Considering Seniors’ Mental Health in Federal and Provincial Policies in Canada: Focus on Home Care and Long-Term Care

Where have we been? Where are we going? And why does it matter?

By
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ABSTRACT

CONSIDERING SENIORS’ PROVINCIAL MENTAL HEALTH POLICIES IN CANADA: FOCUS ON HOME CARE AND LONG-TERM CARE.
WHERE HAVE WE BEEN? WHERE ARE WE GOING? AND WHY DOES IT MATTER?

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Increased life expectancies and the prevalence of chronic illness in late life have illuminated a structural lag in our healthcare systems. While Canada’s publicly insured healthcare system was designed around acute illness, older adults use home and long-term care services more than other age groups. There is also a need for understanding the impact and prevalence of mental illnesses in late life. Given that older adults with mental illness frequently use services outside of the publicly insured healthcare system, this dissertation explores how provinces have organized home and long-term care to support older adults with mental health issues. This research is guided by the political economy theory of aging and the life course theoretical perspective.

Qualitative methods including the Policy Triangle Framework and Framework Analysis were used in this comparative analysis of Alberta, British Columbia, Nova Scotia, and Ontario. Through analysis of 23 policy documents and 18 key informant interviews, findings are organized by themes associated with research questions. This includes analysis of the content of the policies, and an exploration of the key drivers, processes, context, and actors/champions that interact to shape policymaking. Current policy gaps and alignment with evidence in the field are examined.

Cross-provincial analysis found that seniors’ mental health falls between gaps in policies. Furthermore, mental health strategies focus on children/youth, and aging policies often minimize mental health issues beyond dementia. Provincial political ideologies and contexts influence messaging in policies, as evidenced by a residualist social welfare model in Alberta. Apocalyptic demography, especially intergenerational justice, is found within policy documents, focusing on “fair” and “equitable” systems that meet the needs of seniors without compromising other populations. Across provinces there is divergence from research in terms of the perspective around mental illness and dementia. Instead of taking an integrated view, policy silos and legacies separate dementia as a medical/organic issue and mental illness as a psychiatric issue. Promising innovations are also highlighted.

Theses findings contribute to the literature about seniors’ mental health policy in Canada. Challenges to doing applied health policy analysis in an ever-changing landscape are discussed, and future research directions and policy recommendations are offered.
Acknowledgements

For a journey as long as mine through a PhD there are endless individuals to thank. Before anyone, my gratitude must be extended to Dr. Joseph Tindale for his ongoing mentorship and advising. It is an honour to work with someone you respect so tremendously and with someone who has made such significant contributions to the gerontology field. In addition to Joe, I am sincerely grateful for the advising support, kindness, and policy expertise of Dr. Donna Lero. I also want to thank Dr. Gillian Mulvale for her ongoing support and inspiration throughout this process. I’d also remiss if I didn’t acknowledge the editing support from Avril McMckMeekin!

I also want to thank those who participated in my research and assisted in connecting me with key informants across the country.

When I started my PhD I worked full time with the Canadian Coalition for Seniors’ Mental Health. Drs. Ken Le Clair and David Conn graciously allowed me to continue my work while starting my PhD and were incredible sources of support and inspiration. The CCSMH family and network were truly the catalyst for my interest in this project and I’m so grateful for the opportunities I was granted during my 8 years there.

I feel incredibly luck to have found my home within the Department of Family Relations and Applied Nutrition. In particular, the leadership of Michael Nightingale shaped my experience as a graduate student and for that I am deeply grateful. The many incredible colleagues I had during my time as a student are too great to name – from my wonderful friendships with fellow students and the network of PhD student support, to the opportunity to work with exceptionally talented faculty members and research teams – I feel incredibly lucky! I must especially thank my team of supporters who were instrumental in my final stages of writing and defence prep – Carm, Erin, Jane, Jaqui, & Tricia … I genuinely can’t thank you enough. I look forward to our ongoing collaborations!

And finally, as a researcher passionate about promoting mental health I must acknowledge the keys to my own mental health. It might seem silly but thanks to the incredible team at Pilates in Guelph who unknowingly have been a key to my physical and mental health.

Most importantly – there are no words to thank my family who has offered endless support for my (long) journey through academia. Mom, Erin, Steph, Richard, Julie … thank you for being interested in what I do (or being willing to feign interest) and for continuing to keep me healthy and happy and for sharing the highs and lows with me. And for your ongoing willingness to celebrate all the milestones (big and small) with champagne! Plus there is no greater source of joy than my two nephews (and Rox and Jazz). Thanks to the extended family for keeping me around despite my absence! And my dear friends who have at times been neglected as I buried myself in work … thank you for continuing to love me, keeping me laughing, and sharing your incredible lives (and babies!) with me.
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Chapter 1: Introduction

Canada, like many other countries, is experiencing an aging population due to longer life spans, the aging of the baby boom population, and fertility rates that have not met the replacement rate since 1971 (Statistics Canada, 2014a, 2014b). In addition to changes in the demographic profile of Canada, there has been a parallel shift in the health profile of Canadians, often resulting in a mismatch between needs and services available through the publicly funded healthcare system. In particular, the Canada Health Act has been critiqued for excluding community-based mental health services, home care services, and long-term care from the list of insured health services. These exclusions, along with changes to the health policy landscape in Canada, result in increased provincial/territorial responsibility for health policy making in these domains, opening the door for significant variations in the way older adults are positioned in relation to health and mental health policies and services across the country. Given this context, my research is focused on provincial differences in current policy approaches and philosophies and will identify strengths and weaknesses of each provincial policy landscape and offer recommendations for future seniors’ mental health policies. This knowledge is important for ongoing policy development across provinces as regions prepare for demographic changes and will contribute to the development of a foundation of recommendations for any future national polices or strategies focused on seniors’ health.

The guiding research question for this policy analysis is how have provinces organized their extended healthcare services (specifically focused on long-term care and home care) to support older adults with mental health issues? To help answer this question, I compared the structure of government organizations and policy-making processes for seniors and mental health in four provinces (Alberta, British Columbia, Ontario, and Nova
Additionally, within each province I reviewed policy documents in the areas of aging and mental health with a specific focus on how policies in these areas intersect with home care and long-term care policies. I also interviewed key informants working in government and in community agencies in each province to deepen my knowledge about the policies and frameworks that support older adults with mental health problems through home care and/or long-term care. Specifically, I set out to understand the intended goals of each policy/framework and how it aligns with the broader provincial vision for seniors’ mental health and with current evidence in the field. This analysis will illustrate strengths and gaps in policies related to mental health in older adults across the healthcare continuum and offer recommendations for sharing knowledge across provinces and in future policy development.

1.1 Setting the Context: Seniors’ Mental Health in Canada

1.1.1 Changing Demographics

In the year 2011 the first members of the generation known as the baby boomers (those born between 1946 and 1964) in Canada turned age 65, and it is projected that by 2015 Canada will have more seniors than children for the first time ever (Canadian Institute for Health Information [CIHI], 2011). For several decades government, media, and the public have fixated on the potential impacts of the aging of the baby boom cohort, with particularly negative focus on the collapse of public systems, primarily pensions and health care (Gee & Gutman, 2000; Gee, 2002; Martin, Williams & O’Neill, 2009).

As Canadians continue to live longer, the number and proportion of those categorized as seniors (typically identified as those 65 and older) also grow (Chappell & Hollander, 2013). Recent census data illustrate this: in 2011 those aged 60–64 had the highest rate of growth (29.1% between 2006 and 2011), suggesting increasing population aging as the baby boom generation continues to age (Statistics Canada, 2012a). Between 1983 and 2013, those 80

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1 Detailed information about the selection criteria for provincial inclusion is available in Chapter 3.
years and older posted the largest growth rate when compared with the national average, increasing by 108.6% (Statistics Canada, 2013). Growth is also seen through increased life expectancies. According to data collected between 2007 and 2009 in Canada, for those who reach age 65 the average life expectancy is an additional 20 years (Statistics Canada, 2012b). This is also reflected in the growing number of centenarians, a rate that has increased 25.7% between 2006 and 2011, accounting for 5,825 people aged 100 and over in Canada in 2011 (Statistics Canada, 2012a).

While this growth should be considered a success of our time, it also presents a challenge as increased age is related to increased morbidity. Health-adjusted life expectancy (HALE) is an indicator used to estimate the average numbers of years a person can expect to live in good health (Public Health Agency of Canada, 2012; Statistics Canada, 2012c). On average, people in Canada can expect to live approximately 87% (or approximately 70 years) of their life in good health (Statistics Canada, 2012c). Despite this relatively long period of good health, chronic conditions have become a typical part of growing old, with 89% of seniors living with at least one chronic condition and many experiencing multiple chronic conditions (Butler-Jones, 2010). In fact, chronic conditions are so common that

One in four seniors aged 65 to 79 years and more than one in three of those aged 80 years and older reported having at least four chronic conditions, including arthritis or rheumatism, high blood pressure, diabetes, heart disease, cancer, stroke, Alzheimer’s disease, cataracts, glaucoma, mood disorder and anxiety disorder. (Butler-Jones, 2010, p.1)

Canada is not unique when it comes to the prevalence of chronic disease among seniors. Reducing chronic illnesses, or non-communicable diseases (NCDs) as they are often referred to, is of high global priority. Cardiovascular disease, diabetes, cancer, and chronic respiratory conditions are typically identified in the global health literature as the NCDs of primary interest, in part because of their prevalence, but also due to shared risk factors and prevention strategies.
(World Health Organization, 2013) and their known relationship to comorbid mental illness (Canadian Mental Health Association [CMHA] – Ontario, 2008). In fact, data indicate that people living with serious mental illness are at higher risk for a wide range of chronic illnesses, and those living with chronic illness experience mood disorders at twice the rate of their counterparts without chronic illness (CMHA Ontario, 2008). As a result of this relationship, there has been increasing recognition of the need to integrate mental health and mental illness, in addition to these “physical” NCDs, into the policy discussions on NCDs (Ngo, et al., 2013).

Beyond the interplay of mental health and physical health, the General Assembly of the United Nations (UN) has been explicit about the need to recognize the global impact of mental illness. In the 2011 UN Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, members called for the recognition that:

…Mental and neurological disorders, including Alzheimer’s disease, are an important cause of morbidity and contribute to the global non-communicable disease burden, for which there is a need to provide equitable access to effective programmes and health-care interventions. (p. 3)

Broadening the definition of non-communicable disease to include mental and neurological disorders aligns with heightened awareness of the impacts of mental illness in Canada.

1.1.2 Mental Illness in Canada

In any given year in Canada, one in five people will experience a mental health problem or illness (Smetanin et al., 2011). Older adults are not immune to mental illness, and, in fact, the risk for some mental illness can increase with age or with transitions in life that are more common as people grow older. A recent report commissioned by the Mental Health Commission of Canada (MHCC) projected an increase by 2041 in the 12-
Month prevalence of mental illness to 1.3 times the current estimates, driven primarily by aging of the baby boom generation (Smetanin et al., 2011). Unfortunately, there are data gaps in the surveillance of mental illness in older adults in Canada, which may contribute to an underestimation of its prevalence in late life (MHCC, 2014). Experts have also identified potential concerns about the sensitivity and specificity of tools used to measure mental illness in the general population when applied to older adults (MHCC, 2014).

The 2012 Canadian Community Health Survey (CCHS) - Mental Health collected information about lifetime and 12-month mental health status and included approximately 25,000 respondents 15 years of age and older (Pearson, Janz, & Ali, 2013). Although this survey has limitations, such as the exclusion of institutionalized populations, it provides key information about the mental health status of older Canadians. Tables 1 and 2 highlight the survey's key findings on mental disorders for people aged 65 and older. It should be noted that only a sample of the disorders included in the survey are included; limitations in the data collected prevent reliable findings for people aged 65 and older for several disorders, including bipolar disorder and substance use disorders.

**Table 1: Mental health profile of older adults, 12-month prevalence**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number of Persons</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any selected disorder (mental or substance), 12-month prevalence</td>
<td>150,237</td>
<td>3.2%</td>
</tr>
<tr>
<td>Any mood disorder, 12-month prevalence</td>
<td>81,060</td>
<td>1.7%</td>
</tr>
<tr>
<td>Major depressive episode, 12-month prevalence</td>
<td>78,350</td>
<td>1.6%</td>
</tr>
<tr>
<td>Generalized anxiety disorder, 12-month prevalence</td>
<td>57,438 Use with caution</td>
<td>1.2%</td>
</tr>
<tr>
<td>Suicidal thoughts, 12-month prevalence</td>
<td>64,935 Use with caution</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

*Note.* Adapted from Table 105-1101 - Mental Health Profile, Canadian Community Health Survey - Mental Health (CCHS), by age group and sex, Canada and provinces, occasional (number unless otherwise noted), September 2013. Statistics Canada.
### Table 2: Mental health profile of older adults, lifetime prevalence

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number of Persons</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any selected disorder (mental or substance), lifetime prevalence</td>
<td>1,085,920</td>
<td>23.2%</td>
</tr>
<tr>
<td>Any mood disorder, lifetime prevalence</td>
<td>357,949</td>
<td>7.5%</td>
</tr>
<tr>
<td>Major depressive episode, lifetime prevalence</td>
<td>345,303</td>
<td>7.2%</td>
</tr>
<tr>
<td>Generalized anxiety disorder, lifetime prevalence</td>
<td>307,558</td>
<td>6.4%</td>
</tr>
<tr>
<td>Suicidal thoughts, lifetime prevalence</td>
<td>308,492</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

*Note. Adapted from Table 105-1101 - Mental Health Profile, Canadian Community Health Survey - Mental Health (CCHS), by age group and sex, Canada and provinces, occasional (number unless otherwise noted), September 2013. Statistics Canada.*

Other data sources complement the findings of the CCHS survey and broaden the understanding of mental illness in late life. While there are many types of dementia, including vascular dementia, Lewy body dementia, and frontal-temporal dementia (FTD), Alzheimer’s disease is the most common form, accounting for 64% of all dementias in Canada (Alzheimer Society of Canada, 2010). The risk for dementia increases with age. Data from 2008 shows that 7% of Canadians over the age of 60 have dementia, and this percentage increases to 49% for those aged 90 and older (Alzheimer Society of Canada, 2010). Demographic projections forecast a surge in the number of Canadians affected by dementia, particularly when the baby boomer generation ages beyond 75. The Alzheimer Society of Canada (2010) estimates that, “by 2038 the number of Canadians with dementia will increase to 2.3 times the 2008 level to 1.1 million people” (p.17). It is the behavioural and psychological symptoms of dementia (BPSD), affecting up to 90% of persons with dementia over the course of their illness, that are most challenging for persons with dementia and for their caregivers.

The profile of institutionalized older adults is significantly different from that of the community-dwelling population captured in the CCHS survey. Reflective of the data on BPSD and the impact on caregivers, dementia has been found to be the most common reason for admission into long-term care (CIHI, 2010a). It is not surprising, then, that most residents of long-term care (also known as nursing home care) live with some cognitive impairment.
(Banerjee, 2007; CIHI, 2010a). Rates of mental illness outside of dementia are also high in long-term care settings. A recent report from the Canadian Institute for Health Information (CIHI, 2010b) found that nearly half of the residents in their sample of 50,000 seniors living in long-term care had a diagnosis and/or symptoms of depression.

Also of concern to both community-dwelling and institutionalized older adults is delirium. Dementia is often complicated by delirium, an acute confused state affecting perceptions, attention, orientation, emotions, and level of consciousness. Older adults, particularly those who require acute care, can be at risk for delirium as nearly half of seniors admitted to acute care hospitals experience an episode of delirium while under care (CCSMH, 2009). And finally, perhaps the most tragic complication of mental illness is death by suicide. Older men, in particular, have a consistently high rate of suicide (Statistics Canada, 2014c). For example, the suicide rate for males at all ages was 16.3 per 100,000 population in 2011. Males aged 70–74 had a rate of 19.8 per 100,000; which increased to 22.7 per 100,000 for males aged 85–89 (Statistics Canada, 2014c). It is also important to note that the published statistics are widely believed to underestimate the total number of deaths by suicide for older men and women, due, in part, to the stigma of suicide (Monette, 2012).

Stigma extends beyond suicide; it is a well-documented phenomenon related to mental illness and is arguably exacerbated by the stigma of growing old, known as ageism (Kirby & Keon, 2006). Thomas and Shute (2006) found that there is a lack of understanding and awareness of the layered stigma for older adults living with mental illnesses, which might be the most fundamental reason why older people with depression, for example, are not treated. They also noted that there is limited public and professional awareness of stigma experienced by older adults with mental illness, and this lack of information reinforces stigma (Thomas & Shute, 2006). The combination of ageism and stigma also appears to influence care and clinical outcomes for older adults.
with mental illness, with multiple studies reporting that older adults receive less personalized care when compared to younger counterparts with similar illnesses (Robb, Chen, & Haley, 2002).

Although there is an increasing body of literature on seniors’ mental health, divisive silos between aging, health, and mental health remain, not only in the way research data are collected, but often also in the delivery of healthcare services, as well as further upstream in policies and structures. With the aging of Canada’s population it is a vital time to build a bridge across silos and consider seniors’ mental health as a pertinent clinical, research, and policy topic.

1.2 Setting the Context: The Health Policy Environment in Canada

1.2.1 About the Canada Health Act (CHA)

Health policy making in Canada is a complicated dynamic as the federal government is not responsible for health care delivery or service planning (except in the case of federal populations such as Aboriginal people, military, veterans, and federal prisoners), but does set the guiding principles for health services through the Canada Health Act. The responsibility for the administration of healthcare services falls to the provincial/territorial governments, and they exhibit significant diversity in policy landscapes, demographics, political ideologies, and resources.

In 1984, federal legislation was passed for publicly funded health care insurance in Canada, known as the Canada Health Act (CHA) (Graham, Swift & Delaney, 2009). The CHA defines the primary objective of Canadian healthcare policy, which is “to protect, promote, and restore the physical and mental well-being of residents in Canada and to facilitate reasonable access to health services without financial or other barriers” (Health Canada, 2013, p.3).

The roles and responsibilities of Canada’s health care system are shared between the federal and provincial/territorial governments. Provinces and territories are responsible for the
administration and delivery of their healthcare services and have the freedom to set their own priorities and manage their budgets and resources accordingly (Health Canada, 2013). The federal government uses the Canada Health Act to define the criteria and conditions that must be met by each province and territory related to both insured health services and extended health care services (which include home and long-term care) in order to receive the full federal cash contribution under the Canada Health Transfer\(^2\) (CHT) (Health Canada, 2013). As such, the CHA can be seen as a tool for the federal government to maintain standards despite provincial/territorial responsibility for health care delivery (Madore, 2005). These cash and tax transfers are vitally important to provinces and territories, as approximately twenty cents of every dollar spent on health in the provinces comes from federal contributions (Dodge & Dion, 2011). Contributions from the federal government have declined steadily since the mid 1980s; federal contributions were originally designed with a 50-50 per cent cost sharing agreement (Silnicki, 2013); however, restraints and cuts slowed the federal contributions markedly (Provincial and Territorial Ministers of Health, 2000).

Included in the Canada Health Act are five program criteria that apply to insured health services, two conditions that apply to insured health services and extended health care services,\(^3\) and extra-billing and user-charge provisions that apply only to insured health services\(^4\) (Health Canada, 2013). Defined as medically necessary hospital, physician, and surgical-dental services (Health Canada, 2013), insured health services cover the majority of health services and therefore are commonly the focus of debates around health care in Canada. In particular, debates and discussion on health policy in Canada are often centred on the nuances of the program criteria definitions.

The five program criteria of the Canada Health Act are summarized in Table 3.

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\(^2\) The federal government also transfers funds to the provinces and territories via the Canada Social Transfer (CST) for social services and programs.

\(^3\) These conditions relate to sharing of information and recognition of financial commitments.

\(^4\) To circumvent a two-tiered system where those who could afford to pay received better care, billing patients for fees outside of the government agreements and user fees for hospital-based care are prohibited.
Table 3: Program Criteria of the Canada Health Act

<table>
<thead>
<tr>
<th>Program criteria</th>
<th>Provincial and territorial plan responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Administration</td>
<td>Must be administered and operated on a non-profit basis by a public authority accountable to the provincial or territorial government.</td>
</tr>
<tr>
<td>Comprehensiveness</td>
<td>Must insure all medically necessary services provided by hospitals, medical practitioners, and dentists working within a hospital setting.</td>
</tr>
<tr>
<td>Universality</td>
<td>Must entitle all insured persons to health insurance coverage on uniform terms and conditions.</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Must provide all insured persons reasonable access to medically necessary hospital and physician services without financial or other barriers.</td>
</tr>
<tr>
<td>Portability</td>
<td>Must cover all insured persons when they move to another province or territory within Canada and when they travel abroad. The provinces and territories have some limits on coverage for services provided outside Canada, and may require prior approval for nonemergency services delivered outside their jurisdiction.</td>
</tr>
</tbody>
</table>


Although Canada's publicly insured health system (Medicare) is arguably the most valued social program in the eyes of Canadians (Association for Canadian Studies, 2012), for decades there has been debate and discussion about its strengths and weaknesses and sustainability. As noted earlier, recent debates have been centred on the program criteria (often referred to as “the five principles of the Canada Health Act” in informal debates) of the insured health services under the CHA. While each province has a taxpayer-funded, government-run insurance system, the definition of comprehensiveness of these plans is subjective. In fact, about 30% of all health care costs in Canada, including prescription medications, dental, and vision care, is covered directly by patients or through private insurance policies (Sanmartin, Hennessy, Lu & Law, 2014).

Comprehensiveness has long been an area of ambiguity as provinces have the freedom to determine what is considered medically necessary (beyond physician and hospital-based care) and therefore publicly financed, resulting in considerable variation across provinces and
territories (Deber, 2003). Mental health in Canada is one sector that has been significantly affected by the lack of a national definition of comprehensiveness. Historically in Canada, mental health services were provided in institutional settings where services were fully insured; however, in recent years the shift towards community-based mental health services has affected the public insurance component of services and influenced policy development (Mulvale, Abelson, & Goering, 2007; Wiktorowicz, 2005). As explained by Wiktorowicz (2005):

> While a tenet of the Canada Health Act specifies comprehensiveness in the provision of medically necessary services, such services are limited to those provided by hospitals and physicians. Since mental health care includes allied health professionals in community settings, it often extends beyond the services specified in the Canada Health Act, leading to variable coverage among provinces, undermining the comprehensiveness of a health care system in transition. (p. 388–389)

Although mental health and well-being are included in the key objectives of the Canada Health Act and, as a result, are considered insured health services under the act (Health Canada, 2013), this movement towards community-based mental health programs has created barriers to accessing services (Wiktorowicz, 2005). Additionally, the delivery of mental health services in long-term care homes and home care services has been affected, as both are designated extended health services under the Canada Health Act. As a result of these systematic inconsistencies, the mental health system in Canada has been considered piecemeal and patchwork (Romanow, 2002), with significant variations within and across jurisdictions in Canada (Kirby & Keon, 2006).

Extended healthcare services are defined in the CHA as long-term residential care, home care, and ambulatory services (Health Canada, 2013). Given that these services fall outside hospital-based insured services, long-term care and home care are exempt from the program criteria of the Canada Health Act. Instead, extended health services have two
conditions (information-sharing with the federal government and acknowledgement of federal contributions) that they must adhere to in order to receive full funding from the federal government.

1.2.2 Critiques (and Responses) to the Canada Health Act

As a result of the changing landscape of health care in Canada, coupled with rising costs and changing demographics, the extended health care designations of long-term care and home care have garnered considerable criticisms from within government and from interest groups. The 1996 National Forum on Health recommended that a universal home care program be developed for the frail elderly (Rice & Prince, 2003). This sentiment was echoed in the final report from the Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (the Romanow Report) (Romanow, 2002). The ultimate goal of the Romanow Report, beyond addressing issues of sustainability, was to uphold and protect the Canada Health Act (Walker, 2008). It offered an in-depth analysis of the benefits of the CHA yet recognized the need for revisions, including broadening the scope of insured health services to include home care (Romanow, 2002). When making his case for changes to the home care system, Romanow (2002) highlighted its relevance for seniors, in particular the increased independence that would come with a comprehensive home care system. The establishment of such a system was also intended to address persistent concerns about the burden of care falling to family members and the unnecessary placement of people into institution-based care due to inadequate home care services, two issues that were raised in witness testimony about the role of informal caregivers in home care (Romanow, 2002). In addition to the Romanow Report (2002) providing a strong case for incorporating home care into the Canada Health Act, stakeholders such as the National Advisory Council on Aging (2002) also advocated for the inclusion of long-term care as an integral part of the publicly insured health care system (a recommendation not included in the Commission’s final report).
The importance of a publicly funded home care system was underscored in the Final Report of the Special Senate Committee on Aging, *Canada’s Aging Population: Seizing the Opportunity* (Carstairs & Keon, 2009). With a mandate to “review a wide range of complex issues to determine if Canada is providing the right programs and services at the right time to the individuals who need them” (Carstairs & Keon, 2009, p.1), the committee was commissioned to review issues of particular relevance to the aging population, including active living and well-being, health promotion and prevention, and health care needs including mental health services, home care, and caregiving (Carstairs & Keon, 2009).

Carstairs and Keon (2009) illustrated a gap in the division of extended and insured health services and recommended a shift of “resources from the acute care health system to an integrated continuum of care that will allow people to age in the place of their choice, with the right services, at the right time” (p.7). Carstairs and Keon (2009) highlighted the results of the extended health service designation for long-term care, including significant differences in the way long-term care homes are managed and the costs associated with living in long-term care. Such costs can act as “insurmountable barriers” (Carstairs & Keon, 2009, p.50) for some seniors given the private costs associated with this type of care.

A recent study conducted by the University of Toronto–based Medicare to Home Community Research Unit surveyed over 2,500 Canadian policy elites of key stakeholder groups (those involved in health policy discussions either as providers or as businesses) to determine what these policy leaders felt should be “in” or “out” of Medicare (Deber & Gamble, 2007). Interestingly, despite the efforts of interest groups who have advocated for full public funding for residential and home care services, the survey found consensus among those sampled that the costs associated with long-term care and home-based personal support care should be shared between the public and the recipients of care (Deber & Gamble, 2007).
1.2.3 Funding Agreements: A Changing Landscape

As an outcome of the Romanow Report (2002), the Health Ministers in Canada signed the 2004 Health Accord (Healthy Debate, 2011). This funding agreement was the first of its kind, outlining ten years of federal funding transfers for health care in the provinces/territories as a mechanism to infuse additional funds into public health care after significant cuts in the 1990s (Glauser, 2014). Instead of renewing the 2004 Accord upon its expiry, in December 2011, the federal government announced its future plans regarding the Canada Health Transfer: the government committed to a 6% annual growth in federal health transfers until 2016–17 and stated that

Starting in 2017–18, the CHT will grow in line with a three-year moving average of nominal gross domestic product (GDP) growth, with funding guaranteed to increase by at least three percent per year. In addition the CST [Canada Social Transfer] will continue to grow at its current rate of three percent annually in 2014–15 and beyond. The CHT and the CST\(^{1}\) will be reviewed in 2024. (Department of Finance, 2011, para 10)

The federal government positioned this shift as an efficient and fiscally responsible alternative to lengthy accord negotiations and highlighted the increased capacity for provincial/territorial governments to control their own spending (Glauser, 2014; Picard, 2011).

Critics were quick to point out that this funding shift would result in a reduction of $36 billion in healthcare funding and “that the 50-50 per cent cost-sharing agreement made by the federal and provincial/territorial governments when medicare was first negotiated will become 18 and 82 per cent respectively” (Silnicki, 2013, p.23). This downloading of responsibility to provinces disproportionately disadvantages poorer (or “have-not”) provinces, leading to fears that with fewer dollars for health care, provinces will be inclined to reduce the list of provincially insured medically necessary services
(Silnicki, 2013). Given the strong advocacy for a renewal of the healthcare accords, many were concerned that this funding shift signaled the further erosion of the federal role in health care (Tholl, Bujold & Associates, 2012).

1.2.4 Key Milestones and Contributions: The Federal Role in Mental Health Policy

Although the current federal government has been explicit in its stance on the federal role in health care, there have been significant changes to the landscape in terms of a federal role in mental health in the last ten years. In October of 2004, Senator Michael Kirby, as Chair of the Standing Senate Committee on Social Affairs, Science and Technology, was commissioned to examine the state of the mental health and addictions system in Canada and to provide recommendations for system improvements (Kirby & Keon, 2006). The committee’s final report was released in May 2006 and contained principles and extensive recommendations for improvements to the system based on witness testimony and a literature review. The authors employed a social determinants of mental health approach, based directly on witness testimony about the importance of social determinants in preventing and treating mental illness (Kirby & Keon, 2006). The resulting report, Out of the Shadows at Last, covered a broad range of topics, including legal issues, service organization and delivery of services, workplace and employment, and housing and addictions, and focused on two population groups: children/adolescents and seniors (Kirby & Keon, 2006). The committee outlined a vision for creating a mental health system that puts people living with mental illness at the centre, focusing on a person’s ability to recover (Kirby & Keon, 2006).

As an outcome, funding was allocated in the 2007 federal budget for the creation of a Mental Health Commission. The release of Out of the Shadows at Last and the subsequent formation of a national commission with a mandate to create a national mental health strategy

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5 Note: this section is a sampling of key contributions that are particularly relevant when considering an aging population. There are other federal contributions to mental health that are beyond the scope of this paper.

6 As stated by the Health Minister at the time of the launch of the Mental Health Strategy for Canada, “the federal government is committed to providing stable, long-term funding to the provinces to deliver health care” (Fitzpatrick, 2012).
gained significant support from stakeholders. Now, seven years into its ten-year mandate, the Mental Health Commission of Canada is seen by some as a catalyst for much of the recent momentum and attention to mental health and illness in Canada. Key accomplishments of the MHCC to date include:

- Establishment of advisory committees for the first five years of its mandate to ensure inclusive policy, program, and system developments, including an advisory committee focused on seniors;
- Release of *Towards Recovery and Wellbeing: A Framework for a Mental Health Strategy for Canada* (2009);
- Release of *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (2012);
- The initiation of *Opening Minds*, a multi-year anti-stigma program (MHCC, 2013);
- *At Home/Chez Soi*, a research demonstration project on mental health and homelessness; and
- Specific investments in seniors’ mental health, including the *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* (2011) and a multi-year anti-stigma initiative targeted to healthcare providers working with older adults.

Although the MHCC has met many of the goals in its original mandate, so far there has been no federal commitment to implement components of the Mental Health Strategy. The federal government is the fifth-largest provider of health care in the country and thus has the opportunity to lead by example by improving its own capacity to develop mental health policy and deliver services to populations for which it has direct responsibility, specifically Aboriginal Canadians, military personnel, veterans, and those in the federal corrections system (Canadian Alliance on Mental Illness and Mental Health [CAMIMH], 2012a).

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7 The MHCC has not escaped criticism but has undeniably heightened attention to mental health and mental illness in Canada.
Another key milestone for mental health at the federal level was the passing of a private member’s bill focused on suicide prevention. Bill C-300, the Federal Framework for Suicide Prevention Act, was introduced as law in December 2012. The framework requires that the Government of Canada:

(a) Recognize that suicide, in addition to being a mental health issue, is a public health issue and that, as such, it is a health and safety priority; and

(b) Designate the appropriate entity within the Government of Canada to assume responsibility for:

(i) Providing guidelines to improve public awareness and knowledge about suicide,

(ii) Disseminating information about suicide, including information concerning its prevention,

(iii) Making publicly available existing statistics about suicide and related risk factors,

(iv) Promoting collaboration and knowledge exchange across domains, sectors, regions and jurisdictions,

(v) Defining best practices for the prevention of suicide, and

(vi) Promoting the use of research and evidence-based practices for the prevention of suicide.

(Speaker of the House of Commons, 2012, para 10)

The Public Health Agency of Canada was appointed as the entity within the federal government to facilitate mandated consultations that occurred between April 2013 and April 2014 to garner public feedback and expertise on the development of a federal framework for suicide prevention (Public Health Agency of Canada, 2013). Although this framework was a first at the federal level in Canada, suicide prevention advocates criticized the bill for focusing solely on knowledge exchange and encouraged the adoption of the Canadian Association for Suicide Prevention (CASP) Blueprint for a National Suicide Prevention Strategy along with funds to ensure its implementation (CAMIMH, 2012b).
In December 2013 at the G8 London Health Summit, the Minister of Health for Canada committed to action on dementia and set a target of the year 2025 to find a cure working alongside other G8 countries (Department of Finance, 2014). The subsequent federal budget highlighted this commitment and announced funding for the creation of the Canadian Consortium on Neurodegeneration in Aging (CCNA) (Department of Finance, 2014). The CCNA was announced in September 2014 and will be supported by the Canadian Institutes of Health Research.

Interestingly, critiques of the *Mental Health Strategy for Canada* included its lack of focus on suicide prevention and dementia, and the government has responded in part with additional focus and investments in research and knowledge exchange. The lack of implementation and lack of direct improvements in health care and health policy remain gaps in the federal landscape. The responsibility then falls to provinces and territories to determine how to improve policy and care for people with mental illnesses in their regions. How each province is tackling these policy gaps is reviewed in detail in Chapters 4 and 5.

1.2.5 Key Milestones and Contributions: The Federal Role in Seniors / Aging Policy

The structure and organization of seniors’ issues has emerged over time at the federal level. Currently, seniors’ issues fall under the junior cabinet position known as Minister of State (Seniors), within the auspices of Employment and Social Development Canada (formerly Human Resources and Skills Development Canada). The Minister of State (Seniors) has identified social isolation, loneliness, elder abuse, and financial literacy as key priorities (Employment and Social Development Canada, 2014).

As early as 1980 the federal government developed a mechanism for understanding issues related to aging and quality of life through the development of the National Advisory Council on Aging (NACA) (NACA, 1999). Between 1980 and 2006 the membership of NACA assisted and advised the Minister of Health on issues related to the aging of the Canadian
population. Throughout its 26-year history, NACA produced and disseminated key reports including the *Seniors in Canada Report Card* (2001; 2006), intended to be an accountability mechanism that would “sustain the momentum for policy action to improve the health and well-being of seniors in Canada” (NACA, 2006, p.v). NACA also produced position papers, quarterly newsletters, a bulletin of facts on aging, and in-depth writings on emerging issues and challenges for seniors in Canada (Seniors Psychosocial Interest Group, 2004). Although now defunct, the legacy of NACA lives on through the National Framework on Aging (NFA). Meeting the vision articulated in the NFA, Canada would be “a society for all ages, [that] promotes the wellbeing and contributions of older people in all aspects of life, promotes the wellbeing of seniors, recognizes their valuable contributions, and reflects the goals of elimination of ageism in all sectors” (Division of Aging & Seniors, 1998, p.6). The NFA is a principles-based document that was created based on consultations with seniors. The five principles of the NFA — dignity, independence, participation, fairness, and security — are intended to guide all actions taken to meet its vision (Division of Aging & Seniors, 1998). The framework also included tools, one of which was a policy guide created to ensure that the needs and values of seniors were recognized and understood in policy development (Division of Aging & Seniors, 1998). This voluntary framework is often referenced as a key foundation for aging policies (British Columbia Ministry of Health, 2005; MacCourt, Wilson, & Tourigny-Rivard, 2011; Wilson, Osei-Waree, Hewitt, & Broad, 2012); however, to date there is no data available on its federal implementation.

In 2007, under the newly elected federal government, the National Seniors Council was announced as a replacement to NACA. This new iteration was smaller than previous NACA committees (membership was reduced from 18 to 12 individuals) and was charged to provide advice to the Minister of Employment and Social Development, the Minister of Health, and the Minister of State (Seniors) (Government of Canada, 2010).
Outside of the current structure of the National Seniors Council and ministerial responsibility for seniors, over the last decade there has been heightened focus across the federal government on the aging population. As noted earlier, in November 2006 the Special Senate Committee on Aging was initiated and given the mandate to “review a wide range of complex issues to determine if Canada is providing the right programs and services at the right time to the individuals who need them” (Carstairs & Keon, 2009, p.1). Based on the consultation process and literature review, the committee’s final report outlines a series of recommendations rooted in the federal level of government, aiming to assist in preparing for the challenges of an aging population (Carstairs & Keon, 2009).

As evidenced in the report and from witness testimony, current health systems and policy gaps in Canada have created dependency in late life, wherein the absence of a range of health services prematurely requires older adults to enter permanent facility care (Carstairs & Keon, 2009). The committee endorsed a framework for improving the organization of systems of continuing and community care services (Carstairs & Keon, 2009).

The Final Report of the Standing Senate Committee on Aging was released on April 21, 2009. Six months after its release the Government of Canada responded to the report, commending the positive approach to aging taken by the committee (Government of Canada, 2009). The government response acknowledged the current image of aging as “as a time of dependence and decline” and supported the movement towards a society that sees aging as a time of engagement (Government of Canada, 2009, p.2). The response also highlighted a commitment to ensuring that policies meet the needs of seniors and an aging society (Government of Canada, 2009). Despite the stated commitments, no new federal or multilateral policies have been created based on the recommendations of the report.

As noted, the federal government is increasingly distancing itself from health. Despite this position, health and mental health continue to be common themes within recent federal-level reports and publications on aging. Of note, the Chief Public Health Officer’s 2010 annual
Report on the State of Public Health in Canada focused on seniors’ health, acknowledging its relevance given Canada’s changing demographics. In the introductory section, Chief Public Health Officer (CPHO) David Butler-Jones gave significant weight to seniors’ mental health: “the importance of mental health cannot be understated and I am concerned about the shortcomings in addressing this issue in relation to seniors” (Butler-Jones, 2010, p. ii). Along with mental health, Butler-Jones (2010) emphasized the vital role of care and services, including adequate and integrated care in the community and in residential settings, in the well-being and health of older Canadians. In particular, the exclusion of long-term care as an insured health service within the Canada Health Act was identified as a barrier to care for Canadians.

Although extended health care services are covered under the Canada Health Act, long-term care is non-insured and often requires user fees. Not understanding the distinction between insured and non-insured care can cause individuals to experience challenges in navigating, paying for and waiting to access long-term care facilities. (Butler-Jones, 2010, p.80)

Additionally, recognizing the current gaps in home care, Butler-Jones (2010) called for a national strategy, among other items, that would enhance knowledge translation and sharing of best practices in home care across provinces, territories, and communities across the country.

Subsequent to the release of the 2010 CPHO Report, the parliamentary Standing Committee on Health (HESA) launched a study in 2011 on chronic diseases related to aging. In the final report, released in 2012, the committee acknowledged mental illnesses as chronic diseases, with particular emphasis and focus on dementia, depression, and suicide, and acknowledged the critical role of community-based care in chronic disease management and prevention. Reporting on the suggested areas for federal action, the committee noted that many expert witnesses encouraged discussions about investments in home and continuing care with the goal of a reoriented system that was more attuned to the changing needs of older Canadians (HESA, 2012). The discussions were suggested as part of the anticipated renewal of
the Health Accord, which did not come to fruition. As well, the committee heard calls for a suggested National Strategy for Healthy Aging, which would be a guiding strategy integrating the many existing and recommended strategies (e.g. mental health, suicide prevention, dementia prevention and management, falls prevention, etc.). In response, HESA acknowledged its concern regarding the state of seniors’ mental health; however, in contradiction to the suggestions for federal leadership, the report “encourage[d] the provinces and territories to work closely with the Mental Health Commission to implement the [Mental Health] Strategy” (HESA, 2012 p. 24). Appended to the submitted report were minority reports and dissenting reports from other political parties (the NDP and the Liberals, respectively). Both made strong calls for federal leadership and highlighted the need for investment in home care and mental health (HESA, 2012).

As indicated from the sampling of initiatives above, the federal government recognizes the need for heightened focus on the country’s changing demographics and the need to improve quality of life for older Canadians. Outside of the scope of health care, there are many initiatives led by the federal government, including elder abuse prevention, age-friendly communities, and the New Horizons for Seniors granting program (Employment and Social Development Canada, 2013). But beyond these areas of focus, the federal government has actively downloaded responsibility for health and mental health to the provinces, and furthermore has not yet been active in bridging health and mental health with any aging policies or strategies. Given these gaps in policy (or the lack of implementation of policy), there is additional need to focus on provincial responsibility in this area.

1.3 Significance of the Issue

As the current federal government continues to withdraw from responsibility for health care, critics are pointing to the government’s role in promoting national equity (Drover, Moscovitch, & Mulvale, 2014; Norrie, Boadway & Osberg, 1991). As highlighted in a recent
policy paper from the Canadian Association of Social Workers (CASW), “the health care system is one of the hallmarks of equitable social policy in Canada” (Drover et al., 2014, p. 39). In particular, the notion of horizontal equity underscores the idea that wherever Canadians live, they should be provided with similar levels of health care (Drover et al., 2014). Currently, with no pan-Canadian vision for older adults with mental health issues, this horizontal equity is at risk.

The landscape of health care in Canada has changed since the initiation of the Canada Health Act thirty years ago. Although the publicly insured healthcare system was designed with acute illness at its core, the current generation of older adults lives with increased chronicity of illness. Data show that older adults use hospital, physician, home, and continuing care health services more than other age groups (CIHI, 2011). The relationship between age and healthcare costs has been an important contributing factor to the mistaken belief that there is a sustainability crisis in our healthcare systems due to an aging population. This myth has been discredited, with data indicating that population aging accounts for only a 1% increase in public sector spending (CIHI, 2011). Recent data from CIHI (2013) underscores this finding, showing a “stronger correlation between the presence of multiple chronic diseases and higher utilization of health services than between age and utilization” (p.55). Rather than focusing on the non-modifiable demographic change that is occurring, a shift in the philosophy of health care may alleviate some of the current funding pressures. Addressing the structural lag of an acute-care system in a chronic-care world, in addition to the restructuring of healthcare costs, is vital for the quality of life of older adults.

As well as the concerns about healthcare costs and sustainability, the current system also creates barriers for “aging in place” for older adults with mental health concerns. In particular, the focus of services in acute care has disadvantaged the continuing care sector, resulting in older adults unnecessarily waiting in hospital for appropriate services to support them in the community. Data from 2009–2010 documented that 40% of acute hospital stays were for people aged 65 and older, and that the length of stay for older adults was about one
and a half times that of their younger counterparts (CIHI, 2011). These high use rates of acute care services are particularly prominent in older populations living with dementia. In 2009–2010, people living with dementia accounted for 23% of all older adults designated as alternate level of care (ALC) patients; their average length of stay was more than twice that of older adults without dementia (CIHI, 2011). The designation ALC is applied to hospitalized clients who no longer require acute levels of care but are unable to return to their home without support or placement in rehabilitation or long-term care settings (Council on Aging of Ottawa, 2011). The availability of ALC beds is an issue across the country, which has heightened awareness about the cost of keeping people in hospital care unnecessarily. ALC rates have been stable over the last five years, representing approximately 5% of inpatient hospitalizations or about 580 hospital beds occupied by ALC patients on any given day across Canada (CIHI, 2012). There is, however, variation across jurisdictions, in part due to data collection and system differences. Across Canada, “about 16% of ALC patients waited 1 or 2 days for discharge in 2010–2011, 21% waited more than a month and 5% waited more than 100 days” (CIHI, 2012, p. 47). ALC data is but one example of the current barriers to care for older adults, but given its documented impacts on the acute care system, it continues to be a benchmark for health care integration and improvement.

Unless the healthcare system is restructured to allow for appropriate transitions to the community or residential care (with appropriate services), ALC hospitalization will likely remain a concern. It has been argued that the underdevelopment of the home and residential care sectors has not only created unnecessary healthcare costs but has also left older adults with inadequate services (Chappell & Hollander, 2013). It can be hypothesized that the underdevelopment of these services is related to their designation as extended health services under the Canada Health Act. Given this designation and the unlikelihood of the reopening of the CHA, provinces must act now, at the start of the greying of the baby boom population, to implement change.
With the recent announcement from the federal government about the reduction in future contributions to healthcare costs (Silnick, 2013), plus a more comprehensive understanding of key healthcare drivers such as ALC rates, it is time to realign health care to meet the needs of users. The federal government has implemented very little from its commissioned reports in the areas of aging and mental health, and at the same time it has downloaded responsibility for these areas to the provinces despite transferring less money to enable such implementation.

Aiming to implement the principles from the National Framework on Aging and striving for horizontal equity, it should be the goal of every jurisdiction in Canada to support aging with dignity. It is time to bridge silos between aging, health, and mental health and this requires a review of provincial seniors’ policies and suggestions for an improved mental health landscape. Such an analysis, comparing across provinces, has not yet been done. This is a key opportunity to blend gerontology, mental health, and policy development in a time of austerity that continues to be influenced by fears of apocalyptic demography, despite data dispelling this risk. Through this policy analysis, my research will contribute to knowledge about what policies are in place across the country and create opportunities for knowledge translation and sharing of best practices in policies for seniors with mental health problems.
Chapter 2: Literature Review

2.1 Geriatric Mental Health Policy and Service Delivery Models

In order to understand what the ideal service system looks like for older adults, it is necessary to review current literature and best practices in the areas of geriatric mental health policy and service delivery models in continuing care. It should be noted that the ideal of ‘best practices’ is contentious as certain types of evidence are privileged over others. For the purpose of this research, evidence from multiple sources (including outside traditional academic publications) will be included. Given the difficulties faced by older adults with mental health issues, understanding what systems and models have worked in Canada and internationally can help identify strengths of current policies and also illustrate gaps and opportunities for future policy development.

The challenges of defining best practices were addressed by Mary Pat Sullivan and colleagues (2004). Using speciality geriatric mental health outreach services as an example, they offered lessons for implementing mental health reform. Within the article, Sullivan and colleagues (2004) highlight the challenges to this area of research and suggest three strategies for defining best practices in geriatric mental health. The strategies include understanding the older population and their mental health needs while examining trends in mental health reform; examining research and theories that are relevant to the domains of geriatric mental health (in their example this included shared care, education, and program and systems development); and sharing best practices from these fields (Sullivan et al., 2004). Although this example was specific to a speciality service, these strategies can help to organize the literature that informs this policy analysis. In Chapter 1, an overview of the aging population and their mental health concerns was presented in addition to the historical policy legacies in mental health in Canada.
This chapter will focus on research and theory in aging, mental health, and policy, including practice-based evidence.

While there is academic literature in geriatric mental health policy, significant gaps remain in the published knowledge base; for example, the underuse of mental health services by older adults is well documented (Karlin & Duffy, 2004). This underuse has been attributed to policy barriers such as stigma and ageism (Collier, 2005; Karlin & Duffy, 2004; Pachana, 2013). Furthermore, inappropriate quality indicators in data sets can complicate knowledge about prevalence and use of services by older adults (Karlin & Duffy, 2004). An additional barrier to use of services that is documented in the literature is a systematic gap in the education, training, and knowledge of health providers (Bartels & Naslund, 2013; Pachana, 2013). This gap in policies around health human resources is consistently identified as an area where policy development is needed. Pachana (2013) argued that policies should focus on interdisciplinary teams to reduce fragmentation and increase integration of care for older adults with complex physical and mental health illnesses. Similarly, Chappell (2008) advocated for an upstream approach to mental health promotion and recommended that healthcare providers be educated on the social determinants of health. Bartels and Naslund (2013) highlighted the significant dearth of trained geriatric mental health specialists and the dire need for policy enhancements in this area.

Beyond health human resource issues, literature in this area also tends to focus on clinical issues. For example, the policy focus on avoidance of antipsychotic medications with older adults (particularly in long-term care settings) has translated into clinical recommendations about medication use (CCSMH, 2006) and a shift in policy direction towards psychosocial interventions (Brodaty & Arasarantham, 2012; CCSMH, 2006). Collier (2005) noted that depression and dementia are the only mental illnesses that seem to be on the policy agenda when it comes to geriatric mental health, and suggested that policy ignores serious and persistent mental illnesses such as schizophrenia and psychosis. She went on to say that older
adults are not prioritized, or worse, not included, in policy documents on mental health (Collier, 2005).

Despite these gaps, there are examples of policy resources in Canada that focus on seniors' mental health. Two key documents that were developed in Canada are the Seniors’ Mental Health Policy Lens (SMHPL) (MacCourt, 2009) and the Guidelines for Comprehensive Mental Health Services for Older Adults in Canada (MacCourt, Wilson, & Tourigny-Rivard, 2011).

The Seniors’ Mental Health Policy Lens is informed by the values of a diverse sampling of seniors and by the experience of those living with mental health problems. The SMHPL was originally developed in 2004 and was revised in 2009 to reflect the philosophy of recovery and well-being. A notable shift from the SMHPL’s initial focus on identifying whether a policy meets the needs of stakeholders, the philosophy of recovery and well-being focuses on the journey of health and transformation that enables a person living with a mental health problem to live a meaningful life in their community while striving to achieve their full potential (United States Department of Health and Human Resources, 2006). While the philosophy of recovery is not a new one, in many instances its components have yet to infiltrate policy- and system-level change in Canada. There has been resistance in the seniors’ mental health community to using the language of recovery as, on the surface, it suggests the existence of a cure, and some common mental illnesses in late life are progressive in nature with no proven cure (Mulvale & Bartram 2009). Recent literature, however, underscores the symmetry between the recovery philosophy and person-centred philosophies, which are central to dementia care (Hill, Roberts, Wildgoose, & Hahn, 2010). Again, it should be emphasized that the concept of recovery is rooted in the importance of choice, hope, respect, empowerment, and individualized and person-centred care (United States Department of Health and Human Resources, 2006) — philosophies that are consistent with ideal dementia and mental health care for older adults. Use of the SMHPL also facilitates the identification of unintended negative impacts of programs and
policies on seniors’ mental health and addresses strategies for improvement. The SMHPL has been endorsed as a best practice in geriatric mental health policy (Chappell, 2008) and was used as a foundational resource for the development of the *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* (MacCourt et al., 2011).

Developed as a project for the Seniors’ Advisory Committee of the Mental Health Commission of Canada, the guidelines offer several recommendations to support policy makers and service providers in planning, developing, and implementing a mental health service system that can effectively respond to the unique needs of an aging population. Informed by seniors themselves, the guidelines also incorporate the values and perspectives of families, caregivers, mental health service providers, and advocacy groups. The document provides information about the required range of service approaches needed to support older adults and their caregivers, including benchmarks for service planners to target when evaluating existing seniors’ mental health services. Recommendations in the guidelines also align with the MHCC’s *Mental Health Strategy for Canada*, which is designed to achieve the best possible mental health for all Canadians. A key limitation of the above two resources should be noted, however. Both are aspirational in nature, and there is little information available on their implementation in jurisdictions across Canada.

The literature on the organization of health care systems in Canada can also contribute to the concept of best practices in geriatric mental health policy. Hollander and Prince (2002) found that, for seniors and people with chronic mental health conditions (identified as two separate groups), there is fragmentation in healthcare delivery systems. Subsequently, a “best practices blueprint” was proposed for people with ongoing health needs when it comes to designing the ideal service delivery system (Hollander, Chappell, Prince, & Shapiro, 2007). The Hollander and Prince Continuing Care Model outlines ten best practices divided into administrative and service-delivery recommendations (Hollander et al, 2007). Although this model includes older adults and health systems users with mental health issues, it is not a
model that is focused specifically on geriatric mental health. Other systems of care that are viewed by some as ideal for meeting the needs of older adults are the Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) and the System of Integrated Care for Older Persons (SIPA) (Hollander et al., 2007); however, these two models focus on primary care and are not concerned with mental health services.

Often lauded as the “gold standard” of seniors’ health policy in Canada, the Veterans’ Independence Program (VIP) is under the umbrella of the federal government. The VIP is the national home care program for veterans and/or their primary caregivers (Veterans Affairs Canada, 2014). It was developed in 1981 in response to growing care needs of Second World War veterans and as a way to mediate the costs of the federal commitment to offer long-term care beds to veterans (Struthers, 2007). Compared to its provincial counterparts, the VIP is a comprehensive home care program that provides health, housekeeping, and outdoor maintenance support for veterans and their spouses, services that continue for spouses even after the death of a veteran (Struthers, 2007). Services such as housekeeping and lawn maintenance (often called Instrumental Activities of Daily Living) are typically excluded from the basket of publicly funded services in provincial home care programs.

The model used in the Veterans Independence Program is similar to the Balance of Care initiative that started in the United Kingdom. Challis and Hughes (2003) posited that developed nations shared in the policy movement towards providing community-based care to avoid hospital and institutional care, and yet there was no shared understanding on the best possible mix of resources required to facilitate this policy direction. Aiming to close this gap in knowledge, Tucker, Hughes, Burns, and Challis (2008) examined the balance of care for older people with mental health problems. In their paper, the authors suggest that, based on their research, it would be possible to shift the balance of care for older adults with mental health challenges if appropriate supports were available (Tucker et al., 2008). The work of Challis and colleagues on Balance of Care informed demonstration projects in Ontario through the
Canadian Research Network for Care in the Community (Williams, et al., 2009). In their study, Williams and colleagues targeted individuals in nine regions in Ontario who were waiting for a space in long-term care. They reported that up to 50% of individual wait lists could be kept in the community with the necessary mix of health and social services and that the coordination of assistance with instrumental activities of daily living (such as transportation, nutrition, etc.) was a contributing factor to an individual’s presence on the wait list; yet these services are often excluded from the typical mix of publicly funded home care services (Williams et al., 2009). The Balance of Care approach indicates that a broader view of home care services is required to best support older adults who want to age in their community.

Research from Markle-Reid and colleagues (2006, 2008) also found that with minimal supports, many older people aged 75 and older could be delayed from entering long-term care, with a sizeable population showing improvements in health and quality of life. Further work from Markle-Reid and colleagues (2011) specifically examined the role of nursing home support in reducing depression in older home care clients, again strengthening the knowledge base about home care services for geriatric mental health patients.

In addition to research on the mix of services required to support aging in place, there is a strong body of research on home care in Canada, particularly in the areas of the perspectives of workers, safety, economic feasibility, and labour force projections (Martin-Matthews, Sims-Gould & Tong, 2012/2013). Despite this strong evidence base, there are barriers to reform, primarily around the resistance to redistribution of resources and a system that was “designed around the needs of care providers, not patients; the lack of homecare is one of the most glaring examples of that” (Picard, 2011, p.157).

Although there is a growing evidence base around homecare models, there is comparatively less evidence around geriatric mental health policies and models in long-term care. A review from the World Health Organization (Draper & Low, 2004) on the effectiveness of old age mental health services suggested that there was good evidence for outreach services to
long-term care, where there was a liaison style and strong educational support; however, the review did not include policy level recommendations. The authors also suggested that additional research is required on models of care, specifically examining the mental health outcomes in countries where there are integrated old-age mental health services (Draper & Low, 2004). In the Canadian Coalition for Seniors’ Mental Health (2006) *National Guidelines for Seniors’ Mental Health: the Assessment and Treatment of Mental Health Issues in Long Term Care Homes (Focus on Mood and Behaviour Symptoms)*, organizational and systems issues were discussed. Despite the limited evidence in these areas, recommendations were offered based on the existing knowledge, including addressing the current education and training gaps in staff and the need to integrate mental health services from local teams into long-term care homes (CCSMH, 2006).

The literature identified in this section was used to inform my analysis of geriatric mental health policies. While there are examples of successful models internationally and within Canada, innovation and reform is often hindered by Canada’s “habit of being — as one former politician described us — a nation of pilot projects” (McGrail, 2012, p.84). Furthermore, as with many government frameworks, research on geriatric mental health policy is often developed and disseminated, but it is very challenging to find examples of its application and the implementation of these models.

### 2.2 Theoretical Orientation

The political economy theory of aging helps to explain how dominant social institutions reproduce and perpetuate inequalities (Estes & Associates, 2001). This perspective provides a lens for understanding inequities and accumulated disadvantages in late life (Kail, Quadango, & Keene, 2009). Estes and associates (2001) note, “empirical and theoretical work on social policy and aging from a critical perspective opens the way for an alternative understanding and vision of ‘what is possible’ for old age and aging” (p.236). They also encourage reflexivity and
commitment to praxis\(^8\) within a critical approach, with the goal of understanding and changing structures that contribute to or reproduce social inequality (Estes et al., 2001). While commonly positioned as a theory that can play a role in policy development, the explicit application of the political economy theory of aging in the literature and in the policy environment is scant (see Lynott & Lynott, 1996; Pierce & Timonen, 2010). One component of the political economy theory of aging is the moral economy, which focuses on the social constructions of fairness, justice, and social obligations (Kail et al., 2009). The moral economy also examines the key tenets of apocalyptic demography, focusing on sustainability issues and generational equity (Kail et al., 2009). Writing about what she terms the “aging enterprise,” Estes (1999) examines the “relationships between social policy and the conditions and needs of the elderly” (p. 135) and concludes that the individual experience of aging is shaped, in part, by the way society treats its aging population through policies in health. Estes (1993) critically examines the social construction of the “problems” of aging, as well as the health and social policies that rationalize health care and facilitate dependency, through her concept of the aging enterprise (Estes, 1993).

Although theorists concerned with the political economy of aging have established links to social structures and institutions, a strong historical background, and applicability to policy in aging, this framework is not typically explicitly used in policy development in gerontology (Wilson & Tindale, 2010). The use of the political economy theory of aging is also more prevalent in the United States than in Canada. Conversely, the life course theoretical perspective has recently been applied in policy development with the intention of incorporating quantitative and qualitative data to address both social structures and the individual lives of older adults (Marshall, 2009). As a framework, the life course perspective meshes longitudinal perspectives with more traditional types of research, allowing for an understanding of

\(^8\) Defined by Estes et al. (2001) as “practice and social action that dialectically flow both from and into theory and research” (p.237).
intersections and diverse trajectories in life (Marshall, 2009). This perspective yields a greater application for policy analysis than the political economy theoretical perspective given its focus on individual context and its acknowledgement of historical and social influences, such as those left behind in policy legacies and structural lags.

The life course theory of aging recognizes the importance of social structures and historical context as well as individual experiences and meanings. It is structured by the following five key principles (Bengtson, Elder & Putney, 2005):

1. Lives are linked and interconnected to the relationships that influence them;
2. Social and historical contexts are important to the way an individual’s life is shaped;
3. Transitions in life and the timing of such transitions are important in relation to their social contexts;
4. People have agency and are active in the construction of their own lives; and
5. Aging is a lifelong process.

Clarke and colleagues (2011) illustrated these principles through their application of the life course theoretical perspective to understanding mental health patterns throughout life. The authors reference the myth-busting work of Mirowsky and Ross (1992), who dispelled the notion that depression is a part of typical aging. Clarke and colleagues (2011) used this research to explain how mental health prevalence rates can be understood in relation to biographical time and changing social and historical contexts rather than as a product of age.

Although the epistemologies of the life course theoretical perspective and the political economy of aging perspective differ, there are opportunities to dovetail theoretical approaches to policy analysis given the need to understand structural contexts and the impact of structures on individuals. The interpretive nature of the life course theoretical perspective allows for a deepened understanding of how social worlds are constructed (Bengston, Burgess & Parrott, 1997), a necessary perspective for understanding the experience of older adults within social institutions in Canada. Complementing this approach, the critical nature of the political economy
theory of aging allows for a critical focus on social structures and challenges the status quo with a focus on action and improving the experience for those experiencing oppression. As noted by Street (2007):

A life course theoretical orientation provides the capacity for conceptual enrichment as an overlay to other theoretical frameworks, enabling researchers to incorporate increased complexity into explanations about the relations between aging individuals and society by focusing attention on the implications of life course trajectories and transitions. (p.160)

Street (2007) suggests that linking the life course theory to critical perspectives such as the political economy of aging is a valuable approach to research in aging.

Given the lack of a grand theory in gerontology, using both popular theoretical perspectives will inform a broad and thorough analysis of policies for the purpose of this dissertation. The political economy theory of aging is used to highlight structures and policies and will focus in on the way policies create dependency or facilitate independence. The life course perspective will move the discussion beyond examining structures, layering in issues of transitions and social and historical contexts, which are vital when comparing provincial settings.

Using a dovetailed theoretical perspective to examine policy in gerontology is still an emerging practice. By using a macro level theory and a linking theory (one that includes macro and micro levels) and by examining how the two theories interact in the policies of interest, I offer recommendations and strategies for bridging the theory-research-policy interface gaps. A review in the *Canadian Journal on Aging* on the links between research and policy development in aging indicated that Canada had not yet bridged the research-policy interface (Martin-Matthews, Tamblyn, Keefe, & Gillis, 2009). Unfortunately this problem is not unique to the field of gerontology. As noted by Nightingale and Scott (2007), there is commonly a gap between academic research requirements and the reality of the knowledge required for good policy making. As policy makers broaden their scope of good “evidence” for informed decision making,
and as the movement towards citizen engagement in policy making increases (OECD, 2001), it is my hope that through my dissemination and knowledge translation strategies, my findings will have the potential to influence policy changes and provide new ways of thinking about what is possible for late-life mental health policies in continuing care settings.

In addition to using gerontological theory, I will also draw on conceptual and philosophical approaches to social welfare in my analysis. In particular, drawing on the work of Richard Titmuss (1976) and further expanded by Lightman (2003) and Graham and colleagues (2012), I will align provincial perspectives with approaches to social welfare. These include the residual model, the industrial achievement model, and the institutional redistributive models of social policy (Graham et al., 2012). These social welfare models are contrasted by their positioning around the role of the state and who should pay for what. Lightman (2003) also conceptualized the differences in the social welfare models by the extent to which there is a mutual social obligation in a policy approach. The residual welfare model of social policy is arguably the most conservative in ideology. Programs and policies that align with residualism focus on individuals taking care of their own needs; the responsibility of others is limited, and the role of the state is restricted to acting only as a last resort (Lightman, 2003). The Industrial Achievement-Performance Model of Social Policy argues that “social needs should be met on the basis of merit, work performance, and productivity (Graham, et al., 2012, p.5). On the opposite end of the continuum, moving away from residualism, the Institutional Redistributive Model of Social Policy views social welfare as a key institution in a society where health and social services are universal, outside of the private market, and based on need (Graham et al., 2012). As explained by Chappell and Hollander (2013), many of the debates about continuing care fall under the domain of social policy (versus only health policy) and analysis can be enhanced through the use of social policy theories.
2.3 Positionality and Perspective

As a researcher I bring multiple perspectives to this work. In the spirit of transparency and recognizing that my research interests are shaped by my own biases and experiences, I offer the following reflections for consideration. Of note, throughout most of my doctoral studies I worked with the Canadian Coalition for Seniors’ Mental Health (CCSMH). Within my role I was fully immersed in the research and policy developments in the field and played an advocacy role at the federal and provincial levels. In my teaching, research, and previous work roles I have lived by the philosophy of “enlightened opportunism”: that is, using every opportunity to fight ageism and stigma (Stuart, Arboleda-Florex & Sartorius, 2012). As detailed in Chapter 3, I engaged in reflexivity and memoing throughout this research process and have remained highly aware that my own drive for social justice has influenced my research questions and perspectives on geriatric mental health. To address my positionality and potential bias, I have built transparency into my research design and into interactions with participants in my research.

2.4 Research Questions

Several important research questions arise from the discussion of seniors’ health and mental health issues and their potential implications within the context of health policy in Canada. As noted earlier, given the piecemeal nature of mental health services in Canada and the positioning of home care and long-term care within Canadian health policy, provinces design and form policies in these areas outside of the principles of the Canada Health Act. This opens the door for significant variations in the way older adults are positioned in terms of health and mental health policies across the country.

Given this context, the objective of my research is to identify and document the nature of seniors’ mental health policies, strategies, and frameworks in a selection of provinces. I will identify policies/strategies/frameworks and review options for supporting and promoting seniors’
mental health. This exploratory policy analysis will open a dialogue about provincial differences and, in a comparative analysis, suggest strengths and weaknesses in terms of recommendations and best practices for seniors’ mental health policies. This knowledge is important for ongoing policy development across provinces as regions prepare for demographic changes, and it could build a foundation of recommendations for any future national polices or strategies focused on seniors’ health.

The guiding research question for this policy analysis is: **How have provinces organized their extended healthcare services (specifically focused on long-term care and home care) to support older adults with mental health issues?** Through the examination of policy documents and provincial strategies on mental health, aging, and continuing care, and key informant interviews, my data collection strategy is designed to answer the following questions:

1. How have governments (and governmental organizations) taken responsibility for seniors and seniors’ mental health in the sample provinces?
   a. What is the structure of government organizations and policy-making processes in these areas?
   b. What has influenced policy making in these areas?

2. How do provincial policies in home care and long-term care support older adults with mental health problems?
   a. What are the goals of each policy?
   b. How do the policies align with overall provincial philosophies and frameworks?
   c. Do the policies align with evidence and research in the field?

3. What mental health policy gaps or limitations exist that could be remedied in future policy development?
   a. Who is served well under current policies?
Chapter 3: Methods

The methods for this policy analysis have been influenced by my guiding research question: *How have provinces organized their extended healthcare services (specifically focused on long-term care and home care) to support older adults with mental health issues?* As outlined by Crotty’s (1998) writings on research design, in this section I will discuss my research philosophy, the theoretical perspectives underpinning this research, and the methodology and methods for this research.

### 3.1 Research Philosophy

My desire to reduce inequality and promote social equity aligns with the philosophy of critical realism. Critical realism, associated most closely with the work of Roy Bhaskar, offers a bridge between the natural and social sciences through its ontological inclusiveness and recognition of complexity (Bergin, Wells & Owen, 2008). For researchers with a critical realist philosophy, research has a social justice purpose (Robson, 2011) that is aided by developing deeper levels of explanation and understanding (McEvoy & Richards, 2006). A critical realist recognizes that there may indeed be cause-and-effect relationships (as subscribed to by positivist theorists), but posits that by asking the question “what if?” we can explore how the effects may look different in different settings. Therefore, rather than limiting knowledge to the laws of cause and effect, a critical realist considers external and internal factors that are present in the “real world” rather than in the vacuum setting of a laboratory. Critical realism is a relatively new philosophy of research, but its reflection in recent research on mental health (Bergin et al., 2008) and dementia (Kontos, Miller, Mitchell & Cott, 2010) is an indication of its relevance for research in seniors’ mental health.

Critical realism also accounts for and recognizes the interactions between individual agency and structural powers (Archer, 2003). This is a particularly useful philosophy and perspective for studying policy legacies, as individuals in the past have “organized and
constructed social, economic, cultural and political structures (Archer, 1995). Present
generations are therefore born into a largely pre-given social world” (Connelly, 2001, p.115).
Critical realist philosophy also recognizes that neutrality in social science and public health is
not possible (Connelly) and emphasizes the fallibility of scientific knowledge, where even the
most revered theories may end up being disproven (Groff, 2008). The humble nature of this
philosophy, as well as its appreciation for complexity, aligns with my personal perspective
around research and the nature of knowledge, particularly the importance of valuing multiple
types of evidence and appreciating contextual and structural implications in research and
knowledge creation.

3.2 Putting Theory into Practice: Theoretical Perspectives

I bring a critical perspective to my work that aligns with my philosophy of research
through the use of the political economy theory of aging; that is, I am acutely aware of power
relations in society and their influence on policy development (Gray, 2004). The linkages
between a critical realist philosophy and political economy theories have been well documented
(Nielson, 2002), although perhaps not explicitly in gerontology literature. I am also adopting the
life course theoretical model, as discussed in Chapter 2, which aligns closely with a critical
realist philosophy that recognizes individual agency but also considers the influence of
structures and social and historical contexts. My use of gerontological theory aligns with Walt
and colleagues’ (2008) recommendation that health policy analysis would be strengthened with
social science theories. Given the lack of literature on how to do applied health policy analysis
on a complex policy issue like seniors’ mental health, I endeavour to strengthen the body of
literature on theory use in health policy analysis.

3.3 Methodology

Although there are numerous texts on methodology in the social sciences, health and
social policy analysis has been critiqued for not adequately addressing how to do policy analysis
(Walt et al., 2008). Furthermore, analyses are often rooted in quantitative and economic arguments or provide information with little applicability or use in the policy environment (Fischer, Miller & Sidney, 2007). The generalizability, quality, and rigour of health policy research have also been critiqued by those operating from a positivist paradigm whom tend to work outside of the social sciences (Gilson, Hanson, Sheikh, Agyepong, Ssengooba, & Bennett, 2011). This idea has been challenged by scholars such as Howelett, Ramesh and Perl (2009) who state that:

The greatest strength of post-positivist analyses is that they are sensitive towards the messy reality of the public policy process, unlike their positivist counterparts who tend to have an orderly, even mechanistic, conception of the policy realm (p.29).

To manage the ‘messy reality’ of policy analysis, Walt and colleagues (2008) suggest that researchers have to “find ways of organizing their analysis so that it provides a lens that represents but also explains a highly complex environment” (p. 310).

Given my desire for an applied and systematic methodological philosophy and to provide an organizational lens to my research, I have employed two policy analysis methods to help answer my research questions: the Framework Analysis (Ritchie & Spencer, 1994) and the Policy Triangle Framework (Walt & Gilson, 1994). Critical realists have promoted methodological pluralism as a mechanism for deepened understanding and explanation (Olson, 2009). To achieve deepened understanding, I used these two frameworks to strengthen the systematic process of my research as suggested by Walt and colleagues.

The Framework Analysis (FA) is a qualitative method for applied policy research (Srivastava & Thomson, 2009). This overarching framework is a flexible and dynamic process for analysis that typically includes defining concepts, mapping, categorizing, finding associations, seeking explanations, and developing new ideas (Ritchie & Spencer, 1994). The stages of analysis in FA are familiarization, identification of a thematic framework, indexing,
charting, and mapping and interpretation (Ritchie & Spencer). Used for over 25 years in research, FA has more recently been used in health policy (Gale, Heath, Cameron, Rashid, & Redwood, 2013). The strengths of FA are well documented: it allows for analysis across and within cases (e.g., provinces), recognizes the complexity of real-life health systems and multiple perspectives, and can be used with deductive or inductive analysis (Gale et al.). In particular, I have used familiarization, charting, and mapping processes outlined in the FA approach to organize data from policy documents and key informant interviews and to give structure to data analysis. The charting and mapping process also facilitated comparisons across provinces.

A complementary framework developed by Walt and Gilson (1994), the Policy Triangle Framework (PTF), is grounded in the political economy perspective. The PTF considers the content of a given policy, the actors, the contexts, and the processes that interact to shape policy making (Walt & Gilson). Walt and Gilson developed this framework recognizing that most policy reform and analysis focuses solely on the content of the policy and ignores the other key factors. The PTF offers a more comprehensive framework for policy analysis that considers agents and structures as necessitated by a critical realist philosophy and in combination with the social and historical context in a life course theoretical perspective. Figure 1 illustrates the Policy Triangle Framework as described by Walt and Gilson, who recognized that the complexity of the interrelationships are simplified in this model and appear to be considered separately. In reality, Walt and Gilson explain the bidirectional nature of the interrelated components, where “actors are influenced by the context within which they live and work…” (p.355) and the context, in turn, is affected by factors such as political ideology, historical experiences, and culture. How issues get onto the agenda and how they are prioritized is then affected by the values and position of the actors and all of these factors interact and reflect the content of policies (Walt & Gilson).
I have embedded reflexivity into my research as suggested by the writings of Walt and colleagues (2008), who believe that doing so is a key component of advancing health policy analysis. In particular, my experience moving between being a policy “insider” in my role with the CCSMH and an “outsider” as a researcher required reflexivity. While a critical realist philosophy does not dictate neutrality in research, I also struggled with finding the balance between maintaining neutrality as an interviewer and my philosophy of enlightened opportunism.

### 3.4 Putting Methods into Practice

A four-step process outlined in greater detail below drove my analysis. After identifying sample provinces (see section 3.6) and receiving clearance from the research ethics board at the University of Guelph, I used the following methods for data collection and analysis:

1. Collected relevant policy documents and frameworks;
2. Engaged in a mapping and charting process;
3. Conducted key informant interviews; and
4. Developed a thematic framework and cross-provincial comparisons.

Although outlined here as a linear process, this was an iterative and circular process that required ongoing work, revisiting the mapping and charting as needed as new documents and themes emerged.
To answer my research questions I explored the full toolbox of methods and techniques (Olson, 2009) associated with the FA and PTF and aligned with critical realism. Specifically, in-depth document reviews supplemented by key informant interviews were key sources of data. Two Canadian resources, the Seniors’ Mental Health Policy Lens (MacCourt, 2009) and the *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* (MacCourt, Wilson, & Tourigny-Rivard, 2011), were used to provide analytic lenses for the data. This process is outlined in Figure 2 and each step will be described in greater detail.

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**Figure 2: The Research Process**
3.4.1. Criteria for Provincial Selection

As outlined in Figure 2, four provinces were selected for inclusion within this research. While there is great variation across the provinces and territories in Canada, this variation can be systematically categorized so that a strategic selection of four provinces yields insights into all types of provincial variation. In order to address provincial diversities, the following criteria were applied to select provinces for inclusion: provincial structure (regionalized versus centralized), resources and wealth (based on equalization payment status), and political ideology as determined by the party in control of the provincial government. Provinces for inclusion were selected based on diversity within these categories, resulting in the decision to focus on Alberta, British Columbia, Ontario and Nova Scotia.

**Provincial Structure**

Health care reform has been closely linked to regionalization of health services (Forest & Palley, 2008). The move towards regionalized services, as opposed to centralized ones, has been viewed as a mechanism for shifting health services to more community-based models that typically include long-term care and home care (Forest & Palley). The catalyst for moving towards regionalization is often a desire for improved management and accountability to provincial health systems (Forest & Palley). If these notions of regionalization hold true, it is important to examine differences in provincially funded community-based services in provinces that are regionalized compared with those that are not regionalized.

**Equalization Payment Status**

Provincial resources and wealth are often measured in terms of equalization payment status, reflecting a federal transfer program intended to address fiscal disparities among provinces (Department of Finance, 2010). Provinces that receive payments are often called “have-not” provinces compared with their wealthier “have” counterparts. Although equalization

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9 It should be noted that the selection on provinces of my research design was done at a particular point in time (2011), and the elements described below shifted throughout my research period.
payments are not the only measure of wealth and resources, because they are determined based on provincial revenues, they help to illustrate the current economic situation in each province. It should be noted that since equalization payment status changes each year, status was based on the 2011–2012 equalization payments. Forest and Palley (2008) note that “asymmetrical equalization payments to enable poorer provinces to achieve equitable regional health care services have contributed to” strains between federal and provincial authorities (p. 72). The historical implications of equalization payments also help to illuminate the shifting context of different regions; for example, in 2010 the province of Ontario, for the first time in its history, became a “have-not” province.

Political Ideology

Given the variation in political ideology across the spectrum, situating the government of each province is important in terms of understanding the government’s positions on health care, economic approach, and social welfare. Similar to equalization payment status, some provinces will have experienced recent changes in political ideology (as determined by the party forming the government). These shifts are noted in the discussions of the individual provinces, but for the purpose of provincial selection, the government in power in 2011 was used.

Selection of Provinces for Inclusion

After reviewing the differences between provinces in terms of regionalization, equalization payments, and current political climate, I selected British Columbia, Alberta, Ontario, and Nova Scotia as the provinces of interest for this research. Additionally, sampling was based on the currency of policy documents to ensure continuity of policies during the study period. Despite shifts in the landscape over the last four years, the majority of indicators used for selection have remained constant. The four selected provinces also offer diversity in terms of the population of older adults; rates of institutionalization, home care rates, and rates of alternate level of care days. The characteristics of the included provinces are summarized in Table 4.
Although Québec would have been an appropriate provincial choice given the selection criteria, as an English-speaking researcher it was not feasible for me to familiarize myself with the documents and conduct key informant interviews in French. Additionally, the three territories were excluded given their low populations of older adults relative to their population base, lack of inclusion in equalization payments, and territorial governments that are formed by consensus in two of the territories, which made generalizability and comparisons across regions difficult.

Table 4: Characteristics of Included Provinces

<table>
<thead>
<tr>
<th></th>
<th>British Columbia</th>
<th>Alberta</th>
<th>Ontario</th>
<th>Nova Scotia</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of province age 65+</td>
<td>15.65%</td>
<td>11.13%</td>
<td>14.62%</td>
<td>16.64%</td>
</tr>
<tr>
<td>% of province 80+</td>
<td>4.31%</td>
<td>3.00%</td>
<td>4.03%</td>
<td>4.38%</td>
</tr>
<tr>
<td>Average age of long-term care resident</td>
<td>83</td>
<td>85</td>
<td>82</td>
<td>85</td>
</tr>
<tr>
<td>% of seniors in long-term care</td>
<td>5.4% aged 65 and older live in health care facilities (includes assisted living, residential care, hospitals)</td>
<td>14,500 LTC beds (AHS) + Assisted Living Beds; Approx. 3% of seniors live in LTC</td>
<td>Approximately 78,000 LTC beds (serving 112,000 seniors/yr.) representing 2.2% of the population</td>
<td>4.4% (licensed residential care facilities 0.8% + licensed nursing homes 3.6%)</td>
</tr>
<tr>
<td>% of seniors receiving home care</td>
<td>9% aged 65+ received publicly funded home care (2004-5)</td>
<td>60,597 home care clients in 2004/5 - average age 68.9yrs</td>
<td>60% of 616,000 receiving home care are 65+</td>
<td>58% of the 653,730 home care clients were 65+</td>
</tr>
<tr>
<td>Regionalization</td>
<td>Yes – 6 Health Authorities</td>
<td>Recently transitioned back to centralized system</td>
<td>Yes – 14 LHINS</td>
<td>Yes – 9 Districts</td>
</tr>
<tr>
<td>Received Equalization Payment (2011–2) / (2013–4)</td>
<td>No / No</td>
<td>No / No</td>
<td>Yes / Yes</td>
<td>Yes / Yes</td>
</tr>
<tr>
<td>Political Climate (2011) / current</td>
<td>Liberal / Liberal</td>
<td>Conservative / Conservative</td>
<td>Liberal / Liberal</td>
<td>NDP / Liberal</td>
</tr>
</tbody>
</table>

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10 Statistics Canada (2012a).
11 CIHI (2013) CCRS.
12 Strain, Maxwell, Wanless & Gilbart (2011).
14 http://www.health.alberta.ca/newsroom/facts-stats.html
16 Nova Scotia Department of Seniors (2009).
19 Ontario Home Care Association (2013).
3.4.2 Document Review

After selecting my four provinces of analysis I began the process of identifying relevant provincial policy documents in order to begin the familiarization process. As a starting point, I began to examine each of the selected provinces to identify where and how mental health, long-term care, and home care “fit” within its provincial structure (e.g. which ministry leads strategic development for these areas). Once ministries were identified, I conducted web searches to locate documents with a specific focus on provincial planning documents, strategies, and frameworks for the areas of mental health, long-term care, and home care. This process included examining broader health documents and strategies on aging for relevant sections. Given that these documents are typically renewed in five- to ten-year increments, the most recent planning documents were included. In addition to searching reference lists of policy documents, I consulted with key informants to ensure that a thorough review of all relevant documents was integrated into the familiarization stage. In total, 23 documents were included in the analysis; five from Alberta, nine from British Columbia, six from Ontario and four from Nova Scotia. Included documents are listed in Table 5.

As outlined in FA, familiarization is the foundational step of this approach to applied policy analysis (Ritchie & Spencer, 1994). In the familiarization stage, immersion in the policy data is imperative. Within the familiarization stage I read each policy document in its entirety and began to create notations and the preliminary process of mapping the content of the policy documents onto my research questions and using the Policy Triangle Framework (Walt & Gilson, 1994). Charting was used as way to organize content from the policy documents and to link them to my research questions. A sample chart can be found as Appendix I. As I was immersed in the documents I also began to develop tailored interview guides for my key informants.
3.4.3 Key Informant Interviews

As an important component of my research, in addition to document review I also conducted key informant interviews. In particular, I was seeking to speak with key informants working in provincial governments in the areas of focus (mental health, long-term care, home care, aging) who had knowledge of the policy context. I also wanted to speak with clinicians and/or administrators working in the field whose work were in the context of the provincial policy decisions. Key informant interviews were used to deepen my understanding of the policy environment and clarify my interpretations and assumptions with respect to policy documents. They also provided key contextual information and insider perspectives on policy decisions within the participants’ regions and across provinces.

Given the need for informed decision makers and stakeholders, recruitment was purposive (Trochim & Donnelly, 2008) to identify an array of opinions. I began my sampling by contacting colleagues through my connect with the Canadian Coalition for Seniors’ Mental Health, a method which was approved by the University of Guelph Research Ethics Board. Snowball sampling (Trochim & Donnelly) was used to complement the purposive recruitment; that is, identified informants were asked to recommend other key stakeholders who should be included in this research, allowing for the inclusion of like-situated individuals. Complementing the government perspective and offering the “on the ground” perspective, prominent advocacy organizations, champions, and academics were identified, through a review of these organizations and through snowball sampling, and interviewed.

In total, I conducted eighteen key informant interviews. While this was in no way an exhaustive list of the potential key informants who could offer insight into this research, common themes were consistently emerging across interviews, indicating saturation. Interviews were conducted in person or over the phone. All interviews were audio recorded and relevant passages were transcribed verbatim. Given the ethical requirements of this research, the roles and names of key informants who participated in this research are confidential. As part of the
consent process key informants also had the opportunity to indicate their preference not to be quoted verbatim in the analysis with a small proportion exercising this option (n=2).

After receiving consent from participants, I sent a semi-structured interview guide to them in advance. Questions were based on my research questions specifically, but also emerged from my document review. A sample interview schedule is included as Appendix II.

3.4.4. Mapping, Charting & Developing a Thematic Framework

After conducting key informant interviews, following the Framework Analysis (Ritchie & Spencer, 1994) I mapped my key informant data onto my research questions, integrating them with my data from the document review. I also engaged in analyses of key informant data using my theoretical lenses, the political economy theory of aging and the life course theoretical perspective. Aligning with the steps in the Framework Analysis I then began to develop themes and engaged in comparative analysis across provinces. Themes were extrapolated from the charting and mapping processes. A hybrid approach of thematic analysis was used where both inductive and deductive coding led to themes and findings (Fereday & Muir-Cochrane, 2006). This hybrid approach is consistent with Framework Analysis (Oliver, n.d.) and enables a balance between themes that are derived from my discussion with key informants and my process of memoing but also from other sources of evidence that have influenced my research questions (Fereday & Muir-Cochrane). Two key resources guided my deductive analysis: the Seniors’ Mental Health Policy Lens (MacCourt, 2009) and the Guidelines for Comprehensive Mental Health Services for Older Adults in Canada (MacCourt, Wilson & Tourigny-Rivard, 2011). A sample mind map can be found as Appendix III, illustrating the development of themes.
Seniors’ Mental Health Policy Lens (SMHPL)

The Seniors’ Mental Health Policy Lens is a Canadian tool developed by Dr. Penny MacCourt (2009). Informed by the values of seniors and the experience of those living with a mental health problem, the SMHPL was revised in 2009 to reflect the philosophy of recovery and well-being. The SMHPL is organized as a checklist and was designed as a “multi-purpose practical tool that can be applied to any policy, program or practice that directly or indirectly affects seniors” (MacCourt & Krawczyk, 2010, p.3). I used the SMHPL as a tool when reviewing policy documents and in key informant interviews to establish the roles older adults have played in policy development, to evaluate the recovery orientation of policies, and to trigger lines of questioning that would help me to understand the context of how policies were developed or conceptualized.

Guidelines for Comprehensive Mental Health Service for Older Adults in Canada

The MHCC developed its Guidelines for Comprehensive Mental Health Services for Older Adults in Canada in 2011 (MacCourt, Wilson & Tourigny-Rivard). This resource offers several recommendations to support policy makers and service providers in planning, developing, and implementing a mental health service system that can effectively respond to the unique needs of an aging population. Informed by seniors themselves through consultation, the guidelines also incorporate the values and perspectives of families, caregivers, mental health service providers, and advocacy groups. I used the document as an analysis tool as it provided a framework to map provincial services and systemsonto the national recommendations about the required range of service approaches to support older adults and their caregivers.

3.5 Strengths, Limitations and Considerations of the Research Design

This research design builds on existing evidence about how best to conduct qualitative policy analysis. Although the content of this analysis differs there are lessons learned from other health policy research initiatives. In particular a large research team funded by the
Canadian Institute of Health Research recently completed a comparative review of the policy landscape in western Canada (Suter et al., 2014). This team also used the Policy Triangle Framework (Walt & Gilson, 1994) as their overarching framework and used data from document reviews and key informants to develop their policy options. As Suter and colleagues articulated, “this approach is appropriate to account for the complexity of primary health service delivery, its roots in Canadian political economy and the particularities of the provincial health system context in which it takes place (Félix-Bortolotti, 2010)” (p.7). Furthermore, a review of health policy analysis literature published between 1994 and 2007 found that the Policy Triangle Framework was the most commonly used overarching framework (Gilson & Rapaely, 2008).

Using Framework Analysis (Ritchie & Spencer, 1994) to developing a framework for analysing interviews with policy makers is a complementary method outlined by Oliver (n.d.) who suggests that Framework Analysis facilitates qualitative data analysis and also offers rigour while allowing both inductive and deductive approaches.

As noted earlier, issues of generalizability, quality and rigour are common critiques of health policy research. Recognizing that different knowledge paradigms influence ideas about rigour, there are suggested processes to ensure rigour in qualitative data collection and analysis (Gilson et al., 2011). Several of these processes have been embedded into this research, namely the use of theory, case selection, sampling and triangulation (Gilson et al., 2011). As outlined earlier, the use of the political economy theory of aging the life course theoretical perspective have guided analysis and supported interpretation; rigorous case selection allows for purposive sampling to ensure diversity as evidence by my provincial selection criteria. As explained by Gilson and colleagues (2011), rigour in sampling includes diversity in key informants and ensuring a range of viewpoints, which is why I included both decision makers and clinicians in my key informant samples. Triangulation is a process of comparing multiple sources of evidence and looking for convergence and divergence in patterns across cases (Gilson et al., 2011). I used multiple sources of evidence (policy documents and key informant
interviews) as a method of triangulation. I also compared and looked for patterns and highlighted unique variations in my cross-provincial analysis.

Despite these strengths, the ‘messy reality’ of policy analysis was certainly experienced during my own research. As described by Walt and colleagues (2008), there are many challenges to “doing” health policy analysis. In particular, they note the difficulty in obtaining relevant documents and papers and/or being bogged down with excess documentation (Walt et al.). These challenges were reflected in my own experiences when, after completing the document review, I learned from key informants that new policy documents were being used internally but were not yet available for public review. Conversely, the search for relevant frameworks and papers in the complex web-based repository of government documents provided extensive readings, and the narrowing-down process to determine which were relevant was a time-intensive task. Walt and colleagues outline other key challenges, such as the “curse of the temporal challenge” (as coined by Hunter, 2003), whereby decision making and policy changes can be slow and incremental, over time spans of a decade or more. I experienced my own “temporal curse” engaging in this policy analysis over a four-year time period. The years since I began conducting this analysis have seen a federal election and at least one provincial election in each province of study,20 significant changes in the global economy, a general downloading of responsibility for health decisions from the federal to provincial governments, and the beginning of the aging “boom” caused by the aging of the baby boomers. Despite evidence suggesting that policy development is typically slow-moving, the time period during which I undertook my research saw rapid policy change, investments in geriatric mental health, and the emergence of multiple new frameworks and policies. As a result of these external and time-related factors, my research was not linear but iterative, reflective of the challenges of “real world research” (Robson, 2011, p.11).

20 The federal election occurred May 2011; Provincial elections were held in Ontario in 2011 and 2014, British Columbia in 2013, Alberta in 2012, and Nova Scotia in 2013.
3.6 Questioning My Research Questions: A Shift in Research Design

As noted earlier, this research was conducted over several years. At the start of this process, my research motivations were guided by a desire to understand to what extent the principles of the insured services of the Canada Health Act could be applied to extended health services (specifically home care and long-term care) in the sample provinces. My data collection strategy was originally designed to answer the following questions:

- What regional variations are there in the administration of home care and long-term care? If there are variations, what difference do they make? (RQ1)
- How comprehensive, accessible, and universal are the policies (home care, long-term care)? Do they create any barriers / facilitate accessing service? (RQ2)
- How are issues of portability addressed in policy (home care, long-term care)? (RQ3)
- What impact do provincial differences in administration, universality, comprehensiveness, and portability have on the aging process (with a focus on components of mental health recovery in aging)? (RQ4)
- What are the provincial policy barriers to accessing mental health in long-term care and/or home care? (RQ5)

Guided by the Framework Analysis, throughout the familiarization stage I immersed myself in the policy data. This allowed me to develop an understanding of where and how mental health, long-term care, and home care “fit” within each provincial structure (e.g. which ministry leads strategic development for these areas). Engaging in this process for each province quickly illuminated key differences and in many cases highlighted a critical finding: very rarely does any ministry or regulatory body have ownership over seniors’ mental health. As outlined in my methodology, after identifying key policy documents, I read them in their entirety for initial understanding and familiarization. Following earlier iterations of analysis strategies, I planned to use directed content analysis to help organize the data, using the program criteria of the Canada Health Act as organizing themes for analysis across provinces. My intention was to
use a combination of directed summative content analysis and coding organized by keywords and predetermined themes (Hseih & Shannon, 2005) allowing for easy mapping of policy documents onto the program criteria. However, early on in the familiarization stage I was able to see challenges with mapping data to the principles of the Canada Health Act, specifically that there were significant gaps in the content, such as no discussion of portability, and minimal data on accessibility and comprehensiveness, and this was true across documents.

In February and March 2013, I began the process of key informant interviews in Alberta to explore my findings of the policy data. The interviews were rich, providing depth and context to the provincial systems and landscapes when participants were questioned about the current policy landscape. For example, key informants were able to discuss how and where seniors and mental health were located within governmental departments and provide key historical and social context for these policy decisions. As I sought clarity regarding the principles of the Canada Health Act, as per my research questions, I discovered that this line of questioning proved to be outside of the scope of the key informants. For example, when asked about portability, none were able to provide any information, and when asked about who was excluded within certain policies, they provided clinical examples rather than population- or system-level information.

This process was echoed in July 2013 when I conducted three key informant interviews in British Columbia. Again, I gained valuable insights into the landscape and positioning of seniors’ mental health in provincial policy, but key informants struggled to speak directly to the questions pertaining to the principles of the CHA. Upon reflection, and after reviewing content from the key informant interviews, I surmised that the way I had structured my questions did not align with the lived experience of my informants. I had developed research questions that were of interest to me and existed in a hypothetical state. Those engaged in the “real world” of policy decision-making are not asked to operate by the principles of the Canada Health Act (since these principles do not extend to the domains I was researching) and they were being asked to
speculate on theoretical and hypothetical conditions of their policy frameworks. In my reflexive memos I noted that I felt like the researcher in the ivory tower, removed from the reality of the policy decision making world, and I felt that my line of questioning was moving me further into the territory of “policy outsider” who spoke in a language that was unfamiliar to my key informants. I also noted that my focus on the content of the policies was missing the key factors of the context, process, and actors involved in the policy decisions, which Walt and Gilson (1994) note is a common policy analysis error.

At this stage in my analysis and research, I started to consider a shift in my research questions in order to best engage key informants to help me understand provincial contexts and decisions in the domain of geriatric mental health in long-term care and home care. I also noted that while I aimed to understand primarily “big P” policy, I was learning more about “small p” policy within my provincial discussions and analysis of documents (Brownson, Chriqui & Stamatakis, 2009). That is, often the guiding frameworks and strategies focused on seniors' mental health were not enacted as law or legislation, but instead were included in the organizational policy or guiding frameworks of the health systems. Although I retained my interest in answering my original research questions, it was clear that the findings reported above were noteworthy. I recognized through my discussions with key informants that expanding the scope of my research to explore how provinces organized their extended healthcare services to support older adults with mental health issues would add an important dimension to my own knowledge and understanding and perhaps offer important contributions to the policy landscape as provinces prepare for the aging of their populations.

As noted in the literature on qualitative research methods, it is not uncommon for research questions to develop in an unanticipated direction after initial stages of data collection and analysis (Kinmond, 2012). In fact, Wield (2002) cautions that writing research questions

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21 As further evidence of how seniors fall between the cracks and the uniqueness of policy in this area, these 'policies' were actually somewhere in between "big p" and "little p" policy. They are not enacted as law but have further implications than traditional "little p policies."
should not be considered a linear process and emphasizes that “even after they have been formulated, either further reading of the literature or surprises at the piloting or data gathering stages can force the researcher to amend or even rewrite them” (as cited in Gray, 2004, p.69). From a critical realist perspective, the strengths of using qualitative methods include their open-ended nature and the opportunity for themes to emerge during inquiry that could not have been anticipated in advance (McEvoy & Richards, 2006). Since the Framework Analysis (Ritchie & Spencer, 1994) allows for both directed content analysis and more inductive approaches that leave room for surprises in the inquiry process (Gale et al., 2013), retaining it as an overarching framework was deemed compatible with a change in research directions. To provide additional guidance that complemented the new focus of my research questions, I engaged the Policy Triangle Framework (Walt & Gilson, 1994) to help understand policy decisions and frameworks in their broader context. A summary of my revised research design is illustrated in Figure 3. Working in concentric circles from largest to smallest, this design includes the overall research philosophy, theoretical perspectives, methodologies, and methods employed in this research. The use of critical realism allows for methodological pluralism, resulting in my use the Policy Triangle Framework and Framework analysis. Given that the Policy Triangle Framework has its roots in the political economy perspective, employing the political economy theory of aging along with the lifecourse theoretical perspective adds a gerontological lens and also complements policy frameworks with social science theories. To answer my research questions, data from key informant interviews and policy documents were collected and analysed.
Figure 3: Summary of Research Design

- Critical realism
- Political economy
- Lifecourse
- Framework
- Policy triangle
- Framework
- Analysis
- Document review
- Key informant interviews
Chapter 4: Current Provincial Structures and Responsibilities

4.1 Introduction

This chapter is focused on the research question: How have provincial governments (and governmental organizations) taken responsibility for seniors and seniors’ mental health in the sample provinces? To answer this, it is necessary to consider the following questions:

a. What is the structure of government organizations and policy-making processes in these areas?

b. What has influenced policymaking in these areas?

Given the historically siloed nature of policy making, it is not surprising that policies about seniors and mental health are not integrated. Borrowing from the concepts of the moral economy and the aging enterprise, looking at how governments develop policies in seniors’ mental health may provide insight into the positioning and valuation of older adults within the overall context of health policy decisions. Using this theoretical lens, before examining each provincial policy in detail, this chapter will provide a high-level overview of how seniors and mental health are positioned within each provincial context. Aligning with the Policy Triangle Framework (Walt & Gilson, 1994), this chapter will examine the context, processes, and actors involved in policy making to answer the question of how provincial governments have taken responsibility for seniors and seniors’ mental health. In particular, noting the biomedical framing of seniors’ mental health (MacCourt, 2009), intersections between policies focused on aging and those focused on mental health may be meaningful mechanisms to bridge the traditional silos.

To allow for comparison across provinces it is necessary to understand the specific context of each province. This need was highlighted in the pilot stage of data collection when it became apparent that there were not only gaps in provincial oversight for seniors’ mental health but also significant contextual differences across provinces. While this chapter will not propose how to close the gaps, its analysis will provide transparency and clarity about each provincial
context. The content of each policy will be discussed in Chapter 5. Within this chapter, a brief overview of each sample province is presented, followed by an integrated discussion of the context, actors, and processes that have influenced policy decisions in that province.

4.2 Alberta

At the time I compiled policy documents in the early stages of my research, there was no government ministry that was responsible for seniors in Alberta; instead, the Ministry of Health included seniors’ issues, which could be assumed to reflect a biomedical approach to aging (MacCourt, 2008). Despite the responsibility for seniors falling under the Ministry of Health, in 2010 the Government of Alberta released a policy paper focused on the role of government in preparing for an aging population. The policy framework espoused in the paper was a tool to foster collaboration and integration across government ministries, recognizing the need for responsibility outside of the Ministry of Health and for a greater appreciation of the social determinants of health and well-being as they relate to optimal aging (Government of Alberta, 2010). On September 15 2014, the Conservative Party of Alberta, under the newly elected Premier Jim Prentice, announced a Ministry of Seniors. According to the mandate letter from the Premier, the Minister of Seniors in Alberta is responsible for consulting with older adults in the province, working with Albertans to raise awareness of brain health promotion and prevention of cognitive declines, and collaborating with the Ministry of Health, particularly in the area of assisted living (Office of the Premier of Alberta, 2014). As a result of a cabinet shuffle, policy initiatives that were previously housed under the Ministry of Health, such as the Age-Friendly Alberta initiative, were realigned under the Ministry of Seniors.

As a province Alberta has been in flux in terms of the organization of health services. Alberta was a leader in the movements towards regionalization in Canada; however, tensions with the resulting health regions soon followed (Born, Sullivan & Bear, 2013). As a cost cutting measure, in 1994 17 health authorities were created in place of over 250 local health boards of
directors; this was subsequently reduced to 9 regional health authorities in 2004 (Born et al., 2013). Alberta Health Services was announced in 2008 and replaced 9 regional health authorities and three provincial bodies (Alberta Mental Health Board, Alberta Alcohol and Drug Abuse Commission, and Alberta Cancer Board) (“Our History, 2010) and is described as “Canada’s first province-wide, fully integrated health system” (“About AHS, 2015, para 7). The current structure of seniors’ and mental health care is depicted in Figure 4 and illustrates the relationship between Alberta Health Services and the range of living options for seniors including home care, supportive living, and long-term care.

Given the centralized structure of health services in Alberta, Alberta Health Services has responsibility in the province for policy decisions around health, mental health, and continuing care. The organization of the province is reflected in the chart below. A unique feature of the structure in Alberta is the development of Strategic Clinical Networks (SCNs). To date, Alberta Health Services has 10 SCNs, whose goal is to bring together passionate and knowledgeable networks of people who can challenge systems, facilitate innovation, and improve outcomes and value for Albertans (http://www.albertahealthservices.ca/scn.asp). Of the 10 SCNs, two are particularly relevant for this research: the seniors’ health network and the addiction and mental health network. Although clinical outcomes and the development of care pathways are core functions of these networks, SCNs also play a role in influencing and informing health policies developed by the Government of Alberta and Alberta Health Services (Alberta Health Services, 2014).

Born, Tepper, and Cummings (2013) hypothesize that the decades of restructuring in Alberta have led to “change fatigue,” confusion about leadership and accountability, difficulties planning for the future, and general distrust of and disengagement with healthcare providers. These historical contextual pieces are important factors in understanding the province’s current systems and structures and the influence of historical legacies on current policy making.
Figure 4: Organizational Structure in Alberta
4.3 British Columbia

British Columbia follows a model similar to Alberta’s original structure, with primary responsibility for seniors and mental health falling under the Ministry of Health. Within the ministry there are two distinct directorates that are relevant to this research: Seniors and Mental Health and Substance Use. Each directorate has developed strategies and frameworks that are cross-cutting; however, there is no formal mechanism for communication across directorates, despite their umbrella organization under the Ministry of Health. In fact, key informant interviews illustrated chasms in the communication between directorates, with the mental health directorate assuming that seniors’ mental health issues were addressed via the seniors’ directorate and vice versa (Key informant C). Figure 5 illustrates the organizational structure of seniors’ and mental health care in British Columbia (at the time of writing) and outlines the nature of responsibilities of the Seniors Directorate and the Mental Health Directorate.

![Figure 5: Organizational Structure of British Columbia](image-url)
The structure of health care in British Columbia is significantly different than Alberta due to the regionalization of British Columbia. While the provincial Ministry of Health is responsible for establishing expectations and outcomes for the five regional health authorities, each of these regional health authorities is responsible for identifying the needs of the population within their region and managing programs and services accordingly (http://www.health.gov.bc.ca/socsec/roles.html). This regionalized structure allows for prioritization of needs based on the local context of each regional health authority. Home and continuing care services are managed through the aforementioned regional health authorities. For scope and consistency across provinces, policy decisions made at the Ministry of Health level are the focus of this analysis; however, key informants from the community sector offered their local contextual perspectives during our discussions of the overall policy landscape.

Not unlike Alberta, British Columbia also experienced a significant time of restructuring, in its case moving toward, rather than away from, a regionalized model in 1997 (Penning, Roos, Chappell, Roos & Lin, 2002). Research on the impact of regionalization in British Columbia found that older adults were especially disadvantaged by the shift (Penning et al., 2002). According to the Canadian Centre for Policy Alternatives, the ongoing reorganization in British Columbia has been structured around two trends: the reduction in services and privatization (Fuller, Fuller, & Cohen, 2003). Of particular relevance for older adults are reductions and decreases in the allocation of resources, disadvantaging older adults who have complex healthcare needs, including non-medical needs (Penning et al., 2002). This steady erosion of continuing care is a key historical context that has influenced both the content of policies and the processes involved in their development.

4.4 Ontario

Ontario’s provincial structure shares some commonalities with both Alberta and British Columbia. Policy decisions relating to seniors are split between the Ontario Seniors’ Secretariat
(OSS) and the Ministry of Health and Long-Term Care (MOHLTC). While the MOHLTC has ownership of mental health and addictions, decisions about home and continuing care are regionalized as seen in British Columbia. Following the trend of regionalization, within Ontario there are 14 Local Health Integration Networks (LHINs) that are responsible for planning, funding, and integrating local health care aligned with the priorities and needs of each region (http://www.lhins.on.ca). At the centre of each LHIN is a Community Care Access Centre (CCAC), the entry point for home and long-term care services within each region. Ontario was the last province to move to regionalization, and the LHINs came out of legislation enacted in 2006. The movement towards regionalization was not without controversy, and the benefits of regionalized health care continue to be an ongoing source of debate, as evidenced in the 2011 provincial election when the platforms of both the Conservative Party and the NDP outlined plans to dismantle the LHINs (Born & Sullivan, 2011).

Alongside the MOHLTC, the OSS is designed to simplify access to government services for seniors and to ensure programs and services meet the needs of older adults (http://www.seniors.gov.on.ca/en/about/index.php). Working across government is a clear priority of the Minister of Seniors as outlined in the 2014–2015 mandate letter from the premier. Other specific priorities include developing supports and services for seniors and supporting seniors’ health and wellness alongside the MOHLTC (the Premier of Ontario, 2014). Although the OSS has been viewed as a less influential actor in the policy making process when compared to the size and budget of the MOHLTC (Key informant F), recent policy initiatives, such as the shared policy document, Living Longer, Living Well (Sinha, 2012) have demonstrated integration across the two entities.

The current organizational structure for seniors and mental health care in Ontario is outlined in Figure 6, which illustrates the relationship between the MOHLTC and the OSS.
Figure 6: Organizational Structure of Ontario
4.5 Nova Scotia

The current organizational structure of Nova Scotia is similar to that of British Columbia and Ontario and follows the traditional approach whereby mental health and continuing care fall under the domain of the Department of Health and Wellness, and seniors’ issues are viewed independently under the Department of Seniors. Nova Scotia also follows a regionalized health model, with nine districts across the province, each having responsibility over local services and programs. Similar to Alberta, Nova Scotia will be moving to a consolidated provincial authority on April 1, 2015 (“District Health Authority Consolidation,” 2015). The movement away from regionalization was a key election issue in 2013, which saw the Liberal Party replacing the incumbent NDP leadership. The consolidated health authority was the only health issue in the Liberal Platform (Key informant H) and was touted as a mechanism for information sharing and enhanced patient care.

Despite sharing some structures with other provinces, there are key organizational differences in Nova Scotia. For example, while the provincial mental health strategy falls under the mental health program, the newly announced dementia strategy falls under the auspices of the continuing care program. Additionally, Nova Scotia boasts a Seniors’ Mental Health Network with membership from government, district representatives, community groups, and individuals (http://novascotia.ca/dhw/mental-health/seniors.asp). The Network has four objectives: information sharing; mutual learning and support; creating opportunities for collaboration, debate, and discussion on key issues; and responding to requests for information (“Mental Health Services,” 2013). Although this network is not directly responsible for policy decision-making, this unique government-supported structure acts as a mechanism to bridge the silos of seniors’ issues and mental health issues and is often called upon to provide expertise and feedback on key seniors’ issues.
The organizational structure of seniors and mental health care in Nova Scotia is illustrated in Figure 7. Nova Scotia is unique among the provinces studied in that its structure contains built-in mechanisms for communication and information sharing across typical government silos, evidenced by the dotted lines in the organizational chart below.

![Figure 7: Organizational Structure of Nova Scotia](image)

### 4.6 Discussion

This chapter provides a summary of how each sample provincial government (as well as its governmental organizations) has taken responsibility for seniors and seniors’ mental health. While policy analyses typically focus on the content of policies and policy directions (Walt & Gilson, 1994), examining the context, processes, and actors that interact within the policy landscape offers insight into how older adults are positioned within the policy landscape. These additional considerations, and the recognition that contextual factors influence the ways in which policies come to be, are necessary for a consideration of the concept of horizontal equity (Drover et al., 2014), recognizing that contextual factors influence the ways in which policies
come to be. As discussed earlier, Walt and Gilson present the Policy Triangle Framework as if processes, context, and actors are discrete concepts, yet they also acknowledge that the reality of policy making is more complex and intertwined. Actors (individuals and organizations) exist within a context, and the relationships among them influence the processes that bring policies to fruition as well as program implementation. While these factors will be discussed separately below, the complexity of their relationships is acknowledged.

**Context**

Context is a key consideration of the policy-making process. Context encompasses multiple factors, including political instability, ideology, historical experiences, and culture (Walt & Gilson, 1994). Despite the unique makeup of each province, there are shared contextual forces that have influenced the organization of seniors’ and mental health issues across jurisdictions. As depicted in Table 4 the “perfect storm” of an aging demographic, a heightened awareness of mental health and illness, and drivers such as reducing ALC days are shared social contexts that influence policy across the sample provinces. Historical contexts such as the economic downturn and the focus on austerity measures are also reflected across all provinces as governments strive to manage rising healthcare costs in the face of an aging population with an increasing chronicity of illness. While the ideological contexts of sample provinces are varied, it is intriguing that the medicalization of aging is a common thread across the organization of provincial jurisdictions, evidenced by the standard of seniors’ policies falling by and large under the domain of health. It could be argued that the notion of aging as a disease is rooted firmly in the way our health systems are organized, with their focus on illness rather than keeping individuals healthy.

Regionalization versus centralized health care is another key contextual consideration. Alberta, as the only centralized health system to date, is using province-wide Strategic Clinical Networks to standardize health decision-making in both seniors’ health and mental health. The SCNs are facilitated by the centralized context of health care and would be challenging in the
regionalized contexts of British Columbia, Ontario, and Nova Scotia. Conversely, the emphasis on local context and culture is stronger in the provinces where health care is regionalized.

Processes

For Walt and Gilson (1994) processes encompass the ways in which particular issues get on the policy agenda. The social contexts noted above are inherently embedded into how policies on older adults and mental health have emerged. The confluence of a number of social and historical contexts has led to a tipping point where the need for policies to address population aging and mental health cannot be ignored. As an example, the increased focus on mental health issues as a result of the establishment and initiatives of the Mental Health Commission of Canada has been a common driving process across provinces.

Although shared contexts have led to some similarities, it is equally valuable to understand the processes that have shaped differences in organization across provinces. For example, the newly formed Ministry of Seniors in Alberta came about as a result of a shift in leadership in the Conservative Party (under Jim Prentice), but also in response to media and public concerns about high-profile issues, such as a lack of sprinkler systems in the majority of Alberta’s seniors’ facilities (Henton, 2014). Also unique is Alberta’s development of Strategic Clinical Networks as a way to address complex health challenges. Alberta Health Services is currently the only province-wide health delivery organization and as a result is in a unique position to create approaches to health policy (Alberta Health Services, 2012). The SCNs are positioned within Alberta Health Services, which allows for the development of province-wide clinical improvements, reflected in care pathways and policy improvements. This process facilitates horizontal equity across the province, regardless of the regional context within Alberta.

Actors

Actors in the policy making process include individuals and organizations, both within and outside of government. The shaping power of government is evident in the organization of
systems and structures, with the premier of each province determining the cabinet and ministerial structure within their jurisdiction. New leadership can spark a change in direction, as was seen with the development of a Ministry of Seniors under the leadership of Premier Jim Prentice in Alberta. The political will of an individual can have a significant impact on the policy landscape: Prentice referenced his personal frustrations with the healthcare system while his 84-year-old mother was ill as a motivating factor for moving forward on seniors’ issues (Bell, 2014).

Disentangling actors from the process of policymaking is challenging; however, some policy directions have clear champions and influencers. Returning to the example of Strategic Clinical Networks in Alberta, champions from pre-existing clinical networks advocated for the expansion of the network model and worked with Alberta Health Services to determine key priorities across the province (Key informant B). Similar champions can be identified in other provinces: for example, Ontario’s previous Minister of Health (until June 2014) is also a demographer by training, and thus had a particular interest in demography and population aging. The collaboration between actors in Ontario also facilitated a shared strategy for seniors’ care in the province, reflected in *Living Longer, Living Well* (Sinha, 2012), a document that bridged aging and mental health concerns. Within Nova Scotia, the members of the Seniors’ Mental Health Network are significant influencers, despite their lack of decision-making power in the policy arena. The collaborative approach of networks strengthens the messages from across health regions in the province and facilitates communication with government actors.

Notwithstanding the lack of federal oversight in these areas, the federal government can also be considered an actor in the policy making process, due to its lack of action. With the downloading of responsibility to the provinces, decisions at the federal level have significant implications for provincial organization and structures. Other actors that influence policy making include stakeholder and advocacy groups, including national bodies such as the Canadian Association for Retired Persons (CARP) and the Canadian Medical Association (CMA), and
local community groups and associations that lobby and advocate for older adults and for mental health supports. As an example, both CARP and the CMA have heavy advocacy presences at all levels of government, with CMA president Dr. Chris Simpson recently appearing before the Council of Federations pushing the agenda of a national seniors’ care strategy.

**Implications**

There are arguments for and against the current organization of government ministries and how they address aging and mental health. While aging risks becoming medicalized if seniors’ issues fall solely under the umbrella of health, the integration of seniors’ issues into health allows for easier cross-pollination between sectors and for lifespan perspectives to be embedded into strategies and policies. Conversely, having a separate Ministry of Seniors with a focus on aging policies can encourage the viewing of population aging as an exclusively social problem (Wacker & Roberto, 2011) and a widening of existing silos. Moving away from siloed organization requires collaboration and communication across governmental departments. Examples from Ontario and Nova Scotia demonstrate innovative ways to ensure that health and mental health policies include a lifespan approach and that aging policies are inclusive of health and mental health.

In key informant interviews across provinces there was recognition that the siloed nature of provincial structures led to seniors’ mental health issues “falling between the cracks” unless there were explicit oversight mechanisms in place. While systematic reviews of government aging policies exist (Wilson, Osei-Waree, Hewit, & Broad, 2012), there is no comparative analysis of seniors’ mental health policies across jurisdictions. Understanding the variation in context, processes, and actors is a necessary foundational component of this analysis. This overview provides the necessary grounding before an examination in the subsequent chapters of the content of and gaps in relevant polices.
Chapter 5: Focus on Home and Long-Term Care Policies

5.1 Introduction

This chapter addresses research question #2, which asks: How have provincial policies in home care and long-term care been organized to support older adults with mental health problems? Within this question, the following will be examined:

RQ2a. What are the goals of each policy?
RQ2b. How do the policies align with overall provincial philosophies and frameworks?
RQ2c. Do the policies align with evidence and research in the field?

Using the Policy Triangle Framework (Walt & Gilson, 1994), this chapter examines the content of key policy documents in each province, with a specific focus on the goals, the “fit” between the policies and the overall provincial focus, and the policies’ alignment with evidence and research in the field. Given that home care and long-term care fall outside of the shared principles of the Canada Health Act, provincial responses to the mental health concerns of older adults in these sectors can be varied, affecting seniors’ access to mental health services. This variation was already demonstrated in Chapter 4, which examined the provincial contexts for decision making and agenda setting in areas of aging and mental health policy. Moving downstream, this chapter also focuses on the alignment of policies in home care and long-term care with broader provincial approaches to aging and mental health. The data included in these analyses comprise policy documents and strategies and key informant interviews with decision makers. Within each province, clinicians or administrators were interviewed to gain an understanding of how government policies are interpreted and reflected in reality. As described in Section 3.2, “Putting Methods into Practice,” key informants were sampled purposively and with snowball methods to ensure appropriate knowledge of the policy context. This key informant perspective is crucial to understanding how policies align with the reality of their implementation, also described as vertical consistency (Pal, 2010).

For clarity and organization, each province will be discussed separately in terms of core
policies in home care and long-term care and the overall alignment of these policies with provincial philosophies. An integrated discussion at the end of this chapter will include analysis of how each province’s policies align with the evidence base. Prior to the in-depth discussion of each province’s policies, a table summarizing the included policy documents is presented as a reader aid.

An overview of the included policy documents, with indication of their relevance by domain (e.g. health, aging, mental health), is included below in Table 5.
<table>
<thead>
<tr>
<th>Province</th>
<th>Long-Term Care</th>
<th>Home Care</th>
<th>Health</th>
<th>Aging</th>
<th>Mental Health</th>
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<td>Living Longer, Living Well (2012)</td>
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<tr>
<td>Document Title</td>
<td>Date of Release; Author/Owner</td>
<td>Focus/Scope</td>
<td>Strategic Priorities</td>
<td>Research Question</td>
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| Continuing Care Strategy: Aging in the Right Place | 2008 Alberta Health and Wellness | The government’s approach to accelerating the growth of the province’s health and care services. The directions from this strategy are intended to help older adults in Alberta to age in the right place, with a focus on delivering services in new ways, offering choice, and providing care in homes and communities. | 1. Investing in community supports  
2. Building infrastructure that meets the “aging in the right place” vision  
3. Change the way long-term care accommodations are paid  
4. Funding individuals based on needs and/or funding providers  
5. Providing equitable drug coverage for people wherever they live. | RQ2a |
| Transformational Roadmap for the Seniors Health Strategic Clinical Network (SCN) | 2014 Alberta Health Services | A 3-year Roadmap with the mission “to make improvements to health care services and practices that enable Alberta’s seniors to optimize their health, well-being, and independence.” | 1. Healthy Aging and Seniors Care  
2. Aging Brain Care  
3. Anticipating an Aging Alberta | RQ2a |
| Aging Population Policy Framework                | 2010 Alberta Health and Wellness | Articulates the government’s role when it comes to meeting the needs of an aging population, communicating key policy directions, providing the context for the coordination of services, policies and programs, and facilitating collaboration and integration across ministries, government, and community stakeholders. | 1. Financial security and income  
2. Housing and aging in the right place  
3. Continuing Care  
4. Healthy aging and health care  
5. Transportation and mobility  
6. Safety and security  
7. Supportive communities  
8. Access to government | RQ2b |
| Becoming the Best: Alberta’s 5-Year               | 2010 Alberta Health Services was promised stable and predictable funding for 5 | 1. Improving access and reducing wait times; | | RQ2b |
**Health Action Plan**  
Alberta Health Services  
years – the first 5-year commitment in Canada. This document is an action plan developed to match the funding commitment. The Action Plan outlines a goal of having an impact on the health of every Albertan, and will help make their health system the best-performing publicly funded health system in Canada.  

- Providing more options for continuing care;  
- Strengthening primary care;  
- Promoting health and staying healthy; and  
- Building on the health system.

**Creating Connections: Alberta’s Addiction and Mental Health Strategy**  
2011  
Government of Alberta  
The purpose of the strategy is to transform the addiction and mental health system in Alberta. The ultimate goal is to reduce the prevalence of addiction, mental health problems and mental illness in Alberta through health promotion and prevention activities and to provide quality assessment, treatment and support services to Albertans when they need them (p.3).  

- Build healthy and resilient communities;  
- Foster the development of healthy children, youth and families (includes seniors);  
- Enhance community-based services, capacity and supports;  
- Address complex needs; and  
- Enhance assurance (p.12).  

RQ2b
5.2 Alberta Policies: Focus on Home Care and Long-Term Care

As outlined in Chapter 4, Alberta currently has several policies and strategies that focus specifically on the continuing care sector. Within Alberta Health Services, the focus on seniors’ living options is to provide “the right care in the right place” and to “provide a range of services to support choice, wellness and independence” (Alberta Health Services, n.d., p. 1). The range of services offered through Alberta Health Services includes home care, supportive living, and long-term care.

The foundational policy document that focuses on home and long-term care in Alberta is the Continuing Care Strategy: Aging in the Right Place released by Alberta Health and Wellness in 2008. “This strategy is intended to provide new ways of delivering services, offering more choice to Albertans in their home and communities” (Alberta Health and Wellness, 2008, p.2) and is the government’s approach to accelerating the growth of the province’s health and personal care services. “Aging in place” is terminology that is used frequently to describe the process of putting supports into the community to allow individuals to age in the homes of their choosing without having to move to new communities or institutions. Alberta has built on this notion but added a focus on aging in the “right place.” As outlined in the strategy, the “right place” is determined in part by the client’s wishes but also by their functional needs (Alberta Health and Wellness, 2008). Three factors appear to drive the focus on “aging in the right place”: recognition that based on current statistics around population aging and long-term care, it is projected that an additional 15,000 long-terms care beds would be needed over the next 20 years; the high rate of alternate level of care (ALC) days among hospitalized seniors; and the desire to move towards a more person-centred continuing care system that would focus on individual preference (Alberta Health and Wellness, 2008).

22 Alberta uses the term “continuing care” to include supportive living, home care, and long-term care.
The *Continuing Care Strategy: Aging in the Right Place* (Alberta Health and Wellness, 2008) outlines five strategic directions that aim to create a “system that is fair and accountable, where care is accessible, integrated and of high quality, while at the same time meeting the public’s expectation of choice” (p. 20). Within each strategic direction there is a range of proposed initiatives intended to meet the goals of the strategic direction. The strategic directions are:

1. Investing in community supports;
2. Building infrastructure that meets the “aging in the right place” vision;
3. Changing the way long-term care accommodations are paid;
4. Funding individuals based on needs and/or funding providers; and
5. Providing equitable drug coverage for people wherever they live.

Of particular relevance to my research are strategic directions 1, 2, 3, and 4. In particular, the section on investment in community supports describes seven initiatives that, if implemented, would support older adults in making the choice to age in place in their communities, for example increasing home care funding to improve access, efficiency, and effectiveness. At the same time, additional investments into infrastructure within the continuing care system aim to reduce ALC days and costs. Infrastructure investments include working with outside partners to develop and operate long-term care facilities, increasing supportive living spaces, and refurbishing or replacing older long-term care facilities.

To facilitate these outside partnerships, the strategy also outlines the need to create a variable accommodation fee structure for new long-term care facilities to encourage investments from the private sector. The assumption that future continuing care residents will be less reliant on government sources of income, will have more disposable income, and will have increased expectations for available choices in living accommodations has informed this strategic direction. In envisioning a new model of continuing care, the strategy proposes a change to the funding structures to create a new (voluntary) system that would allow older adults and
caregivers to shop for their own health providers and make choices about where they receive services. This differs from the previous system, in which those requiring long-term care did not receive funding directly; instead those funds went to support the operation of the facility in question.

Taken together, the initiatives in the *Continuing Care Strategy: Aging in the Right Place* are focused on keeping people out of government-funded long-term care, instead emphasizing aging in the community and non-government institutions. Although mental health and dementia are not the focus of this strategy, presumably many of the older adults who are served within continuing care would be affected by mental health concerns and/or dementia. The lack of explicit initiatives focused on improving mental health supports within continuing care could be interpreted to mean this is an existing area of strength; however, key informants acknowledged that this lack of content was reflective of current gaps in mental health supports within continuing care.

*There’s been a strong emphasis on increasing spaces in LTC and there were targets for doing that…. I think from the policy side there has been this notion of age in place … but at the same time, I think there has been that focus on expanding long-term care places, and that has been happening, but I don’t know that there is — in terms of policies that have been formally released either by Alberta Health or Alberta Health Services — much of a focus on cognitive impairments and how some of those issues, like behaviours and so on, should be addressed in those settings. In terms of what has been formally released, I don’t think you’ll see that explicitly addressed in any policy documents. (Key informant A)*

The strategic directions also indicate a shift away from government supports as people age, based on the assumption that individuals will be able and willing to contribute more of their personal funds to their own health care. The overall goal therefore of the *Continuing Care*
Strategy is to improve health and personal care options for older adults by providing additional supports to allow them to age in the community, within a mixed model of care provision.

In April 2014, Alberta Health Services (AHS) released their 3-year Transformational Roadmap for the Seniors Health Strategic Clinical Network (SCN). With a mission to “make improvements to health care services and practices that enable Alberta’s seniors to optimize their health, well-being, and independence” (AHS, 2014), the SCN Roadmap outlines three key areas of strategic focus. They are:

- Healthy Aging and Seniors Care;
  - Whereby strategies for the prevention and management of delirium, and the assessment and treatment of co-morbid depression inform care pathways for older adults across the province.

- Aging Brain Care;
  - Whereby a provincial framework and strategy on dementia is developed.

- Anticipating an Aging Alberta.

While the Seniors Health SCN crosses sectors, its broad focus on optimizing health, well-being, and independence ensures relevance for continuing care. Additionally, the Roadmap recognizes and places a strong emphasis on the prevalence of mental health problems and dementia in the aging Alberta population. Implementation of the items within the Strategic Roadmap will ensure that the SCN meets the overall goal of promoting and supporting healthy living while enabling Albertans to remain in their own homes and communities as long as possible and optimize their quality of life as they age (AHS, 2014).

The use of provincial networks builds on the centralized model of health delivery in Alberta and facilitates equity across the province. It also allows for enhanced knowledge translation and sharing of best practices. When envisioning the long-term impact of the SCN, Key informant B explained that the goal is to put the person-centred focus into action:

*We’re just trying to figure out what is not working from the patient/family*
perspective. What we are hearing so far, and clinicians often know this but sometimes they don’t, is that I think there’ll be differences in supporting people to live with dementia or cognitive impairments in the community. So supporting families and caregivers better ….

The work of the SCN is a key mechanism that is capable of bridging gaps in the Continuing Care Strategy: Aging in the Right Place by focusing on the particular needs of those with mental illness and dementia growing older in the province of Alberta.

5.2.1 Alignment with Alberta’s overall provincial philosophies and frameworks

As outlined in section 4.2, there are broad provincial frameworks in place in Alberta in the areas of mental health and aging that influence decisions in the continuing care sector. In particular, the Aging Population Policy Framework (Government of Alberta, 2010), Becoming the Best: Alberta’s 5-Year Health Action Plan 2010–2015 (Alberta Health and Wellness, 2010) and the provincial mental health strategy, Creating Connections: Alberta’s Addiction and Mental Health Strategy (Government of Alberta, 2011), have implications for decision making in seniors’ mental health.

In November 2010 the Government of Alberta released their Aging Population Policy Framework, which is intended to articulate the roles and responsibilities of the Alberta government in preparing for an aging population. The purpose of the framework is to clearly articulate the government’s role when it comes to meeting the needs of an aging population; to communicate key policy directions; to provide the context for the coordination of services, policies, and programs; and to facilitate collaboration and integration across ministries, government, and community stakeholders (Government of Alberta, 2010). The Aging Population Policy Framework also outlines the related responsibilities of individuals and family members (designated as the parties primarily responsible for preparing for an individual’s senior years), private and non-profit sectors, and municipal and other governments. The Aging Population
Policy Framework also outlines 10 principles for government decision making to ensure that all government policies, programs and services are:

- Fair and equitable to future generations;
- Aimed at encouraging the independence of Albertans;
- Proactive and flexible to changing circumstances;
- Affordable to taxpayers;
- Effective and efficient at achieving intended objectives;
- Structured to assist Albertans most in need;
- Informed by evidence and input;
- Collaborative with communities; and
- Respectful of individual choice. (p. iv)

The Aging Population Policy Framework is divided into eight strategic policy directions. They are:

1. Financial Security and Income;
2. Housing and Aging in the Right Place;
3. Continuing Care;
4. Healthy Aging and Health Care;
5. Transportation and Mobility;
6. Safety and Security;
7. Supportive Communities; and

While all of the strategic policy directions are important, of particular relevance to my research are strategic policy directions 2, 3, and 4.

The first of these relevant three strategic policy directions builds on messages from the Continuing Care Strategy: Aging in the Right Place (Alberta Health and Wellness, 2008) by
focusing on aging in the “right place.” Reinforcing this language and messaging indicates the continuity between the two documents and builds on the earlier evidence and approach outlined in the Continuing Care Strategy. Within the Aging Population Policy Framework there is a focus on ensuring that older adults have access to living arrangements that are “appropriate to their circumstances” (p.21). The Framework highlights the benefits of keeping older adults in their own homes, with supports as appropriate, to ensure social connectedness and promotion of physical and emotional health.

In addition to the focus on “aging in the right place,” the framework touches upon home living, facility living, and supportive living under the strategic policy direction of continuing care, again building on the earlier work of the Continuing Care Strategy. The Aging Population Policy Framework reinforces earlier messaging and focuses on ensuring that “Albertan seniors will have access to a range of continuing care services that enable them to reside in an environment that is appropriate for their circumstances” (p.24). It too leverages the priorities of the Continuing Care Strategy and focuses on creating new affordable living options and increasing the number and range of home and community services to assist those living and receiving services in the community. There is an additional focus on monitoring the provision of health care and accommodation services in long-term care facilities and supportive living units, as well as home care, to ensure safety and quality services. This strategic policy direction also promotes appropriate levels of service to facilitate aging in place and keep people in home environments (Government of Alberta, 2010).

The final relevant strategic policy direction within the Aging Population Policy Framework is the focus on healthy aging and health care. This section highlights the government’s role in developing policies that support healthy aging and healthy living and promote social connectedness. This section also highlights the need to integrate mental health services into the broader health system, recognizing the frequent fragmentation of the two systems. Within this strategic policy direction there are specific areas of focus, including the promotion of healthy
living practices for individuals and communities, and support for the provision of access to services that meet the needs of older adults (Government of Alberta, 2010). This includes an emphasis on improving knowledge about the mental health needs of older adults, supporting rural and facility-based mental health care, and reviewing the administration of health-related programs (Government of Alberta, 2010).

The heavy emphasis on health and mental health is a strength of the Aging Population Policy Framework, and there are clear synergies between it and the Continuing Care Strategy: Aging in the Right Place (Alberta Health and Wellness, 2008). Given that these documents were released in quick succession, their shared language and focus is appropriate and clearly articulates the position of the government when it comes to the health and aging of the Alberta population. Despite the focus on aging “in the right place,” which is typically considered to be person-centred, it is also important to understand the underlying ideologies and motivations that shape the province’s policy frameworks. The onus on individuals and families as the parties primarily responsible for preparing for aging, along with the emphasis on nongovernment-provided housing, aligns with the residualism approach to social policy, whereby the proper concern of social welfare is primarily an individual responsibility (Lightman, 2003). This approach is reinforced by the Aging Population Policy Framework’s principles for government decision making, with the focus placed squarely on independence and individual choice. The principle that services and programs will be structured to assist the Albertans most in need also aligns with the model of residualism, within which the state is responsible for individuals only when individuals, families, and communities are not able to provide (Lightman, 2003). The focus on developing policies, programs, and services that are fair and equitable for future generations also points towards ideas of apocalyptic demography, whereby generations are pitted against one another, often to the detriment of older populations (Gee, 2002).

At the same time as the release of the Aging Population Policy Framework, Alberta Health and Wellness, released a five-year health action plan, Becoming the Best: Alberta’s 5-
Year Health Action Plan (2010). Although Becoming the Best applies to individuals across the age spectrum and health continuum, there is strong emphasis on older adults, mental health, and the continuing care sector. Within the Health Action Plan there are five key priority areas:

1. Improving access and reducing wait times;
2. Providing more options for continuing care;
3. Strengthening primary care;
4. Promoting being healthy and staying healthy; and
5. Building on the health system.

Becoming the Best: Alberta’s 5-Year Health Action Plan provides expected outcomes and benchmarks for each of the identified priorities. The following targets are of note:

- Appropriate care options for seniors and those requiring ongoing care within one month;
- Providing more supportive living options that combine housing with supports for daily living and health care;
- Improving access to long-term care beds for those with complex, chronic conditions; and
- Adding over 5,300 continuing care spaces over the next five years. (Alberta Health and Wellness, 2010)

In addition to the above benchmarks, Becoming the Best: Alberta’s 5-Year Health Action Plan also outlines general goals for the range of services available to keep people mentally healthy and to avoid addiction and chronic diseases. Its focus on filling the gaps within the health system and integrating mental health and addiction services into primary care is of particular relevance for the purpose of this research.
While all of the priority areas have relevance to older adults, priority #2, “Provide more choice for continuing care,” has the greatest implications for my particular area of research. The goals listed under this priority are:

- Adding and refurbishing more long-term care beds and supportive living spaces for a total of 5,300 continuing care spaces;
- Expanding and adjusting home care so people can remain independent for as long as possible. This includes expanding home care hours to increase services to 3,000 more people, and updating and aligning policies and services across the province for consistency;
- Ensuring that people with special needs receive support, care, and skilled attention from trained staff. This includes action to increase supportive living beds for people with dementia; and
- Enhancing access, coordination, and standards for continuing care. This includes the development and implementation of a new vision for the delivery of a full continuum of care from home to long-term cares.

Although primary care is not the focus of this research, it is notable that within *Becoming the Best: Alberta’s 5-Year Health Action Plan*, the focus on strengthening primary health care includes a significant emphasis on mental health, albeit with a particular focus on children and youth. Despite the youth focus, within this priority area there is a goal to develop a provincial strategy for addressing addiction and mental health issues that includes a focus on suicide prevention, treatment of depression, standardized screening and assessment, and development for staff, all of which would presumably have a lifespan focus and approach.

The following year, in September 2011, the Government of Alberta released the provincial mental health strategy, *Creating Connections: Alberta’s Addiction and Mental Health Strategy*. The stated purpose of the mental health strategy was “to transform the addiction and mental health system in Alberta” (Government of Alberta, 2011, p.3), and in building the case for
this transformation, aging demographics were cited. In particular, the anticipated increase in Albertans living with dementia by the year 2038 (a number estimated at 102,000 individuals or 2.2% of the population) was referenced as a motivating economic case for change. While the strategy takes a population health approach overall, key populations, including seniors, are identified as requiring particular focus. Within Creating Connections: Alberta’s Addiction and Mental Health Strategy, five strategic directions are identified:

1) Build healthy and resilient communities;
2) Foster the development of healthy children, youth and families (includes seniors);
3) Enhance community-based services, capacity and supports;
4) Address complex needs; and
5) Enhance assurance. (Government of Alberta, 2011, p.12)

Within strategic direction #1, particular emphasis is placed on the development of healthy living environments for older adults, ones that “foster mental and physical wellbeing, including promoting opportunities for older adults to remain socially connected and meaningfully engaged in their communities” (Government of Alberta, 2011, p.17). Although seniors are included within “families” in strategic direction #2, the major key priorities within this strategic direction are focused almost exclusively on children and youth. Seniors with complex health needs and addiction and/or mental health challenges are included as a population of interest under strategic direction #4. Appropriate and timely access to continuing care is identified as a priority action item for these individuals, with successful implementation linked to the goal of reducing bottlenecks in the service system.

Despite the inclusion of older adults in some key parts of Creating Connections: Alberta’s Addiction and Mental Health Strategy, the emphasis remains on children and youth even given the noted economic drivers of an aging population. While the other provincial-level documents made explicit reference to one another and built on core policy directions, Creating Connections has no explicit linkage to the Aging Population Framework (Government of Alberta, 2010).
Continuing care is recognized as an area where improved policy direction alignment would have significant benefits; however, there are no action items in the strategy to support this policy alignment (Government of Alberta, 2011). While there is also no formal linkage to the Continuing Care Strategy: Aging in the Right Place (Alberta Health and Wellness, 2008), the section focused on addressing complex needs notes a potential for reduced bottlenecks in the continuing care system should enhanced community services be made available and accessible (Government of Alberta, 2011).

Taken together, these three overarching strategies shed light on the vision for seniors’ mental health within the province of Alberta. Released between November 2010 and September 2011, the three strategies begin to dovetail and scaffold goals related to the health and mental health care of the aging demographic. Shared values, such as a focus on personal agency, choice, and self-determination, permeate the three frameworks. They also share an emphasis on aging in the right place, although at times that emphasis is focused more on ALC and long-term care bed reduction than supporting aging in the place of choice of the older adult. Nonetheless, seniors’ mental health is underrepresented in Creating Connections: Alberta’s Addiction and Mental Health Strategy (Government of Alberta, 2011).

Within the three frameworks, there is also a clear understanding of the potential for systems and policies to create silos as well as the cumulative negative impacts of policies on vulnerable populations, such as older adults with mental health challenges. Although a commitment to integration is reflected in the policy language around systems and services that need to “talk” to one another, key informants in the province reflected on the fact that older adults with mental health problems often still fall between the cracks of policies. In particular, the historical legacies of policies continue to affect older adults, as explained by one key informant:

*I don’t think seniors’ mental health at the policy level — at the strategic or directional policy level, from a provincial ministry perspective — I don’t think it has a clear home. And I think within Alberta Health Services, that is reflected as well,*
in terms of there being siloing between seniors’ health, which tends to focus on the development of services … and then addiction and mental health services.

(Key informant A)

As an example, earlier policies and funding models created a system where the funding for many services ends at age 65, leaving older adults to fall between the cracks in services if there are no psychogeriatric services available. This also creates equity issues across the province as specialized services are centred in urban regions of the province. The key informant above also highlighted the dichotomy that persists in services for older adults, wherein many mental health services and systems do not include dementia as part of their mandate and instead feel this work is the responsibility of geriatricians and neurologists, despite the commitment to integration as outlined in the provincial frameworks.

Returning to the question of how provincial policies in home care and long-term care support older adults with mental health problems, there are clear signals from the five relevant policy documents. While the *Continuing Care Strategy: Aging in the Right Place* (Alberta Health and Wellness, 2008) continues to be the foundational document, in terms of both chronology and sector focus, some of its gaps are filled by the subsequent documents, such as Alberta Health Services’ *Transformational Roadmap for the Seniors Health Strategic Clinical Network* (AHS, 2014), which builds on the provincial philosophies in seniors’ care. The *Transformational Roadmap* has strong convergence with broader provincial philosophies: In particular, the recognition of an aging population leverages the messaging of the *Aging Population Framework* (Government of Alberta, 2010) and provides concrete action items from the health perspective. As well, the commitment to the development and implementation of a dementia strategy signifies recognition of significant omissions in *Creating Connections: Alberta’s Addiction and Mental Health Strategy* (Government of Alberta, 2011) and the overall provincial landscape of seniors’ mental health. Reviewing these policy documents together helps to paint an integrated picture of how older adults with mental health problems are supported. The linkages between
these policy documents and the evidence and research that supports them will be reviewed in greater detail in section 5.6.
<table>
<thead>
<tr>
<th>Document Title</th>
<th>Date of Release</th>
<th>Author/Owner</th>
<th>Focus/Scope</th>
<th>Strategic Priorities (bolded to indicate relevance to my research)</th>
<th>Linkage to Research Question</th>
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<tbody>
<tr>
<td>The Best of Care: Getting it Right for Seniors in British Columbia (Part I)</td>
<td>2009</td>
<td>Office of the Ombudsperson</td>
<td>In 2008 the Ombudsperson initiated a province-wide investigation to look at seniors’ care, with a specific focus on issues of access to information, access to services, quality of care, standards of care, monitoring and enforcement, and complaints processes. The first report focuses on the most frail and vulnerable seniors: those who need 24-hour care provided in residential care facilities. The report contains 10 recommendations on rights for seniors in residential care, access to information about residential care, and the role of resident and family councils.</td>
<td>Overarching categories for recommendations included: 1. Commitment to Care &amp; Resident’s Rights 2. Public Information and Reporting 3. Resident and Family Councils</td>
<td>RQ2a RQ2b</td>
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<td>The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)</td>
<td>2012</td>
<td>Office of the Ombudsperson</td>
<td>The second report is a comprehensive and in-depth investigation that includes 143 findings and 176 recommendations. The recommendations are designed to improve home and community care, home support, assisted living, and residential care services for seniors.</td>
<td>176 Recommendations in the areas of: 1. Home and Community Care; 2. Home Support; 3. Assisted Living; and 4. Residential Care.</td>
<td>RQ2a RQ2b</td>
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<tr>
<td>Improving Care for B.C. Seniors: An Action Plan</td>
<td>2012</td>
<td>British Columbia Ministry of Health</td>
<td>The goal of these actions is to establish an improved province-wide system of seniors’ care by: • Appointing an advocate to assist and protect seniors receiving public and private community and care system for B.C. seniors has six themes that address system-wide change through key actions: 1. Concerns and Complaints</td>
<td>The Ministry of Health’s plan for improving the home and community care system for B.C. seniors has six themes that address system-wide change through key actions: 1. Concerns and Complaints</td>
<td>RQ2a RQ2c</td>
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health care services and ensure complaints are resolved.
- Expanding non-medical home support to help seniors stay at home longer.
- Providing clear policies and measurable standards for home support, home health, assisted living, and residential care services.
- Ensuring that provincial inspection, quality assurance programs, enforcement and staff training in residential facilities align with standards.
- Strengthening protections from abuse and neglect, including improved protections for those who report care concerns or complaints.
- Increasing transparency and accountability through public reporting of the quality of care in publicly funded care facilities, such as patient and family satisfaction, and the incidence of falls. Privately funded facilities will have an opportunity to participate.
- Improving system flexibility and sustainability.

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Recommended Action Areas</th>
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<tbody>
<tr>
<td>1. <strong>Support Prevention and Early Identification</strong></td>
<td>RQ2a</td>
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<tr>
<td>2. <strong>Ensure Quality Person-Centred Dementia Care</strong></td>
<td>RQ2b</td>
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<tr>
<td>3. <strong>Strengthen System Capacity and Accountability</strong></td>
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The Provincial Dementia Action Plan for British Columbia: Priorities and Actions for Health System and Service Redesign

2012
British Columbia Ministry of Health

The Provincial Dementia Action Plan is intended to demonstrate government’s continued commitment to people with dementia and their families, and underlines the significance of dementia as a contributor to frailty and the loss of independence, particularly for seniors. The action

Three priorities, each with recommended action areas.

Priorities are:
1. Support Prevention and Early Identification
2. Ensure Quality Person-Centred Dementia Care
3. Strengthen System Capacity and Accountability
| Healthy Aging through Healthy Living: Towards a comprehensive policy and planning framework for seniors in B.C.: A discussion paper | 2005 | British Columbia Ministry of Health. | The development of a healthy aging framework would provide the catalyst to stimulate collaborative action that promotes, supports and enables healthy aging for B.C. seniors. This paper starts to present the evidence that will lead to the development of an evidence-based framework for a comprehensive approach, and establishes the Ministry’s strategic platform for healthy aging in the context of health redesign (p. 6). | 1. Awareness and education (public and professional)  
2. **Healthy public policy and legislation**  
3. Strengthen community action  
4. Personal skills development  
5. Research, surveillance and evaluation  
6. Knowledge transfer  
7. **Reorient health services/Building partnerships** | RQ2b |

| Aging Well in British Columbia: Report of the Premier’s Council on Aging and Seniors’ Issues | 2006 | Premier’s Council on Aging and Seniors’ Issues. | The Premier gave the Council the task of identifying how society can support the participation, health and well-being of older people in B.C. Recommendations from the report are intended to help B.C. deal successfully with the dramatic demographic and social changes. The Premier’s Council on Aging and Seniors’ Issues envisions a society where everyone benefits from the wealth of talent and | Sixteen recommendations were provided under the overarching themes:  
1. Participating in Society  
2. Transforming Work  
3. Reshaping Neighbourhoods  
4. **Staying Healthy**  
5. Ensuring Sufficient Incomes  
6. **Supporting Independence**  
7. **Providing Medical Services**  
8. Making it Happen | RQ2b |
experience of older adults, where older people are actively involved, integrated rather than isolated, supported in our desire to remain engaged with our communities, and assisted when poor health, lack of income or other barriers stand in the way of a good quality of life. (p.i)

| Seniors in British Columbia: A Healthy Living Framework | 2008 | The government’s comprehensive action plan to support health and well-being of B.C. seniors and their families, caregivers, and communities. | The framework has four cornerstones:
1. Create Age-friendly Communities
2. Mobilize and Support Volunteerism
3. Promote Healthy Living
4. Support Older Workers | RQ2b |

| Healthy Minds, Healthy People | 2010 Government of British Columbia | This 10-year plan provides a framework of population-centred priorities to enable and support change over 10 years using practice-based evidence. Vision: Children, youth and adults from all cultures in British Columbia achieve and maintain sound mental health and well-being, live in communities free of problems associated with substances, access effective support to recover from mental health and/or substance use problems that may develop over the lifespan, and lead fulfilling lives as engaged members of society without discrimination when these conditions persist. | Using a population health approach there are 3 overarching goals for this strategy. Over the next 10 years, the plan aims to:
1. Improve the mental health and well-being of the population
2. Improve the quality and accessibility of services for people with mental health and substance use problems
3. Reduce the economic costs to the public and private sectors resulting from mental health and substance use problems

Populations are defined as:
a. All people of B.C.
b. People vulnerable to mental health and/or substance use problems
c. People with Mild to Moderate Mental Health Problems | RQ2b |
| Setting Priorities for the B.C. Health System | 2014 | Ministry of Health | Setting Priorities for the B.C. Health System presents the strategic and operational priorities for the delivery of health services across the province. Outlines a vision of achieving a sustainable health system that supports people to stay healthy and provides high quality publicly funded health care. (p.iii) | Eight priority areas for service delivery were identified.  
1. Provide patient-centred care.  
2. Implement targeted and effective primary prevention and health promotion through a coordinated delivery system.  
3. **Implement a provincial system of primary and community care around interprofessional teams and functions.**  
5. Provide timely access to quality diagnostics.  
6. Drive evidence-informed access to clinically effective and cost-effective pharmaceuticals.  
7. **Examine the role and functioning of the acute care system, focused on driving inter-professional teams and functions with better linkages to community health care.**  
8. Increase access to an appropriate continuum of residential care services. | RQ2b |
5.3 British Columbia Policies: Focus on Home and Long-Term Care

Within British Columbia, there is a range of home-based community care options, including home supports, community nursing, community rehabilitation, assisted living, and residential long-term care (“Home & Community Care,” 2014). However, the continuing care sector in British Columbia has been subject to significant criticisms for the last decade. The historical legacy of earlier governments was outlined in a seminal paper published by the Canadian Centre for Policy Alternatives' B.C. Office, titled An Uncertain Future for Seniors: BC's Restructuring of Home and Community Health Care, 2001–2008 (Cohen, Tate & Baumbush, 2009). In particular, the authors cite the narrowing of the scope of eligibility for residential long-term care to those older adults with “complex care needs (severe cognitive impairment, dementia, multiple disabilities and complex medical problems)” (Cohen et al., 2009, p. 7). This decision was intended to support more aging in place through enhanced community supports; however, community care was experiencing cuts at the same time, which led to older adults falling through the cracks in the home and community care system. The Canadian Centre for Policy Alternatives was but one voice among many pushing the government to review seniors' services. In August 2008 the provincial Ombudsperson announced a systematic investigation into seniors’ care, including residential and assisted living facilities and home support services (British Columbia Office of the Ombudsperson, 2008). The resulting investigation and two-part report, titled The Best in Care: Getting it Right for Seniors in British Columbia, spanned a period of three years with the first report being released in 2009, followed by the in-depth second report in 2012.

The Ombudsperson is designated “B.C.’s Independent Voice for Fairness” and is an independent officer of the legislature, and thus these two reports are uniquely positioned in the landscape of policies and strategies included in this dissertation. Despite not originating from the government, these reports have been significant influencers and drivers in terms of the policy directions in home and long-term care in British Columbia. The first report, published in
2009, focused specifically on the most frail and vulnerable older adults: those who require 24-hour residential care. The Ombudsperson provided ten recommendations, four of which were approved and accepted by the government in a response included as an appendix to the final report (BC Office of the Ombudsperson, 2009). Of particular relevance to this research was the recommendation around public information and reporting, which proposed that each residential care facility should outline their ability to offer care to residents with dementia and mental health concerns. Although the B.C. Government accepted the intent of this recommendation and agreed with it in principle, the recommendation was not implemented.

The subsequent report, released in February 2012, offered significant detail including 134 findings and 176 recommendations. The goal of the recommendations was to improve the continuum of home and community-based care for older adults (BC Office of the Ombudsperson, 2012). Although federal policy frameworks were outside the scope of the investigation, the report highlighted the reality that seniors’ care issues are complicated by their positioning outside of the insured health services of the Canada Health Act, even as it acknowledged the provincial Ministry of Health taking a more active role in the area of seniors’ care in British Columbia (BC Office of the Ombudsperson, 2012). While many of the report’s findings and recommendations have relevance to this dissertation (in that if they were to be implemented, the overall care experience would be improved), most are not specific to older adults with mental health disorders and/or dementia. That said, four key recommendations are relevant for this discussion. The first criticized the Mental Health Act being used to admit older adults involuntarily to residential care facilities, the second called for clarification around restraints policies, and the third was about the use of “as needed” antipsychotic medications in residential care (BC Office of the Ombudsperson, 2012). Of most relevance, however, were the recommendations around services for residents with dementia. The Ombudsperson noted that the Ministry of Health had no provincial standards, policies, services, or training requirements specific to dementia care and encouraged a provincial policy to guide delivery of dementia care.
in residential facilities and ensure that all staff receive training in the area (BC Office of the Ombudsperson, 2012).

Coinciding with the release of the second report from the Office of the Ombudsperson, the province released *Improving Care for B.C. Seniors: An Action Plan* (British Columbia Ministry of Health, 2012) to address the concerns raised in the Ombudsperson’s report. Within the action plan, the following relevant recommendations were outlined:

- **Information:**
  - Information provided by October 2012 to assist older adults and their families to understand dementia, including the available First Link programs and supports offered through the Alzheimer Society;

- **Flexible Services:**
  - Invest, in partnership with the United Way of the Lower Mainland, in the expansion of non-medical home support services in up to 65 communities across the province over the next three years to support aging in place (p.7); and
  - Produce guidelines for dementia care to support caregivers and promote evidence-based practice in all care settings by October 2012 (p.7).

In a progress report released in April 2013, the Ministry of Health reported on its accomplishments and progress in terms of the actions outlined in *Improving Care for B.C. Seniors: An Action Plan*. Under the theme of Information, all relevant recommendations related to information about dementia had been accomplished. In fact, information about dementia had been expanded beyond the original recommendations with a suite of resources for older adults and families, plus clinical resources for providers and organizations. Additionally, a resource document titled *Meeting Seniors’ Mental Health Care Needs in British Columbia: A Resource Document* (MacCourt & Donnelly, 2012) was touted as a related accomplishment. This resource document bridges dementia services and mental health services and aims to provide context for the provincial mental health policy, which will be discussed in depth in section 5.3.1.
Under the theme of Flexible Services, the Ministry also reported success in implementing key recommendations (British Columbia Ministry of Health, 2013). Specifically, an investment of over 20 million dollars was made to establish Better at Home, a community-based program that provides instrumental activities of daily living support (such as yard work, housekeeping, and transportation) to keep older adults in their homes. This commitment allows for program operation in 68 communities until December 2015 (British Columbia Ministry of Health, 2013).

As promised in Improving Care for B.C. Seniors: An Action Plan (British Columbia Ministry of Health, 2012), dementia guidelines were released in November 2012. The Provincial Dementia Action Plan for British Columbia: Priorities and Actions for Health System and Service Redesign (British Columbia Ministry of Health, 2012) is narrow in its scope, with only three priority areas and four accompanying action items for each priority; however, with the goal of province-wide implementation in a two-year period, a narrow scope is appropriate as a starting point. Relevant action areas include the implementation of evidence-based interdisciplinary education and clinical tools, and guidelines for appropriate medication use for behavioural and psychological symptoms of dementia (British Columbia Ministry of Health, 2012). Action is also planned for an increase in flexibility of living options and care models to support those who cannot live independently (British Columbia Ministry of Health, 2012). Now past the end of the two-year action timeline, the Ministry of Health has provided no implementation updates.

Also, as an outcome of Improving Care for B.C. Seniors: An Action Plan, in March 2014 the government appointed a provincial Seniors Advocate, a first in Canada (British Columbia Ministry of Health, 2014). The Seniors Advocate, as outlined in the legislation, has a wide scope to:

Examine and advocate for seniors on issues related to: health care; personal care; transportation; housing; and income supports. In fulfilling the obligations of the Act, the Advocate will: monitor services to seniors; provide information and referral;
analyse systemic issues that relate to the health and well-being of seniors; provide recommendations to governments and service providers on improvements that can be made to enhance the health and well-being of British Columbia seniors. (Office of the Seniors Advocate, 2014, p. 1)

The role of the Seniors Advocate is still in its infancy but service providers in British Columbia view it positively.

_I have spoken with them [the Seniors Advocate and her deputy] in person and they certainly indicate that they are well aware of the kinds of issues that people face in the community; and while they can’t deal with or address individual concerns, they are looking at those kinds of problems and challenges on a larger scale and looking for themes and looking for ways to influence change. So I have spoken to them specifically about mental health concerns of seniors and they are well aware. So that is very positive to me, very encouraging, I mean … change goes very slowly. But hopefully, that is, they are going to have, you know, some amount of influence and be able to put some pressure on systems, which are not responsive at all._ (Key informant L)

Although there is no doubt that the Ministry of Health is working to improve the home and community care sector for those living with mental illness and/or dementia, it appears that most of the work is reactive and in response to significant concerns of older adults and advocates, rather than using a proactive approach based on existing evidence in the field. Many of the investments and successes in this area were clustered around the critiques found in the Ombudsperson’s reports, which can be viewed as paying lip service or a mechanism for damage control. A closer look at the action plans discussed below shows that much of the work being cited by the Ministry of Health as action items and successes were actually initiatives already underway before the publication of these government reports. While this is not necessarily a negative timing concern, it will be vital that continued investments are made
beyond the two-year timeline of the *Provincial Dementia Action Plan for British Columbia: Priorities and Actions for Health System and Service Redesign* and *Improving Care for B.C. Seniors: An Action Plan*.

### 5.3.1 Alignment with British Columbia’s overall provincial philosophies and frameworks

While the policies and strategies that focus on home and community care in British Columbia have a strong focus on dementia, the broader provincial policies and frameworks on aging tend to focus on health promotion and healthy aging, perhaps reflecting their earlier presence in the landscape of government papers. In 2005, the Ministry of Health published *Healthy Aging through Healthy Living: Towards a Comprehensive Policy and Planning Framework for Seniors in B.C.: A Discussion Paper*. This framework was designed to provide “a blueprint that promotes, supports and enables healthy aging for B.C. seniors” and “an evidence-based framework for a comprehensive approach and establishes the Ministry of Health’s strategic platform for healthy aging” (British Columbia Ministry of Health, 2005, p. 3). Within this framework, mental health is incorporated into the definition of healthy aging, with particular emphasis on enhancing social supports and social connectedness to improve mental health and healthy aging. Concurrently, the premier at the time, Liberal Gordon Campbell, appointed a Council on Aging and gave it the task of identifying how society can support the health and well-being of older adults in B.C. The resulting report, *Aging Well in British Columbia: Report of the Premier’s Council on Aging and Seniors’ Issues* (Premier’s Council on Aging and Seniors’ Issues, 2006) offered recommendations in 16 overarching themes with the goal of preparing for an aging society.

The *Healthy Aging through Healthy Living* Framework, along with the recommendations from the Premier’s Council on Aging, served as foundational documents that informed *Seniors in British Columbia: A Healthy Living Framework* (British Columbia Ministry of Healthy Living and Sport, 2008), which included four cornerstones for action. The cornerstones, while not
specific to mental illness, serve to promote positive mental health. In particular, the focus on age-friendly communities and promoting healthy living align with core features of mental health promotion.

Released in 2010, *Healthy Minds, Healthy People* (British Columbia Ministry of Health) is a 10-year mental health plan that uses a population health approach and outlines priorities to enable and support change using practice-based evidence. In the introduction to this report, the authors note that mental illness affects people “of all ages and all walks of life,” but the plan places a strong emphasis on children and families. This decision to focus on children and families is rationalized by the argument that “for the majority, mental health problems originate in childhood, pointing to the need for early intervention to mitigate risk of future illness” (British Columbia Ministry of Health, 2010, p.3). A “return on investment” argument is also suggested, the idea being that a strong foundation in childhood “sets the course for a healthy, fulfilling and productive life … providing personal, social and economic returns” (p.3). Emphasis is placed on listening to the experience of clients and families to inform planning, which aligns well with the recovery philosophy; however, given the focus on children and families, it is not clear if older adults were included in the feedback process.

*Healthy Minds, Healthy People* is divided according to specific population groups, starting with interventions for all British Columbians, and then moving to more focused interventions for those who are vulnerable or at-risk and those with mild to moderate mental health problems, and therapeutic interventions for people living with severe and complex mental health disorders. The plan focuses on opportunities to enhance the response to people in each of these four population groups. Within each sub-section there are priorities, actions, and outcome measures.

Among the actions tailored to the general population, there is one that focuses on promoting seniors’ mental health, linking to the earlier *Seniors in British Columbia: A Healthy Living Framework* (British Columbia Ministry of Healthy Living and Sport, 2008), which suggests
building on the work of Age-Friendly Communities Initiatives to foster cognitive stimulation and community connectedness. Unfortunately, this is the one action item that has no concrete outcome measures, which perhaps indicates its lack of priority status in the evaluation of this plan. In 2010 and 2011 Seniors BC released progress reports on the implementation of the *Healthy Living Framework*. While many of the actions focus on changing individual behaviours, there were also linkages drawn to *Healthy Minds, Healthy People* (British Columbia Ministry of Health, 2010). Specifically, *Seniors in British Columbia: A Healthy Living Framework* (British Columbia Ministry of Healthy Living and Sport, 2008) was positioned as a way to promote the mental health of seniors and to develop partnerships with local government and other organizations (British Columbia Seniors’ Health Promotion Directorate, 2011). This is an interesting linkage given the heavy focus on children and youth in the provincial mental health plan.

In the second identified population, those who are vulnerable to mental health problems, the identified groups are parents and families, children and youth, adults, seniors, and people with chronic physical disease or compromised health. The last two groups are relevant to this analysis given the high rates of comorbidities and chronic disease in late life. It is counterintuitive that in the special section on people with chronic disease, the focus is on children, youth and adults, despite the high rates of chronic disease or compromised health in older adults.

The section on seniors provides context around why this age group is identified as an at-risk population, including risk for dementia, rates of depression, and associated caregiver stress. Again, *Seniors in British Columbia: A Healthy Living Framework* (British Columbia Ministry of Healthy Living and Sport, 2008) is identified as a potential platform to develop partnerships and to promote opportunities for seniors to remain socially connected and meaningfully engaged in their communities; however, as noted earlier, this framework has very little specific focus on mental health. Within the second section of *Healthy Minds, Healthy
People, there is an action item about developing resources to support broadened routine screening of older adults for mental health/substance use in all health regions by 2016, but it does not include specific mention of those in residential long-term care. Given its highly regulated environment and the profile of residents, many of whom would be at-risk for mental illness, residential long-term care would be an ideal starting place for implementation of this action.

The third identified population in Healthy Minds, Healthy People are those with mild to moderate mental health problems who can be served with low intensity, community-based services. This section is broadly aimed at “children, youth and adults,” and while its recommendations apply to older adults as well, seniors are not specifically addressed in the introductory context of this section. Identifying and addressing problems as early as possible are highlighted as mechanisms to reduce costly hospitalizations and residential specialized care services. Earlier assessment and intervention would likely reduce ALC days and could potentially reduce long-term care admissions if assessment strategies and interventions were tailored to meet the needs of older adults; however, this connection is not overtly stated in the plan.

The final population identified and addressed in this plan is the small proportion of the population who live with severe and complex mental health disorders. Within this section, the recovery philosophy is introduced and promoted as an ideal approach. Priorities listed for this population are to:

- Enhance evidence-based community interventions across the lifespan;
- Enhance housing with supports;
- Strengthen community residential treatment options;
- Ensure appropriate access to hospital and specialized bed-based treatment; and
- Develop improved coordinated responses for people with complex challenges.
Despite the fact that many of these priority areas are relevant for older adults and fall within the scope of this research, the emphasis continues to be only on tertiary services for children and youth.

Housing is also identified as a key determinant of physical and mental health for people living with severe mental illness. Recognizing the housing challenges within this population, an enhanced housing strategy is the core action item to address homelessness among those with severe mental illness. The lack of attention to older adults who are considered “hard to house” is a gap in the discussion around housing. Older adults with severe and persistent mental illness often fall between the cracks as most long-term care homes do not have appropriate training and staffing models to support this population.

These themes continue to be reflected in the recent priority setting for the British Columbia health system. In February 2014, the Ministry of Health released *Setting Priorities for the B.C. Health System*, which outlines priorities and recommendations to meet the vision of “achieving a sustainable health system that supports people to stay healthy and provides high quality publicly funded health care” (p. ii). Of note, a key goal of this report is to increase access to an appropriate continuum of residential care services, a commitment that acknowledges the deficits of the current system, particularly for older adults with dementia (British Columbia Ministry of Health, 2014). Another key action item is to develop province-wide quality standards that address the changing needs of frail seniors, including those living with dementia. This appears to represent a significant bridge between the earlier focus on healthy living and the current need to focus on dementia and aging within the mental health strategy, one that would serve to mediate the gaps in care for older adults, should it be implemented as outlined.

While the cascade of reports coming out of British Columbia may be viewed as positive and proactive, it can also appear to be unmanageable to implement and evaluate so many
recommendations in short periods of time. These ambitious plans were criticized as lip service by key informants who viewed the government’s production of reports as a way to present action in a time of inaction and erosion in services for seniors. This was articulated through a recent example, as described by Key informant L:

And that kind of lip services is paid on a regular basis for sure … I was talking with somebody who runs [redacted – region in B.C.] home support service here. She told me last year that they had just had more funding cut and one of the policy changes that had happened, you know, while we’re paying lip service to fact that we’re trying to do more and better the service it that happened as result of less funding was that previously, the previous protocol was that if a person living at home with dementia needed help with bathing the home support worker could do that, that was part of their job. Then with less funding, with more funding cuts, the policy was changed to read that if there is anyone in the home, anyone in the home, with that person who has dementia, they need to take on the role of bathing that person. That is no longer the job of the home support worker. And the problem with that obviously is … is that let’s say the wife has Alzheimer’s and doesn’t recognize her husband anymore, thinks he’s a stranger and he’s not able to get her undressed and into the bathtub or the shower because she won’t let him. He is still expected to do that by policy and the home support worker can no longer assist her with her bath or shower.

Reviewing the content of the provincial policies and frameworks in British Columbia brings an understanding of how older adults with mental health problems are supported. The recent focus on dementia in residential care settings is a positive development, particularly given the demographic profile of long-term care residents. The work of MacCourt and Donnelly in *Meeting Seniors’ Mental Health Care Needs in British Columbia: A Resource Document* (2012) to articulate how dementia and mental health services can be integrated is an important bridging mechanism given the lack of focus on seniors in the provincial mental health strategy.
However, the fact that this document was developed as a resource, rather than a policy document with attached implementation plans, again speaks to the potential for silos that prevent the integration of mental health and dementia. Not unlike the context in Alberta, within British Columbia it does not appear that any provincial body has responsibility for seniors’ mental health. The key informant interview process supported this conclusion. The Seniors Directorate was approached to participate in this research and they responded with an overview of their scope and areas of decision-making, and in so doing articulated that “mental health isn’t part of that” (Key informant C).

The provincial perspective on dementia versus mental health/illness also complicates the division of responsibility. One key informant put this issue into context, saying, “the issue of dementia or Alzheimer’s … is it a mental health issue? In B.C. [we’re] saying no. It is a part of aging — it is a physical condition, it’s not a mental health condition. It is an organic condition” (Key informant D). While British Columbia is not the only province examined to have this view, this belief that dementia is not under the domain of mental health is clearly reflected in the content of the mental health strategy, creating potential for gaps given the high comorbidities of mental illness and dementia and the functional needs of those who live with cognitive impairments. Additionally, the mental health strategy within the province is still largely focused on children and youth, and the return-on-investment argument is exclusionary for older adults. While the mental health strategy does leverage work in healthy aging and healthy living, these strategies focus on principles of health promotion and have little impact on services for those who are currently living with mental illness. The focus on individual behaviour and health promotion throughout many of the documents has a different tone than the residualism of Alberta; instead the document language seems to align more with a merit model of social policy (Graham et al., 2012). Merit in this sense is not directly related to work performance and productivity, but instead is expressed in terms of who is “deserving” of support from the government. Older adults with severe and persistent mental illness or behavioural and
psychological symptoms of dementia have been labelled as less deserving. Key informants, however, expressed significant frustration with the erosion of services and discussed the reality of residualism in their own practice-based experience.

Key strengths of the current policy landscape include the provision of flexible services that permit homemaking for older adults living in the community to truly facilitate aging in place. Support for instrumental activities of daily living is often excluded from provincial funding, and yet it is particularly important for allowing frail older adults to remain living in their communities. It will be vital that these investments remain beyond the initial short-term funding stage to ensure vertical consistency and ongoing support for aging in place. Additional discussion about the evidence that has informed policy decisions in British Columbia will be detailed in section 5.6.
Table 8: Summary of Ontario Policy Documents

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Date of Release Author/Owner</th>
<th>Focus/Scope</th>
<th>Strategic Priorities (bolded to indicate relevance)</th>
<th>Linkage to Research Question</th>
</tr>
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| Ontario’s Aging at Home Strategy (A@H)                 | 2007 (expanded in 2010)      | Financial investment from the province over three years to provide seniors and their caregivers with an integrated continuum of community-based services to enable them to stay healthy and live more independently in their homes. | Each Local Health Integration Network (LHIN) set their priorities and administered the A@H funding allocated based on demographic information of the LHIN. Provincial priorities identified in 2010 included:  
- More beds to help hospital patients transition to the community through restorative and rehabilitative care  
- Strategies to ensure patients receive high quality care inside and outside the hospital to avoid unnecessary readmissions  
- Enhanced home care  
- Nursing outreach teams for high-risk seniors living in long-term care homes and in the community. | RQ2a                         |
| Caring For Our Aging Population and Addressing Alternate Level of Care | 2011                         | The Minister of Health and Long-Term Care appointed Dr. David Walker as Provincial ALC Lead in January 2011, with a mandate to provide recommendations on | 1. Improve Access to the Right Care Through Community Investments  
2. Improve Patient Flow Across the System  
3. Optimize and Differentiate | RQ2a                         |

* Alternate Level of Care
### Living Longer, Living Well

<table>
<thead>
<tr>
<th>2012</th>
<th>Dr. Samir Sinha</th>
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<tbody>
<tr>
<td>Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors</td>
<td></td>
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<tr>
<td>This Seniors Strategy lays out the findings and recommendations that will help to define and shape, in the most sustainable ways possible, Ontario’s opportunity to achieve its vision to be the healthiest place in North America to grow up and grow old.</td>
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<td><strong>Capacity</strong></td>
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<td>4. System Enablers</td>
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<td>1. Supporting the Development of Elder Friendly Communities</td>
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<td>2. <strong>Promoting Health and Wellness</strong></td>
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<td>3. Strengthening Primary Care for Older Ontarians</td>
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<tr>
<td>4. <strong>Enhancing the Provision of Home and Community Care Services</strong></td>
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<td>5. Improving Acute Care for Elders</td>
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<td>6. <strong>Enhancing Ontario’s Long-Term Care Home Environments</strong></td>
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<td>7. <strong>Addressing the Specialized Care Needs of Older Ontarians</strong></td>
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<td>8. Medications and Older Ontarians</td>
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<td>9. Caring for Caregivers</td>
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<td>10. Addressing Ageism and Elder Abuse</td>
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<tr>
<td>11. Addressing the Unique Needs of Older Aboriginal Peoples in Ontario</td>
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<tr>
<td>12. Necessary Enablers to Support a Seniors Strategy for Ontario</td>
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RQ2a

RQ2b
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<thead>
<tr>
<th>Document Title</th>
<th>Year</th>
<th>Author</th>
<th>Summary</th>
<th>Key Points</th>
<th>Reference</th>
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<tbody>
<tr>
<td><em>Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy</em></td>
<td>2011</td>
<td>Ontario Ministry of Health and Long-Term Care</td>
<td>Outlines a vision for Ontario where every person enjoys good mental health and well-being throughout their lifetime, and where all Ontarians with mental illness or addictions can recover and participate in welcoming, supportive communities. Our Mission: To reduce the burden of mental illness and addictions by ensuring that all Ontarians have timely access to an integrated system of excellent, coordinated and efficient promotion, prevention, early intervention, community support and treatment programs. (p. 7)</td>
<td>1. <strong>Improve mental health and well-being for all Ontarians</strong>&lt;br&gt;2. Create healthy, resilient, inclusive communities&lt;br&gt;3. Identify mental health and addictions problems early and intervene&lt;br&gt;4. Provide timely, high quality, integrated, person-directed health and other human services</td>
<td>RQ2b</td>
</tr>
<tr>
<td><em>Ontario's Action Plan for Health Care</em></td>
<td>2012</td>
<td>Ontario Ministry of Health and Long-Term Care</td>
<td>The goal is to make Ontario the healthiest place in North America to grow up and grow old. This action plan outlines the path to achieving this goal.</td>
<td>1. Keeping Ontario Healthy&lt;br&gt;2. Faster Access and a Stronger Link to Family Health Care&lt;br&gt;3. <strong>Right Care, Right Time, Right Place</strong></td>
<td>RQ2b</td>
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<tr>
<td><em>Ontario's Action Plan for Seniors</em></td>
<td>2013</td>
<td>Ontario Seniors Secretariat</td>
<td>Vision: Ontario will be a province where seniors are valued and respected as integral members of their community. Ontario seniors will be supported so they can remain active and engaged, leading independent, productive lives in comfort, dignity and good health. (p.2)</td>
<td>1. <strong>Healthy Seniors</strong>&lt;br&gt;2. Senior-Friendly Communities&lt;br&gt;3. Safety and Security</td>
<td>RQ2b</td>
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</table>
5.4 Ontario Policies: Focus on Home and Long-Term Care

In 2007 Ontario’s Ministry of Health and Long-Term Care announced the province’s Aging at Home Strategy. The rationale for this strategy was grounded in data showing that 85% of Ontarians aged 65 and older would prefer to continue to live at home and that the cost to support older adults in home is less than in hospital or long-term care, as well as the fact that at the time there was no comprehensive system to support aging in place (Government of Ontario, 2007). Additionally, the demographic pressures of an aging population, coupled with economic concerns about the sustainability of situational models and shortages in qualified providers, were core drivers for the $700 million investment in Aging at Home initiatives. The intent behind the funding was to spark innovative solutions that would respond to Ontario’s aging population and to ensure that older adults received the right services in the right place at the right time.

Funding was dispersed through the Local Health Integration Networks (LHINs) to enable services that were needed in regions across the province and that responded to the needs of diverse older adults in each community. Although government priorities included investing in innovation, creating supportive social environments, enhancing home safety and supportive housing options, and providing access to a flexible continuum of services, critics of the program noted that instead of focusing on aging at home, the funding was more centred on ALC reductions and long-term care diversion. In response to these criticisms, the government invested additional funds and expanded the program in 2010, including an enhanced focus on home care and nursing outreach teams for high-risk seniors living in long-term care homes and in the community (Ontario Ministry of Health and Long-Term Care, 2010).

An exemplary initiative that emerged from Aging at Home is First Link ®. As a model of service, First Link ® was piloted in Ottawa and subsequently the Alzheimer Society of Ontario received funding from the Ministry of Health and Long-Term Care for an evaluation period of two-years. First Link ® is a collaboration between the Alzheimer Society of Ontario and local communities that aims to fill the care gaps in the community for people living with dementia and
their caregivers (McAiney, Hillier, & Stolee, 2010). Now offered through 38 Alzheimer Societies across Ontario, the program has received $2.4 million in funding from the Ministry of Health and Long-Term Care, but has yet to be standardized across the province (Sinha, 2012).

The pressure to address Ontario’s high rate of ALC days was a driving force in the appointment of Dr. David Walker as Provincial ALC Lead in January 2011. Walker was commissioned by the Ministry of Health and Long-Term Care to undertake a study and submit a report within 6 months. Caring for Our Aging Population and Addressing Alternate Level of Care was released in June 2011 and included recommendations across the full continuum of care. Dr. Walker noted that in order to truly address the ALC issue, full system redesign would be required. A consistent message communicated throughout the report was that older adults with responsive behaviours due to dementia, neurological disease, or mental illness were a sub-population of ALC patients who occupied beds for excessive periods of time because there were minimal supports for them in other sectors of the health care system (Walker, 2011). As a result of Walker’s report and the gaps in the Aging at Home Strategy, in August 2011 the Ministry of Health and Long-Term Care announced $40 million in funding to support Behavioural Supports Ontario (BSO). The BSO initiative followed a similar process to the Aging at Home Strategy, wherein each LHIN determined how to use its funding to meet the BSO goal of:

Enhanc[ing] the health care services of seniors across Ontario, their families and caregivers, who live and cope with responsive behaviours associated with dementia, mental illness, addictions and other neurological conditions, when they require it and wherever they live, at home, in long-term care or elsewhere. (Behavioural Supports Ontario, 2011, para 1)

The BSO initiative aimed to be the comprehensive system redesign that was called for in Dr. Walker’s report, encouraging collaboration and knowledge translation, and fostering partnership. Although significant work went into the BSO strategy, the government has not invested additional funds beyond its initial investment to support the work of the BSO. As a result, it has
typically served older adults with behavioural and psychological symptoms of dementia while gaps continue to exist in supports for older adults with severe and persistent mental illness. 

There’s a bit of a difference I’m noticing in the treatment of people with severe and persistent mental health [issues]…. There is a population of people who have always had serious and persistent mental health [issues] and who now are over sixty-five. That’s one way of thinking about psychogeriatrics. The other way of thinking about psychogeriatrics is people who, as they age, develop an overlay of severe depression or some other — maybe it’s even substance abuse related — concerns…. And so I think those two populations (and I can’t prove it) but I actually think those two populations get treated differently and are conceptualized differently in the mental health community as well. (Key Informant F)

Also in response to the ALC issues, the Home First Philosophy was introduced in a LHIN in central Ontario. This initiative intends to reduce ALC days by offering intensive case management to seniors who are discharged from acute care (who would otherwise stay in-hospital) back into the community (Health Council of Canada, 2012). Over a two-year period in the pilot LHIN, employing the Home First Philosophy resulted in 2,500 people going home rather than staying in hospital or moving to long-term care (Health Council of Canada). As a result of this success, all remaining LHINs are now implementing this philosophy in collaboration with their local CCAC (“Home First – Putting Patients at the Centre of their Health Care,” 2014). Aggregate data from all LHINs now shows a significant reduction in the demand for long-term care between 2009 and 2012, but the overall ALC rates remained stagnant, indicating a likely need for further investments in system redesign (Sinha, 2012).

The recognition that system redesign is needed in the face of an aging population was underscored by the Living Longer, Living Well report (Sinha, 2012). Appointed by the Ministry of Health and Long-Term Care in May 2012, Dr. Samir Sinha was charged to lead the
development of a Seniors Strategy for Ontario. The final report included 166 recommendations to inform a comprehensive seniors strategy for the province. Within the report, there are 12 chapters, each with multiple recommendations. Of particular relevance for this research are the four chapters on promoting health and wellness, enhancing the provision of home and community care services, enhancing Ontario’s long-term care environments, and addressing the specialized care needs of older Ontarians (Sinha, 2012). The report has a strong focus on mental health and a comprehensive and integrated view of mental health and illness with dementia as compared to B.C. There is recognition of gaps in the mental health system in both services and funding and recommendations about the development of standardized core geriatric mental health services across the province.

5.4.1 Alignment with Ontario’s overall provincial philosophies and frameworks

Dr. Samir Sinha's (2012) Living Longer, Living Well made specific mention of and drew linkages to Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy, released in 2011 by the Ministry of Health and Long-Term Care. Open Minds, Healthy Minds is intended to be long-term and transformational with a focus on a person-centred approach to health care across the life span. Not unlike the other provinces, Ontario identified children and youth as the focus for the first three years of the strategy, despite the stated lifespan approach. Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy has four guiding goals: improving the mental health and well-being of all Ontarians, creating healthy and resilient communities, identifying problems early and intervening, and providing timely, high quality, integrated, and person-directed health and social services (Ontario Ministry of Health and Long-Term Care, 2011). Given the focus on children and youth, there are very few recommendations that are specifically tailored to older adults; however, implementation of all the guiding goals across the lifespan would benefit older adults. Dementia is referenced in the strategy in terms of needing to integrate services and develop
best practices and standards that promote the recovery philosophy (Ontario Ministry of Health and Long-Term Care, 2011).

*Ontario's Action Plan for Health Care* (Ontario Ministry of Health and Long-Term Care, 2012) builds on earlier provincial strategies and continues to incorporate a demographic and sustainability lens. Continuing with the theme of providing the right care at the right time, in the right place, *Ontario's Action Plan for Health Care* highlights the need to continue to aggressively reduce ALC days through additional investment in community capacity, including house calls for frail community-dwelling older adults. The *Action Plan for Health Care* also cites the investment in mental health interventions for children and youth through the *Open Minds, Healthy Minds* mental health strategy as a mechanism for keeping Ontarians healthy (Ontario Ministry of Health and Long-Term Care, 2012).

A key recommendation of the *Action Plan for Health Care* was the development of a dedicated seniors strategy. Released in 2013, *Ontario's Action Plan for Seniors* (Ontario Seniors Secretariat) is a linking document, bringing together ideas from Dr. Sinha's 2012 *Living Longer, Living Well* report and *Ontario's Action Plan for Health Care* (Ontario Ministry of Health and Long-Term Care, 2012). *Ontario's Action Plan for Seniors* identifies three overarching goals: healthy seniors, senior-friendly communities, and safety and security. Of most relevance to this research is the emphasis on health, particularly the initiatives focused on enhanced long-term care and improved access to community care. Upon the release of this action plan, the government announced a $10 million investment to increase house calls for older adults experiencing physical or mental frailty.

In terms of overall alignment and “fit,” on paper Ontario’s strategies and action plans work together to support older adults with mental health challenges, despite the focus on children and youth in the mental health strategy. The demographic and fiscal drivers of increased support for seniors are common themes in each plan, teetering on the brink of perpetuating apocalyptic demography. There appears to be a continual building of messaging
and themes from the earliest *Aging at Home Strategy* to the recent *Action Plan for Seniors*. That said, the focus on ALC reductions appears at times to be a stronger motivating factor than ensuring that the care given is based on the needs and preferences of older adults.

Compared to British Columbia in particular, Ontario appears to have a more integrated view of seniors’ mental health when it comes to the language used within policies and strategies. This sense of integration is exemplified by the mission of the Behavioural Supports Ontario initiative, which serves to meet the needs of older adults with complex behaviours, regardless of diagnosis (of dementia versus mental illness). Despite this sense of integration, historical legacies of service delivery systems and policy silos also affect Ontario. The difficulty in defining how and where dementia “fits” is also a struggle within Ontario, where, as one key informant points out, “*there is bit of a debate about how dementia is viewed. Is dementia a medical condition or a mental health condition?*” (Key informant F). This debate is evidenced across the regions where services for seniors’ mental health are often split between “psychogeriatric services” and “geriatrics.” The consequence of such a split is that older adults with mental illnesses risk being passed between services that defer responsibility to one other. The movement towards creating “any door as the right door” is bringing integration and collaboration to the forefront; however, change is incremental and varied throughout regions in Ontario.

More so than in Alberta and British Columbia, in Ontario mental health is woven consistently into other strategies and action plans; however, this is due in part to the data related to the highest ALC users (those with responsive behaviours). While data is important in terms of building evidence-informed policy, other sources of evidence must also be examined to ensure that the system does not create new gaps or barriers to services. When contrasted with the explicit residualism in Alberta, and the sense of residualism in the vertical consistency (i.e., the consistency of the framework and the specific implementation and programs) (Pal, 2010) of policies described by key informants in British Columbia, Ontario appears to align more closely
with an industrial achievement-performance model of social policy. Within the various action plans, there is an explicit role for the province to strengthen its provision of health and social services based on need. While individual responsibility is not excluded in Ontario’s approach to seniors' mental health, there appears to be more recognition that caregivers and families should not bear the full responsibility of care for older adults. Although much of this approach aligns with an Institutional Redistributive Model of Social Policy, services in Ontario are no longer universal and the private market is entrenched in social service delivery. This evidence will be examined in more detail in section 5.6.
### Table 9: Summary of Nova Scotia Policy Documents

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Date of Release</th>
<th>Focus/Scope</th>
<th>Strategic Priorities (bolded to indicate relevance)</th>
<th>Linkage to Research Question</th>
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<tbody>
<tr>
<td><strong>Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care</strong></td>
<td>2006 Nova Scotia Health</td>
<td>A ten-year strategic action plan to improve and expand the province’s continuing care system.</td>
<td>1. Support for individuals and families; 2. <strong>Support for community solutions</strong>; 3. Investment in health providers; 4. Strengthening the continuing care services; and 5. Investment in infrastructure.</td>
<td>RQ2a</td>
</tr>
<tr>
<td><strong>Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians</strong></td>
<td>2012 Health and Wellness Nova Scotia</td>
<td>A five-year plan that is focused on health promotion, early intervention, reducing gaps in the system, and improving supports and services.</td>
<td>1. Intervening and Treating Early for Better Results 2. <strong>Shorter Waits, Better Care</strong> 3. <strong>Aboriginal and Diverse Communities</strong>. 4. Working Together Differently 5. Reducing Stigma</td>
<td>RQ2b</td>
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5.5 Nova Scotia Policies: Focus on Home and Long-Term Care

In May 2006, Nova Scotia Health released the *Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care*, a ten-year strategic action plan to improve and expand the province’s continuing care system. The strategy was informed by “the voices of more than 1,400 Nova Scotians, national and international research of best practices, and detailed analysis of community needs and population trends” (Nova Scotia Health, 2006, p. 3) and by the vision of a province where “every Nova Scotian lives well in a place they call home” (p.3).

While continuing care serves all ages, the impetus for the *Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care* (Nova Scotia Health, 2006) was the recognition of the province’s aging demographic and related concerns around the health status of the aging population. An additional motivator was the acknowledgement that the status quo resulted in unnecessary pressures on the system: when continuing care is inadequate, people who could be served at home or in the community use hospital resources. The *Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care* outlined five key areas requiring improvement, including:

1. Support for individuals and families;
2. Support for community solutions;
3. Investment in health providers;
4. Strengthening of continuing care services; and
5. Investment in infrastructure.

Within the *Continuing Care Strategy for Nova Scotia* there was a commitment to the addition of 1,320 new long-term care spaces in response to the aging of the population. Alongside these infrastructure investments, the Province also committed to an expansion of the Challenging Behaviours Program in both home and long-term care settings, and an increase in the range of services available through home care (to include home maintenance,
housekeeping, and social interaction). The strategy looked at areas that required strengthening and recognized that individuals with complex physical and mental health care needs require additional supports and services within home and long-term care and that the system needs to be fully aligned and integrated to best support individuals and families.

A criticism of the Continuing Care Strategy for Nova Scotia is that the majority of the investments detailed in the report went into increasing capacity in the form of new beds for long-term care, and yet the wait lists have not yet been reduced. Additionally, the investment’s focus on long-term care beds drew support from community resources, even though this investment has been refocused in the last 3 years.

The biggest challenge that we’ve had is the first … probably 6 or 7 years of the strategy [were] really focused on building beds. The money – the investment – was there and that was huge, and just time, energy, and resources from the department and also the continuing care sector … was a huge draw [on resources] to put in place 1,000 new beds. We needed to do that; we didn’t have good bed capacity, particularly in certain areas of the province. But, in hindsight, and we knew it at the time, it was drawing us away from the community. So we’ve tried to shift that balance in the last 3 years or so, and focus more of the investment on home care and also more our resources in terms of policy and planning and efforts to try keep more people at home (Key informant G).

In January 2014, acknowledging the age of the Continuing Care Strategy, the Government announced a promise to review and refocus the strategy. As an outcome of this commitment, the Minister of Health and Wellness announced the development of a provincial dementia strategy to fall under the auspices of Continuing Care. The full update of the strategy has not yet been released.
5.5.1 Alignment with Nova Scotia’s overall provincial philosophies and frameworks

Two key provincial strategies guide the Province’s approach to population aging and mental health. In 2005, the Nova Scotia Seniors Secretariat released the *Strategy for Positive Aging in Nova Scotia*. The strategy was intended to be a long-term guide for all sectors and stakeholders of the province. Within the strategy nearly 200 “societal actions,” crossing all boundaries of jurisdictional responsibility, are outlined. These action items can be organized under nine key goals: Celebrating Seniors; Financial Security; Health and Well-Being; Maximizing Independence; Housing Options; Transportation; Respecting Diversity; Employment and Life Transitions; and Supportive Communities.

The third key goal, Health and Well-Being, outlines the importance of having a range of supports and services available that facilitate health and well-being. There is clear recognition of the need for a continuum of care, with particular emphasis on those aging with dementia. A key action item proposed to meet this goal was the implementation of seniors’ mental health standards across the province, which has been achieved, albeit only in specialized service settings. There are clear synergies between the *Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care* (Nova Scotia Health, 2006) and the *Strategy for Positive Aging in Nova Scotia* (Nova Scotia Seniors Secretariat, 2005), likely reflecting their development and release within a similar timeline. In fact, the *Strategy for Positive Aging in Nova Scotia* highlights the need to ensure that recommendations from the *Continuing Care Strategy* are reflected in the health system as a key societal action, reinforcing key messages from stakeholders. A reduction in the number of older adults in ALC beds is also outlined as a key societal action item, a view that is reinforced through the *Continuing Care Strategy for Nova Scotia*. Building on the action around health and well-being, Goal #4 focuses on maximizing independence, including additional in-home and community supports. This action is reflected in the *Continuing Care Strategy*, which enhances in-home supports to include home maintenance
and housekeeping.

Although there is strong convergence between the two strategies, the responsibility for implementation is missing within the *Strategy for Positive Aging in Nova Scotia*. The “societal action” focus is, in fact, implemented through community grants to non-governmental organizations. As a result, the *Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care* is a key resource for implementation in the areas where there are shared action items. Both are long-term strategies that continue to inform the decisions and directions of the Government of Nova Scotia.

In 2012, Health and Wellness Nova Scotia launched the first-ever provincial mental health strategy. *Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians* (Health and Wellness Nova Scotia, 2012) is a 5-year plan that is focused on health promotion, early intervention, reducing gaps in the system, and improving supports and services. Despite the provincial recognition of an aging demographic, *Together We Can* clearly outlines that children and youth are a priority population under this 5-year plan. As a result of this youth focus, many of the recommendations and action plans are not inclusive of older adults. That said, within *Together We Can* there is recognition of the fact that speciality services are often required for older adults as well as recognition of the strengths of the Seniors’ Mental Health Network as a model mechanism to promote specialty knowledge across the province. Seniors are also listed as a “diverse community” and have an accompanying action item for 2014–2015 to improve education to providers in the area of seniors’ mental health. Overall the implementation of *Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians* has been viewed positively, although there is recognition that implementation on the seniors’ action item is behind schedule (key informants J, K). The accumulation of disadvantage and a lifespan approach, in addition to the role of the environment, are key considerations for implementation around seniors. As well, there is awareness that the principle of “nothing done for you, without you,” in terms of engaging people with lived experience, has
not yet successfully engaged seniors to ensure that their voices are heard and integrated into the work (key informants J, K).

One clear benefit of the implementation of the *Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care* (Nova Scotia Health, 2006) is that it created a full-time staff position focused on implementation.

*In fact, [in] the government at the time (which was the previous government), our Minister of Health and Wellness … was a PhD in social work and she had a particular interest in mental health … and she clearly wanted to leave her mark and leave a legacy. [She] wanted to leave her mark and really put a lot of attention and focus on this. And then became finance minister afterwards and ensured that the implementation of the strategy actually had funds to go with it. (Key informant H)*

Given the lack of focus on seniors’ mental health within *Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians* (Health and Wellness Nova Scotia, 2012), it is challenging to suggest a relationship between it and the *Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care* (Nova Scotia Health, 2006). The lack of connection between the two strategies is perhaps indicative of the dichotomous relationship between mental health and dementia that was also seen in other provinces. While the *Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care* (Nova Scotia Health, 2006) creates a separate dementia strategy, the current mental health strategy excludes action on improving the mental health of older adults generally, and, in particular, does not acknowledge the needs of those within the continuing care system.

Not unlike in other provinces, the financial state of the province is a key driver for policy decisions in Nova Scotia. There is recognition that health consumes the largest portion of government dollars and, with fewer workers due to demographics and migration, there are fewer dollars to develop a tax base than in provinces with more workers. This economic driver, which directly affects expectations for personal capacity and individual responsibility, was cited as the
key factor driving change to the provincial healthcare system. For example, the principle of comprehensiveness is being discussed within the government to determine what should be funded by the province versus what should lie with individuals (Key informant G).

We will have to have more conversations — as a community, as a province, even as a country — about what is universal health care. What is in that basket and what’s not? What should we expect and provide to each one of us when we need it? And what is it that is our personal responsibility? And what is it that we may want to, as a community, invest in if somebody can’t afford it? And we’ve started to design programs and look at that kind of thing. So what is the universal benefit so [that] it doesn’t matter what your resource capacity is, you can have access to it? Because it is smart, and a good investment, and it’s the right thing to do. But what is it that — and this happens a lot in continuing care because of the nature of our business — but what is it that helps keep someone in their home and out of more resource-intensive, more costly health system resources.... (Key Informant G)

In particular, for continuing care, these decisions influence access to community-based services; decisions on whether or not to fund services outside of physical care, such as transportation, assistance with meal preparation, and cueing, depend on the ability to determine whether a mental health condition or dementia precipitates this level of support. Despite the more progressive ideology of Nova Scotia when compared to Alberta, it is compelling that the idea of personal responsibility is influencing policy decision. Again not as explicit as Alberta’s residualist approach, these discussions in Nova Scotia point to contemplation of the role of the state in social welfare. The current approach to social welfare is quite similar to Ontario, aligning with an industrial achievement-performance model, in which the provinces provides services on the basis of need and home and long-term care are not universal.

Perhaps as an outcome of the size of the province, there appear to be more synergies and communication between government organizations in Nova Scotia than in the other
provinces studied. In the policy landscape there are key individuals who bring perspectives on seniors and/or seniors’ mental health to all of the strategies. As explained by one key informant, because Nova Scotia is a relatively small jurisdiction,

>You have the capacity to do things … when you’re an elected official, or even in some respects when you look at the landscape of services. We all have a bit more influence sometimes because of the friends and neighbours who are elected officials or bureaucrats or whomever, or just the fact that people get to know each other. (Key Informant H)

This sense of connectedness was reflected in the fact that key informants easily knew their counterparts in other departments and often discussed how they worked together to support one another to implement policies in a time of challenging economics and in the face of an aging demographic. This sense of connectedness was also reflected in my experience of gathering key informant data; when compared with the three other provinces, Nova Scotia was uniquely positioned in terms of the ease of liaising with key informants. Other sources of evidence, and the ways that evidence influences policy decisions in Nova Scotia, will be discussed in greater detail in the following section.

5.6 Discussion: Provincial Alignment with Evidence and Research

The gap between research and policy is well documented in health care and yet continues to be an ongoing challenge in public policy (Brehaut & Juzwishin, 2005). It is understood that values, politics, and ideology have a significant influence on policy decisions and directions (Brehaut & Juzwishin). Competing interests further complicate policymaking and the setting of policy directions. In the case of seniors’ mental health, there are multiple competing interests. These may include reducing healthcare costs while meeting the needs of an aging population; providing quality and accessible care within provinces despite working with fewer federal dollars than had traditionally been the case; balancing the needs of older adults
when compared with younger populations; and valuing the voices of older adults and people with lived experience along with the voices of service providers and clinicians, among many other competing interests. There are also different perspectives on what constitutes research and what evidence is most valued. Historically, health care has been influenced by biomedical traditions that value randomized control trials and other scientific models; however, more recently the movement to valuing practice-based evidence and lived experience has shifted our understanding about how evidence should influence policy making.

Using Framework Analysis as a mechanism to organize provincial data helped to clarify themes in the evidence that influenced provincial decision-making. These themes include political ideology, statistics and economics, and the recovery philosophy. Much of the research on the ideal service system for older adults was summarized in the recent *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* (MacCourt et al., 2011). These guidelines will be used as a lens for evaluating the use of research evidence in provincial policies.

As noted in Chapter 3, political ideology was a part of the selection criteria for determining the provinces to be included in this research. The conservative political climate of Alberta was reflected in its policy frameworks, particularly in terms of the focus on individual responsibility and the retrenchment of the role of government in providing services and supports for seniors. This socially conservative messaging was most evident in Alberta, and yet this theme also permeated more liberal and progressive governments such as Nova Scotia’s. The current federal ideology also influences the ways provincial governments make decisions, particularly in terms of the role of the federal government in health care and the reduction in federal spending in this area. As a result, ideology and economics become challenging to disentangle. Despite some provinces representing a more progressive social perspective, the reality of the lack of funding to support innovation and new models of service delivery hinders the policy agenda. Closely tied to the economic efficiencies driving health care are the statistics
and demographic realities in each province. Although the percentage of the population over the age of 65 varies across provinces, population aging has influenced each and every policy framework reviewed. How population aging is discussed varies, but the predominant message in each province is that changes to the status quo are required. Tenets of apocalyptic demography, particularly the idea of intergenerational justice, permeate the strategies that discuss “fair” and “equitable” systems that meet the needs of seniors without compromising other populations. Interestingly this same tenet is often used in strategies and policies on mental health, but with different context. Each province used statistics and demographics to rationalize a focus on children and youth as a fair and equitable distribution of resources since “we know that 70% of all mental illnesses begin in childhood” (Key informant H). Unfortunately, this focus leaves the current generation of adults and older adults at a disadvantage when it comes to policy initiatives in mental health. Using a life course theoretical perspective would help to justify the need to expand mental health strategies across the age span. In particular, the recognition of the influence of social and historical contexts on mental health and mental health policies might underscore the need for tailored policy interventions in seniors’ mental health. Additionally, the political economy theory of aging helps to illuminate the cumulative impacts of policies and again reinforces the need for focus on older adults, perhaps with particular consideration of those with lifelong severe and persistent mental illness now growing old. While gerontological theories would offer an important lens for the way older adults are viewed in policy, models of social welfare appear to have more of an influence in the current climate of policy-making. Residualism, as a model of social welfare, stands in stark contrast to the ideas of the moral economy and life course perspectives, and therefore it is not surprising that these gerontological theories are not well utilized. Unfortunately, Collier’s (2005) earlier assertions that policy often ignores those with serious and persistent mental illnesses and older adults in mental health policy appear to be true in the provinces examined. Martin-Matthews and colleagues (2013) also posited that neo-liberal developments have resulted in significant
erosions in the provision of home support services, and this too was reflected in the policy context of included provinces.

As a positive finding, the diffusion of innovation was also reflected in the knowledge translation and sharing of best practices across provinces. Examples include the expansion of an Ontario model, “Putting the P.I.E.C.E.S. Together,” into Nova Scotia and Alberta. As well, the Behavioural Supports Ontario initiative is currently being explored in Alberta and was referenced as a gap by key informants in the landscape in Nova Scotia. This sharing of information occurs at the government level, but more often appears to be the result of clinical champions and advocates who push for change based on the work of their colleagues in other provinces. As such, the role of the champion is a significant consideration in policy development and direction setting. Similarly, while First Link® is now available in all sample provinces, it is led by the provincial and local Alzheimer societies and not embedded into government policy.

In terms of aligning with the system-level principles recommended in the Guidelines for Comprehensive Mental Health Services for Older Adults in Canada (MacCourt et al., 2011) there were similarities across provinces. Although the adoption of the recovery philosophy was not explicit in any of the provinces, the principles of choice, individual responsibility, and person-centred care emerged across strategies. And while older adults’ voices were often included in the planning and strategies on aging, they were less likely to be engaged in the mental health strategies. Again, given the focus on children and youth in the mental health discourse within each province, this is not surprising and emphasizes again that a lifecourse perspective has not been adequately employed. The authors of the Guidelines for Comprehensive Mental Health Services for Older Adults in Canada (MacCourt et al., 2011) advocate for the use of the Seniors’ Mental Health Policy Lens (MacCourt, 2009), and yet even in British Columbia, the province where it was developed, it has not been adopted in any provincial documents. This perhaps is

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23 “P.I.E.C.E.S. is a best practice learning and development initiative that provides an approach to understanding and enhancing care for individuals with complex physical and cognitive/mental health needs and behavioural changes” (Hamilton, Harris, Le Clair, & Collins, 2008, p.1).
again reflective of the fact that seniors’ mental health does not have a clear “home” in any of the provinces included. The Seniors’ Mental Health Policy Lens is a piece of research that could be employed to minimize that gap or bridge the multiple competing perspectives.

Across provinces, there is a divergence from the research evidence in terms of perspectives around mental illness and dementia. While the movement within the research is to take a functional approach to health, policy silos and legacies still separate dementia as a medical or organic issue and mental illness as a psychiatric issue. This gap between policy and service delivery is a core area of divergence and one that is unfortunately prevalent across the country. The ideal model for mental health services in late life is one that is integrated, flexible, and seamless and responds to older adults based on need and not diagnosis (MacCourt et al., 2011).

Despite these gaps, there are good examples of how research evidence informs policy decisions in each province. For example, the Caring for Our Aging Population and Addressing Alternate Level of Care report in Ontario had direct implications for the Behavioural Supports Ontario initiative and funding. Similarly, in developing the implementation plan for seniors under the mental health strategy in Nova Scotia, documents such as the national Mental Health Strategy and the Guidelines for Comprehensive Mental Health Services for Older Adults in Canada (MacCourt et al., 2011) were cited as key sources of evidence. Alberta’s Strategic Clinical Networks identified research and innovation as a foundational pillar. Finally, in British Columbia, the extensive work of the Provincial Ombudsperson is an exemplary model of incorporating lived experience into research evidence and advocating for policy change.

Understanding how research and evidence informs the content of each of these policies and frameworks is valuable in answering the question of how older adults with mental health problems are supported in each province. However, disentangling competing interests, such as political ideology and social contexts, is complex and at times seems to shape the value of research-informed policymaking. An examination of who is not served well under current
policies may help to clarify whether political ideology or research evidence is a stronger driver of policy. To fully understand the strengths of a policy, it is important to also identify any weaknesses gaps. This question will be examined in greater detail in Chapter 6.
Chapter 6: Gaps and Limitations in Existing Policies

6.1: Introduction

Throughout the process of mapping policy documents and key informant data from each interview, themes about gaps or limitations in the current landscape of policy documents emerged. My third research question explores these gaps and limitations with a specific lens as to who is served well in current policies and who is not. In particular, I aim to uncover common gaps in policies that might be remedied through sharing of best practices and knowledge translation. Revisiting the concept of horizontal equity, this research question specifically helps to uncover equity issues. Given the notion of portability that Canadians expect as one of the core features of the publicly funded health care system, it is important to consider how the experience of aging might look different for older adults with mental concerns in terms of how they would be supported in each one of the provinces of study.

Gaps in the policy landscape also speak volumes about the perceived value of potential problems. As explained by Leslie Pal (2010) “at the most extreme, if a problem is not widely recognized at all, there will be little or no policy response” (p. 107). When gaps are found, it is necessary for them to be made visible to ensure they become recognized, defined, and structured to ensure that the discrepancy between the current state and the desired state is addressed (Pal, 2010). Conversely, a policy may identify dilemmas and offer solutions, but gaps may exist between the theoretical framework and the specific implementation and programs, highlighting a lack of vertical consistency (Pal, 2010). Using the Policy Triangle Framework (Walt & Gilson, 1994) to examine the content of policies and Framework Analysis (Ritchie & Spencer, 1994) to compare across sample provinces, themes about gaps emerged. While each province had unique gaps depending on its local context, shared gaps also emerged as themes. Each province will be addressed individually below, followed by an integrated discussion about commonalities that could be addressed in future policymaking.
6.2 Alberta

Within the current policy landscape in Alberta, there is a strong focus on aging in place. While this aligns with evidence around facilitating choice and respect for personal preference, it also potentially creates gaps in the system and makes admission to long-term care more challenging for those individuals who may require this level of support. The perception that supportive living is equal to long-term care also influences policy investments and directions:

*I think our use of long-term care is still too high on a population basis because we have a lot of other alternatives. I think what our challenge is right now is to support that shift through more investment in home care. We've been investing a lot in supportive living including specialized units in supportive living for people with dementia, although there are some communities in the province that don't have the full range of choices.* (Key informant B)

Recent literature from Alberta, however, has indicated that the health profile of those living in supportive housing is similar to those living in long-term care in terms of the average number of disease diagnoses, with dementia and depression being two of the most prevalent diseases in both settings (Strain, Maxwell, Wanless, & Gilbart, 2011). Although the complexity is heightened in long-term care due to resident health profiles, the average number of residents in supportive living with depression, dementia, and aggressive behaviours is comparably quite high, and yet the staffing ratios and training of staff are less than in long-term care (Strain et al., 2011). As more individuals are encouraged to enter supportive living rather than long-term care, there is a risk that the health profile between residents will narrow and the gap in staffing ratios will widen, opening opportunities for gaps in care and services for those requiring more specialized care. Additionally, the idea that access is not equitable across the province is another key consideration and critique of the current policy landscape, a concern that is relevant across sample provinces.
Key informants did acknowledge that there are gaps in the continuing care system, particularly in terms of how to manage behavioural and psychological symptoms of dementia and severe and persistent mental illness in long-term care homes. Behavioural Supports Alberta was inspired by the work of Behavioural Supports Ontario and is described as:

A newly forming provincial network of service providers, caregivers, policy and decision makers, researchers, and academics interested in supporting those exhibiting challenging responsive behaviours (due to mental health conditions, addictions, cognitive impairment, developmental disabilities, brain injury and other neurological conditions), as well as those who support or offer care to them.

("Behavioural Supports Alberta," n.d.)

If successfully implemented, Behavioural Supports Alberta aims to fill this gap in service delivery and policy. However, it is important to note that this initiative is researcher driven, unlike the government-led initiative seen in Ontario.

Similarly, Alberta’s Strategic Clinical Networks were formed partially in recognition of the gaps in the system. Specifically, it was noted by key informants that individuals living with dementia in the community do not have a seamless experience. This reflects a vertical consistency issue, as the gaps in the system contradict the policy language of commitment to integration as described in the guiding policy frameworks. The lack of integration is also a result of policy legacies that put age parameters on mental health systems, as explained by key informant B: “It’s part of our historical baggage too, the way mental health was set up in terms of funding. It ends at 65, and then there is this grey area of psychogeriatrics.”

The political culture of Alberta, with its return to residualism, can be viewed two ways. To some, this approach may be viewed as a strength of the system as resources are freed up for those most in need, required particularly since responsibilities being downloaded to provinces means that federal funding for health care is reduced. Conversely, for those who believe that continuing care should governed by the principles of the Canada Health Act, this can be viewed
as a period of retrenchment that erodes the universality of health services for older adults with mental health concerns.

6.3 British Columbia

British Columbia differs from the other provinces of study in terms its strong policy focus on health promotion. This is an unique approach in the sample provinces, as the upstream approach employed builds on the principles of a social determinants health approach; however, there is a notable gap when it comes to mental health, which is not explicitly addressed in policy. Additionally, there are minimal connections between health promotion and the mental health system. An explicit linkage to the mental health system would indicate an understanding that health promotion is also relevant for those living with mental health challenges. The current language and policy landscape seems to differentiate healthy active older adults and those who are considered more frail or vulnerable in terms of their health status.

The use of innovative investments to support older adults with mental health concerns is also a strength of the current continuing care system in British Columbia. The introduction of flexible care, which funds homecare supports for instrumental activities of daily living, has significant implications for community-dwelling older adults who live with mental health challenges. Non-medical services provided through the Better at Home initiative are available to seniors on a sliding income scale, aligning with a market-state approach to policy (Graham, Swift, & Delaney, 2009). These exemplary investments, which demonstrate an innovative and holistic approach to non-medical supports, in line with evidence that they can provide a mechanism for long-term diversion (Lum, Williams, Sladek, & Ying, 2010), are time-limited commitments with funding only guaranteed until December 2015. If these investments are not renewed, approximately 5,000 seniors in British Columbia will be affected. In the recent evaluation report of the Better at Home initiative, concerns were raised about the sustainability of the program without commitment from the government both in terms of the philosophy of care
(of providing non-medical supports) and in funding dollars (Better at Home Program Evaluation, 2014). Additionally, the need to revisit the sliding scale to ensure access by more seniors was suggested as a key consideration for the future (Better at Home Program Evaluation, 2014).

Under a market-state approach to policy, the means test may be influenced by the overall economic picture in the provinces, which is concerning given the reduction in federal funds to provincial health care.

Beyond the non-medical home care service initiative, there has been significant attention on the part of healthcare advocates to the continuing care system in British Columbia in response to the feedback of those falling between the cracks of the system. The lack of implementation of key recommendations from the Ombudsperson’s reports is a concern, particularly for those with severe and persistent mental illnesses who are served within continuing care. Key informants also noted other gaps in the policy landscape, particularly in the areas of end-of-life care for people with dementia and socially isolated older adults. Leveraging existing resources could strengthen the policy landscape in British Columbia. In particular, *Meeting Seniors’ Mental Health Care Needs in British Columbia: A Resource Document* (MacCourt & Donnelly, 2012) is a significant piece of work that aims to bridge current gaps in the policy landscape; however, implementation of the report’s recommendations has never been prioritized. Additionally, the Seniors’ Mental Health Policy Lens (MacCourt, 2009) was developed by the British Columbia Psychogeriatric Association and has been widely endorsed, yet none of the key informants I spoke with in the province were familiar with it, nor did they think the use of a seniors’ mental health policy lens was relevant to their work.

### 6.4 Nova Scotia

The strength of British Columbia’s the Better at Home initiative is contrasted by a significant gap in the Nova Scotia continuing care system and policy landscape. Key informants in Nova Scotia cited the lack of support for those living in the community who do not need
physical care. These may be individuals who have the physical abilities to manage their activities of daily living but, due to their mental health issues, would benefit from in-home support. This gap is exacerbated in the complex cases of those growing older with severe and persistent mental illness, a group that is not served well, partially due to staffing issues. A more comprehensive continuing care strategy would include human resource issues in terms of training and education for home care workers, raising awareness of mental illness, and reducing the stigma associated with mental illness. As a result of this current gap, individuals with behavioural and psychological symptoms of dementia and those with severe and persistent mental illnesses who fall between the cracks in continuing care often require hospital care instead (Key informant G). In fact, multiple key informants in Nova Scotia who identified the Behavioural Supports Ontario model as the ideal model cited this gap. They viewed the development of a comprehensive behavioural support plan as a necessary next step and saw the need to integrate continuing care more fully with mental health services as a key strategy for improving the experience of older adults in the province.

Beyond needing a comprehensive behavioural support plan, there was recognition that there is no province-wide lens for seniors’ care:

I don’t know that we have a healthcare setting or district health authority-wide approach to looking at seniors and the needs of seniors. We have all kinds of different services; they fall under different administrative and bureaucratic components of our healthcare landscape here, but they’re not necessarily integrated … a gap would be that we simply do not have the within healthcare system overarching strategy that really looks at the needs of seniors. (Key informant H)

The lack of a comprehensive provincial approach leads to a “care by chance” model rather than a “care by design or coordination” model as explained by key informant I.

Aligning with the Continuing Care Strategy for Nova Scotia, the Care by Design project builds primary care capacity within long-term care homes. This is particularly relevant given data
about the mental health profile of long-term care residents and the lack of knowledge about managing mental illness in such settings. Currently, this initiative exists only in the Capital District in Nova Scotia despite the good evidence it has produced related to improvements in the quality of care and reduction of hospital transfers (Marshall, Boudreau, Clarke, Burge & Andrew, n.d.). Although the Capital District contains the critical mass of the population of Nova Scotia, enhancing primary care in long-term care was outlined as a provincial goal in the continuing care strategy. This lack of consistency in implementation across the province represents a gap in the continuum of services in more rural communities where, perhaps, capacity building is especially important given the lack of specialized supports.

Although much of the response to the mental health strategy in Nova Scotia has been positive, key informants did identify gaps related to seniors’ mental health. Specifically, the province’s philosophy of engaging people with lived experience in the implementation process has not been as inclusive of older adults as it has of other populations. Additionally, while seniors’ mental health standards exist, they are only for specialized services and do not apply to the continuing care sector, even if this sector is serving a high proportion of older adults with mental health challenges. Again this divide was attributed to the historical silos between mental health and other sectors in health. In conversations with key informants, there was also thoughtful consideration of intersecting diversities and their impact on older adults with mental illness. For example, there was recognition that diverse communities are insufficiently supported by the mental health system and that layering age adds a level of vulnerability, and with it an increased risk of falling into cracks in the system: “Senior[s] with a mental health issue from a diverse community… they’re lost, completely lost” (Key informant J). This layered vulnerability and accumulated risk is often exacerbated in a continuing care system that is already unprepared to support older adults with mental illnesses without the additional consideration of intersecting diversities.
6.5 Ontario

Key informants in other provinces referenced the Behavioural Supports Ontario (BSO) initiative as an exemplary model. That said, within Ontario key informants were able to identify gaps within BSO and its contribution to the landscape of seniors’ mental health policy. Although viewed as an excellent and much-needed addition to the system, key informants also noted the lack of vertical consistency related to its implementation. Although BSO has a mandate to serve older adults with complex behaviours (regardless of diagnosis), it still does not yet address the needs of those with severe and persistent mental illness or those with behavioural and psychological symptoms of dementia (Key informant F). Additionally, while BSO is intended to serve community-dwelling older adults and those in long-term care, the home-care component is not as well developed as the institutional component.

When mapping the diffusion of innovation in seniors’ mental health, Ontario is often an early adopter in innovation. In addition to BSO, First Link ® is implemented most widely in Ontario. While this initiative has been found to positively support caregivers and people with dementia when it comes to knowledge and information, evaluation was unable to confirm any impact on coordination of care (McAiney et al., 2010). Furthermore, while this program is embedded in the framework of the Alzheimer Society of Ontario, it potentially serves to perpetuate the idea that dementia and mental illness are separate entities given its focus solely on dementia. Adopting a more holistic approach to seniors’ mental health would strengthen the elements of First Link ®.

Another gap identified through interviews relates to support for those aging with developmental delays.

*It's a huge gap because they are living long and running out of the time in the programs that were designed to serve them. So if they're over 65, I don't think they are eligible for those programs anymore. And they're not perceived to be … the*
geriatric community has not really picked up that population, so it’s a huge gap. (Key informant F)

Beyond the population aging with developmental delays, it was noted that diverse groups, or those who may not be seen as the “typical: aging population, tend to be missed in the services systems. This also includes younger populations with acquired brain injuries who live in long-term care because “there is nowhere else to go” and those aging with dementia in the jail system (Key informant F). These gaps are also unaccounted for in the policy landscape, reflecting the need to integrate more diversity into the definition of seniors’ mental health policy to account for the heterogeneity in the aging population in Ontario.

6.6 Shared Challenges

While each province has policy strengths and opportunities to improve the landscape of seniors’ mental health policies, there are some shared challenges. These shared challenges present key windows for sharing knowledge across the country to tackle complex policy gaps.

First, although there have been significant shifts in the mental health policy landscape across Canada, seniors are not well represented in any of the provincial plans examined within this study. All four provinces explicitly prioritize children and youth in their respective mental health strategies and as a result miss key opportunities to support the current generation of older adults living with mental illness.

Additionally, key informants in each province spoke about the division between mental health and dementia at the policy level. Alberta, Ontario, and Nova Scotia are currently developing dementia strategies (British Columbia already has a modest plan in existence), but they are all in the formative stage; by virtue of coming after existing mental health strategies, these plans miss key opportunities to integrate the policy frameworks.

Another shared challenge across provinces relates to the emphasis on keeping older adults in their communities. This movement towards supporting aging in place aligns with
evidence and the preference of older adults; however, as key informants explained, investments in home care have not kept pace with this system shift, and services are not yet adequate to meet the needs of all older adults with mental health concerns living in the community.

Further into the continuum of continuing care, it appears that there is still a gap in long-term care for people living with severe and persistent mental illnesses. While this presents differently across provinces, the message is consistent that current policies and services do not yet fully address the needs of this population. In Ontario this may manifest in delays in being matched to a long-term care home (Key informant F), whereas in Nova Scotia the fundamental problem is a lack of communication across sectors that would ensure smooth transitions along the continuum of care (Key informant H). There was also recognition that there are other groups, beyond older adults with severe and persistent mental illnesses, who are not well represented in policy, including those with developmental delays who are growing older with comorbid mental health conditions. Within long-term care there have been shared clinical policy initiatives such as reducing antipsychotic use in long-term care homes (in both Alberta and British Columbia), but these are not situated within a comprehensive policy on seniors’ mental health across the continuum.

Beyond the gap in mental health strategies there appears to be an overarching lack of responsibility for seniors’ mental health at the government policy level. As illustrated in each provincial analysis, this is reflected by the gaps in the inclusion of seniors and mental health across guiding frameworks and policies. These exclusions are echoed at the clinical or systems level. As explained by Alberta key informant B:

There is still that dichotomy where the mental health community is not that interested in dementia and the geriatric community is, so then they end up being multi-skilled. And only when they really need some really specialized testing or if there is an overlay of a serious mental illness do they refer because it is so difficult.
Key informants in each province echoed with nuanced reflections on how this dichotomous relationship plays out in systems and services. As explained by Nova Scotia key informant I:

*There is a split between seniors’ teams and mental health teams. The fractioning off is related to budgets where dementia is viewed as neurology, geriatrics, and the purview of family docs, but especially in DSM 5 there are tons of psychiatry, and when there is severe BPSD it is psychiatry usually involved in the management.*

Given the changing demographics and the projected increased in the prevalence of mental illness, it is vital that provinces start to address these key gaps in the seniors’ mental health policy landscape. Although local context is important in policymaking, shared drivers such as aging demographics and health care expenditure pressures open a policy window for collaboration and knowledge translation in policy making. Recommendations for how to improve the policy landscape to better address seniors’ mental health are presented in Chapter 7.
Chapter 7: Conclusions and Recommendations

As the baby boom generation moves into their senior years, the issues of health and aging are increasingly permeating the discourses around policy and healthcare spending (Delacourt, 2014). As Canadians move towards the 42nd general election (assumed to be in October 2015), champions are advocating for a national seniors’ care strategy (Canadian Medical Association & CARP, 2014). Projections from Statistics Canada (2014) suggest that the proportion of seniors could start to exceed the proportion of children as early as 2017, and as the gap widens, the prevalence of mental illness and dementia are also projected to increase substantially (Smetanin et al., 2011). In addition to concerns about health care costs and the need for improved system efficiencies, there are added incentives to address seniors’ mental health in the policy landscape. The confluence of emerging social issues such the Supreme Court decision on physician-assisted suicide (Carter v. Canada [Attorney General], 2015, SCC 5); concerns about resident violence in long-term care homes (attributed to the behavioural and psychological symptoms of dementia and mental illnesses) (MacQueen, 2014); and research on the risk of distress for family caregivers of people with mental illness and cognitive impairments (Health Council of Canada, 2012) contributes to the tipping point for policy changes.

Furthermore, there has been a heightened focus on social inequality over the last several years in Canada (Alexander & Fong, 2014; Broadbent Institute, 2012; Conference Board of Canada, 2013), and age can be a contributing factor to inequality. The risk of social inequality can be exacerbated when policy decisions are influenced by the notion of apocalyptic demography, particularly in the context of the distribution of resources and issues of intergenerational equity. As illustrated in the Canadian Association of Social Workers’ 2014 report, Promoting Equity for a Stronger Canada: The Future of Canadian Social Policy, the current federal government has been moving away from the principle of national equity, and gaps exist in the horizontal equity of health polices across the country.
Demographics, social and economic factors, increased awareness of mental health, and the changing health profile of older Canadians come together, creating a potential policy window to address seniors’ mental health. Taken together, momentum is building to put seniors’ mental health on the policy agenda.

This research was focused on the question: How have provinces organized their extended healthcare services (specifically long-term care and home care) to support older adults with mental health issues? To answer this, I explored the following questions:

1. How have governments (and governmental organizations) taken responsibility for seniors and seniors’ mental health?
   a. What is the structure of government organizations and policy-making processes in these areas?
   b. What has influenced policy making in these areas?

2. How do provincial policies in home care and long-term care support older adults with mental health problems?
   a. What are the goals of each policy?
   b. How do the policies align with overall provincial philosophies and frameworks?
   c. Do the policies align with evidence and research in the field?

3. What mental health policy gaps or limitations exist that could be remedied in future policy development?
   a. Who is served well under current policies?

To capitalize on this potential policy window, this chapter revisits the research questions and offers recommendations for future policy development. Additionally, I discuss the research limitations of this study, as well as suggestions for future research in this area.
7.1 Making Sense of the Data – Revisiting the Research Questions

Throughout the process of this research, using the various analytic tools and theoretical frameworks, several core themes emerged. Using the methods in the Framework Analysis approach (Walt & Gilson, 1994) helped to organize the data and make comparisons across sample provinces. The components of the Policy Triangle Framework (Walt & Gilson) offered structure for the development of themes including contextual influences, and the relationship between political ideology and a focus on seniors’ mental health within the provincial policy landscape. Themes derived from my data analyses are examined in more detail and aligned with my research questions in the following sections.

7.1.1. Research Question #1

My first research question examined how governments and governmental organizations take responsibility for seniors’ mental health in the sample provinces. This includes examining the influences and structures of government organizations and policy-making processes in these areas and influences. Using the Policy Triangle Framework, this question specifically examines provincial contexts and actors that shape policy processes.

Should each province be held to the principles of the Canada Health Act, an expectation of horizontal equity would follow. The reality, however, is that each province makes decisions based on local context and the processes for decision making are influenced heavily by this context. Key contextual issues that influence the way seniors’ mental health is positioned in each sampled province include the political ideology of the current government and its related stance on social welfare. During the course of this research there was a shift in leadership in Nova Scotia (from NDP to Liberal), while all other provinces remained under the same political party. The result is shared Liberal values in British Columbia, Ontario, and Nova Scotia, contrasted with the Conservative values represented in Alberta. This ideological difference is also reflected in each province’s alignment with social welfare models, with Alberta exhibiting
features of residualism and allowing a greater role for the private sector in service provision. Conversely, despite the shared liberal ideologies of the other provinces, British Columbia stands out with its merit model of social welfare, where those “deserving” of service are prioritized. Ontario and Nova Scotia are more closely aligned, also reflecting the industrial achievement-performance model, with a focus on need. If home and long-term care were included as insured health services, not only would horizontal equity follow, but it is likely that sample provinces would move closer towards an institutional redistributive approach to social welfare, where such services are viewed as key institutions and are universal (Graham et al., 2012). Instead, the ongoing period of austerity and neo-liberal developments have resulted in significant erosions in the provision of services.

How and where seniors’ mental health or seniors’ issues more generally are positioned within the ministerial structure is an additional contextual consideration. Until September 2014 Alberta was structured similarly to British Columbia, with seniors’ issues falling under the auspices of the Ministry of Health. Ontario and Nova Scotia (and Alberta as of September 2014) each have a ministry responsible for seniors. Although Ontario has a Seniors’ Secretariat, it is seen by the public to have less clout than the Ministry of Health and Long-Term Care and many of the key policy documents related to seniors’ issues are developed and funded through that Ministry. The Department of Seniors in Nova Scotia could face a similar image issue as the Ontario Seniors’ Secretariat. The core policy document from the Department of Seniors (the Strategy for Positive Aging in Nova Scotia) is a long-term aspirational policy framework that is implemented via community and not directly by government. Given the lack of government role in implementation, the Department of Seniors in Nova Scotia may also be perceived to have less clout than its counterparts in health who have funding for implementation. While aligning seniors’ issues with health portfolios runs the risk of medicalizing aging, the segmentation of seniors from other populations and issues can also create potential silos. British Columbia’s approach of having a Seniors’ Advocate may be a key complement to its lack of a seniors’
ministry. While current government (and ideology) seems to align with social welfare models, there is less clarity about the presence of a Seniors’ Ministry in terms of the approach to seniors’ mental health. These differences between provinces are summarized in Table 10.

Table 10: Comparison of Provincial Contexts

<table>
<thead>
<tr>
<th>Province</th>
<th>Current Government</th>
<th>Regionalized or Centralized</th>
<th>Alignment with Social Welfare Model</th>
<th>Seniors’ Ministry</th>
<th>Seniors’ Advocate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta</td>
<td>Conservative</td>
<td>Centralized</td>
<td>Residualism</td>
<td>As of Sept 2014</td>
<td></td>
</tr>
<tr>
<td>British Columbia</td>
<td>Liberal</td>
<td>Regionalized</td>
<td>Industrial Achievement-Performance Model (focus on merit)</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>Liberal</td>
<td>Regionalized until April 1 2015</td>
<td>Industrial Achievement-Performance Model</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Ontario</td>
<td>Liberal</td>
<td>Regionalized</td>
<td>Industrial Achievement-Performance Model</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

7.1.2 Research Question #2

Building on the provincial contexts, my second research question seeks more detail about the content of the policies in home and long-term care in order to understand how they support older adults with mental health problems. This process includes mapping the goals of each policy and determining how they align with broader provincial philosophies and frameworks and with research evidence from the field.

In addition to the ideological and structural differences between provinces, there is also variation in the policy landscape in each province, with differences including the status of dementia strategies, the inclusion of seniors in mental health plans, and the overall focus in
policy documents pertaining to seniors. As discussed earlier and summarized in Table 11 below, no province has expressly focused on older adults within its mental health strategy; instead, children and youth are the focus. At the same time, most provinces are in the process of developing parallel dementia strategies (with the exception of British Columbia, which already has a plan in place), often without an explicit link to existing mental health strategies.

Table 11: Comparison of Policy Landscapes

<table>
<thead>
<tr>
<th>Province</th>
<th>Dementia Strategy/Plan</th>
<th>Seniors included in MH strategy</th>
<th>Overall Focus in Landscape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta</td>
<td>In progress</td>
<td>Seniors with complex health needs and/or addictions or mental health challenges</td>
<td>Aging in place</td>
</tr>
<tr>
<td>British</td>
<td>x</td>
<td>Mental health promotion for seniors through age-friendly communities</td>
<td>Aging well / health promotion</td>
</tr>
<tr>
<td>Columbia</td>
<td></td>
<td>Broadening routine screening for older adults by 2016</td>
<td></td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>In progress</td>
<td>Improving education to providers in the area of seniors' mental health</td>
<td>Positive aging</td>
</tr>
<tr>
<td>Ontario</td>
<td>Historical strategy</td>
<td>No specific recommendations, although implementation of guiding goals across lifespan would benefit older adults</td>
<td>Aging at Home</td>
</tr>
<tr>
<td></td>
<td>(1994-2004); no current strategy</td>
<td>Document references the need to integrate dementia services and develop best practices and standards that promote the recovery philosophy</td>
<td></td>
</tr>
</tbody>
</table>

The parallel process of developing dementia strategies speaks to the relationship between dementia and mental illness in each province. Articulated differently by various key informants, the takeaway message is that historical legacies, funding mechanisms, and clinical service systems influence the way dementia and mental illness are integrated or (more typically) separated in the policy landscape. This division persists, despite the frequency of comorbidities in late life and the complexity of clinically disentangling the cause of symptoms. Explanations
from key informants for this split, along with a comparison of the innovations or best practices in each province as well as the gaps in the policy landscape, are presented in Table 12.

To answer my second research question I also explored how theory informs policy decisions in the areas of seniors and mental health. The movement towards evidence-informed policy making should also include the integration of theory as an interpretive tool. Applying gerontological theory can help to uncover implicit themes about the value of seniors’ mental health. Using the political economy theory of aging as a lens, it could be interpreted that society does not value those aging with dementia and/or mental illness, given the lack of health policy that speaks directly to these populations. Particularly for those seniors falling between the gaps in services, the accumulation of disadvantage is a concern, and the risk of social inequality rises. The moral economy perspective also helps to illustrate the ways in which the social construction of fairness, justice, and social obligations (Kail et al., 2009) influences decisions related to the distribution of resources, particularly in the context of concerns about sustainability and equity across generations. As noted in Chapter 5, equity has been a common concern for decision makers, reflected in many policy documents and in fact used as justification to prioritize other groups over older adults. Using the political economy critical theoretical perspective also invites a challenge to the status quo, suggesting a need to focus on action to improve conditions for those aging with mental illness and dementia.

Components of the life course theoretical perspective can be seen to influence the policy landscape too, although it could be argued that they are used selectively and outside their original context. For example, the idea that aging is a lifelong process aligns with the idea of focusing on children and youth in mental health policies, and may support the idea of a return-on-investment philosophy. Additionally, the belief that people have agency and are active in the construction of their own lives is used as a rationale for residualism in social welfare policies. That is, the belief that individuals have primary responsibility for their own health and wellness leads to the conclusion that they should not rely on the state for support in domains in which
they have active agency. While these ideas are important components of the life course theoretical perspective, they are not integrated with other key components of the theory. The life course theoretical perspective frames lives as linked and interconnected and focuses on relationships (Bengston et al., 2005). Using this lens as a guiding framework, it would seem obvious to focus on the mental health of older adults within the policy landscape. Recent research has demonstrated the impact of being a caregiver for an older adult with responsive behaviours (aggression, agitation etc.) and the resulting risk of burnout (CIHI, 2011). Typically these behaviours are the result of cognitive impairment and/or mental illness, and yet these are the groups that are consistently identified as a gap within the services system and policy landscape.

Furthermore, society is on the cusp of a historical shift in demographics. The fact that the baby boom generation, one that has higher rates of mental illness than any previous generation, is aging into a period of heightened vulnerability for particular mental illnesses should be a factor that shapes policy development, and yet lags persist. This is a precedent-setting time; the aging of the population should be seen as a historical context that shapes policy priorities. If seniors' mental health issues are not well addressed in policy during a time when there is a critical mass of older adults, it is concerning to think about the value placed on future generations of older adults. The life course theoretical perspective also reminds decision makers of the importance of social structures in shaping the experience of aging.

7.1.3 Research Question #3

My final research question builds on the previous two and explores who is served well under current policies and what gaps or limitations exist that could be remedied in future policy development.

The context and processes that create these policies influence the content tremendously; however, it is interesting to note that despite contextual differences, there are
shared challenges across provinces. In particular, regardless of the ideology, governance structure, or social welfare model in place, gaps in services for seniors with severe and persistent mental illnesses are a shared concern across provinces. Additionally, key informants in each sample province and across the continuum of services discussed the need for services for individuals with behavioural and psychological symptoms of dementia. It is interesting to note both populations being identified, as the complexity of symptoms is typically the challenge to address. Perhaps a policy landscape that responds to complexity in late life is also one that has an integrated view of mental illness and dementia, wherein the diagnosis itself matters less than how a person is supported throughout the service system. It could be argued that the dichotomy between mental illness and dementia presented in the policy landscape exacerbates the challenge of aligning services and in fact widens the gaps in services, allowing more seniors to fall through the cracks.

Within each province there were examples of innovation in the policy landscape and the application of best practices in seniors’ mental health. These are summarized in Table 12, which shows the diffusion of innovation and sharing of best practices across provinces. Although none of the listed innovations have completely addressed the gaps in provincial policy landscapes, they have contributed to the overall approach to seniors’ mental health in their respective provinces. Through knowledge translation and ongoing communication, these successes could be leveraged and shared further. In particular, when strong evaluation data exist in one province, capitalizing on the opportunity to implement similar strategies could help to reduce the ongoing cycle of pilot projects. Although local context is key to implementation, given many of the shared drivers and challenges, it follows that these innovations could be harnessed and implemented with appropriate adaptations in other jurisdictions/regions. It should be noted that regionalization was a key feature of the implementation of the Behavioural Supports Ontario initiative, wherein each Local Health Integration Network determines its own model based on local needs, but shared values and principles guide all decisions across the province.
Conversely, key informants in Alberta credited the centralization of Alberta as a key component of the success of the Strategic Clinical Networks. Learning from the Seniors’ Mental Health Network in Nova Scotia could offer a mechanism to understand networks in a regionalized jurisdiction.

Table 12: Comparison of Policy Content & Themes

<table>
<thead>
<tr>
<th>Province</th>
<th>Innovation / Best Practices in Seniors’ Mental Health</th>
<th>Gaps</th>
<th>Key informant perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta</td>
<td>• Strategic Clinical Network</td>
<td>• Behavioural and psychological symptoms of dementia in long-term care</td>
<td>“There is a dichotomy where the mental health community is not that interested in dementia…” (Key informant B)</td>
</tr>
<tr>
<td></td>
<td>• P.I.E.C.E.S</td>
<td>• Access to long-term care</td>
<td></td>
</tr>
<tr>
<td>British Columbia</td>
<td>• Seniors’ Advocate and Ombudsperson Reports</td>
<td>• Gaps between mental health promotion and the mental health system</td>
<td>“The issue of dementia or Alzheimer’s … is it a mental health issue? In B.C. [we’re] saying no. It is a part of aging - it is a physical condition, it’s not a mental health condition. It is an organic condition.” (Key informant D)</td>
</tr>
<tr>
<td></td>
<td>• Pilot project in flexible home care services</td>
<td>• Lack of implementation of Ombudsperson’s reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Seniors with severe and persistent mental illness</td>
<td></td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>• Seniors’ Mental Health Network</td>
<td>• Community-dwelling seniors without medical needs</td>
<td>“There is a split between seniors’ teams and mental health teams.” (Key informant I)</td>
</tr>
<tr>
<td></td>
<td>• Care by Design Initiative</td>
<td>• Comprehensive Behavioural Supports plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• P.I.E.C.E.S</td>
<td>• Seniors with severe and persistent mental illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Care by chance instead of care by design</td>
<td></td>
</tr>
<tr>
<td>Ontario</td>
<td>• Behavioural Supports Ontario</td>
<td>• Seniors with severe and persistent mental illness</td>
<td>“There is a bit of debate about how dementia is viewed. Is dementia a medical condition or a mental health condition?” (Key informant F)</td>
</tr>
<tr>
<td></td>
<td>• P.I.E.C.E.S</td>
<td>• Home care for seniors with behavioural and psychological symptoms of dementia</td>
<td></td>
</tr>
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</table>
7.1.4 Making Sense of the Data – What Can We Learn?

Returning to the guiding research question for this project, I now ask: *How have provinces organized their extended healthcare services (specifically focused on long-term care and home care) to support older adults with mental health issues?* Beyond the themes emerging from the relationship of provincial contexts and their relationships to the content of its policies, perhaps the most pressing finding is the consistent lack of focus on seniors’ mental health within the policy landscape. Although health is a prominent topic in each province, mental health is still coming out of the shadows. This is a theme across provinces, and, more broadly, nationally and internationally. The slow emergence of mental health policy is also affected by ageism, and thus it is not surprising that seniors’ mental health policy is still underdeveloped.

The common saying that there is “no health without mental health” does not seem to have permeated the policy decision-making environment. The health expenditures on an aging population are a source of concern for all governments sampled. A proactive approach to seniors’ mental health might be a key component for improving the health of an aging population, and yet this approach remains underrepresented in policy.

More simply, I argue that despite a clear need, public interest, and evidence available to promote seniors’ mental health, current institutions and historical policy legacies result in a lack of support for older adults with mental health issues in the extended health services policy frameworks in sample provinces. To uncover this phenomenon, the “3-i” Framework can be utilized; it posits that interests, ideas, and institutions shape policy decisions and processes (Gauvin, 2014). In the case of seniors’ mental health, it is clear that interest exists amongst societal groups. This interest is evidenced by the push for attention on seniors’ care and dementia care by advocacy groups, which may, in turn, also push forward the interest in seniors’ mental health; however, the lack of political will seems to outweigh public and advocate interest. When examining interest in a policy issue there should be an analysis of who benefits as a result (Gauvin, 2014). Although outside of the scope of this research, a more thorough
analysis of interests would include perspectives from seniors, caregivers, provider groups and associations to help illustrate the overall support and conflicting interests in seniors’ mental health.

Understanding how ideas including knowledge, evidence, values, and culture can influence policy decisions is also a valuable lens for analysis (Gauvin, 2014). While there is a growing body of literature on innovative approaches in seniors’ mental health (see Brodaty & Arasarantham, 2012; CCSMH, 2006; Chappell, 2009, Collier, 2005; Draper & Low, 2004; Markle-Reid, 2006; 2008; Markle-Reid et al. 2011) the evidence often falls short of the policy level or exists only on a theoretical level, without evidence of examples of implementation. Ideas and evidence from other health domains appear to influence decisions as well. Using mental health policies as an example, the current focus on children and youth and the “return on investment” mindset outweighs the focus on seniors’ mental health. However, an analysis of ideas should also include an assessment of the costs, and the demographic imperative should shift the focus to older adults. There is a clear need for policy and services across the agespan and policy should reflect this need.

Additionally, the lack of theoretical lenses is a gap in the application of policy ideas. The lack of gerontological theory in discourses on aging and seniors’ mental health is not surprising; however, it speaks to the lenses and perspectives that guide decision making and the policy environment. Perhaps of greater importance is how values and cultures influence policy decisions. A provincial government’s political ideology, values, and related approach to social welfare may dictate a policy option that is not in the best interest of seniors living with dementia and/or mental illness. For example, within a residual model of social welfare where individual responsibility is paramount, only a very small proportion of the “deserving few” receives support from the government (Lightman, 2003). Merit models too may disadvantage those seen as less deserving either by nature of their illness or their financial status (Graham et al., 2012). Moreover, the current ideological thinking shared across sample provinces about the
development of policies, programs, and services that are fair and equitable for future
generations pits generations against one another, often to the detriment of older populations
(Gee, 2002). Despite the knowledge and evidence about seniors’ mental health, the values and
cultures of provincial governments seem to override policy decisions in this arena.

Finally, the third set of factors that shape policy decisions under the “3-i” framework is
institutions, including government structures, policy networks, and policy legacies (Gauvin,
2014). Within this research, the influence of institutional structure has been a significant theme.
Before discussing provincial government structure, it is also worth noting that Canadian
federalism is an important institutional structure that affects how policies in the areas of seniors
and mental health are developed. Additionally, as explored in Chapter 4, the fact that seniors’
mental health has no “home” and is not within the mandate of particular government structure or
organization opens the door for it to be off the policy radar screen. The division of seniors’
mental health and dementia within the sample provinces is also reflective of policy legacies that
viewed the two concepts as discrete and distinct, despite the fact many older adults live with
comorbidities.

The components of the “3-i” Framework help to shed light on the factors that influence
decision-making in seniors’ mental health. Pal (2010) suggests that gaps in the policy landscape
speak volumes about the perceived value of a potential problem, noting that if the problem is not
recognized at all there will be a minimal policy response. Following Pal’s reasoning, it could be
inferred that there is little value in addressing seniors’ mental health through an examination of
the current policy landscape. Conversely, using the “3-i” Framework has demonstrated that
there are interest and ideas in this area, but perhaps institutions have not yet been open to
change in this policy arena. Policy legacies, political ideology, and perhaps ageism and
apocalyptic demography are factors to consider when exploring why seniors’ mental health has
not gained traction. It is also plausible that seniors’ mental health is viewed as an intractable
policy dilemma, and the state of policy evidence does not yet provide concrete guidance for decision makers.

In light of this possibility, building on the analysis of the “3-i” Framework and my research questions, the following section presents considerations and recommendations for future policy development.

7.2 Recommendations for future policy development

As noted earlier, critical perspectives as well as a personal commitment and desire to improve the policy response to individuals aging with dementia and mental illness guide my research. When gaps in the policy landscape are found, in order to make change it is necessary to make them visible so they will be recognized (Pal, 2010). In recognition of the opportunity this potential policy window creates to offer recommendations for change, the following are points of consideration for provinces, regions, or jurisdictions interested in improving their policy response to seniors’ mental health. A summary of recommendations and their relationship to my research questions is presented in the table below.
Table 13: Summary of Recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Relationship to Research Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Within provincial government structure, seniors’ mental health should ideally be articulated as a responsibility of a particular ministry or at least explicitly shared amongst ministries.</td>
<td>RQ1</td>
</tr>
<tr>
<td>2. Dementia and mental illnesses, while perhaps distinct in some individuals, should be fully integrated in policy documents and service systems</td>
<td>RQ 2</td>
</tr>
<tr>
<td>3. The Seniors’ Mental Health Policy Lens and/or Guidelines for Comprehensive Mental Health Services for Older Adults in Canada should be used to guide future policy making and assess current policies and systems.</td>
<td>RQ 2</td>
</tr>
<tr>
<td>4. Gerontological theory should be integrated into policy development and its use should be explicit and transparent.</td>
<td>RQ 2</td>
</tr>
<tr>
<td>5. Existing evidence should be used to support policy development in the areas of continuing care to support older adults with mental illness and/or dementia.</td>
<td>RQ 2</td>
</tr>
<tr>
<td>6. Older adults should be active partners in the policy making process.</td>
<td>RQ 2</td>
</tr>
<tr>
<td>7. Provinces should contribute to the systematic evaluation and understanding of the value of regionalization versus centralized health care.</td>
<td>RQ 2</td>
</tr>
<tr>
<td>8. Canada needs a comprehensive seniors strategy, developed in conjunction with provinces/territories, which focuses on the social determinants of health and mental health.</td>
<td>RQ 3</td>
</tr>
<tr>
<td>9. Across provinces, as an extension of the insured health services, home and continuing care should adhere to the program criteria of the Canada Health Act (with a focus on comprehensiveness, universality, and accessibility).</td>
<td>RQ 3</td>
</tr>
</tbody>
</table>

**Consideration #1: Seniors’ mental health matters**

A common theme across provinces was that seniors’ mental health had no “home” in the policy landscape. Given the youth focus in mental health strategies and the lack of emphasis on mental health in aging strategies, seniors’ mental health was not seen as any party or department’s responsibility. This is a structural gap that creates a perfect storm for seniors to fall between the cracks in the policy landscape. As we move into a time when the proportion of older adults is higher than ever before, it is time to ensure that seniors’ mental health is adequately addressed in the ministerial structure. While there is some debate over the proper
“home” for seniors within the organization of government, an ideal arrangement would be that seniors’ mental health would be articulated within the mandate of a particular ministry.

**Recommendation:** Within provincial government structure, seniors’ mental health should ideally be articulated as a responsibility of a particular ministry or at least explicitly shared amongst ministries.

**Consideration #2: Dementia versus mental illness**

Framing dementia as an organic brain disease or a medical illness, and outside of the domain of mental health/illness, has created a false dichotomy. Although diagnostic labels serve many purposes, in the case of seniors’ mental health these labels can actually create barriers to services for older adults given the way systems are structured with distinct divisions between mental illness and dementia. Shaping policy around the individual experience and support needs, as opposed to diagnosis, would serve to support older adults and their families more fully. The reality for many older adults with dementia is that they live with comorbidities such as depression. Fully integrated policies would help to address the complexities of seniors’ mental health and would offer a more seamless experience for the older adult living with mental illness and/or dementia.

**Recommendation:** Dementia and mental illnesses, while perhaps distinct in some individuals, should be fully integrated in policy documents and service systems.

**Consideration #3: Using theory, research, and tools to support change**

While many of the recommendations presented in this section are aspirational, perhaps appearing out of current reach, strong tools and evidence already exist. These include the Seniors’ Mental Health Policy Lens (MacCourt, 2009) and accompanying implementation toolkit, and the *Rising Tide Report* from the Alzheimer Society of Canada (2010), which offers evidence
for policies to support individuals with dementia. Additionally, available research from the Mental Health Commission of Canada is available and can lay the groundwork for the necessary components of mental health policy. These resources include: *Towards Recovery & Well-Being: A Framework for a Mental Health Strategy in Canada* (MHCC, 2009); *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (MHCC, 2012); and the *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* (MacCourt et al., 2011). In particular, the *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* offers policy recommendations with a specific focus on older adults and offers an integrated approach to dementia and mental illness.

**Recommendation:** The Seniors’ Mental Health Policy Lens and/or *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* should be used to guide future policy making and assess current policies and systems.

These resources can be complemented with the explicit use of theoretical perspectives. Despite the movement towards evidence-informed policy making, policy makers, by and large, have remained atheoretical in policy development. Specifically, in the case of policy development in seniors’ mental health, critical perspectives such as the political economy theory of aging can help to ensure that the cumulative impacts of policies are acknowledged and considered. In particular, consideration of diversity and intersectionality will be a necessary component of future policy development given the heterogeneity of the aging population. Furthermore, the application of the life course theoretical perspective would strengthen policy making in seniors’ mental health as it highlights the importance of social structures and historical context as well as individual experiences and meanings.

**Recommendation:** Gerontological theory should be integrated into policy development and its use should be explicit and transparent.
Policy makers can also look to existing successful models in addition to theory and resources. As noted earlier, there is a need to move away from the pilot project mentality and to implement sustained programs and policies that have a strong evidence base. As an example, work from the Canadian Research Network for Care in the Community (Williams, et al., 2009), adapted from the *Shifting the Balance of Care* initiative in the United Kingdom (Challis & Hughes, 2003), as well as the *Veterans Independence Program* (Struthers, 2007) can offer support for home care services that better address the needs of older adults with mental illness and/or dementia.

**Recommendation: Existing evidence should be used to support policy development in the areas of continuing care to support older adults with mental illness and/or dementia.**

**Consideration #4: Involving older adults in the policy making process**

Two distinct but related trends encourage the participation of older adults (including those with lived experience of mental illness/dementia) in the policymaking process: first is the movement towards citizen-engaged policy making (OECD, 2001), and second is the push for the development of a recovery-oriented system (MHCC, 2012). Both prioritize the involvement of individuals in the policy making process to ensure that decisions align with the needs and wants of affected individuals and to flatten the hierarchy of decision making. True engagement is important to ensure that older adults are not “token” participants in the policy making process and are instead seen as partners with key insights into the experience of aging and living with mental illness.

**Recommendation: Older adults should be active partners in the policy making process.**
Consideration #5: Regionalization versus centralization — Does it matter?

Across Canada, the debate over regionalized versus centralized administration of health services continues. This was exemplified in the most recent Ontario election, in which multiple parties campaigned on the promise to disband the Local Health Integration Networks. Similarly, in the 2013 Nova Scotia provincial election, a key campaign promise of the Liberal Party was to reduce the district health authorities from ten regions to two zones, with an estimated savings of $13,000,000 for the province (Liberal Party of Nova Scotia, 2013). As of April 1, 2015, the existing district health authorities will be consolidated into one unified provincial authority (“District Health Authority Consolidation,” 2015). This seemingly never-ending debate on health care administration and organization could be minimized with strong data on the “best” organization for both individuals and the broader health system. In the absence of such evidence, it is likely that debates will continue. Based on the restructuring experiences in Alberta and British Columbia, it is clear that the risk of “change fatigue” is high along with confusion about leadership and accountability, and difficulties planning for the future, as well as a general distrust of and disengagement with healthcare providers (Born et al., 2013). As we move into a period when there are more seniors than ever before, there is no time for confusion or disengagement. Healthcare systems and policies will serve older adults and their families best when there is clarity and accountability. There are strengths to both regionalized and centralized healthcare systems, but the ongoing restructuring delays progress and processes. Evaluating existing systems and policies on a systematic basis can offer best practices in policy design that can be shared across provinces, regardless of their administrative structures. In particular, tailoring approaches to the local context and using networks to create a unified province-wide approach appear to be critical success factors that are relevant for both regionalized and centralized systems.
Consideration #6: Seniors care — Is it enough?

The Canadian Medical Association and other national bodies such as the Canadian Nurses Association are championing a national seniors’ care strategy. While this would be a significant shift in the current national policy landscape, based on this research I would challenge the idea of seniors’ care as a comprehensive framework. Is seniors’ care enough? Does “care” imply a reactive approach in line with the ongoing medicalization of aging? A more comprehensive and holistic seniors strategy would include care, but would also be broadened to include health and mental health promotion and would be inclusive of the social determinants of health. This recommendation aligns with Chappell’s (2009) recommendation that urges an upstream approach to mental health promotion along with ensuring that healthcare providers be educated on the social determinants of health. Valuing the lived experience of mental illness, a social determinants approach would align with the work of Kirby and Keon (2006), who cited compelling witness testimony about the importance of social determinants in preventing and treating mental illness in their seminal report on the state of mental health and mental illness in Canada. A holistic strategy could be presented within an “Aging Well” approach, which includes the social determinants of health. Such a strategy could be used as a tool to reduce social inequality among older adults with mental health issues. A broader strategy focused on aging (versus care alone) also diminishes the idea that aging is an illness and moves away from the prominent theme of medicalization as a philosophical approach to seniors’ mental health. Clear messaging that frames aging as a universal process rather than a social problem would be a key component of this strategy.
Currently, Canada has a national mental health strategy and a framework for suicide prevention, and is in the process of developing a dementia strategy. Adding a separate seniors strategy opens the door for “strategy fatigue” and runs the risk of defaulting to these other strategies in the domains of mental health and dementia. A truly comprehensive seniors strategy would leverage the recommendations and knowledge produced in these earlier frameworks and would integrate fully into a tailored strategy focused on aging well.

Recommendation: Canada needs a comprehensive seniors strategy, developed in conjunction with provinces/territories, which focuses on the social determinants of health and mental health.

Consideration #7: Continuing care as part of the broader healthcare system

This research has focused on policies in the areas of home care and long-term care; however, the alignment of these sectors with broader policies in health, mental health, and aging offers important insights for the policy making and for consideration of seniors’ mental health. Throughout the research process, it became apparent that priorities in other sectors had significant impacts and directed priorities in home and long-term care, such as the focus on reducing alternate level of care days in acute care, the goal of emergency room diversions (both from long-term care and home settings), and the focus on strengthening primary care. What is happening in home and long-term care needs to be understood in the overall context of provincial policy landscapes and healthcare systems and this can be complicated by the fact that home care and long-term care are designated as extended healthcare services. While there is no expectation that the Canada Health Act will be amended to include home and long-term care among its insured health services, in my view seeing these vital components of the service system for older adults as part of the bigger picture of services would be a natural extension for decision makers. The private market plays a significant role in the delivery of home and
continuing-care in the sample provinces, and access is increasingly less universal. Given the data about home care use and the demographics in long-term care, it is clear that home and long-term care are necessary healthcare services, and thus provinces should strive to adhere to the concepts of universality, comprehensiveness, and accessibility despite their designation as extended health services. In doing so, there would likely be a shift in dominant social welfare models, moving further away from residualism and industrial achievement-performance models, and more towards an institutional redistributive model that views social welfare as a key institution in a society where health and social services are universal and outside of the private market and based on need (Graham et al., 2012).

**Recommendation:** Across provinces, as an extension of the insured health services, home and continuing care should adhere to the program criteria of the Canada Health Act (with a focus on comprehensiveness, universality, and accessibility).

### 7.3 Strengths, Contributions, Limitations and Future Directions

This research adds to the relatively sparse knowledge base on methods in applied health policy analysis. As explained by Mallinson and Misfeldt (2015), there is a dearth of practical guidance on conducting comparative policy research, particularly in the context of “real world research” where there are shifting priorities and ongoing political changes. Additionally, this research adds to the body of literature on the use of the Policy Triangle Framework (Walt & Gilson, 1994) as a method, as well as integrating both gerontological theory and conceptual and philosophical approaches to social welfare into policy analysis.

The political economy theory, which draws from many disciplines but is predominantly rooted in economics and politics, is the foundation of the Policy Triangle Framework (Walt & Gilson, 1994). In the context of gerontology, aging is added as a lens to the political economy perspective, focusing in particular on social institutions that reproduce and perpetuate
inequalities (Estes & Associates, 2001). I would argue that my complementary use of the life course theoretical perspective of aging is unique in this analysis and is a contribution to the field. As noted earlier, this dovetailed theoretical perspective to examine policy in gerontology is still an emerging practice. My experience using a macro level theory and a linking theory (one that includes macro and micro levels) was positive and I feel it strengthened my analysis as it broadened the scope of my thinking and encouraged me to consider structures and institutions and the influence of these within social and historical contexts to consider impacts on the individual experience of aging.

Tenets of the life course theoretical perspective were critical in my development of themes and key findings, particularly in terms of considering social and historical contexts of policies and policy legacies and the connections between individuals and their experience of aging within social/historical contexts. In particular, given the structural lags that have attributed to gaps in services and policies in home and long-term care, the life course theoretical perspective is especially useful to illuminate the impacts on individuals and to encourage decision makers to remember that social structures shape the individual experience of aging. Furthermore, the use of the life course theoretical perspective helps to counteract ‘return on investment’ arguments, as exclusion of seniors within mental health policies fails to consider a significant portion of the lifespan and the population. This is particularly necessary as healthcare decisions are currently being made within the context of an aging population.

This research is the first of its kind in Canada: in addition to methodological and theoretical contributions, it makes practical advances in bringing together the discourses around aging and mental health in order to identify new organizational possibilities. While there are recent reviews of provincial mental health strategies (see, for example, National Collaborating Centre for Healthy Public Policy, 2014) and population aging frameworks (Wilson et al., 2012), this is the first study that examines how provincial policy making might intersect in these domains. Furthermore, the additional focus on home and long-term care, and particularly
seniors’ mental health, extends this analysis to domains that have not been well addressed in the policy landscape. This contribution is both timely and relevant, in light of the recent calls for a national focus on both brain health and population aging. Should government (at any level) proceed with policy development in the area of seniors, this analysis may serve to highlight key gaps in the policy landscape and offer directions to minimize those gaps in the future. In doing so, this research helps to bridge policy areas that have traditionally been separated (aging and mental health, dementia and mental health, continuing care and mental health) and opens the door for knowledge translation across regions in Canada. In particular, the identification of innovative practices across jurisdictions offers concrete examples to regions seeking to make change.

Despite these contributions, there are limitations to this work. Most notably, this research focuses on only four provinces in Canada, and there are undoubtedly lessons to be learned from the excluded provinces and territories. Additionally, while diversity and difference are not the focus of this work, intersecting diversities are critical to consider when it comes to the care of, and policies for, older adults with mental health issues. This lens is admittedly underrepresented in this policy analysis and would be strengthened, in particular, with lessons from Francophone communities, Aboriginal and immigrant communities, and other diverse communities. Furthermore, ensuring that a disability lens is used would be inclusive of those with physical, mental, and developmental differences, helping to fill a current gap in the seniors’ mental health policy landscape. The geographic diversity of the landscape in Canada is also an important consideration, and a particular examination of how older adults in rural and remote regions are served in policies is also a gap in this work.

In the spirit of transparency and reflexivity, there are other important lessons to be learned from this research for researchers engaging in applied health policy research. Described as “bumps in the road” by Mallinson and Misfeldt (2015) in their recent policy analysis, unexpected challenges were encountered during this research. These included
challenges with feasibility, setting boundaries around what are considered “significant” issues in each province, and what is considered policy (e.g., is a framework policy?), and finding consistency amongst language used and in the policies across provinces. Perhaps the most pressing challenge was the experience of researching in real time. Mallison and Misfeldt adeptly summarized this challenge as ongoing “organizational churn” and the timing challenges associated with policy publications and shifts in the politics stream. In my own experience, keeping up with the ongoing changes in policy context in four provinces over multiple years was an onerous, but worthy task. The fear for many researchers is that work will instantly become out of date when published, and this concern is relevant in policy analysis as well. Change can be swift and significant, and the use of the Policy Triangle Framework helps to map out what affects the policy decision making process and how. Mallison and Misfeldt also cite the challenge of vertical inconsistency, whereby policies do not always match what is happening on the ground. While my work incorporates key informant perspectives from outside government to help illuminate these differences, the voices of older adults and caregivers are missing. These perspectives would undoubtedly offer additional insights into the policy landscape and the reality of life for individuals aging with mental illness and/or dementia.

Finally it should be noted that as a researcher with a critical perspective, my own viewpoints and experiences shape my understanding of this work. Pulling together this diverse data is a challenge in policy work, and it is important to acknowledge that my analysis attempts to highlight relevant issues and considerations for policy makers, rather than trying to offer causal explanations and make direct links. This analysis offers one interpretation of the data and, aligning with a critical realist philosophy, it is understood that the complexity of these policy dilemmas does not occur in a vacuum and instead is shaped continually by individuals, science, and social structures.

In light of these contributions, and recognizing the limitations of this work, there are opportunities to expand on this research. As a next step, expanding this analysis to other
provinces and territories would offer a more comprehensive understanding of the shared challenges in policy making in seniors’ mental health. This would potentially open the door to collaborative work to find solutions and build strong policy across the country. An expansion of this work would also help to identify other pockets of innovation and application of best practices, again building opportunities for knowledge translation and collaboration and building the collective evidence base. Another important expansion of this work would be to add the lived experience of older adults and caregivers into this analysis. These perspectives would strengthen our understanding of policy impacts and would potentially generate new priorities for policy making in seniors’ mental health.

Finally, as many provinces and the federal government continue to move forward with standalone dementia strategies/plans, a key next step in the research process would be to find mechanisms to build bridges to integrate these dementia strategies more fully into the seniors’ mental health policy landscape and service system.

7.4 Conclusion and Final Thoughts

Health policy in Canada is a fundamental component of our collective national identity. As we enter an era of demographic change, this is a crucial time to ensure that the aging population is sufficiently addressed in health and mental health policies. While there are unique contextual differences between the different regions of Canada, this research has highlighted that there are shared challenges, as well as shared policy and system gaps, when it comes to seniors’ mental health. There is now an opportunity to capitalize on the current policy window and to leverage national platforms and networks to collaborate to address these shared challenges and gaps. Demography is a convincing argument for addressing seniors’ mental health, but it is also important to recognize that the landscape is always being shifted and influenced by political ideologies and socio-political climates.
Perhaps a critical success factor for making change in the seniors’ mental health policy landscape is to find an influential champion. Walt and Gilson (1994) emphasize that actors are significant influencers in how policy processes evolve. While there has recently been traction in dementia policies, a credible champion who views seniors’ mental health broadly and as a key Canadian health and wellness issue is still lacking; and, as a result, seniors’ mental health policy remains invisible.

In terms of future policy development, a life course perspective is recommended. While investing in children and youth is necessary and will have an impact on later generations, to solely focus on children is a short-sighted approach. The current generation of older adults and the aging baby boom generation require a proactive approach to mental health policy; not responding adequately will have significant costs to individuals, families, systems, and society.

Decision makers, and the public more broadly, should keep in mind that aging should not be seen through a disease-focused lens; instead, the phenomenon of population aging should be viewed as a success of our time. For those working in the field of gerontology there is a strong emphasis on maximizing quality of life for individuals despite challenges that may accompany transitions common with aging. How society responds to such challenges can deeply influence and shape the individual experience of aging, as well as the experience of caregivers. Policy that focuses on maximizing quality of life cannot adequately designed and implemented without addressing mental health. This research offers insights into the policy landscape in seniors’ mental health and proposes recommendations that could improve the experience of aging with a mental illness/dementia. In order to build a society that is just, fair, and one that values and promotes the health of its older population, seniors’ mental health must be addressed within government policy.
References


Adults and Mental Health Care. The New England Journal of Medicine, 368(6), pp.493-
496

from: http://brainxchange.ca/Public/Resource-Centre-Topics-A-to-Z/Behavioural-
Supports-Ontario.aspx

Bell, R. (2014, October 11). Move over, AHS — Alberta Premier Jim Prentice says he
knows first-hand what’s wrong with health care. Retrieved from:
http://www.calgarysun.com/2014/10/11/move-over-ahs--alberta-premier-jim-prentice-
says-he-knows-first-hand-whats-wrong-with-health-care

Cambridge Handbook of Age and Ageing. (pp. 493-501). Cambridge University Press:
Cambridge.

Bengston VL, Burgess, EO, & Parrott TM. (1997). Theory, explanation, and a third
generation of theoretical development in social gerontology. Journal of Gerontology:
Social Sciences, 52B, S72-S88.

framework for the study of gender and mental health. Nursing Philosophy, 9, 169-179.

Evaluation Findings and Recommendations. Retrieved from:
http://betterathome.ca/sites/default/files/Better%20at%20Home%20evaluation%20report
%20-%20public.pdf

care system. Healthy Debate. Retrieved from:


Canadian Coalition for Seniors’ Mental Health. (2006). *National Guidelines for Seniors’ Mental Health. The Assessment and Treatment of Mental Health Issues in Long-Term Care (Focus on Mood and Behaviour Symptoms)*. Toronto, ON: CCSMH.

for Seniors and their Families. Toronto, ON: CCSMH.


Forest, P.G., & Palley, H.A. (2008). Examining fiscal federalism, regionalization and


Health and Wellness Nova Scotia. (2012). *Together We Can: The Plan to Improve*


Columbia Psychogeriatric Association. Retrieved from:

http://seniorspolicylens.ca/?page_id=65


http://www.chnet-works.ca/index.php?option=com_rsevents&view=events&layout=show&cid=349%3A428


The Mental Health Strategy for Canada. Calgary, AB: MHCC.


National Collaborating Centre for Healthy Public Policy. (2014). *Scan of Mental Health Strategies across Canada*. Montréal, QC: NCCHPP. Retrieved from: [http://www.ncchpp.ca/553/Publications.ccnpps?id_article=1257](http://www.ncchpp.ca/553/Publications.ccnpps?id_article=1257)

doi:10.1371/journal.pmed.1001443


Nova Scotia Health and Wellness. (2012). *Together We Can: The Plan To Improve*


Ritchie, J., & Spencer, L. (1994). Qualitative analysis for applied policy research. In


Statistics Canada. (2012c). Health-adjusted life expectancy, at birth and at age 65, by
sex and income group, Canada and provinces, occasional (years) (CANSIM Table 102-0122). Ottawa: Statistics Canada. Retrieved from http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=3#hale

Statistics Canada. (2013). Table 105-1101 - Mental Health Profile, Canadian Community Health Survey - Mental Health (CCHS), by age group and sex, Canada and provinces, occasional (number unless otherwise noted), CANSIM (database). Ottawa, ON: Statistics Canada. Retrieved from http://www5.statcan.gc.ca/cansim/pick-choisir#F2


http://www.crncc.ca/knowledge/factsheets/pdf/InFocusBoCNovember2009FINAL.pdf

Wilson, D.M. (2008). *Seeking Information on Linkages Between Chronic Illness and Home Care Through an Analysis of Alberta’s Home Care Data*. Retrieved from: 


# Appendix I: Sample Charting Process

<table>
<thead>
<tr>
<th><strong>Research Question</strong></th>
<th><strong>General Notes</strong></th>
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</thead>
</table>
| How have governments (and governmental organizations) taken responsibility for seniors and seniors’ mental health? | Primary responsibility for seniors in the province falls under Ministry of Health. Relevant responsibilities of this Ministry include:  
- Leadership and support for the health service delivery system  
- Health promotion, protection and preventative health  
- Public health planning  
- Provincial Health Officer  
- Performance management of the health authorities  
- Women and seniors  
- Community and home support services  
- Assisted living and residential care  
- Mental health and addictions services  
- Communicable diseases prevention and addictions services promotion  
- Healthy living/chronic disease prevention |
| What is the structure of government organizations and policy-making processes in these areas? | Mental health - Managed through Home, Community & Integrated Care  
- Regions make decisions aligning with the integrated care management strategy |
| What has influenced policy making in these areas? | **Specific from Healthy Minds, Healthy People**  
- Impact of mental health and substance use problems significant  
- Cost of ignoring affects all – 2008/9 data indicates $1.3 billion on services addressing mh/a  
- Indirect costs - $6.6 billion/year  
- Focus on evidence-based practice  
- Government wants to maximize investments and yield long-term positive outcomes and economic gains for individuals, businesses and government. |
| How do provincial policies in home care and long-term care support older adults with mental health problems? | Home is Best program, which aims to help seniors, who otherwise would need residential care, live safely at home and avoid future hospital emergency admissions. The program specifically targets seniors waiting for a residential care bed, or residential care eligibility assessment.  
- More funding for non medical home care supports  
- B.C. Dementia Guidelines |
| Specific Charting Notes from **Healthy Minds, Healthy People – Government of British Columbia** | **What are the goals of each policy?**  
- This ten-year plan provides a framework of population-centred priorities to enable and support change over ten years using practice-based evidence. |
Seniors considered an at-risk population with a focus on dementia, depression and caregiver stress
- Primary care noted as an intervention site
- Relevant outcome measure “By 2016, resources to support broadened routine screening of senior citizens for mental health/substance abuse in all health regions.”
- Focus is on children, youth and adults

Seniors also included in population of interest “People with Mild to Moderate Mental Health Problems” although the focus of the section is on children, youth and adults.
- Highlights need to align existing community capacity to identify and address problems to reduce hospitalizations and residential specialized services

Seniors included in “people with severe and complex mental health disorders”
- Background and prevalence only for children, youth and adults
- Introduction of recovery philosophy
- Goal to enhance community interventions across the lifespan and enhance housing supports
- Focus on develop improved coordinated responses for people with complex challenges

<table>
<thead>
<tr>
<th>How do the policies align with overall provincial philosophies and frameworks?</th>
<th>Links to <strong>Seniors in British Columbia: A Healthy Living Platform</strong> to opportunities to connect older adults to engage in their communities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improving Care for BC Seniors: An Action Plan</strong></td>
<td><strong>Meeting Seniors’ Mental Health Care Needs in British Columbia: A resource document</strong></td>
</tr>
<tr>
<td>- Actions around Standardized Care, Information (focus on dementia and First Link), Flexible Services, and System Redesign</td>
<td>- Meeting seniors’ mental health care needs in BRITISH COLUMBIA; a resource document</td>
</tr>
<tr>
<td>- This plan is the one that will address dementia in older adults and care system including both home care and long term care.</td>
<td>- This document was funded by the government after the release of the 10-year plan as a complement given the lack of focus (and outcry) on older adults in the plan</td>
</tr>
<tr>
<td></td>
<td>- It is intended to be used as a resource for those in the province involved in providing care to seniors, including planners, program managers, policy makers, mental health and other health professionals.</td>
</tr>
<tr>
<td></td>
<td>- This document provides evidence based/best practices for enhancement of the quality of seniors’ mental health services and addresses the implications of new trends and initiatives for the mental health care of seniors, reflecting emerging “best practice”.</td>
</tr>
</tbody>
</table>
| Do the policies align with evidence and research in the field? | • Introduces and advocates for the recovery philosophy  
• In the introduction of this report, it is noted that mental illness affects people ‘of all ages and all walks of life’ but explains that the plan places a strong emphasis on children and families.  
• They rationalize this focus by saying that ‘for the majority, mental health problems originate in childhood, pointing to the need for early intervention to mitigate risk of future illness’ (p.3), contradicting their earlier lifespan approach.  
• They also link to the ‘return on investment’ argument, as a strong foundation in childhood ‘sets the course for a health, fulfilling and productive life … providing personal, social and economic returns” (p.3). (note: clear link to moral economy / political economy theory).  
• Emphasis is placed on listening to the experience of clients and families to inform planning which aligns well with the recovery philosophy (note: given the child focus of the plan – need to determine if older adults were included in that client feedback process – SMHPL).  
• Housing identified as a social determinant of health and discussed a range of housing options for people with severe and persistent mental illness but the focus was on those who are homeless  
\( \text{note: could have been a link to appropriate housing for those in late life – e.g. often can’t live in LTC so are at risk for homelessness or are unnecessarily hospitalized).}  
| What mental health policy gaps or limitations exist that could be remedied in future policy development? | • Dementia seen as distinct from mental illness (dementia is ‘organic’)  
• Other BC initiatives while they may not be labelled as mental health promotion are the ones adding mental health promotion and support for older adults (e.g. Age Friendly B.C)  
\( \text{Note: nothing specific about people living in LTC homes? Specific risks here especially and a place that could have some measureable outcomes).}  
| In the context and action item of the special section on people with chronic disease it is interesting to note that the focus is on children, youth and adults, despite the high rates of chronic disease or compromised health.  
| Who is served well under current policies? | Need to verify with key informants – at this point it seems that seniors are not well served under this mental health strategy.  
| Memos / Notes: | • A real challenge to link to research questions given the clear focus on children and youth and the exclusion of context and concern to home care and long term care  
• Given that this is the overarching mental health plan for B.C. it
is extra important to see how mental health is represented in the policy docs that discuss home care and LTC

- Highlights the need to align existing community capacity to identify and address problems earlier to reduce costly hospitalizations and residential specialized services later on (note: link here to ALC days? Also couldn’t this reduce LTC admissions as well?).
- 680 people will receive Assertive Community Treatment services in the community by 2013). (note: but are older adults included? Often fall outside of inclusion criteria for services).

Life Course perspective

- Interesting because this document intends to use a lifespan perspective but doesn’t consider the linkages to life course
- Can make clear theoretical linkages to how they could have been more inclusive and considered elements of the lifecourse
- Clear linkages to moral economy and political economy – from this policy doc alone the perception of how older adults are treated by policies in health would be very negative
- The only sections that explicitly talk about older adults have the weakest outcome measures
Appendix II: Sample Interview Schedule

Thank you for taking the time to meet with me to support my dissertation research. The guiding research question for this policy analysis is *How have provinces organized their extended healthcare services (specifically focused on long-term care and home care) to support older adults with mental health issues?* Through the examination of policy documents and provincial strategies on mental health, aging, and continuing care, and key informant interviews, my data collection strategy is designed to answer the following questions:

1. How have government (and governmental organizations) taken responsibility for seniors and seniors’ mental health in the sample provinces?
   a. What is the structure of government organizations and policy-making processes in these areas?
   b. What has influenced policymaking in these areas?

2. How do provincial policies in home care and long-term care support older adults with mental health problems?
   a. What are the goals of each policy?
   b. How do they align with overall provincial philosophies and frameworks?
   c. Do they align with evidence and research in the field?

3. What mental health policy gaps or limitations exist that could be remedied in future policy development?
   a. Who is served well under current policies?

Given your roles within [redacted], I’m hoping you can provide context to support my work to date. In particular, I’m interested in the policy directions from *Together We Can: The plan to improve mental health and addictions care for Nova Scotians* and how they fit within the ‘big picture’ of seniors’ mental health policy/strategy in Nova Scotia.

To help with my own understanding of the context I created this flow chart. Can you confirm if this is an accurate depiction of the relevant stakeholders in Nova Scotia?
In 2012, Health and Wellness Nova Scotia launched the first-ever provincial mental health strategy. *Together We Can: The plan to improve mental health and addictions care for Nova Scotians*, is a five-year plan that is focused on health promotion, early intervention, reducing gaps in the system, and improving supports and services.

1. How has the implementation of the Strategy gone? Any barriers? Facilitators?
   a. Improving action in 2014-2015 around education in seniors’ mental health?

2. Thinking about the policy directions of the Strategy / government decisions related to mental health are there key drivers for change?

3. How does evidence inform policy directions?
   a. Are there key sources of evidence?

In terms of the relationship between the Mental Health Strategy and other provincial initiatives:

4. What are the mechanisms for addressing mental health/illness within continuing care?
   a. In particular, do you have a sense of if/how the forthcoming Dementia Strategy will dovetail with the Mental Health Strategy?

5. Thinking about seniors’ mental health, from your perspective, are there any groups that ‘fall between the cracks’ in the current system?
6. If the Mental Health Strategy were being redesigned right now, would you want to see anything done differently?

7. Is there anything you feel is important for me to understand about your current context / environment?
Appendix III: Sample Mind Map – Developing Themes

Dementia versus mental illness

“There is a bit of debate about how dementia is viewed. Is dementia a medical condition or a mental health condition?” (Key informant F - NS)

“Dementia is...”

“Dementia lives....”

“B.C. dementia is...”

“Organic”

“Medical”

“Seniors action plan”

“B.C. dementia guidelines”

“B.C. is a ‘seniors issue’”

“Ontario: BSO – integrated and yet still more BPSD focused”

“Gaps between mental health teams and seniors teams”

“Alberta: policies driven by population aging significant concern re: dementia”

“Nova Scotia: HHR gaps”

“SCNs separate seniors care and brain”

“S & P M.I”

“The issue of dementia or Alzheimer’s... is it a mental health issue? In B.C. [we’re] saying no. It is a part of aging - it is a physical condition. It’s not a mental health condition. It is an organic condition.” (Key informant D – BC)

“‘There is a dichotomy where the mental health community is not that interested in dementia...’” (Key informant A – AB)

“‘There is a split between seniors’ teams and mental health teams.” (Key informant I - ON)