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Barriers to Mental Health Treatment in Rural Older Adults

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Abstract

Objectives—The purpose of this study was to identify the barriers to seeking mental health treatment experienced by rural older adults. We also examined if barriers differed by age and worry severity.

Methods—Participants were 478 rural older adults responding to a flyer for a psychotherapy intervention study. Interested participants were screened by telephone, and barriers to mental health treatment were assessed. Participants completed a demographic questionnaire and the Penn State Worry Questionnaire-Abbreviated.

Results—The most commonly reported barrier to treatment was the personal belief that "I should not need help". Other commonly reported barriers included practical barriers (cost, not knowing where to go, distance), mistrust of mental health providers, not thinking treatment would help, stigma, and not wanting to talk with a stranger about private matters. Multivariable analyses indicated that worry severity and younger age were associated with reporting more barriers.

Conclusions—Multiple barriers interfere with older adults seeking treatment for anxiety and depression. Older age is associated with fewer barriers, suggesting that the oldest old may have found strategies for overcoming these barriers. Young-old adults may benefit from interventions addressing personal beliefs about mental health and alternative methods of service delivery.

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Keywords

barriers; elderly; mental health; rural

Introduction

Anxiety and depressive disorders are common in older adults, with 12-month prevalence rates of 4.9% and 11.6% respectively (1). Nonetheless, rates of mental health care utilization remain low; approximately 70% of older adults with anxiety and depressive disorders do not obtain treatment (2,3). One largely understudied population is older adults with mental health disorders living in rural communities. This group is particularly important, as elderly and rural dwelling adults have the greatest unmet need for treatment (4).

Recognition of a problem and need for treatment are the first steps in receiving care. Older adults are less likely than younger adults to recognize mental health problems (5,6) and to perceive a need for treatment (7,8). However, not all older adults with a perceived need for treatment receive help (3,8), and barriers for this group may differ. Further, barriers to mental health treatment among rural adults are high (9) and include access to affordable care, availability of mental health providers in rural areas, transportation and long distances to providers, and difficulty navigating the health care system (10). Stigma may also be of greater concern in rural versus urban communities (11). It is likely that rural older adults may be even more likely than their urban and suburban counterparts to experience barriers to treatment, particularly due to a combination of a lack of mobility, transportation, and nearby services. Understanding factors that serve as barriers to mental health care utilization may allow researchers and clinicians alike to develop strategies for overcoming these barriers and ultimately increase utilization. The purpose of this study is to identify barriers to receiving treatment for anxiety and depression among rural older adults with a perceived need for care and to determine whether these barriers differ by age and symptom severity.

Methods

Study sample

As part of a larger intervention study of telephone psychotherapy for the treatment of anxiety (12), a commercial mailing company was used to send flyers to adults 60 years and older living in rural NC. Interested participants were encouraged to call a toll free number and received a summary of the study. Those who provided verbal consent then underwent a brief screening by telephone to assess whether they met inclusion and exclusion criteria for the study. This screener included demographic information, a measure of worry, and barriers to receiving care for anxiety or depression. These were all administered by telephone by a trained research assistant.

Inclusion criteria for the larger intervention study included a principal or co-principal diagnosis of generalized anxiety disorder (GAD) and living in a rural county in NC (population < 20,000). Exclusion criteria included current psychotherapy; active alcohol or substance abuse; a diagnosis of dementia or global cognitive impairment; psychotic symptoms; active suicidal ideation with a plan and intent; any change in psychotropic

medications within the last 1 month; bipolar disorder; and any hearing that would prevent a person from participating in telephone sessions. (All criteria except a diagnosis of GAD were assessed during this brief telephone screening.)

From a total of 422,896 mailed flyers, we received 1,447 calls of interest. We were unable to reach 133 people. Among the 1,314 people reached, 359 were not interested in the study, and 955 were screened. Because screening ended when a person met an exclusion criterion or did not meet an inclusion criterion and the barriers measure was the final measure administered during the screening process, we obtained complete data on 478 people. Reasons for ineligibility are included in Table 1. In the current manuscript, we describe the barriers that older adults reported to receiving care for anxiety or depression.

Measures

Demographic information, including age, race, gender, county of residence, and education was collected.

Worry was assessed with the Penn State Worry Questionnaire-Abbreviated (PSWQ-A). The PSWQ-A is an 8-item measure of the frequency and intensity of worry (13). The items are rated on a 5-point scale and then summed, with higher scores indicating more severe worry. The full PSWQ has demonstrated reliability and validity in older adults with GAD (14–16). The PSWQ-A has similar internal consistency, better test-retest reliability, and comparable convergent-divergent validity as the full length version (13,17). Participants with a PSWQ-A score ≥ 16 underwent a diagnostic interview to determine if they met criteria for a DSM-IV diagnosis of GAD.

Questions that assessed barriers to getting help for anxiety or depression were from the Healthcare for Communities Study measure (18) and the Perceived Barriers to Psychotherapy measure (19). Participants rated how much 14 practical (cost, not knowing where to go, transportation, distance, loss of pay, caregiver responsibilities, Medicare not accepted), personal beliefs (do not think it would help, should not need help, mistrust of providers, do not want to talk about private matters with a stranger), and stigma (embarrassment, what others would think, racial or cultural discrimination) barriers interfered with getting help. Response options were “not at all,” “a little,” “somewhat,” and “quite a bit.” Responses of “a little,” “somewhat,” or “quite a bit” were summed to create a measure of any interference from barriers (range 0 to 14). Scores by type of barrier (practical, personal beliefs, stigma) were obtained by summing across all relevant barriers. This measure is included in Appendix 1.

Statistical Methods

Demographic characteristics, health characteristics, and barriers were summarized with means, standard deviations, counts, and percentages. The relationship between the number of barriers reported and age and worry severity were examined with Pearson’s correlation coefficient and analysis of variance. Multiple linear regression modeling was used to determine independent predictors of the overall barriers score with age, gender, race, education, and worry severity entered as independent variables.

Results

The participants ranged in age from 60 to 95 years, with most participants in their 60s and 70s (M = 68.4, SD = 7.1). The sample was largely white (80.8%; African American = 15.3%) women (77.4%) who completed at least 11 years of education (94.0%). Only 1 person reported being in therapy, and 57.7% reported taking psychiatric medications. (See Table 2.) A large proportion of the sample (75.3%) reported that they needed help with anxiety or depression in the last year.

In Table 3, we present the frequency of occurrence of each barrier, in addition to summary statistics on the overall and sub-scale scores. The most commonly reported barrier related to personal beliefs about seeking help, with 80.1% reporting that they "should not need help." More than a third of the sample reported that they mistrust mental health providers (41.9%), do not want to talk about personal matters with a stranger (41.2%), and do not think treatment would help (40.0%).. Practical barriers were also reported, including cost (58.4%), not knowing where to go (49.6%), distance from provider (37.0%), and providers not accepting Medicare (27.8%). Other frequently endorsed barriers were embarrassment (39.8%) and worry about what others would think (39.8%).

Significant associations were found between total number of barriers and age ($r = -0.19$, $n=478$, $p < .0001$) and worry severity ($r = 0.21$, $n=478$, $p < .0001$). Older adults tended to report fewer barriers, and more severe worry was associated with a greater number of reported barriers. Additional correlational analyses were conducted to determine the types of barriers associated with age and worry severity. Older adults reported fewer practical barriers ($r = -0.12$, $p < .05$), personal beliefs ($r = -0.18$, $p<.001$), and stigma ($r= -0.14$, $p < .01$). Increased worry severity was positively correlated with practical barriers ($r = 0.16$, $p<.001$), personal barriers ($r=0.14$, $p<.01$), and stigma ($r = 0.18$, $p<.0001$).From the multiple linear regression modeling, age was negatively associated [Coefficient (Standard Error) = −0.06 (0.02); $t=-2.96$, $df=452$, $p < .01$] and worry severity [Coefficient (Standard Error) = 0.09 (0.02); $t=3.98$, $df=452$, $p<.0001$] was positively associated with the number of barriers reported.

Discussion

Rural older adults endorsed a number of barriers to receiving mental health care. Personal beliefs about mental health care were the most frequently reported barriers. In particular, 80% of the sample endorsed the belief “I should not need help.” Further, 40% reported a mistrust of mental health providers, the belief that treatment would not help and a desire not to talk about personal matters with a stranger, as well as stigma and embarrassment. These negative personal beliefs are particularly important as these older adults reported a need for help and displayed a basic willingness to consider psychotherapy as evidenced by their inquiry into the study, yet they still endorsed personal beliefs that interfere with getting the care they need. Thus, recognition of a need for help may be necessary but is not sufficient for receiving care.

Compared with other findings, our sample of rural dwelling older adults reported similar or greater levels of interference from barriers. Primary care patients with panic disorder reported less interference from practical barriers, the belief that treatment would not help, and embarrassment than the current sample, but more interference from taking time off from work and losing pay than the current sample (20). Compared with adults 55 years and older from the National Comorbidity Study-Replication, our sample reported higher levels of stigma and a stronger belief that treatment would not help (21). This finding is problematic, as stigma (as well as discomfort in talking about personal problems) is associated with decreased use of mental health care among older adults, and lack of belief in the efficacy of treatment has been associated with decreased mental health care among older adults with severe anxiety or depression (2).

MacKenzie and colleagues (8) examined barriers to mental health care treatment among older adults who perceived a need for treatment and were included in the Collaborative Psychiatric Epidemiology Surveys (n = 36–58). Our sample reported greater worry over what others would think and concerns about costs. They reported comparable concerns about lack of efficacy, not knowing where to go, worry about insurance coverage, and logistical problems of family care and transportation. Further, 69% of their sample reported a desire to handle problems on their own, while 80% of our sample believed that they should not need help.

In addition to attitudinal barriers, half the sample reported cost and not knowing where to go for help as barriers. These results are consistent with those of Weinberger and colleagues (22). Their sample of depressed older adults reported logistical barriers, including transportation, cost, insurance, and mobility to be the most frequent barriers that interfered with accessing mental health care. Bocker and colleagues sampled rural older adults about barriers to mental health treatment and found that over half of their sample reported cost was a barrier (9).

In the current study, increased age was associated with fewer barriers to seeking mental health treatment. The oldest old may perceive fewer barriers to mental health care because they have developed successful strategies for overcoming these barriers. As people age and develop more health conditions, they may be more likely to have developed solutions to overcome obstacles to receiving health care. Alternatively, older adults may have fewer competing demands for their time and resources. Worry was associated with increased barriers which is consistent with literature showing a correlation between symptom severity and barriers. Increased depression severity has been associated with increased barriers to treatment (23,24). In the current study, increased worry severity was associated with increased number of total barriers reported. People with a tendency to worry are more likely to interpret information in a negative or threatening manner and therefore may be more likely to perceive more barriers to care than those who do not worry.

Because this study included participants who were screened as part of a larger study, some of the inclusion and exclusion criteria for study participation might be considered barriers to treatment. Basic literacy was required in order to read and understand the recruitment flyer. The most common reasons for ineligibility included unavailability during business hours,

currently receiving psychotherapy, global cognitive impairment, and not residing in a targeted rural county. The study was conducted during the confines of regular business hours, excluding potential participants who may work or have other regular obligations. Potential participants who were currently receiving psychotherapy were excluded in order to prevent interference with their current treatment. Participants with global cognitive impairments or dementia also were excluded. The rates of mild cognitive impairment range from 3.7% to 7.9% (25), and the prevalence dementia is 6.5% (26). These individuals were excluded due to the reliance on only telephone-based contact and heavy reliance on cognitively intense tasks (i.e, cognitive-behavioral therapy) that would likely be difficult for individuals with cognitive impairments. This is an important area to study, as anxiety may be associated with cognitive impairment (27). Further, some studies have modified treatments for this population and have found promising results (28). It should be noted that the prevalence of these barriers is likely an underestimate as these factors may have also prevented potential participants from making contact with the study.

There are a number of limitations of this study. First, the sample was predominantly comprised of white women; thus findings may not generalize to other ethnicities/races or men. Second, because the study was conducted by telephone, people with hearing difficulties were excluded. Although those without a telephone were excluded, only 4% of NC residents do not have a telephone (29). Finally, these findings apply only to people who express some degree of willingness to consider psychotherapy as well as those who are willing to respond to a solicitation. All respondents for this analysis had called in response to a flyer received in the mail for a study of treatments for anxiety. Barriers may differ for those who are not willing to consider psychotherapy.

Anxiety and depression are associated with negative consequences. In particular, anxiety is associated with insomnia (30), physical disability (31), and mortality (32), while depression is associated with cognitive impairment (33), medical comorbidity (34), and mortality (35). Thus, it is important that older adults receive treatment for these problems and understanding barriers to treatment can help with this. Public awareness and education campaigns designed for older adults living in rural areas may be needed to address negative beliefs that people have about seeking mental health treatment. Zanjani and colleagues (36) demonstrated that a brief mental health awareness intervention resulted in improved attitudes toward mental health treatment. Stigma intervention programs have been used successfully with older adults to reduce stigma (37) and increase compliance with anti-depressant medications (38). Other changes, such as the inclusion of mental health services in the same location as primary health services, can reduce access barriers (39). A problem solving intervention to address barriers to mental health care has been shown to increase acceptance of a referral to a mental health provider (40). Addressing these barriers may result in an increase in mental health care utilization and improved outcomes for rural elders.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Reasons for ineligibility

Reasons for ineligibility	Number
Unavailable during business hours	68
Currently receiving psychotherapy or counseling	63
Global cognitive impairment	61
Does not reside in a rural county in NC	61
PSWQ-A scores < 16	43
Hallucinations	42
Unable to hear well	38
< 60 years old	33
Dementia diagnosis	25
Bipolar disorder	18
Moving out of the area within next 6 months	15
Change in psychiatric medications within last month	14
Undergoing treatment for cancer	14
Active illicit drug use	9
Other	6

Note. Some participants were excluded for more than 1 criterion.

Table 2

Demographic and Health Characteristics (N=478)

Characteristic	
Age, years, mean (standard deviation)	68.4 (7.0)
Female, number (%)	370 (77.4)
Race, number (%)	
American Indian	18 (3.8)
African American	73 (15.3)
White	386 (80.8)
Hispanic	1 (0.2)
Education, number (%)	
< 8th grade	4 (0.8)
8–10th grade	25 (5.2)
11–12th grade	110 (23.1)
> 12th grade	338 (70.9)
PSWQ-A, mean (standard deviation)	29.9 (6.1)
Taking psychiatric medications, number (%)	276 (57.7)

Table 3

Barriers to Getting Help for Anxiety and Depression (N=478)

Barriers	Any degree of interference N (%)
Practical	
Cost	279 (58.4)
Do not know where to go	237 (49.6)
Too far away	177 (37.0)
Do not accept Medicare	133 (27.8)
Transportation	84 (17.6)
Need care for family member	58 (12.1)
Time off from work/lose pay	52 (10.9)
Total practical barriers, mean (standard deviation)	2.13 (1.64)
Personal beliefs	
Should not need help	358 (80.1)
Mistrust of MH providers	200 (41.9)
Do not think it would help	191 (40.0)
Do not want to talk about private matters with a stranger	197 (41.2)
Total personal barriers, mean (standard deviation)	1.98 (1.31)
Stigma	
Embarrassed to talk about problem	190 (39.8)
Stigma-what would others think	190 (39.8)
Racial/cultural discrimination	31 (6.5)
Total stigma barriers, mean (standard deviation)	0.86 (0.96)
Total barriers overall, mean (standard deviation)	4.97 (2.91)