Barriers to Mental Health Treatment in Rural Older Adults

Gretchen A. Brenes, Ph.D., Suzanne C. Danhauer, Ph.D., Mary F. Lyles, M.D., Patricia E. Hogan, M.S., Michael E. Miller, Ph.D.

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.* (Am J Geriatr Psychiatry 2015; ■:■—■)

Key Words: Barriers, elderly, mental health, rural

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] 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

Received September 22, 2014; revised May 26, 2015; accepted June 9, 2015. From the Departments of Psychiatry and Behavioral Medicine (GAB), Social Sciences and Health Policy (SCD), Geriatrics (MFL), and Biostatistics (PEH, MEM), Wake Forest School of Medicine, Winston-Salem, NC. Send correspondence and reprint requests to Gretchen A. Brenes, Ph.D., Wake Forest School of Medicine, Department of Psychiatry and Behavioral Medicine, Medical Center Blvd., Winston-Salem, NC 27157. e-mail: gbrenes@wakehealth.edu

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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 because of 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 was 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 North Carolina. Interested participants were encouraged to call a toll-free number and receive 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 screening 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 North Carolina (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 month; bipolar disorder; and any hearing problem 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 article, 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 eight-item measure of the frequency and intensity of worry.[13] The items are rated on a five-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 greater than or equal to 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 barriers (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) interfered with getting help. Response options were "not at all,"