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ORIGINAL RESEARCH

Perceived barriers to mental health care and goal setting among depressed, community-dwelling older adults

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Objective: Older adults are particularly vulnerable to the deleterious effects of depression and tend to underutilize mental health services. The current study aims to characterize the perceived barriers to care and goal setting in a sample of depressed, community-dwelling older adults.

Methods: We report on the association among perceived barriers to care, goal setting and accepting a mental health referral using a subset of data from a larger study. The Patient Health Questionnaire (PHQ-9) was used to assess depressive symptoms.

Results: Forty-seven participants completed the study (Mean age = 82, SD = 7.8, 85% female). Accessing and paying for mental health treatment were the barriers most frequently cited by participants. Clinical improvement and improved socialization were most cited goals. In bivariate associations, participants who set goals ($\chi^2 = 5.41$, $p = 0.02$) and reported a logistic barrier ($\chi^2 = 5.30$, $p = 0.02$) were more likely to accept a mental health referral.

Conclusion: Perceived barriers to care and goal setting appear to be central to accepting a mental health referral among community dwelling older, depressed adults. Developing interventions that can be used to increase mental health service utilization of older adults is necessary.

Keywords: depression, older adults, community, perceived barriers to care

Introduction

Late-life depression is a growing public health problem and is associated with increased suffering, disability, and diminished health-related quality of life.[1,2] Approximately 1%–4% of community-dwelling older adults,[3] 6%–8% of primary care patients,[2] and more than 30% of nursing home patients[4] have major depressive disorder (MDD).

Depression is prevalent among community-dwelling older adults with functional limitations[1–4] and often goes untreated and unrecognized.[1] Data from several studies have shown that anywhere from 25%–33% of older adults receiving home-based services suffer from depression.[4–6] Moreover, up to 50% of community-dwelling older adults with psychiatric illness do not receive mental health services and even fewer elders receive evidenced-based treatments.[7] Given the large percentage of homebound older adults who do not receive depression treatment, increased understanding of the barriers to utilization of mental health services and factors that can facilitate mental health referrals could improve access to care among those elders with need.

Perceived barriers to mental health care may be conceptualized as psychological (ie, stigma, social attitudes, beliefs about depression and its care), logistical (ie, transportation, availability of services)[8] or illness-related that are either modifiable or not (eg, comorbid anxiety, depression severity, cognitive status).[9] For example,

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stigma represents a psychological barrier that can reduce access to care in elders and impede recovery.[10,11] While older persons face greater logistical barriers as a result of aging-related disabilities and the disparity in Medicare mental health coverage, these seemingly intractable barriers may be more surmountable when care is perceived as necessary and useful.[8] Moreover, cost, insurance, transportation, and mobility issues can all have a negative impact on engaging older adults in mental health treatment.[6,12] Patient perception is particularly important in expanding our understanding of the barriers to mental health treatment. In a study of mixed-aged adults beginning treatment for depression, an individual's perception of his/her depression severity predicted medication adherence better than objective ratings of severity on the Hamilton Depression Rating Scale (HDRS).[10]

Anticipated barriers to care can erode the perceived view of the usefulness of the recommended treatment. Individuals who perceive a number of barriers they must overcome, a mental health referral can appear burdensome rather than helpful. Defining a personal goal for treatment may be thought of as potentially increasing the relevance of seeking help and improving access to care. In the current study, we present descriptive data on the treatment goals and barriers to care reported by a sample of depressed, community-dwelling, older adults receiving home-delivered meals. We also examine the relations among goal setting, perceived barriers to care, and accepting a mental health service referral.

Goal setting has been shown to improve outcomes in treatment studies conducted among adults with depression.[13–15] The process of setting a goal has become the major focus in several of the current psychotherapies used to treat depression including interpersonal psychotherapy (IPT), cognitive and cognitive behavioral therapy (CT and CBT) and problem-solving therapy (PST). All of these evidenced-based treatments define a goal in their treatment plans to improve treatment compliance and adherence to the psychotherapy.

Several recent studies have been conducted on the impact of goal setting on depressive symptoms. Cognitive inconsistencies between attitudes and beliefs about certain goals were higher among depressed patients than nondepressed patients.[13] Uebelacker and colleagues[13] argue that a better understanding of depressed patient's treatment goals may lead to improved treatment and help guide researchers and clinicians in developing and selecting appropriate outcome measures. By better understanding the role and nature of treatment goals, clinicians and researchers can more effectively manage and personalize treatment, which is one of the National Institute of Mental Health's cornerstone values in their strategic plan.

Methods

Sample

Interviews were conducted from December 2004 through June 2006 with all consecutive and willing older adults applying for home-delivered meals and receiving a meal certification interview. Data for the current study were collected as part of a larger study on the incidence of depression among home-delivered meal participants with the goal of developing improved interventions for this high-risk group. In the larger study of 403 meal recipients,[1] approximately 12% of older adults reported clinically significant depression (47/403).

The sample for the current study consisted of 47 older adults who scored a 10 or above on the Patient Health Questionnaire (PHQ-9)[16] indicating "clinically significant" depressive symptoms requiring a plan as part of routine screening. All participants were recommended a mental health follow up or free follow-up screening for depression.

The sampling process has been described in detail elsewhere.[1] In brief, an older adult is eligible for the home delivered meal program if that individual has a condition, due to illness or injury that restricts the individual's ability to leave the home except with the assistance of another individual or the aid of a supportive device.

Measures

To measure depression severity, the PHQ-9 was used. The PHQ-9 measures the frequency of depressive symptoms on a four-point scale from 'not at all' to 'nearly every day.' The PHQ-9 has been to be found easy to administer and has been reliability used by nonpsychiatric interviewers in home health care settings[17] and in community samples.[18] The PHQ-9 is widely used because it offers a measure of symptom severity, rates the pervasiveness of each symptom used as criteria to establish a DSM-IV major depressive disorder, and has established treatment planning guidelines.

Next, participants were asked questions regarding their treatment goals and perceived barriers to treatment. Participants were asked to identify any barriers to accessing care. After their spontaneous response, lists of barrier domains were reviewed in an open-ended manner. Barrier domains included logistic barriers such as transportation, cost, insurance, and mobility, lack of knowledge about depression, attributional barriers (ie, attributing their depression to outside stressors such as another medical illness, financial trouble, or a recent loss), social barriers (ie, stigma, concern for family

members), self-reliance, ageism, resignation, poor prior mental health experience, and/or using informal support.

Participants were then asked if they had a goal they would like to achieve if treatment worked. Goals were recorded in the participant's own words, and then later categorized into one of the following groups based on the frequency of responses: (1) increased socialization (eg, I want to "be more active with my family"), (2) clinical improvement, (eg, "I want to feel better") (3) mobility (eg, "I want to go out more"), (4) knowledge about depression (eg, "I want to understand my symptoms"), (5) too hopeless to create a goal, and (6) treatment ambivalence (eg, "I am not depressed, and I don't need help.")

Data analysis

We characterized the barriers to care and treatment goals among depressed, community-dwelling older adults. We present data on the descriptive nature of our sample in relation to barriers to care, treatment goals, and on accepting a mental health referral. In addition, we were able to conduct Chi-square analyses to examine the relation between these variables.

Results

The mean age of the sample was 82 years old (standard deviation [SD] = 7.8 years) and primarily female (85%). The mean level of depression on the PHQ-9 was 13.4 (SD = 4.43), corresponding to "moderate" depressive symptoms. Fourteen of the 47 (30%) participants were minority (11/47; 23% African American, 3/47; 6% Latino). Twenty-three out of the 47 (49%) participants in the study accepted a mental health referral. Table 1 illustrates the number of participants who endorsed each category of barrier to care. Of note, barrier responses are not mutually exclusive, as participants can report multiple barriers. The majority of participants (39/47; 83%) reported more than one barrier (M = 2.61, SD = 0.99). Logistic barriers including cost, transportation, mobility, and insurance were cited most frequently. Attribution of illness (ie, attributing their depression to outside stressors such as another medical illness, financial trouble, or a recent loss) was second most frequent with the most frequent attribution of depression being caused by a medical illness which was cited by one third of the participants (7/21) within this domain.

Table 2 illustrates the number of participants who set specific goals for treatment. Thirteen percent (6/47) of patients did not set a treatment goal. Of those individuals who set goals, (87%, 41/47), 68% (28/41) of participants set one goal, 32% (13/41) set two goals, and 5% (2/41) set three goals. Clinical improvement was the goal most often stated by those older adults interviewed (49%, 20/41). Participants who set this type of goal made statements such as I want "to live a depression-free life," "to feel better and be less overwhelmed", and "resume pleasure in hobbies, and not be depressed anymore."

Table 3 illustrates the number of participants who endorsed each barrier domain and the frequency with which they accepted a mental health referral. For participants who accepted a mental health referral, logistical barriers were most frequently endorsed. Conversely, for participants who did not accept a mental health referral, self-reliance was the

Table 1 Barriers reported by domain

Barriers*	Number of Participants (n = 47)	Percentage
Logistical	31	66
Cost	5	11
Transportation	19	40
Insurance	1	2
Mobility	17	36
Knowledge	7	15
Attribution	21	45
Medical Illness	7	15
Reluctance for care	4	9
Recent loss	4	9
Finances	1	2
Social	16	34
Stigma	5	11
Concern for family	11	23
Self reliance	19	40
Ageism	9	19
Resignation	10	21
Poor prior experience	3	6
Using informal support	8	17

Note: *Patients could endorse more than one barrier. Percentages represent absolute percentages of the entire sample (ie, X/47).

Table 2 Number of participants who endorsed each goal

Goals*	Number of participants (n = 41)
Increased socialization	15
Clinical improvement	20
Independence/Mobility	14
Knowledge about depression	3
Too hopeless to create a goal	3
Not depressed or interested in outside help	4

Note: *Patients could endorse more than one goal.

Table 3 Number of participants who endorsed each barrier domain and whether or not they accepted a mental health referral

Barrier domain endorsed	Yes Referral	No Accepted
Logistical	18	11
Knowledge	1	6
Attribution	9	9
Social	5	8
Self-reliance	6	13
Ageism	4	5
Resignation	7	2
Poor prior experience	4	7
Using informal support	2	1
Total number of barriers	56	62

most often cited reason. In other words, participants who felt they could address their symptoms themselves were more likely to refuse a mental health referral.

In bivariate analyses, participants who set goals were significantly more likely to accept a mental health referral ($\chi^2 = 5.41$, df = 1, p = 0.02) than participants who did not set goals. Moreover, participants who reported a logistic barrier (ie, transportation, insurance, mobility, or cost) were also significantly more likely to accept a mental health referral ($\chi^2 = 5.38$; df = 1, p = 0.02) compared to individuals without a logistic barrier. Age, race, and gender did not have a significant impact on accepting a mental health referral.

Discussion

The majority of older adults who reported depressive symptoms that would warrant treatment cited barriers to accepting a mental health referral. Overall, logistical barriers represented the most often encountered barrier endorsed by this sample. As expected, older adults are aware that their ability to engage in treatment are affected by factors related to access and payment for care that are beyond their control including transportation, cost, and mobility. Of note, this barrier was more frequently endorsed among participants who accepted a mental health referral compared to individuals who did not. At first glance, it would appear that this finding is counterintuitive. However, it may be that engaging in barrier identification is the first step to initiating treatment.[13] It is also possible that these individuals may have greater social support or other factors that could explain this finding that were not collected or analyzed in this study (eg, marital status, living arrangements). Future research should explore the different factors (ie, enabling and predisposing) that can support and hinder access to mental health care.[19]

Despite the seemingly widespread knowledge of depression and antidepressant therapy, many older persons are unfamiliar with treatment and have concerns. Psychoeducational approaches aimed at educating patients about depressive symptoms, their treatment options, and risk factors should be a part of any access intervention. For example, the Treatment Initiation Program (TIP) is an early intervention to address older adults' attitudes about depression and treatment and has been found to be a successful way to overcome stigma in older adults.[20]

Goal setting may be viewed as a bridge between the older adults' perspective and the professionals' view on why treatment is recommended. The goals most often reported among the patients in this sample were to "increase socialization" and for "clinical improvement." Simply put, these patients wanted to feel better and become more socially engaged. Both goals could be achieved if treatment was initiated and sustained.

Participants who set goals were more likely to accept a mental health referral. Though our findings are preliminary, goal setting appears a necessary first step in having an older depressed adult accept a mental health referral. Setting treatment goals help assess an individual's attitudes towards mental health treatment in general, and allows for a more collaborative process of depression care.[13]

The current study has limitations. First, this study had a relatively small sample size, which precluded more sophisticated statistical methods for data analysis. Therefore, the current study was primarily descriptive in nature. Second, we elicited barriers from the participants. If participants initially denied having barriers, the interviewer continued to go through a list in an orderly fashion asking about potential barriers. Therefore, the barriers assessed in the current study were not spontaneously reported but were cued. This approach may be necessary among older adults given their reluctance to report barriers to care, yet, for the purposes of the current study may have biased or over-represented the barriers endorsed. Lastly, the definition and classification of concerns and attitudes as barriers originate with the clinicians' perspective. Our findings suggest that many patients share these views. However, more work could elucidate older adults', especially minority elders, perspectives on treatment seeking and depression.

Conclusion

Depression is highly prevalent in community-dwelling older adults with difficulties carrying out tasks of daily living. Barriers to mental health care remain obstacles to effective treatments for depression. Being able to articulate the barriers

to care and setting a goal appear to be central to accepting a mental health referral in this sample. Developing interventions that can be used to increase mental health service utilization of older adults is necessary. Moreover, increased attention and focus is needed to better understand and reduce the barriers to care in this high-risk population.

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