Aging Well in Rural Places:

Development and PilotTesting of a Community-Based Strategy for Addressing Depression in Seniors in Atlantic Canada

Literature Synthesis

Aging Well in Rural Places.

AHPRC
Atlantic Health Promotion Research Centre

Aging Well in Rural Places is an initiative of the Atlantic Health Promotion Research Centre.

"AGING WELL IN RURAL PLACES"
KEY FINDINGS FROM THE LITERATURE REVIEW

- There is limited literature dealing specifically with depression in the rural older adult population, especially in the Canadian context. The lack of literature is exacerbated by the fact that there is no single definition for what constitutes a "rural" population, and no single definition of "depression". Thus, it is extremely difficult to determine the actual prevalence of depression in senior population.

- The literature describes a number of generalized characteristics of the rural senior population including a strong work ethic and need for independence, reliance on family and informal support networks, distrust of formal services and programs, dislike of personal disclosure, and barriers to accessibility related to the geographic reality of rural areas). However, researchers are increasingly making note of the heterogeneity of this population, and caution must be exercised to avoid over-generalization.

- The rates of chronic depression among the rural older adult population appear to be low relative to the general population. However, the rates of depressive symptoms appear to be much higher in the senior population and one group suffering from alarmingly high rates of depression is older informal caregivers.

- There is general agreement on the barriers to accessing and delivering programs and services for mental health to the rural senior population. Barriers include: geographic and social isolation and their inherent service issues; lack of transportation; illiteracy and low education levels; attitudes among rural families about mental health and lack of knowledge about available services; confidentiality; stigma; intergenerational miscommunication; ageist attitudes, especially among health care professionals; and a perceived bias towards urban populations in the delivery of health care services.

- There are a number of effective initiatives being carried out in the Atlantic region, many of them informally. These initiatives are reflect five general approaches: (1) health promotion and social marketing, (2) outreach, (3) gatekeeping, (4) technological, and (5) technological. Many programs contain aspects f more than one model.

- Ageism in social marketing images and messages must be avoided if the messages are to successfully reach the target audience and influence their behaviour.

- The use of technology to reach elderly mental health consumers in rural and remote areas is in its infancy. However, as "baby boomers" age, it may become more widely utilized.

Note: The detailed literature review is available from the Atlantic Health Promotion Research Centre, Dalhousie University. (Phone 902-494-2240 or email AHPRC@dal.ca)

"AGING WELL IN RURAL PLACES"

LITERATURE SYNTHESIS

Scope of the Literature Review

A comprehensive literature review was a central component of the Aging Well in Rural Places project. The review examined definitions of "depression" and "rural" communities; characteristics of the rural senior (65+ years of age) population; prevalence of depression among rural seniors; the relationships between depression and other illnesses, suicide and the use/misuse of medication; depression in elderly caregivers; barriers to the treatment of depression in the rural senior population; access to services; "rural" attitudes that may effect understanding and treating depression; ageism; and effective approaches to programs and services. Following the project's parameters, the literature review concentrated on seniors living in the community, and not in long-term care facilities.

Introduction

Someone once said, "growing old is not for the faint of heart". Chronic illness, dementia, and many types of loss are some of the challenges that seniors may face as they move into the "golden years" of 65 and beyond. For a significant portion of this rapidly growing age group, one of the biggest challenges to be faced is depression, which often arises out of life changes and circumstances. While there is a great deal of literature dealing with older adults and mental health issues, including depression, there is relatively little related specifically to older adults living in rural areas.

The Senior Population in Atlantic Canada

The population of the Atlantic provinces (Newfoundland and Labrador, New Brunswick, Nova Scotia and Prince Edward Island) is one of the most rapidly aging populations in the world (Lilley & Campbell, 1999). As "baby boomers" age, seniors will make up nearly one third of the population of Atlantic Canada by 2036, especially since the population under 20 years of age has been declining rapidly in the region, a trend that is expected to continue. The smallest centers in the region, those with populations between 1,000 and 10,000 people, have the highest levels of population aging.

Defining Depression

The term "depression" has a wide variety of definitions.

> "The term depression is confusing… because it can refer either to a full clinical syndrome or to the normal feelings of sadness and disinterest in life that accompany crisis periods." (Bruckbauer, 1997).

The term "depression" is used to describe both a sad, despairing mood and a psychiatric illness. The difference between these two understandings of depression is generally in the duration of the feelings (Thompson, Stancer & Persad, 1987). Despite the differences

in definitions, there is general agreement on at least some of the symptoms of depression. These include:

- preoccupation with failure(s) or inadequacies and a loss of self-esteem
- feelings of uselessness, hopelessness, excessive guilt
- slowed thinking, forgetfulness, difficulty in concentrating and in making decisions
- loss of interest in work, hobbies, or people (family and friends)
- agitation or loss of energy (so restless that one can't keep still or too tired and weak to do anything)
- changes in appetite and weight
- sleeping too much or an inability to sleep at all
- decreased sexual drive
- crying easily, or an inability to cry when it is appropriate to do so
- suicidal and perhaps homicidal thoughts
- excessive use of alcohol and/or non-prescription drugs

Many authors point out that a number of these symptoms are indicators of the normal physiological changes associated with aging, and therefore must be considered cautiously when determining depression in seniors (Mossey, 1997; Rovner, 1997; CMHA, 1995; Beckingham, 1993; Cappeliez, 1993; Mohide & Steiner, 1993).

Hughes & MacCormack (2000) describe mild depression as depression that follows a disappointment, and *situational depression* as depression following a stressful event. For the purposes of this literature review, the term depression will refer to either situational depression or diagnosed major chronic depression, as these are the conditions most often referred to in published materials.

"Situational" Depression

The Aging Well in Rural Places project focuses on situational depression, defined as depression arising from particular life events. Older adults may be at risk for situational depression because of changes in their lives over time, such as: retirement, death or illness of spouse and/or friends, children relocating to another town or city, changes in health that prevent participation in usual activities, and changes in residence which may result in loss of connections in the community or neighbourhood.

Defining "Rural"

There is no single accepted standard of what "rural" means, and the concept is the subject of considerable discussion in the literature (DuPlessis, Beshiri & Bollman, 2001; Pitblado et al., 1999; Bollman, 1993). For the purposes of the literature review, the Statistics Canada definition of "rural" was employed. "Rural" refers to regions outside of urban areas with populations of less than 10,000 people (Statistics Canada, 1996).

Characteristics of the Rural Senior Population

Rural dwellers are generally characterized as independent and hard-working people who rely strongly on informal support systems (McInnis-Dittrich, 1997). Susnad et al. (1992) found that there is minimal support for the idea that change is possible in the rural senior population. This finding was echoed by Chalifoux et al. (1996), who ascribe

traditionalism, a strong work ethic, conservative beliefs, strong religious values, and an emphasis on relationships and family ties to the rural culture.

Where urban living is more anonymous, rural living is much more under community scrutiny, which in turn leads to the reluctance of disclosure (i.e., everyone eventually knows everyone else's business) (Jennings, 1992). This fact acts as a barrier to seniors identifying depression and seeking treatment for it. In some cases, the resistance to self-disclosure may be accompanied by a general distrust of mental health professionals, and a disinclination to rely on help from anyone outside the immediate family (McInnis-Dittrich, 1997). Some of the literature, however, suggests that it is difficult to make these urban/rural distinctions because of the heterogeneity of rural populations (Keefe, 1999; Hoyt et al., 1997; Clifford & Lilley, 1993; Keating, 1991).

Kelly & MacLean (1997) identify the following as unique rural characteristics to be considered when designing health services for rural areas.

- a belief and value system that stresses both independence and helping others;
- a low population density;
- out-migration of children to urban areas;
- limited, if any, public transportation;
- fewer and less varied social supports and health care services;
- lower past and current levels of income;
- lower level of formal education;
- lower quality of housing; and,
- less variety of housing options for people in their later years.

Prevalence of Depression Among Rural Seniors

As noted above, definitions of depression vary in the literature reviewed, making it difficult to accurately determine rates of depression. While some authors refer to depression or depressive symptoms (Meeks, Murrell & Mehl, 2000; Murphy et al., 2000; Rokke & Klenow, 1998; Susman, Crabtree & Essing, 1995; Rost et al., 1994; Wallace & O'Hara, 1992), others distinguish between chronic and situational depression (Tice & Perkins, 1996; Beckingham, 1993; Mohide & Steiner, 1993; Cappeliez, 1993; Blazer et al., 1991), or break depression down into a number of types (Chalifoux et al., 1996).

Another challenge in measuring rates of depression in a population relates to the number of different scales used. A literature review conducted for the Canadian Mental Health Association (1995) describes 12 different assessment tools. The Geriatric Depression Scale (Rokke & Klenow, 1998) was the only scale specifically designed for older adults found in the literature search. However, Mohide & Steiner (1993) point out that most depression inventories are inappropriate for older people because many of the indicators for depression such as disturbed sleep patterns and poor appetite are often part of the physiological aging process. Cappeliez (1993) suggests that these quantitative scales not be used for diagnosis, but only to determine the severity of depression, i.e., chronic versus situational depression.

The authors considered in this review are divided into two main perspectives related to depression among seniors. On one hand, some authors - usually those who ascribe to a biomedical health model - consider depression as a natural part of aging (Barnes, 2001; Mossey, 1997; Beckingham, 1993; Mohide & Steiner 1993; Lapierre et al., 1992; Lipsey & Parikh, 1989). On the other hand, some authors, while

acknowledging that chronic depression exists among the elderly, see its prevalence as having more to do with coping skills than natural progression. These researchers typically ascribe to a psychosocial health model. (Hybels et al., 2001; Whitbeck, Hoyt & Tyler, 2001; Groulx, 2000; Scheidt, 1998; Rokke & Klenow, 1998; Cappeliez, 1993; Blazer et al., 1991).

Statistics Canada's *Portrait of Seniors in Canada* (1999), while not delineating between urban and rural senior populations, states that in 1998-99, 3.6 % of Canadians aged 65-74 years were at possible or probable risk of depression, and of the population 75+ years, 2% were at a probable risk. Of particular interest to the Atlantic region, the Stirling County Study (Murphy et al., 2000), a 40-year longitudinal study of a rural / small town population in Nova Scotia, found that rates of depression did not change significantly over the years. They also found that rates were consistently lowest in the 65+ population, although higher among women than men (5.0 and 3.8 per 1000 respectively).

It may be the case that the senior generation hides or ignores symptoms and so figures are under reported (Chalifoux et al., 1996; Susman et al., 1995). This view has been supported in a study of how rural physicians manage depression in rural patients (Rost et al., 1994). Due to the stigma associated with mental illness in rural areas, depression is often noted and treated very subtly, but not formally diagnosed. The rural elderly most vulnerable to depression are those with fewer coping resources, in the form of income and education, and with poorer health (Rokke & Klenow, 1998).

The U.S. Surgeon General's (1999) report states that 8% to 20% of older adults living in the community suffer from depressive symptoms. The report also notes that the symptom profile for depression is different in older adults than the rest of the population. Many other studies conclude that while the diagnosis of major depression appears to decline with age, depressive symptoms, especially among elderly women, appear to increase (Hybels et al., 2001; US Surgeon General 1999; Hooyman & Kiyak, 1999; Rokke & Klenow, 1998; Hoyt et al., 1997; Cappeliez, 1993; Blazer et al., 1991).

Chalifoux et al.'s (1996) study on the prevalence of mental illness among rural seniors suggests that they are at higher risk for life stresses and mental disorder than their urban counterparts and younger rural dwellers. It appears that depression in seniors may be far more a sociological problem than a psychiatric one (Scheidt, 1998; Rovner, 1997; Blazer, 1993).

Depression and Suicide

The Canadian Mental Health Association (1995) notes that depression can have both direct and indirect effects on suicide. In the senior population, depression may contribute to suicide or may result in self-neglect, which hastens death. Factors influencing suicide include loss, physical illness, depression, retirement and isolation (Lapierre et al., 1992). Depression seems to be the risk factor most frequently reported in relation to suicide in the elderly (Ibid). The risk for suicide in dementia patients is highest among those with depressive symptoms (Groulx, 2001). Elderly men in particular are at risk for suicide (Raschko & Florio, 1999; Hoyt et al., 1997), particularly following the loss of a spouse (Groulx, 2001; Statistics Canada, 1999; Chiles & Strosahl, 1995; Lapierre et al., 1992).

Depression and Other Illnessses
Conditions related to the aging process such as dementia, Alzheimer's disease, chronic illness, stroke, heart disease, and pharmaceutical use / misuse can all manifest depressive symptoms (Thorpe & Groulx, 2001; Barnes, 2001; US Surgeon General, 1999; Cravern, 1998; Mossey, 1997; CMHA, 1995; Cappeliez, 1993). Studies with stroke patients indicate that they are prone to depressive symptoms (Bruckbauer, 1996; Lipsey & Parikh, 1989). Estimates of the prevalence of depression in the chronic pain population vary from 10% to 90% (Pearlson & Strain, 1989).

Depression and the Use / Misuse of Pharmaceuticals and Over the Counter (OTC) Medications
One of the major causes of depression among older adults is the side effects attributable to medications, and especially to the inappropriate mixing of both prescription and non-prescription drugs (Beckingham, 1993; Reynolds & Madden, 1992; Pascualy & Veith, 1989). This problem is further compounded by the medicating of depression itself, often creating a dangerous mix with drugs being concurrently taken for other medical conditions (Watson, 1998; Cravern, 1998; Mione, 1996; Beckingham, 1993; Reynolds & Madden, 1992; Pascualy & Veith, 1989). The tendency for some physicians to prescribe medications has led to an overprescribing of antidepressants for seniors, especially senior women (Kaye, 2001; Chalifoux et al., 1996; Jacobson, 1995; Susman et al., 1995; Rost et al., 1994; Blazer, 1993; Susnad et al., 1993).

Depression in Elderly Caregivers
Small focused studies have shown numbers as high as 85% for depression in caregivers (Mohide & Steiner, 1993). The U.S. Surgeon General's (1999) report states that virtually all studies find elevated levels of depressive symptoms among caregivers, and those using diagnostic interviews report high rates of clinical depression and anxiety.

Barriers to Treatment of Depression in the Rural Senior Population
There is consensus in the literature on a number of barriers faced by rural elders when seeking help for mental health problems (as well as physical health problems) Some of these barriers are externally imposed, while others arise from the rural culture itself. Identified barriers include:

- geographic and social isolation and their inherent service issues (Whitbeck et al., 2001; Adam & Hoehne, 1989; Atlantic Committee-CHPNA, 1997; Hoyt et al., 1997; McInnis-Dittrich, 1997; Jacobs, 1997; Chalifoux et al., 1996; Rost et al., 1995; Keating, 1991)
- lack of transportation (CMHA, 2001; Krout, 1998; Campbell, Bruhn & Lilley, 1998; Kihl, 1993; Rathbone-McCuan, 1993; Susnad et al., 1993)
- illiteracy (Jacobs, 1997; McInnis-Dittrich, 1997; Corbett, 1990). According to Statistics Canada (1999), only 8% of all Canadians aged 65 and over had a university degree in 1996. Over 60% of seniors had not completed high school.
- attitudes among rural families about mental health and lack of knowledge about available services (Jacobs, 1997; Campbell et al., 1998; CHPNA, 1997; Susnad et al., 1993; Keating, 1991)

- confidentiality and stigma (Whitbeck et al., 2001; Raschko & Florio, 1999; Jacobs, 1998; Atlantic Committee-CHPNA, 1997; Hoyt et al., 1997; McInnis-Dittrich, 1997; Chalifoux et al. 1996; Tice & Perkins, 1996; Rost et al., 1995; Susnad et al., 1994; Blazer, 1993; Jennings, 1992; Keating, 1991; Adam & Hoehne, 1989)
- intergenerational miscommunication (Whitbeck et al., 2001; Raschko & Florio, 1999; Atlantic Committee-CHPNA, 1997; Hoyt et al., 1997)
- ageist attitudes, especially among health care professionals (Thorpe & Groulx, 2001; Wilson, 2000; U.S. Surgeon General, 1999; Watson, 1998; Rost et al., 1995; Susnad et al., 1994; Blazer, 1993)
- a perceived bias towards urban populations in the dissemination of health care services (Kelly & MacLean, 1997; Chalifoux et al., 1996; Krout, 1996; Susnad, 1994; Keating, 1991)

Thus, the barriers to treatment of depression (and other mental and physical illness) for rural seniors are largely related to access, rural attitudes and ageism. Each of these three barriers is further elaborated below.

Access to Services

By far the biggest barrier to the treatment of depression among rural seniors is access to services, including transportation. Specific barriers include distance from neighbours and family, distances to be traveled by service providers, and the problem of effectively managing resources for a sparse population spread out over a large geographical area (CMHA, 2001; Krout, 1998; Campbell et al., 1998; Langille, MacLellan & Berrigan, 1998; Rathbone-McCuan, 1993; Keating, 1991; Adam & Hoehne, 1989).

Some authors are beginning to explore the relationship between seniors' mental well-being and their ability to drive (Kihl, 1993; Keating, 1991). McInnis-Dittrich (1997) notes that many older adult rural women, whose lives were often centred around the traditional role of homemaker, never learned how to drive.

The services needed by rural seniors may not exist in their communities (Corbett, 1990). Health care professionals may be hesitant to relocate to rural communities (Krout, 1998; Atlantic Committee-CHPNA, 1997; Corbett, 1990). Seniors may have to relocate to an urban area in order to receive the care they need, leaving behind most of their family and social network, and putting them at greater risk for depression (Kelly & MacLean, 1997). Wilson (2000) suggests that in many rural areas, there is a sense that seniors have been left behind in dying communities.

"Rural" Attitudes that Affect Understanding and Treating Depression

Attitudes characteristic of rural populations may present barriers to the treatment of mental illness. For example, a strong sense of independence, particularly among rural men (Hoyt et al., 1997) may prevent the acceptance of home care or other services (Raschko & Florio, 1999). Rural women might rather rely on members of their immediate family than outside agencies for help (McInnis-Dittrich, 1997). Unfortunately, an attitude of independence can result in treatment not being received (Whitbeck et al., 2001; Hoyt et al., 1997).

Contrary to the belief that rural physicians may ignore depression in their patients, one study found that physicians actually had a deliberate and organized approach to

treatment. Recognizing the stigma attached to mental health problems, physicians preferred to treat depression surreptitiously, keep an eye on the patient over time, and offer a lot of "talk therapy" in place of more active intervention (Susman et al., 1995).

The older adult rural population may find it easier to deal with depression by moving it into the biomedical sphere, and thus seek help from their primary care physicians (McInnis-Dittrich, 1997). Chalifoux et al. (1996) observed that many rural seniors would prefer to discuss mental health problems with their doctors or their ministers. Unfortunately, this inclination may lead to improper diagnosis, or no diagnosis at all (Tice & Perkins, 1996; Susman et al., 1995; Rost et al., 1994).

There may be a general distrust of mental health professionals and interventions among rural elders, perhaps arising from historical perceptions of mental health institutions as places where people were grossly mistreated (Tice & Perkins, 1996). Distrust and fear may arise from a lack of knowledge about mental wellness/illness, and what treatment for mental illness entails (McInnis-Dittrich, 1997; Hoyt et al., 1997, Tice & Perkins, 1996; Keating, 1991). As well, confidentiality may be difficult to ensure in a small rural communities where 'everybody knows everybody else's business' (Jennings, 1992).

Ageism

Popular images of the elderly subtly imply a devalued body and mind, and conceptualize aging as moving toward a position of disempowerment (Wilson, 2000). Rovner (1997) suggests that many seniors have trouble accepting the aging process, because we have been conditioned to believe that aging is somehow shameful, and that death is tragic. People in North America are not very well socialized for old age (Raschko & Florio, 1999). Values associated with youth and middle age - material wealth, productivity, independence, individualism, and physical beauty – may become detrimental as we age and no longer measure up to these ideals.

Ageist attitudes can also be found among some health professionals. A recent study in the U.S. found that three quarters of physicians thought that depression was understandable in older persons (U.S. Surgeon General, 1999). It is not surprising that, given pervasive ageist attitudes, rural elders may 'accept their lot' and not complain or seek services when they are needed.

Effective Approaches to Programs and Services

When it comes to designing programs and services for rural areas, it is clear that taking an urban model and dropping it into a rural context will not work (Kelly & MacLean, 1997; Keating, 1991). Strategies for dealing with depression in rural seniors must take into account the relationship between physical health and mental health, and the unique characteristics of rural communities (CMHA, 1995; Cappeliez, 1993; Blazer et al., 1991; Holt & Alexopoulos, 1989). One message that must be emphasized is that depression is <u>not</u> a normal part of aging (Cappeliez, 1993).

Programs based on community development principles have the best chance of being sustained in a rural environment, especially those with a peer support or peer-led educational component. In general, educational materials, including materials that address the social myths associated with aging and with mental illness, need to be developed and transmitted using adult education techniques. Ageism in social marketing

images and messages must be avoided if the messages are to successfully reach the target audience.

Program Models: Health Promotion and Social Marketing

Many common causes of death and disability are derived in large part by social, environmental and behavioural elements that individuals and communities are able to influence. The main emphasis of health promotion in the 21st century is on "wellness" rather than illness. Social marketing communicates health messages in positive ways and are targeted to increase public awareness and support behaviour change. The *Healthy Brain Program: A Novel Approach to Healthy Aging Promotion* in Vancouver, BC is a good example of this model. The program was designed to acquaint the participant with the brain as an organ that requires care and maintenance, and provides evidence to clarify confusing and often contradictory information from the marketplace (Kiraly et al., 2001).

Program Models: Outreach

One of the most useful methods used in programming for rural seniors is the outreach model, which addresses many of the barriers found in the rural environment. By going into seniors' homes, accessibility is guaranteed and confidentiality is also addressed (Krout, 1998). Outreach services can link formal community based services with informal community resources, which allows for the maintenance of self-reliance (MacLean & Kelley, 1996; Susnad et al., 1992). A highly successful outreach program in Atlantic Canada is *Harvey Outreach for Seniors* in Harvey Station, New Brunswick (Weeks, 2000).

Program Models: Gatekeepers

Gatekeepers in a rural community include physicians and other health professionals, outreach workers, pharmacists, banker tellers, store clerks, postal carriers, informal social networks and any other people that rural elders regularly come into contact with. This model is incorporated into the *Quality of Life and Mental Well-Being: Improving the Network of Support for Isolated Seniors* project in eastern Charlotte County, New Brunswick (CHPNA, 1997). "Gatekeepers" in the community are trained to recognize changes in seniors' habits or demeanor which may indicate they need some form of help.

Program Models: Empowerment

The empowerment perspective emphasizes the process and outcomes of helping clients gain or reclaim power over their lives (McInnis-Dittrich, 1997). The models in this category include mutual aid (especially useful for rural and remote areas), peer counseling and education, community leadership development, and other community based programs (often including outreach, especially with at-risk, isolated, and hard-to-reach elderly). One model that may apply particularly well to rural adults coping with depression is the Strengths Model (Tice & Perkins, 1996), which focuses on people's strengths, rather than on their deficiencies, problems or disabilities. Programs which are typical of the empowerment model include *Toward the Prudent Use of Medication* in Nova Scotia (CHPNA, 1997), the *Seniors Wellness Program* and *Sharing Community Care* in Newfoundland (CHPNA, 1997), and *Seniors Influencing Change* in Prince Edward Island (CHPNA, 1997).

Treatment Models: Technological

No literature dealing specifically with the use of technology in delivering mental health programming to remote and rural areas was found. However, of particular interest is the use of video-conferencing for "telepsychiatry" counselling and referral services. Many provinces in Canada (including New Brunswick) have such programs in place; most others are currently exploring the idea. As well, many rural communities have "life-line" programs in place, where seniors can call for help by pushing a button tied into their alarm systems.

Uses of the Literature Review

Findings from the literature were used to inform project partners and others about current knowledge related to rural seniors and depression, and contributed to the development of data collection tools for use in the pilot sites. The review of programs was used to help build capacity in the pilot communities in order to respond to the mental health and social integration needs of seniors.

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