Improving Mental Health Treatment Initiation among Depressed Community Dwelling Older Adults

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Objective: *Depression screening has been widely implemented in community settings to increase detection of late-life depression. Rates of treatment initiation are low without additional structured follow-up, however. The current study evaluates the effectiveness of a brief psychosocial intervention, Open Door, designed to improve initiation of mental health treatment among clients of aging service meals programs.* **Design:** *Older adult social service clients with depressive symptoms were randomized to either the Open Door intervention or a Service Referral control condition. In Open Door, the counselor collaborates with the client to identify and address both attitudinal and structural barriers to seeking mental health treatment. Independent research assessments were conducted 12 and 24 weeks after baseline to document treatment initiation (at least one session).* **Results:** *At follow up, 64.6% (104 out of 161) of participants had initiated a provider visit. Participants in Open Door were more likely to initiate treatment compared with those in the control condition ($\chi^2 = 5.83$, $df = 2$, $p = 0.016$). Among participants with at least mild depressive symptoms, Open Door remained significantly more effective than the control condition ($p < 0.05$). In multivariate analyses controlling for gender differences, both participation in the Open Door group and depression severity predicted treatment initiation ($\chi^2 = 15.18$, $df = 3$, $p = 0.002$).* **Conclusions:** *High rates of depression have been documented among older adults receiving social services (case management or home meals). The Open Door program offers a useful strategy to overcome the barriers to treatment initiation while fitting within the responsibilities of aging service staff. The intervention can improve initiation of late-life depression care.* (Am J Geriatr Psychiatry 2016; 24:310–319)

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INTRODUCTION

Depression screening has been implemented in many settings with the assumption that increasing recognition of depression will prompt a successful mental health referral, resulting in treatment participation. In community settings, however, there is a wide chasm between screening, referral, and attending treatment. Aging service staff in New York State report that, without any intervention, only 22% of clients screening positive for depression accept a mental health referral.[1] When screening and referral procedures were standardized, supervised, and administered together in a single session, 38% of depressed homebound adults accepted the referral.[2] In research investigating major depression and service use among older adults, depression prevalence rates as high as 42% have been identified in samples of homebound elders, nearly three times the average rate found in community settings.[3,4] Among depressed, homebound older adults receiving services from Meals on Wheels, a little over half (56%) reported mental health service use in the past year.[5] In another sample of homebound older adults, only 29% of individuals with a diagnosed axis I disorder were found to be seeing a mental health professional, despite the vast majority (97%) reporting being willing to see one.[6] Untreated depression in older adults is associated with increased rates of suicide,[7] non-suicidal mortality,[8] risk of falling,[9,10] and disability.[11]

The need for strategies to enhance the likelihood that community-based screening leads to treatment initiation is consistent with the National Institute of Mental Health priorities for innovative service delivery models to improve treatment access and outcomes of older adults.[12] The World Health Organization mental health survey found that among adults who had a diagnosed mental disorder, low "perceived need" was the greatest barrier reported for those who did not seek mental health care, defined broadly as attending a visit with a range of providers.[13] When adults did perceive a need for mental health care, reported attitudinal barriers (e.g., maladaptive beliefs and attitudes) were a greater hindrance to accessing care than structural barriers (e.g., transportation and finances).[14]

Treatment initiation is a necessary first step toward the goal of full participation in quality mental health care. When mental health treatment is recommended after routine screening in a non–mental health setting (e.g., primary care or aging services), the goal is to make a referral that results in a mental health visit. This first visit typically involves evaluation of the individual's mental health needs and recommendation of care.

Interventions to improve treatment initiation among older adults in varied settings have had mixed success. The challenge of making mental health referrals in primary care was documented by the PRISME study; among older adults with major depressive disorder referred to outside mental health providers, only 54% followed through on the referral. Among those with milder symptoms, rates of successful referral were as low as 38%.[15] Motivational interviewing has been found to improve the rates of successful referral and treatment initiation among returning veterans referred to a mental health provider.[16] When the Veterans Administration Primary Care-Mental Health Integration program (depression screening and referral) occurred on the same day as a primary care visit, it was found to increase the likelihood of initiating mental health services;[17] in addition, increased odds of returning for a second visit for psychotherapy and antidepressant medication were increased when initial mental health services were delivered on the same day.[18]

The challenge of successfully referring depressed older adults documented in primary care settings is compounded among older adults found in community social service settings. Older adults who are applying for in-home aging services such as home meals or case management face significant structural and attitudinal barriers to initiating mental health care. At the same time, integrating mental health interventions into aging services provides a unique opportunity to address unmet mental health needs with high rates of depression (25%) and both structural and attitudinal barriers to treatment.[19–21] Although depression screening has been recommended and implemented by many providers, in this setting it has been challenging to translate recommendations for depression screening and referrals into actual visits with mental health providers, because of high rates of social isolation, chronic medical conditions, disability, and patient preferences for more "informal" sources of care.[22–24]

The aim of this study was to evaluate the effectiveness of a brief psychosocial intervention (Open Door) to improve initiation of depression treatment among homebound older adults eligible for a home-delivered meals program. The Open Door intervention was designed to address the individual-level barriers faced