Abstract

Although mental disorders occur commonly in later life, it has been reported that older adults are reluctant to seek help for their mental health problems.

The purpose of this research study was to analyze the contact with healthcare professionals, self-perceived mental health problems and unmet needs, as reported by a nationally representative sample of community-dwelling adults. We report a cross-sectional analysis of all the respondents of the Australian National Survey of Mental Health and Wellbeing aged 55 years and older (N=3,178).

Results indicated that 306 (9.6%) participants had a DSM-IV classifiable mental disorder based on self-identified symptoms over the preceding 12 months. Of these, 146 (48%) reported that they had not consulted a healthcare professional to deal with their mental health problems. Among those who consulted with a healthcare professional, the general practitioner was the main point of contact. Medication and psychotherapy/counseling were the most frequent form of help obtained. Informational and instrumental help, such as help to sort out practical problems and to look after oneself, were the most reported unmet needs.

These results suggest a gap in the provision of healthcare services for mental health problems directed toward the specific needs of ageing adults. The reported unmet needs might be met by increasing awareness amongst healthcare professionals regarding mental health problems in later stages of life and by improving the access of older people to the services commonly provided by multidisciplinary teams.

Key words: Aged; Healthcare; Health Services; Mental health, DSM-IV mental disorder
1.1 Introduction

Mental disorders occur commonly and are associated with adverse personal, social and economic impact (Demyttenaere et al., 2004). It has been previously suggested that the likelihood of receiving minimal adequate treatment decreases with age (Garrido, Kane, Kaas, & Kane, 2011; Mosier et al., 2010; Wang et al., 2005). De Beurs and colleagues (1999), for example, reported that less than three per cent of those older adults diagnosed with an anxiety disorder consulted a psychiatrist for their mental health problems. This has been explained by factors associated both with the older person, who might be reluctant in disclosing the mental health symptoms, instead preferring to self-manage (Garrido et al., 2011), and with the healthcare professional, namely the general practitioner, who might consider that certain mood states become normative with increasing age (Burroughs et al., 2006). Additional characteristics of the healthcare system, such as availability of mental health services and reimbursement rates, can also constrain the extent to which older adults would seek help for their mental health problems (Knight, 2011). Finally, it is worth noting the likelihood of comorbid medical illnesses or used medication that may cause, mask, interfere, mimic or distract the attention from mental disorders such as depression or anxiety, also increases with age (e.g., Roy-Byrne et al., 2008; Volkers, Nuyen, Verhaak, & Schellevis, 2004).

All these factors amount and contribute to the decreased use of mental health services in older adults. The main goal of the current study was to analyze the contact with healthcare professionals for mental health problems as reported by a representative sample of Australian community-dwelling middle-aged and older adults. Healthcare in Australia is universal, and subsidized by the federal government (Department of Health and Ageing, 2013). An additional goal was to understand the main forms of help that participants received from their mental health providers. Finally, we explored the main perceived obstacles for not accessing healthcare services for mental health problems.

2 Methods
2.1 Sample & measures

The study sample was taken from the National Survey of Mental Health and Wellbeing (NSMHWB), conducted by the Australian Bureau of Statistics in 2007 (ABS, 2007). The survey methodology has been previously described (Slade, Johnston, Browne, Andrews, & Whiteford, 2009). Residents aged 16-85 years old living in private dwellings in urban and rural locations were selected through a multi-sampling procedure stratified for each Australian state and territory. The national response rate was 60%, with 8,841 complete responses obtained (Mean age= 46 years, standard deviation= 19 years; 54% female). The Composite International Diagnostic Interview (CIDI 3.0, Kessler & Ustun, 2004) was administered face to face to participants by trained surveyors. The survey purposively oversampled older participants to improve the standard errors for prevalence estimates. All participants aged 55 years and older at the time of the interview (n= 3,178) were considered for the present study. This cut-off point has been previously employed for ascertaining the prevalence and pattern of mental disorders in ageing adults (e.g., Beekman et al., 1998).

Data were collected during a face-to-face interview focusing on socio-demographic characteristics and chronic physical health problems. Current diagnoses for mood, anxiety and substance abuse disorders were generated using criteria from the fourth edition of the Diagnostic and statistical manual of mental disorders (DSM-IV) (American Psychiatric Association, 2000). The use of healthcare services for mental health related problems over the past 12 months was established by asking participants the number of consultations they had had with seven types of healthcare professionals for self-perceived mental health problems. Participants could select from a list that included general practitioners; psychiatrists; psychologists; mental health nurses; other specialist doctors; other mental health professionals; and complementary therapists. Participants were also asked about the specific type of help received (e.g., information, tablets, and help with everyday life); whether they felt that their needs were met; and, if they did not receive that specific help, what was the main perceived reason.
2.2 Analyses

Data were analyzed through chi square tests. To control for Type I errors the significance level was established at $\alpha < 0.01$. All analyses were conducted through Stata 11.1 (StataCorp, 2009).

3. Results

Approximately one tenth of the participants fulfilled the criteria for a 12-month DSM-IV mental disorder ($n=306, 9.6\%$), whereas almost 8% of all participants ($n=268$) reported having at least one consultation with a health provider for mental health problems over the past 12 months (results not tabulated). As expected, those participants who had consulted a healthcare provider for their mental health problems were also more likely to have a current mental disorder ($\chi^2(1)= 433.35, p<0.001$). However, almost half of those participants who fulfilled the DSM-IV criteria for a current mental disorder reported not having had a consultation with any healthcare professional for their mental health problems ($n=146$). There were no significant differences in the use of healthcare services for mental health problems by education, place of residence or chronic physical health problems. Table 1 presents the detailed findings.

Among those who consulted a healthcare professional for their mental health problems, about one third consulted two or more professionals ($n=87, 32\%$). The professional most frequently consulted was a general practitioner ($n=195$), followed by a psychologist ($n=57$). There was an inverse relation between age and the likelihood of seeking help for mental health problems ($\chi^2(2)= 43.48, p<0.001$), and while 12% of the participants aged between 55 and 64 years old reported seeking help, only 5% of those aged between 75 and 85 did so. Those who consulted a healthcare provider for mental health problems were also more likely to be female ($\chi^2(1)= 15.86, p<0.001$) and not married ($\chi^2(1)= 7.27, p<0.01$).

The main type of help received by the participants was “medicine or tablets” (73%), followed by “psychotherapy/counseling” (54%), and “information about mental illness” (34%). General
practitioners had a preponderant role in service provision, being the main providers in all types of help except “psychotherapy/counseling” and “help to meet people”. Among those participants who were receiving specific types of help, the majority felt that their needs were being fulfilled, and the main reason for not seeking further help was a preference for self-management. However, almost one fourth of those who reported seeking and receiving information about mental illness reported not having received enough information even after asking. Furthermore, one tenth of those taking tablets felt that nothing else could help and thus did not seek further help for their unmet needs. Table 2 presents further details regarding these analyses.

The main perceived needs for other services were informational and instrumental, or social, rather than pharmacological or psychotherapeutic. Furthermore, the number of participants who expressed a perceived need for instrumental and social support was higher than the number of participants who were actually using such services. The main reported reasons for not having access to those services were a preference for self-management and not getting them even after asking.

4. Discussion

Through the analysis of the contact with healthcare professionals for self-perceived mental health problems and unmet needs, as reported by a nationally representative sample of community-dwelling adults aged 55 years and older, it was found that less than half of those with a diagnosable current mental disorder consulted with a healthcare professional for their mental health problems over the preceding 12 months. Our results corroborate the average treatment gap for people with mental disorders, previously suggested to be more than fifty percent (Patel et al., 2010). This main finding supports the premise that community-dwelling ageing adults with a mental disorder underuse healthcare services for mental health. Moreover, age was inversely associated with the likelihood of having had a consultation with a healthcare provider for mental health problems, independently of mental health status. This is consistent with results previously published using similar observational data (Mosier et al., 2010).
Our findings also indicate that many older individuals have perceived unmet needs. These needs were reported both by those who obtained help for their mental health problems, considering that the help that they had received was not enough, and by those who were not able to access the required service, even after they had requested it. The findings also showed that the majority of the help was being provided by the general practitioner, consistent with previous observations (de Beurs et al., 1999; Holvast et al., 2012; Scott, Mackenzie, Chipperfield, & Sareen, 2010).

The main strengths of the study are the representative sample interviewed, of over 3,000 community dwelling adults; the use of the Composite International Diagnostic Interview, which has been used worldwide to ascertain the prevalence of mental disorders (e.g., Kessler et al., 2005; Wang et al., 2005); the covered services providers; and the analysis of the unmet needs reported. One of the main limitations of this study was the exclusion of adults living in institutions such as hospitals and nursing homes by the NSMHWB. Further limitations included the focus on mental disorders with high prevalence and the exclusion of those aged 86 years and older. Additionally, the reported results refer to non-weighted data. Finally, another possible limitation concerns the diagnostic uncertainty surrounding mental disorders in older adults. It is not yet clear whether the decline of mental health disorders in older cohorts (e.g., Kessler et al., 2005) really reflects a better mental health in late life or is better explained by the inadequacy of the current screening instruments and classification systems to accurately detect and measure mental disorders in older adults. These limitations might constrain generalizability of our findings, which are an estimate and not a universal representation of unmet needs.

For older adults, the main point of contact for addressing their mental health problems was the general practitioner. However, general practitioners might lack the time and the training to properly identify and address mental health problems, especially in older adults (Mitchell, Rao, & Vaze, 2010), as well as normalising the occurrence of certain conditions, such as depression (Burroughs et al., 2006). The high prevalence of physical chronic conditions in this age group might also deter the clinician of focusing on psychological problems.
When the primary care services have the required resources to address mental health problems, the results seem to indicate clinical effectiveness in the short but not in the long-term, as indicated by a recent systematic review and meta-analysis of the provision of counseling services for mental health and psychosocial problems in primary care (Bower, Knowles, Coventry, & Rowland, 2011). However, of the nine trials included in that review, only one sampled adults aged 55 years and older, and results were found to be not significant. A cluster randomized controlled trial specifically targeting depression in primary care patients aged 55 years and older found that patients in both arms showed considerable improvement from baseline at 6 months (van Marwijk, Ader, de Haan, & Beekman, 2008). According to the authors these results demonstrate the adequacy of the stepped care approach to detect and intervene in depression in primary care, although further work still needs to be done in order to put in place adequate follow-up processes. A study just published reiterated the importance of depression management programs in primary care, finding that an intervention jointly delivered in primary care by a care manager and general practitioners decreased the mortality risk in older adults with major depression (Gallo et al., 2013).

Some positive aspects should also be highlighted from our results. The rates of healthcare service use for mental health problems were higher than rates previously reported for older cohorts (e.g., Scott et al., 2010). Furthermore, the participants seldom reported fear of being stigmatized as a reason for not seeking help. These results are in line with recent findings, which indicate that older adults are progressively open to mental health treatment, displaying positive attitudes towards help seeking (Mackenzie, Scott, Mather, & Sareen, 2008; Mohlman, 2012; Segal, Coolidge, Mincic, & O'Riley, 2005). Nevertheless, the likelihood of seeking help for mental health problems still decreased with age. Additionally, the odds of dropping out of mental health treatment seem to increase with age (Pinto-Meza et al., 2011). It is thus essential for those healthcare professionals providing care to older cohorts to raise awareness and promote access to mental health services.

5. Conclusion
Several implications for clinical practice can be taken from these findings. To start with, it seems likely that the mental health needs of community-dwelling ageing adults could be better addressed through multidisciplinary teams, with specific areas of expertise and able to address the different areas of need expressed by the older adults (Chiou & Chen, 2009). For instance, the main perceived needs concern informational and instrumental help, rather than increased provision of pharmacological or therapeutic services. Although integrated models of care, where mental healthcare is integrated into primary and community healthcare, is considered to be highly effective with geriatric populations (Karel, Gatz, & Smyer, 2012; Prins et al., 2011), more research needs to be conducted with older adults, as to disentangle the factors underlying short and long-term results.

As population ageing has led to a worldwide shortage of skilled healthcare professionals to work with older adults, it is essential that policy makers, legislators and clinical teachers invest in training opportunities within geriatrics and gerontology (Houde & Melillo, 2009), providing whole-person care (Royal College of Psychiatrists, 2013). The inclusion of age-related topics in curricula, along with supervised contact with older adults, are likely to be essential ingredients for promoting the interest of healthcare professionals who might subsequently work with older people (Gonçalves, 2009), as knowledge and formal contact with older adults are significantly related with interest in working within ageing contexts (Gonçalves, Guedes, Fonseca, Cabral Pinto, Martin, et al., 2011). For those healthcare professionals who are already working with older adults, the acquisition of information about mental health topics increases not only knowledge but also confidence to deal with late life mental health problems (Mayall, Oathamshaw, Lovell, & Pusey, 2004).

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**Ethical approval**

Access to data from the National Survey of Mental Health and Wellbeing was granted by the Australian Bureau of Statistics. Data were accessed in an anonymised form.

**Conflict of interest statement**

None to declare.
References


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Table 1 – Socio-demographic and clinical characteristics of the participants according to their healthcare services use status for a self-perceived mental health problem (N= 3,178)

<table>
<thead>
<tr>
<th>Variable (N, %)</th>
<th>No use in last 12-month (n= 2,910)</th>
<th>12-month use (n= 268)</th>
<th>test (d.f)= , p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>χ²(2)=43.48, &lt;0.001</td>
</tr>
<tr>
<td>55-64 years</td>
<td>1,116 (38%)</td>
<td>157 (59%)</td>
<td></td>
</tr>
<tr>
<td>65-74 years</td>
<td>1,032 (35%)</td>
<td>72 (27%)</td>
<td></td>
</tr>
<tr>
<td>75-85 years</td>
<td>762 (26%)</td>
<td>39 (15%)</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>χ²(1)= 15.86, &lt;0.001</td>
</tr>
<tr>
<td>Female</td>
<td>1,498 (51%)</td>
<td>172 (64%)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td>χ²(1)= 4.22, 0.04</td>
</tr>
<tr>
<td>8 years or less</td>
<td>658 (23%)</td>
<td>46 (17%)</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td>χ²(1)= 7.27, &lt;0.01</td>
</tr>
<tr>
<td>Married</td>
<td>1,628 (56%)</td>
<td>127 (47%)</td>
<td></td>
</tr>
<tr>
<td>Residency</td>
<td></td>
<td></td>
<td>χ²(1)= 0.32, 0.57</td>
</tr>
<tr>
<td>City</td>
<td>1,718 (59%)</td>
<td>163 (61%)</td>
<td></td>
</tr>
<tr>
<td>Chronic physical health problems</td>
<td></td>
<td></td>
<td>χ²(1)= 0.01, 0.78</td>
</tr>
<tr>
<td>Yes</td>
<td>2,391 (82%)</td>
<td>222 (83%)</td>
<td></td>
</tr>
<tr>
<td>12-month mental disorder</td>
<td></td>
<td></td>
<td>χ²(1)= 433.35, &lt;0.001</td>
</tr>
<tr>
<td>Yes</td>
<td>184 (6%)</td>
<td>122 (46%)</td>
<td></td>
</tr>
</tbody>
</table>

d.f.: degrees of freedom; p: alpha level obtained for the test; t: Student’s t-test; χ²: chi square test; M: mean; SD: Standard deviation
### Table 2 – Mental health services use and perceived needs

<table>
<thead>
<tr>
<th>Help received</th>
<th>Received this type of help</th>
<th>Did not receive this type of help</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes*</td>
<td>Main provider</td>
<td>Unmet needs**</td>
</tr>
<tr>
<td>Information about mental illness</td>
<td>91 (34%)</td>
<td>GP (51%)</td>
<td>22 (24%)</td>
</tr>
<tr>
<td>Medicine or tablets</td>
<td>195 (73%)</td>
<td>GP (80%)</td>
<td>21 (11%)</td>
</tr>
<tr>
<td>Psychotherapy/Counseling</td>
<td>145 (54%)</td>
<td>Psych (29%)</td>
<td>21 (14%)</td>
</tr>
<tr>
<td>Help to solve problems, e.g. housing</td>
<td>11 (4%)</td>
<td>GP (55%)</td>
<td>4 (36%)</td>
</tr>
<tr>
<td>Help to use time better</td>
<td>22 (8%)</td>
<td>GP/OMHP (23% each)</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>Help to look after yourself</td>
<td>20 (7%)</td>
<td>GP (25%)</td>
<td>5 (25%)</td>
</tr>
<tr>
<td>Help to meet people</td>
<td>19 (7%)</td>
<td>OMHP (26%)</td>
<td>4 (21%)</td>
</tr>
</tbody>
</table>

* Percentages refer to participants that received this type of help for their mental health problems on the past 12 months (N=268); ** Percentages refer to participants that received this type of help from their mental health providers and who assessed to still have unmet needs after the consultation; *** Raw number of participants who felt that they required this type of help but did not have access to it; # No predominant reason was given; Psych: Psychologist; OMHP: Other mental health professional
Unmet needs:
The use of healthcare services for mental health problems by middle-aged and older adults

Running head: Use of healthcare services for mental health in late life

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