Senate committee hearing on Dementia: CAGP presentation—April 13, 2016

Thank you for inviting the Canadian Academy of Geriatric Psychiatry to contribute to this important study on Dementia in our Society. The CAGP is composed of nearly 300 geriatric psychiatrists who provide clinical care to thousands of persons affected by dementia every day in collaboration with primary care providers, mental health colleagues, geriatricians and other specialists. CAGP members are actively involved in education of future physicians and specialists as well as research.

I am a recently retired geriatric psychiatrist, who helped develop mental health services for the 175,000 seniors of the Champlain region and the francophones of North Eastern Ontario through the U of Ottawa geriatric psychiatry specialty program, which allowed our region to train and retain a critical number of geriatric psychiatrists. I participated actively in Ontario's 5-year dementia strategy, from 2000 to 2005, a strategy that tried to address many of the issues you have heard about so far. I also helped develop a document addressing the specific needs of Long Term Care residents ('Building a Better System for persons with aggressive behaviors') serving as the basis for the Behavioral Support Ontario Program, which greatly enhanced mental health services for persons

affected by dementia. Finally, I was the Chair of the Seniors Advisory Committee of the Mental Health Commission of Canada (which your committee had recommended in 2006) and remain a member of its current Advisory Council. As you may already know, the MHCC has developed our first Mental Health Strategy for Canada as well as 'Guidelines for comprehensive mental health services for seniors in Canada', a document that outlines in some detail the range of mental health services that we hope would be accessible in each province and region for those who live with a mental illness or the psychiatric complications of dementia.

Like almost all Canadian families, my family has been affected by Alzheimer disease. In preparing these remarks on human resources, I used both my personal and professional experiences to reflect on resources that are needed by those affected by dementia and those who care for them over the course of this very long illness. With an early diagnosis of dementia, we have to plan for care and support services to maintain our loved ones at home for approximately 6 to 10 years and accept that the majority of persons with dementia will require a move to a residential or long term care setting for an additional 2 to 6 years, even if the best home support services can be put into place.

In the first stages of the illness, family caregivers and family physicians usually provide most of the care. They, in turn, need access to community support services, including services that encourage socialization and promote healthy habits as well as services that have typically been provided by Alzheimer Societies (education, peer support, family support and day programs for stimulation, socialization and respite). In the first stages of the illness, they also need time-limited support from specialists such as neurologists, geriatricians and geriatric psychiatrists**,** mostly to establish a diagnosis and determine if contributing or aggravating factors can be removed (such as medications that interfere with cognition or treatable illnesses such as depression). For example, geriatric psychiatrists often help determine whether anxiety or depression are the cause or result of cognitive problems or can be treated successfully without worsening dementia, as this will greatly improve the quality of life of the person with dementia and the quality of life of his or her caregivers.

In the middle to late stages of the illness, there is an increased need for respite and residential care services and a higher risk of hospitalization for delirium or caregiver burnout**.** Specialized teams, such as geriatric mental health outreach and community teams, staffed with geriatric psychiatrists, mental health nurses and other health professionals, are

needed to help develop person-centered treatment plans for the highly prevalent behavioral and psychological symptoms of dementia called BPSD. 80 to 90% of persons with dementia will experience BPSD at some point during the course of their illness and behaviors are the major risk factors or predictors for both long-term care placement and caregiver stress. Geriatric psychiatrists are experts in this part of dementia management and, because of this, have an important role in supporting family caregivers and increasing the capacity of staff from Care homes to deal safely with those problems. This helps prevent visits and admissions to hospital.

I was asked to address issues surrounding resources, for example how many more doctors, nurses will be needed.

We will never have enough specialized human resources to directly and longitudinally provide care for all people affected by dementia in Canada. As you have heard already, we need to make sure that all existing and future health care providers have the capacity to provide good mental health care for persons affected by dementia. This includes family doctors and specialists, nurses, occupational therapists, social workers, personal support workers and physiotherapists who will undoubtedly have clients with dementia. In order to do so effectively, they need to have acquired sufficient knowledge and skills during their

university or college degree ***and also*** need to be supported by interdisciplinary specialized services in shared-care or collaborative-care arrangements during their years of practice in community, long term care or hospital settings.

Yes there is a need for more training!

We need to make sure that the educational and training content of all university and college programs that prepare future health professionals include caring for persons with dementia in their curriculum. The Royal College of Physicians has recognized this need for specific training in geriatric psychiatry (which includes caring for persons with dementia) for all its future psychiatrists, in addition to establishing 12 accredited training programs to develop subspecialists.

Recommendation 1: A***s part of a national dementia strategy, it will be important to have a mechanism to monitor whether colleges and universities are providing the kind of knowledge and training that is required by health professionals to care for persons with dementia.***

We also need to have enough specialized mental health human resources (not just geriatric psychiatrists but also clinical nurse specialists,

psychologists, social workers, occupational therapists) to fulfill the following roles:

- have ‘advanced’ knowledge and skills to provide exemplary care in the most challenging situations and, in doing so, participate in the development new knowledge that can be transferred to other caregivers and providers.
- know how to provide support and ongoing education in the form of consultation, mentoring and shared care arrangements to increase the capacity of existing services offered by family physicians, psychiatrists, staff of LTC homes, home care staff, etc...

Specific comments on how many geriatric psychiatrists a successful national dementia strategy would require.

Benchmarks exist to estimate the number of geriatric psychiatrists needed to serve a given population with mental health problems, including persons with dementia and BPSD. Some are described in the Guidelines for comprehensive services for elderly persons in Canada (MHCC, 2011), for example 1 Full Time Equivalent geriatric psychiatrist per 10,000 elderly to do all the work needed in the community (including care homes). Some can be estimated from the study of provincial health regions where geriatric mental health services seem to be able to respond to need, for example the Champlain region in

Ontario (+0.5 FTE per 10,000 elderly for work related to hospitals) or some regions in BC. At this time in Canada, with approximately 250 FTE geriatric psychiatrists (200 recognized by the Royal College), we are at 43% of benchmarks. In the UK, where they have an ambitious dementia strategy, they are at approximately 60% of these benchmarks and they feel they will need more geriatric psychiatrists to meet the needs related to dementia. In parts of Canada where geriatric mental health care is more accessible to persons with dementia and their families, the number of geriatric psychiatrists is consistently above 60% of benchmarks. In these regions, there are also good consultation-liaison and educational services in Long term care homes and acute care hospitals and fewer problems with persons with dementia being admitted to hospital to await placement because of BPSD. It is clear that at 43% of benchmarks, there will not be enough resources available across Canada for the successful implementation of a national dementia strategy that would respond to the needs of my family.

Unfortunately, existing Geriatric Psychiatry training programs for sub-specialists do not have ‘protected funding’ except for one province (Alberta) that has committed to funding geriatric psychiatry R-6 training positions in order to ensure a growing supply for their population. In fact, we are unable to train all the candidates who want to have a career

in geriatric psychiatry and are training fewer than previously. Similarly, the Care of the Elderly family medicine training positions do not have secure funding in all provinces and, with budgets constraints, we will likely see a decrease in the number of Care of the Elderly family physicians who are important partners when it comes to dementia care.

Due to time constraints, I will not expand on the other recommendations. However, I would be open to discuss the need to address mental health human resources and long-term care and residential options for persons living with dementia.

To summarize, CAGP recommends:

2. An increase of specialized geriatric mental health resources and a sufficient number of funded Residency training positions in geriatric psychiatry.

3. In the context of the National Strategy for mental health, the Mental Health Commission of Canada in collaboration with Health Canada and the Canadian Institute for Health Information should be tasked with a study that would provide a more specific human resources plan for the mental health strategy, including a specific study that addresses the needs of its rapidly growing older population and foreseeable needs in regards to dementia care.

4. Expand and increase the availability of high-quality home care and Long term care.

5. Improve the quality of life of Canadians who currently reside in LTC homes and those who will need LTC in the future due to dementia.

In summary, information such as the Guidelines for MH services for seniors in Canada, MHCC mental health strategy and some model services for dementia do exist. The challenge has been to convince health ministries to fund the range of mental health services that would help maintain a viable health system while also addressing the growth of its elderly population. We urge your committee to consider a recommendation to earmark some of the federal transfer payments in the upcoming health accord to address this issue specifically.