FACTORS AFFECTING THE MENTAL HEALTH OF OLDER ADULTS IN RURAL AND URBAN COMMUNITIES: AN EXPLORATION

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ABSTRACT

Stakeholders in rural and mid-size urban communities were asked to share their views concerning factors that affect the mental health of older adults, and indicate how, and how well, these factors were addressed in their community. The identified factors clustered into six categories: clinical, physical, organizational, educational, psychosocial, and spiritual. Additional factors impacting care providers and caregivers and their ability to support the mental health of older adults also emerged. Similarities and distinct differences between rural and urban communities were reported and call for innovative strategies to meet the needs of seniors, particularly those living in rural areas.

While the majority of older adults in Canada enjoy good physical and mental health, a significant percentage experience mental health problems, leading to a wide range of special health needs. Current estimates of the percentage of elderly people in need of mental health services range from 10 to 30% (British Columbia Ministry of Health and the Ministry Responsible for Seniors, 1992). Although literature exists that describes some Canadian community-based geriatric outreach programs designed to address these needs (Stolee, Kessler, & Le Clair, 1996; Wargon & Shulman, 1987), there is little documentation on the breadth of factors that contribute to the mental health of older adults in Canada.

Research from the United States suggests that the mental health needs of elderly people living in rural areas may differ from those living in urban centres (Yawn, Bushy, & Yawn, 1994). A review by Abraham, et al. (1993) indicates that a higher prevalence and risk of mental health problems is reported for rural populations compared to urban populations. Furthermore, there is some evidence that those living in rural areas are less likely to receive needed mental health services (Smith & Buckwalter, 1993). It is unknown to what extent concerns voiced in the United States around the prevalence and delivery of mental health care services are relevant for communities throughout Canada (Bushy, 1994a; Bushy, 1994b).

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In the province of British Columbia (BC), the proportion of elderly people in the population (13.2%) is slightly greater than in Canada as a whole (12.6%). In specific regional districts within BC, the percentage of the population aged 65 and over is as high as 22.9% (Gutman, Wister, Campbell, & Diguid, 1995). A conservative estimate is that by the year 2006, approximately 100,000 elderly people (or 16% of the elderly population) in BC will have cognitive, behavioural, or emotional problems that significantly interfere with their ability to function independently and enjoy their lives (British Columbia Ministry of Health and the Ministry Responsible for Seniors, 1992). Thus, understanding the range of factors that contribute to the mental health of older adults becomes important.

Furthermore, many regions in BC have small rural communities that are widely dispersed. In some regions, extreme weather and topography make for challenging travel and access to facilities, services, and healthcare providers. This makes relevant the questions of how, and how well, the mental health needs of elderly people living in these communities are being met.

To explore these issues, focus groups were conducted in four rural settings (< 20,000 population) and two mid-size urban centres (75,000 to 80,000) to obtain information about the perceived mental health needs of older adults in these communities. Descriptions of how mental health needs are currently being met, including innovative strategies being used to meet these needs, gaps in services, and challenges being encountered were obtained.

This paper describes the breadth of factors affecting the mental health of older British Columbians living in rural and mid-size communities as reported by stakeholders from these communities, highlighting the similarities and differences in how, and how well, the mental health needs of older adults are being met.

METHOD

Participants

Key individuals, working in the mental health area, provided lists of local stakeholders as potential focus group participants. Stakeholders were individuals in the community having knowledge or experience that enabled them to provide information about factors affecting the mental health of older persons. For each community, stakeholders representing a variety of professions, caregiving roles, and interests were contacted by telephone and invited to participate, until up to 10 stakeholders for each group expressed an interest. A follow-up letter and consent form were sent to each of these individuals. Informed written consent was obtained from each participant.

Sixty-three stakeholders, including service providers (e.g., mental health workers, home support workers, volunteers); administrators; managers; directors; program coordinators; representatives of non-government agencies (e.g., Alzheimer's Society); as well as family caregivers and other older adults, participated in this project. Some of the professional disciplines represented were family physicians, psychiatrists, nurses, social workers, psychologists, and recreational therapists. Stakeholders were involved in community and/or facility care.

Procedure

Eight two-hour focus groups, with six to ten participants in each, were conducted in six communities, two mid-size urban and four rural**,** located across six

health regions and four geographical regions of the province—Sunshine Coast, Northern BC, Thompson/Okanagan and the BC Rockies. Rural and mid-size urban communities were selected because little is known about the structure of systems and services available in these areas. The two large urban centres in BC (i.e., Victoria, Vancouver) are unique within the province and were not included in this study since information specific to them might not pertain to the majority of other health regions. Communities identified for this study were selected for their ease of physical accessibility and the availability of an active network of persons involved with mental health issues of older adults, who could serve as contact persons. Due to a smaller number of stakeholders living and working in rural, as compared to urban, communities, one focus group was held in each of the four rural communities and two focus groups were held in each of the two mid-size urban communities.

Focus group methods, introduction, ground rules, and questions were developed in accordance with Krueger (1994) and Morgan (1993). On arrival to the focus group, participants were given an overview of the topic and the ground rules. The group began with an opening question that engaged all participants and served to "break the ice." This was followed by seven questions designed to elicit the participants' perceptions of factors affecting the mental health of older adults, how their community was addressing these factors, innovative strategies being used, gaps in services, and the challenges being encountered. Probes, developed to elicit greater detail from participants without disrupting the flow of the discussion, were used by the moderator throughout each focus group. Each group's discussion was audiotaped and all discussions were moderated by the same researcher.

Analysis Process

Following each focus group, the moderator summarized key comments, themes, noteworthy quotes, and unexpected comments that had emerged to aid in the analysis process. Audiotapes were used to create verbatim transcripts for analysis. A qualitative analysis of the raw data was conducted by systematically coding the data based on emerging categories and themes. The data were then clustered into categories and subcategories, and succinct statements were constructed to convey the content and/or essence of what was being expressed and to identify emerging themes. This systematic analysis process was used to ensure that the findings would be grounded in the data (Glaser & Strauss, 1967).

Verification of Findings

In an effort to ensure that the results would be trustworthy and a valid reflection of the participants' responses, several steps were taken: (1) questions were piloted and then edited to ensure that they would be understood and elicit the range of information that was sought; (2) during each focus group, clarification was sought on areas of ambiguity; (3) a second analyst reviewed two of the eight transcripts, as well as the resulting categories and themes for validation, and determined that categories and themes accurately reflected the content of the transcripts; (4) results were presented at a meeting attended by participants from each of the eight focus groups, who verified that the results portrayed their perspectives and reflected the content expressed in their focus group.

FINDINGS

Similarities Between Rural and Mid-size Urban Communities

Participants identified and described a wide range of factors associated with, and required for, the mental health of older adults in rural and mid-size urban communities. These factors included not only the assessment, treatment, and follow-up care of persons with mental health problems, but extended far beyond this to include needs for good physical hygiene, accessible transportation, a life-enhancing psychosocial milieu, awareness of community resources, and opportunities to meet religious and spiritual needs. These factors, as described by stakeholders, clustered under six categories: clinical, physical, organizational, educational, psychosocial and spiritual (see Table 1).

TABLE 1

Examples of Factors Affecting the Mental Health of Older Adults in Rural and Urban Communities

Category	Examples of Factors
Clinical	▪ timely access to assessments by trained professionals; range of effective intervention and treatment alternatives; and ongoing monitoring and follow-up of care providers
Physical	▪ medical care; physical exercise; physiotherapy; nutrition; and personal hygiene (e.g., bathing)
Organizational	▪ access in community to housing and support/care options; affordable transportation options; emergency/crisis response services; and advocacy
Educational	▪ information on a wide range of health related topics; awareness of community resources and how to access; public campaign to increase recognition of mental health
Psychosocial	▪ counselling, transition support and empowerment; socialization, activities, and companionship; life-enhancing psychosocial milieu with respect and dignity
Spiritual	▪ opportunities to meet religious/spiritual needs in the community or the care facility; and respect for spiritual beliefs and choices regarding participation

In addition, stakeholders in rural and urban communities perceived paid care providers (i.e., professional and non-professionals) and unpaid caregivers (i.e., family and friends) as having sets of needs that affected their ability to assist and meet the mental health needs of older adults. As such, they felt that any discussion on the mental health needs of older adults must include factors affecting the ability of care providers and caregivers to assist and meet those needs. Examples of these factors are listed in Table 2.

TABLE 2

Factors Affecting the Ability of Care Providers and Caregivers to Assist and Meet the Mental Health Needs of Older Adults in Rural and Urban Communities

Group	Factors
Care Providers	▪ adequate resources for reasonable workloads, standards of care, and support; ▪ access to specialists; ▪ effective communication links; ▪ formal and informal education; ▪ support and financial assistance for education; ▪ flexibility in rules and regulations; ▪ ethics committee in community-based settings; future planning
Caregivers	▪ to be seen as part of the unit of care; ▪ assessment and early identification of need for respite and support; ▪ flexible respite options; ▪ support from individuals/groups in home/community; and ▪ information and education on resources and services, illnesses, caregiver roles, running the home, rights of clients, and guardianship

Participants from both rural and urban communities described variability in the availability and accessibility of personnel, services, and programs throughout their regions. This variability emerged as stakeholders talked about their *region as a whole* and reported that services exist in some communities within their region and not in others. This variability was typically characterized by decreased availability of, and access to care providers, services, and programs as communities became smaller and further away from more urban centres.

Despite this variability, similar themes emerged between rural and urban groups around availability and accessibility of personnel, education, and tertiary care. Specifically, participants in all focus groups described a general lack of personnel available to meet the mental health needs of older adults. These shortages included professionals as well as non-licensed and non-accredited care providers. Difficulties in recruiting care providers to live and practice in either small or mid-size communities highlighted the sense of isolation of persons living in these areas. Furthermore, focus group participants described personnel as lacking the necessary knowledge and skills in specific areas as they related to mental health in the older adult. Major gaps in knowledge were repeatedly reported in two specific areas: (1) aging in the developmentally disabled individual and (2) alcohol and substance abuse in the elderly. Other areas where care providers were reported to lack knowledge and skills included: dementia, personality disorders, understanding and managing difficult behaviours, mental health and competency assessments, emotional problems, loss and grief, medication and the elderly, alternative treatments, elder abuse and neglect, and improving communication links.

Consistent with these findings were comments describing insufficient availability and accessibility of education in aging issues. Care providers from both rural and urban centres described a lack of knowledgeable local personnel to conduct the

training, as well as insufficient support and financial assistance for education. Funding for travelling to conferences, for speakers to be brought into the region, and for paid time to attend formal and informal sessions/meetings for learning, were identified as examples. Stakeholders also described a general lack of public awareness of mental health issues related to older adults as well as a lack of information about resources and services and how to access them.

Participants in rural and mid-size urban communities reported limited access to specialized mental health services (e.g., behavioural units) where there are more expert assessments, interventions, and supports. Communities were typically not equipped to provide a tertiary level of care, yet stakeholders described great difficulties and frustrations in transferring persons to centralized provincial tertiary facilities.

Differences Between Rural and Mid-size Urban Communities

Participants in rural and urban communities reported distinct differences in the range of personnel available to provide mental health services to older adults and in the availability and accessibility of services and programs suitable for older adults.

Participants from mid-size urban centres described interdisciplinary mental health teams with as many as 11 team members from a wide range of disciplines (e.g., physicians, geriatric psychiatrists, nurses, occupational therapists, social workers, psychologists, home support workers); while mental health teams in rural communities were often described as small and primarily made up of nurses, lacking representation from other disciplines. In other rural communities, mental health teams did not exist, because of an insufficient number of care providers or their unavailability due to workloads and the travelling demands of "outreach" work. Participants acknowledged that a critical mass is needed to sustain an interdisciplinary team and that this is more difficult to create in smaller communities compared to larger centres. Some form of liaison (e.g., small groups, informal liaising, access to a specialist in psychogeriatrics via telephone or a few visits per year for consultation and support), however, was considered by rural care providers both valuable and necessary, even with its limitations.

A related difference between urban and rural communities emerged in the meaning of the provision of outreach services. In some communities, outreach services meant travelling to clients living a few minutes away. In other communities, outreach referred to driving two hours to see clients living in outlying communities, or to a professional (e.g., a geriatric psychiatrist) flying into remote rural areas once or twice a year to provide mental health services.

Stakeholders indicated that many programs and services available in urban centres for older adults and their caregivers were unavailable in rural areas. Participants spoke of the challenge in providing needed services and programs to older adults living in small isolated rural communities that are spread out over a large area. These communities lack the population base to support the development of programs and services similar to ones available in urban areas (e.g., home support, adult day care, respite, facility care and housing options, emergency response teams), thus, the availability and accessibility of services within their own community are limited. In contrast, in urban areas, stakeholders discussed the need for greater availability of an already existing service or the need to expand or refine a service to include seniors with special needs. For rural residents, access to services in larger communities, or from outreach services, was restricted by geographical constraints

created by the long distances between communities, the topography of the region, the road conditions and limited transportation.

Transportation services for older adults living in rural areas were reported as limited in a number of ways: when a bus service was available, access to the service was described as limited by the number of buses, the number of days per week the buses were available, the distance they could transport someone, and the criteria for their use (e.g., medical appointments but not a meeting, program, group, social, shopping or leisure activity). In some rural areas, bus service was not available and access to transportation, either within the community or to another community, was unreliable. This was in contrast to reports of transportation services in the mid-size urban centres. In addition to traditional transportation services (e.g., bus, taxi) in these centres, some innovative strategies for addressing transportation needs were reported. For example, in one community, groups have access to vehicles owned by seniors' care facilities. Seniors are picked up at their home and transported to local programs and services at a nominal fee.

DISCUSSION

Results from the focus groups indicate that the factors affecting the mental health of older adults, caregivers, and care providers are similar regardless of whether they live in a rural or urban community. For the older adult, these factors span a wide range, extending from assessment and an appropriate level of treatment to transporttation and education. For service providers, factors affecting their ability to provide care span from adequate resources and reasonable work loads to education and the need for ethics committees. And for caregivers, factors range from being part of the unit of care and receiving education, to flexible respite options and support groups.

However, there was great variability in how well needs were met, with the availability and accessibility of mental health personnel and related services differing between rural and urban communities as well as within regions. For example, while professionals, such as psychologists and social workers, were available in urban centres, nurses were typically required to fill these roles in rural communities. Similarly, for rural residents, day care services were often unavailable or severely limited, while geographical characteristics of the area and a lack of transportation frequently restricted access to these services in neighbouring communities. Housing options available in urban centres (e.g., supportive housing with assisted living) were typically non-existent in rural communities. These differences between rural and urban communities regarding the availability and accessibility of personnel and services were consistent with US studies that found a lack of trained professionals and services for seniors living in rural communities (Buckwalter, McLeran, Mitchell, & Andrews, 1988; Smith & Buckwalter, 1993).

Variability also extended to the structure of *how* needs were met. In urban centres, many care providers worked as part of an interdisciplinary team and participated in regular team meetings. In contrast, rural communities typically lacked the number and diversity of professionals needed to create and sustain interdisciplinary teams. As a result, rural "teams" were primarily made up of nurses or were non-existent, the latter case creating a greater need for informal liaising between professionals. These findings are similar to those of studies from elsewhere (Bushy, 1994b) but highlight the specific issues faced in many areas of Canada where populations with special needs are thinly distributed across geographically large and topographically diverse regions.

The emerging categories: clinical; physical; organizational; educational; psychosocial; and spiritual, provide a framework for seeking solutions. For example, it may be possible to provide *clinical and physical* support for elderly persons, their caregivers and care providers through multidisciplinary visiting consultation services. Professionals from a variety of different disciplines could visit communities on a regular schedule to provide assessments, treatments, and recommendations for the care of elderly clients as well as provide support, consultation, and education to care providers and caregivers for elderly persons.

Tele-health conferencing between professionals, or between professionals and clients, is a possible alternative to travelling. A psychiatrist or social worker specializing in psychogeriatrics, for example, could provide consultations to family physiccians or conduct assessments of an older person for whom there are mental health concerns. At the very least, telephone support from professionals in large urban centres could be made available on a regular basis for professionals working with older adults in rural communities. Kates, Crustolo, Nikolaou, Craven, and Farrar (1997) found telephone back-up from a consulting psychiatrist to be a "time-efficient and effective method of supporting family physicians and reducing utilization of mental health services" (p. 955).

Innovative strategies for addressing *organizational* issues, such as access to mental health services, transportation, home support, respite, and caregiver support, are beginning to develop within communities. Participants in some focus groups described the use of volunteers and the sharing of facility buses for transporting seniors (at no or minimal cost) to psychosocial activities and appointments. Providing home support intermittently throughout the day through "cluster care" is allowing seniors who require periodic monitoring and other assistance to live independently in their own apartment units. Clustering resources is also occurring in cases where home support services are doubling, in order to give respite hours to caregivers, and where empty beds of facility care residents who have been hospitalized are being used temporarily for respite purposes. For caregivers unable to attend support groups due to a variety of reasons, including travelling difficulties (e.g., distance, weather, geography, or lack of transportation), telephone support may be an alternative. Telephone contact with supportive volunteers and care providers associated with the Scottish Alzheimer Society has proven effective in Scotland where geography presents many of the same challenges found in British Columbia (www.alzscot.org). In Northwestern Ontario, a 24-hour support line called "Caring Connections" provides information, referrals, and emotional support for caregivers (M.L. Kelley, personal communication, February 14, 2002). Developing cooperative sharing of resources, with mutually agreed upon benefits for all parties concerned, is needed to maximize the existing resources and provide optimal accessibility to services.

For meeting *educational* needs, strategies in effect elsewhere include a variety of approaches and models (e.g., train the trainer). Educational opportunities, such as regularly scheduled conferences or sessions, could be provided across regions through contracted agencies or firms. Events such as these provide opportunities for care providers to share ideas, solve problems, and engage in mutual support. Alternatively, professionals could travel from one community to another, providing educational workshops and seminars for care providers, caregivers, and the older person. Such programs have been successful at providing continuing education to personnel in the funeral industry throughout BC (Funeral Service Association of British Columbia, 2001). In Ontario, the Ministry of Health has contracted with local agencies (e.g., universities, colleges) to provide continuing education programs

throughout their region. Tele-learning or tele-conferencing is another educational strategy that could be further developed. The BC Alzheimer Society recently telecast a live evening forum to six sites throughout BC. These sites were in large and mid-size urban centres. Audiences from each of the sites participated in the question and answer period. This method of providing education to care providers, caregivers, and clients will open up new opportunities as more rural and urban areas become equipped with the required technology. In addition, greater depth of learning could be achieved by offering credit courses on topics such as "Mental Health and Aging" or "Counselling the Older Adult" as part of the initial training of service providers planning to work in the area of mental health. Through the use of modern technology, such in-depth courses could also be made available through distance education as part of credential up-grading, post-graduate specialization programs or for continuing education credits.

The *psychosocial and spiritual* needs of older adults are affected by the availability and accessibility of resources that address physical, clinical, organizational, and educational concerns. However, they are needs that must be addressed in their own right if an important goal of intervention is to enhance quality of life (British Columbia Ministry of Health Services, 2002). Factors associated with psychosocial and spiritual needs should not be seen as dependent on, or secondary to, physical and clinical needs, but of equal importance (MacCourt, Tuokko, & Tierney, 2002). This is unlikely to occur without a paradigm shift from an acute-care biomedical approach, to a holistic social model of seniors' mental health. A variety of psychosocial interventions have been shown to be effective when used with older adults, many of which are highly modifiable and flexible (Pinquart & Sorensen, 2001). Building on this evidence base through future research will enable such a paradigm shift.

It must be noted that the information obtained within this study is selective in that only a few regions within British Columbia were included and not all persons within each community were invited to participate. Additional information obtained from older adults with mental health problems and/or their families may provide new insights into other factors affecting their mental health, and how their needs can best be met within their communities. Furthermore, a more comprehensive survey of resources available within communities may provide information from which relative comparisons could be made, and specific factors (e.g., proximity to larger centres, topographic barriers) could be taken into consideration. The detailed descriptive information concerning the factors affecting the mental health of older British Columbians provided by stakeholders in rural and mid-sized urban communities in this study serves as a guide for the continuing development of diverse strategies needed to increase access to services and support for mental health regardless of where an older adult resides.

RÉSUMÉ

On a demandé à certains représentants et représentantes de divers milieux tant professionnels que communautaires des régions rurales et des régions urbaines de taille moyenne de partager leur opinion concernant les facteurs qui affectent la santé mentale des adultes plus âgés, ainsi que les mesures prises et les résultats obtenus en regard de ces facteurs dans leur région. Les facteurs identifiés ont été divisés en six catégories: cliniques, physiques, organisationnels, éducatifs, psychosociaux et spirituels. Les entretiens ont également permis de dégager d'autres facteurs affectant les fournisseurs de soins et les soignants, ainsi que leur capacité à favoriser la santé mentale pour les adultes plus âgés. Des similarités et des dif-

férences distinctes entre les régions urbaines et rurales ont été identifiées; les participants et participantes ont également signalé le besoin de mettre sur pied des stratégies innovatrices pour satisfaire aux besoins des personnes âgées, particulièrement en région rurale.

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