniors: **48%**

Referral sources for seniors: *Check all that apply*

<p>18 Self referred</p> <p>17 Family</p> <p>16 Health care professional</p>	<p>13 Hospital</p> <p>14 Other agency</p> <p>0 Other: _____ (Specify)</p>
--------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------

2. Indicate the age groups that are addressed by your services:
Check all boxes that apply

	Children 15 and under	Youth 16 to 18	Adults 19 to 59	Seniors 60+
Addictions services	2	3	5	4
Mental health services	4	7	9	11
Other services/supports	8	8	14	14

3. Do you provide any services that are intended primarily for seniors?

10 Yes -----> 3a. Please specify below:

11 No **Various initiatives**

4. A list of existing services and supports for seniors with mental health and/or addictions issues appears below. Please review the list and indicate the five services that you feel are currently experiencing the greatest system pressure in terms of gaps between demand and supply in Brantford and Brant County. Do this for both mental health and addictions services - so you will be checking five items in each column.

	<u>Mental Health</u> (Check five)	<u>Addictions</u> (Check five)
Information and Prevention		
Health promotion and prevention initiatives	5	4
Information and referral	5	6
Public education	3	4
Diagnosis and Treatment		
Assessment	5	2
Counselling and psychotherapy (one to one or group)	6	4
Family physicians	15	11
General psychiatric services	6	3
Geriatric psychiatric services	7	5
Mental health in-patient care	7	-
Residential treatment	-	8
Service coordination and monitoring	7	4
Withdrawal management	-	7
Community Support		
Adult day programs	6	4
Client advocacy	2	1
Court supports	2	1
Crisis intervention	9	4
Family/caregiver supports	7	3
Linking to services and supports	7	4
One to one and/or group therapy	3	4
Peer support and self-help initiatives	4	3
Social and recreational programs	4	5

Comments to explain your choices:

Low awareness of services; physician shortages; wait times; overall lack of resources

5. Are there any other necessary services or supports for this target group that presently do not exist in the community?

8 Yes -----> 5a. Please specify below:

2 No

Outreach, nutrition, behavioural issues, transportation, recreation in LTC

6. Still thinking of the system of services and supports for seniors with mental health or addictions issues, rate its overall effectiveness in accomplishing the following:

	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>
2.0 Responding to the unique needs of seniors	0	6	6	6
2.1 Coordination across programs and practitioners in the health care sector	0	5	9	4
1.7 Coordination across sectors	0	2	10	7
1.7 Providing flexibility and choice to clients	0	1	10	6
2.0 Ensuring individuals receive the right services	0	4	8	4
2.1 Ensuring individuals receive services in a timely fashion	0	5	9	4
1.9 Identifying and responding to community needs	0	3	10	4
2.3 Having a positive impact on clients	0	8	8	2

7. If you gave a rating of "fair" or "poor" to any of the items in Question 8, please explain below:

Limited options; lack of service awareness; lack of physicians; poor coordination; transportation.

8. Do you feel there is any unnecessary duplication of services for seniors with mental health or addictions issues in Brantford or Brant County?

0 Yes -----> 8a. Please specify below:

9 No _____

9. Assume that you have \$1,000 in new funding to distribute to the various services and supports for seniors with mental health and/or addictions issues in your community. Thinking in terms of your answers to the previous questions, allocate these funds across the services below:

You can allocate the funds any way you want but the total should add up to \$1000

	Amount
Information and Prevention:	
Health promotion and prevention initiatives	24
Information and referral	32
Public education	16
Diagnosis and Treatment:	
Assessment	56
Counselling and psychotherapy (one to one/group)	53
Family physicians	209
General psychiatric services	26
Geriatric psychiatric services	84
Mental health in-patient care	14
Residential treatment	0
Service coordination and monitoring	37
Withdrawal management	8
Community Support:	
Adult day programs	71
Client advocacy	8
Court supports	5
Crisis intervention	82
Family/caregiver supports	95
Linking to services and supports	72
One to one and/or group therapy	16
Peer support and self-help initiatives	34
Social and recreational programs	42
Others: Refer to your answer in Q. 5a and list below:	16
Total:	1000

10. A number of potential obstacles or barriers to individual seniors with mental health or addictions issues accessing services are listed below. Indicate the extent to which each of these are a problem in your community:

	<i>Not a problem at all</i>	<i>Not too much of a problem</i>	<i>Somewhat of a problem</i>	<i>A large problem</i>
2.7 The hours that supports or services are available	1	3	12	0
2.7 The geographic location of where the services are provided	1	5	10	2
3.3 Transportation.....	0	3	7	9
3.1 Physical mobility	0	3	11	5
3.2 Stigma related to accessing mental health and addictions services.	2	1	7	8
3.2 The financial cost or out-of-pocket expenses to individuals	0	2	10	5
3.2 Long wait lists/wait times	0	2	11	5
2.9 Prohibitive admission criteria ...	0	4	10	3
3.4 Lack of awareness of services ...	0	1	8	8
2.6 Language or cultural differences ...	2	5	10	2

11. Are there any other obstacles or barriers that interfere with members of this target group receiving the services or supports that they need?

“Double dipping” of recreation in LTC; lack of awareness; stigma

12. Some of the local agencies that provide specialized mental health and addictions services to seniors are listed below: Rate how well each agency is doing in meeting the needs of seniors with mental health or addictions issues. Use a five-point scale where “5” represents meeting needs very well and “1” represents not meeting needs at all. *If you feel you do not have enough information to rate a particular agency, check the “don’t know” category.*

	<i>Rating (circle) 5-high; 1-low</i>	<i>Feedback or suggestions for this agency:</i>	<i>Don't Know</i>
Brant Community Healthcare System - Mental Health Services	5 4 3 2 1		11 Cont'd

Q. 14 - Continued	Rating (circle) 5-high; 1-low	Feedback or suggestions for this agency:	Don't Know
Brant Geriatric Mental Health Outreach Program	5 4 3 2 1		8
Brantford Vocational Training Association	5 4 3 2 1		17
Canadian Mental Health Association, Brant County Branch	5 4 3 2 1		7
St. Leonard's Community Services :			
• Addictions Services	5 4 3 2 1		10
• Crisis Support	5 4 3 2 1		10

Average rating for all agencies was 3.4 out of 5

13. Feel free to make any additional suggestions for overall service improvement for seniors with mental illness or addictions issues in Brantford and Brant County:

14. Completed by: _____ *Name*
 _____ *Title*

If necessary, may the consultant contact you directly for clarification or elaboration?

- 19** Yes → Contact information: _____ *Phone*
4 No _____ *e-mail*

Please return your questionnaire (mail, fax or on-line) directly to the research consultant at the address below.

Dr. David Sheridan
 SHERCON ASSOCIATES INC.
 99 Bronte Road #102
 Oakville, ON L6L 3B7

Fax: (905) 465-0845
 E-mail: dsheridan@shercon.ca
 Phone/voice mail: (905) 465-2600

Remember, you can also complete this questionnaire on-line by going to www.shercon.ca clicking on "Surveys" and following the instructions.

Regardless of which method you use to reply to the survey, the deadline is Friday, May 23, 2008.