



ORIGINAL ARTICLE ARTICLE ORIGINAL

The needs of rural and urban young, middle-aged and older adults with a serious mental illness

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This article has been peer
reviewed.

Objective: The delivery of mental health services is often provided through agencies set up to serve both young and older adults. Young and older adults with a severe mental illness (SMI) have different needs; this study was designed to identify important differences.

Methods: This is a descriptive study based on a representative sample of mental health services users from northwestern Ontario ($n = 532$ [one-half rural and one-half urban]). The service provider most familiar with each user completed a questionnaire. We compared the characteristics and needs of users aged 18–29, 30–59 and 60 years and older.

Results: The results showed that a greater proportion of individuals in the older group (55.3%) had physical comorbidities, compared with people in the younger and middle-aged groups (30.3% and 45.2%, respectively; $p = 0.004$), and more people in the older group used psychotropic medications (83.0% v. 62.9% and 75.5%, respectively; $p = 0.006$). Although the level of need was great for all age groups, the older group had greater need for medication management, physical health care, self-care and other activities of daily living ($p < 0.05$). A greater need for support was also identified for the family of older adults ($p = 0.005$). A lesser need was identified for psychotherapy or counselling, vocational training, and correction, probation or parole matters ($p < 0.05$).

Conclusion: We identified important differences in the needs of young, middle-aged and older people with an SMI. Addressing the needs of the older adults assumes a system that is responsive to their particular situations. Further work to ensure that the treatment of older adults reflects these differences and is based on best practices should be conducted.

Objectif : Les services de santé mentale sont souvent fournis par l'intermédiaire d'organismes établis pour servir à la fois les adolescents et les adultes plus âgés. Les adolescents et les adultes plus âgés atteints de une maladie mentale grave (MMG) ont des besoins différents. Cette étude visait à cerner les différences importantes.

Méthodes : Il s'agit d'une étude descriptive fondée sur un échantillon représentatif d'utilisateurs de services de santé mentale du nord-ouest de l'Ontario ($n = 532$ [moitié ruraux, moitié urbains]). Le fournisseur de services qui connaissait le mieux chaque utilisateur a rempli un questionnaire. Nous avons comparé les caractéristiques et les besoins des utilisateurs âgés de 18 à 29 ans, de 30 à 59 ans et de 60 ans et plus.

Résultats : Les résultats ont montré qu'une proportion plus importante de personnes du groupe des sujets plus âgés (55,3 %) avaient des comorbidités physiques comparativement aux jeunes et aux groupes d'âge moyen (30,3 % et 45,2 %, respectivement; $p = 0,004$) et que plus de personnes du groupe des personnes plus âgées prenaient des psychotropes (83,0 % c. 62,9 % et 75,5 %, respectivement; $p = 0,006$). Même si le niveau de besoin était grand dans tous les groupes d'âge, les besoins des sujets plus âgés l'étaient davantage pour la gestion des médicaments, les soins de santé physiques, les soins auto-administrés et les activités de la vie quotidienne ($p < 0,05$). On a aussi déterminé que la famille des adultes plus âgés avait davantage besoin de soutien ($p = 0,005$).

Dans ce groupe, on a constaté un besoin moindre en psychothérapie ou counselling, en formation professionnelle et pour les questions reliées aux services correctionnels, à la libération sur parole ou à la libération conditionnelle ($p < 0,05$).

Conclusion : Nous avons dégagé d'importantes différences entre les besoins des jeunes, des personnes d'âge mûr et des personnes âgées atteints d'une MMG. Pour répondre aux besoins des adultes plus âgés, il faut un système adapté à leur situation particulière. Il faudrait effectuer d'autres travaux pour veiller à ce que le traitement des adultes plus âgés tienne compte de ces différences et se fonde sur les meilleures pratiques.

INTRODUCTION

Presently, there are 3.8 million Canadians over the age of 65 years and Statistics Canada estimates that by 2011 they will number almost 5 million. From 2001 to 2011 Statistics Canada predicts that the growth rate of the population aged 65 years and older will show the greatest increase. Consequently, there will be an increased demand for services for older individuals who have a severe mental illness (SMI).¹

Because most individuals with an SMI are cared for in the community, the psychiatric care for the geriatric population needs to be provided in outpatient settings. However, it is often perceived that this cohort is best treated on an inpatient basis, and as a result resources for geriatric outpatient care have not been a priority.² Further, older adults are often neglected by mental health services,³ possibly because "community mental health programs have tended to operate on the assumption that their services are most appropriate for younger people with mental or emotional distress" (p. 69).⁴ Hence, researchers have asserted that it is very likely that current community geriatric mental health services will be unable to meet the future demand.⁵ Some have even gone as far as referring to the pending deficit as a "crisis."¹

This potential crisis may be exacerbated in geographical areas with fewer mental health services or reduced accessibility. Rural and remote areas are potential places where the needs of older adults with an SMI may be even more pressing given that service accessibility is compromised because of distance issues and the lack of health care professionals. In addition, it is increasingly evident that older adults with an SMI often have other medical comorbidities⁶; these older adults may be further compromised by these comorbidities.⁷ Sullivan and colleagues have argued that to provide best practices for older adults we will need to understand older populations and their

needs within a local context that emphasizes the relevant catchment area.⁸

Unfortunately, there is a paucity of data comparing the situation and needs of older and younger adults with an SMI across age cohorts and even less regarding the needs of older adults living in rural and remote areas. Yet, a better understanding of the differences between older and younger adults will allow service providers to more effectively address problems confronting older adults. The purpose of this study was to document differences and similarities between young, middle-aged and older adults regarding their individual characteristics and mental health needs.

METHODS

Sampling

The data used in this study were part of a larger assessment of mental health services in northwestern Ontario. The region encompasses the districts of Thunder Bay, Kenora and Rainy River, an area of approximately 526 000 km². This area represents about one-half of the whole province area yet is home to a total of only 250 000 inhabitants (approximately one-half are located in one urban centre), yielding a very low population density.

Program managers (who were health professionals with various backgrounds) of all community mental health programs ($n = 61$) who provided services to individuals with an SMI and received funding from the Ontario Ministry of Health and Long-Term Care filled out a detailed profile that included information on community context, staffing levels and disciplines represented on staff. The program managers of 51 of these programs (27 urban and 24 rural) supplied us with a list of patients over the age of 18 years who had used their services between September 1, 2001, and November 30, 2001 ($n = 3246$). We created a database using initials of patient sex and date of birth

and drew a representative sample based on age, sex and geographic region ($n = 549$) for staff assessment.

Data collection

Using a “train-the-trainer” approach, one staff member from each program attended a one-day training session to learn how to correctly complete the assessment tool. This individual then shared training information with colleagues involved in the assessment of patients. Subsequently, the mental health worker (e.g., nurse or social worker) most familiar with the selected patient completed the staff assessment. The assessment included demographic information and a needs profile (number of monthly visits). The needs were rated on a 5-point scale (1 = none, 5 = 8 or more times per month), but to simplify the interpretation of the findings we dichotomized the data as “no need” versus “any” (analyses with analyses of variance using the 5-point scale provided similar results to those presented here).

Analytical plan

For our comparisons, we divided the sample into 3 groups: 18–29 years old, 30–59 years old and 60 years and older. We present descriptive information using means and standard deviations (SDs) and frequencies (along with proportions). To formally compare the older and younger groups, we used the chi-squared statistic. Statistical significance was set at $p \leq 0.05$. However, given the large number of comparisons and the increased risk of type I errors, we also present actual p values.

RESULTS

Of the 549 patients for whom we requested an assessment, 532 were completed (response rate of 97%). Of the 532 for whom we had data, there were 97 patients aged 18–29 years, 347 aged 30–59 years, and 88 who were aged 60 years and older. Exactly 266 were from the urban setting and 266 from the rural setting. Demographic characteristics of the patient sample are shown in Table 1.

Differences between the 3 groups of patients emerged for DSM-IV diagnostic categories (more than 1 diagnosis could be provided if appropriate) and other clinical attributes of the patients. The most frequent diagnosis was the presence of a mood disorder (45%). However, while the second most frequent diagnostic category for the older

group was the presence of an organic disorder (e.g., dementia; 26.1%), this type of diagnosis was present in only 1% of the younger group and 4% of the middle-aged group ($p = 0.001$). We noted that a greater proportion of patients from the urban setting, compared with those from the rural setting,

Table 1. Demographic characteristics of the patient sample

Characteristic and setting	Age, yr, n (and %)*		
	18–29	30–59	≥ 60
Sample size, n			
Urban	36	177	53
Rural	61	170	35
Mean age, yr (SD)			
Urban	25.75 (2.95)	44.18 (8.48)	75.07 (10.01)
Rural	23.68 (3.58)	42.95 (7.74)	74.14 (9.88)
Female sex			
Urban	19 (52.8)	96 (54.2)	27 (50.9)
Rural	34 (55.7)	105 (61.8)	25 (71.4)
Education			
Less than high school			
Urban	17 (53.1)	71 (47.3)	30 (66.7)
Rural	25 (45.5)	64 (42.1)	13 (41.9)
Completed high school			
Urban	9 (28.1)	47 (31.3)	12 (26.7)
Rural	25 (45.5)	57 (37.5)	15 (48.4)
Completed post-secondary			
Urban	6 (18.1)	32 (21.3)	3 (6.7)
Rural	5 (9.1)	31 (20.4)	3 (9.7)
Marital status			
Single			
Urban	19 (52.8)	77 (43.5)	14 (26.4)
Rural	28 (45.9)	42 (24.7)	10 (28.6)
Married or common law			
Urban	6 (16.7)	42 (23.7)	20 (37.7)
Rural	19 (31.1)	72 (42.4)	14 (40.0)
Separated, divorced or widowed			
Urban	11 (30.6)	58 (32.8)	19 (35.8)
Rural	14 (23.0)	31 (18.2)	11 (31.4)
Main source of income			
Public assistance, pension or insurance			
Urban	25 (71.4)	127 (82.9)	47 (88.7)
Rural	23 (40.3)	74 (45.9)	23 (67.7)
Employment			
Urban	6 (17.1)	25 (14.4)	1 (1.9)
Rural	15 (26.3)	53 (32.9)	5 (14.7)
Family			
Urban	1 (2.9)	18 (10.3)	4 (7.5)
Rural	14 (24.6)	26 (16.1)	3 (8.8)
Other			
Urban	3 (8.6)	4 (2.3)	1 (1.9)
Rural	5 (8.8)	8 (5.0)	3 (8.8)

SD = standard deviation.

*Values are frequency counts unless otherwise indicated.

appeared to have diagnoses. To examine this issue formally, we compared the overall number of psychiatric diagnoses across settings. Although we found similar overall proportions of diagnoses across age groups within settings, we found significant differences across settings. In the urban set-

ting, the proportion of patients with no diagnoses was 1.9%; with 1 diagnosis it was 45.1%; and with 2 or more diagnoses it was 53.0%. Conversely, these proportions were 18.4%, 47.4% and 34.2%, respectively, for the rural settings ($\chi^2_2 = 46.77$, $p = 0.001$). Also, while most patients were using psy-

Table 2. Diagnostic category (DSM-IV) and medical issues						
Diagnostic category and setting	Age, yr, n (and %)*			χ^2 †	df	p
	18–29	30–59	≥ 60			
Mood disorder				1.09	2	0.581
Urban	20 (55.6)	90 (50.8)	24 (45.3)			
Rural	20 (32.8)	65 (38.2)	19 (54.3)			
Anxiety disorder				0.31	2	0.857
Urban	10 (27.8)	44 (24.9)	14 (26.4)			
Rural	13 (21.3)	35 (20.6)	4 (11.4)			
Schizophrenia or psychotic				6.47	2	0.39
Urban	10 (27.8)	72 (40.7)	11 (20.8)			
Rural	6 (9.8)	20 (11.8)	4 (11.4)			
Personality disorder				2.85	2	0.240
Urban	9 (25.0)	28 (15.8)	7 (13.2)			
Rural	10 (16.4)	20 (11.8)	3 (8.6)			
Substance-related disorder				6.00	2	0.50
Urban	12 (33.3)	31 (17.5)	6 (11.3)			
Rural	11 (18.0)	27 (15.9)	3 (8.6)			
Organic disorder				58.38	2	0.001
Urban	1 (2.8)	9 (51.)	18 (34.0)			
Rural	0 (0)	5 (2.9)	5 (14.3)			
Mental retardation				1.03	2	0.597
Urban	1 (2.8)	12 (6.8)	0 (0)			
Rural	3 (4.9)	8 (4.7)	3 (8.6)			
Childhood or adolescence				3.92	2	0.141
Urban	3 (8.3)	14 (7.9)	0 (0)			
Rural	4 (6.6)	6 (3.5)	1 (2.9)			
Eating disorder				7.59	2	0.023
Urban	4 (11.1)	6 (3.4)	5 (9.4)			
Rural	4 (6.6)	5 (2.9)	3 (8.6)			
Other				2.54	2	0.281
Urban	1 (2.8)	21 (11.9)	7 (13.2)			
Rural	4 (6.6)	13 (7.6)	3 (8.6)			
Unknown				1.71	2	0.425
Urban	1 (2.8)	2 (1.1)	1 (1.9)			
Rural	5 (8.2)	16 (9.4)	1 (2.9)			
Number of diagnoses				0.35	4	0.990
No diagnoses						
Urban	1 (2.8)	3 (1.7)	1 (1.9)			
Rural	9 (14.8)	37 (21.8)	3 (8.6)			
1 diagnosis						
Urban	15 (41.7)	81 (45.8)	24 (45.3)			
Rural	32 (52.5)	75 (44.1)	19 (54.3)			
2 or more diagnoses						
Urban	20 (55.6)	93 (52.5)	28 (52.8)			
Rural	20 (32.8)	58 (34.1)	13 (37.1)			
Other medical diagnoses				11.30	2	0.004
Urban	12 (35.3)	87 (50.9)	30 (58.8)			
Rural	15 (27.3)	63 (39.1)	17 (50.0)			
df = degrees of freedom.						
*Values are frequency counts (percentages within the age group for each region).						
†Chi-squared values are based on the overall test of association between age and the presence of diagnoses.						

chotropic medications in the urban area (88.0%), a lower proportion of patients living in rural areas were using them (60.9%; $\chi^2_1 = 51.21, p = 0.001$). Further, the patterns across age groups were also different across settings. A greater proportion of middle-aged (90.4%) and older (90.6%) adults were using these medications, compared with the younger adults (72.2%) in the urban setting ($\chi^2_2 = 9.76, p = 0.008$), whereas the pattern of use did not differ significantly across age groups in the rural setting (57.4%, 60.0% and 71.4%, respectively; $\chi^2_2 = 2.01, p = 0.367$). In addition, the presence of other medical, non-psychiatric diagnoses was noted in 55.3% of older adults, compared with 30.3% of the younger ones and 45.2% of the middle-aged ones ($p = 0.004$; Table 2), but fewer such diagnoses were recorded for the rural setting (38.0%) than for the urban setting (50.4%; $\chi^2_1 = 7.87, p = 0.005$).

The documented disabilities identified by staff

illustrate different functional limitations in older adults (Table 3). Although the overall number of disabilities was similar, a greater proportion of older patients had hearing disabilities ($p = 0.001$). Further, 15.9% of older patients were non-ambulatory, compared with only 4.3% of the middle-aged adults and none of the younger adults ($p = 0.001$).

An analysis of the need for services and supports revealed considerable needs for this population as a whole, yet a number of differences between the 3 groups appear consistent with the above-noted medical issues and disabilities, in addition to differences that may arise because of age-related changes. Staff reported greater needs for older adults, compared with younger ones, regarding medication management, physical health care, self-care and other activities of daily living. In addition, the respondents identified greater needs for the families and caregivers of older

Table 3. Patients' documented disabilities as identified by staff.						
Type of disability	Age, yr, n (and %)*			χ^2 †	df	p
	18–29	30–59	≥ 60			
Developmental				2.56	2	0.279
Urban	1 (2.8)	13 (7.3)	0 (0)			
Rural	4 (6.6)	10 (5.9)	2 (5.7)			
Deaf				32.23	2	0.001
Urban	0 (0)	2 (1.1)	7 (13.2)			
Rural	1 (1.6)	7 (4.1)	7 (20.0)			
Blind				3.83	2	0.147
Urban	0 (0)	6 (3.4)	4 (7.5)			
Rural	1 (1.6)	3 (1.8)	1 (2.9)			
Speech impairment				1.30	2	0.522
Urban	0 (0)	6 (3.4)	3 (5.7)			
Rural	1 (1.6)	1 (0.6)	0 (0)			
Non-ambulatory				25.12	2	0.001
Urban	0 (0)	9 (5.1)	11 (20.8)			
Rural	0 (0)	6 (3.5)	3 (8.6)			
Learning				4.72	2	0.095
Urban	1 (2.8)	11 (6.2)	1 (1.9)			
Rural	7 (11.5)	9 (5.3)	0 (0)			
Other				2.52	2	0.283
Urban	9 (25.0)	41 (23.2)	5 (9.4)			
Rural	5 (8.2)	29 (17.1)	8 (22.9)			
Number of disabilities				6.75	4	0.150
No disabilities						
Urban	26 (72.2)	110 (62.1)	33 (62.3)			
Rural	46 (75.4)	117 (68.8)	19 (54.3)			
1 disability						
Urban	9 (25.0)	52 (29.4)	13 (24.5)			
Rural	12 (19.7)	41 (24.1)	12 (34.3)			
2 or more disabilities						
Urban	1 (2.8)	15 (8.5)	7 (13.2)			
Rural	3 (4.9)	12 (7.1)	4 (11.4)			

df = degrees of freedom.

*Values are frequency counts (percentages within the age group for each region).

†Chi-squared values are based on the overall test of association between age and the presence of diagnoses.

adults, compared with those of younger adults. However, fewer needs for older adults were reported regarding psychotherapy and counselling, substance abuse programming, vocational issues, and correction, probation or parole issues. These data are shown in Table 4.

DISCUSSION

We found important differences between older and younger users of community mental health services. Not only is this a relevant observation on its own, but it also highlights the importance of carefully considering the local context when devising services for older adults with an SMI.⁸ We found that a greater proportion of older adults, compared with younger ones, had a diagnosis of organic disorder, used psychotropic medications and had other, non-psychiatric medical diagnoses. This is consistent with the results of others showing increased comorbidity among older adults⁶ and also illustrates that the mental health system must be able to adequately

serve distinct groups, whether based on age, as in this study, or based on ethnic differences as suggested by others.⁹

The needs of the older adults were consistent with these medical and functional problems and contrasted with those of younger adults in important ways. A greater proportion of older adults needed support with medication management. This is consistent with our observation that a greater proportion of older adults are using psychotropic medications. It is also consistent with the greater use of medication in older adults, in general, and the heightened risk of medical complications related to medication use.¹⁰ There was also a greater need regarding physical care, self-care and other activities of daily living, possibly compounding the medical difficulties identified above.

Another observation was the greater need for support of the family of older adults. One explanation for this finding is that some of the caregivers are becoming older and have medical concerns or functional limitations of their own. Another possibility is

Table 4. Need for supports or services						
Support or service and setting	Age, yr, n (and %)*			χ^2 †	df	p
	18–29	30–59	≥ 60			
Medication management				6.55	2	0.038
Urban	23 (67.6)	139 (81.1)	43 (82.7)			
Rural	30 (53.6)	83 (52.5)	21 (67.7)			
Assessment or diagnosis				4.85	2	0.088
Urban	23 (74.2)	120 (71.9)	39 (81.3)			
Rural	35 (63.6)	86 (56.6)	23 (71.9)			
Psychotherapy or counselling				10.31	2	0.006
Urban	31 (93.9)	136 (80.0)	35 (70.0)			
Rural	55 (91.7)	147 (90.7)	29 (82.9)			
Substance abuse program				7.08	2	0.029
Urban	17 (56.7)	57 (33.9)	13 (28.9)			
Rural	23 (40.4)	57 (37.5)	8 (22.9)			
Crisis intervention				3.39	2	0.184
Urban	20 (64.5)	99 (58.9)	19 (43.2)			
Rural	29 (50.9)	73 (48.0)	15 (42.9)			
Physical health care				7.43	2	0.024
Urban	26 (74.3)	135 (83.3)	44 (88.0)			
Rural	38 (70.4)	103 (67.8)	30 (88.2)			
Dental care				0.39	2	0.821
Urban	23 (67.6)	107 (69.9)	29 (65.9)			
Rural	34 (69.4)	80 (59.7)	22 (68.8)			
Self-care				17.59	2	0.001
Urban	3 (8.6)	63 (37.1)	23 (46.0)			
Rural	8 (14.8)	24 (15.4)	11 (32.4)			
Other ADL				15.81	2	0.001
Urban	9 (25.7)	76 (45.5)	31 (64.6)			
Rural	15 (27.8)	46 (29.1)	15 (44.1)			
Vocational				14.64	2	0.001
Urban	21 (63.6)	83 (50.3)	14 (32.6)			
Rural	26 (46.4)	52 (32.9)	4 (12.1)			

that many of the older patients have dementia (26% of older adults had a diagnosis of organic disorder). There is sufficient evidence demonstrating that caring for someone with dementia can result in considerable strain.¹¹ With current trends favouring community living over institutionalization¹² it is likely that families will assume greater responsibilities in the care of older adults.

It is not surprising that respondents reported fewer needs for older adults regarding vocational and correction, probation or parole issues. However, the respondents also reported fewer needs of older adults for psychotherapy or counselling, compared with their younger counterparts. This finding may be explained by the larger proportion of older individuals with an organic diagnosis; it is possible that people with such a diagnosis may not benefit from psychotherapy or counselling interventions. However, older adults are often perceived as less likely to benefit from interventions and some illnesses (e.g., depression) are often seen as part of normal aging.¹³ Further research should examine whether all older adults with an SMI receive the psychotherapy or counselling they need.

We found that fewer people in the rural setting had diagnoses (psychiatric or other) and that fewer used psychotropic medications. One possible explanation is that people with more severe illness moved to the urban centre to access treatment. Another is that there are fewer physicians available in the rural setting to make formal diagnoses and prescribe medications. While it is not possible with the current data to answer this question, we noted that the number of disabilities (which is not dependent on the presence of a physician) did not differ across settings. It will be important to resolve this issue to ensure that people with an SMI can "age in place."

Implications for service delivery

Possibly the first important observation regarding our sample is the great level of need regardless of the age category. This should not be surprising given that we surveyed providers of services to individuals with SMIs. However, the greater proportion of older adults with functional limitations and physical disabilities results in a distinct profile of needs for

Table 4. continued						
Meaningful activity				2.75	2	0.253
Urban	24 (68.6)	120 (70.2)	43 (81.1)			
Rural	30 (53.6)	79 (51.3)	16 (51.5)			
Educational				5.12	2	0.077
Urban	18 (52.9)	77 (46.4)	14 (31.8)			
Rural	23 (41.1)	44 (27.7)	8 (24.2)			
Social or recreational				3.78	2	0.151
Urban	25 (71.4)	123 (73.2)	42 (79.2)			
Rural	33 (58.9)	83 (52.9)	22 (66.7)			
Housing support				0.50	2	0.778
Urban	13 (38.2)	79 (46.5)	25 (50.0)			
Rural	17 (28.8)	35 (22.2)	6 (18.2)			
Income or financial assistance				0.20	2	0.906
Urban	16 (47.1)	94 (55.3)	24 (54.5)			
Rural	25 (43.1)	63 (38.4)	13 (8.2)			
Rights protection				2.00	2	0.369
Urban	10 (31.3)	64 (37.9)	24 (48.0)			
Rural	15 (26.8)	47 (30.1)	8 (24.2)			
Support to family				10.42	2	0.005
Urban	17 (48.6)	67 (39.2)	30 (56.6)			
Rural	22 (40.0)	49 (32.0)	17 (51.5)			
Correction, probation or parole				11.02	2	0.004
Urban	8 (23.5)	21 (12.2)	2 (4.3)			
Rural	13 (22.4)	21 (13.0)	3 (8.6)			
Developmental disability				4.16	2	0.125
Urban	1 (2.9)	10 (5.9)	0 (0)			
Rural	6 (10.5)	14 (8.8)	1 (2.9)			
<i>df</i> = degrees of freedom; ADL = activities of daily living. *Values are frequency counts (percentages within the age group for each region). †Chi-squared values are based on the overall test of association between age and the presence of need for supports or services.						

older adults, compared with that of younger adults. Our findings corroborate other studies indicating that services need to address physical illnesses, caregiver burden, organic disorders and problems with activities of daily living for older users of mental health services.¹⁴

The differences between older and younger users of community mental health programs point to the necessity of ensuring that health care professionals devising the treatment plans consider what is for many a lifetime of SMI, medication use and poor health behaviours.⁷ Because these older adults have been living under unfavourable conditions for a long time they require comprehensive and well-coordinated care according to best practices.⁸ These considerations should be included when developing programs for older adults with an SMI. A necessary condition for the successful delivery of services to this population includes more training in geriatrics for care providers.¹⁰

It is also necessary to recognize that older adults can be helped by community treatment. Researchers, clinicians and patients need to continue to contest the stereotype that depression, anxiety disorders or alcohol abuse are a component of old age.⁵ Many therapies have proven effective for older adults (see Bartels and colleagues for a review of evidence-based practices).¹⁵ Early recognition and responsive treatment of mental illnesses can result in improved quality of life for patients and their caregivers. For example, cognitive behavioural therapy has been successful when working with the elderly in outpatient settings.¹⁶ Older adults who received the services of a psychiatrist have also shown improvement.⁶ Outreach mental health programming has been found to effectively support patients and their families.¹⁷ An intensive case management model targeted to older adults also resulted in improvements for patients and their caregivers.¹⁸ However, one obvious challenge is to deliver adequate services in a rural and remote context where these specialized services may be less accessible. Although this setting poses considerable challenges, it may be feasible by using nurses trained in psychiatric and medical issues as case managers,⁷ other health care professionals and tele-medicine.

The data also highlight important needs of the informal caregivers. This reinforces our belief that the health care system should consider the dyad (care recipient and caregiver) as the focus of interventions. Not surprisingly, guidelines for the management of dementia suggest the consideration of

caregivers in the development of care plans.¹⁹ Supporting caregivers is an additional approach to best serve the needs of people with SMIs.

LIMITATIONS

Our study has sampling limitations that should be taken into account when considering the results. Staff assessments could only be done on people who were accessing services; we do not have information about people who were not using specialized mental health programming in their communities. Similarly, we did not include individuals who received mental health care from primary care providers such as general practitioners. Research has shown that older adults are more likely to see their general practitioner about a mental health problem,²⁰ but it is unclear how this pattern fits with the more severely ill. Also, the First Nations population in the region was underrepresented in the sample. Several of the programs providing services to First Nations people have not had data collected on program participants, which prevented us from including them in the project. Further, mental health programming provided to First Nations people is federally sponsored and these organizations did not take part in this study. However, for the users of the programs examined, we obtained a large representative sample.

CONCLUSION

This sample provides a clear picture of the considerable needs of people with SMI. It also identifies older people with SMI as a distinct group, requiring special attention. While the geographical limitations imposed by rural and remote regions are substantial, developing and embracing innovative approaches to the delivery of care for people with an SMI has the potential to improve their health outcomes and quality of life.

Acknowledgements: The authors thank the staff and management at all of the participating programs.

This study was made possible with funding from the Northwestern Ontario District Health Council and the Ontario Ministry of Health and Long-Term Care. The opinions expressed herein are those of the authors and do not necessarily reflect the Northwestern Ontario District Health Council, the Ontario Ministry of Health and Long-Term Care, St. Joseph's Care Group or Lakehead University. Michel Bédard is a Canada Research Chair in Aging and Health (www.chairs.gc.ca); he acknowledges the support of the Canada Research Chair Program.

Competing interests: None declared.

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