11-3-2022

Older adults access to mental health and social care services during COVID-19 restrictions in Western Australia

Claire Adams
Edith Cowan University

Eyal Gringart
Edith Cowan University

Daniel McAullay
Edith Cowan University

Moira Sim
Edith Cowan University

Brigitta Scarfe
Edith Cowan University

See next page for additional authors

Authors

Claire Adams, Eyal Gringart, Daniel McAullay, Moira Sim, Brigitta Scarfe, Amy Budrikis, and Natalie Strobel

Older adults access to mental health and social care services during COVID-19 restrictions in Western Australia

Claire Adams, Eyal Gringart, Daniel McAullay, Moira Sim, Brigitta Scarfe, Amy Budrikis & Natalie Strobel

View supplementary material

Published online: 03 Nov 2022.

Submit your article to this journal

Article views: 175

View related articles

View Crossmark data

APS Australian Psychological Society

Taylor & Francis
Taylor & Francis Group

Older adults access to mental health and social care services during COVID-19 restrictions in Western Australia

Claire Adams [a,b], Eyal Gringart [b], Daniel McAullay [a], Moira Sim [c], Brigitta Scarfe [a], Amy Budrikis [a] and Natalie Strobel [a]

aKurongkurl Katitjin, Edith Cowan University, Perth, Australia; bSchool of Arts and Humanities, Edith Cowan University, Perth, Australia; cSchool of Medical and Health Sciences, Edith Cowan University, Perth, Australia

ABSTRACT

Objective: This study aimed to understand the impact of COVID-19 on access to mental health and social services among older adults in Western Australia.

Method: A cross-sectional study was conducted with 194 adults aged ≥70 years or ≥60 years with chronic conditions. A questionnaire co-developed by a consumer reference group was used to collect data on social networks and service access. Frequency analyses were used to assess quantitative data. Qualitative data were assessed using thematic analyses.

Results: 62.7% of participants reported being not at all/slightly affected by COVID-19; 40.7% reported having three/four people to chat with. 76.3% of participants did not access mental health or social services during the 2020 COVID-19 restrictions. The remaining 23.7% mostly accessed mental health-related services, with GPs the most common source of support. 18.0% of the total sample reported choosing not to access services even though they would have liked to.

Conclusions: Most older adults in this sample did not access mental health or social care services. 18.0% of all participants felt they needed services but did not access them. This suggests there were some unmet needs within the community. Strengthening social networks may help protect older adults against psychosocial declines during and post-COVID-19.

KEY POINTS

What is already known about this topic:

(1) Older adults are at an increased risk of social isolation, loneliness, and mental health declines during COVID-19.

(2) COVID-19 has brought a substantial need for, and disruption to, mental health and social care services locally and globally.

(3) Services have had to change the way they deliver care, which has presented challenges in providing mental health and social support to older adults.

What this topic adds:

(1) Most older adults did not access mental health or social care services during the 2020 COVID-19 lockdown.

(2) The greatest barriers to access were the belief that I "should be able to cope on my own" and a preference for face-to-face care.

(3) Local governments and community organisations play a key role in strengthening social networks and protecting older adults' psychosocial wellbeing during and post-COVID-19.

Introduction

Older adults are at a high risk of severe morbidity and mortality due to COVID-19. Pooled data from 16 countries indicate 86.2% of COVID-19-related deaths were among people aged 65 years and older (Yanez et al., 2020). To protect older adults from contracting COVID-19, governments worldwide have posed restrictions such as lockdowns, curfews, social distancing, and isolation measures. Further, they advised people aged 70 years and older and those with chronic conditions to stay at home and avoid contact with others (Armitage & Nellums, 2020; Healthdirect, 2021).

Social isolation, resulting from such restrictions, is known to have adverse consequences for older adults' physical, mental, and psychosocial health (Wong et al., 2020). Prolonged social isolation is commonly linked to loneliness, and has been associated with higher rates

of cardiovascular disease, poorer immune functioning, increased psychological distress, and greater risk of developing dementia (Nair et al., 2021; Wu, 2020). During COVID-19 restrictions, high rates of anxiety, depression, and sleep disturbances have been observed in older adults, and one in eight older people reported they were lonely "very often" (Bailey et al., 2021; Sepúlveda-Loyola et al., 2020). It is predicted that detrimental mental health effects of COVID-19 will be enduring, thus it is paramount to understand how services can better meet the mental health and social needs of older adults (Veldhuis et al., 2021).

COVID-19 has brought a substantial need for, and disruption to, mental health and social services (Giebel et al., 2021). Services have been required to adapt to different modes of delivery and provide alternate forms of support, including telephone and online formats (Organisation for Economic Co-operation and Development [OCED], 2021). This has posed challenges in providing mental health care to older people, who already experience inequalities in accessing mental health treatment (The Royal College of Psychiatrists, 2018).

Staff perspectives on delivering mental health care to older adults during COVID-19 suggest loneliness and limited access to support from family, friends, and usual services (e.g., primary health care, social care) are relevant problems (Ashcroft et al., 2021; Bhome et al., 2021). However, less attention has been paid to service delivery from the perspectives of older adults themselves, and preferences in the type of mental health and social support remain unclear. It is important to understand service delivery from the perspectives of potential and current service users, to ensure services are appropriate, and meet the needs of those they intend to serve.

In Australia, rates of service use declined in the 2020–2021 period compared with the year prior, and mental health service use showed the greatest declines (Australian Bureau of Statistics, 2021). Cost was often cited as a reason for not seeking help (Australian Bureau of Statistics, 2021). In Western Australia (WA), although the spread of COVID-19 has been limited compared with other states and countries, service use has still been impacted (Callis et al., 2020), and continues to be affected since the easing of interstate and international borders in March 2022.

Given the challenges faced in service provision during COVID-19, it is important to understand older adults' patterns of service use during the pandemic, to identify effective ways to support older adults' psychosocial needs. This is particularly important as the mental health impact of COVID-19 is expected to be long-lasting and future epidemics/pandemics are anticipated (Marani et al., 2021; Veldhuis et al., 2021). Research in this area may help to better equip our mental health and social care services for future crises, as well as potentially mobilise initiatives to improve the health and wellbeing of our ageing society post-pandemic.

The aim of the present study was to understand the impact of the COVID-19 pandemic on access to mental health and social care services among older adults in WA. We chose the period in which Western Australians have been most affected by COVID-19 restrictions to investigate service use: the mid-March 2020 to early June 2020 period. During this time, social and work restrictions were posed, and older adults were encouraged to stay at home to reduce the risk of infection. As such, we refer to COVID-19 restrictions and stay at home orders as lockdowns for older adults. The research questions for this study are: What are older adults' experiences with mental health and social care services during COVID-19? What are common barriers and facilitators to accessing mental health and social care services during the 2020 COVID-19 lockdown among older adults in WA and what factors influenced this access? What are current and future implications of the COVID-19 pandemic on mental health and social care services among older adults in WA?

Materials and methods

Study design and setting

The present study was conducted in Perth, WA. On 15 March 2020 the WA State Government declared a state of emergency due to the spread of COVID-19 locally and globally (Government of Western Australia, 2020a). From 23 March 2020 COVID-19 restrictions were implemented including social distancing measures, public facilities were closed, restaurants and cafes were restricted to takeaway only, and older adults were encouraged to stay at home to reduce the risk of infection (Government of Western Australia, 2020b). Restrictions were gradually eased through to 6 June 2020, where the easing of social distancing measures permitted businesses to reopen and social activities to resume (Government of Western Australia, 2020c). This was the longest period in which Western Australians experienced COVID-19 restrictions.

Data collection

The current study employed an online survey design to assess older adults' experiences with mental health

and social care services during the mid-March 2020 to early June 2020 period. Cross-sectional data were collected online using Qualtrics research services (Qualtrics, 2022), and in person through convenience sampling from health centres and community groups. Potential participants were invited to take part in the study online via an email sent by Qualtrics or in person by a member of the research team. Participants were provided with a link to the online survey, which included a study information letter, online consent section, and the study questionnaire. Data collection took place April-August 2021, during which time restrictions had been eased in WA, and there was no longer community spread of COVID-19.

Participants

Adults 70 years and older, or 60 years and older with chronic medical conditions were recruited as this cohort is more likely to have severe illness from COVID-19 and were subject to greater COVID-19 restrictions than other groups in WA. Participants were excluded if they did not reside in WA, if they had a diagnosis of dementia, including Alzheimer's disease, based on self-report data, or if they did not meet the age and/or health criteria. Such screening questions were included at the beginning of the online survey to determine eligibility. Participants who did not meet the criteria were automatically excluded by the survey program. Participants provided informed written consent prior to commencement of the study via a check box at the beginning of the online survey.

Data source

Data were collected via a questionnaire delivered online using the Qualtrics platform.

Questionnaire development

A questionnaire co-developed by a consumer reference group and the research team was used to collect data. The consumer reference group comprised eight older adults living in WA (Adams et al., 2022). The research team included a general practitioner with primary care knowledge, a registered psychologist, two epidemiologists, and researchers with expertise in psychology, gerontology, and public health. The questionnaire was informed by qualitative interviews conducted with older adults in WA as part of another study by the authors.

The consumer reference group had input into each item in the questionnaire. Specific questions were driven by the reference group, including options for getting out of the house and preparedness for lockdowns. Upon advice from the reference group, when asking about the utilisation of mental health and social care services, terms such as anxiety and depression were phrased in general to aid in participants interpretation of the questions. The phrasing "did you discuss or try to discuss feeling down, worried or alone with any of the following?" was agreed upon by the reference group. Based on feedback from the reference group, all COVID-19 restrictions were referred to as "lockdowns" to aid with recall and comprehension.

The questionnaire was piloted with 14 older adults in WA, who were recruited using Qualtrics research services. Minor amendments were made before the questionnaire was implemented in the present research. In addition to individual quantitative items, the questionnaire included open-ended questions to collect qualitative data on barriers and facilitators to accessing services. A copy of the questionnaire is provided in supplementary material.

Measures

Demographic information
Participants provided demographic information and were asked to indicate their options for getting out of the house through one multiple choice question. Participants were asked to rate the extent to which they had been personally affected by COVID-19 on a 5-point Likert-type scale from not at all to extremely.

Social networks
Participants were asked to respond to two items measuring the strength of their pre-existing social networks. Each item was rated on a 6-point Likert-type scale, higher scores indicate wider social networks.

Utilisation of mental health and social care services
Mental health and social care services were defined as any service or organisation that provides formal or informal mental and psychosocial support to older adults. Support may be provided by government funded specialist and non-specialist services, not for profit organisations, and/or community groups A list of services is provided in Table 1.

Participants reported whether they accessed mental health and social care services during the 2020 COVID-19 lockdown (mid-March 2020 to early June 2020). Participants who reported accessing services during this time were asked to indicate which one service provided them the greatest support.

Table 1. Mental health and social care services.

Mental Health-Related Services
General Practitioner (GP)
Nurse
Hospital emergency department
Aboriginal health worker
Psychologist, counsellor, or therapist
Psychiatrist
Mental health facility
Online chat service, e.g., Beyond Blue
Telephone support, e.g., Lifeline, The Samaritans
Social Care Services
Recreational group or support group, e.g., men's shed, art class, bowling club, knitting club, book club, RSL, cultural group
Religious or spiritual support
Community support services, e.g., in-home aged care support, family, and carer support services

Satisfaction with services

Participants who accessed services during the 2020 COVID-19 lockdown were asked to rate their overall experience with the service(s) in meeting their needs. This was assessed using 11 self-report items, rated on 4-point Likert-type scales from strongly disagree to strongly agree. Needs rated included time frame, communication, cultural and language needs, affordability, safety, ease of access, and comfort with technology/remote delivery. Items were considered individually, however, reliability testing was conducted for the overall construct of satisfaction with services, which demonstrated good internal consistency (r = .88).

Barriers to accessing services

All participants were asked to indicate whether there were any services they would like to have accessed to support their mental health during the 2020 COVID-19 lockdown but chose not to access. Participants who chose not to access services were asked to indicate what prevented them from accessing services from a list of 17 possible reasons. The possible reasons listed were based upon barriers identified in previous qualitative research by the authors. Participants were also asked to describe any difficulties or barriers to accessing services during lockdown with one open-ended question.

Facilitators to accessing services

All participants were asked whether there was anything that made it easier to obtain the support they needed during lockdown with one open-ended question.

Attitudes towards service use post-lockdown

Attitudes towards accessing services since the 2020 COVID-19 lockdown were assessed using four items, designed to measure knowledge and comfort in accessing help, and perceived changes in access to support since COVID-19. Each item was rated on a 4-point Likert-type scale from strongly disagree to strongly agree. Participants could also indicate if there were no perceived differences. Items were considered individually, however, reliability testing was conducted for the overall construct of attitudes, which demonstrated good internal consistency (r = .76).

Preparedness for lockdowns

In February 2021, the Perth, Peel and Southwest regions of WA entered a five-day lockdown. People were required to stay at home unless they needed essential services or supplies. Participants' preparedness for the February 2021 lockdown was measured using one item, rated on a 3-point scale from more prepared, the same, to less prepared for the February 2021 lockdown than the 2020 COVID-19 lockdown. Participants were asked to provide a reason for their response.

Data analysis

Frequency analyses were used to report on demographic information, social networks, utilisation of services, satisfaction with services, barriers, attitudes, and preparedness for lockdowns. Continuous data were reported as means (M) and standard deviations (SD). Categorical data were reported as counts and percentages. Missing data were not replaced as less than 5% were missing (Jakobsen et al., 2017). Logistic regressions were conducted to identify demographic and social factors associated with access to services during the 2020 COVID-19 lockdown. The dependant variables were whether or not participants accessed services during the lockdown and whether there were any services they would like to have accessed but chose not to. Independent variables were sex (binary), age (continuous), the extent to which they had been personally affected by COVID-19, defined as COVID-19 impact (continuous), two items measuring the strength of participants pre-existing social networks (continuous), relationship status (binary), education (binary), and financial situation (binary). Odds ratios and 95% confidence intervals (CIs) were derived for each model. Unadjusted and adjusted logistic regression were conducted, adjusting for sex and age. SPSS version 27 was used to analyse quantitative data. Qualitative data obtained from open-ended questions were assessed using thematic analyses. Qualitative data were analysed using Microsoft Excel.

Community participation

The consumer reference group provided input into all stages of the research process, from study design to translation of findings. The study documents (e.g., information letter, questionnaire) were co-developed by the researchers and reference group, and the research findings were presented to the reference group, supporting the interpretation and dissemination of results. Reference group members discussed whether they considered the findings to be representative of the community and made recommendations for future research and changes to service delivery. Including a consumer reference group helped ensure the research was relevant to and informed by the target population.

Ethics approval

Ethics approval was granted by the Edith Cowan University Human Research Ethics Committee, approval number 2020–01693-STROBEL.

Results

There were 194 older adults included: 109 (56.2%) females and 85 (43.8%) males. The mean age of participants was 71.41 years (SD = 6.93). Most participants resided in the Perth metropolitan area (n = 154, 79.4%). Most participants were born in Australia (n = 111, 57.2%), followed by the United Kingdom (n = 52, 26.8%), and New Zealand (n = 5, 2.6%); 191 (98.5%) spoke English as their main language at home. There were 75 participants (38.7%) who reported living with a chronic health condition. Participant characteristics are presented in Table 2.

Regarding options for getting out of the house, most participants 186 (95.8%) were able to get out of the house by driving, public transport and/or walking, 4 (2.1%) could only leave the house with aid, and 4 (2.1%) were housebound. When asked to rate the extent to which they had been personally affected by COVID-19, 60 (31.1%) reported not at all affected, 61 (31.6%) slightly, 55 (28.5%) moderately, 15 (7.8%) very, and 2 (1.0%) extremely affected.

To assess participants' social networks, an indication of social isolation, frequency analyses were conducted (Table 3). Participants commonly reported having three or four people they could call on for help (n = 86, 44.3%), and three or four people they were able to have a chat with if they were feeling down, worried or wanted to be less alone (n = 79, 40.7%). Concerningly, 8 (4.1%) participants had no one they could call on for help, and 13 (6.7%) participants had no one they felt able to have a chat with.

Table 2. Characteristics of participants.

Characteristics	Total (N =194)
Age M(SD)	71.41 (6.93)
Sex n(%)	
Female	109 (56.2%)
Male	85 (43.8%)
Relationship Status n(%)	
In a current relationship	106 (54.6%)
Not in a current relationship	87 (44.8%)
Other	1 (0.5%)
Level of Education n(%)	
Up to Year 10	52 (26.8%)
Year 11 or above	142 (73.2%)
Employment Status n(%)	
Employed	22 (11.3%)
Unemployed	13 (6.7%)
Retired	156 (80.4%)
Volunteer work only	3 (1.5%)
Financial Situation n(%)	
Always/Mostly able to make ends meet	165 (85.0%)
Sometimes able to make ends meet	24 (12.4%)
Never able to make ends meet	5 (2.6%)
Government healthcare card or pension card n(%)	156 (80.4%)
Private Health Insurance n(%)	112 (57.7%)

Table 3. Participants' social networks.

Social network	n (%)
How many people do you feel close to that you could call on for help?	
None	8 (4.1%)
One or two	47 (24.2%)
Three or four	86 (44.4%)
Five or more	53 (27.3%)
How many people would you feel able to have a chat with?	
None	13 (6.7%)
One or two	62 (32.0%)
Three or four	79 (40.7%)
Five or more	40 (20.6%)

Older adults experiences with mental health and social care services

Most participants (n = 148, 76.3%) did not access mental health or social care services during the 2020 COVID-19 lockdown, 23.7% (n = 46) did access services. Of the participants who did access services, 54.4% (n = 25) accessed mental health-related services only, 17.4% (n = 8) accessed social care services only, 21.7% (n = 10) accessed both mental health and social care services, and 6.5% (n = 3) accessed other services. Most participants reported that mental health-related services provided them with the greatest support, with GPs the most common source of support (n = 24, 58.5%).

Of those who accessed services, participants were generally satisfied with the services received. Most participants agreed the services met their needs (n = 33, 76.7%), felt their needs were met within a reasonable timeframe (n = 31, 72.1%), and were able to discuss their needs (n = 33, 76.7%). However, 65.1% (n = 28) would have preferred getting information or support face-to-face. A summary of participants' satisfaction with services is provided in Table 4.

Table 4. Satisfaction with mental health and social care services during the 2020 COVID-19 lockdown.

Statement	Disagree	Agree	N/A
These services met my needs	7 (16.3%)	33 (76.7%)	3 (7.0%)
I felt like my needs were met within a reasonable timeframe	8 (18.6%)	31 (72.1%)	4 (9.3%)
I was able to discuss my needs	8 (18.6%)	33 (76.7%)	2 (4.7%)
I felt these services met my cultural needs	2 (4.7%)	17 (39.5%)	24 (55.8%)
I felt these services met my language needs	2 (4.8%)	20 (47.6%)	20 (47.6%)
I could afford these services	5 (11.4%)	31 (70.4%)	8 (18.2%)
I felt safe from COVID-19 in my dealings with these services	3 (7.0%)	35 (81.4%)	5 (11.6%)
I could easily find information about these services	4 (9.3%)	30 (69.8%)	9 (20.9%)
I felt comfortable using online technologies to get information	7 (16.7%)	21 (50.0%)	14 (33.3%)
I felt comfortable using the telephone to get information	4 (9.8%)	23 (56.1%)	14 (34.1%)
I would have preferred getting information or support face-to-face	3 (7.0%)	28 (65.1%)	12 (27.9%)

Participants with missing data were excluded from the analyses.

Barriers and facilitators to accessing services during the 2020 COVID-19 lockdown

Of the overall sample of 148, 35 participants (18.0%) reported they would have liked to access a mental health or social care service during the 2020 COVID-19 lockdown but chose not to. Among this group, 42.8% did access a service but wanted to access other services. Barriers to accessing services are presented in Table 5.

The two most endorsed barriers to accessing services were the belief that I "should be able to cope on my own" (n = 15, 42.8%) and I "prefer face-to-face care" (n = 11, 31.4%). Interestingly, no participant endorsed the belief that services cannot help them.

Qualitative feedback regarding barriers and facilitators to accessing services are presented in Figure 1. Eight participants provided qualitative feedback regarding barriers to service access and 18 participants reported on facilitators.

Factors that influence service access during the 2020 COVID-19 lockdown

Factors that influence service access can be found in Table 6. For every 1-point increase in COVID-19 impact, there was a 73% increase in the odds of not accessing services after controlling for age and sex (aOR 1.73, 95% CI 1.21, 2.49; p = 0.003). Participants not in a current relationship had 55% decreased odds of not accessing services compared with those who have a partner after controlling for sex and age (aOR 0.45, 95% CI 0.22, 0.90, p = 0.023).

For every 1-point increase in COVID-19 impact, there was a 53% decrease in the odds of choosing not to access services despite wanting to after controlling for sex and age (aOR 0.47; 95% CI 0.31, 0.71; p < .001). Participants who were able to save always or most of the time had 67% decreased odds of choosing not to access services despite wanting to, compared with those who were able to save half of the time through to never after controlling for sex and age (aOR 0.33; 0.14, 0.82; p = 0.016).

Current and future implications of COVID-19 on mental health and social care services

Participants' attitudes towards accessing services since the 2020 COVID-19 lockdown were assessed in 2021. Attitudes were generally positive. Most participants

Barriers to accessing services	
Limited availability of care	"It was nearly impossible to get an appointment"
Lack of information	"There was not enough information [about how to access services]"
Lack of face-to-face care	"Having to have appointments over the phone"
No care for milder symptoms or concerns	"No one cared, I wasn't depressed enough"
Facilitators to accessing services	
Able to obtain services remotely	"GP rang me for phone appointments, and I was able to chat with her" "Zoom and Facetime [made it easier]" "Mental health service rang when I felt close to the edge"
Continuity of care	"I was able to obtain the social support I needed from home services" "Support person came regularly"

Figure 1. Themes and quotes from participants on barriers and facilitators to accessing services.

Table 5. Barriers to accessing services during the 2020 COVID-19 lockdown.

Barrier	n (%)
Should be able to cope on my own	15 (42.8%)
Prefer face-to-face care	11 (31.4%)
Afraid of being exposed to COVID-19	6 (17.1%)
Had more important responsibilities	6 (17.1%)
Limited/no access to digital technologies	4 (11.4%)
Difficulties communicating online	4 (11.4%)
Worried that staff would not take my concerns seriously	4 (11.4%)
Believed services were too overwhelmed, my concerns were not severe enough	4 (11.4%)
Could not afford it	3 (8.6%)
Did not know what services were available	3 (8.6%)
Did not know how to use digital technologies	3 (8.6%)
Difficulties communicating through face masks	2 (5.7%)
Difficulties accessing transport	2 (5.7%)
Did not feel I could trust service providers	1 (2.9%)
Do not believe services can help me	0 (0.0%)

reported knowing where to get information to help them (n = 122, 64.9%), most felt comfortable getting care that will help them (n = 108, 57.8%), and most thought support is easier to get now than before COVID-19 (n = 97, 51.9%). Changes made to service delivery appeared to have minimal impact on participants' perceived access to services; 88 (47.8%) felt the changes made no difference, 57 (31.0%) reported the changes benefitted them, and 39 (21.2%) reported the changes did not benefit them.

Regarding preparedness for lockdowns, participants either felt more prepared (n = 91, 48.9%) or the same (n = 85, 45.7%) for the February 2021 lockdown than the 2020 COVID-19 lockdown. Participants reported they "knew what to expect" and it is "becoming a way of life". Ten participants (5.4%) reported feeling less prepared, indicating it was "too much to take in".

Discussion

The present study aimed to shed light on the impact of the COVID-19 pandemic on access to mental health and social care services among older adults in WA. Overwhelmingly, previous research has focused only on access to medical services during COVID-19. In our sample, 76.3% of participants did not access mental health or social care services during the 2020 COVID-19 lockdown. It is possible that many older adults did not require mental health or social support services during this time, as 62.7% of participants reported being "not at all" or "slightly" affected by COVID-19, and 40.7% reported having three or four people to chat with if feeling distressed or alone. This supports earlier work indicating older adults are able to adapt well to challenges (Neubauer et al., 2019), and suggests older adults in the present sample may have relied on their existing social networks for psychosocial support during COVID-19 restrictions if needed, rather than formal services.

Nevertheless, 18.0% reported choosing not to access services during lockdown, even though they would have liked to. This is consistent with research by Strutt et al. (2022), who found 15% of older Australians with pre-existing medical conditions delayed accessing health services during COVID-19, and is greater than in the general population, where 6% of Australians reported needing to use a mental health or social support service since March 2020 but chose not to (Australian Bureau of Statistics, 2020). Older adults often have low rates of mental health service engagement and low perceived need for help (Byers et al., 2012; Wuthrich & Frei, 2015) and thus are more likely to be self-reliant than seek support. Furthermore, concerningly, 6.7% of participants had no one they felt able to chat with. It is therefore important that attention is paid to older adults in times of crisis, particularly now that border restrictions have eased in WA, as they may be likely to abstain from help-seeking.

Of the 23.7% of participants who did access services during the 2020 COVID-19 lockdown, mental health-related services were more commonly accessed than social care services. Most participants who accessed services had positive experiences; they felt their needs were met, and they felt able to discuss their needs, within a reasonable time frame. This is encouraging, as it suggests despite the challenges of delivering services during COVID-19, mental health and social care services were able to provide the care and support older adults needed.

The main reasons for not accessing care reported by the 18.0% who chose not to access services include I "should be able to cope on my own" (42.8%) and I "prefer face-to-face care" (31.4%). The belief that I should be able to cope on my own may indicate a low perceived need for help. A recent systematic review of 32 articles on barriers to mental health

Table 6. Logistic regressions of demographic factors on service access.

Variables	Total number of participants n = 194	Total number of participants who experienced the outcome	Unadjusted Odds Ratio	95%Cls	Adjusted Odds Ratio	95%Cls
Did not access services						
Sex (n %)						
Male	85 (43.8%)	70 (82.3%)	1.85	0.92, 3.72	1.80	0.89, 3.62
Female	109 (56.1%)	78 (71.5%)	1.00			1.00
Age (M ± SD)						
Age in years	71.41 ± 6.93		1.03	0.98, 1.08	1.02	0.97, 1.07
COVID-19 impact (M ± SD)						
Personally affected by COVID-19	3.84 ± 0.99		1.75*	1.23, 2.47	1.73*	1.21, 2.49
Social networks (M ± SD)						
Number of people to call on for help	3.95 ± 1.12		1.30	0.97, 1.74	1.28	0.94, 1.74
Number of people able to chat with	3.62 ± 1.27		1.03	0.79, 1.34	0.98	0.75, 1.30
Relationship status (n %)						
Not in a current relationship	87 (45.0%)	59 (67.8%)	0.43*	0.22, 0.85	0.45*	0.22, 0.90
In a current relationship	106 (54.9%)	88 (83.0%)	1.00			1.00
Education (n %)						
Less than high school	52 (26.8%)	38 (73.0%)	0.79	0.38, 1.64	0.85	0.41, 1.78
High school and above	142 (73.2%)	110 (77.4%)	1.00			1.00
Financial situation						
Able to save always or most of the time	165 (85.0%)	128 (77.5%)	1.56	0.65, 3.71	1.33	0.54, 3.26
Able to save half the time/never	29 (14.9%)	20 (68.9%)	1.00			1.00
Wanted to access services but chose not to						
Sex (n %)						
Male	85 (43.8%)	11 (12.9%)	0.53	0.24, 1.15	0.57	0.26, 1.24
Female	109 (56.1%)	24 (22.0%)	1.00			1.00
Age (M ± SD)						
Age in years	71.41 ± 6.93		0.95	0.89, 1.00	0.95	0.90, 1.01
COVID-19 impact (M ± SD)						
Personally affected by COVID-19	3.84 ± 0.99		0.45**	0.30, 0.67	0.47**	0.31, 0.71
Social networks (M ± SD)						
Number of people to call on for help	3.95 ± 1.12		0.74	0.54, 1.02	0.78	0.55, 1.09
Number of people able to chat with	3.62 ± 1.27		0.90	0.68, 1.20	0.98	0.72, 1.33
Relationship status						
Not in a current relationship	87 (45.0%)	18 (20.6%)	1.37	0.66, 2.84	1.32	0.62, 2.81
In a current relationship	106 (54.9%)	17 (16.0%)	1.00			1.00
Education						
Less than high school	52 (26.8%)	12 (23.0%)	1.55	0.71, 3.40	1.44	0.65, 3.20
High school and above	142 (73.2%)	23 (16.2%)	1.00			1.00
Financial situation						
Able to save always or most of the time	165 (85.0%)	24 (14.5%)	0.28*	0.12, 0.66	0.33*	0.14, 0.82
Able to save half the time/never	29 (14.9%)	11 (37.9%)	1.00			1.00

*<.05, **<.001. M = mean, SD = standard deviation, CI = confidence intervals. For the adjusted models sex and age were entered as covariates.

services among older adults found a lack of perceived need for professional help was a common barrier to accessing mental health care (Lavingia et al., 2020). Choi et al. (2014) found adults aged 65 years and older were less likely to perceive a need for treatment than younger age groups. Endorsement of this barrier may also be reflective of mental health stigma, which has been shown to reduce help-seeking and lead to self-reliance (Clement et al., 2015).

Preferring face-to-face care was the second most common reason for not accessing services in the present study. Older adults may not be comfortable using remote means (e.g., telephone, online) to discuss their mental health and prefer traditional forms of communication. However, it is important to note that this finding is not unique to older adults. March et al. (2018) conducted a community survey in Australia on attitudes towards online mental health services and

found most adults in their sample (85.7%, n = 264) preferred traditional, face-to-face mental health support rather than internet-based support.

Being able to access mental health support remotely was also reported as a facilitator to accessing care by some participants. This highlights that there is not a "one-size-fits-all" approach to service delivery. Older adults are diverse and have individual preferences and needs (Fulmer et al., 2021). Services that are adaptable and use multiple methods to provide care may increase the likelihood of older adults engaging with services to discuss their mental health.

It is also interesting that no participant believed services could not help them. This indicates that all older adults in our sample felt mental health and social care services can provide them with the support they need, if/when required. Knowledge of available treatments, including beliefs that services are likely to be helpful, is a key component of mental health literacy (Jorm, 2012). Studies have demonstrated increases in mental health literacy in Australia over the past three decades; improvements in the perceived helpfulness of GPs, mental health professionals, and telephone support in providing mental health care have been observed (Jorm et al., 2006; Reavley & Jorm, 2011, 2012). Indeed, GP's provided older adults with the greatest support during lockdown, accessed by 58.5% of service users. Thus, to encourage timely access to services, efforts should be focused on increasing knowledge of when to seek help, and reducing stigma, to alleviate barriers to care.

There are also a number of sociodemographic factors found in our study to influence older adults access to mental and social services. Concerningly, participants who reported greater COVID-19 impact were less likely to access mental and social services. COVID-19 has had a profound impact on older adults' psychosocial health, and people who are in the greatest need of support may therefore not be accessing the care that they need (De Pue et al., 2021).However, participants who reported greater COVID-19 impact were less likely to report choosing not to access services despite wanting to. It is possible that people who were more affected by COVID-19 prioritised accessing medical services during this time than other support services, and thus did not access nor want to access mental and social care. These findings also suggest that although people who were more impacted by COVID-19 were less likely to access services overall, if they did want to access them, they were more likely to act on their intentions than those who were less

impacted by COVID-19. COVID-19 impact may provide greater motivation to actually assess services if they wanted to.

It is important to consider how participants financial situation impacts their desire to access services, as participants who reported being able to save always or most of the time were less likely to choose not to access services than those less able to save. Financial constraints are a common barrier to accessing mental health services among older adults (Lavingia et al., 2020; Wuthrich & Frei, 2015), and this finding is consistent with national data that indicates in Australia cost is a key reason for not seeking mental health services(Australian Bureau of Statistics, 2021).

Participants who were in a current relationship were also less likely to access services, compared to those who are not partnered. Thus, people who are not partnered may rely more on mental and social services for support than those with a partner. Older people living alone have been found to be at higher risk of loneliness and poor mental health outcomes during COVID-19 than those living with others (Wong et al., 2020). Mental and social services may be an important avenue through which people not in a relationship can combat isolation during lockdowns, and this group is therefore an important target population for service delivery during times of crises.

We reported our findings back to the consumer reference group who highlighted important areas for consideration. The reference group was concerned that 4.1% of participants had no one they could call on for help, and 38.7% had two or less people they can chat with. Whilst our sample may not be representative of the WA population, if it were, this represents 14,193 and 133,973 older adults respectively, who have no one they can call on for help or chat with, based on the latest 2016 census (Australian Bureau of Statistics, 2017). Improving relationships within older adults' local communities may be important to fostering mental health and social wellbeing. The consumer reference group was also interested in participants' options for getting out of the house, as this may be an indicator of their ability to access services. In our sample, 95.8% of older adults were able to get out of the house by driving, public transport and/or walking, which is comparable to the wider population of older adults in WA (Department of Communities, 2016). Including a more heterogenous sample of older adults, particularly those with English as a second language, was deemed important by the reference group to understand the needs of older adults who may have additional barriers

to care. We were not able to detect whether services met older adults' cultural needs and language needs in this study, as 98.5% of the sample spoke English as their main language at home.

The reference group felt that having health appointments via remote means during lockdown could be a barrier to care, but also enabled access to care, reduced physical barriers such as travel time and finding parking, and thus could be helpful particularly for routine appointments. Fear of catching COVID-19 was another barrier to care considered relevant by the reference group, which may have led to reduced service utilisation. Furthermore, additional data comparing the use of primary health and mental health services may have provided important information as to the type of mental health treatment received, however, we were unable to draw these comparisons in the present study due to limited sample size.

As this is a descriptive study, we are unable to generalise our findings to other populations and contexts and causal inferences between barriers/facilitators to access and actual service use cannot be drawn. WA has been relatively unaffected by COVID-19 compared with other states in Australia and overseas, with duration of lockdown being short compared with other jurisdictions, which may account for the low rates of service use in our study. Although results are unlikely to be generalisable to older adults living in other regions, service delivery was still disrupted by COVID-19 and changes to service provision were widespread, thus our findings may be of interest to service providers, policy makers and practitioners nationally and internationally (Callis et al., 2020). There is also a possibility of recall bias, given the near 12-month gap between the 2020 COVID-19 lockdown and our 2021 data collection period. Previous studies have indicated there is often an under-reporting of primary health care utilisations when participants are asked to recall events that occurred 12 months prior (Brusco & Watts, 2015; Khare & Vedel, 2019). It is possible that more people accessed services than was reported in the present study. Future studies may benefit from collecting administrative data to assess service utilisation more accurately during the COVID-19 lockdown.

Participants reported preferring face-to-face care, however, we did not collect data on which services did not deliver face-to-face care during the 2020 COVID-19 lockdown. Therefore, the actual availability of face-to-face care during this time is unclear. Further information on the availability of face-to-face care during lockdown would help to clarify this barrier.

Additionally, nearly all data were collected via an online survey. This may have resulted in a sample with greater digital literacy than the general population. Although we offered face-to-face and telephone data collection to ensure participants with low digital literacy were not excluded, we were unable to recruit as many participants as we expected via these methods. Hence, it is likely that those hardest to reach were not represented in our study, biasing our sample. These factors, as well as other important factors that have been shown to influence service access in the literature (e.g., ageism, mental health diagnoses, accommodation, health-related quality of life (Bastani et al., 2021)) should be considered in future research.

A key strength of the present study is the inclusion of a consumer reference group who provided input into all stages of the research process. This aided in the interpretation of results and helped to ensure the research is relevant to older people in our community. Including consumers in research is significant to responsible health research and is in accord with recommended best practice (National Health and Medical Research Council, 2016).

Conclusions

Since the global spread of COVID-19, there has been an increased demand on mental health and social care services to meet the needs of their communities. WA has experienced increased community transmission of COVID-19 with the easing of interstate and international borders in March 2022. Thus, it is pertinent and timely to investigate older adults' access to mental health and social care during COVID-19 restrictions, which may help inform the delivery of services. In the present study, older adults who did access services reported having their needs meet, indicating services have been resilient to coping with the increased demands and changes in service provision. However, some older adults (18.0%) reported choosing not to access services during the 2020 COVID-19 lockdown, and 38.7% had two or less people they felt able to chat with, which is concerning, and suggests more needs to be done to foster relationships within older adults' local communities. Opportunities exist to enhance older adults' mental health and wellbeing through interventions that increase community engagement and connectedness. Local governments and community organisations can play an important role in maintaining and building community relations during and post-COVID-19. Strengthening social networks,

particularly among those who are unpartnered and among people with limited financial resources, may help to improve older adults' psychosocial health and ease pressure on the healthcare system during and post the pandemic.

Data availability statement

The data that support the findings of this study are available from the corresponding author, CA, upon reasonable request.

ORCID

Claire Adams http://orcid.org/0000-0002-0667-8088
Eyal Gringart http://orcid.org/0000-0002-6683-3879
Daniel McAullay http://orcid.org/0000-0002-0651-899X
Moira Sim http://orcid.org/0000-0001-5962-6639
Brigitta Scarfe http://orcid.org/0000-0002-3313-9151
Amy Budrikis http://orcid.org/0000-0002-6450-385X
Natalie Strobel http://orcid.org/0000-0002-2962-5704

References

Adams, C., Albert, P., Benson, T., Cordingley, A., Daniels, B., Fynn, N., Gurgone, M., Jeffery, C., White, C., & Strobel, N. (2022). The realities and expectations of community involvement in COVID-19 research: A consumer reference group perspective. *Research Involvement and Engagement*, 8(1), 54. https://doi.org/10.1186/s40900-022-00389-z

Armitage, R., & Nellums, L. B. (2020). COVID-19 and the consequences of isolating the elderly. *The Lancet Public Health*, 5(5), e256. https://doi.org/10.1016/S2468-2667(20)30061-X

Ashcroft, R., Donnelly, C., Dancey, M., Gill, S., Lam, S., Kourgiantakis, T., Adamson, K., Verrilli, D., Dolovich, L., Kirvan, A., Mehta, K., Sur, D., & Brown, J. B. (2021). Primary care teams' experiences of delivering mental health care during the COVID-19 pandemic: A qualitative study. *BMC Family Practice*, 22(1), 1–12. https://doi.org/10.1186/s12875-021-01496-8

Australian Bureau of Statistics. (2017). *2016 Census quickstats*. https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/5?opendocument

Australian Bureau of Statistics. (2020). Household Impacts of COVID-19 Survey 6-10 July. https://www.abs.gov.au/statistics/people/people-and-communities/household-impacts-covid-19-survey/6-10-july-2020#mental-health-and-related-services

Australian Bureau of Statistics. (2021). *Patient experiences in Australia: Summary of findings*. https://www.abs.gov.au/statistics/health/health-services/patient-experiences-australia-summary-findings/latest-release

Bailey, L., Ward, M., DiCosimo, A., Baunta, S., Cunningham, C., Romero-Ortuno, R., Kenny, R. A., Purcell, R., Lannon, R., McCarroll, K., Nee, R., Robinson, D., Lavan, A., & Briggs, R. (2021). Physical and mental health of older people while cocooning during the COVID-19 pandemic. *QJM: An International Journal of Medicine*, 114(6), 1–6. https://doi.org/10.1093/qjmed/hcab015

Bastani, P., Mohammadpour, M., Samadbeik, M., Bastani, M., Rossi-Fedele, G., & Balasubramanian, M. (2021). Factors influencing access and utilization of health services among older people during the COVID − 19 pandemic: A scoping review. *Archives of Public Health*, 79(1), 1–11. https://doi.org/10.1186/s13690-021-00719-9

Bhome, R., Huntley, J., Dalton-locke, C., San Juan, N. V., Oram, S., Foye, U., & Livingston, G. (2021). Impact of the COVID-19 pandemic on older adults mental health services: A mixed methods study. *International Journal of Geriatric Psychiatry*, 36(11), 1748-1758. https://doi.org/10.1002/gps.5596

Brusco, N. K., & Watts, J. J. (2015). Empirical evidence of recall bias for primary health care visits. *BMC Health Services Research*, 15(1), 1–8. https://doi.org/10.1186/s12913-015-1039-1

Byers, A. L., Arean, P. A., & Yaffe, K. (2012). Low use of mental health services among older Americans with mood and anxiety disorders. *Psychiatric Services*, 63(1), 66–72. https://doi.org/10.1176/appi.ps.201100121

Callis, Z., Seivwright, A., Orr, C., & Flatau, P. (2020). *The impact of COVID-19 on families in hardship in Western Australia. The 100 families WA project*. Centre for Social Impact, University of Western Australia. https://doi.org/10.25916/5f3b2a5e4bb42

Choi, N. G., DiNitto, D. M., & Marti, C. N. (2014). Treatment use, perceived need, and barriers to seeking treatment for substance abuse and mental health problems among older adults compared to younger adults. *Drug and Alcohol Dependence*, 145, 113–120. https://doi.org/10.1016/j.drugalcdep.2014.10.004

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking?

A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(1), 11–27. https://doi.org/10.1017/S0033291714000129

Department of Communities. (2016). *Older adults in Western Australia*. Government of Western Australia. https://www.housing.wa.gov.au/aboutus/publications/researchandreports/Documents/Older-Adults-In-Western-Australia.pdf

De Pue, S., Gillebert, C., Dierckx, E., Vanderhasselt, M. A., De Raedt, R., & Van den Bussche, E. (2021). The impact of the COVID-19 pandemic on wellbeing and cognitive functioning of older adults. *Scientific Reports*, *11*(1), 1–11. https://doi.org/10.1038/s41598-021-84127-7

Fulmer, T., Reuben, D. B., Auerbach, J., Fick, D. M., Galambos, C., & Johnson, K. S. (2021). Actualizing better health and health care for older adults. *Health Affairs*, *40*(2), 219–225. https://doi.org/10.1377/hlthaff.2020.01470

Giebel, C., Pulford, D., Cooper, C., Lord, K., Shenton, J., Cannon, J., Shaw, L., Tetlow, H., Limbert, S., Callaghan, S., Whittington, R., Rogers, C., Komuravelli, A., Rajagopal, M., Eley, R., Downs, M., Reilly, S., Ward, K., Gaughan, A., Gabbay, M. ... Gabbay, M. (2021). COVID-19-related social support service closures and mental well-being in older adults and those affected by dementia: A UK longitudinal survey. *BMJ Open*, *11*(1), e045889. https://doi.org/10.1136/bmjopen-2020-045889

Government of Western Australia. (2020a). *COVID-19 coronavirus: State of emergency declarations*. https://www.wa.gov.au/government/document-collections/covid-19-coronavirus-state-of-emergency-declarations

Government of Western Australia. (2020b). *Important new COVID-19 measures come into effect*. https://www.mediastatements.wa.gov.au/Pages/McGowan/2020/03/Important-new-COVID-19-measures-come-into-effect-.aspx

Government of Western Australia. (2020c). *Phase 3 of COVID-19 roadmap to commence from Saturday, June 6*. https://www.mediastatements.wa.gov.au/Pages/McGowan/2020/05/Phase-3-of-COVID-19-roadmap-to-commence-from-Saturday-June-6.aspx

Healthdirect. (2021). *COVID-19 information for older Australians*. Australian Department of Health. https://www.healthdirect.gov.au/coronavirus-covid-19-information-for-older-australians-faqs

Jakobsen, J. C., Gluud, C., Wetterslev, J., & Winkel, P. (2017). When and how should multiple imputation be used for handling missing data in randomised clinical trials - a practical guide with flowcharts. *BMC Medical Research Methodology*, *17*(1), 1–10. https://doi.org/10.1186/s12874-017-0442-1

Jorm, A. F. (2012). Mental health literacy; empowering the community to take action for better mental health. *The American Psychologist*, *67*(3), 231–243. https://doi.org/10.1037/a0025957

Jorm, A. F., Christensen, H., & Griffiths, K. M. (2006). The public's ability to recognize mental disorders and their beliefs about treatment: Changes in Australia over 8 years. *The Australian and New Zealand Journal of Psychiatry*, *40*(1), 36–41. https://doi.org/10.1080/j.1440-1614.2006.01738.x

Khare, S. R., & Vedel, I. (2019). Recall bias and reduction measures: An example in primary health care service utilization. *Family Practice*, *36*(5), 672–676. https://doi.org/10.1093/fampra/cmz042

Lavingia, R., Jones, K., & Asghar-Ali, A. A. (2020). A systematic review of barriers faced by older adults in seeking and accessing mental health care. *Journal of Psychiatric Practice*, *26*(5), 367–382. https://doi.org/10.1097/PRA.0000000000000491

Marani, M., Katul, G. G., Pan, W. K., & Parolari, A. J. (2021). Intensity and frequency of extreme novel epidemics. *Proceedings of the National Academy of Sciences*, *118*(35), e2105482118. https://doi.org/10.1073/pnas.2105482118

March, S., Day, J., Ritchie, G., Rowe, A., Gough, J., Hall, T., Yuen, C. Y. J., Donovan, C. L., & Ireland, M. (2018). Attitudes toward e-mental health services in a community sample of adults: Online survey. *Journal of Medical Internet Research*, *20*(2), e59. https://doi.org/10.2196/jmir.9109

Nair, P., Gill, J. S., Sulaiman, A. H., Koh, O. H., & Francis, B. (2021). Mental health correlates among older persons residing in Malaysian nursing homes during the COVID-19 pandemic. *Asia-Pacific Journal of Public Health*, *33*(8), 940–944. https://doi.org/10.1177/10105395211032094

National Health and Medical Research Council. (2016). *Statement on consumer and community involvement in health and medical research*. https://www.nhmrc.gov.au/about-us/publications/statement-consumer-and-community-involvement-health-and-medical-research

Neubauer, A. B., Smyth, J. M., & Sliwinski, M. J. (2019). Age differences in proactive coping with minor hassles in daily life. *The Journals of Gerontology: Series B*, *74*(1), 7–16. https://doi.org/10.1093/geronb/gby061

Organisation for Economic Co-operation and Development. (2021). *Tackling the mental health impact of the COVID-19 crisis: An integrated, whole-of-societyresponse*. OECD. https://www.oecd.org/coronavirus/policy-responses/tackling-the-mental-health-impact-of-the-covid-19-crisis-an-integrated-whole-of-society-response-0ccafa0b/

Qualtrics. (2022). *Qualtrics XM*. https://www.qualtrics.com/au/

Reavley, N. J., & Jorm, A. F. (2011). Recognition of mental disorders and beliefs about treatment and outcome: Findings from an Australian national survey of mental health literacy and stigma. *The Australian and New Zealand Journal of Psychiatry*, *45*(11), 947–956. https://doi.org/10.3109/00048674.2011.621060

Reavley, N. J., & Jorm, A. F. (2012). Public recognition of mental disorders and beliefs about treatment: Changes in Australia over 16 years. *British Journal of Psychiatry*, *200*(5), 419–425. https://doi.org/10.1192/bjp.bp.111.104208

The Royal College of Psychiatrists. (2018). *Suffering in silence: Age inequality in older people's mental health care (No. CR221)*. https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2018-college-reports/cr221

Sepúlveda-Loyola, W., Rodríguez-Sánchez, I., Pérez-Rodríguez, P., Ganz, F., Torralba, R., Oliveira, D. V., & Rodríguez-Mañas, L. (2020). Impact of social isolation due to COVID-19 on health in older people: Mental and physical effects and recommendations. *The Journal of*

Nutrition, Health & Aging, 24(9), 938–947. https://doi.org/10.1007/s12603-020-1500-7

Strutt, P. A., Johnco, C. J., Chen, J., Muir, C., Maurice, O., Dawes, P., Siette, J., Botelho Dias, C., Hillebrandt, H., & Wuthrich, V. M. (2022). Stress and coping in older Australians during COVID-19: Health, service utilization, grandparenting, and technology use. *Clinical Gerontologist*, 45(1), 106–119. https://doi.org/10.1080/07317115.2021.1884158

Veldhuis, C. B., Nesoff, E. D., McKowen, A. L. W., Rice, D. R., Ghoneima, H., Wootton, A. R., Papautsky, E. L., Arigo, D., Goldberg, S., & Anderson, J. C. (2021). Addressing the critical need for long-term mental health data during the COVID-19 pandemic: Changes in mental health from April to September 2020. *Preventive Medicine*, 146, 106465. https://doi.org/10.1016/j.ypmed.2021.106465

Wong SYS, Zhang D, Sit RWS, Yip BHK, Chung RY, Wong CKM, Chan DCC, Sun W, Kwok KO, Mercer SW. (2020). Impact of Covid-19 on loneliness, mental health, and health service utilisation: A prospective cohort study of older adults with multimorbidity in primary care. *British Journal of General Practice*, 70(700), e817-e824. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7523921/

Wu, B. (2020). Social isolation and loneliness among older adults in the context of COVID-19: A global challenge. *Global Health Research and Policy*, 5(1), 154–156. https://doi.org/10.1186/s41256-020-00154-3

Wuthrich, V. M., & Frei, J. (2015). Barriers to treatment for older adults seeking psychological therapy. *International Psychogeriatrics*, 27(7), 1227–1236. https://doi.org/10.1017/S1041610215000241

Yanez, N. D., Weiss, N. S., Romand, J. A., & Treggiari, M. M. (2020). COVID-19 mortality risk for older men and women. *BMC Public Health*, 20(1), 1–7. https://doi.org/10.1186/s12889-020-09826-8