Barriers to Depression Care for Black Older Adults
Practice and Policy Implications

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ABSTRACT
Late-life depression is a public health problem in the United States. Untreated, depression contributes to poorer health outcomes and increased mortality among older adults. Specifically, Black older adults are at higher risk for misdiagnosis, undertreatment, and more severe depressive symptomatology than other groups. Barriers to identification and treatment of depression in Black older adults include lack of access to quality mental health care, the stigma of mental illness, mistrust of mental health providers, and poor provider-client communication. Recommendations for gerontological nursing practice, education, and research to improve the care of depressed Black older adults are discussed. Implications for policy development are presented.

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In the United States, depression is the leading cause of disability; however, many people with depression never receive treatment (National Institute of Mental Health [NIMH], 2007). Untreated, the disease can progress to major depressive disorder and a higher risk of suicide (Conwell, 2001). Depression has also been linked with sedentary lifestyle (Teychenne, Ball, & Salmon, 2010), higher rates of cardiovascular disease (Johansson, Dahlström, & Alehagen, 2007), diabetes, and increased morbidity (NIMH, 2007). For the purpose of this article, depression is defined as a continuum from depressive symptomatology to subthreshold or subsyndromal depression to minor and major depression (Hybels, Blazer, & Pieper, 2001; Lyness et al., 2007). Minor depression is often a precursor to major depression (Chopra et al., 2005).

According to the NIMH (2007), among community-dwelling older adults, an estimated 13.5% are in need of home care services and 11.5% of hospitalized older adults have major depression. Furthermore, approximately 5 million have subsyndromal or minor depression. Although it has been found that Black older adults have lower rates of psychiatric illness, including depression, than older non-Latino White adults (Jimenez, Alegria, Chen, Chan, & Laderman, 2010), serious ethnic/racial disparities exist in the care given to Black older adults with depression. Specifically, when compared with other groups, Black older adults are less likely to seek help from mental health providers, are less likely to be identified as depressed, and often delay or fail to seek treatment until their symptoms are severe (McGuire & Miranda, 2008; Neigh et al., 2005).

After entering the mental health care system, Black older adults are less likely to receive the best available treatment for depression and often drop out of the system (U.S. Surgeon General, 2001). Identified barriers to mental health care use by Black older adults include the inability to afford services, a lack of awareness of mental health services, and the lack of culturally tailored mental health programs designed specifically for this population (Morrell, Echt, & Caramagno, 2008). Additional causes of mental health disparities in the care of depression include stigma associated with depression, mistrust of mental health service providers, and poor health care provider–client communication (Bailey, Blackmon, & Stevens, 2009; Connor et al., 2010; McGuire & Miranda, 2008). Thus, the purpose of this article is to review barriers to identification and treatment of depression in Black older adults. Strategies to address these barriers and implications for policy will be presented. It is also important to note that ethnicity refers to a common heritage shared by a particular group, and, consistent with the National Institutes of Health (2001), the term Black includes individuals of African, African American, and African Caribbean descent and White includes individuals of European descent.

**BARRIERS TO IDENTIFICATION AND TREATMENT OF DEPRESSION**

Prevalence rates of depression among Black older adults are varied because few studies have sufficient numbers of Black individuals to identify prevalence rates of depression in this population. Complicating the accurate evaluation of depression in Black older adults is that many with mental illnesses, including depression, are found in high-need populations such as homeless populations and low-income housing areas.

Black older adults are less likely than other older adult groups to be identified as depressed (Gallo, Bogner, Morales & Ford, 2005). Poor detection of depressive symptoms in this population is the result of mistrust of providers, poor patient-physician communication, and somatic symptom presentation (Bailey et al., 2009). Furthermore, when Black older adults do seek treatment for their depressive symptoms, they tend to go to primary care offices (Cooper-Patrick et al., 1999), where providers may be less likely to detect depression in this population (Gallo et al., 2005) because Black older adults often exhibit somatic symptoms.

Research indicates that Black older adults have a general mistrust of mental health care providers (Connor et al., 2010). There is the belief among this group that health care providers lack the appropriate knowledge of Black older adults’ life experiences and may misdiagnose them. There is also fear that health care providers will label them as crazy (Thompson, Bazile, & Abkar, 2004). Poor health care provider–client communication also influences identification of depression in Black older adults. In a study that compared patient-physician communication patterns between Black and White patients, Ghods et al. (2007) reported that Black patients experienced less depression and trust-building communication with their physicians than White patients. One of the barriers to achieving quality mental health care for Black older adults is the lack of culturally competent health care providers (Ton & Lim, 2006) and poor provider communication (Gastong-Johansson, Hill-Briggs, Oguntomilade, Bradley, & Mason, 2007). Studies have repeatedly shown a need to educate health care providers to cultural norms, beliefs, and values, as well as sensitizes providers to the cultural variations that exist in the expression of depressive symptoms (Shaya & Gbarayor, 2006).

Religion plays a key role in the identity and lives of many Black older adults (Taylor, Chatters, & Jackson, 2007). The association between religiosity and mental health in this population is complex. Religiosity has been reported to be associated with well-being in Black older adults (Jang, Borenstein, Chiriboga, & Mortimer, 2005) and serves as a
protective factor to prevent depression (Levin, Chatters, & Taylor, 2005). However, many Black older adults feel stigmatized by depression and are more likely to perceive depression as a personal weakness. Therefore, Black older adults may use negative religious coping, such as identifying depressive symptoms as a punishment from God or a weakness of their faith (Pargament, Koenig, & Perez, 2000).

**UNDERUTILIZATION OF MENTAL HEALTH SERVICES**

Underutilization of mental health services for depression among Black older adults is a serious problem. Black older adults seek treatment 50% less often than older White adults (Brown & Palenchar, 2004). In a study that examined 12-month mental health service use for African American and Caribbean Black adults, the oldest and least educated among these two groups were the least likely to obtain care from a mental health specialist (Neighbors et al., 2007). Several barriers contribute to the underutilization of mental health services by Black older adults: the stigma of depression, poor quality of care, access to care, and general mistrust of mental health professionals (Choi & Gonzalez, 2005).

One of the most powerful factors affecting mental health service utilization among Black adults is the stigma associated with depression. Several descriptive studies have found that Black older adults believe depression to be a sign of personal weakness (Mills, Alea, & Cheong, 2004; Shellman, Mokel, & Wright, 2007) and loss of faith (Wittink, Joo, Lewis, & Barg, 2009), and identify depressed individuals as crazy or violent (Connor et al., 2010).

According to the U.S. Surgeon General’s (2001) report on mental health, Black adults are more likely to receive mental health care in primary care settings or emergency departments and receive poor-quality care when treated. Black older adults are less likely to use counseling or psychotherapy due to mistrust of the mental health system, lack of knowledge about available services, and a lack of cultural sensitivity of the counselors (Connor et al., 2010). Financial barriers, lack of Black mental health specialists, and location of mental health services for at-risk populations are significant factors affecting access to care. One fourth of the Black population is uninsured or relies on public financing such as Medicaid. Many Black older adults prefer Black health care providers and rate their interaction with Black physicians more favorably than with White physicians (Cooper-Patrick et al., 1999). There is a documented need for Black mental health specialists. Even though Black older adults represented 13% of the U.S. population in 2005, only 3% of psychiatrists and 2% of psychologists were Black (Mental Health America, 2007).

**DISCUSSION AND RECOMMENDATIONS**

According to the U.S. Administration on Aging (2011), older Blacks are living longer and by 2050 will account for 11% of the U.S. older adult population. With the expected increase in the older Black population, the need for early identification and culturally appropriate treatment of depressive symptoms is critical. Besides the factors that have already been discussed, the inability to obtain jobs with good pensions and health benefits has left many Black older adults without access to the mental health care system.

Gerontological nurse experts, whether working in home care, nursing homes, community health centers, or in higher education, can play an integral role as advocates, educators, and clinicians in the improvement of depression care for Black older adults in the United States. Knight (2011) used a multi-level approach to discuss reducing barriers to mental health access for older adults.

**Patient and Provider Education**

Educational interventions to decrease the barriers to care of depressed Black older adults must occur at the patient and provider levels. The Institute of Medicine (IOM, 2002) recommended integration of cultural competency education into the curricula for all health professional programs. Increasing cultural competency of health care providers may facilitate a more positive experience for Black older adults and decrease their mistrust of the mental health system. Cultural competency training that includes educating physicians, nurses, and students about the stigma associated with depression among Black older adults, how to best identify depression in this population, and culturally appropriate interview techniques to build trust would assist with early identification of depression and treatment engagement. Reminiscence is a cost-effective communication technique that has been shown to increase nursing students’ confidence in caring for older adults of different ethnic groups (Shellman, 2007) and facilitates the development of trust between researchers and participants (Shellman & Mokel, 2010).

Health care providers need to acknowledge the importance religion plays in the older Black community by allowing religion to be part of the treatment plan. Educating patients and pastors that depression is an illness and is not unfaithfulness to God.
is equally important. Payne (2009) found that Black pastors defined depression as a “hopelessness resulting from a lack of trust in God” (p. 363). Pastors serve as gatekeepers for church members and are often the first contact when there is a mental health crisis such as depression, a suicide, or death in the family. The way that pastors view depression can facilitate or hinder treatment of church members. Therefore, educating and engaging pastors as members of the mental health team is essential in the identification and treatment of depression in Black older adults.

Community Outreach

Current mental health services have been inadequate in reaching and effectively treating underserved individuals such as Black older adults. Strategies to reach out to Black older adults at senior centers, senior housing, and churches are key to improving depression care in this population. Engaging community agencies to transform the current method of mental health service delivery to include a more community-integrated approach could improve identification of depression and treatment acceptance and engagement. Collaborative partnerships between universities, clinics, churches, or senior centers have been identified as an effective strategy to reduce and eliminate health disparities (IOM, 2002).

Mental health services researchers must modify interventions to improve treatment engagement in Black older adults with depression. The model of mental health research traditionally rooted in testing specific treatments with measurement of outcomes in a clinical environment has failed to reach Black older adults. Factors such as Black older adults’ mistrust of research and negative experiences with health care delivery; a lack of culturally appropriate measurements; and researchers having their own agendas with little regard for the people or communities have resulted in poor participation among this population.

IMPLICATIONS FOR POLICY

A national commitment to improve the capacity of the mental health care system to meet the needs of depressed Black older adults is a priority. Since many Black older adults seek mental health care from their primary care providers, improved training in the mental health issues facing this population must be mandated. A concerted effort to support and recruit ethnic minorities into mental health care is crucial, considering the sensitivity and stigma associated with depression in this population. Recruitment of ethnic minorities could be done by reducing financial barriers to specialized mental health care training and by improving admissions and retention policies in colleges and universities.

Increasing Medicaid reimbursement rates for mental health providers will improve access to care in the primary health care arena. Important providers of service to homebound older adults are visiting nurse and home care agencies. Currently, reimbursement for mental health care in the home is inadequate (Knight, 2011). The agencies are restricted by private and public insurance and the number of visits they can provide in a given episode of care. Given the long-term nature of depression, increasing private and public reimbursement of home care would enable continuous and comprehensive assessment of the psychosocial and mental health of Black older adults and their families.

Finally, gerontological nurses can share their experiences of caring for depressed Black older adults and their families to assist legislators in understanding the barriers to the identification and treatment of depression in Black older adults and thus influence depression care policy.

The enactment of the Patient Protection and Affordable Care Act (PPACA) expands insurance coverage for mental health care to millions of Americans. While the PPACA improves mental health care for some, it is estimated that approximately 40% of individuals currently uninsured will still be uninsured (Garfield, Lave, & Donohue, 2010). Additionally, the PPACA does not substantially change mental health services covered under Medicare, Medicaid, or other existing private plans. However, expanding coverage plans or increasing mental health services will not necessarily meet the mental health care needs of depressed Black older adults because the majority are not using the services currently available to them. Culturally appropriate strategies to mitigate the multiple barriers to depression care are needed at individual, community, and policy levels. For example, policy makers could mandate training programs to educate health care providers, Black older adults and their families, and pastors about barriers to depression care. Consequently, Black older adults may begin to seek out the services that are available to them. On the other hand, gerontological nurses can share their experiences of caring for depressed Black older adults and their families, and pastors about barriers to depression care. Consequently, Black older adults described in this article are complex and require a multifaceted approach involving all levels of mental health care.

SUMMARY

Black older adults have multiple risk factors for depression and experience a number of health disparities related to race/ethnicity. In addition, barriers to the identification and treatment of depression and under-utilization of mental health services leave many depressed Black older adults with unmet needs. Gerontological nurses, mental health care professionals, pastors, and policy makers can create partnerships to implement culturally tailored interventions to improve depression care and strengthen the capacity of our mental health care system at the individual, provider, and system levels for Black older adults.