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Race, Stigma and Mental Health Recommendations Among Depressed Older Persons in Aging Services

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Abstract

Objective—The mental health needs of the growing older adult population are often detected informally by the Aging Service Network (ASN) funded by the U.S. Health and Human Services to provide nutrition and support services to older persons. Stigma has been a barrier to mental health treatment. This study examines the rates of anticipated stigma and its impact on successful mental health referrals among depressed elderly.

Methods—ASN Elderly Nutrition Program admissions (N=732) were assessed for depression (PHQ-9), cognitive impairment and anticipated stigma. Gender and race comparisons were conducted and predictors of a successful mental health referral were identified.

Results—Anticipated stigma was higher among African Americans, with African American men endorsing the highest anticipated stigma. There were no race differences in depression rates depression or mental health referrals. Among depressed elders, lower stigma, younger age, and an interaction of race and anticipated stigma predicted a successful mental health referral.

Conclusion—Anticipated stigma can hinder the process of referring older adults to mental health treatment.

Keywords

Stigma; race; mental health referrals; aging services; depression

According to the Institute of Medicine 2012 Mental Health and Substance Abuse Workforce Report entitled “In Whose Hands?” 5.6 million to 8 million older Americans have mental health or substance-use disorders, and these numbers will double by 2030. With this “silver tsunami” will come extraordinary need that cannot be met by traditional mental health providers alone. The Aging Service Network (ASN) funded by the U.S. Health and Human

Services provides nutrition, education and support services to older persons will be called upon to implement evidence-based screening and interventions to address unmet need (1). The ASN case management and home meal programs serve older adults with high rates of depression, disability and suicidal ideation (2, 3). However, the implementation of evidence-based mental health screening, referrals and interventions is not without challenges such as client stigma, and the increase in staff workloads (4).

Both personal and public stigma remain significant barriers to mental health treatment with high rates of discrimination reported by individuals with depression worldwide (5, 6). Among older adults in the community, many report concerns about public stigma with a stronger relation between stigma and seeking care among African American older adults than Caucasian older adults (7). Reluctance to engage in treatment among older African Americans may also reflect the history of abuses in science and medicine, and the double consequences of racism and mental health stigma (8). Knowing that individuals worry about being stigmatized, physicians and providers in non-mental health settings, like primary care and aging services, report stigma as a barrier to mental health referrals (4, 9) with some men perceived as especially vulnerable to the ‘cultural meaning’ of depression (9). To avoid stigma some physicians reported deliberately misdiagnosing major depression to avoid patient stigma (10). In this study we examine race and gender differences in reporting anticipated stigma, a type of public stigma that focuses on views of an individual’s friends and family. Specifically, anticipated stigma is the concern that one’s own social group would react negatively as a result of mental health need or treatment. We examine anticipated stigma in a large sample of older adults receiving ASN services and within a subsample of adults with depression. Specifically, we hypothesized that African American older adults would report greater anticipated stigma than Caucasian adults. In the subsample of depressed adults, we expected that individuals with higher stigma would less likely to receive a successful mental health referral, even if clinically warranted. This is based on the premise that stigma may affect the referral process as a whole, both an individual’s willingness to accept a mental health referral and the willingness or ability of staff to successfully make a mental health referral.

Methods

The U.S. Department of Health and Human Services, Administration for Community Living (Administration on Aging) authorizes meal provision to individuals who are homebound, with nearly 149 million home-delivered meals provided to more than 880,000 homebound individuals in 2009. Compared to the overall U.S. population age > 60, these meal recipients were more likely to be older, poor, Black, and living alone; they were more likely to be in poor health, have greater difficulty performing everyday tasks, and at high nutritional risk (11). To integrate mental health assessment into aging services, a community-academic partnership was created, and Westchester County Department of Senior Programs and Services added depression screening into the routine assessment of all applicants for home meal service.

To integrate screening for mental health treatment into routine assessments, measures were chosen by the community-academic partnership through a collaborative and iterative

process. All consecutive applicants for home meal service undergo a routine assessment of functioning, nutritional risk and social support that culminates in recommendations for nutritional support and other services. Supplemental measures were selected that had low client burden, were easy to administer by staff without a mental health background, and could produce service recommendations.

The Patient Health Questionnaire (PHQ-9), a widely used depression screen was added to detect clinically significant depressive symptoms (PHQ-9 ≥ 10) that would warrant a mental health referral (12). The Blessed Memory Orientation and Concentration test (BOMC) was used to assess cognitive impairment (BOMC ≥ 16) (13). Finally, the Anticipated Cost of Stigma Scale (ACS) was administered to capture concerns that disclosure of depression or mental health treatment would result in negative treatment by people in one's social network. The seven negative social responses are: being treated differently, excluded, criticized, having lower expectations, being judged, distrusted, or viewed as weak. Each ACS item is rated based on level of agreement on a four-point scale; (the ACS scale is provided in Appendix I). A median split of scores is used to identify individuals most concerned about anticipated stigma. In previous analyses with diverse, English-speaking samples, the scale was found to have good internal consistency (Chronbach's $\alpha = 0.89$) (14). All of the selected measures have been used with older adults in previous research studies.

To improve the detection and referral for mental health, training was provided on the administration, scoring of the supplemental measures and use of the standard cut-off score of 10 or above to indicate clinically significant depression warranting a mental health referral. Aging service staff were trained to make a referral for clients scoring 10 or above and provided with community mental health referral resources. Referral guidelines, when combined with screening, increase the likelihood of further assessment in other care settings. The routine assessment, supplemental measures, and the mental health referral were all completed in one visit. A written referral form was completed to indicate the services recommended. This written referral was defined as a successful referral. This secondary data analysis project was approved by the Weill Cornell Internal Review Board (# 0504007864).

Data analyses were conducted on the de-identified data from two client samples, the total sample screened ($N=732$) and the subgroup of individuals who had clinically significant depression on the PHQ-9 ($N=81$). Those clients with missing data comprised less than 1% of the sample and did not differ from the larger sample. Bivariate comparisons (t-tests and chi-squares) were conducted to examine racial differences in anticipated stigma between African American older adults and Caucasian older adults in the total sample. In the subgroup of depressed clients, racial differences in anticipated stigma were re-examined. To examine the relation between client report of high anticipated stigma and being offered a referral for mental health treatment, a parsimonious linear model was developed using a logistic regression with a successful mental health treatment referral (yes/no) as the outcome variable. The final model was subjected to the Hosmer and Lemeshow goodness of fit test. All data analyses were done in SPSS version 19.0.

Results

The total sample was comprised of 732 older adults; 190 participants (26%) self-identified as African American and 542 participants (74%) self-identified as Caucasian with 16 Caucasian individuals indicating that they were of Hispanic origin. There were 540 females (total=732, N=540, 70%) with an average age of 82 ± 8.8 years and 12.5 ± 3.1 years of education. Only educational level differed by race, with Caucasian adults having more education (12.7 ± 3 versus 11.7 ± 3.4).

Case management (additional follow-up visits) was recommended to 89 individuals (total N=732, N=89, 14%), and 46 individuals were referred for additional nutritional counseling (total N=732, N=46, 6%). Only a fraction of the sample, 20 persons (total N=732, N=20, 3%), received both a nutritional counseling and a case management referral. African American clients were referred to case management (total N=190, N=32, 17% vs. total=542, N=57, 11%; $\chi^2=5.39$, $df=1$, $p>.05$) and nutritional counseling more often than Caucasian clients (total N=190, N=24, 13% vs. total N=540, N=22, 4%; $\chi^2=17.61$, $df=1$, $p<.001$).

In the total client sample, 11% (total=732, N=81) endorsed significant depressive symptoms (PHQ-9 10), with similar rates among African American and Caucasian clients (total N=190, N=22, 12% vs. total N=540, N=59, 11%; $\chi^2=.13$, $df=2$, $p=.72$). A subgroup of clients (total=732, N=70, 10%) had cognitive impairment on the BOMC, with rates of cognitive impairment twice as high among African American clients (total=190, N=31, 16% vs. total N=540, N=39, 7%; $\chi^2=14.3$, $df=1$, $p<.001$).

A successful mental health referral was documented for 43 of the 732 older adults (6%) with African Americans and Caucasian adults referred at the same rate (total N=190, N=11, 6% vs. total N=542, N=32, 6%). Most referrals (total N=43, N=31, 72%) for mental health treatment were given to older adults with depression. Cognitive impairment, age and years of education were unrelated to being offered a mental health treatment referral. Clients referred for mental health were more likely to receive a case management referral (total N=43, N=13, 30% vs. total N=692, N=76, 11%; $\chi^2=5.11$, $df=2$, $p<.05$).

For the 732 client sample, the mean score on the anticipated stigma scale (ACS) was $2.09 \pm SD=.51$. Dichotomizing stigma into “high” versus “low” using a median split revealed that African American clients endorsed high stigma more frequently than Caucasian older adults (total N=190, N=130, 68% vs. total N=540, N=288, 53%; $\chi^2=13.66$, $df=2$, $p<.001$). There were significant differences in high stigma across the four race by gender groups ($\chi^2=14.42$, $df=3$, $p<.01$) with African American men endorsing the highest rates of anticipated stigma (total=63, N=46, 73%). (Rates for each group are provided in Appendix 2).

The depressed subgroup (N=81) was significantly more likely to endorse high anticipated stigma than the non-depressed group (total N=81, N=57, 70% vs. total N=651, N=360, 55%, $\chi^2=7.32$, $df=1$, $p<.01$). Of the 81 subjects with depression, 31 (38%) successfully received a mental health referral. A logistic regression was conducted to examine the relation of race, gender, age, depression severity (PHQ-9 score) and anticipated stigma on a successful mental health referral (reference category) defined as a written referral form completed to

indicate the mental health service was recommended versus no referral documented. To capture potential gender by race differences, an interaction term was created. In the final model, lower anticipated stigma, younger age, and race by gender interaction significantly ($p < .05$) predicted who successfully received a mental health treatment referral. In this subsample analysis, there were no significant associations between receiving a mental health referral and cognitive functioning, or depression severity. The relation between having received a referral and being recommended case management at the bivariate level was not sustained in the final model. Maximum Likelihood Estimates of the main and interaction effects are presented in Table 1.

Age was associated with receiving a mental health referral, such that for each year of age the odds of not receiving a referral (vs. receiving a referral) increases by a factor of 1.067 ($=1/\exp(-.065)$). For an adult with high anticipated stigma there is a 70% decrease in the odds of getting a mental health referral compared to an adult with low stigma. The interpretation of the significant interaction term between gender and race is not straightforward and can only be described by taking into account the non-significant main effects (e.g. gender and race). The odds ratio of an African American man getting a referral compared to an African American woman is .26 ($=\exp(-3.96 \cdot .067)$). Keeping all other factors constant, a man of African descent has the least possible chance of getting a mental health referral while a Caucasian woman has the highest chance of a successful referral.

Discussion

The primary findings of this study were that reported anticipated stigma varied by race and gender and that among depressed older adults those with high anticipated stigma were less likely to receive a referral. Among non-depressed older adults who are receiving services through the Aging Service Network, both African American men and women had the highest anticipated stigma concerns. They are more likely to express concern that being depressed or seeking mental health treatment will result in being negatively treated by their social network. Alarming, among depressed older adults the likelihood of being successfully referred for mental health treatment was associated with the level of anticipated stigma. Specifically, clients who were younger and had lower anticipated stigma were more likely to be successfully offered a referral when their depression was detected during screening. African American men were least likely to be referred for mental health care.

The finding of the interrelation of gender, race, anticipated stigma and a successful mental health referral illustrate the compounded barriers to mental health care for diverse older adults. Our findings add to research documenting individual level barriers reported by minority older adults in other non-mental health settings. African Americans in a primary care setting were concerned about the public stigma from family, friends, and their community, and viewed seeking mental health services as a form of weakness. Asking about anticipated stigma also highlights the role of one's social network in obtaining mental health treatment. As increasing attention is paid to barriers, awareness of the role of a client's social network may improve the likelihood of making a successful referral to mental health treatment.

A limitation of this study is that it captures a single moment in a complex process of being referred for mental health treatment. The data do not capture the subtle interactions between clients and staff that could elucidate how anticipated stigma, gender, race and age affect the mental health referral process. Staff may offer mental health referrals later in time, or only when they believe that the referral is likely to be accepted, even when clear referral guidelines are set. As this work is the product of a community partnership, there is a limitation to what factors were available to predict the referral process. Other client characteristics, such as income, functional status or medical burden, may have affected who received successful referrals. Likewise, the characteristics of the staff and their beliefs were not assessed, and could have affected the client outcomes. In addition, our measure of anticipated stigma has been used in research with older adults in other settings (e.g., primary care, homecare) but has not been cross culturally validated. Finally, this sample of older adults does not represent the heterogeneity of the African American or Caucasian older adult population, but is consistent with national profile of participants in the homebound Nutrition Services Program (<http://www.aging.senate.gov/crs/nutrition1.pdf>). Future work should include other racial and ethnic groups served by the Aging Service Network, including a larger sample of Latino elders.

Conclusions

Aging services can provide a unique opportunity to detect depression, but screening cannot be implemented effectively without addressing the challenges of referral and engaging depressed clients in mental health treatment (15). The challenges exist at both the individual and systemic levels. Anticipated mental health stigma may affect both the older person's willingness to consider a referral and the staff's ability to offer a mental health referral, even when there is adequate training to screen and referral resources. In the move to the delivery of mental health services to older adults, we need to consider the complexity of detection and referral in non-mental health community settings. Interventions that address barriers may facilitate successful referrals as mental health care for older adults falls 'into the hands' of the Aging Service Network.

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References

1. Bartels SJ, Naslund JA. The underside of the silver tsunami--older adults and mental health care. *N Engl J Med*. 2013; 368(6):493–6. [PubMed: 23343039]
2. Richardson TM, Friedman B, Podgorski C, Knox K, Fisher S, He H, et al. Depression and Its Correlates Among Older Adults Accessing Aging Services. *J Nurs Care Qual*. 2011
3. Sirey JBM, Carpenter M, Booker D, Reid MC, Newell KN, Alexopoulos GS. Depressive Symptoms and Suicidal Ideation among Older Adults Receiving Home Delivered Meals. *International Journal of Geriatric Psychiatry*. 2008; 23(12):1306–11. [PubMed: 18615448]
4. Steinman L, Cristofalo M, Snowden M. Implementation of an evidence-based depression care management program (PEARLS): perspectives from staff and former clients. *Prev Chronic Dis*. 2012; 9:E91. [PubMed: 22537909]

5. Corrigan PW, Watson AC. Understanding the impact of stigma on people with mental illness. *World Psychiatry*. 2002; 1(1):16–20. [PubMed: 16946807]
6. Lasalvia A, Zoppei S, Van Bortel T, Bonetto C, Cristofalo D, Wahlbeck K, et al. Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. *Lancet*. 2013; 381(9860):55–62. [PubMed: 23083627]
7. Conner KO, Copeland VC, Grote NK, Koeske G, Rosen D, Reynolds CF 3rd, et al. Mental health treatment seeking among older adults with depression: the impact of stigma and race. *Am J Geriatr Psychiatry*. 2010; 18(6):531–43. [PubMed: 20220602]
8. Washington, H. *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times*. New York, NY: Random House; 2007.
9. Hinton L, Zweifach M, Oishi S, Tang L, Unutzer J. Gender disparities in the treatment of late-life depression: qualitative and quantitative findings from the IMPACT trial. *Am J Geriatr Psychiatry*. 2006; 14(10):884–92. [PubMed: 17001028]
10. Rost K, Smith R, Matthews DB, Guise B. The deliberate misdiagnosis of major depression in primary care. *Arch Fam Med*. 1994; 3(4):333–7. [PubMed: 8012621]
11. Greenlee, K. Subcommittee on Health E, Labor and Pensions; Subcommittee on Primary Health and Aging; US Senate. Testimony on Senior Hunger and the Older Americans Act. 2011.
12. Kroenke K, Spitzer RL. The PHQ-9: A New Depression Diagnostic and Severity Measure. *Psychiatric Annals*. 2002; 32:509–15.
13. Katzman R, Brown T, Fuld P, Peck A, Schechter R, Schimmel H. Validation of a short Orientation-Memory-Concentration Test of cognitive impairment. *Am J Psychiatry*. 1983; 140(6):734–9. [PubMed: 6846631]
14. Sirey, J. Faces of Stigma: Older Adult and Provider Perspectives; Annual Meeting of American association of Geriatric Psychiatry; March 10–13, 2006; San Juan, Puerto Rico. 2006.
15. Raue PJ, Sirey JA. Designing personalized treatment engagement interventions for depressed older adults. *Psychiatr Clin North Am*. 2011; 34(2):489–500. [PubMed: 21536170]

Logistic regression analysis of factors associated with receiving a mental health referral among depressed older adults (PHQ-9 10; N=81)

Table 1

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
Gender by race	-.2725	1.355	4.044	1	.044	.066	.005	.933
Gender (0=female, 1=male)	1.376	.868	2.511	1	.113	3.958	.722	21.706
Race (0=Caucasian, 1= African American)	.533	.660	.652	1	.420	1.703	.467	6.206
High anticipated stigma	-1.194	.545	4.797	1	.029	.303	.104	.882
Age	-.065	.029	4.948	1	.026	.937	.884	.992
Constant	5.440	2.439	4.975	1	.026	230.403		

* Hosmer and Lemeshow Goodness of Fit Test (Chi=9.14, df=8, p=.33)