ABSTRACT

The current study evaluated barriers to detection of depression among older people. Focus groups were conducted with 21 professional carers, 4 nurses, 10 general practitioners, and 7 aged care managers. The results demonstrated that care for older people is primarily focused on physical care. Further, staff resources, a lack of continuity of care, multiple co-morbidities, reluctance by older people to discuss depression, negative attitudes among carers, as well as a lack of skills all contributed to a failure to detect and treat depression. The implications of these findings for training programs for professional carers are discussed.

Depression among older people in both residential care and in the community has become an area of increasing concern over the past decade. Past studies suggest that 4%-13% of older people in the general community experience depression (Baker & Miller, 1991; Blank, Gruman, & Robison, 2004; Préville, Coté, Boyer, & Hérbert, 2004), and the figure rises to 15% to 25% among older
people in residential care (Blank et al., 2004; Teresi, Abrams, Holmes, Ramirez, 
& Eimicke, 2001). Other studies indicate that many of these older people do
not obtain treatment for their depression. This lack of treatment appears to be
partly related to the lack of recognition of depression among this population
(Brown, McAvay, Raue, Moses, & Bruce, 2003), and partly related to a lack
of appropriate action being taken to procure treatment when older people are
recognized as having signs of depression.

The barriers to recognizing and treating depression among older people have
not been clearly identified. It would appear that care staff working with older
people have little time to devote to identifying their psychological problems.
For example, Baillon, Scothern, Neville, and Boyle (2006) found that there
were high levels of stress among care staff working with older people, and that
staff had little time or training to address the cognitive and emotional needs of
their patients. Beck, Ortigara, Mercer, and Shue (1999) also identified the working
conditions of staff (e.g., poor pay, insufficient recognition of the value of their
work) as factors that impeded nursing assistants’ capacity to provide compre-
hensive care for older people in residential care. High levels of stress (Brodaty,
Draper, & Low, 2003) and burnout (Berg, Welander Hansson, & Hallberg,
1994) are other factors that have been shown to limit the nature of the care
provided by nursing staff and care assistants. Finally, and not unsurprisingly
given the above findings, high turnover rates (Burgio & Burgio, 1990) have also
been identified as impediments to the recognition of mental health problems
among older people.

These high levels of stress and lack of training may lead to negative attitudes
toward residents with depression (Brodaty et al., 2003). However, research has
demonstrated that residents respond to staff with high levels of job satisfaction
and to staff who show an interest in them (e.g., Burgener, Jirovec, Murrell, &
Barton, 1992; Chou, Boldy, & Lee, 2003). It is therefore important for both
staff and residents that staff are trained to deal with behavioral or psychological
problems among older people (Kaasalainen, 2002). Without these skills and
support, care workers are only likely to provide physical care for residents or
older people living in the community.

In addition to a lack of skills among staff, research indicates that older people
themselves are reluctant to identify that they may be experiencing depression.
For example, Lyness et al. (1995) found a general reluctance among older
people to self-report symptoms, as there is a high level of stigma associated with
admitting that they have mental health problems. Our own studies (e.g., Mellor,
Davison, McCabe, George, Moore, & Ski, 2006) have found that depressed
care recipients believe that their treating general practitioners are too busy to
bother with their mental health concerns.

Despite these general findings, there is a lack of systematic research that
has investigated the barriers to providing appropriate care for older people with
depression. The current study was designed to investigate these barriers within
residential and community care settings in an Australian setting. In order to obtain a comprehensive understanding of staff perceptions of these barriers from multiple perspectives, the interviews for the study were conducted with personal care assistants (or nursing assistants), registered nurses (RNs), general practitioners (GPs), and managers of residential facilities or community teams. Personal care assistants in the Australian setting provide low level care, nurses provide medical care, and GPs are not generally on-site at the facility and visit when required. It was predicted that barriers would be identified in the organizational structure, the attitudes of care staff, and the attitudes of older people. The purpose of the study was to document more systematically the factors that contribute to the failure to detect depression among elderly care recipients, and the failure of those with depression to be referred for appropriate treatment.

METHOD

Participants

Participants were 21 professional care assistants who worked in one of four aged care settings: a residential nursing home (high level care, \( n = 4 \)), two residential hostels (low level care, \( n = 11 \)), and a community-based aged care service (\( n = 6 \)). There were two RNs (one Division 1 and one Division 2), and two trainee Registered Nurses. In addition, seven male and three female GPs who worked with aged care residents in metropolitan or regional areas also participated in the study. Finally, five female and two male senior aged care managers participated in the study.

Materials

A semi-structured interview schedule was developed specifically for this study. The interview schedule focused on the following areas:

- levels of detection of depression among older people; and
- perceived barriers to the detection of depression among older people: if depression is present why is it frequently not detected?

Procedure

Managers from four residential and community aged care settings were invited to allow staff from their facilities to be approached to participate in the research. Professional carers who were interested in participating in the study attended a focus group interview held in their workplace, and were provided with information about the study, prior to giving signed, informed consent. The GPs who participated in the study were drawn from a medical advisory panel which met regularly at an aged care facility to discuss health-related issues in aged care, and members of a Regional Division of General Practice. GPs in each group
were sent an e-mail outlining the research, followed by a telephone call to
discuss the project further, and to invite them to participate. In total, 15 GPs
were approached, with 10 agreeing to complete an interview. This was a good
response rate from this population.

Three managers from residential facilities and four managers from community
age care settings were also invited to participate in the study. All managers
approached agreed to take part.

Participants took part in an individual semi-structured interview conducted by
a clinical psychologist with experience in aged care settings. All interviews were
tape-recorded, transcribed, and analysed using NVivo version 2.0, a software
package that assists in the analysis of qualitative data.

RESULTS

Three aspects of perceived barriers to the care of people in aged care with
depression emerged from interviews with the participants:

1. factors related to the workplace;
2. factors related to older care recipients; and
3. factors related to characteristics of professional carers themselves.

These are reported separately. Themes were extracted from the interviews under
each of these headings.

Workplace Factors

Three main factors related to the aged care setting emerged from interviews:
communication, staff resources, and staff roles.

Communication in Aged Care Settings

Several personal care assistants (PCAs) from the residential care setting
reported problems in top-down and bottom-up communication processes. Many
participants were unaware of the psychiatric presentation or history of the older
people for whom they cared. Although they noted that this information was on
file, PCAs did not appear to access the information routinely or regularly. Some
PCAs and trainee nurses reported that their opinions that a resident may be
depressed were not always taken seriously by their supervisor. These carers
often felt that no effective action was likely to result from passing observations
on to their supervisor, who was typically a RN:

You report it to your manager at the time, the RN, and you are hoping with
all their paperwork, they do actually. . . . But they can say, “Oh well, so
and so is always depressed.” And you become complacent about it. And
as carers, it’s really hard. (Nursing home PCA)
Participants also discussed communications between care staff and GPs. Many PCAs felt that GPs simply did not stop and listen to their concerns, and a large number reported that GPs were not receptive to their opinions and their observations related to the mood or behavior of an older person in their care. These participants often felt that their concerns were dismissed by GPs, who preferred to either make their own judgments about the older person or to obtain their information from a more senior staff member:

... in comes this PCA, and says, “Oh guess what? This happened this afternoon.” And usually they [the GPs] say, “Are you a nurse?” and I go, “No, I’m not.” And they’ll go, “Well, can I see one?” So then what I just said wasn’t worthwhile telling them. (Hostel PCA)

Analysis of the interviews revealed that a previous diagnosis of depression, as with all medical illnesses, was recorded in older person’s residential care plan, but few professional carers actually took the time to read these care plans. Several GPs felt that the written communication system currently used in hostels and nursing homes was inadequate for the conveying of information between the GP to the PCAs.

I often find that no one will ever read the notes. Unfortunately, their care plans and my notes can be miles apart. I don’t know where they put theirs and they never seem to read mine. (Metropolitan GP)

Staff Resources

Many professional carers reported that a lack of available time during their working day was a major obstacle to them providing effective care to older persons, and detecting signs of depression. They reported that aged care was centered on carrying out tasks related to the physical well-being of the older person, leaving limited time to consider their emotional state.

You’re too busy doing chores. (Hostel PCA)

Even when they recognized that someone could be depressed, they often did not have the time to respond appropriately:

You’ll notice them but you think, “Oh yeah, I’ll do something about that.”
You haven’t got time. (Nursing home PCA)

Participants suggested that the nature of the particular presentation of depression resulted in less attention from available staff members than other problems in aged care:

If someone is depressed and they are quiet... they slip through, because your attention sometimes is caught up with the more difficult behaviors. (Nursing home PCA)
Several GPs expressed concern over the continuity of care in hostels and nursing homes. They reported that they would frequently communicate with different professional carers each time they visited the facilities, which created complications in terms of monitoring the mental state of a patient. Often the carers would have different perceptions as to how a patient’s depression was progressing over time:

>[It’s] particularly difficult because there are different carers there [in hostels] for me to speak to each time. Each one may have a widely varying interpretation of how an old person is. (Regional GP)

Aged care managers also expressed concerns about the pressure on professional carers to attend to a large number of tasks. The resultant lack of time was seen to impact on the carers’ ability to sit and talk with aged care residents:

The tasks of aged care are so numerous. . . . There is a certain personal push that everyone has to have a wash by ten o’clock in the morning. . . . On-coming staff will say, “Oh, she didn’t do this” or “She’s only done five washes and I’ve done eight.” . . . (Senior manager of a large nursing home)

Similarly, the limited time available to professional carers in community settings was seen to impact on the likelihood that they would pick up signs of depression:

Once a week visit [by a direct carer] to assist Mrs Jones with her shopping is not necessarily going to give the carer enough time to elicit changes other than those that would be really obvious to them. . . . Care managers have monthly visits, so are less likely [than direct carers] to notice a change. (Manager of direct care workers in a community aged care service)

**Staff Roles**

A number of participants differentiated between the physical and the emotional care of a resident. Professional carers seemed to feel that time constraints forced them to focus on completion of practical tasks, such as showering and dressing. Some carers felt that attending to the emotional needs of the residents was not part of their primary role as a professional carer:

It’s not our job. We’d like to do it if we could stretch that hour each time. But it’s just not possible in the structure that we are working in. We do the best we can with the time we’ve got. (Nursing home PCA)

In the community aged care setting, managers reported that it was not the role of professional carers to determine the presence of depression in older care recipients, viewing this as more of a medical role:

For care managers . . . it isn’t their role to be judging . . . The thing about formal diagnosis and all that . . . it’s not the case manager’s role to diagnose it. It’s the care manager’s role to pick up these sorts of signs, to have good
awareness of what depression is and the impacts and how it plays out.
(Team leader of care managers in a community aged care service)

**Factors Related to Older Care Recipients**

Many professional carers reported that older people in their care often masked signs of depression by behaving in a positive manner when in the presence of particular professional carers and GPs. The fact that older persons often did not wish to discuss the possibility of their being depressed with others was seen by professional carers as a generational factor that was often difficult to overcome:

> The generation that they came from . . . they didn’t get depressed. It wasn’t accepted. That generation was the stoic, stand back, and you don’t complain. I suppose they try to cover it up and things like that. (Nursing home PCA)

Similarly, several GPs felt that older peoples’ views on depression were a barrier to the detection of depressive symptoms by professional carers. They suggested that older persons perceived a stigma surrounding depression and would try to normalize or mask their symptoms:

> It’s a subject that older people don’t like to discuss, and they don’t like to admit that they might even have depression. So often patients are in denial. (Regional GP)

In addition, several carers believed that the common concern among older persons of being a burden to their carers or GPs was a large barrier to their detecting depression in this population and to older persons receiving adequate treatment from their GPs:

> . . . there is a “sprucing up” process. They go along [to the medical practice] looking magnificent and say, “I’m fine.” The doctor needs to get into the house to actually see the reality. (Community care manager)

A recurring theme raised by professional carers was the complexity in the clinical presentation of aged care recipients. Carers reported particular difficulty in distinguishing symptoms of depression from what may be symptoms of other conditions common among older persons, particularly dementia or physical illnesses:

> What else makes it tricky is a lot of my clients, well, all of my clients, they’re high-level and they’ve got multiple co-morbidities. So sometimes that flat affect, the low voice volume, and some other indicators . . . could be related to dehydration, dementia . . . (Community care manager)

Many GPs also commented that the complex medical presentation of older care recipients may challenge professional carers’ ability to detect depression in older persons. Participants noted that other conditions that are highly prevalent among this patient group may manifest in a similar way to depression:
[Depression] is harder to tease out in the older person than it is in a younger person who does not have as much mental or physical impairment. (Regional GP)

**Factors Related to Professional Carers**

Two major themes emerged from interviews with professional carers: training issues and staff attitudes.

*Training Issues*

Poor previous training in understanding depression, and in how to care for an older person suffering from depression, was raised as a concern among all professional carers. Several care managers felt that the training received by PCAs or direct care workers was inadequate:

>*A big concern for me, and I think I speak for everyone here, is the quality of carers available in the system at the moment.* (Community care manager)

*Staff Attitudes*

Several professional carers felt that some of their colleagues held negative attitudes towards older persons. They believed that because some older people complained or sought out their carer’s attention, a number of carers had “switched off” to the emotional needs of residents in order to complete their daily tasks in time:

>*You sometimes wonder whether you do dismiss people who may be depressed as just complaining all the time. . . . You would be more understanding with someone who is really depressed than with someone who complains every day.* (Hostel PCA)

Several GPs also reported a belief that staff attitudes toward their role as a professional carer were a barrier to effective care of older persons with depression.

>*Some of them are probably more switched on than others. Some of them seem uninvolved and just see themselves as doing specific tasks. . . . Some of them do not spend a lot of time with the patient and they seem to move around a bit. For some it is just a mechanical job.* (Metropolitan GP)

Some professional carers were reported by aged care managers to be less inclined to inquire as to how residents are feeling than carers with a genuine interest in, and positive relationship with, the older people for whom they provide care:

>*Some staff are more tuned in than others. . . . The ones who have good rapport with residents would be tuned in to the resident’s mood. . . . I think they would try and ask them what was going on. But the others, I think they just want to get their work done and go home.* (Clinical care coordinator in a hostel)
In particular, the willingness of professional carers to engage with older people with depression was seen to vary, and many carers may be hesitant to discuss sensitive, emotional issues:

Staff may think: What if I say something . . . will he go jump off the roof? . . .
What you don’t want is someone to open up a whole Pandora’s Box and then be so distressed they don’t know where to go with it. (Manager of a large nursing home)

DISCUSSION

The most significant of the factors associated with the lack of detection and treatment of depression among the elderly is that aged care services are primarily focused on providing practical, physically-oriented care to frail older people (e.g., assistance with showering and dressing, meal preparation, or laundry). This finding is consistent with previous studies that have indicated that aged care services focus on providing care for chronic and severe physical disorders, rather than attending to psychiatric conditions (e.g., Rovner & Katz, 1993).

Staff resources were highlighted as a second substantial barrier to the detection of depression by all participants. Professional carers suggested that attending to the emotional needs of older people may require more time than is available to them during busy, task-focused shifts, particularly for those care recipients who received only limited services from community based aged care agencies.

Resources were also implicated as a barrier to the detection of depression in residential settings in that a lack of continuity among staff, who often have only irregular contact with care recipients, means that there is no single carer who is in a position to notice changes in the presentation or functioning of the older people receiving care. In contrast, older people receiving care in their own homes were more likely to receive consistency of care, and therefore have the opportunity to develop closer relationships with their professional carers.

A third barrier to the identification and treatment of depression were problems related to a lack of communication between professional carers in the aged care sector. Most notably, professional carers reported a lack of information about the older people for whom they provided care. There were several reasons for this lack of information in residential settings, including that the majority of carers were unaware of a history of depression among their care recipients, due to their failure to read their history or care plans. The community-based setting presented particular challenges for communication, with care managers often working out of different offices to the direct carers who provided the hands-on care.

A fourth barrier was the tendency among the current cohort of older people in aged care to minimize or deny symptoms of depression. Professional carers agreed that older persons’ reluctance to discuss how they feel makes it difficult to tell if they might be depressed. Finally, professional carers and GPs noted the difficulty
of determining the presence of depression in a group characterized by high levels of physical illness and dementia, and so the high level of co-morbidities with this population.

Professional carers and GPs commented on the limitations of their training in providing the knowledge and skills necessary to work with depressed older people. Professional carers noted that some of their colleagues appeared to minimize the impact of depressive illness or seemed to view depression as a normal consequence of ageing.

Such attitudes among professional carers have been previously reported in the literature, with Bagley et al. (2000) noting that “. . . depressive symptoms can also be perceived as an understandable reaction to the loss, bereavement, ill-health or loss of social status which often accompany ageing” (p. 446). The authors further suggested that “. . . as well as reinforcing negative attitudes to ageing, such view points may impair the recognition of significant and treatable mood changes” (p. 446). In addition, Wells, Foreman, Gething, and Petralia (2004) documented more negative attitudes toward working with older adults among nurses in residential settings than those reported by nurses working in other settings. The authors proposed that such negative attitudes may impact on the quality of care provided to older people.

**Overcoming the Barriers**

A common theme in the interviews was the necessity to improve the communication skills of professional carers. Carers require training in how sensitively to ask about and listen to the concerns of older people who might be depressed. Both professional carers themselves and GPs require specific training in how to respond appropriately to disclosures of negative feelings by older people. There also needs to be a priority set on addressing the emotional needs of older people. Further, organizational barriers that prevent carers from having sufficient time to assess and provide pathways of care to depressed older people need to be removed.

At another level, communication skills training was seen as important to help professional carers to communicate their concerns effectively with senior staff in the aged care setting and with medical professionals and family members. This supports a previous call by Brown et al. (2004) to provide training to improve professional carers’ ability to communicate effectively with GPs, to improve treatment of depression among older people. However, some professional carers suggested that GPs do not always take their concerns about care recipients seriously, despite their efforts to communicate effectively. GPs may also benefit from communication skills training, to facilitate effective communication between aged care and primary care service providers. In addition, general communication systems within aged care services need to be improved, to ensure information about care recipients is dealt with appropriately. In addition to skills in detecting and inquiring into depression among older people, professional carers and their
aged care managers require training in how to respond to depressive illness, in terms of providing appropriate assistance and support or implementing strategies to manage depression, or method of referral to GPs.

In summary, the current study demonstrated a large number of barriers to the detection of depression among older people in both the community and in residential care. The study highlighted a number of training and procedural changes that are necessary in the aged care setting to ensure that depression is detected among older people. These findings have implications for the development of training programs for PCAs, nurses, and care managers to improve their knowledge, skills, and self-efficacy in the area of depression among older people.

This study was conducted with a relatively small sample of care providers, managers, and GPs working with older people in the community and residential care. Further studies are needed to validate the results of this study and further explore barriers to care among depressed older people. This information can then be used to develop training programs so that the mental health needs of older people in both the community and residential care settings can be improved.

REFERENCES


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