

**Late-Life Mental Health, Substance Use and Addiction Service Needs in Manitoba**

by

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## Abstract

Adults ages 65+ may experience mental health or substance use / addiction ('SUA') challenges that can endanger their quality of life, health, and longevity. Yet mental health and/or SUA services are often unavailable or inaccessible for adults 65+, which can perpetuate unmet needs. Services become more accessible when they reflect the needs and priorities of intended users; however, few studies have engaged individuals who use and deliver late-life mental health and/or SUA services to better understand their needs and priorities. The primary objective of this mixed-methods research was to describe the mental health and SUA service needs and priorities of adults 65+ and those who deliver services to adults 65+. A secondary objective was to explore adults' 65+ SUA literacy (i.e., knowledge of how to recognize and manage SUA problems and find and access SUA services and information). Six adults 65+ who had tried to access services participated in two virtual focus groups, and six service leaders and providers participated in a separate two-part focus group series, to discuss service and research needs, and define and set service priorities. Using reflexive thematic analysis, four main themes described adults' 65+ experiences of services: 1. "What you need just isn't there"; 2. "Where do I go?": Knowing about and finding services; 3. "Roadblocks" along pathways to services; 4. COVID-19 "forced" new ways of connecting with people and services. Four additional themes reflected service leader and provider perspectives. Priority-setting was achieved with each group using a modified nominal group technique. Emergent priorities were then built into an online survey for validation with a convenience sample of community-living adults 65+ ( $n = 138$ ). Respondents selected protection and advocacy services for older adults as a top priority, followed by more involvement of caregivers in treatments and care teams. The survey was also used to examine differences between respondents' SUA and mental health literacy (analyzed using a paired

samples *t*-test), and sociodemographic and psychosocial predictors of SUA literacy (analyzed using hierarchical linear regression). *Low to moderate* SUA literacy ( $M = 3.1$ ,  $SD = 0.97$ ) among the adult 65+ sample was significantly lower than their mental health literacy,  $t(137) = -3.30$ ,  $p = .001$ , and both older age and limited SUA lived experience were significant predictors of lower SUA literacy. Findings inform future selection, funding, and delivery of services that are targeted to the needs of aging populations and recommend clarifying pathways into them.

*Keywords:* Older adults, mental health services, substance use services, mental health literacy, patient and public engagement in health research

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## **Dedication**

In memory of my Babka, Anna Holic

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## Chapter I

Research has highlighted the high prevalence of mental health and substance use/addiction ('SUA') challenges in the growing population of adults ages 65 years and older ('adults 65+'). Despite evidence of the potentially severe outcomes associated with these problems in later life, including higher likelihood of co-occurring health problems, premature death, suicide, and diminished quality of life, most older adults, including those who may need help the most, do not use mental health or SUA services (e.g., Byers et al., 2012). A growing body of research has begun investigating factors that prevent or enable service use among this population. Although progress has been made toward better understanding their knowledge of mental health problems and help-seeking attitudes and beliefs (e.g., Farrer et al., 2008), little is known about their mental health and/or SUA service needs and priorities, their experiences of trying to find, navigate and access services for these problems in later life, or their knowledge of how to recognize and manage SUA problems and find and access SUA services and information. Through this dissertation, I aimed to enhance our understanding about each of these areas.

### **Mental Health and SUA Terminology**

**Mental health and SUA problems.** Whether any mental, emotional, or behavioural experience can be considered problematic is highly dependent on an individual and their unique circumstances. DSM-5-TR mental disorders, including substance-related and addictive disorders, are each characterized by abnormal thoughts, emotions, and behaviours, significant distress, and impaired functioning (APA, 2022). However, many people whose symptoms do not meet full diagnostic criteria still experience mental, emotional, or behavioural challenges that may lead them to seek advice, services/treatment, or support for coping and recovery. Indeed, many older adults experience subclinical symptoms, whereby some but not full clinical diagnostic criteria

are met. For example, harmful or hazardous use of substances, such as misuse of pain relievers, is much more common among adults 65+ than diagnosed substance use disorders (Jaqua, 2022). As another example, 14% of older adults experience subthreshold depressive symptoms compared to 2% who have diagnosed major depressive disorder (Kok & Reynolds, 2017). If left untreated, subclinical symptoms can persist and, for some people, may even worsen into a diagnosable disorder (Lee et al., 2018; Shankman et al., 2009). To ensure that the language used in my dissertation is maximally encompassing, I use the term *mental health and SUA problems* to broadly refer to a range of lived experiences, including but not limited to the experience of living with a diagnosed disorder. I use this term to broadly encompass both mental health and SUA problems under one umbrella; that is, lived experience of *either* a mental health problem, *or* an SUA problem, or both (as opposed to only considering co-occurring or dual diagnoses per se). Although appropriate for my broad, community-level research aims, I do acknowledge the limitations of this population-focused approach. Particularly, differentiating needs in relation to severity of problems is outside the scope of this definition and not reflected in findings/actions.

My decision to integrate mental health and SUA, rather than explore them separately, is based on the growing public policy focus in recent years on integrating mental health and SUA systems/services in Canada, including in Manitoba. Integration of mental health and SUA must take place at many different levels, and I believe this also extends to the research arena. As I embarked on this research, I was inspired by Manitoba's mental health and addictions strategy, which underscores that SUA is noticeably missing in opportunities for research and evaluation due to its separate, and often neglected, status within the mental health system and initiatives (Virgo, 2018). I strongly believe that research is a form of leadership that has the power to spur policy/practice changes (I elaborate on my lens further in Chapter II). Although extant literature

has largely considered these areas separately, I wondered about the new insights and applications that might emerge by integrating mental health and SUA in a single inquiry. Although helpful for achieving my broad, community-level research aims, I do acknowledge that findings and recommendations concerning SUA services are incomplete because of this population-focused approach. Specifically, my research is limited by an under-representation of individuals who have experienced a SUA problem (I elaborate further on this limitation in Chapter IV).

**Mental health and SUA services.** Mental health and SUA services are defined in the health services literature in terms of direct and indirect clinical care, support or treatment to people experiencing mental, emotional, or behavioural problems in inpatient, outpatient, and community settings (Moroz et al., 2020; Thompson, 2020). Direct services (e.g., diagnostic and problem evaluation, crisis intervention, individual, group and family interventions) are often provided through specialized, professional-led programs. In some settings, specialist practitioners (e.g., psychologists, psychiatrists, social workers, or psychiatric nurses) may deliver services; however, in other settings, service delivery may include primary health or other care providers. Indirect services (including informal and preventive care) are population-focused and may be provided by a wide range of community-based organizations or government entities (e.g., public health, justice, and social services). Throughout this dissertation, I use the term *mental health and SUA services* to refer to all the aforementioned areas – that is, professional led services (e.g., hospital or community-based programs or treatments), primary care services, indirect/informal services (e.g., self-help groups, service navigation support), and preventive care (e.g., education and information resources). I use the term *service providers* to refer to direct care practitioners who are “core members” of mental health or SUA service/care teams, whatever their discipline, without limiting the term to any singular profession (Thompson, 2020, p. 278). I

use the term *service leaders* to describe representatives of mental health and/or SUA service delivery organizations, whose leadership role may additionally – or exclusively – involve providing other aspects of indirect care (e.g., management, regulation, funding).

**Mental health and SUA service needs and priorities.** Throughout this research, I relied on participants to define their *service needs* inductively, without providing them with an a priori definition of this term. Similarly, rather than pre-defining the term *service priorities*, I explored the meaning that participants gave to this concept; its definition was shaped through the ultimate research outcomes. Nevertheless, my research was underpinned by extant health policy theory and definitions, which considers both met and unmet service/care needs of people experiencing a health problem for which they require assistance. A met need exists when a person receives assistance that appropriately meets their need; in contrast, an unmet need exists when a person does not receive appropriate assistance (wrong kind or no assistance) (Harrison et al., 2013).

### **Mental Health and SUA Problems in Later Life**

Population ageing is occurring rapidly worldwide. By 2050, the proportion of the world's population aged over 60 years is expected to grow to 2.1 billion, doubling from 1 billion in 2020 (WHO, 2023). Although this is not in and of itself a problem, the number of people facing mental health and SUA problems in later life is also growing. Approximately 14% of the global population of older adults is estimated to be living with a mental health problem (Institute of Health Metrics and Evaluation, 2019), most commonly anxiety and depression (Andreas et al., 2017). The prevalence of major depression among older adults globally is over 13% (Abdoli et al., 2022) and, in some jurisdictions, may be as high as 30% (Zenebe et al., 2021). For older adults living in the community, between 3% to 7% meet diagnostic criteria for any past-year mood disorder, and between 2.5% to 11% any past-year anxiety disorder (Reynolds et al., 2015).

In Canada, the prevalence of major depressive disorder and generalized anxiety disorder among adults 65+ is 7.2% and 6.6%, respectively (Chireh et al., 2021). More than one in five older adults also experience significant caregiving burden, which can further elevate rates of anxiety, mood, and emotional difficulties in later life (Cummings et al, 2015; Ekström et al., 2020; Fekih-Romdhane et al., 2020; Pinquart & Sörensen, 2003).

The mental health of community-dwelling older adults also appears to have worsened since the COVID-19 pandemic. In Canada, nearly 1 in 3 older adults consider their mental health either somewhat or much worse than before the pandemic (Statistics Canada, 2022). Compared to the pre-pandemic period, older adults experienced higher levels of depression, stress, and loneliness (Kotwal et al., 2021; 2022; Krendl & Perry, 2020; Whitehead & Torossian, 2021).

Regarding SUA, the prevalence of substance use disorder among adults 65+ is estimated at 4% (Kettaneh, 2015), though rates vary depending on measure and substance (Yarnell et al., 2020). Alcohol, prescription medications (especially opiates and benzodiazepines), and over-the-counter drugs (especially pain relievers) are most used. Misuse of prescription drugs is prevalent (up to 11%) and highest among older women (Bulut & Isik, 2022; Grant et al., 2017; Kuerbis et al., 2014). Relative to men, research suggests that women are more likely to develop chronic conditions with pain symptoms, seek medical assistance, and be prescribed and use these medications (Serdarevic et al., 2017; 2019). Although adults 65+ are vulnerable to problematic prescription and over-the-counter drug use, few studies have investigated this type of substance use disorder (Blazer & Wu, 2009; Boyd et al., 2018; Kuerbis et al., 2014). Extant research shows that these drugs may be misused by older adults because of inappropriate dosing, polypharmacy, overprescribing, and inadequate communication regarding safe use (Abayateye et al., 2022; Kettaneh, 2015; Kuerbis et al., 2014; Thompson & McDonald, 2024; Vyas et al., 2021).

Alcohol use in later life is trending upwards. Results of a USA national epidemiologic study over a 10-year time frame show a 22.4% increase in alcohol use, 65.2% increase in high-risk drinking, and 106.7% increase in alcohol use disorder (AUD) among adults 65+ (Grant et al., 2017). Although between 2% to 3% percent of adults 65+ are living with diagnosed AUD, alcohol misuse among this population is estimated to be much higher, up to 11% (Grant et al., 2004; 2017; Joshi et al., 2021; Kuerbis et al., 2014; 2020; Volkert, 2013). Combined, alcohol and prescription drug misuse may affect up to 17% of the older adult population (Joshi et al., 2021; Kuerbis, 2020). This high rate of mental health and SUA problems among older adults has become an urgent and escalating public health concern in Canada because of the considerable impact of these problems on health, wellbeing, functionality, and longevity in later life.

### ***Impacts of Mental Health and SUA Problems in Later Life***

The consequences of late-life mental health and SUA problems can be severe. Older adults make up the highest proportion (27%) of deaths by suicide worldwide (WHO, 2023). Older adults with mental health and/or SUA problems experience higher mortality rates, relative to the general population (Ortolá, 2019), and whereas the prevalence of SUA disorders is lower in older than younger adults (Vasilenko et al., 2017; Yarnell et al., 2020) problematic SUA can take a much greater biological toll in later life (Kuerbis et al., 2020). Older adults with mental health problems have poorer health outcomes (El-Gabalawy et al., 2011) especially when these problems are untreated (Chapman & Perry, 2008; Lin et al., 2011), and they are more likely to develop chronic medical comorbidities (Lin et al., 2011; Paradis et al., 2023). Older adults who drink heavily or binge drink have elevated morbidity risk compared with abstainers (Ortolá, 2019), and there is evidence that heavy alcohol use puts older adults at higher risk of developing cognitive problems, including major neurocognitive disorders (Lee et al., 2010; Schwarzingner et

al., 2018; Visontay et al., 2021) and associated functional difficulties (Sternberg et al., 2015). Prescription drug misuse can have dangerous and sometimes fatal outcomes for older adults, especially when mixed with alcohol or other drugs (Blow & Barry, 2014; Slattum & Hassan, 2016). Heavy substance use also increases the risk of developing co-occurring mental health problems (Keyes et al., 2019). The risk of developing chronic physical health conditions is highest for older adults with co-occurring problems (Onyeka et al., 2019). As the consequences of mental health and SUA problems in later life can be so devastating, prompt identification and treatment is essential. However, recognizing and detecting mental health and SUA problems among older adults can be more difficult than for other age groups, as I will review next.

**Recognizing and treating mental health and SUA problems in later life.** There are differences in the presentation and complexity of mental health problems among older adults compared to younger adults, which can affect their recognition. Symptoms of mental health and SUA problems are often overlooked or misdiagnosed in later life because they can mimic symptoms of other health conditions that are common in older adults (Chhatre et al., 2017; Reynolds 3<sup>rd</sup> et al., 2022; WHO, 2023). For example, service providers, families, and even patients/clients may mistake the symptoms of depression or substance misuse for chronic pain, digestion difficulties, or reduced sleep related to managing another health condition. Sometimes lack of detection can also result from co-occurring cognitive difficulties in later life. Attribution to physical or cognitive health concerns or comorbidities delays detection/diagnosis of mental health and SUA problems (Cheung et al., 2017). Limited knowledge and awareness of these problems by patients/families, as well as service providers' limited knowledge, skills, or time, may also play a role in delayed detection, relative to younger adults (Cheung et al., 2017). Older adults are also more prone to underreporting symptoms of mental health and/or SUA problems,

with evidence suggesting several age-associated and/or cohort factors (e.g., cultural norms established in earlier generations leading to a lasting reluctance to self-disclose distressing internal experiences; differences in pathogenic mechanisms and symptom expression in later life) as possible reasons (Kuerbis et al., 2020; Lyness et al., 1995). If problems remain undetected, older adults become less likely to access effective services/treatment, which can worsen health and functioning (Lyness et al., 2007; Speerforck & Schomerus, 2020) and make managing these problems complicated (El-Gabalawy et al., 2011; Wetherell et al., 2009).

Use of patient-oriented mental health and/or SUA services that are timely, integrated, and consider individualized needs and barriers to accessing care have been found to be protective for people across the lifespan (Moroz et al., 2020). Research shows that older adults respond well to treatment for mental health problems and, in some cases, even do so better than younger adults (Saunders et al., 2021; Lippens & Mackenzie, 2011). Similarly, treatment can effectively reduce problematic SUA among older adults while improving health, functioning, and quality of life (Aubut et al., 2020; Bhatia et al., 2015; Mowbray & Quinn, 2016; Moy et al., 2011; Satre, 2015). Yet there is limited availability of services delivering these treatments in either public health care or community-based settings in Canada (Moroz et al., 2020; Stephenson, 2023). Even if available, people in Canada, including older adults, too often face excessive wait times for such specialized services (Statistics Canada, 2024). Despite the high prevalence and potentially severe consequences of mental health and SUA problems, and the protective outcomes associated with receiving treatment, older adults' use of services is low, as described in the next section.

### **Adults' 65+ Mental Health and SUA Service Use**

Most older adults do not use mental health services (Byers et al., 2012; Han et al., 2011; Karlin et al., 2008; Karlin & Norris, 2006; Mackenzie et al., 2012; Mosier et al., 2010; Reynolds

et al., 2015; Speer & Schneider, 2003; Stanley & Duong, 2015). Even among older adults who are most in need of care and who are living with diagnosed disorders, a majority (70%) report that they do not use mental health services (Byers et al., 2012). Although no extensive body of research has explored adults' 65+ use of services for SUA problems, evidence suggests that they may use SUA services even less. For example, older adults constitute only 7% of admissions to publicly funded SUA treatment programs in the United States (Chhatre et al., 2017) and only 18% of such programs are specifically designed for older adults (Schultz et al., 2003). In Canada, people across all age groups are less likely to seek services for SUA problems than for mental health problems, such as anxiety and depression (Urbanoski et al., 2017).

Rates of mental health and SUA service use among older adults remain much lower than for other age groups, despite a recent increase in service use across all age-groups (Chiu, 2020), which highlights the need for policy and practice solutions to address this enduring gap in care. Fewer than 1 in 10 community-dwelling older adults living with severe mental health problems use outpatient mental health services in the United States, which is three times lower than for younger adults (Karlin et al., 2008). In Canada, older adults' frequency and intensity of mental health service use varies between professional led services (e.g., attending hospital or community-based programs, consulting with psychologists, psychiatrists, or other mental health specialists), primary care services (e.g., consulting with family doctors, nurses, or other general practitioners in the absence of specialist care) and informal services/supports (e.g., attending self-help groups, receiving support from family, friends, work, or school, obtaining Internet-based psychoeducation/information in the absence of primary or specialist care) (CCHS, 2012; MHACS; 2023; Urbanoski et al., 2017). Canadians aged 65+ are the least likely of any age group to access any of these services. For example, Canadians aged 65+ are two to three times less

likely to use professional led (specialist) services and three to four times less likely to use informal supports compared to younger and middle-aged adults. Relative to 15- to 24-year-olds, adults 65+ are seven times less likely to use informal services/supports. As they age into much later life, older adults become even less likely to access such services (Crabb & Hunsley, 2006; Mackenzie et al., 2008; 2012; Mosier et al., 2010, Urbanoski et al., 2017).

Since timely access to services can be protective against worsening mental health or SUA problems in later life, it is important to understand what contributes to low rates of service use among adults 65+. One explanation may be that the types of mental health and/or SUA services that older adults value, need, or prioritize as important are not available or do not exist in the jurisdiction where they live; however, extant research, which I will review next, is limited in informing us of what these needs and priorities might be. Another explanation is that adults 65+ face barriers that prevent their use of services, which I will outline in the section that follows.

### **Adults' 65+ Mental Health and SUA Service Needs and Priorities**

Very little research has focused on the mental health and SUA care/service needs of adults 65+ living in the community, which also makes it difficult to understand their service priorities. Evidence does show that there is a concerning lack of mental health resources (information and services) for adults 65+ (Stephenson, 2023). With the exception of the literature reviewed above, there is no extensive body of research investigating mental health and SUA service needs in later life, and no studies have explored, defined and set adults' 65+ service priorities in the local Manitoba context. As mental health and SUA services vary by jurisdiction, identifying the mental health and SUA service needs and priorities of adults 65+ who have tried to access services for mental health or SUA problems (and the individuals and organizations who deliver these services) within their jurisdictional context is necessary to facilitate service use in

later life within that jurisdiction. Although there exists no instrument specifically designed to comprehensively measure the mental health and SUA service needs and priorities of adults 65+ living in the community (and the individuals and organizations who deliver services to this population), the support needs of older adult caregivers have been explored using a priority-setting exercise called the nominal group technique, which appeared effective (Herron and Runacres, 2023). However, very few studies (e.g., Barrio et al., 2008; Palinkas et al., 2007) have integrated the perspectives of impacted individuals across multiple levels (i.e., those who use, provide, and deliver services) to identify mental health service needs and priorities in their local jurisdiction. Given the public health emphasis on ensuring the mental health of older adults is adequately supported, and the benefits of using services to maintain and enhance quality of life, health, and longevity in later life, it is important to gain greater knowledge of what kinds of services that adults 65+ want service providers, organizations, and policy/decision-makers to prioritize, as well as the services that providers and organizations want policy/decision-makers and funders to prioritize, and the barriers that keep people from receiving these services.

### **Individual Dimension Barriers and Facilitators to Adults' 65+ Service Use**

Research shows that older adults face barriers that limit their access to and use of services, which are related to both characteristics of individuals (e.g., knowledge of and acceptability of services) and service delivery systems (e.g., availability and accessibility of services). Barriers that can be conceptualized as within an individual dimension include lack of readiness for treatment (especially lack of readiness to stop using substances); lack of social support that might predispose them to know about and/or use services; financial constraints; and mobility limitations (Beatie, et al., 2020; Choi et al., 2014; Morgan et al., 2017; Pepin et al., 2015; Titov et al., 2016; Wuthrich et al., 2015). Other individual barriers include limited

perceived need for services/treatment; negative attitudes and/or beliefs about the usefulness of services/treatment; stigma (especially self-stigma related to ‘generational taboos’); concerns about confidentiality, and self-sufficiency beliefs (Beatie, et al., 2020; Choi et al., 2014; Conner et al., 2010; Elshaikh et al., 2020; Jimenez et al., 2013; Mackenzie et al., 2008; 2010; Murphy & Mackenzie, 2023; Oleski et al., 2010; Pepin et al., 2015; Reynolds et al., 2021; Volkert et al., 2018; Wetherell et al., 2004; Wuthrich & Frei 2015). The latter five factors, however, may not be greater barriers for older compared to younger adults (Mackenzie et al., 2019; Segal et al., 2005).

There are also some unique barriers that are associated with the rapid shift to virtual and mobile-based mental health and SUA services as a consequence of the COVID-19 pandemic. Barriers to uptake of virtual and mobile-based options among adults 65+ include lack of awareness, concerns about interacting with and/or sustaining use of technology and the effort required to do so, lack of face-to-face interaction to facilitate therapeutic alliance, perceived inability of general practitioners to help with mental health-related issues, concerns about privacy and confidentiality pertaining to their identity and any information they share (Pywell et al., 2020), and discomfort with using new technologies to connect with others (Kotwal et al., 2021). One additional well-established individual dimension barrier that is most relevant to the current research is limited mental health literacy among older adults, which I discuss in the next section. Low SUA literacy may also be a barrier; however, rates and predictors of adults’ 65+ SUA literacy are not yet well understood.

### ***Adults 65+ Mental Health and SUA Literacy***

**Mental health literacy.** According to the most widely used definition first introduced by Jorm and colleagues (1997a), mental health literacy constitutes “knowledge and beliefs about mental disorders which aid in their recognition, management or prevention” (p. 182). This

definition has since expanded to include the ability to recognize different types of psychological distress; knowledge of how to seek mental health information; knowledge and beliefs about risk factors and causes, self-treatments, and professional help (which can also be conceptualized as services); and attitudes that facilitate recognition and help-seeking (Jorm; 2000; 2012; Jorm et al., 1997a; 1997b; 2000; 2005; 2006). To align with and build upon this expanded definition, I define mental health literacy throughout this dissertation as knowledge of how to recognize and manage mental health problems and find and access mental health services and information.

Extant research has focused primarily on the role of mental health literacy in improving understanding of mental health problems; namely, the ability to recognize symptoms (including a developing problem), risk factors, and preventive measures (Cabassa, 2009; Lauber et al., 2003; Reavley & Jorm, 2011; Winsor & McLean, 2016). Relating to service use, evidence shows that poor understanding of mental health problems delays help-seeking and limits access to supportive resources, and also leads people to be less involved in their treatment decision-making (Altweck et al., 2015; Bonabi et al., 2016; Gulliver et al., 2010; Jorm, 2012; Jorm et al., 2000; Kelly et al., 2007; Mason et al., 2015; ten Have et al., 2010). A growing body of research has focused on the role of mental health literacy in increasing awareness of how to seek support for mental health problems. Evidence shows that better knowledge of how to seek help can increase relevant service use, promote better coping, and improve health outcomes (Altweck et al., 2015; Bond et al., 2015; Gulliver et al., 2010; Hansson et al., 2016; Jorm et al., 1997a; Jorm, 2012; Kelly et al., 2007; Mackenzie & Pankratz, 2022; Mason et al., 2015; Mohamad et al., 2012). Cross-cultural studies indicate that Western populations show greater knowledge of mental health problems compared to non-Western populations (Jorm, 2000); however, there is limited research examining the reasons. Notably, mental health literacy is a concept that has

emerged from Western cultures, which may in part explain some of this discrepancy (Jorm, 2012). Different cultural groups likely hold different views on mental health and, considering social norms surrounding behaviours and emotionality, have different conceptualizations of problems (including stigmatization of problems), types of help, and ways of seeking help (Furnham & Hamid, 2014). Western definitions of mental health literacy may thus have limited applicability to non-Western cultures unless appropriate cultural adaptations are made.

**Substance use and addiction (SUA) literacy.** The term ‘SUA literacy’ is not used extensively in the extant literature, as SUA problems are generally embedded into the broader mental health literacy construct without distinction. However, it is my intention to bring explicit focus to SUA problems in the current research; therefore, I will use the term ‘SUA literacy’ throughout this dissertation to mean mental health literacy for SUA problems. In this way, I conceptualize SUA literacy as related to but distinct from mental health literacy, even though there is not yet an established theoretical or operational definition of the concept in the literature.

SUA literacy, which I define as knowledge of how to recognize and manage SUA problems and find and access SUA services and information (to align with my previously described definition of mental health literacy), has been under-investigated in the literature despite evidence showing that limits in knowledge about recognizing and managing problems may detrimentally affect use of services among people living with SUA problems (Aubut et al., 2020; Marshall et al., 2017; Weeks et al., 2016). Although SUA has not been excluded per se from traditional definitions of mental health literacy in the extant research body, SUA is nevertheless rarely an explicit area of focus. SUA problems have rarely been featured in studies on mental health literacy and, relative to mental health problems (e.g., anxiety, depression), SUA problems are seldomly depicted in measures or vignettes (i.e., brief clinical descriptions designed

to represent real-world scenarios). Investigations within the very small body of literature on SUA literacy (within existing health and mental health literacy research) have used varying labels, definitions, methodological approaches, and measurements, without consensus on best practice.

Gallagher and colleagues (2019) sought to address limitations within the extant mental health literacy literature by examining the ability of the Canadian public (mean age 28) to identify vignette-based depictions of less common mental health problems, including substance use disorder. Most participants appeared similarly able to correctly identify mental health and SUA problems (e.g., 86% correctly identified depression, 82% anxiety, and 84% substance use disorder). Males were significantly more apt to think that individuals should deal alone rather than seek services or support for SUA problems. In a contrasting study, Maina and colleagues (2015) found that respondents showed low ability to recognize SUA problems when examining the relationship between SUA literacy and medication adherence among adults with HIV. Less than half of the respondents accurately recognized alcoholism (40%) or substance misuse (42.5%). Half of all respondents (50%) wrongly identified the alcohol-use vignette problem as stress; 43% thought it was depression. These two studies are among the very few to have ever examined SUA literacy among any age group using depictions of SUA problems in mental health literacy scales. Furthermore, only a handful of studies have examined the broader health literacy construct in populations of young to middle-aged people living with SUA problems and/or receiving SUA treatment (Dahlman et al., 2020; Degan et al., 2019; 2022; Dermota et al., 2013; Rolová et al., 2018; Rolova et al., 2021). Nevertheless, this small body of research shows that individuals living with SUA problems may have higher rates of health literacy than those without, including knowledge of risks associated with substance use and ability to understand

health information. As none of these studies involved samples of older adults, however, characteristics and predictors of this population's SUA literacy remain largely unexplored.

**Mental health and SUA literacy of older adults.** In general, older adults' mental health literacy is more limited than younger or middle-aged adults, with research showing that older adults make more errors in recognizing even common mental health problems such as depression and anxiety (Connery & Davidson, 2006; Farrer et al., 2008; Fisher & Goldney, 2003; Wetherell et al., 2009). Farrer and colleagues (2008) investigated age differences associated with mental health literacy in an Australian sample and found that older adults (ages 55 to 69, and 70+) are much worse at correctly identifying mental health problems relative to younger age groups (18 to 54), and their knowledge and beliefs about direct/formal and indirect/informal service options, as well as endorsement of the helpfulness of such services, is much lower than younger adults. Older adults are also more likely to misunderstand or misattribute changes in mood and behaviour to another cause rather than to a mental health problem (Drayer et al., 2005). It is possible that cohort effects may play a role in these findings (e.g., cultural norms may have led earlier generations to be less aware of or self-disclosing about mental health problems).

There is growing support in the literature that poor mental health literacy is a barrier that prevents older adults from seeking and using mental health services (Beatie et al., 2022; Farrer et al., 2008; Fisher & Goldney, 2003; Jorm et al., 1997; Jorm, 2012; Kim et al., 2017; Wetherell et al., 2009). Extant research shows that older adults report less knowledge of how to seek mental health treatment relative to younger adults (Robb et al., 2003) and prefer to handle problems on their own (Andrade et al., 2014; Lawrence et al., 2006; Mackenzie et al., 2010; Mechanic, 2007; Reynolds et al., 2022; Wuthrich & Frei, 2015) or through primary care (Cairney et al., 2010; Gerlach et al., 2022; Speer & Schneider, 2003). Relative to younger adults, older adults consider

mental health services less appealing, find fewer sources of treatment helpful, and view informal sources of support less favourably (e.g., talking to friends or family, self-help resources) (Farrer et al, 2008). Older adults are also less likely to recommend mental health services to others experiencing a problem (Farrer et al., 2008; Fisher & Goldney, 2003; Wetherell et al., 2009).

There is little known from the literature about the characteristics of SUA literacy among older adults, including differences between their SUA literacy and more general mental health literacy, and predictors of their SUA literacy as, to my knowledge, no research study has yet investigated this as a distinct topic. Extant research does demonstrate that low awareness of available SUA services prevents use of such services among younger age groups (Gulliver et al., 2010), which may similarly impact older age groups. Findings derived from research examining predictors of older adults' mental health literacy can plausibly inform us of possible influencers of their SUA literacy. Poorer mental health literacy is associated with male sex, older age, lower educational attainment, and limited lived experience, either personal or by exposure to others (Piper et al., 2018; Reavley et al., 2014). Also, the few studies of SUA literacy among younger age groups, and health literacy among people living with SUA problems, informs us that poorer SUA literacy may be associated with male sex (Gallagher et al., 2019), no or low-risk substance use (Dermota et al., 2013), higher psychological distress, poorer social support (Degan et al., 2019), and better self-perceived health and mental health status (Rolova et al., 2021).

Collectively, there is growing evidence to suggest that health and wellness in later life can be supported by enhancing adults' 65+ literacy about mental health and SUA problems and types of help/resources available, which can in turn reduce this individual-dimension barrier. Studies are still needed to understand whether adults' 65+ SUA literacy skills are on par with

their more general mental health literacy skills. If differences exist, psychoeducational intervention to close the gap may be warranted. I will now turn to ‘system dimension’ factors.

### **System Dimension Barriers and Facilitators to Adults’ 65+ Service Use**

At the ‘system level’ (i.e., organizational/service delivery system for the purpose of this research), access to health services is a complex concept. If services physically exist and are in adequate supply/capacity, then an opportunity to obtain services exists, and a population technically has access to the services. However, even if they are available, services must also be properly located, affordable, approachable, acceptable, appropriate, and effective to be truly accessible (Levesque et al., 2013). Access is accordingly conceptualized as the opportunity to identify service/care needs, find and obtain services when they are needed, and have needs met (Levesque et al., 2013; Shengelia et al., 2005). Barriers to access must therefore be considered.

Key factors influencing older adults’ underutilization of services that can be categorized as system dimension barriers include lack of clarity about service/care needs and pathways into available services; difficult service navigation; long wait times; eligibility criteria; lack of targeted programs and specialized service providers with competence to address older adults’ needs (especially for complex physical health comorbidities); and inaccessible transport systems (Beatie et al., 2020; Berard et al., 2020; Elshaikh et al., 2023; Reynolds et al., 2020; Reynolds 3<sup>rd</sup> et al., 2022; Valaitis et al., 2020). There is also evidence that fragmented/siloed care and limited communication/collaboration among service providers is a barrier reducing access to and navigation of services in later life, which is evident across multiple levels (for example, between institutions; between service disciplines such as physicians, nurses, and allied health; between mental and physical health service delivery; and in the transition from hospital to community-based care) (Ross et al., 2015; Wang et al. 2024). On the other hand, research has identified

shared decision-making, integrated/collaborative care, and community-based services as key facilitators of mental health and SUA service use in later life (Beatie et al., 2020; Berard et al., 2020; Reynolds et al., 2020; Reynolds 3<sup>rd</sup> et al., 2022; Valaitis et al., 2020; Wang et al., 2024).

Next, I will review a theoretical model illuminating how and why people come to use mental health services (which, although understudied, may also apply to SUA services), to establish theoretical context for the current study. I will then define and review a system-dimension barrier to adults' 65+ service use that is most relevant to the current research (i.e., difficult service navigation), followed by a review of the three key service use facilitators.

### ***Theoretical Model of Accessing Services ('Help-Seeking')***

Several theoretical models, using qualitative and quantitative methods, have been developed to elucidate how and why people try to gain access to mental health treatment/services (i.e., 'help-seeking') (Andersen 1995; 2008; Goldberg & Huxley, 1980; Henshaw & Freedman-Doan, 2009; Parsons, 1951; Vogel et al., 2006). Most relevant to the current research is the network episode model ('NEM'; Pescosolido, 1991; 1993; Pescosolido & Boyer, 2010), which conceptualizes help-seeking in response to a mental health or SUA problem as a social process that is managed by peoples' networks and is influenced by person- and service-related factors (i.e., the illness careers, social support system, treatment system, and social context). Rather than being exclusively individualistic and rational, help-seeking is theorized to be complicated by a complex intermingling of social systems and processes. Informed by the NEM, Pescosolido and colleagues (1998) interviewed people with lived experience of a severe mental health problem as they accessed treatment/services for the first time and described three help-seeking pathways: choice, coercion, and muddling through. Choice pathways were characterized by participants who decided to seek help on their own (individual choice) or with the help of others (supported

choice). Coercion pathways were characterized by participants who lacked agency and control in decision-making, with decisions made by informal (e.g., friends, family) or formal (e.g., service providers) supports. Muddling through pathways were characterized by participants who displayed passive/uncertain decision-making, being neither resistant nor active in the pursuit of services. Over half of the participants did not appear to follow a choice pathway, which suggests that factors beyond individual characteristics must influence help-seeking.

Berard and colleagues (2020) explored these three pathways (i.e., Pescosolido et al., 1998) in a sample of older adults and found that older adults' pathways to treatment/services were generally consistent with the NEM. Rather than being static, their pathways tended to include all three elements to varying degrees. Most older adults willingly accessed services by choice; the remaining participants' pathways into services typically involved muddling through, and to a much lesser extent, coercion. While Pescosolido (1998) showed that help-seeking in response to mental health problems can be complex for all age groups, exploration of help-seeking among older adults has revealed how difficult it can be in later life, as this population faces a number of system-level barriers. One of these barriers is difficult service navigation.

### ***Difficult Service Navigation***

Lack of clarity about 'what is out there' and 'where to go' to address mental health and SUA problems is a key factor that influences adults' 65+ underutilization of services, as is difficult service navigation, which complicates pathways to care. The few studies that have so far explored adults' 65+ experiences and perspectives of navigating mental health or SUA services have collectively demonstrated that navigation is difficult for older adults, who generally do not obtain much help or support while navigating services. Although adults 65+ may be interested in using services, pathways through the mental health and SUA system can be complex, confusing,

or unknown. Notably, our current understanding is limited by the lack of extant research exploring the experiences and perspectives of adults' 65+ navigating SUA services, in particular.

Reynolds and colleagues (2020) qualitatively explored the narratives of older adults seeking treatment for mental health problems in Manitoba, with main storylines highlighting the complexity of their pathways into services. Siloed care, lack of a clear 'road map' to follow, and inadequate guidance from and coordination among health care providers were illuminated as barriers. Notably, narratives revealed how common it was for older adults to experience a loss of voice and active participation on their path to care. Their stories were marked by accounts of blindly traversing from one referral or treatment option to the next. Limited knowledge of mental health services was thought to precipitate and sustain this passive involvement, as was having few opportunities to have their needs understood by people with the power to address them.

Berard and colleagues (2020) described that although older adults in Manitoba may be willing to use services to address mental health problems, most do not know how to navigate into these services. Aubut and colleagues (2020) similarly described older adults' experiences of not knowing where to get help for SUA problems in Quebec. Older adults generally face long, complex, and unsteady pathways into services, which they disproportionately 'muddle' through as they first begin trying to find and access care. Lack of preferred type of service provider, inappropriate referrals or advice from service providers, and low rates of referrals by general or other practitioners to specialist services (e.g., psychological services) have each emerged as a factor that makes service navigation more difficult (Beatie et al., 2022; Pettit et al., 2017; Robb et al., 2003; Ross et al., 2015). Older adults living with mental health and SUA problems also face ageism within the healthcare system and biased offering of treatment strategies from clinicians (Bodner et al. 2018), which can make service navigation even more challenging.

Very few studies have examined the perspectives of individuals who deliver services to adults 65+ in healthcare or community settings. Valaitis and colleagues (2020) used focus group methodology to examine service provider perspectives on ways to facilitate older adults' access to and navigation of health and social services in Ontario. Contradictory care pathways, resulting from multiple assessments with different service providers, and care coordination problems were illustrated within themes. Linkages between different types and levels of services were perceived as deficient by the providers, complicated by barriers including poor health literacy among, and communication with, patients. Providers voiced much frustration concerning the complex nature of service navigation faced by their patients in later life. Better understanding the perspectives of impacted individuals (i.e., adults 65+ and individuals/organizations that deliver services to them) on how to improve knowledge and navigation of services in later life is critical. There are some known system level facilitators of adults' 65+ service use that I will outline next: shared decision-making, collaborative and integrated care, and community-based services.

### ***Shared Decision-Making***

Most older adults desire to be actively involved in obtaining information and making decisions about their health and healthcare treatment options (Chiu et al., 2016; O'Neal et al., 2008; Reynolds et al., 2022). Shared decision-making, which has become increasingly central in the delivery of patient-centered health services, is a model of care that promotes and enables people to take an active role in the decisions that affect their health (Montori et al., 2023). Emphasis is placed on active participation by both patients and health care providers in decision-making and their agreement on an ultimate decision to act on (Charles et al., 1999a; 1999b; Sandman & Munthe, 2010). Shared decision-making thus relies on the preferences, information, and/or knowledge that patients may bring to decision-making processes. The extant research on

shared decision-making for mental health problems provides evidence for its effectiveness in increasing quality (i.e., knowledge, participation, and congruence with values; Drake et al., 2009) of decisions (Hamann et al., 2006; Joosten et al., 2009; Loh et al., 2007; Malm et al., 2003; Priebe et al., 2007; Van Korff et al., 2003; Van Os et al., 2004). Enhancing adults' 65+ mental health and SUA literacy may support shared decision-making (Curtis et al., 2010; Muscat et al., 2021) and, in turn, facilitate better access to services in later life. However, research evidence (e.g., Alguera-Lara et al., 2017) underscores that we need to develop more tools to assist shared decision-making in mental health contexts (and likely SUA contexts too). Next, I discuss collaborative and integrated care as another facilitator of adults' 65+ service use.

### ***Collaborative and Integrated Care***

Integrated mental health and SUA care involves providing a seamless pathway for individuals and communities to gain access to all aspects of the continuum of care and services that they require. In Canada, there is a growing recognition that integrating physical and mental health care using collaborative care approaches can improve access to services and facilitate continuity across transitions in care/services (Kates et al., 2023). Service users and providers both prefer to address physical, mental, behavioural, and social support needs in one location. Collaborative care requires professionals to work together in the same setting with a high degree of coordination and interdependence (Babor et al., 2017; Reist et al., 2022; Reiter et al., 2018).

Implementation of collaborative and integrated care approaches for the treatment of mental health and SUA problems among older adults has been shown to improve access to services and outcomes of treatment (Dham et al., 2017; Unützer et al., 2002), especially for individuals with complex or co-occurring health needs (Ross et al., 2015), which older adults may be more likely to exhibit. However, there has been little research exploring the perspectives

of impacted individuals on the availability and accessibility of integrated care to address mental health and SUA problems in later life, or on the level of coordination and collaboration among service providers and between service delivery organizations. Next, I will discuss how locating services in the community is another important system level facilitator of service use in later life.

### ***Community-Based Services***

Most people, including older adults, prefer to access mental or behavioural services in the community (Cohen-Mansfield & Frank, 2008; Lavingia et al., 2020). Community-based services commonly use integrated and collaborative care approaches and can often meet older adults' physical and/or mental health needs better than more traditional health service delivery settings (Cohen-Mansfield & Frank, 2008; Gates et al., 2008; Gitlin et al., 2012; Guo et al., 2014; Heisel et al., 2020; Wilkins et al., 2019). In Manitoba, a small but growing body of research has begun to illuminate older adults' preference for locating mental health resources within their communities. Nurmi and colleagues (2018) investigated perceptions of the need for and access to supportive services and found that older adults (particularly men) prefer to access programs in the community to reduce social isolation and promote positive mental health. Reynolds and colleagues (2022) found that older adults prefer to access mental health resources within the community, despite being mostly unfamiliar with these community-based options. Although older adults identified community organizations as particularly important sources to consult when looking for help for a mental health problem, they lacked clarity about available services or resources in their communities to do so. Together, this evidence suggests that locating services in the community will match the preferences of older adults and thereby promote access to these services. Better understanding their knowledge of and pathways into these services is critical.

## **Summary of the Current Research**

### **Gaps in the Literature**

There is limited extant research on late-life mental health and SUA service needs from the perspectives of adults 65+ and the individuals/organizations who deliver these services; their service needs and priorities are largely unknown, as these topics have rarely been explored in the literature. These and other research gaps are thus evident, which I will elaborate on next.

First, there is a dearth of qualitative research examining help-seeking for mental health and SUA services in later life, and no qualitative research, to my knowledge, has explored the mental health or SUA service needs of adults 65+ who have tried to find help/services, or the individuals and organizations who deliver these services. Research designed with the aim of better understanding the combined perspectives of these groups may thus be informative for improving access to services. Drawing from my background and experiences (described further in Chapter II), I considered it important to combine the perspectives of both these groups. In the transaction of health services, I have observed that power tends to lie more heavily in the hands of those who deliver rather than receive services. Generating knowledge that considers differences in the experiences, perspectives and preferences of the two participants groups could be a way to redistribute power in the research context. Tuning into whether differing levels of importance ascribed by those who use and deliver services, respectively, might provide insights into what shapes the availability and accessibility of services.

Second, available research is limited in informing us about the mental health and SUA services that are deemed high priority to adults 65+ in Manitoba and the individuals and organizations who deliver these services. Research to elucidate their service priorities, using an established priority setting exercise, is thus warranted. Third, although qualitative studies have

begun outlining older adults' descriptions of their service navigation experiences and service navigation needs, this budding area of research would benefit from continued investigation, and integrated exploration of the perspectives of those who deliver late-life mental health and SUA services is also warranted. Fourth, although a growing body of research has pinpointed access barriers and facilitators across individual and system domains, much remains unknown about what adults 65+, community service leaders, and service providers in Manitoba identify as the barriers currently limiting (and opportunities to enhance) access to and navigation of services.

Although the research literature on rates of mental health literacy among older adults is growing, the evidence of SUA literacy among adults' 65+ is limited. We have only a small body of information about SUA literacy across the adult lifespan, with only a handful of studies examining SUA literacy or health literacy in SUA contexts (Dahlman et al., 2020; Degan et al., 2019; Dermota et al., 2013; Gallagher & Watt, 2019; Maina et al., 2015; Rolová et al., 2018; Rolova et al., 2021). Research on the topic of SUA literacy is therefore still in its infancy, and some key gaps and limitations are apparent. First, no studies that I am aware of have investigated SUA literacy among older adult populations, with or without SUA problems. Considering growing SUA trends, enhancing understanding of their knowledge about the signs, symptoms, and causes of SUA problems, the types of services available, and how to go about finding and accessing services, could provide valuable insight towards reducing the negative outcomes associated with SUA problems in later life. Second, no studies that I am aware of have yet investigated how adults' 65+ SUA literacy compares to their general mental health literacy using a measure that enables comparison; further research is thus required. Finally, while we have established research on predictors of older adults' mental health literacy, evidence for the demographic and psychosocial predictors associated with adults' 65+ SUA literacy is missing.

## **Research Objectives**

The primary objective of the current research was to describe the late-life mental health and SUA service needs and priorities of adults 65+ and the individuals and organizations who deliver these services to adults 65+ in Manitoba. Within this overall objective, I explored their perspectives on access to and navigation of services, including barriers and opportunities for enhancement. A secondary objective was to describe adults' 65+ SUA literacy, evaluate differences between their SUA literacy and mental health literacy, and examine the sociodemographic and psychosocial predictors of their SUA literacy.

### ***Hypotheses (for secondary objective)***

In contrast to exploring my primary research objective qualitatively, I investigated my secondary objective primarily using a quantitative (survey) method and hypothesis testing. As such, hypotheses are only relevant to my secondary research objective. I formulated my hypotheses based on research investigating the predictors of older adults' mental health literacy and information preferences, and correlates/predictors of SUA literacy in younger populations. I expected to find a significant difference between adults' 65+ SUA literacy and their mental health literacy, such that they would endorse worse knowledge on measures of SUA literacy. I also expected that sociodemographic and psychosocial characteristics would be associated with adults' 65+ SUA literacy. Specifically, I expected that lower SUA literacy would be associated with sociodemographic variables including older age, male sex/gender, and lower education, and psychosocial variables including limited SUA lived experience, less social support/more social isolation, no or low-risk substance use, higher psychological distress/poorer perceived quality of life, and better self-perceived mental and physical health status.

## Research Strategy

I used an exploratory, sequential mixed-methods research design with a participatory patient-engagement component to answer: (1) What are the mental health and SUA service needs and priorities of adults 65+ and those who deliver services to adults 65+? (2) How accessible, available, and navigable are services, and what are the barriers and opportunities for enhancement? (3) What is the level of SUA literacy among adults 65+? Figure 1 illustrates how I first explored my primary research objectives using qualitative methods and then validated findings using quantitative methods, which I also used to explore my secondary objective.

Mixed methods research is a powerful way to explore complex health service issues and processes as it integrates the strengths of both qualitative and quantitative approaches (Creswell et al., 2004; Curry et al. 2013; Fetters et al., 2013; Ivankova et al., 2006). Qualitative methods are commonly applied to explore an under-investigated phenomenon, and to describe individual or group experiences, whereas quantitative methods are used to ascertain associations, causality, generalizability, or magnitude of effects (Creswell et al., 2004). Two advantages of mixed methods research provide rationale for my research strategy selection: first, qualitative inquiry can inform development of quantitative data collection approaches/measures, and second, quantitative data can be used to validate qualitative findings (O'Cathain et al., 2010).

In mixed-methods research, integration is achieved at the study design, method, or interpretation and reporting stages, or any combination thereof (Fetters et al., 2013). My research strategy involved qualitative and quantitative integration at all three levels. Integration at the design level consisted of using a sequential exploratory approach. As my research questions do not have a well-developed base of literature, my research endeavour was exploratory, with data primarily driven by participants' perceptions and preferences informed by their subjective

experiences, rather than guided by preconceived researcher-driven theories and ideas. In sequential exploratory designs, qualitative data is collected and analyzed first, with findings used to inform the quantitative data collection that follows (Onwuegbuzie et al., 2010).

Participatory research uses participant engagement to influence the direction of the research (Fetters et al., 2013). Specifically, patient and public engagement in health research (i.e., ‘patient-engagement’) (CHI, 2020) invites participants to contribute their valuable experience-derived knowledge to address research questions that are relevant and important to them, typically with the aid of established patient-engagement methods or strategies (JLA, 2021). ‘Patients’ can include any person with lived experience of a health issue such as service users (patients/clients), members of the public, caregivers, families, service providers, and service delivery organizations. Manitoba’s Centre for Healthcare Innovation (CHI; 2020) has established levels of engagement to define the amount of involvement that participants have in research. My research strategy used a moderate, collaborative approach to patient-engagement during the data collection research stage. Participants were engaged actively in a structured focus group, and decision-making about content (i.e., list of priorities) that was ultimately built into the quantitative component was shared between participants and researchers (although the list itself was entirely generated by participants; I only made decisions about other aspects of the survey).

Integration at the methods level consisted of building and connecting. Fetters and colleagues (2013) describe that, “integration through building occurs when results from one data collection procedure inform the data collection approach of the other procedure, the latter building on the former” (p. 2140). In the current study, the qualitative component involved adults 65+, community service leaders, and service providers participating in two focus groups each (one semi-structured and one structured using a patient-engagement technique). The quantitative

component, which sequentially followed from the qualitative component, invited a larger sample of adults 65+ to respond to an online survey, which partially included content that was developed by participants during the structured focus group for their validation. Qualitative thematic findings were also built upon by measuring a key concept (i.e., SUA literacy) derived from the semi-structured focus groups. The language that participants used also informed the wording of survey items (e.g., ‘challenges’ instead of ‘problems’) (Fetters et al., 2013). Integration was also achieved through connecting qualitative and quantitative data collection through a multi-level sampling frame (Onwuegbuzie & Collins, 2007), which involved the selection of survey respondents from the same age group in the same setting as was targeted for focus groups.

Integration at the interpretation and reporting level was achieved primarily through a contiguous narrative approach (Fetters et al., 2013) and, where appropriate, data transformation and the use of joint tables. For reporting patient-engagement results, I used data transformation to achieve integration, whereby I transformed items (qualitative data) into numeric ranks (quantitative data), and then integrated these transformed items into the online survey as variables in a multiple response survey question. The priority-setting exercise that I used was specifically chosen for its built-in mechanism to achieve this transformation directly during the focus group. Finally, a joint table was used to further illustrate connections between qualitative (priority setting) and quantitative (validation of priorities) findings.

In the pages that follow, I summarize in detail the methods that I used to conduct each component of this mixed-methods study (Chapter II), followed by a presentation of results (Chapter III). In the final section (Chapter IV), I integrate and discuss the meaning of my findings and how they contribute to the literature, and highlight important implications and future directions for research, clinical training and practice, and health services and policy.

## **Chapter II**

### **Methodology**

#### **Ethical Approval**

Research Ethics Board (REB 1) approval from the University of Manitoba (Protocol # HE2021-0196) was received prior to launching recruitment activities, and electronic informed consent was obtained from all research participants prior to data collection. An external impact assessment from Shared Health – Soins Communs (Manitoba) was additionally completed before recruiting through their associated service delivery organizations (Protocol # SH2022-029).

#### **Qualitative Methods**

To address my primary research questions/objectives, I first applied a qualitative methodology. Qualitative methodologies are informed by philosophical and methodological assumptions that inform the types of data collected and analyses conducted (Creswell & Poth, 2016). As a first step, I adopted a pragmatic worldview (guided initially by constructivist assumptions) and data collection and analysis methods (focus groups, nominal group technique, reflexive thematic analysis) to align with my objectives and enrich applicability of findings.

#### ***Pragmatism (A Worldview Combining Qualitative and Quantitative Inquiry)***

When I first set out to explore my primary research questions/objectives, I was guided by the basic assumptions of social constructivism (Vygotsky, 1978), which posits that people actively create their knowledge based on previous experiences. Subjective experiences determine reality in this worldview (Lincoln & Guba 2013; Raskin, 2002). Guided by constructivist assumptions, I grounded my research in understanding participants' experiences and perspectives from their unique, subjective points of view. I strove to co-create with them knowledge about late-life mental health and SUA service needs, priorities, access, and navigation (Creswell &

Clark, 2017; Schwandt, 2000). As I progressed through the research process and developed more specificity in my exploratory aims and outcomes, my approach evolved to rest more fully on a pragmatic research paradigm (Dewey, 1931; Maxcy, 2003). Compatible with constructivist approaches, knowledge in pragmatism is purposefully constructed and socially shared (Kvale, 1992; Yardley & Bishop, 2017). It differs, however, in that the aim of inquiry is to help “achieve a better, richer [human] experience”, by enhancing understanding of “what changes need to be made” within a particular context (Yardley & Bishop, 2017, p. 5). Tied to a particular goal and context, knowledge is thus actionable. Knowledge/action is intended to persuade the views, policies, or practices of groups/societies, and lead to real change (Yardley & Bishop, 2017).

My research questions, which were honed and refined throughout the research process as I developed deeper insight (Braun & Clarke, 2022), were concerned with identifying *what* needs/priorities exist in Manitoba (and *what* can be done to address those needs/priorities), rather than *why*, which aligned with the pragmatic pursuit of actionable knowledge. I wanted to help make sure that late-life mental health and SUA services in Manitoba are shaped by an understanding of the perceptions and preferences of impacted people/organizations, and likewise make my research relevant and valuable to them. Since I wanted to emphasize meaningfulness in my findings, I adopted an experiential orientation to data interpretation, aiming to portray meaning as ascribed by participants (Byrne, 2021). In doing so, I acknowledge the interplay of subjective and intersubjective construction that produced my findings. Namely, that the themes, subthemes and lists of priorities produced are a result of my interactions with participants, participants’ interactions with each other, the questions I presented in focus groups, the prompts I offered in follow-up, and participants’ time-bound responses combined with their efforts to make sense of, interpret, and construct meanings out of their complex experiences in the context of

their cultural backgrounds, values, and beliefs, as well as my own and my research team's prior life experiences, backgrounds, and worldviews, and the relative influence that each of these factors had on the findings and interpretations generated. My openness/attunement to interactions with and between participants also interlaced with my pragmatic approach. Through dialogue, I came to understand that participants largely defined their needs/priorities as discrete, tangible, and applied in nature. Discussion, including my follow-up prompts, became increasingly more specific because of this knowledge co-creation, and reflected in the applied results generated.

### **Setting: Manitoba Context (Jurisdiction of Interest)**

The jurisdiction of interest for this research is Manitoba, Canada. Manitoba stands out as the highest or very high on almost all mental health and SUA need indicators nationally (Virgo, 2018). Rather than being a distinct entity, Manitoba's 'mental health and SUA system' is embedded within the province's broader health and social services system. High acuity mental health and/or SUA needs are addressed by a variety of publicly funded agencies, including five regional and one provincial (i.e., Shared Health) health authorities. Manitoba, like other provinces and territories in Canada, covers the full cost of mental health and/or SUA services through public health insurance when they are delivered by these public agencies (Manitoba, 2024). However, there are often long wait times for services as demand is high. Direct services are also provided by community-based organizations/providers, often for lower acuity needs. Community-based service delivery organizations are typically not-for-profit or charitable entities and are often at least partially funded through service agreements with national or provincial governments. Community-based organizations typically provide cost-free services although some entities may operate as a for-profit business and charge user fees (e.g., private psychology practices, residential SUA treatment programs). Over the last number of years, the Province of

Manitoba has taken steps to better understand the population's mental health and SUA service needs and improve access to services through system planning and policy efforts, including by developing a provincial mental health and addictions strategy. Two strategy recommendations that I outline next motivated me to explore – and influenced – my research questions/objectives.

### ***Manitoba Mental Health and Addictions Strategy***

The Manitoba Government has established a provincial mental health and addictions strategy to improve access to and coordination of services within Manitoba's complex mental health and SUA system (i.e., 'Virgo Report', 2018). The strategy contains 125 system and service improvement recommendations. A main focus is on improving services for high need populations, including "more focus on the older adult population" (p. 63), who face notable challenges in accessing care for their mental health and SUA needs. To address these challenges, the report recommends "collaboration across a range of community resources" (p. 149), and the development or enhancement of public services and programs for older adults in Manitoba:

3.7 Enhance program design and content as well as workforce competencies to work with older adults, recognizing the significant aging of people in services for some time (i.e., aging in place) and the long-term impacts of their substance use, addiction, and mental health challenges, including on physical health status and high risk of suicide (p. 230).

Improving the mental health and SUA literacy of Manitobans, including older adults, is also recommended, as a current inadequacy appears to be limiting access to services:

2.1 Develop and implement a SUA and mental health literacy program to educate the general public ...about SUA and mental health challenges and how the Manitoba system is organized to respond to the needs of community members (p. 223).

## **Participants and Recruitment**

I recruited two distinct participant groups referred to as ‘Group A’ (adults ages 65+) and ‘Group B’ (leaders of community organizations and service providers) through purposive sampling, each with a target of six to eight participants. Individuals with personal lived experience of using or delivering mental health or SUA services were purposefully chosen as I wanted to draw from their experiential knowledge. For pragmatic reasons (and since data saturation is not considered a necessary concept to ascertain within reflexive thematic analysis; Braun & Clarke, 2021b), recruitment continued until the minimum target number was met. The target number was selected to align with what is commonly considered appropriate for applying the nominal group technique (‘NGT’; Van de Ven & Delbecq, 1972; discussed in more detail later) and was also practically driven by the number of interested and eligible service delivery organizations in Manitoba. While there is not an extensive body of research focused on determining an optimal number of NGT participants, the method generally involves a smaller number compared to traditional focus groups. Guidelines recommend between three and seven participants (Fox, 1989; Khurshid et al., 2023; McMillan et al., 2014, 2016; Roth et al., 1995) and groups with fewer (e.g., three to five) can be optimal to ensure that each participant’s input is thoroughly considered, while effective group communication and engagement is maintained (Gallagher et al., 1993; Hutchings et al., 2010; Khurshid et al., 2023; McMillan et al., 2016).

### ***Adults 65+ (Group A)***

I recruited adults aged 65+ in Manitoba, Canada from January to June 2022. Recruitment materials (electronic and printed posters in Appendix A, recruitment letters in Appendix B) were distributed to a broad range of community, health, and social service organizations (see Appendix F) that provide services or programs to adults 65+. Many organizations were contacted via

telephone by a research assistant ahead of the electronic distribution to confirm their interest in receiving materials and population served. Interested organizations then collaborated with me to distribute recruitment materials for potential participants to view using their internal electronic and onsite distribution platforms (e.g., website, social media, newsletters, email lists, poster boards). Participants indicated their interest by confidentially contacting the secure email address provided in recruitment materials. As the recruitment strategy involved a broad-based and anonymous distribution of materials, I was not able to track or assess response rates.

Group A inclusion criteria specified that eligible participants be aged 65 years or older; live in the community; have a previous or current personal lived experience of a mental health or SUA problem; sought or attempted to find help or services for the problem; be able to give informed consent; be fluent in English; have access to a computer or other electronic device and email address; have access to an Internet connection; have access to a private space while joining focus groups; be able to participate in a virtual videoconference format without significant challenge (including absence of severe hearing difficulties); and be able to complete a background survey online. Participants were excluded if their mental health challenge consisted of schizophrenia or another psychotic disorder, a neurocognitive disorder, or if their current substance use would self-reportedly interfere with participation. These criteria were population-driven; selected to ensure that the make-up of focus groups reflected common late-life mental health and SUA experiences. As I was already integrating mental health and SUA in one study, I also wanted to narrow the scope of my investigation and avoid too much additional integration (e.g., cognitive problems) to increase both the meaningfulness and specificity of my findings.

### ***Community Service Leaders and Service Providers (Group B)***

I recruited a combination of community service leaders and service providers who

provide aging, mental health and/or SUA-related services to adults 65+ in Manitoba, Canada from February to May 2022. Electronic recruitment materials (electronic posters in Appendix C and D; recruitment letters in Appendix E) were distributed to a broad range of community, government, and healthcare organizations in Manitoba (see Appendix F) that have responsibility for the delivery, planning or oversight of aging, mental health, and SUA services in the province. Interested organizations then collaborated with me to distribute recruitment materials for potential participants within their network to view using internal distribution processes. Participants indicated their interest by confidentially contacting the secure email address provided in recruitment materials. As the recruitment strategy involved a broad-based and anonymous distribution of materials, I was not able to track or assess response rates.

Group B inclusion criteria specified that eligible community service leaders hold a current leadership position (e.g., executive, managerial, supervisory) within a community-based aging, mental health, and/or SUA organization serving older adults, and that eligible service providers be licensed clinicians practicing within a seniors/geriatric mental health or SUA service. Additional inclusion criteria specified that all eligible participants be able to give informed consent; be fluent in English; have access to a computer or other electronic device and email address; have access to an Internet connection; have access to a private space while joining focus groups; be able to participate in a virtual videoconference format without significant challenge; and be able to complete a background survey online.

### **Data Collection, Procedure and Instruments**

Following REB approval and prior to being enrolled in the study, each adult 65+ participant partook in a 30-minute eligibility screening with me over the phone (see script in Appendix G), and each service leader and service provider completed an online eligibility

checklist through Qualtrics software (see Appendix H and I for blank forms). All enrolled participants then completed an online informed consent form (see blank forms in Appendix J and K) before engaging in research activities.

Qualitative data were primarily derived from virtual focus group discussion (Bolin et al., 2023; Carey & Asbury, 2016). My decision to use focus groups was guided by my choice to apply the structured NGT (outlined in a later section), which requires a group of people to work together to form a consensus on their priorities, in turn necessitating a group-based data collection format (Van de Ven & Delbecq, 1972). However, I also wanted to explore a range of views, gather broad community-level information, and allow for and observe how group interactions might shape discussion (Hennink, 2013). This included establishing a social environment marked by cohesiveness around the importance of exploring service needs, which I have learned, through my prior clinical and advocacy experiences, is a part of building safety for people to openly share their experiences, ideas, opinions, and perspectives. For all these reasons, I determined that a group-based method to collect qualitative data was most suitable (rather than individual interviews). Additional data points were also obtained from a background survey.

### ***Focus Group Background Survey***

I invited each enrolled participant via secure email link to complete a background survey administered online using Qualtrics software, prior to joining their first focus group. The short background survey was modified to each participant group and captured sociodemographic, psychosocial, and health-related information for the purpose of describing the samples and their unique lived experiences (see blank forms in Appendix L, M and N).

**Group A Measures.** Sociodemographic variables posed in open-ended format included age, gender, highest level of education, occupational status, annual household income, and

marital status. Participants were also asked to provide information on their population group (*racial identification*) and location of residence (*urban, rural*). Psychosocial variables included personal lived experience of a mental health or SUA problem (*yes/no*), personal lived experience of trying to find or use mental health or SUA services and information (*yes/no*) and resources accessed (open-ended), self-rated physical and mental health status (*poor, fair, good, very good, excellent*), knowledge of mental health and SUA resources for adults 65+ in the community (*poor, fair, good, very good, excellent*), and knowledge about navigating mental health and SUA services (5-point scale, with 1 = *not at all*, to 5 = *extremely*). Adults' 65+ self-rated mental health literacy was assessed using a 4-item Mental Health Literacy Scale previously developed in the Health Information Exchange Lab (Reynolds et al., 2020, unpublished), which prompts participants to indicate on a five-point rating scale (1 = *not at all*, to 5 = *extremely*) how knowledgeable they are about signs and symptoms, possible causes, types of professional help available, and how to seek help. This scale was adapted in the current study for SUA content to similarly assess self-rated SUA literacy. Psychometric properties are described later in the quantitative methods section (see Adults 65+ Online Survey on Health, Wellness and Services).

**Group B Measures.** Sociodemographic variables posed in open-ended format included age, gender, profession, length of time in current position or organization, and highest level of education completed. Participants were also asked to provide information on their population group (*racial identification*), occupational status (*full-time, part-time, casual*), and service delivery area (*mental health, SUA, both mental health and SUA*) and location (*urban, rural*). Psychosocial variables included self-rated knowledge about navigating/referring to mental health and SUA services (5-point rating scale, with 1 = *not at all*, and 5 = *extremely*), and how the mental health system in Manitoba is organized (5-point rating scale, with 1 = *not at all*, and 5 =

*extremely*). Participants' self-rated mental health and SUA literacy was assessed using the same 4-item Mental Health Literacy Scale (Reynolds et al., 2020, unpublished) previously described.

### ***Focus Group Protocol***

Adults 65+ participated in a series of two 90-minute virtual focus groups, and community service leaders and service providers participated together in a separate series of two 90-minute virtual focus groups, in May to July 2022. The two focus groups associated with each series were held four weeks apart and were administered using Zoom Professional videoconference software. Two research assistants attended to co-facilitate and record observational field notes. As the timeline of the current study took place in the wake of Canada's fifth COVID-19 pandemic wave, ensuring the safety of participants and researchers was vital, as was enabling participatory engagement even if social restrictions limiting in-person interactions were to continue or be reinstated. Adopting a virtual research environment was optimal to address both these factors.

During the *first* (semi-structured) focus group in each series, I began by offering open-ended probing questions to prompt an organic discussion *with* and *between* participants about various aspects of their mental health and/or SUA service needs, factors that influence use or delivery of services, and experiences with service navigation/referral (help-seeking) informed by the NEM (Pescosolido, 1991; 1998; 2010). Although I adhered to a discussion guide (Appendix O) of key topics, dialogue was simultaneously steered by what was considered meaningful to the group based on their interactions with the research team and each other. Discussion accordingly weaved in and out of these and other relevant topics. I also formulated specific follow-up questions on discussion points at times, or offered neutral probes (such as, 'who has had a similar or different experience') to obtain additional information. In this way, the focus group dynamic tended to go back-and-forth between non-dialogical (i.e., Q/A between researcher-participant)

and more ideal dialogical (i.e., participant-participant and participant-researcher) models of focus group interaction (Bolin, 2023). Although the Zoom chat function was disabled, participants occasionally used the virtual ‘raise hand’ function to indicate their intention to elaborate on discussion points or to respond to the comments of another group member.

To achieve the objective to define and set service priorities, I administered the structured NGT during the *second* focus group in each series (outlined in a separate section below). I emailed each adult 65+ participant a \$25.00 e-gift card honorarium to Amazon.ca for their time and contributions after each focus group attended. Community service leaders and service providers attended focus groups during regular business hours; I did not provide them with any honoraria to avoid a perceived conflict of interest or breach of organizational policies.

### **Qualitative Analytic Strategy (Focus Groups)**

#### ***Descriptive Statistics***

Participant background information was compiled and analyzed descriptively using IBM Statistical Package for the Social Sciences (SPSS) Version 28. Data did not require processing before running analyses as all survey forms were completed in full, with no missing data. Frequencies and medians for categorical data and means and standard deviations for continuous data were obtained from all descriptive analyses.

#### **Reflexive Thematic Analysis (RTA)**

Focus groups were audio-video-recorded using Zoom. Audio recordings were transcribed using Trint™ AI transcription services and the copyedit aid of a research assistant for content accuracy and de-identification, using Microsoft word files (video recordings were not used in analyses and were deleted). I analyzed the transcript produced from the *first* focus group in each series with reflexive thematic analysis (‘RTA’; Braun & Clarke, 2006; 2019; 2021a; 2023; Clarke

& Braun, 2021) using NVivo 12 qualitative analysis software to assist with data organization. I also used RTA to analyze discussion on future research from the *second* focus group.

RTA is a flexible analytical method that embraces researcher subjectivity in the analytic process (Braun & Clarke, 2019). The result of RTA is the generation of themes, which are patterns of meaning anchored by a shared idea/concept (Clarke & Braun, 2021). RTA is particularly well suited to investigating topics given little prior research attention. I considered RTA to be most appropriate because of the exploratory aims of my research and the lack of pre-existing literature to guide an a priori framework. RTA also aligned with my experiential orientation, with focus on “exploring the truth of participants’ contextually situated experiences, perspectives, and behaviours” (Braun & Clarke, 2022, p. 8). As well, RTA supported comparing commonalities and variations in participants’ perspectives/experiences (Braun & Clarke, 2006).

Group A and Group B transcripts were analyzed separately with RTA, in accordance with focus group scheduling. The Group B series transcripts (i.e., Transcript B1 and discussion of future research from Transcript B2) were analyzed first, followed by the Group A series transcripts (i.e., Transcript A1 and discussion of future research from Transcript A2). For each series, a research assistant and I proceeded iteratively through the RTA analytical process: data familiarization, generation of initial codes, constructing initial themes, reviewing and refining themes, naming and defining themes, and reporting themes (as per Clarke & Braun, 2021). First, we read each of the transcripts and organized files into NVivo to gain familiarity. Second, we each independently coded the data to describe and interpret individual data items using ‘nodes’ in NVivo. We used semantic and latent coding to describe both implicit and explicit ideas. Third, we grouped codes according to shared meaning to produce an initial thematic framework of candidate themes and subthemes using ‘maps’ in NVivo. Fourth, we returned to the coded data to

ensure that its full scope was represented in the themes/subthemes. I reconceptualized several of my initial interpretations of the data and revised and removed themes, accordingly, ultimately generating an amended thematic map. Fifth, I named (or-renamed) each theme/subtheme and selected quotation extracts. Sixth, I produced a report of the analysis (embedded in Chapter III), which explains the data within each theme/subtheme, contextualized to my research questions.

### ***Rigor, Trustworthiness, and Sincerity***

I emphasized rich rigor, trustworthiness, and sincerity in my research methods, analysis, and findings. Steps were taken to ensure rigorous qualitative quality in accordance with Tracy's (2010) 'Big-Tent' criteria for excellent qualitative research.

Rigor involves care and practice of data collection and analysis procedures (Tracy, 2010). To achieve rigorous data analysis and research findings, the types, breadth, and depth of questions asked during focus groups were carefully selected, as were the participants. Focus group questions were posed in open-ended format. Steps were also taken to ensure raw data was transformed into verbatim transcripts for accuracy. After data collection, a research assistant and I met weekly to discuss generated codes until initial thematic frameworks were constructed, after which my research advisor and I met to review and refine themes and subthemes. We strove for quality results by allowing nuances in data interpretation to develop reflexively rather than by consensus per se (Braun & Clarke, 2019). Coding and theme development was thus achieved collaboratively with the aim of enhancing reflexivity and depth in the interpretations generated.

Attaining trustworthy results involves generating credible and plausible research findings (Tracy, 2010). I was motivated to undertake the current study as a means to communicate with and generate evidence for policy/decision-makers on ways to improve late-life mental health and SUA services in Manitoba. I wanted these policy/decision-makers to regard my findings as

trustworthy enough to act on and make decisions in line with. To promote credible and trustworthy findings, I emphasized multivocality in the current study by attending to divergent viewpoints and alternative interpretations of dominant thematic discoveries, as well as differences among participants (e.g., gender; role in use or delivery of services), and between participants and researchers. With the aid of research assistants, observational field notes were documented during focus groups to record observations of participant behaviours, body language, and emotionality as well as group interactions. In reporting findings, I provided verbatim quotations from the group discussion, contextualizing experiences by elaborating on time, place, reasons, or characteristics. Field notes helped provide a description of group dynamics and were used to enrich the interpretation of selected participant quotations (e.g., audible expressions by multiple group members at the same time such as sighing; body language such as affirmative head nodding; voices becoming more animated). Field notes were also compared against initially developed themes (e.g., to examine convergence and divergence of developed themes/subthemes with observations, such as comparing elevated emotionality by several group members when speaking about roadblocks). Finally, I sought to ground findings in the lived experiences of individuals who use or deliver mental health and/or SUA services. My patient-engagement method was intentionally selected to help depict the ideas of populations that differ from that of my own as a researcher (Vander Laenen, 2015).

Sincerity in research involves transparency about unexpected challenges ('twists and turns') encountered (Tracy, 2010). To this end, I acknowledge the evolution of my research process, which I embarked upon guided by constructivist assumptions before adopting a pragmatic research approach aligned with more action-oriented aims and intended outcomes. I also acknowledge that although I followed the technical process/steps of RTA, the pragmatic

underpinnings of my research and intent to produce actionable knowledge propelled me to, at times, emphasize more *semantic* or descriptive interpretations of the data (akin to Thorne et. al., 1997), as I dialogued between thematic patterns/commonalities and my evolving research questions. Sincerity in research also involves self-reflexivity about how researcher backgrounds, life experiences, and worldviews may impact data interpretation. To promote self-reflexivity during coding, a research assistant and I met weekly to discuss coding progression, to ensure that the breadth/depth of group discussion was considered, and to address decisions, uncertainties, and clarifications, keeping an audit trail documenting key decisions, insights, and challenges (Creswell, 2014; Tracy, 2010). My research advisor and I also reviewed and refined themes/subthemes at two time-points: first, after all data had been coded and initial thematic frameworks developed, and again after production of a draft report. Practicing these techniques of collaboration, immersion and distancing helped to foster reflexivity (Braun & Clarke, 2023).

### ***Reflexivity***

Reflexivity has been described as, “the researchers’ insight into and articulation of their generative role in research” (Braun & Clarke, 2022, p. 9). The assumptions inherent in social constructivism (by which I was originally guided, and which also align with the pragmatic worldview I adopted) emphasize that any interpretation of meaning is influenced by one's own personal, social, cultural, and historical experiences. I outline my interpretational lens below.

### ***Reflexivity Statement/Lens***

As a researcher, the data I gathered, the guiding questions I chose to ask, the probes I used to prompt group discussion, my interpretations of the data, and construction of themes and subthemes were collectively shaped by my experiences and background (and that of my research team) (Creswell & Poth, 2017). I acknowledge that I am a White, cis-gender, 38-year-old female.

I am a first-generation Canadian and I was raised in a middle-class family. I have had access to advanced educational opportunities and meaningful occupational pursuits. I have some close friends who are aged 65+ and I also had the privilege of providing clinical psychology assessment, consultation, and treatment services to adult 65+ patients experiencing a broad range of mental health and SUA problems, often comorbid with physical health problems, during the time period of my data collection and other research phases. Specifically, my roles included being a clinical psychology practicum student in geriatric psychology and, subsequently, a clinical health psychology resident (in geriatric and health psychology). In these roles, I have personally assisted adults 65+ in navigating services within the formal healthcare system and the community, and witnessed first-hand their difficulties with knowing about, finding, and accessing needed services. Far too often, I realized alongside my patients that many of these services simply do not exist in Manitoba. My clinical work with patients, and relationships with my personal contacts, rest at the forefront of my mind and I reflected on their journeys as I conducted this research. I wanted to develop insights to bring to geriatric psychology services, programs, and teams, within which I plan to continue working long-term. I also acknowledge that a personal passion of mine is to shine light on the needs and help improve the experiences of people seeking support for mental health and SUA problems in later life through research, policy, and advocacy activities. My entire research team is part of a research lab that aims to understand population health needs and service gaps, and to use this knowledge to help create evidence-based resources. I also have an employment background in healthcare policy, planning and oversight within Manitoba's mental health and addictions system. My roles within the provincial government provided me with the opportunity to deeply understand how healthcare funding and policy decisions are made and the kind of evidence that informs these decisions. I value and

believe in the power of data-driven evidence to shape public opinion and drive system/service improvements. My combined experiences in clinical, policy development, and advocacy roles influenced the direction of my chosen research, informed my interpretive lens, and shaped the outcomes of my research towards practical application. This background also likely influenced participants' comfort with disclosing information during the focus group process, as I was able to develop strong rapport and facilitate empathic interactions similarly with both participant groups.

### **Patient Engagement: Nominal Group Technique (NGT)**

I used a patient engagement strategy to address the study objective to define and set late-life mental health and SUA service priorities during the *second* focus group in each series. As the goal of RTA is to identify themes (i.e., patterns in the data that are meaningful), I determined that it would create too many limitations to apply RTA as an analytical method for determining participants' specific priorities and their relative importance. This is largely because priority setting (i.e., consensus-based identification and prioritization activities; Forsythe et al., 2019) can be difficult or impossible to achieve through dialogue alone.

The NGT is a variation of a small-group discussion, which derived from studies on group decision-making, problem-solving, and aggregate group judgements. Van de Ven and Delbecq (1972) first described the NGT as a “structured meeting which seeks to provide an orderly procedure for obtaining qualitative information from target groups who are most closely associated with a problem area” (p. 338). This technique is essentially used to generate ideas and then assign prioritization to those ideas (Lavalley et al., 2020). Considered a collaborative patient engagement strategy (as per CHI, 2020; participatory levels of engagement), the NGT can be effective to include in focus groups when the aim is to help participants generate and prioritize their thoughts and ideas about research outcomes that greatly matter to or impact them.

***Patient Engagement (NGT) Procedure***

I adapted the NGT for a virtual environment and administered it as the second focus group within each series using Zoom Professional videoconferencing software (see Appendix P). Figure 2 depicts the major steps that I followed in administering the adapted NGT. As a participatory method, the NGT involves both individual and group work, and starts by asking participants to take turns offering responses to a question that has been posed within a focus group. The entire group then works together to assign priority to the responses, ideas, and suggestions of all participants (CHI, 2020).

I administered a series of steps, which a traditional NGT is comprised of: presentation of the nominal question, where participants are presented with a single, pre-formulated research question; silent generation of ideas in writing, where participants brainstorm their own definitions and ideas in response to the nominal question (individually and without engaging in any discussion); round-robin feedback, where participants present their ideas to the entire group in a round-robin fashion until all are recorded and displayed; serial group discussion, where participants discuss each idea in turn for clarification, understanding, and evaluation; voting on ideas, where participants first privately vote on individual priorities followed by tabulation of a group decision (derived through sum total using rank-ordering or rating); and feedback of results, where the group is shown the hierarchical list of results and offered an opportunity for further discussion (Cantrill et. al., 2006; Maguire et al., 2022; Van de Ven & Delbecq; 1972).

I determined several advantages of using the NGT to achieve group consensus about service priorities in the current study (rather than RTA and the difficult or even impossible task of determining rank-ordered priorities based on discussion alone). First, the NGT effectively enables participants to generate, organize and prioritize their own ideas about a research question

to assist them in identifying their individual priorities (see Figure 2, Step 1). Second, the NGT helps with group dynamics as it enables each participant to meaningfully contribute (see Figure 2, Step 2); prevents the voices of more vocal participants from dominating discussion and becoming overrepresented in results (see Figure 3, Step 3); distributes voting power equally among group members (see Figure 2, Step 4); and mitigates problems associated with typical group interactions such as lingering discussion of a single topic for too much time (Gallagher et al., 1993). Finally, as all group members equally participate, findings credibly represent the entire group's preferences (i.e., each group's hierarchical list of priorities). Furthermore, as facilitators hold no voting power, participants hold maximum influence over final outcomes.

I completed a virtual 90-minute pilot administration with three volunteer participants (two research assistants and my sister) one month before focus groups commenced to ensure intended adaptations were implementable and effective, and to improve the administration protocol based on feedback received from the volunteers after completion of the exercise. In its original structure, the NGT is administered in-person; I therefore altered several steps for virtual administration while retaining the overall method for defining and setting priorities. First, I added three pre-steps: 1) requesting participants ahead of time to bring a 'brainstorming notebook', five blank sheets of paper ('index cards'), and a pen to the session as necessary materials to complete the exercise; 2) creating Field Note Templates (see Appendix Q) using Microsoft PowerPoint with the nominal question displayed as the first slide, a pre-populated 'virtual flipchart' displayed on the next slide (consisting of a numbered table with corresponding blank boxes for recording ideas), and an illustration of a completed index card as an example of how to rank the top individual priorities on the final slide; and 3) creating a Tally Sheet (using

Microsoft Excel auto-sum function) to use during group voting with numbered columns generated to correspond with anticipated round-robin items (see Appendix R).

During the NGT process, a research assistant and I co-facilitated the session and managed the group processes and dynamics, and a second research assistant recorded ideas and managed virtual screen sharing. To begin, I presented the nominal question, while also verbally reading the question to the group. To accomplish the silent generation of ideas in writing step, I directed the group to write their ideas silently and independently using brief phrases or statements in their own brainstorming notebooks. To complete the virtual round-robin feedback step, ideas shared by participants from their notebooks were recorded by a research assistant in a succinct phrase in the ‘virtual flipchart’, which was projected for group discussion using the Zoom share screen function. Individual voting was accomplished using participants’ blank index cards and the Field Note Template tally sheets (with Excel auto-sum function). Participants were directed to select and write their top-five ideas from the group’s total list of ideas onto their blank index cards (one idea per index card with the phrase written in the middle of the page and the corresponding idea number written in the top left-hand corner). Once completed, participants were then led through a structured exercise to systematically allot points to rank each index card in order of importance using a 5-point rating scale (1 = *Least important*, to 5 = *Most Important*). After all participants completed individual rankings, the group was then asked one-by-one to read the content of their index cards (in order of importance using the recorded idea number from the top left-hand corner and points allotted from the bottom right-hand corner) while I recorded results in the virtual tally sheet with the aid of a research assistant, who cross-referenced recorded ideas for accuracy.

### **Patient Engagement (NGT) Analytic Strategy**

While the NGT is essentially a qualitative technique, its product is usually presented

quantitatively by ranking or rating the items generated (CHI, 2020; Van de Ven & Delbecq, 1972). As outlined previously in Chapter I (research strategy section), I used data transformation to achieve integration, whereby I transformed the items generated (definitions) into numeric ranks (priorities). Taking into consideration the number of unique items generated in session, a scoring system for ranking identified priorities was devised. Each participant was asked to rank their top five priorities out of the total generated ideas, from most to least important (5 = *Most Important*, 1 = *Least important*). The auto-sum function embedded in the Field Note Template tally sheet was used in-session to rapidly produce a total sum of scores for each item that received votes, which enabled identification of the top-five items most highly rated by the entire group. In other words, the item with the highest number of points allotted was considered the first priority, followed by the item with the second highest number of points allotted, and so on, resulting in a hierarchical list of prioritized services that credibly represented the entire group's preferences. Emergent service priorities were thus identified first using qualitative methods during initial steps in the procedure and then transformed, by quantitative ranking, in the final step according to how participants collectively scored each idea.

### **Quantitative Methods**

After completing focus groups and preliminary qualitative analyses, I integrated the quantitative component of the study, by collecting quantitative data that built upon the thematic and NGT findings (Fetters et al., 2013). Whereas the qualitative component was used to identify a hierarchical list of service priorities that was constructed by adult 65+ focus group participants with lived experiences of attempting to find and access mental health and/or SUA services, the subsequent quantitative component built upon these findings by presenting the list of service priorities to a larger sample of community-dwelling adults 65+ for their validation. I also used

quantitative methods to address my secondary research objective: to describe adults' 65+ SUA literacy; evaluate differences between their SUA literacy and mental health literacy; and examine the sociodemographic and psychosocial predictors of their SUA literacy.

### **Participants and Recruitment**

I used a similar but expanded collaborative recruitment strategy as outlined previously to recruit survey respondents, this time targeting only community-based channels. I recruited adults 65+ in Manitoba, Canada from May to August 2023, with a goal of collecting data from approximately 135 participants to achieve adequate statistical power. I conducted a priori power analyses using G\*Power version 3.1.9.7 (Faulk et al., 2007) to determine the minimum sample size required to test the study hypotheses using effect size conventions (as my research topic does not have an established literature base to draw from). Results indicated the required sample size to achieve 80% power for detecting a small effect (0.25) at a significance criterion of  $\alpha = .05$ , was  $n = 128$  for a paired samples  $t$ -test. In addition, the required sample size to achieve 80% power for detecting a medium effect (0.15) at a significance criterion of  $\alpha = .05$ , was  $n = 135$  for regression analysis. I thus considered the obtained sample size of  $n = 138$  adequate.

Recruitment materials for the online survey (electronic PDF and printed posters in Appendix S; recruitment letters in Appendix T) were distributed to a broad range of community-based organizations throughout Manitoba that provide services, programs, or information to adults 65+ (see Appendix F). Interested organizations then collaborated with me to distribute recruitment materials for potential participants to view using their own internal distribution platforms. Electronic posters were also advertised in a newspaper and community events targeted to older adults in Manitoba, and through a targeted social media advertisement (for two weeks only in July 2023). Recruitment materials instructed participants to click the hyperlinked URL or

scan the embedded QR code to access the online survey. As the recruitment strategy involved a broad-based and anonymous distribution of materials, I was not able to assess response rates. Inclusion criteria specified that eligible participants be aged 65 years or older; live in the community in Manitoba; be fluent in English; have access to a computer or other electronic device; and be able to complete the survey online. Participants were excluded if they did not meet criteria. All ineligible submitted responses were manually screened out and discarded.

### **Data Collection, Procedure and Instruments**

The primary data used in the quantitative component was derived from the Adults 65+ Online Survey on Health, Wellness and Services. All respondents first completed an electronic informed consent (see Appendix U for blank form) through Qualtrics before accessing the online survey. After completing the survey, respondents were given the option of entering their name into a random draw for a chance to win one of three \$100.00 e-gift card honoraria to Amazon.ca. Three individuals were randomly selected and emailed their honoraria after the survey closed.

#### ***Adults 65+ Online Survey on Health, Wellness and Services***

The Adults 65+ Online Survey on Health, Wellness and Services (see Appendix V) consisted of a mixed battery of items. The data collected was based in part on questions from the Canadian Community Health Survey (Statistics Canada CCHS-MH, 2012) and language contained in the Statistics Canada Mental Health and Access to Care Survey (Statistics Canada, MHACS, 2023) as well as prior research conducted by the Health Information Exchange Lab at the University of Manitoba (e.g., Reynolds et al., 2022). The first section of the online survey examined participants' sociodemographic characteristics including age, sex/gender, education, income, racial identification, occupational status, and marital status. These data were primarily used to describe the sample. Select sociodemographic characteristics (age, sex/gender, education)

were also examined for their relative influence in predicting adults' 65+ SUA literacy.

The second part of the online survey assessed respondents' perceptions of their mental health and SUA literacy using a self-report measure (Mental Health Literacy Scale, Reynolds et al., 2020, unpublished, adapted). An original standalone item also asked respondents to indicate on a five-point rating scale (1 = *not at all*, to 5 = *extremely*) how knowledgeable they are about navigating available mental health services and SUA services in Manitoba, and to self-rate their knowledge of community-based mental health and SUA resources for adults 65+ (*poor, fair, good, very good, excellent*). Respondents were also prompted to self-report current (*yes/no*) and lifetime (*yes/no*) experience of trying to access mental health and SUA services/programs. These data were used to describe respondents' perceptions of their mental health and SUA literacy, and access to services, and to better understand how their SUA literacy compares with their mental health literacy for more common mental health problems. Select psychosocial characteristics were also examined for their relative influence in predicting respondents' SUA literacy.

**Mental Health Literacy Scale (Reynolds et al., 2020, unpublished) (adapted).** This four-item scale was used to assess adults' 65+ perceived mental health and SUA literacy. Respondents were cued to consider common mental health problems (e.g., anxiety, depression) and prompted to indicate on a five-point rating scale (1 = *not at all*, to 5 = *extremely*) how knowledgeable they are about signs and symptoms, possible causes, types of professional help available, and how to seek help. In the adapted version, respondents were cued to consider SUA problems (e.g., misusing or being dependent on alcohol, cannabis, sleeping pills, pain pills, or other prescription or recreational drugs, or problems with gambling) and prompted to indicate on the same five-point rating scale (1 = *not at all*, to 5 = *extremely*) how knowledgeable they are about signs and symptoms, possible causes, types of professional help available, and how to seek

help. A composite mental health literacy score (ranging from 4 to 20) was calculated by adding together the four mental health item scores; a composite SUA literacy score (ranging from 4 to 20) was likewise calculated by adding together the four SUA item scores. To aid interpretation of descriptive findings, composite scores were subsequently divided by four to calculate overall descriptive scores that mapped back onto the five levels in the scale: 1 (= *none*), 2 (= *low*), 3 (= *moderate*), 4 (= *high*), and 5 (= *extremely high*). This measure was optimal to use predominantly due to the ease and flexibility of adapting items to depict SUA content cues, which provided directly comparable results for within-subject analyses. The measure is also very brief and ensured that the length of the survey did not become overly onerous and time-consuming, which are factors that are associated with careless responding and reduced data quality (e.g., Baer et al., 1997; Berry et al., 1992). In addition, the scale was developed using representatives from the Canadian population, which my study also drew from. The scale has good internal consistency ( $\alpha = .91$ ) and is positively correlated with attitudes towards seeking professional help and mental health service use. Good internal consistency of the scale was also demonstrated with the current sample ( $\alpha = .93$  for mental health literacy, and  $\alpha = .93$  for adapted SUA literacy).

The third section of the online survey asked respondents to rank the list of seven items, which was developed by Group A during the NGT focus group, in order of importance (1 = *least important*, to 7 = *most important*). Survey logic was used to ensure respondents only used each number from one to seven once. Respondents were also asked to indicate whether they considered other mental health or SUA services to be more important than the items presented in the survey and, if so, to list that service in an open-text option. These data were used to validate the list of late-life mental health and SUA service priorities generated through NGT focus groups and to clarify a rank order of importance for each item with a larger sample of adults 65+.

The fourth and final section of the online survey asked about respondents' perceptions of their current mental and physical health status (*poor, fair, good, very good, excellent*) and mental health and SUA lived experience (*yes/no*). This section also contained self-report measures assessing respondents' current mental health (Geriatric Depression Scale, Short Form; Geriatric Anxiety Inventory), SUA behaviours (Short Michigan Alcohol Screening Test, Geriatric Version; CAGE Questionnaire, Adapted to Include Drugs) and social connection/isolation (Lubben Social Network Scale, abbreviated). These data were used to describe additional psychosocial characteristics of adults 65+. Select psychosocial characteristics were also entered into regression analysis to ascertain their relative influence in predicting adults' 65+ SUA literacy.

**Geriatric Depression Scale – Short Form ('GDS-SF'; Yesavage et al., 1982; 1986; Sheikh et al., 1991).** The GDS is the most widely used self-report measure to assess for depression in older adults. The original version of the measure consists of 30 items to evaluate depressive symptoms over the past week. The short 15-item form was used in the current study to ensure the length of the survey was appropriately confined. Questions prompt respondents for dichotomous answers (1 = *yes*; 0 = *no*) with some items reverse scored. A composite score is obtained by adding the individual item scores (range of 0 to 15). Clinical cut-off scores of '5' for psychological distress in the form of depression and poor perceived quality of life have been suggested (e.g., Laudisio, et al., 2018). The GDS has been shown to have high internal consistency ( $\alpha = .92$  in the original study) as well as test-retest reliability ( $r = .89$  in the original study). Friedman, Heisel and Delavan (2005) carried out a study of 960 North American community-dwelling primary care patients aged 65+ and found the GDS-SF had adequate internal consistency ( $\alpha = .74$ ) and was significantly associated with life satisfaction. Good internal consistency of the GDS-SF was demonstrated with the current sample ( $\alpha = .87$ ).

**Geriatric Anxiety Inventory ('GAI'; Pachana et al., 2007; Byrne & Pachana, 2011).**

The GAI is a 20-item self-report measure of anxiety symptom severity in older adults over the past week. The GAI is the recommended screening scale for assessing anxiety in later life as the format and content are designed specifically for older adults (e.g., emphasizes somatic symptoms that can be confounded with physical health problems, uses a single direction response format). Respondents are instructed to respond to each item with 1 = *yes*, or 0 = *no*. A composite score is obtained by adding the total overall score (range 0 to 20). A clinical cut-off score of '9' has been suggested in identifying anxiety disorders (e.g., Johnco et al., 2015). In the original study, with a community sample, the GAI showed good internal consistency ( $\alpha = .91$ ). The GAI has since been normed with samples of community-dwelling older adults, and a systematic review (Champagne et al., 2021) of the scale's psychometric properties across multiple studies shows a range of adequate to excellent internal consistency (range of  $\alpha = .71$  to  $.97$ ), poor to excellent test-retest reliability ( $r = .53$  to  $.99$ ), and adequate to good convergent validity ( $r = .65$  to  $.86$ ). Good internal consistency of the GAI was also demonstrated with the current sample ( $\alpha = .87$ ).

**Short Michigan Alcohol Screening Test - Geriatric Version ('SMAST-G'; Blow et al., 1992; 1998).** The SMAST-G is designed to identify problematic alcohol use specifically among older adults. Items focus on potential stressors and behaviours that are relevant to or common among older adults. The original version consists of 24 items addressing problems controlling amount of alcohol consumed, connection between alcohol use and emotional states, reactions of others to an older person's alcohol use, and physical signs of excessive alcohol use. The short version, which was used in the current study to ensure that the survey did not become overly onerous and time-consuming, consists of 10 questions probing respondents for a 1 = *yes*, or 0 = *no* answer. A composite score is obtained by adding each individual item score, ranging from 0 to

10. Two or more *yes* answers indicate problematic alcohol use (clinical cut off scores of ‘2’ for problematic alcohol use, and ‘4’ for alcohol use disorder, have been established) (e.g., Naegle, 2008; Ryou et al., 2012). Generally strong psychometric properties of the SMAST-G have been demonstrated with older adult samples although there are fewer studies with community samples. The SMAST-G has good sensitivity and specificity, and good internal consistency ( $\alpha = .78$  to  $.84$ ). Internal consistency of the SMAST-G with the current sample was poor ( $\alpha = .58$ ).

**CAGE Questionnaire (Ewing, 1984) (Adapted to Include Drugs; Brown 1995).** The self-report CAGE questionnaire is designed to screen for problematic alcohol use, with a modified version (CAGE-AID) adapted to screen additionally for problematic substance use (e.g., Hinkin et al., 2001). Although not targeted to older adults, the measure is commonly used with this population (e.g., Han & Moore, 2018). The CAGE-AID consists of four items (1 = *yes*; 0 = *no*). A composite score is obtained by adding each item score (range 0 to 4). Higher scores indicate increasingly problematic use of substances. A total score of ‘2’ or greater is considered clinically significant (although a clinical consensus panel has suggested lowering the threshold to any one *yes* answer to cast a wider net in identifying SUA problems; Johns Hopkins Medicine, 2024). In the current study, the CAGE-AID was further modified to cue respondents to consider use of cannabis, prescription tranquilizers, sleeping pills, pain pills, or any other prescription or recreational drugs over the past week in their responses. The CAGE questionnaire has adequate internal consistency ( $\alpha = .74$ ) although this is not specific to older adult samples. The CAGE-AID has been shown to have good sensitivity and specificity in a community sample of adults ages 60+ and acceptable inter-item reliability ( $\alpha = .68$ ) (Hinkin et al., 2001). Adequate internal consistency of the modified CAGE-AID was demonstrated with the current sample ( $\alpha = .75$ ).

**Lubben Social Network Scale – abbreviated ('LSNS-6'; Lubben et al., 2006).** The Lubben Social Network Scale (Lubben, 1988) measures frequency, size, and closeness of respondents' social networks by assessing perceived level of social support received on a 5-point rating scale. The abbreviated version contains three items assessing social support from family and three items assessing social support from friends. Composite scores are obtained by totalling the sum of all items (range 0 to 30). Higher scores indicate higher levels of social support and lower scores (cut point of <12) indicate problems with social isolation. Among community-dwelling older adult samples, the LSNS-6 has been shown to have good psychometric properties including good internal consistency ( $\alpha = .83$ ) (Lubben et al., 2006). Good internal consistency of the LSNS-6 was also demonstrated with the current sample ( $\alpha = .85$ ).

### **Quantitative Analytic Strategy**

#### ***Data Processing***

Quantitative data were compiled and analyzed using IBM Statistical Package for the Social Sciences (SPSS) Version 28. Prior to running analyses, data were cleaned and prepared in accordance with established guidelines and recommendations (Meade & Craig, 2012; Pallant; 2020). Responses that did not meet inclusion criteria, such as responses reporting age < 65 and responses from individuals not living/located in Manitoba, were screened out and discarded. Eligible forms ( $n = 33$ ) that had many unfilled pages of response options (defined as two or more missing sections) were removed, with rationale being that the sample remained large enough after deletion for statistical power to not be compromised. No duplicate entries occurred. A final sample of  $n = 138$  remained with 0 to 3.6% missing data per measure. Missing values analysis showed no clear patterns to the missing data, which supports the likelihood that data was missing in a random way (Little's MCAR chi-square = 691.58,  $p = .58$ ). Given that less than 5% of the

data was missing for any variable, any form of handling missing data is considered appropriate to similarly and effectively reach valid conclusions (although methods such as mean substitution and multiple imputation are not appropriate to treat missing categorical data) (e.g., Little & Rubin, 2019; Memon et al., 2023; Quintero, 2018). Given that only categorical and ordinal data were missing (there were no missing continuous data), I used the most frequent value method. For missing items on a measure, I used other items from the same measure to determine a mode and inserted that value. Most frequent value method on missing items resulted in imputed values for household income and marital status, and imputed items on the GDS-SF, GAI, SMAST-G, modified CAGE-AID, and LSNS-6 measures. Imputed datasets were used in analyses.

After these steps were complete, I analyzed the dataset for outliers. According to conventional criteria (e.g., Tabachnick & Fidell, 2013), using Z-scores of less than - 3.29 or greater than 3.29, there were five outliers in my dataset. I inspected the outlying values, but I identified no factors that could have unduly influenced the results. I chose not to exclude these items from analyses as they likely represent natural variations in the adult 65+ population under investigation. Next, I calculated composite scores for relevant measures. I also created a dichotomous variable ('SUA lived experience') for personal experience of a SUA problem and/or attempting to access any resources (i.e., services, programs, information) for SUA problems (1 = *yes*, any problem and/or attempt to access any resource; 0 = *no*, no problem and/or attempt). Collapsing these variables into one predictor variable was justified for the following reasons. Visual inspection of the data showed that all adults 65+ who endorsed current SUA service use also endorsed lifetime attempt to access SUA services or programs. Adults 65+ who endorsed lifetime attempt to access SUA services or programs were significantly more likely to have also looked for information about SUA problems and how to get help for self or others,  $\chi^2 (1, 138) =$

5.06,  $p = .02$ . Adults 65+ who endorsed lifetime attempt to access any SUA resources were significantly more likely to have also experienced an SUA problem,  $\chi^2 (1, 138) = 6.62, p = .01$ .

### **Descriptive Statistics**

Participant background information from the Adults 65+ Online Survey on Health, Wellness and Services was compiled and analyzed descriptively using IBM Statistical Package for the Social Sciences (SPSS) Version 28. Frequencies for categorical data and means and standard deviations for continuous data were obtained from all descriptive analyses. Medians and ranges were also obtained for relevant variables. Frequencies, weighted means, and weighted standards deviations were calculated for each of the seven service priority items, which considered the varying degrees of importance that were assigned to each item by each respondent. In calculating the weighted means and standard deviations, each item in the data set was multiplied by a weight (from one to seven in accordance with how each participant ranked each item) before the final weighted calculation for each item was made.

### **Inferential Statistics**

To test my hypothesis of differences between adults 65+ composite SUA literacy scores and composite mental health literacy scores, I used a paired samples  $t$ -test. I used Wilcoxon matched-pairs signed-ranks tests to examine differences for each scale item, and for the original standalone item. Prior to running analyses, I evaluated statistical assumptions. I determined that normality for each of the variables of interest was met, assessed by skewness and kurtosis values falling within conventionally acceptable ranges and visual inspection of quantile-quantile (Q-Q) plots and histograms. Kolmogorov-Smirnov test was also  $p > .05$  for the SUA literacy variable.

To test my hypothesis of sociodemographic and psychosocial characteristics as predictors of adults' 65+ SUA literacy, I used hierarchical regression analysis with SUA literacy composite

scores as the outcome variable. I first considered statistical assumptions necessary for interpreting multiple regression analyses. I determined that the assumption of normality was met by inspecting a predicted probability (P-P) plot of the standardized residuals of the regression. The assumption of independence of residuals was adequately met (Durbin-Watson statistic of 1.02). Visual inspection of a scatterplot of the standardized residuals against the standardized predicted values showed me that the assumption was met for homoscedasticity of the variances of the dependent variable. I found no problems with multicollinearity (VIF and tolerance values fell within acceptable ranges), studentized deleted residuals greater or less than three standard deviations, leverage values, or values for Cook's distance above 1. Finally, I assessed partial regression plots and plots of standardized residuals against the predicted values for each case to determine that the evaluated predictor variables were linearly related to the outcome variable.

I selected sociodemographic and psychosocial variables to enter into the regression model based on previous research examining predictors of older adults' mental health literacy and information preferences (Piper et al., 2018; Reavley et al., 2014; Reynolds et al., 2022) and variables associated with SUA literacy in younger populations (Degan et al., 2019; Dermota et al., 2013; Gallagher et al., 2019; Rolova et al., 2021). I controlled for sociodemographic variables in step one, before entering psychosocial variables in step two, which informed the order of the variables added. In step one, I entered: age, sex/gender, and education. In step two, I entered: mental health status, physical health status, SUA lived experience, and GDS-SF, SMAST-G, modified CAGE-AID, and LSNS-6 composite scores.

In the next chapter of this dissertation, I present my results. To begin, qualitative and quantitative sample characteristics are presented together. I then use a contiguous narrative approach (Fetters et al., 2013) to present qualitative results, followed by quantitative results.

## Chapter III

### Results

#### Participant Characteristics

Tables 1, 2 and 3 summarize sociodemographic, psychosocial, and health-related characteristics of adults 65+ in the Focus Group A series, community service leaders and service providers in the Focus Group B series, and adult 65+ survey respondents, respectively.

#### *Characteristics of Adults 65+ (Focus Group A Series)*

Three men and three women (total  $n = 6$ ) participated in Group A. Their average age was 77 years ( $SD = 7.42$ ; range 69 to 89 years). Each had a current or lifetime personal lived experience of a mental health problem; none had a personal lived experience of an SUA problem (this limitation is discussed further in Chapter IV). Their self-reported mental health status ranged from *good* to *excellent*. Some participants also had physical health problems (range *fair* to *excellent* self-reported physical health status). All participants had a personal lived experience of trying to find and access mental health services and information, and two participants had tried to find and access SUA services and information, including through community, healthcare, and religious organizations, and self-help groups or resources. Overall, adult 65+ participants were highly educated, with an average educational attainment of 15 years ( $SD = 2.83$ ; range 11 to 19 years). All lived in an urban location within Manitoba. Three were married, two were single, and one was divorced. Regarding racial background, four participants identified as White, one participant identified as Indigenous and White, and one participant identified as White and Multi-Racial. Four participants reported being currently retired, one participant was currently employed (part-time or full-time status was not disclosed), and one participant reported being currently unemployed. Adult 65+ participants reported household income ranging from \$0-

\$29,999 (four participants) to \$50,000-\$69,999 (one participant). One participant chose not to report their income. The pattern of participants' responses showed a *moderate* level of perceived SUA literacy ( $M = 3.0$ ,  $SD = 0.64$ ) and a *high* level of perceived mental health literacy ( $M = 3.7$ ,  $SD = 0.76$ ). They self-reported an overall *low* level of knowledge about how to navigate SUA services ( $M = 2.3$ ,  $SD = 0.82$ ) and an overall *moderate* level of knowledge about how to navigate mental health services ( $M = 3.5$ ,  $SD = 1.38$ ). Participants' perceived knowledge of available mental health and SUA resources for adults 65+ in the community ranged from *poor* to *excellent*, with half (50%) reporting *good* knowledge. Participants' perceived knowledge of how the mental health system in Manitoba is organized varied, ranging from *not at all* (17%) and *somewhat* (17%) to *very* (33%) and *extremely* (33%) knowledgeable. One additional participant initially completed a background survey but then chose not to join any focus groups; their data were excluded from analyses.

### ***Characteristics of Community Service Leaders and Service Providers (Focus Group B Series)***

Five women and one man participated in Group B (total  $n = 6$ ). Their average age was 49 years ( $SD = 9.44$ ; range 33 to 59 years). The professional roles and backgrounds of community service leaders and service providers were varied: community education, program management, and service team leadership for service leaders; social work, psychology, and nursing for service providers. The organizations within which each participant worked were all located in an urban location within Manitoba (although one participant also provided services in a rural area). Each participant worked within a community-based organization or provincial health authority. Five participants worked in mental health settings, and one participant worked in a combined mental health *and* SUA setting. All participants reported being employed full-time in their current roles for an average of 13.7 years ( $SD = 4.68$ ; range 8 to 20 years). Overall, participants were highly

educated; each had a college or university education with an average educational attainment of 17 years ( $SD = 3.13$ ; range 14 to 23 years). Regarding racial background, all six participants identified as White. The pattern of service leaders' and providers' responses showed a *moderate* level of perceived SUA literacy ( $M = 3.5$ ;  $SD = 0.79$ ) and a *high* level of perceived mental health literacy ( $M = 4.3$ ,  $SD = 0.68$ ). Their perceived knowledge of how to navigate or refer to SUA services was *high* ( $M = 4.0$ ,  $SD = 0.63$ ) as was their perceived knowledge of how to navigate or refer to mental health services ( $M = 3.83$ ,  $SD = 0.41$ ; *high*). Service leaders' and providers' perceived knowledge of how the mental health system in Manitoba is organized varied, ranging from *somewhat* (33%) and *moderately* (33%) to *very* (17%) and *extremely* (17%) knowledgeable.

### ***Characteristics of Adult 65+ Survey Respondents***

The average age of the  $n = 138$  adult 65+ survey respondents was 72 years ( $SD = 5.8$ ; range 65 to 92 years), and a majority were women (75%). Despite most respondents (70%) endorsing that they have experienced a mental health problem in their lifetime, less than half (47%) had ever tried to access mental health services, and only 8% were currently using mental health services. Although 15% of respondents endorsed experiencing a SUA problem in their lifetime, only 9% had ever tried to access SUA services and only 1.4% were currently using SUA services. As a whole, respondents scored within the non-clinically significant range for psychological distress/depressive symptoms on the GDS-SF ( $M = 3.0$ ,  $SD = 3.3$ ), anxiety symptoms on the GAI ( $M = 3.0$ ,  $SD = 4.3$ ), alcohol use on the SMAST-G ( $M = 0.7$ ,  $SD = 1.1$ ), drug use on the modified CAGE-AID questionnaire ( $M = 0.2$ ,  $SD = 0.6$ ), and within the normal range for social connectedness on the LSNS-6 ( $M = 16$ ,  $SD = 5.9$ ). Some respondents endorsed scores above established clinical cut-offs indicating possibility of a current mental health or SUA

problem<sup>1</sup>, including 24% on the GDS-SF indicating possible current mental health problem, 17% on the SMAST-G indicating possible current alcohol use problem, and 5%<sup>2</sup> on the modified CAGE-AID questionnaire indicating possible current substance use problem (with cannabis, prescription tranquilizers, sleeping pills, pain pills, or any other drugs). Adults' 65+ mean SUA literacy score ( $M = 12.59$ ,  $SD = 3.87$ ) was at the *moderate* level ( $Mdn = 3.0$ ,  $M = 3.1$ ,  $SD = 0.97$ ) and their mean mental health literacy score ( $M = 13.40$ ,  $SD = 3.61$ ) was also at the *moderate* level ( $Mdn = 3.5$ ,  $M = 3.3$ ,  $SD = 0.90$ ). A *moderate* level was the most frequent endorsement regardless of cue (39% for SUA literacy, 42% for mental health literacy). Over one third of respondents ( $n = 51$ , 37%) scored below three on the SUA literacy measure, corresponding with *none* to *low* levels. In contrast, one third of respondents ( $n = 45$ , 33%) scored four or higher on the mental health literacy measure, corresponding with *high* to *extremely high* levels. A slight majority of respondents (55%) endorsed low knowledge (22% *poor*, 33% *fair*) of available mental health and SUA resources, services, and programs in the community for adults ages 65+. One in every two respondents (52%) perceived that they are *not at all* or only *somewhat* knowledgeable about navigating SUA services in Manitoba, whereas 43% perceived that they are *not at all* or only *somewhat* knowledgeable about navigating mental health services in Manitoba.

### Qualitative Findings

Semi-structured focus groups were employed with Group A and Group B participants to understand their late-life mental health and SUA service and research needs and perspectives on availability, accessibility, and navigation of services, including barriers and opportunities for enhancement. Two thematic frameworks were constructed, one for each series. Figure 3 outlines the content and characteristics of adults' 65+ (Group A series) descriptions of their experiences

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<sup>1</sup>Cut-offs used signified possible problems rather than signifying diagnoseable disorders; see Chapter II methods.

<sup>2</sup> Increasing to 11% when the single *Yes* cut-off was used as proposed by some clinicians; see Chapter II methods.

and perspectives, whereas Figure 4 outlines the same for community service leaders and service providers (Group B series). The components of each thematic framework are separately described in detail in the sections to follow. Selected quotations from participants are attributed to their identification codes, and either “GA” to signify that they were in the Focus Group A series, or “GB” to signify that they were in the Focus Group B series. Integration of Group A and B findings is briefly presented at the end of this section, with further discussion on points of convergence and differences in perspectives elaborated upon in Chapter IV.

### **Group A Qualitative Findings (Adults 65+)**

Qualitative analyses of the adult 65+ focus group transcripts were used to develop a thematic framework with four main themes, which represent the group’s experiences of trying to find help for mental health or, to a lesser extent, SUA problems: (1) “What you need just isn’t there”; (2) “Where do I go”: Knowing about and finding services; (3) “Roadblocks” along pathways to services; and (4) COVID-19 “forced” new ways of connecting with people and services. Figure 3 depicts a final Group A thematic framework that illustrates relationships between each of the four main themes, and between the main and subthemes generated. The four main themes are related in that they reflect the group’s experiences and perspectives related to the accessibility and availability of services, and how these can be improved. Whereas the first two themes illuminate important services to introduce, enhance, or develop in Manitoba, the last two themes highlight areas that impede or otherwise influence access to services, even when available. In this analysis, *“What you need just isn’t there”* is the overarching theme that extends across each main theme and subtheme, as it reflects the group’s primary focus on what is currently missing, or what we need more of, in Manitoba. Dialogue on critical service and research areas, for which the group voiced unmet needs, was conceptualized as three subthemes

(“It’s a family that’s involved”; coping with change, loss and loneliness; and prescription drug use problems and other research priorities). The second theme, *“Where do I go”: Knowing about and finding services*, relates to the first as it continues to highlight the group’s perception about what is missing but distinctly centers here on support for service navigation, with concurrent dialogue conceptualized as three separate subthemes (tools and approaches to improve service navigation; “making the journey with that person”; and “health by stealth” for men).

*“Roadblocks” along pathways to services* was the third theme generated, which relates to both previous themes in that the factors contained appear to play a role in reducing access to existing services and make navigating into these services more difficult. Three constructed subthemes highlight independently informative factors that were perceived as impediments (siloed care and narrow eligibility criteria; and restrictions on information sharing) and depict how wellness in later life can be impacted by the systems within which adults 65+ must interact (emotional response to “roadblocks”). Finally, the fourth theme, *COVID-19 “forced” new ways of connecting with people and services*, collated discussion on changes that were catalyzed by the pandemic, which impacted access to services and supports, with two subthemes constructed to reflect this changing reality (worsening social connection and isolation; shifting to virtual services). Each main and subtheme is described in further detail in the sections that follow.

### ***Theme 1: “What you need just isn’t there”***

The predominant shared view and main theme that developed from adults’ 65+ discussion about late-life mental health and SUA services focused on how Manitoba currently does not have enough of the right services to meet their needs: “And most of the time, nine times out of ten, you're going to find what you need just isn't there. Our community doesn't provide those services that are needed and then we're getting into something else” (GA3). The group converged around

a shared meaning of having constrained choices because of a scarcity of services; either they are sent to existing services that are less relevant to their needs because of a lack of alternatives, or they simply do not engage with any services. Nearly all adults 65+ shared experiences of their service needs going unaddressed, in part or in full, because of such mismatches between needs and services. Cohesiveness around this theme evolved into group members identifying discrete service gaps – that is, needed services that do not currently exist at all in Manitoba or exist only limitedly. Consistent with the pragmatic underpinnings of this research, this main theme was thus constructed to reflect adults' 65+ perspective and preferences on the services that they want to be more available and accessible in Manitoba. It also includes their identification of research that will be important to explore in future investigations on this topic. Three subthemes are woven into this main theme: (1) "It's a family that's involved", (2) Coping with change, loss and loneliness, and (3) Prescription drug use problems and other research priorities.

**"It's a family that's involved".** Adult 65+ participants perceived that Manitoba has a gap in adequate mental health support for families and caregivers in later life: "There's a huge loophole for help, I guess, for the seniors looking after the other person" (GA4). This subtheme was evident in the way the group talked not only about their own personal experiences but also their experiences of supporting or otherwise trying to access or navigate services on behalf of others. Several participants shared personal accounts of having no access to services for their *own* mental health difficulties that have surfaced in association with managing the care – either formally or informally – of family members, both younger and older, who are living with mental health or severe SUA problems. Conceptually, their discussion reflected the idea of *linked lives*, whereby the distress experienced by family members (e.g., partners, adult children, younger grandchildren) directly linked to their own psychological/relational distress. For example, several

group members attributed onset and maintenance of their own experiences of depression and anxiety directly to care demands in their role/relation to a distressed family member (e.g., living with an addiction). Improving access to (or developing) services designed to address their mental health needs in the context of supporting someone else was perceived by the group as critical. The group also emphasized a need for access to practitioners who are knowledgeable about the unique stresses and burdens that they face because of these linkages to others' problems, which are at times amplified by other age-related changes (e.g., contending with physical health problems). A 73-year-old woman gave voice to this shared perspective when she stated:

But I would, just, I would like it to be easier made for the families, the caregivers, for us, because it is family illnesses and it is family dealing, whether it be, you know, some type of mental health, whether it be addiction, whether it be depression. It's a family that's involved. (GA4)

Her comment was met with validating statements and affirmative head nodding by other group members. Despite the observable group cohesiveness on this subtheme, one group member did express a different view, which reflected a resigned acceptance of the constrained choices that he has encountered along his quest to support the people that he is linked to, stating, "So sometimes we, as caregivers or people involved with people that need help, we've got to get our expectations in line, in my opinion" (GA5). Other group members appeared reluctant to agree.

In addition to identifying a gap in services to address the mental health of caregivers and families as they in turn support someone else with mental health and SUA difficulties, the group highlighted a gap in advocacy support for older caregivers. In discussing their experiences of being unable to access services that they or their family members need, some members of the group voiced a desire for advocacy support, which could play a role in spurring change in

Manitoba to ensure needed services are made available. One 89-year-old man suggested the introduction of a formal Manitoba advocate service that could play a role in influencing change:

There is an American organization that I think is doing very well, but we don't have anything like that in Canada. It's called the Treatment Advocacy Center...part of it is working within individual families, helping the families to get the care and treatment that their family members need. And the other half of their work is lobbying with governments, and they have both at the federal level and at the state level. They're working with governments, trying to improve programs for – [pauses], psychiatric programs, and improve legislation and so on. (GA3)

His idea was quickly followed by expressions of support from the group, including affirmative head nodding and voiced consensus: “I completely agree with that” (GA4).

**Coping with change, loss and loneliness.** In addition to discussing services gaps in the form of support and advocacy for families and caregivers, the group also discussed common experiences of contending with change, loss and loneliness in later life and associated support needs. The group shared convergent descriptions of some common experiences that drive feelings of loneliness in later life, as highlighted by one 89-year-old man's comments: “But it's a basic problem that affects a lot of people as they get older, as your family situations change, as your friends die, as you stop working” (GA3). An 81-year-old man also highlighted another change that can contribute to loneliness and social isolation among older adults, when he spoke of how “more and more couples are divorcing after age 65 than ever before” (GA5), and then pointed out that there are no known resources for these individuals to access that might aid their coping. Overall, the group perceived a lack of formal services available to help older adults cope with the multitude of changes and losses that occur in later life, which can so often leave them

feeling “very lonely and alone” (GA5). Although group members generally agreed that the challenges of coping with mental health difficulties in the context of stage-of-life transitions without professional led services can be partially mitigated through indirect/informal supports – specifically, engaging in positive self-help behaviours – mixed opinions about self-help emerged. Whereas engaging in individual self-help activities such as meditation was seen as favourable, perceptions of group-based self-help activities were met with apprehension, with some participants conveying experiences of disappointment with this type of informal support, as it has not fully assisted with their difficulties as hoped. In this way, discussion implied that pursuing some forms of self-help may be a less optimal solution that adults 65+ fall back on when desired professional led services to address coping with common hardships in later life are not available.

And then I also look at if I'm going to go to [self-help groups], which I have in the past, I try to examine what my expectations are of the group [an audible “yes” is heard overlapping] ...and sometimes my expectations are not within the parameters of the group or way beyond for more extensive help. (GA5)

**Prescription drug use problems and other research priorities.** When considering research topics or questions that researchers should focus efforts on learning more about to improve access to and navigation of late-life mental health and SUA services, group discussion centered on the “huge” (GA6) issue of prescription drug use problems in later life, when people are more likely to be using multiple medications. Group discussion specifically focused on taking too many drugs at once and drug interactions as research priorities. A 71-year-old woman suggested a future research direction, that others in the group quickly affirmed:

Many seniors that I know, and work with, and am related to, and visit, are taking four, five, six, seven, eight, nine, ten tablets at once. And I don't think there's any

pharmacological studies that ever study what is the interaction between two drugs, let alone three or four or five or ten? (GA6).

A 69-year-old woman's comments converged on this topic, as she also highlighted her desire for better access to psychoeducational resources on safer medication use:

And I, working in the field, I saw so many people taking over-the-counter drugs without letting their doctor or pharmacist know what they were, yeah. And so, I would like to see programs that educate people on the dangers of taking too many over-the-counter drugs when they're taking a lot of prescription drugs. (GA2)

Additional research priorities identified by adults 65+ included investigations on improving funding models to better enable community mental health agencies to “spend more time actually helping the people they're trying to help” (GA2); increasing understanding of how to get more older men involved in mental health-related research studies; and rapidly mobilizing research findings on important late-life mental health topics to relevant stakeholders who can use the research evidence to drive system change. The group also voiced a desire to stay involved in research on improving access to and navigation of late-life mental health and SUA services:

If there's some way that your study can include this group of people coming together to now discuss any one of those 18 or 21 or 22 things, let's do that, because I feel that you've got a pretty sharp group of people here who could give you a lot of in-fill to those issues or priorities that they raised. But we didn't really have time to discuss any one of them, but we could if we got the time or opportunity. (GA6)

### ***Theme 2: “Where do I go”: Knowing about and findings services***

In contrast to their discussion about a lack/gap in services, the group also discussed their view of a different problem that affects accessibility of services in Manitoba, as they perceived

that there may be services out there waiting to be discovered that might meet their needs, if only they could learn about them and the pathways into them. A collective sense of uncertainty was implicit in the group's accounts of their frequently unsuccessful experiences of attempting to find needed services. This uncertainty about what mental health and SUA services are out there and how to find them contrasted with the concept of lack of services/constrained choices depicted in the previous theme, which reflects an implicit belief that access is influenced by more than a single issue. Their shared experiences were punctuated by a collective appeal for it to be, "made easier for me to know where to go and to have access for what I need" (GA4). The three subthemes developed from this main theme include (1) Tools and approaches to improve service navigation, (2) "Making the journey with that person", and (3) "Health by stealth" for men.

**Tools and approaches to improve service navigation.** The group perceived that the right service navigation tools, including better information resources and clearer pathways to services (e.g., a service map), would have a positive impact on their ability to access mental health and SUA services in later life. For example, in describing a "tough road" of trying to learn about, find, and navigate services for herself and family members in her caregiving role, a 73-year-old woman reflected the group's view on the value of enhancing service navigation tools: "For me, it would be life changing because I try to find my way around, just by people I know, contacts, going to the different things. But I don't always know if it's the right one" (GA4).

Although the group collectively supported the development of tools to aid service navigation for older adults in Manitoba, rather than spend time pinpointing exactly what form these tools should take, they instead focused their conversation on the function of the tools, as intended to make it easier for them to know where to go and how to navigate services. The group shared a convergent view about the need for service navigation resources, information aids, and

tools to be differentially targeted to various audiences who may benefit from their use. The main takeaway from this extensive group dialogue was summarized by one 81-year-old man:

So, I guess we're talking about different levels here, aren't we? One directly involved with, when personally, you know you're in difficulties, how do you seek help? Or secondly, where there's a loved family member that needs help, or maybe a next-door neighbor that you know very well, and how do you possibly intervene? How do you get involved? What resources are available? (GA5)

Another 76-year-old man also emphasized that any tools developed need to especially “consider the age group we're discussing” (GA1), which may reflect the importance of continuing to engage or partner with older adults on any tools that are being developed for this population. Beyond discussing information aids and tools, the group voiced a desire for clarification on how to get into services (i.e., clearer service pathways), to guide them as they seek support. One group member described how they have been challenged by uncertainty about which direction to go when seeking help in later life (for self or on behalf of other older adults) and compared those experiences to more favourable situations of greater clarity when they have navigated services alongside younger family members, where “there are certain directions that they can go” (GA4), implying that the same clarity is needed for older age groups too.

**“Making the journey with that person”.** Discussion on making service navigation easier evolved to consider broad service navigation approaches, with some participants offering a critique against a narrow focus on simply developing and distributing more tools or information. One participant voiced a preference for the integration of interpersonal approaches within service navigation models, to facilitate building personal connections with knowledgeable people:

If you're going to help people to get the help they need, it's not a simple thing of handing

people a list. You've got to give an awful lot of your time and a lot of your emotional carry [sic] to making the journey with that person, to go with that person as you try to navigate the system ...And just giving people information isn't usually that helpful. You've got to walk this journey with them. You've got to take their hand and go with them and find out if A or B or C actually is what they need and see if it actually does fit and does meet the need. (GA3)

These comments reflect a perception that integrating person-centered, empathic connection and support within service navigation models might help better connect individuals and families to needed services in later-life; however, a few participants expressed that they had not ever encountered this kind of navigation support in Manitoba. When queried about existing services in Manitoba that do integrate interpersonal elements to support service navigation, participants largely expressed dissatisfaction. Two examples were provided: existing peer support services for navigation and 'referral hubs' known as Seniors Resource Finders (who work within the formal healthcare system to link and refer adults 55+ to community supports). The group's perspective was that, although these entities play a part in making service navigation easier by, at least theoretically, linking people to the right services to match their need, each are insufficient in their current forms. An 81-year-old man's voice reflects the group's convergent viewpoint on the topic:

And most of them have such a narrow point of view on what they're really trying to resource and pass on. I find it's limited, even though there is someone with that title, it's available and you can get the information off the Internet. (GA5)

His comments were followed with general agreement: "I think there's definitely a role for peer support. But I think there's also limitations. It can help so much but more is needed" (GA3).

In using the term limitation, this participant referred back to the lack of interpersonal connection. His comments reflect the experience he shared of not being afforded an opportunity to express specific needs that could be understood and acted upon by someone who could help and who would then circle back to him, to ensure that what was suggested worked for him.

**“Health by stealth” for men.** Moving beyond a discussion of service navigation needs as they apply to the general population of adults 65+, conversation focused on a specific need to “reach” older men, who generally “don't seek help or don't know where to go to get help” (GA5). It was the male participants in the group, especially, who voiced the perception that older men are limited in recognizing and managing mental health or SUA problems in later life, relative to older women. The men tended to shy away from directly disclosing details of their own experiences, and instead conversed about their experiences and observations in an indirect way, as marked by their frequent reference to a rather generalized other. The women in the group agreed that men are more prone to shut down offers of help, which was met with affirmative responses (“Yes, that's exactly right” – GA5) from the men. Beyond this agreement, the women offered no further commentary as they simply listened. The men contemplated how to help break down barriers for populations of older men, so that they become more likely to seek help when it is needed. One 81-year-old man acknowledged: “And so there's psychological barriers for men to even open up, admit they need help or, or say, I don't know where to go. Yeah, it's a huge challenge” (GA5). The view of another 76-year-old male participant converged on this point:

I can add something there. Yeah. I think the comment was made that men don't want to open up. The first step is for a man to know that he does need help. And many are not aware that they need help or that help of that kind is available. So that's the first step way back. (GA1)

His comments were quickly followed with, “And where they can go and find help” (GA5), which reflects back to the subtheme of clarifying pathways. Beyond benefiting older men who are living with a mental health or SUA problem, improving *every* older man’s mental health and SUA literacy was perceived by the male participants as a means of enabling men to support each other, as they implied that strong connections between men can facilitate help-seeking in a safe and acceptable way. Rather than providing direct psychoeducation, a disarming “health by stealth” (GA5) approach to improve men’s literacy was favoured by the men in the group:

And yet, if you get the men within a small group or one on one with another man, then they'll open up...as men get to know each other, you can bring in speakers on various subjects, mental health, nutrition, Alzheimer's, all sorts of things. And where men don't necessarily realize that they're learning, or they have an opportunity to learn, or they have an opportunity to ask questions. And they do it in front of people who they trust and know they won't be judged. (GA5)

The men shied away from labelling such an approach as a mental health or SUA intervention or peer-support group; indeed, it seemed important these labels are *not* used, which may reflect stigma concerns, although notably stigma was not explicitly discussed by the group.

### ***Theme 3: “Roadblocks” along pathways to services***

Moving beyond a discussion about making it easier to know about, find, and navigate services, this third theme, “Roadblocks” along pathways to services, deepens understanding of broader ‘system-dimension’ factors (including service design issues) that complicate adults’ 65+ ability to access services for self or others. Nearly all participants had personal experiences to share about what blocks their ability to get into existing services that they readily identify a need for (these will be detailed further below). Each time a group member introduced an account of

facing a roadblock, they were quickly met with reactions from the others. Validating statements such as, “I’ve had the same” (GA3), and “I too have hit a lot of the roadblocks” (GA4), affirmative head nodding, and audible sighs of empathy formed the receptive environment in which additional personal accounts were then shared. Although they spoke of their own experiences, the group implied that these barriers are not uniquely faced by only older adult populations; they de-emphasized any age-related focus and spoke globally of their encounters with and observations of the mental health and SUA system in Manitoba. The three subthemes constructed under this main theme include (1) Siloed care and narrow eligibility criteria, (2) Restrictions on information sharing, and (3) Emotional response to “roadblocks”.

**Siloed care and narrow eligibility criteria.** When discussing their perception of siloed care as a roadblock, some group members shared accounts of shuttling between various services that each only partially addressed their chronic difficulties, which reflects a broader healthcare system issue. The group highlighted how services are typically designed to address only one type of difficulty (for example, a singular mental health problem) while neglecting or even excluding co-occurring difficulties. Juxtaposed against this service delivery trend was their perspective that co-occurring problems are very common, especially with SUA, as described by one participant:

My experience in the many years of experience with [addiction services], a lot of people that are addict[ed], whether it be drugs, alcohol, cannabis, whatever it be, if they do get assessed and they do get help or go for treatment there usually is an underlying mental health problem. And that's my experience from families that I've met. (GA4)

Breaking peoples’ problems and needs into fragments, and addressing them separately, was considered a roadblock that not only reduces access to care but complicates it too.

Eligibility criteria that incentivize older adults to get worse before they can rightfully

access appropriate services was also voiced as a related but distinct system-level roadblock encountered, which also highlights the group's perception that the mental health and SUA system in Manitoba is perhaps too crisis-oriented. A 69-year-old woman shared her experience, stating:

Well, when I was told it wasn't bad enough, I felt frustrated. I thought, how bad is bad enough? You know, do I – [pauses], I was frustrated. I thought, do I have to run naked through the streets or what? You know, and I thought, it's pretty sad when they – [pauses] it seems like you have to be quote 'bad enough' before you can get help. (GA2)

Another 73-year-old woman shared a convergent view in the context of caregiving:

And each time that my [family member] has been released from the hospital or, you know, I've taken [them], I feel like we're sent from there, as the other [participant] said, because [we're] not 'bad enough'. And I feel that's sort of how we're sent, we are sent too, and it's like we leave and it's like, until the next time. Until the next episode. Because we have not accomplished anything. I don't have help for my mental health. (GA4)

Offering his thoughts on a solution, an 89-year-old man suggested that, in contrast to their experiences, introduction of person-centered models of care that are holistic and comprehensive would better meet the needs of older adults and improve accessibility of services:

But in reality, every human being is different and has different needs. We need to be able to build a service to meet the unique needs of the individual. We don't have to somehow squeeze and compress the individual to fit them in to some existing service that partly meets their need, but partly doesn't. We have to look at the person as a total person and what they need and then build a program or a service to address that as opposed to fitting them into whatever services might exist that might be available. (GA3)

**Restrictions on information sharing.** Beyond discussing barriers impeding the

availability and accessibility of services to address their own mental health and SUA needs, adults 65+ highlighted privacy-related restrictions on information sharing as a roadblock to helping others in their care access services. “I don't ever want to hear the word privacy from anybody anymore” (GA4) describes the group’s collective perspective. Perceived limits on information sharing between healthcare providers and caregivers, intended to protect patient privacy, were viewed by participants as excessively restrictive, even to the extent of being misused. The words of a 73-year-old woman exemplifies a typical experience shared by the group when she recounted her experience of caregiving for a family member with SUA problems and being repeatedly kept in the dark about information that she deemed pertinent to caring for them, stating, “But your hands are tied, because you're doing your best to take care of them. Take them to the hospital. Take them to emergency. Take them to the Crisis Center. But nothing is shared with us” (GA4). An 81-year-old man voiced a convergent perspective, stating, “Part of that comes back to the privacy issue, what information you can learn, or learn from maybe someone who's been counseling the person you're with and that's not available usually unless the person shares that with you themselves. So, there's communication challenges there” (GA5).

While sharing another account of this subtheme, an 89-year-old man voiced his frustrations of being unable to obtain adequate information about the care of an at-risk family member with serious mental health and safety issues, despite him being a primary caregiver, sharing his perceptions with expressions of exasperation and visible emotionality: “they've cut off all communication with me and they won't talk to me about what's happening with my [family member] and what they're doing” (GA3). The group shared the view that safety should be prioritized over privacy. Yet, the experiences of most participants involved being refused help and kept in the dark when they attempt to provide care for and even access services on behalf of

others. The group perceived that involving caregivers more readily into care plans and promoting better collaboration between caregivers and service providers is critically important to protect vulnerable people in their care and improve their access to services on behalf of others:

And I think privacy needs to be rethought, especially with respect to the psychiatric conditions and how much you talk to the, what I call the informal support network of the patient, the family and friends of people who care about the patient. (GA3)

When discussing restrictions on information sharing, most of the group became observably animated visibly (use of more hand gestures) and audibly (sped up rate of speech), signifying their frustration. These emotional responses are the focus of the next subtheme.

**Emotional response to “roadblocks”.** In discussing their experiences of coming up against the roadblocks described previously, nearly all group members used words that signified experiences of negative emotionality along the help-seeking journey, which many agreed had “gone on for years” (GA4). “Fighting the system” (GA5), is a primary example of the dominant descriptor that adults 65+ used to define the experience of encountering barriers when trying to find and access services for self or others. The definitions were marked by friction and included terms depicting combat, struggle, obstruction, and defeat. Regardless of the specific roadblock in discussion, common words, and their derivatives, repeatedly surfaced including stress (“extremely stressful” GA3), anxiety (“my anxiety is very, very bad” GA4), frustration (“I was frustrated” GA2), exhaustion (“I’m very, very worn out” GA4), and helplessness (“I feel really helpless” GA4). Only one participant, a 76-year-old man, voiced consistently successful experiences of finding and accessing services for his mental health challenges. Juxtaposed with the negative emotionality noted by the others, he described being “very, very thankful” (GA1) about his ease along the help-seeking journey. This discrepancy in emotional responding served

to underscore how emotional states can be tied very closely to the effectiveness/ineffectiveness of the health and social systems that older adults find themselves interacting with in later life.

***Theme 4: COVID-19 “forced” new ways of connecting with people and services***

Related to but distinct from discussions about ways to enhance access to and availability of late-life mental health and SUA services – and barriers that are currently impeding access – the group also spoke about the impacts of the COVID-19 pandemic on their lives, including how the pandemic influenced their need for and access to services and, especially, informal supports and personal connections. This theme is best described by the words of an 89-year-old man who stated, “I’ve changed in how I live my life and how I communicate with people and contact people and seek help or whatever has changed” (GA3). The two subthemes woven into this main theme include: (1) worsening social connection and isolation, and (2) shifting to virtual services.

**Worsening social connection and isolation.** The profound impacts of COVID-19 on connection and social isolation were highlighted by adults 65+, who agreed that the pandemic, which was still ongoing when participants joined this focus group series (Canada had just emerged from its fifth wave), significantly reduced opportunities to connect with others and amplified experiences of social isolation: “And social isolation is, in any case, a long-standing problem, especially for lots of older adults. And the COVID experience is simply greatly exaggerated, that it’s really made us acknowledge it and face it” (GA3). This subtheme links back to and underscores the earlier subtheme on the need for more services to assist older adults in coping with change, loss and loneliness in later life. Although discussion was largely marked by acknowledgement of losses experienced in terms of contact and connection with other people, some group members also spoke of how the pandemic spurred them to find new ways of addressing the often-encountered experience of social isolation in later life. Their experiences

demonstrated resilience and a kind of compulsory growth, as reflected in the voice of one 89-year-old man. The collective *we* and *us* was used in his descriptions, which underscores the group recognition and consensus that was observed here:

But it's also forced us to find alternatives to meet our social needs. And so, we're finding different ways of doing things and different ways of trying to get past the social isolation and still accomplish the things that need to be accomplished and have other ways of having relationships with people. And so, its forced changes with respect to how we live with and how we approach, how we struggle with social isolation... we've had to sort of try other things and experiment. (GA3)

**Shifting to virtual services.** Adults 65+ discussed how shifting from in-person to virtual services has impacted access to services, and important factors to consider should virtual service delivery persist. Participants' perception of the shift was mixed but leaned positively, with some benefits acknowledged. The group perceived that the addition of virtual service options has generally improved access to needed services, as exemplified by the voice of a 76-year-old man,

I've noticed one change that may be very useful in the future, and that is more appointments by telephone. Which can be, of course, done well for things like mental health or counseling as opposed to something medical and physical. I've had quite a few different kinds of appointments over the phone. I think that's really saved a lot of time and is quite useful. (GA1)

Overall, adults 65+ expressed a positive opinion about their growing knowledge and use of virtual services that was catalyzed by the COVID-19 pandemic, even while acknowledging that it has required some adjustments and learning. The group linked their own enhanced ability to use virtual service delivery options with experiences of improved access to services, even as

far as from “the other side of the world” (GA3). Discussion also highlighted some perceived drawbacks of virtual services, which will need to be considered going forward, especially if in-person services become less readily available. For example, some participants raised concerns about the interplay of age-related sensory changes and technology interaction:

I am having increasing problems in hearing loss. And if we depend more upon talking to people on the telephone, that sort of thing, well, that hearing loss can generally get in the way. So, I think if we're going to try to help people in these other ways, we have to address the fact that it's not just me, but quite a few older people are going to have some degree of hearing loss, and that has to be taken into account in terms of how things are planned and delivered. (GA3)

Interpersonal communication style was also raised as a drawback by some male participants:

Men quite often don't like Zoom. And this is something that if communicating with a man face-to-face, especially if you're a woman, it's better to communicate shoulder-to-shoulder. And Zoom is virtually forced face-to-face. I've seen some people absolutely become totally, I don't want to, I don't want to see you. (GA5)

Collectively, adults' 65+ voices shine light on not only their experience-driven preferences and needs, but also their values, related to how services are delivered.

### **Group B Qualitative Findings (Community Service Leaders and Service Providers)**

To understand and integrate community service leaders' and service providers' perspective on the availability, accessibility, and navigation of late-life mental health and SUA services in Manitoba, a separate qualitative analysis of the transcripts from the combined community service leader and service provider focus groups was used to develop an additional thematic framework with four main themes: (1) “Get the word out of what’s where”: Enhance

knowledge and collaboration; (2) Bridge “really huge gap” in SUA literacy and services; (3) Targets for research and service development from an interprofessional lens; (4) Features of service delivery that influence access to services. Figure 4 depicts a final Group B thematic framework that illustrates the relationships between each of the four themes, and between the main and subthemes generated. The four themes are related in that they reflect different aspects of the group’s perception of how we can better address mental health and SUA problems in later life through enhancing services. In this framework, the first three themes illuminate several important service areas to enhance or develop, while the fourth and final theme highlights factors that influence the accessibility of existing services. In this analysis, “*Get the word out of what’s where*”: *Enhance knowledge and collaboration* is an overarching theme that extends across each main theme and subtheme, as it reflects the group’s primary focus on how service providers and service delivery organizations (i.e., ‘the system’) can better support the mental health and SUA needs of adults 65+ through enhancing their own practices. Two synergistic descriptions of ways to achieve this aim were conceptualized as two separate subthemes (improve proactive collaboration and referral pathways; and “help people access resources and navigate”). The second theme, *Bridge “really huge” gap in SUA literacy and services*, relates to the first as it highlights the group’s perception about service areas to enhance to better meet the needs of adults 65+ but here distinctly centers on addressing SUA needs, with one subtheme constructed (substances and coping). *Targets for research and service development from an interprofessional lens* was the third theme generated, which relates to and builds on both previous themes in that it highlights research and service areas that the individuals working within the mental health and SUA system in Manitoba perceive as currently missing. Concurrent discussion of specific types of missing research evidence and services were constructed into three separate subthemes (late-

life hoarding problems; support for life transitions; and integrated community services). The fourth theme, *Features of service delivery that influence access to services*, collated discussion on factors that limit the accessibility of mental health and SUA services into four independently informative factors (resources and coordination; range of services offered; promotion of available services; and COVID-19 impacts). Each main and subtheme is described in further detail in the sections that follow.

***Theme 1: “Get the word out of what's where”: Enhance knowledge and collaboration***

A main theme that emerged from service leaders’ and providers’ discussion about the availability, accessibility and navigation of late-life mental health and SUA services in Manitoba centered on enhancing their own (and their organizations’) knowledge of available services and the pathways to get into those services, as well supporting this knowledge among their adult 65+ clients and families. The receptive environment within which this theme was discussed was characterized by expressions of recognition and affirmation, such as when one service provider summarized what became a prominent consensus point: “But it's just getting the word out of what's where” (GB2). In discussing this theme, service leaders and providers spoke of their own experiences but also drew from their experiences observing and guiding their adult 65+ clients. Two subthemes were generated from this main theme, including (1) Improve proactive collaboration and referral pathways, and (2) “Help people access resources and navigate”.

**Improve proactive collaboration and referral pathways.** When deliberating on how they can better address the mental health and SUA needs of adults 65+, service leaders and providers held lengthy discussions about the importance of forming collaborative connections with each other and clarifying the right referral pathways into services, concepts that they tended to circle back to even while discussing other themes. Converging viewpoints were voiced by

several group members, illustrated by the comments of one service provider, “Just, I think in geriatrics especially, there's you know – it's such a –there's such a need for multi-disciplinary kind of collaborative work to meet all these various holistic needs” (GB5). The group placed emphasis on building connections and making more proactive efforts to understand what each organization does and offers to adults 65+ within the broad mental health and SUA system. The group's perspective on current collaboration and referral processes between organizations and providers who serve adults 65+ was mixed. On the one hand, some service providers described approaches that they considered effective and that could be built upon or adopted more broadly:

And so, we always connect with the referral source and try and get their as much information as we can and then collaborate with them after we've done our assessment and sort of looking at how we can best meet those needs and what possibly other referrals that need to be made or what can the [sic], what pieces can the referral source, you know, help with and that kind of thing. So, it is fairly collaborative in that way. (GB3)

Leaders of community organizations also spoke of their perceptions of the practices that their organizations have introduced that seem to be working well and could be broadly adopted too:

So, one of the things that we've put into place, we have our intake worker who is taking calls from all of those people who are doing referrals and making sure, as much as possible, when we get to talk to them that those referrals are appropriate...you can't get what is an adequate or good referral without having that discussion. (GB6)

On the other hand, some members of the group also acknowledged that there are areas to clarify and improve upon, especially highlighting the need to proactively enhance knowledge between organizations about the respective services that they each provide and the pathways into those services. The voice of one community service leader illustrates some of this dialogue:

People still don't understand what [our organization] does, and it's a constant sort of, you know, fight to get people to understand, what is a good referral for us and what we're going to be successful with, because otherwise we're setting up people to fail. (GB6)

When it comes to collaboration within the system more broadly, a service provider described how altering what was affirmed by the group as a typical approach could make things better:

I will say that my efforts to collaborate are generally pretty reactive. I have a patient sitting in my office or that I'm working with who has particular needs. And then I start searching for who can I collaborate with or what organization makes sense to kind of connect this patient up with... as I'm thinking now, it would probably make more sense to form some of those collaborations in more of a proactive kind of way, or at least to have some familiarity. To be able to call and say, well, what are the things that [sic] what are the appropriate referrals? Who might I be able to send to you? (GA5)

The group also agreed that they have very few opportunities to discuss and collaborate in general on the topic of late-life mental health and SUA services, and this focus group series was seen by them as an opportunity to not only voice their experience and perspective, but to also learn from each other and build connections with others in the field, including researchers.

**“Help people access resources and navigate”.** Beyond discussing their ideas and opinions on ways to promote collaboration and improve referral pathways, service leaders and providers were unanimous in their perspective that current service navigation models and approaches, which are largely characterized by the individual efforts of individual practitioners, are not enough and that more is needed to more uniformly, “help people access resources and navigate” (GA5) services for late-life mental health and SUA problems in Manitoba. Outside of their own practice areas or organizational mandates, the group agreed that their own knowledge

about available late-life mental health and SUA services in Manitoba is limited, including how to find and get their clients into these services. Although they did not attribute this limitation to a single factor per se, they pointed to the little opportunity they have to proactively connect with other organizations as one reason, although it is likely that more nuanced factors also contribute, such as lack of time/scope to devote to indirect or non-clinical activities, which I myself, as a researcher who also holds clinical roles, have both observed and experienced. The group shared the perception that their own limitations in knowing how to navigate services, that exist and are available, can impact negatively upon their adult 65+ clients' access to services:

I think one of the issues that's hard is, again, just a lack of awareness of what sorts of resources are out there, both by older adults themselves, but also in a lot of ways by professionals who might be in a position to refer but aren't aware that this kind of service is even available. (GB5)

The group expressed a desire for the development of Manitoba-specific service navigation tools (including resources, information, and service mapping) that would enable them to be more proactive in knowing about, finding, and helping their clients to access services that exist outside of their own organization or practice areas, empathizing with each other's current uncertainties about how to do so now. The group also desired opportunities to bridge knowledge between their various entities and organizations (and others that deliver late-life mental health and SUA services in Manitoba) to strengthen service navigation. This included the suggestion to map out the late-life mental health and SUA services that currently exist in the province and how they can be accessed or referred to, as illuminated in the dialogue between group members:

It might be nice if there was – [pauses], if people would be able to collaborate on like a province-wide resource manual so that no matter who's been in that position for 20 years

or two months, they can just kind of pull it out and go, ‘Hey, this is kind of the things, this is what these people do’. Whether they’re our partners, whether they’re involved with a [health authority], or they’re other non-profits, and just have that resource available for everyone. (GB2)

Overlapping voices are immediately heard trying to simultaneously respond to this statement with agreement (e.g., “absolutely”), and offer further comments to reinforce the idea:

Does anybody remember the seniors guide that the Province of Manitoba used to publish? [audible affirmative responses of “yeah”]. We need that back desperately. (GB4)

### ***Theme 2: Bridge “really huge gap” in SUA literacy and services***

When describing their view of important areas to address through research and service development, service leaders and providers, more than all other areas, voiced their perception of the “really huge gap for older adults” (GB3) concerning services for SUA problems. One service provider highlighted the group consensus about how there are major differences in the availability of services and supports for SUA challenges in later life, relative to other mental health challenges, stating, “I find in our work that the whole area of addictions is very lacking in terms of services that are more sensitive to the needs of older adults” (GB3). Service leaders’ and providers’ discussion on this main theme centered on their perception of the experiences of adults 65+ living with SUA problems in later life, rather than their own personal experiences with SUA, and their perceptions were formed from their lived experience of working with this population. One subtheme was constructed out of this main theme as: (1) Substances and coping.

The view of SUA as a significant problem in later life, that is prone to being overlooked, was shared by all participants, as illustrated by the voice of one service provider whose comment was affirmed by others in the group: “I don’t know what the answer is, but I think it’s something

we need to be talking about because I think a lot of people have their head in the sand that old people don't do drugs" (GB2). The group agreed that more is needed to support the SUA literacy of adults 65+ living in Manitoba – that is, to help them recognize and manage SUA problems and find and access the right services, support, and information resources. A major point of discussion on this main theme centered on how providers and organizations within Manitoba's mental health and SUA system need to enhance their effectiveness in helping adults 65+ learn that there are other resources available for individuals with SUA problems, beyond the intensive programming that the group perceived people erroneously believe is the only service/treatment option for SUA in the province (e.g., services through the Addictions Foundation of Manitoba). Stigma and lack of perceived need for such intensive services were mentioned as potential factors contributing to reluctance to pursue these SUA services. The group of leaders and providers suggested enhancing broad understanding of alternative services for SUA problems that are available in the community, which they perceive adults 65+ currently know little about:

And I think, I don't know if it's the addictions system in Manitoba, but people think they need to go to [name of residential addiction treatment facility] or [name of another residential addiction treatment facility] or some of these things to understand, to get treatment. And it's really about just that understanding. So, I don't know if there's a way we can help people learn that there are other options. (GB6)

**“Substances and coping”.** Dialogue between group members focused on the link between substance use and coping, with the latter perceived as an underlying reason for the former. Although the group acknowledged that some adults 65+ may have longstanding problems with SUA, their discussion illuminated how older adults may be vulnerable to misusing substances – sometimes for the very first time ever – to aid management of distress associated

with a variety of physical and emotional issues that they have not previously encountered. In this way, the group drew a link between use of substances and coping with age-related changes, losses, and adjustments, as reflected in the dialogue that ensued among some group members.

One service provider explained:

I think for me, what I see a lot of is people that lose their partners. And so, they're going through a grieving. They may also be having cognition challenges that are adding to that. So, either they don't know where to go to get the services or sometimes, yes, they're self-medicating with alcohol and that kind of thing. (GB2)

Another service leader reinforced this perceived link between late-life SUA and coping, stating:

But yeah, I mean, they come to us with that [SUA], but it's always something underlying. Like I think it was, I don't know who [reference to other participants' comments] ...but she said about people who are grieving and self-medicating, I think that's the number one is we see folks who have lost their partners and have been coping and just got a little too heavy into one particular coping method. (GA6).

Voicing their observations of this substance use and coping link, another service provider stated, the use of cannabis is also sort of something that's a little bit new on our spectrum. I find that some folks are using that to help them sleep or to help cope with anxiety and that, you know, they sometimes run into issues with that as well. (GB3).

The group agreed that better psychoeducational support is needed in Manitoba to enhance adults' 65+ knowledge of how to recognize problematic substance use and notice any link between their SUA and coping. Convergent viewpoints emerged on emphasizing skills building in later life, to help adults 65+ identify alternative coping strategies – drawing from strategies that have been effective for their coping in the past – and learn how to apply those more adaptive

coping strategies to new situations, instead of resorting to or falling back on substance use:

And so just some more education on, you know, if you're suffering with depression, that these [substances] aren't the best. You know, they might have helped for a moment, for a bit. But just how many other coping skills are more effective at moving forward and having a healthier lifestyle, if that makes sense. (GB6)

Another service provider shared a convergent viewpoint, stating:

And if it can't be, how do we give support to people, whether it's formal or informal, ideas on how other people maybe have coped with the different changes as they get older? Yeah, just kind of more, I guess, what is available for them and kind of just leaning on what they did in the past that maybe could still work for them. (GB2)

### ***Theme 3: Targets for research and service development from an interprofessional lens***

Beyond their focus on what is missing related to SUA services, the group highlighted some other critical late-life mental health and SUA service gaps in Manitoba, that although needed, are typically not offered by their respective service delivery organization. This main theme illuminates the insights offered by the interprofessional group on actions to target in research and service development (or enhancement and/or expansion of current services) to better serve adults 65+ and address their unmet mental health and SUA service needs. Although this theme evolved to become quite descriptive and discrete/specific in nature, I still considered it important to construct as the group's collective experience of delivering services targeted to people in later life has provided them with a valuable vantage point to ascertain opportunities for improving service offerings within Manitoba's mental health and SUA system. The three subthemes constructed reflect three discrete gaps/targets identified by the group: (1) Late-life hoarding problems, (2) Support for life transitions, and (3) Integrated community services.

**Late-life hoarding problems.** The group highlighted hoarding problems in later life as an understudied and underserved mental health and SUA issue faced by many adults 65+. Service leaders and providers voiced that very few organizations in Manitoba offer assistance for hoarding problems in later life, such as excessive acquisition and inability to discard items, or for associated difficulties such as loss of their home, income, job, and even loved ones. In Manitoba, services that are designed to holistically address the mental health needs that often underlie hoarding behaviours (rather than only addressing the immediate safety risks associated with hoarding) are rare – perhaps only one specialized program exists. The group described a dearth of services, supports, and policies for addressing late-life hoarding problems in the province and emphasized a need for service development, especially in rural areas. Learning more about and investigating late-life hoarding problems through research was further identified by the group as a particularly important action, as described by one community service leader:

There are very few places in Canada, never mind Winnipeg [Manitoba], that address late-life hoarding disorder and the implications of it as a mental health condition... and it has huge implications to housing, isolation, loneliness, health, physical health, not to mention more co-morbidities with mental health conditions like depression and anxiety, and grief and bereavement and loss. And I think a little bit more research there might be able to help older adults navigate this condition (GB4)

In addition to enhancing broad understanding, the group specified using research to better understand the situations and factors that precipitate hoarding in later life as well as the situations or factors that contribute to or maintain the problem (e.g., loneliness, anxiety).

**Support for life transitions.** Service leaders and providers perceived a need to increase knowledge about and support for the varied experiences and impacts of stage-of-life transitions

that are associated with aging, including grief and loss. The group agreed that although these are common experiences, there is a current dearth of services in Manitoba designed to consider and address the emotional impacts of stage-of-life transitions, as voiced by one service leader:

Not only was I talking about the grief and loss of a loved one, but the grief and loss of what comes with aging...I think there needs to be more understanding of the different experiences around loss and grief...we often when we hear grief, go to the loss of a loved one, but we grieve so many things in our lives that impact our mental health. And I think as we get older, we grieve even more so. (GB1)

Preventive education on topics of aging, loss and mental wellness was highlighted as a critical support area by all community service leaders, who perceived a need to improve adults' 65+ understanding of "what does positive mental health look like as we age and how do we maintain it" (GB1). Service providers voiced agreement and built upon this perspective further:

it would be wonderful to be able to have people go out and give seniors the education on how to cope with grief, how to cope with loss, how to cope with changes physically and mentally, with whether that's within themselves or their partners. (GB2)

A community service leader suggested development of transitional services to prepare people for the adjustments that occur later-life, while other group members nodded affirmatively and offered validating gestures and empathic support:

Well, we're going in schools and things and trying to teach about mental health in that before. And that's preventative. But we're not doing anything for like, [*visibly gesturing*], aging out is a huge transition [*audible "yesses" can be heard agreeing*] and nobody's preparing us for what occurs when we lose a partner, when we lose our, you know, the ability to, not the ability to work, but we retire out of a job that we may have been in for a

long time. It takes your purpose away. It takes your meaning from it, and then there's no one there who tells you how to retire successfully or how to plan. You know, when they talk about planning for retirement, it's all cash based, right? There's nothing about your mental health and the way your life is going to change drastically. (GB6)

The group supported the development of psychoeducational materials and programs to deliver to people in mid- to later life as a starting point to preventively address these issues.

**Integrated community services.** As discussion evolved about what is currently missing, the group identified a general need to enhance integration and collaboration within services, specifically for those located in the community. The idea of building more wrap-around services for adults 65+ living in community formed the foundation of the group's discussion about collaborative and integrated services. Embedded throughout the discourse between service leaders and providers was a shared acknowledgement that although adults 65+ commonly experience multiple often overlapping service needs in later life, their organizations and programs are designed to respond to only a portion of such needs, which may negatively impact care continuity and contribute to unmet needs (e.g., without “enough support in place... they're very likely going to have a relapse of the issue and end up back in the unit” – GB5). Participants discussed the benefits of having “more of those hubs where it's a one access place” (GB2) and “like the model of the Access Centre” (GB5) at the community level, to address the unique and often complex needs of older patients together in one place. Reducing limitations of existing service hubs – namely, the granting of access only to people who live within certain catchment areas – was also highlighted as a possible opportunity to enhance/improve access to these services. Dialogue between group members, which has been pared down for readability, also illustrates the importance participants placed on enhancing supports in the community for adults

65+ that embed links to mental health and other supportive services within them:

Service leader (GB6): Housing situations where people have... that chance to make connections and staff there who are supporting making those connections would be something that I think would work.

Service leader (GB4): Yeah, I agree. But where I see the, really there's a lack of affordable housing options that have those kind of supports.

Service provider (GB2): And maybe if we had those places, those facilities that had affordable, safe housing, then the services could go to them instead of them trying to navigate to the services.

Service leader (GB4): That was going to be my point! [laughter ensues]

Service provider (GB2): Oh, sorry! [laughs]

Service leader (GB4): But you touched on it. It's in-home supports. We have a lot of older adults that come to us for case management or assistance in their home or assistance with accessibility to food or transportation. And it's not what we do here, but there's a gap.

#### ***Theme 4: Features of service delivery that influence access to services***

Moving beyond discrete service and research needs, the group discussed the accessibility of their respective services and their perception of the features/factors that prevent their programs and organizations from delivering adequate quantities and types of services to match current demand. The group acknowledged that, collectively, the features identified can influence the accessibility of their services, usually by driving up wait times, which impedes timely access and, in some situations, puts the health and safety of those adults 65+ in need of services at-risk. The discussion of features/factors was based on their own experiences of working with adult 65+ clients. Implicit in their discussion was the notion that addressing the identified factors may

improve the accessibility of services in Manitoba and help to better protect the wellbeing of adults 65+. This theme was broken down into four subthemes: (1) Resources and coordination, (2) Range of services offered, (3) Promotion of available services, and (4) COVID-19 impacts.

**Resources and coordination.** All service leaders and providers acknowledged that an insufficient service delivery workforce within their organizations and programs limits their ability to deliver enough mental health and SUA services to match current demand by the adult 65+ population in Manitoba. Discussion highlighted a limited number of practitioners within existing services or programs who are trained to work specifically with older adults despite most programs being regional or even provincial in scope, and few specialists to provide targeted services for the complex mental health and SUA difficulties that can occur in later life: “we don't have specific people for specific things like for alcohol use, for hoarding, for grief. It all falls on the [generic] Seniors mental health program and they do a whole gamut of different things” (GB2). The group agreed that a lack of practitioners is apparent in both rural and urban parts of the province but perhaps more profoundly in rural. Service leaders and providers also noted that a lack of coordination amongst the resources that do exist – that is, amongst multi-disciplinary professionals within a program or organization – influences the ability of adults 65+ to gain timely access to their services. The group spoke of how poor coordination in an organization reduces access, as scattered service delivery can prevent timely information sharing among multidisciplinary partners, delay treatment planning, prolong time spent waiting, and ultimately interrupt continuity of care, as illustrated by one service provider:

And when sometimes they do get into acute settings, like I'm only there three days a week because I'm in other places other days of the week, and physio is not there.

Occupational therapy is another day, somebody else. Just to even do those assessments

and be able to come together as a team and discuss that, it's all scattered. And so, it prolongs that time period again (GB2).

Other group members affirmed this comment and elaborated on how a lack of coordination occurs not only within organizations but also *between* organizations, which can further impact time spent waiting and reduce care continuity. Relative to mental health services where there is better perceived coordination and collaboration, SUA service delivery was perceived to be especially scattered and lacking in coordination. One service provider stated as other group members nodded affirmatively:

So, that's where I find that with addictions, that there's a lack of that kind of coordination.

Yeah. I think I mentioned that previously, that I see that as a really huge gap for older adults, is there doesn't really seem to be a lot of connections between sort of the work that I do in the community and accessing services for people who are, who need some ongoing assistance with addiction issues. Yeah. (GB3).

Although the group did not extrapolate on possible reasons for this difference, they pointed out how their organizations largely focus on addressing mental health problems to the exclusion of SUA, which points to a possible historically driven oversight of SUA-related needs.

**Range of services offered.** In addition to speaking about their perception of resource and coordination limitations, service leaders and providers voiced their perception that limits on the range of services offered by their respective organization or program can also influence access to their services, identifying three levels of challenge. A narrow range of presenting problems eligible for services was the first challenge highlighted: “Where we maybe aren't as accessible has to do with, kind of, some of the limits to the types of issues that we might see” (GB5). The group acknowledged that this factor especially impacts older adults who present with SUA

problems, as their largely mental health-focused organizations and programs are not typically designed nor equipped to adequately address SUA difficulties.

The second perceived challenge was that of limits on the type and level of services offered, which can reduce adults' 65+ access to services in cases where their service need does not match what is available and when they have already used the service. A service provider explained the experience of observing this challenge and its consequences, stating:

recently I've had at least two or three clients say that they have accessed crisis services and been told that if they phone more than once that they are not, that they're like, it's kind of like, well, we've dealt with your issue already. Don't call back. I was like, really? Like, that really stunned me because, I mean, that's where we're telling people this is kind of like, you know, a backup kind of resource that you can use if you're in a crisis, you should be able to call. (GB3)

Finally, the third challenge discussed by the group involved constrained time limits on services, usually because of short term service delivery mandates within the public healthcare system that prevent "actually getting to the root of the issue" (GB3). The group perceived that time limits especially hinder access to adequate continued care for adults 65+ with complex, longstanding, or dynamic mental health and SUA service needs, who may be most vulnerable.

**Promotion of available services.** In further discussing factors that prevent organizations and programs from delivering services to match existing demand, some of the group members described a constant balancing act between active promotion of services and control of demand:

It's one of those things where we have to tread gently, because if we promote it too much, then we get flooded with referrals that we really can't manage. But at the same time, if we're not sort of promoting what we do in a bigger way, then it risks people just not being

aware that the resource is there. (GB5)

Recognition and empathy between participants were observed, such as: “We encounter very similar circumstances where we want to be as visible in the community as possible on the one hand, and then on the other, having to meet the needs of those older adults that find our resources” (GB4). Group members acknowledged that this push to limit demand naturally arises because of too few people with too little time trying to effectively deliver services, which plays a role in how accessible services are at any given time. Limited promotion was portrayed as facilitating access solely for those with prior awareness of what is available and restricting access for those without prior awareness, which (though not explicitly discussed) raises equity concerns.

**COVID-19 impacts.** The group shared the perspective that the COVID-19 pandemic substantially impacted service delivery within their respective organizations, which has and continues to influence the accessibility of services. Unprecedented volumes of new people seeking services for the first time, especially within community organization, was expressed as especially difficult to keep up and further underscores the limited resources within these organizations. One service leader expanded this viewpoint by pointing out how increased volumes of people seeking support drove up waitlists and wait times, which has had lasting consequences for organizations. A rapid rise in the number of adults 65+ presenting to their organizations specifically with “depression” (GB6), “anxiety-like issues” (GB3) and “social isolation” (GB3) was highlighted by the group. Particularly, as the consequences of social isolation among adults 65+ was growing, services within their organizations that had been addressing social isolation among this population simultaneously shrunk because of public health restrictions, presenting organizations and programs with a whole new service delivery challenge.

Unprecedented adoption of technology solutions within service delivery models was

highlighted as the second major COVID-19 impact. The group shared mixed perspectives about the shift to virtual service delivery, which highlights that one-size does not necessarily ‘fit all’; for some people, in-person connection may still be optimal. Drawbacks (e.g., concerns about “trust” and privacy – GB2, reduced openness/rapport) and, sometimes contradictory, benefits (e.g., “improved access in such a great way for patients” – GB5, “free/uninhibited” information sharing – GB4) of virtual service delivery were highlighted, as were some safety concerns:

So, we found that sometimes people were declining a lot in their home environment. And nobody really caught on to that ... we just found that more things were missed and also that things that might have been, like anxiety issues, that might have been addressed earlier, were sort of left, and the social isolation, it's compounded, and the issues became more challenging than they may have been if they'd had earlier intervention. (GB3)

Concluding with this final theme, I now turn to the results of the patient engagement exercise.

### **Patient Engagement Results (Service Priorities)**

The structured NGT (variation of a focus group discussion) was used to address the research objective to identify late-life mental health and SUA service priorities, as it was the most appropriate method to determine group consensus about the relative importance of generated ideas. Two lists of items were developed, one from each participant group, and these provided the results of the NGT focus groups. Table 4 (Group A) and Table 5 (Group B) contain the respective lists of ranked service priorities for each group. I did not refine these lists after the NGT focus groups concluded apart from clarifying language to differentiate preventive services (e.g., educational supports, information resources) from direct care/interventional services. Associated verbatim quotations from participants, providing a richer description of each group’s serial discussion on these priorities, are contained in Table 6 and 7.

During the NGT, each group was fully engaged with the process and numerous items (47 separate items) emerged. In Group A, 21 items were developed by the four participants who joined the second focus group. Two items were repeated twice each (on the topics of prescription drug use/interactions and reducing sole reliance on medication treatments for mental health problems in later life). In Group B, 26 items were generated by the six participants who joined the second focus group. Only one item was repeated (advocacy and protection services). The virtual NGT thus appeared to be a productive method to generate the data for defining and setting service priorities with adults 65+, community service leaders, and service providers alike.

Following my sequential research design, the Group A list was subsequently built into the Adults 65+ Online Survey on Health, Wellness and Services, for the purpose of validating the list with a larger sample of adults 65+ living in community in Manitoba. Table 8 contains the final list of ranked service priorities obtained from adult 65+ survey respondents. Frequency of endorsements are presented in Table 9. Integration of results demonstrates a high degree of consistency with the ordering assigned during the NGT focus group. The rank order of the three items tied for fifth place after the NGT focus group was successfully resolved through this validation exercise. Nearly one in every two adults 65+ ( $n = 66$ , 48%) rated the protection and advocacy services *or* the combined patient and caregiver service as most important. A majority of adults 65+ (73%) rated the first priority (protection and advocacy services), second priority (combined patient and caregiver service), third priority (healthcare providers and caregiver collaboration service), or fourth priority ('Where to go' educational service) as most important. Just over one in every five adults 65+ (22%) responded that a different service priority was more important than the options provided in the survey. Alternative priorities offered through open-ended text included services for adults 65+ who have family members with addictions to help

them understand, cope and deal with [sic] the situations; follow-up services after addictions treatment; services for mood/depression in cardiac patients; better resources for rural and northern; emotional supports for caregivers; and services to integrate caregivers and extended family into the care plan for people over 65 with substance use and mental health disorders [sic].

I next briefly present an integration of these mixed-methods findings (Focus Group and NGT findings), which will be elaborated upon more fully in terms of implications in Chapter IV.

### **Integration of Thematic and NGT Findings**

Integrating the perspectives of adults 65+ and those who deliver services to adults 65+ divides their unmet mental health and SUA service needs into two broad categories, which in turn reflect two key opportunities for enhancement: making non-existent or limited services more available and existing services more appropriate; and making it easier to navigate to the right resources. Differences in how these categories of unmet needs were experienced, and accordingly emphasized in discussions and priority-setting exercises, connect to participants' respective roles in use and delivery of services. The perspectives of adult 65+ participants grew out of their experiences of frequently unsuccessful attempts to find and access services for self or others, which resulted in an emphasis on identifying discrete service gaps. Although service leaders and providers also identified specific service gaps, this group touched more deeply on many service/system design factors that they have observed through delivering services over decades. Priorities that fell under the first broad category included: more protection and advocacy for vulnerable older adults living with mental health and SUA problems; more support for and involvement of older caregivers/families; and meaningful social connection to address loneliness and isolation in later life. Priorities that fell under the second broad category included: improving awareness and navigation of services; enhancing coordinated, collaborative and

integrated services; and bolstering SUA literacy. I discuss these broad categories and their implications further in Chapter IV. I now turn to the remaining results of the quantitative component, which I used to investigate my secondary research objectives: to describe adults' 65+ SUA literacy; evaluate differences between their SUA literacy and mental health literacy; and examine the sociodemographic and psychosocial predictors of their SUA literacy.

### **SUA Literacy Results**

Using data from the Adults 65+ Online Survey on Health, Wellness and Services, I conducted a paired samples *t*-test to examine differences between adults' 65+ SUA literacy and their general mental health literacy. Analysis of composite scores showed that adults' 65+ SUA literacy ( $M = 12.59$ ,  $SD = 3.87$ , *low to moderate*) was significantly lower than their mental health literacy ( $M = 13.40$ ,  $SD = 3.61$ , *moderate to high*), with a small effect,  $t(137) = -3.30$ ,  $p = .001$ ,  $d = 0.28$ . Wilcoxon matched-pairs signed-ranks tests for individual items in the scale indicated that adults 65+ were significantly less knowledgeable about the signs and symptoms of SUA problems ( $Mdn = 3$ ,  $M = 3.25$ ,  $SD = 1.07$ ) relative to mental health problems ( $Mdn = 3$ ,  $M = 3.48$ ,  $SD = .941$ ),  $Z = -2.88$ ,  $p = .004$ ,  $r = 0.17$ . Adults 65+ were also less knowledgeable about the types of professional help available for SUA problems ( $Mdn = 3$ ,  $M = 3.04$ ,  $SD = 1.06$ ) than for mental health problems ( $Mdn = 3$ ,  $M = 3.27$ ,  $SD = 1.02$ ),  $Z = -3.12$ ,  $p = .002$ ,  $r = 0.19$ . Adults' 65+ knowledge of how to go about seeking professional help for SUA problems ( $Mdn = 3$ ,  $M = 3.05$ ,  $SD = 1.15$ ) was poorer than for mental health problems ( $Mdn = 3.5$ ,  $M = 3.36$ ,  $SD = 1.05$ ),  $Z = -4.01$ ,  $p < .001$ ,  $r = 0.24$ . Only on an item measuring adults' 65+ knowledge about the causes of SUA problems ( $Mdn = 3$ ,  $M = 3.26$ ,  $SD = .999$ ) compared to the causes of mental health problems ( $Mdn = 3$ ,  $M = 3.30$ ,  $SD = 1.01$ ) was there no statistically significant difference found,  $Z = -0.49$ ,  $p = .623$ ,  $r = 0.03$ . Finally, analysis of an original standalone item, which was not

included in the composite score calculations, revealed that adults 65+ were significantly less knowledgeable about how to navigate SUA services in Manitoba ( $Mdn = 2$ ,  $M = 2.48$ ,  $SD = 1.09$ ) compared to navigating mental health services in Manitoba ( $Mdn = 3$ ,  $M = 2.64$ ,  $SD = 1.06$ ),  $Z = -3.18$ ,  $p = .001$ ,  $r = 0.19$ . These results are collectively summarized in Table 10.

### ***Predictors of SUA literacy***

I used hierarchical linear regression analysis to examine sociodemographic and psychosocial characteristics associated with adults' 65+ SUA literacy, using composite SUA literacy scores as the outcome variable. Collectively, sociodemographic (age, sex/gender, education) and psychosocial variables (SUA lived experience, mental and physical health status, social support/isolation, psychological distress/perceived quality of life, current substance use) accounted for 28% of the variance in adults' 65+ SUA literacy, with a large effect,  $F(10,127) = 4.96$ ,  $p < 0.001$ ,  $R^2 = 0.28$ ,  $f^2 = 0.40$ . Sociodemographic variables added in step one of the model accounted for 6% of the variance,  $F(3,134) = 2.72$ ,  $p < 0.05$ . Age emerged as a unique significant predictor, with older individuals exhibiting poorer SUA literacy. After controlling for sociodemographic variables, psychosocial variables added in step two of the model accounted for an additional 22% of the variance,  $F(7,127) = 5.64$ ,  $p < 0.001$ . Only SUA lived experience emerged from step two as a significant psychosocial predictor of SUA literacy, whereby limited lived experience of a SUA problem and/or of attempting to access SUA resources (services, programs, or information) led to poorer levels of SUA literacy. These results are summarized in Table 11.

In the next and final chapter of this dissertation, I integrate my mixed-methods findings, and I discuss how these findings contribute to the extant literature. I also highlight the implications of my findings for research, clinical practice/training, and health services/policy, describe the strengths and limitations of my study, and propose future directions.

## Chapter IV

### Discussion

Using an exploratory sequential mixed-methods approach, I explored: (1) What are the mental health and SUA service needs and priorities of adults 65+ and those who deliver services to adults 65+? (2) How accessible, available and navigable are services, and what are the barriers and opportunities for enhancement? and (3) What is the level of SUA literacy among adults 65+? Two diverse groups of participants ( $n = 12$  in total) from Manitoba, Canada, first joined a two-part focus group series. Using RTA, the four main themes constructed from the Group A series (adults 65+) were: (1) “What you need just isn’t there”, (2) “Where do I go?": Knowing about and finding services, (3) “Roadblocks” along pathways to services, and (4) COVID-19 “forced” new ways of connecting with people and services. The four main themes generated from the Group B series (service leaders and providers) were: (1) “Get the word out of what’s where”: Enhance knowledge and collaboration, (2) Bridge “really huge gap” in SUA literacy and services, (3) Targets for research and service development from an interprofessional lens, and (4) Features of service delivery that influence access to services. I used the NGT patient engagement strategy to support the research objective to define and set service priorities with each group. Emergent findings were subsequently built into the Adults 65+ Online Survey on Health, Wellness and Services, for validation of service priorities with a larger, convenience sample of adults 65+ ( $n = 138$ ). The survey was also used to describe their self-reported SUA literacy (*low to moderate*), evaluate differences between their SUA and mental health literacy (significantly lower SUA literacy), and examine predictors of SUA literacy (older age, limited SUA lived experience). Findings, as well as highlights of the demographic and psychosocial characteristics of adults 65+ in Manitoba, are integrated and discussed in the following sections.

### **Contextualizing the Samples**

This mixed-methods study involved six adults 65+ with lived experience of a mental health problem for which they had tried to find help/services (of note, two of these participants had also tried to find help/services for SUA problems); six inter-professional representatives with lived experience of providing mental health and, to a much lesser extent (one participant), SUA services to adults 65+; and 138 adults 65+ from the general community. Findings on SUA service needs, priorities, access and navigation should be interpreted with this context in mind; they are incomplete because of the under-representation of SUA problems among the samples recruited and accordingly do not reflect the full spectrum of SUA experiences in later life.

Regarding demographic variables, the mean age and age ranges of both the qualitative and quantitative adult 65+ samples in the current study are similar (just slightly older) to other studies that have explored mental health help-seeking (Beatie et al., 2022; Berard et al., 2020; Reynolds et al, 2020; 2022) and SUA help-seeking (Aubut et al., 2020) among older adults in Canada. All adults 65+ were living in Manitoba, and most were retired and racially identified as White. Although males and females were equally represented in the adult 65+ focus group sample, most survey respondents were female. Among the general community sample (survey respondents), a diverse range was found for educational attainment and household income indicating a good variability of socioeconomic status. A majority of survey respondents were married/common law although many were also single or previously married. Study demographics (particularly in the quantitative component) best represent White, female, retired Manitobans aged 65+ who are living in the community and have a varied level of socioeconomic status. Findings (particularly quantitative) should be interpreted with this context in mind.

### **Mental Health and SUA Service Needs and Priorities**

There is little previous research exploring the mental health and SUA service needs of aging populations. In relation to research question/objective 1, the current research contributes to the literature by providing evidence of the needs and priorities of those who use and deliver mental health services in later life (and to a much lesser extent SUA services, given the limited representation of participants with SUA lived experience in this study). In relation to research question/objective 2, findings also make evident that existing services and pathways into them are not fully aligned with the voiced needs and priorities of adults 65+, which may partially explain their low use of mental health services. It is possible that existing SUA services also do not align with adults' 65+ needs/priorities; however, given the limited representation of individuals with SUA lived experience in the current samples, evidence generated is incomplete on this issue and must therefore be acted upon with caution. I briefly integrate findings on access next. I then discuss specific needs/priorities and potential actions informed by this research.

#### ***Access to Mental Health and SUA Services in Later Life***

Consistent with previous studies (Montgomery et al., 2018; Mosier et al., 2010; Prévile et al., 2009; Reynolds et al., 2015), findings reveal that a high proportion of adults 65+ living in the community may be experiencing challenges with mental health or SUA, including anxiety, depression, and problematic alcohol/drug use. However, given that the recruitment strategy in the quantitative component involved a convenience sampling approach, it is possible that older individuals with a past or present experience of these problems may have been more interested in the study and motivated to respond to the survey. Although nearly one in four adults 65+ in the general community sample reported symptoms of a mental health problem at the time of the survey, very few ( $n = 11$ , 8%) were using mental health services, leaving this population with a

high likelihood of unmet mental health care needs. Notably, only a tiny fraction was using SUA services ( $n = 2$ , 1.4%), despite nearly one in five reporting symptoms of an alcohol use problem and 5% reporting symptoms of problematic cannabis, medication, or illicit drug use at the time of the survey. These findings suggest that there is room to improve adults' 65+ access to services. Boosting mental health and SUA literacy may help them to better recognize the signs and symptoms of problems and find resources that may be available to appropriately match the severity of their difficulties. Adults 65+ with mild concerns may be able to manage their symptoms effectively with enhanced knowledge of indirect/informal services (e.g., self-help groups, information resources), whereas those with moderate to severe concerns may benefit more from increased awareness of options for professional led services. However, service/system level changes will evidently be required to ensure availability of needed services.

### **Advocacy and Protection Services for Vulnerable Older Adults**

Integration of findings points to a clear service priority, shared by all participants, on establishing a formal advocacy and protection service for vulnerable older adults. The need to formalize advocacy is supported by prior research indicating that individual patient and isolated government advocacy alone is not enough to create the large-scale healthcare system changes required to meet older Canadians' needs (Jabbar et al., 2019). In the current study, the importance of advocacy and protection services was directly highlighted by adults 65+ as the subtheme, "*It's a family that's involved*", and by converging as the only overlapping item that was similarly defined and set as a priority item by adults 65+, service leaders, and service providers alike. For adults 65+, the item "protection and advocacy services for adults living in care facilities who are experiencing severe mental health, substance use or addiction challenges", resulted in a final first place rank in the priority-setting and validation exercise. Close to half of

the adult 65+ survey respondents ( $n = 58$ , 42%) chose this item as their first or second priority. For service leaders and providers, the item “adult protection services for older adults with authority to implement safety measures (similar to child protective services) in instances of abuse or neglect”, emerged as a fifth-place rank during their priority-setting exercise (however, a validation exercise was not conducted with this population).

In Canada, four provinces (British Columbia, New Brunswick, Newfoundland, and until 2019, Alberta) have established independent advocate offices for older adults. Calls to establish such an entity in Manitoba have been visibly observed in the public sphere for years, which may have shaped participants’ perception on this issue/need in the current study. Funding has now been allocated to establishing a Manitoba Seniors Advocate (Manitoba Budget, 2024). Current findings suggest that this entity should set the mental health of older adults as an advocacy priority. Findings make evident that providing advocacy, protection, and support to older adults can be challenging due to organizational/service delivery system barriers, which in the current study included limited access to services and, for caregivers/families, to information and integration into clinical care teams. An opportunity exists to shape the Manitoba Seniors Advocate to have a key role in addressing these and other system dimension challenges in mental health service delivery and protection of persons. Extant research specifies possible advocacy frameworks that could be adopted here in Manitoba (e.g., Boyd et al., 2013; Jabbar et al., 2019).

### **Involvement of Caregivers and Families**

Home- and community-based care for individuals with complex mental health and SUA challenges is often provided by family caregivers. Findings suggest that the current demand for services to address the mental health of older caregivers/family members exceeds the available resources in Manitoba; the need is likely even greater considering the myriad of reasons that

older adults take on a caregiving role in later life. Adults 65+ clearly prioritized expanding service offerings for caregivers, which was highlighted by a final second *and* third place rank in the priority-setting and validation exercise. The item, “wholistic and simultaneous support and education to people experiencing mental health, substance use, addiction, and/or physical health challenges together with their caregivers” emerged as the second priority, whereas the item, “more cooperation and collaboration between healthcare providers and caregivers that allows for freer sharing of information about the person being cared for...” emerged as the third priority. Notably, over a third ( $n = 54$ , 39%) of adult 65+ survey respondents selected one of these two items as their first choice, and several of the alternative priorities offered by some respondents also centered on increasing support for caregivers and family members. Although the sample of service leaders and providers did not discuss caregiver and family support needs/services, both adult 65+ samples emphasized it so strongly that it emerges from this research as a clear priority. It is also possible that service leaders and providers did not discuss this topic because this topic has been highly spotlighted/advocated for in the public sphere in recent years, and they preferred to focus discussion on less ‘visible’ service needs that do not currently receive much advocacy.

Regarding the need for services to aid coping, previous research has described how caregiving often comes with numerous ‘hidden’ consequences, such as poor physical and mental health, social isolation, professional sacrifices, interruption of personal relationships, and economic loss (Kuluski et al., 2018; Ormel et al., 2017), for which caregivers have previously voiced having little support (Law et al., 2021). Notwithstanding that previous research has heard that many caregivers themselves find value and satisfaction in caring for another person (Greenwood et al., 2009), the voices of adults 65+ in the current study shine additional light on how common it is for their *own* mental health difficulties to surface in direct association to their

role as a support person. Given this significant personal burden that caregivers or family members may carry, we must better support them in their roles through policy and program/service development. We should focus especially on supporting older caregivers' awareness of and ability to recognize developing mental health and SUA problems in self or others, how to best respond to or support people experiencing these problems, and how both can assist older adults to build confidence in providing care to others while protecting their own mental health. Extant research shows that support in these areas can help alleviate caregiver burden, stress, anxiety, and other mental health impacts (Shepherd-Banigan et al., 2022).

Adults' 65+ expressed desire to be integrated to a greater extent within clinical care teams, care planning, and educational/interventional opportunities coincides with previous qualitative research that has heard caregivers describe wanting to be more meaningfully included within clinical care teams (Raj et al., 2021). However, prior research indicates that caregivers and family members are often *not* meaningfully included in interactions with clinical care teams. For older or vulnerable adults, inclusion of caregivers/families is an important element of patient-centered care (Shepherd-Banigan et al., 2021). In their construction of meaning pertaining to inclusion in the current study, adults 65+ especially desired to obtain more fulsome information about those in their care, so that they might be able to influence the type, direction, and outcomes of care provided. Inclusion was furthermore perceived as critical to help alleviate their own consequential mental health challenges arising from their roles as a support person. In Manitoba, inclusive care should thus be prioritized, whereby caregivers and/or family members are provided, as a standard of care, with an active invitation to participate in shared decision-making, treatment planning, and even education/intervention. There is also an opportunity to shift the focus of existing services to provide more simultaneous support to both patients/clients

and caregivers together. Some existing models in Manitoba (e.g., Early Cognitive Change Clinic for Older Adults, Memory Partner Program; WRHA 2024) could be more widely adopted.

### **Meaningful Social Connection to Address Isolation and Loneliness in Later Life**

During the priority-setting exercise, service leaders and providers selected the item, “services and support for combating loneliness and finding connections” (especially with others who are facing similar stage-of-life difficulties) as their first-choice priority. Although adults 65+ did not set a similar priority, in their discussion they did acknowledge the individual efforts they make to reduce the negative impacts of social isolation and loneliness. Divergent viewpoints between the two groups emerged. Whereas service leaders and providers framed the solution to the issue as requiring the development of targeted services/programs, adults 65+ spoke of it as a more multi-component issue, which included at least some reference to individual responsibility (e.g., “trying to get past the social isolation”). Notably, only two adults 65+ in the general community sample, who endorsed alternative priorities than those listed in the survey, suggested addressing social isolation – and no one loneliness – as a *service* priority per se. Although these findings are consistent with previous research that has heard the voices of older adults on how they consider loneliness a private matter to manage without external support (Kharicha et al., 2017), adults’ 65+ perspective may also reflect a need to address broader systemic/structural considerations that require far more than a single service or program as a solution.

The topic of social isolation and loneliness among older adults has become increasingly prominent in the literature, with the emergence of growing evidence of associated physical and mental health risks (Newall & Menec, 2019; Ong et al., 2016). The introduction of interventions to reduce social isolation and loneliness is relatively new but growing. Previous research on improving social connections for socially isolated or lonely older adults outlines various

interventions, with additional focus on the role of education, use of public health approaches, and establishment of jurisdictional standards and policy priorities (Donovan & Blazer, 2020).

However, emerging qualitative research shows that most older adults do not consider existing services for loneliness desirable, appropriate, or helpful, and instead prefer group-based activities involving shared interests (Kharicha et al., 2017). Notably, older adults' descriptions of primary care or community-based services as being for loneliness, and specific to older people, has been shown to discourage their engagement. Opportunities may accordingly be found in adopting a public health rather than clinical services approach to intervention and modifying existing programs to address isolation and loneliness in ways that do not preclude engagement or foster undesirability (for example, by introducing or modifying services to focus on building meaningful connections with likeminded people through shared activities). It is also notable that despite many detrimental impacts, the COVID-19 pandemic appears to have also impelled demonstrations of personal and collective resilience and growth among older adults in the current study sample, especially related to addressing social isolation and loneliness, which is consistent with findings from previous research (Fuller et al., 2022).

### **Opportunity to Improve Awareness and Navigation of Services**

Doing more to enhance service navigation was another priority shared by all participants. Its importance was directly highlighted in two separately constructed but interrelated themes (*"Where do I go": Knowing about and finding services*, which reflects adults' 65+ perspective, and *"Get the word out of what's where": Enhance knowledge and collaboration*, which reflects the perspective of service leaders/providers), and by a final fourth place rank in the priority-setting and validation exercise (i.e., education/support for adults 65+ in knowing where to go and how to find the mental health and SUA services they need or are looking for), which nearly one

in three ( $n = 40$ , 29%) survey respondents chose as their first or second priority. Knowledge of how to navigate services appeared equally *low* in the adult 65+ samples, with similar levels observed in the sample with lived experience of a mental health problem and the general community sample. Service leaders and providers appeared to have the most knowledge relative to all participants; however, they still voiced a desire for more clarity.

Similar individual dimension knowledge gaps were acknowledged by those who use and deliver services alike. Both groups wanted to raise their awareness of the mental health and SUA resources that are available in their communities, and to better understand the complexities of navigating into services, so that they can access the right care when it is needed and offer better support or guidance to others. This finding coincides with previous studies exploring service navigation in the context of aging in Canada for mental health (Beatie et al., 2022; Berard et al., 2020; Reynolds et al., 2020; Valaitis et al., 2020) and SUA (Aubut et al., 2020) problems, which collectively highlight barriers including limited availability of services, siloed care, inadequate coordination of services, and lack of clear roadmaps. Beyond mental health and SUA services, prior research used to support policy development indicates that these and other gatekeeping concerns contribute to difficult service navigation for older adults across a broad spectrum of health, social, and community services (Funk, 2019). In the current study, service leaders and providers perceived an association between their own knowledge and their patient/clients' access to services, which is supported by prior research showing that it is primarily clinicians (and secondarily peers with lived experience) who provide support to others in navigating services (McBrien et al. 2018; Parker & Lemak, 2011; Waid et al., 2021). This finding underscores the necessity of not only providing service navigation support to service users and their families, but to service providers and organizations too.

***Conceptualizing Service Navigation Findings with Theory ('Help-Seeking')***

The NEM (Pescosolido et al., 1998) appeared to be a fitting theory for understanding adults' 65+ pathways to mental health services (and to a much lesser extent, SUA services) as described in the qualitative component of the current study. In considering participants' perspectives on and experiences of help-seeking in relation to the NEM, there are many shared characteristics. The intra and interpersonal nature of the NEM aligns with the descriptions provided by focus group participants in that individual factors (e.g., lived experience of a mental health problem, caregiving role, professional role), social factors (e.g., interpersonal connection/guidance, information sharing, mental health or SUA problems of linked others), and the healthcare system (e.g., availability of services, delivery format, coordination/referral processes), all influenced experiences/perceptions of mental health (and less so SUA because of the make-up of focus group participants) help-seeking in later life (Pescosolido & Boyer, 2010).

Participants described the process of trying to learn about, find and navigate into services as being far from linear. The adult 65+ participants moved through systems such as direct/professional led services and indirect/informal sources of help as they tried to find the right fit. They also described instances of moving back to indirect/informal sources when help-seeking attempt did not immediately result in access to preferred direct/professional led services, or when direct/professional led services were simply non-existent. Adults 65+ also moved *between* different direct/professional services in attempt to match their needs to the right kind of help. Service leaders and providers further described how their older adult patients/clients may be 'set up to fail' by inappropriate referrals, which can further result in them moving to yet another potential service once a more appropriate option is sorted out. However, future research is needed to better understand help-seeking pertaining to movement between systems and

associated timelines (e.g., between direct/professional led services and indirect/informal sources of help or other sources altogether). Nuances of help-seeking will be especially important to investigate further among older individuals seeking SUA services, given the low representation of lived experience of SUA problems in current the study. Nevertheless, current findings do provide some ideas about possible facilitators and barriers along pathways to mental health services in later life, such as the importance of integrating interpersonal support/guidance into the help-seeking process, involvement of caregivers/families and sharing information with them, widespread promotion of services, and the need for timely services that align with actual support needs of older adults. These factors may inform future research, interventions, and clinical practice/policy changes aimed at improving access to and navigation of services in later life.

Pescosolido and colleagues (1998) have described three help-seeking pathways in accessing mental health services: choice, coercion, and muddling through. Choice pathways involve decision-making about help-seeking on an individual basis (individual choice) or with the support of others (supported choice). Coercion pathways involve the absence of agency, with decisions made by informal or formal supports. Muddling through involves passive/uncertain help-seeking that neither actively resists nor engages in the process. The findings of Beatie (2022) and Berard (2020) and have since suggested that, rather than occurring through three distinct pathways, older adults' engagement in help-seeking may be more accurately characterized as a co-occurring process through each of these three pathways, to varying degrees, which was also observed in the current study. Regarding choice, adults 65+ described individual choices and, especially, choices informed by the needs of others with whom they have linked lives (Elder et al., 2003), as they actively tried to find/navigate services. There may have been an unintentional coercion present when adults 65+ described 'getting into something else', such as

when they spoke of being sent to existing services that were less relevant to their support needs because of a lack of alternatives. However, the most typical pathway described was one of muddling through (being unsure of where and how to access the right supports or bouncing around the system as they ‘guessed’ their way through options). Navigating healthcare and community-based services was described as extremely challenging for adults 65+, who face uncertainty in the process and often land in a service purely by happenstance, if at all. Muddling through was also present in the inter-professionals’ descriptions of service navigation via referral processes, when service providers described being unaware or uncertain of where to make an appropriate referral on behalf of their older patients/clients and a general lack of proactive familiarity with referral options, and service leaders described ‘fighting’ to get others in the system to understand what makes an appropriate referral to their respective organization.

Service navigation programs are relatively new interventions, designed to promote timely access to services by identifying and resolving barriers to care. Navigation activities commonly involve engagement, needs assessment, identification of service options, referrals, monitoring, and follow-up (Waid et al., 2021). The perspectives of adults 65+ and service leaders/providers converged on the need to clarify available service options and the pathways into those services, which previous research in Canada has similarly highlighted (Aubut et al., 2020; Beatie et al., 2022; Berard et al., 2020; Reynolds et al., 2022; Valaitis et al., 2020). For service leaders and providers, tools included mapping appropriate referral options and pathways. Convergent perspectives were also formed on differentially targeting service navigation tools to specific audiences (for example, service users versus caregivers, families, and friends, versus service providers and organizations). Relative to other areas of healthcare with an instituted provincial program, such as cancer navigation services (CancerCare Manitoba, 2024), mental health and

SUA service navigation is still in its infancy as an established program in Manitoba, which points to an evident program development opportunity. To promote holistic, integrated care, it would be worthwhile to consider how mental health and SUA service navigation could be embedded within a broader health and social service navigation support system for older adults.

Beyond enhancing service navigation support for individuals, it will be important to bolster knowledge, awareness, and coordination/bridges between services on a system-level. Some disparate views on service navigation were also evident. In contrast to service leaders and providers, who offered a clinical practice/policy recommendation to develop and keep updated a province-wide late-life mental health and SUA service manual/map, adults 65+ highlighted an opportunity to embed interactive and person-centered models of service navigation into existing (or future) services. Adults 65+ also voiced a need to raise older *men's* recognition of mental health and SUA problems and engagement with services, whereas service leaders and providers did not differentiate between genders. Although findings from the quantitative analyses did not support sex/gender as a significant predictor of SUA literacy, previous studies examining older adults' mental health literacy have (Piper et al., 2018; Reavley et al., 2014). Further investigation of this sociodemographic characteristic is warranted, ideally using samples with sex/gender representations that more closely approximate the population in Manitoba (Manitoba, 2023).

### **Opportunity for Coordinated, Collaborative and Integrated Services**

Consistent with previous studies in Canada (Corace et al., 2022; Kates et al., 2023; Ross et al., 2015; Wang et al., 2024), the sample of service leaders and providers within the current study highlighted the fragmented nature of mental health and SUA services and the sub-optimal coordination of services both within and between organizations, which perpetuates unmet needs among adult 65+ patients/clients. Extensive wait times for services contribute to the complexity

of delivering care and complicates access. Allied professional integration has been suggested as necessary to support collaborative and integrated care, which current findings also support.

From a service delivery standpoint, health problems tend to be categorized, and treatment broken up into segments. Few hubs deliver ‘one-stop shop’ services, and coordination between fragmented/siloed health services is lacking. Both the adult 65+ and service leader/provider focus group participants converged on a preference for fewer silos and more ‘one-stop shop’ models of health and social services for older adults in Manitoba. This need was also highlighted by a final fifth place rank in the priority-setting and validation exercise (i.e., services designed to more wholistically address multiple overlapping conditions together including physical health concerns, mental health concerns, and substance use or addiction concerns), which nearly a quarter ( $n = 33$ , 24%) of adult 65+ survey respondents chose as their first or second priority.

Service leaders and providers suggested focusing on developing more service delivery approaches that are modelled on principles of integrated and collaborative care – ideally locating them in the community – which aligns with previous recommendations provided to the Manitoba Government for health system transformation (Provincial Clinical and Preventive Services Plan, 2016; Virgo Report, 2018). A small but growing body of research supports introducing stepped-care approaches (i.e., care that is appropriately adjusted to need in stages) into mental health and SUA service delivery, particularly for older adults who may have comorbidities (Kastner et al., 2018; King et. al., 2023; Morse et al., 2023). Prior research also shows that people who misuse substances especially benefit from coordinated/integrated care to address physical, mental, behavioural, and social service needs together (Corace et al., 2023; Gage & Melillo, 2011).

### Opportunity to Bolster SUA Literacy

In relation to my secondary research question/objective 3, results of the current study address a gap in the literature by providing a clearer picture of adults' 65+ SUA literacy. In addition to the service leader and providers themes generated on enhancing adults' 65+ ability to recognize problematic substance use, relationship with coping, and knowledge of the full spectrum of SUA-related resources available in Manitoba, integration of quantitative findings supports the argument that there is a need to bolster SUA literacy among adults 65+. A majority (76%) of adult 65+ survey respondents reported a *low* to *moderate* level of SUA literacy; in comparison, most (75%) reported a *moderate* to *high* level of mental health literacy. As per the study hypothesis, I expected this difference to be significant, such that adults 65+ would endorse worse knowledge on literacy measures with SUA problem cues relative to mental health problem cues. The result of a paired samples *t*-test comparing composite scores supports this hypothesis.

Adults 65+ endorsed significantly lower SUA-related knowledge across three of the four key literacy domains; we should thus focus efforts, at a minimum, on bolstering adults' 65+ SUA literacy to be at least on par with their mental health literacy across these areas. The effect was largest for knowledge of how to seek help for SUA problems, relative to mental health problems. This finding closely coincided with their significantly *low* level of knowledge about how to navigate SUA services, specifically in Manitoba, where approximately one in five did *not know at all*. As the sample of service leaders and providers stressed the need to specifically enhance knowledge of lesser known (and possibly less stigmatizing) SUA service options, it will be especially important to learn more about and incorporate a full range of options into future development of information/education resources, paying particular attention to language used in talking about various services and their purpose (for example, to aid coping). Of note, however,

findings collectively demonstrate that awareness of community-based SUA *and* mental health services among many adults 65+ is quite limited, which is similar to previous research showcasing older adults' lack of familiarity with mental health resources in the community (Reynolds et al., 2022). Adults 65+ will thus likely benefit from strategies to improve *both* their mental health and SUA literacy, especially for knowing about the types of help/resources that are available, and how to go about finding and accessing help/resources when needed.

Regarding specific content areas, during focus groups adults 65+ explicitly focused discussion on reducing harms related to prescribed and over-the-counter medications/substances by raising their SUA literacy. Service leaders and providers also spoke about SUA in later life, but their discussion centered on addressing problems that arise from 'intentional' misuse of substances, which may reflect limited awareness of or differing attitudes towards 'unintentional' SUA problems (for example, dependency on a prescribed medication). Discussion among the adult 65+ participants reflected their concern about the consequences of unsafe medication use, including interaction effects, polypharmacy/overprescribing, and possible development of dependency or addiction. The importance of getting better access to information resources on drug interactions was also highlighted by a final sixth place rank in the priority-setting and validation exercise. Adult 65+ focus group participants also suggested future research on better understanding the consequences of unsafe medication/substance use, how to reduce associated harms, and program development to guide safer use of medications/substances in later life.

These findings coincide with extant research highlighting unsafe medication use among older adults – including polypharmacy, inappropriate dosing, overprescribing/medication overload, harmful interaction effects, and even overdose – as a growing but understudied issue in Canada requiring urgent public health/clinical practice changes (Abayateye et al., 2022;

Thomson & McDonald, 2024; Vyas et al., 2021). To complicate matters, older adults' use of substances such as alcohol and cannabis is increasing and risk perceptions diminishing and, when used alongside medication, may further contribute to risk of harm (Yarnell et al., 2020). In Canada, misuse of prescription drugs is more prevalent among older adults who also use other substances, cannabis in particular (Abayateye et al., 2022). Notably, substances may be misused by older adults because of poor understanding of and communication about safe medication use (Butt et al., 2020; Kettaneh, 2015; Kuerbis et al., 2014). There is an opportunity to boost adults' 65+ SUA literacy by developing/collating information and psychoeducation resources (that go beyond drug advisories provided by pharmacists, for example) and making it readily available and accessible to them. Raising service leaders' and providers' knowledge and awareness of how to recognize problems, contributing/maintaining factors, risks, and unsafe practices, may also be beneficial. Together, these actions could support shared decision-making about medication use in later life (Tannenbaum et al., 2014). However, evidence on the impact of such educational interventions on reducing actual SUA-related harms (and in particular, medication-related harms) is mixed/inconclusive (e.g., Cooper et al., 2015). Further research would be needed to ascertain actual harm-reduction impacts of psychoeducational tools in the Manitoba context.

In contrast, service leaders and providers spoke more generally about their perceptions that there are stage-of-life changes that increase adults' 65+ risk of misusing substances, which a small body of research supports. Prior research has identified retiring from work, losing a loved one, and moving into an assisted living or long-term care facility (Kelly et al., 2018; Kuerbis et al., 2014). Findings from the adult 65+ focus group in the current study add in marital breakdown/divorce in later life as another potential factor, although future evaluation is needed to determine if this factor is generalizable beyond this sample. Service leaders and providers

wanted more attention placed on better understanding and addressing the underlying reasons for SUA in later life, which intersects with previous research suggesting that there is a gap in our knowledge about the motives for drug misuse among older adults in Canada that should be more thoroughly studied (Abayateye et al., 2022). In the current study, service leaders and providers cautioned that service delivery organizations in Manitoba are underequipped to address the growing trends in SUA among older patients/clients. This is consistent with previous research indicating that current SUA treatment models are inadequate to address the new wave of older individuals experiencing SUA problems (Yarnell et al., 2020). Notably, service leaders and providers acknowledged that there are not enough mental health professionals in Manitoba who are trained to work with older adults, especially those with co-occurring or complex mental health and SUA difficulties. Prior evidence shows that without targeted training, service providers are less likely to screen, assess, diagnose, or treat older patients with SUA difficulties (Bartels et al., 2014; Cochran, 2023; Coogle et al., 2015). In Manitoba, an assessment of the training needs of organizations, teams, and professionals, followed by targeted training, may be warranted to ensure service delivery organizations and service providers are better equipped.

### ***Predictors of SUA Literacy***

Confirming the hypothesis of the current study, findings on predictors of SUA literacy indicated that, overall, sociodemographic and psychosocial characteristics accounted for some of the variance in predicting adults' 65+ SUA literacy composite scores. The significant predictors that emerged were age and SUA lived experience. Consistent with the literature on mental health literacy and help-seeking for mental health problems among older adults (Piper et al., 2018; Reavley et al., 2014; Reynolds et al., 2022), older age predicted poorer SUA literacy in the current study. The independent variable that emerged by a large margin as the strongest predictor

of SUA literacy was a personal SUA lived experience. Adults 65+ with no SUA lived experience had significantly poorer SUA literacy. This result is consistent with and adds to findings from previous studies showing that prior life experience with mental health problems or treatment is associated with better ability to detect problems, understand what may be contributing to problems, and know where to go to find support (Piper et al., 2018; Reavley et al., 2014; Reynolds et al., 2022). Yet findings differed from prior studies examining mental health, which in addition to lived experience have identified social isolation or support (Degan et al., 2019; Reynolds et al., 2022) and, in younger populations, current substance use (Dermota et al., 2013), psychological distress (Degan et al., 2019), and self-perceived physical and mental health status (Rolova et al., 2021) as significant psychosocial correlates/predictors.

Future studies may benefit from introducing additional steps into the regression model, specifically to control for the overwhelmingly influential effect of SUA lived experience. Although age and SUA lived experience accounted for some of the variance in adults' 65+ SUA literacy, the variance accounted for by these significant predictors was 28%. This result suggests that additional variables are likely contributing to a portion of the variance unexplained by the variables included in the current study. Additional variables that may be associated with adults' 65+ SUA literacy may include type and severity of SUA problem, perceived need for SUA treatment, services, programs, or information, and stigma/self-stigma. Future research is needed to further explore these and other variables that may be influencing adults' 65+ SUA literacy.

### **Strengths of the Current Study**

This study was among the first to my knowledge to use mixed-methods to describe late-life mental health service needs (and to a lesser/incomplete extent SUA service needs) from the perspective of impacted individuals who either use or deliver services. Administering a patient-

engagement technique enabled the generation of lists of service priorities that are entirely developed and defined by people with lived experience of this research topic, who have been most impacted by it. Using mixed methods to explore service priorities enabled validation of the priorities by a larger sample of adults 65+ beyond the narrow focus group sample size, which strengthens the credibility and usefulness of findings. This study was also among the first to my knowledge to examine mental health literacy for SUA problems among adults 65+ living in the community (and predictors of SUA literacy), and to have directly compared their SUA literacy to their mental health literacy for more common mental health problems (e.g., anxiety, depression).

This research contributes to the patient engagement literature by providing evidence of the feasibility and likely acceptability of a novel adaptation of the NGT in a virtual environment and is the first, to my knowledge, to administer a virtual NGT with a sample aged 65+. Emergent research indicates that to stay in step with technological advances, modern patient engagement research will benefit from increasingly incorporating virtual environments and methods into study designs to create meaningful and accessible participatory research opportunities (Chudyk et al., 2024). In the current study, virtual administration was advantageous in reducing participation barriers including amount of time away from other activities, costs associated with transportation or travel, mobility difficulties and, for service leaders and providers, mitigating complications of geographical spread across the province and amount of time away from direct patient care. Bringing community service leaders and service providers from various service areas and geographical locations together was a strength of the study design and helped to enhance understanding of a range of experiences, challenges, insights, and ideas. It emerged that these individuals and organizations have infrequent opportunities to discuss and collaborate on the topic of late-life mental health and SUA services, and my research was seen by them as an

opportunity to not only voice their perspectives and experiences, but to also learn from each other and build connections. Relevantly, research supports that strong clinical professional networks can, in turn, facilitate better patient care (Cunningham et al., 2012).

There are some notable reasons for the success I experienced in transforming the NGT to a virtual format. Prior research has shown that experience with and preparation of the mechanics and dynamics of the session are key to achieving successful outcomes (Junger et al., 2020; Mason et al., 2021). I accordingly engaged extensively in preparatory activities associated with my role and function as the primary facilitator. Pilot testing the adapted procedure with volunteers after all preparatory materials and activities were completed, to evaluate efficacy and make procedural improvements, was a critical task that contributed to the successful outcomes achieved with research participants. Pilot testing helped delineate the roles and functions of the facilitator and research assistants, and each of their preparatory and group management responsibilities, and identify and fix issues with unclear instructions and suboptimal screen share sequencing. Pilot testing also identified important preparatory steps for research participants to engage in before joining the session, such as familiarizing themselves with how to use Zoom by joining the first focus group in their series (which was unrelated to the NGT).

My approach differed from previous studies that have used a virtual NGT, in that I chose not to use the Zoom chat function to obtain round-robin ideas from participants. Previous feasibility studies on virtual NGT administrations have shown that extracting and collating information from participants in this way can create significant challenges, including facilitator difficulties with transferring data from Zoom Chat to other materials in real-time, and participant inability to access the chat function because of firewall settings or lack of skill (Khurshid et al., 2023; Mason et al., 2021). Instead, I stuck closely to the traditional method of allowing

participants to verbally relay ideas, with a research assistant assigned the role of recording each verbalization on our version of a ‘virtual flipchart’, which worked to mitigate the chat function issues observed in prior studies. It also appeared to be helpful for building group rapport.

Despite extensive preparation, challenges in adhering to the time allocated for several steps were encountered, particularly during the serial discussion of ideas. However, it is unlikely that virtual administration is the cause of these time-related challenges as it was actually the extensive discussion of each topic that filled up the time rather than any procedural aspects, and it is unlikely that I would have managed this process differently in an in-person environment. Moreover, extensive discussion and thoughtful individual and group deliberation signaled to me that engagement among and between participants, and between participants and researchers, remained consistently high throughout the entire NGT process, allowing me to draw preliminary conclusions about the likely acceptability of this method among the participants engaged (however, this was not formally tested). Although time constraints could be mitigated in future studies by allotting more time to the process, I was nevertheless able to collect considerable amounts of data within the time allotted, which is a strength of applying the NGT acknowledged in previous studies (Harvey & Holmes, 2012; Maguire et al., 2022; Potter et al., 2004). Results are tabulated in-session; thus, participants were able to see the outcome of their efforts (i.e., a list of their collectively chosen priorities) in real-time, which has been shown to provide a sense of achievement (Cooper et al., 2020; Cunningham, 2017) and, in my study, prompted a meaningful discussion among participants about potential next steps on the priorities identified.

Although a future study designed with the objective of evaluating effectiveness is still needed, my research suggests that this unconventional NGT administration is feasible and likely acceptable to diverse participant groups, including older adults. This work may be useful to other

researchers looking to transform patient engagement methods to a virtual format, as the steps taken to adapt the technique can be easily replicated in future studies across any discipline.

### **Limitations**

This study had several limitations that I will highlight. With regard to the qualitative component, which used focus group and NGT methods, a major limitation is that findings primarily reflect the perspectives of individuals with a lived experience of a mental health problem for which they had tried to find help/services and *not* an SUA problem, and those who deliver mental health rather than SUA services (although it is noteworthy that two adult 65+ participants had tried to find help/services for an SUA problem despite not endorsing one themselves, and one service leader/provider worked for a combined mental health and SUA service organization). It was exceedingly difficult to recruit participants with personal lived experience of SUA problems (or who deliver SUA services) despite extensive efforts to reach these populations. As such, their unique perspectives are not well-represented in the themes and priorities identified; neither are the perspectives of adults 65+ with a co-occurring mental health *and* SUA problem. Although improving SUA literacy was broadly discussed by service leaders and providers, adults' 65+ discussion on the topic was much narrower, which may be due to the limited representation of lived experience of SUA problems among the focus group sample.

Previous research has shown that the experience of living with a SUA problem in later life can be highly stigmatizing (Choi et al., 2014; Mitchell et al., 2024; Schomerus et al., 2010; Woodhead et al., 2019), which the current research may underscore. Stigma (especially self-stigma) has been shown to reduce willingness to disclose SUA problems to others (Hing et al., 2014; McCann & Lubman, 2018; Woodhead et al., 2019), which may have kept some adults 65+ with SUA lived experience from participating in this study. Previous research has also shown

that adults 65+ may not realize that their SUA is problematic (Kuerbis et al., 2014; Sacco & Kuerbis, 2013). For example, some older adults think their alcohol consumption is not problematic even though it exceeds low-risk guidelines (Borok et al., 2013). Difficulty recognizing SUA problems (such as problematic alcohol, drug use or gambling) may have played a role in keeping some adults 65+ from participating in this research (for example, if they erroneously assessed that they did not meet study criteria). It will be necessary to adopt additional/alternative sampling approaches and recruitment techniques in future studies.

Another limitation is that the number of total participants recruited for the qualitative component was low despite being appropriate to meet standards for conducting focus groups, which may have limited the richness and complexity of data collected. Furthermore, only groups of individuals comfortable enough with technology to be able to participate in a virtual-based research setting were involved in this study, which may limit the applicability of findings. This limitation may be minor, however, as emergent research shows that older adults are increasingly adopting, using, and preferring technology options (e.g., Harris, 2024). The NGT method also had some limitations. Since only a singular nominal question can be posed during administration, time constraints did impede opportunity for participants to also define and set research priorities, which were instead ascertained through open discussion and analyzed using RTA. Additionally, time constraints prevented me from doing a deeper dive into the three service priorities that were tied for fifth place in Group A and establishing a consensus-based resolution in session (e.g., re-voting). As such, I reported all seven identified priorities and included each in the quantitative survey for validation and, ultimately, resolution of the ties by a larger sample of adults 65+.

For the quantitative component, which involved an online survey method, there are limitations related to generalizability of findings that are important to consider when interpreting

results. Results are limited to participants from Manitoba, Canada. From this jurisdiction of interest, a relatively small, non-random, convenience sample was surveyed, and although adequate for the analyses conducted, findings cannot be considered representative of the entire adult 65+ population in Manitoba, which shows more diversity than was observed in the current sample (Manitoba, 2023). Additional limitations related to the survey method include the self-report nature of the data and the possibility that responses were affected by a response bias motivated by social desirability or stigma (e.g., reluctance to disclose past need for or use of services), and the non-laboratory (uncontrollable) setting. Participants were also required to be familiar and comfortable enough with technology to respond to an online survey, and have access to equipment to do so, which may bias results to a narrow subgroup of older adults. However, there is evidence to suggest that engagement with technology/telehealth opportunities may be more of a factor of socioeconomic status than age (Okoye et al., 2021). As good socioeconomic diversity was observed in the current sample, this limitation may be minor.

Although additive to the literature, there are some limitations to consider related to the method selected for assessing adults' 65+ SUA literacy. In the extant literature, methods for measuring mental health literacy (both perceived and actual) have been numerous and disparate, which makes it challenging to identify an optimal method for measuring the construct. The construct of mental health literacy is also a largely Western scientific conceptualization of awareness of and responsiveness to mental health problems (extended in the current study to apply to SUA problems) (Jorm, 2012). It is likely that people from other cultural backgrounds may validly conceptualize mental health and SUA differently (Furnham & Hamid, 2014). There are thus limitations related to the definition of mental health and SUA in the current study, as I did not investigate nor implement appropriate cultural adaptations. Although the mental health

literacy measure that I used/adapted was optimal for comparing the effects of applying different content cues, the measure's applicability is limited due to its narrow focus on only select components of the construct and because it relied on self-assessment and perception, rather than on directly measuring knowledge. As such, the utility of the measure and its adaptation in this study was to build upon qualitative findings and provide a glimpse of adults' 65+ mental health and SUA literacy needs/skills in four key domains, rather than to conduct a comprehensive assessment of the construct. In the context of this research, I determined that the measure had good internal consistency, including both the original version used to measure perceived mental health literacy and the novel version adapted to measure perceived SUA literacy.

Another limitation arises from the likelihood that there are more characteristics associated with adults' 65+ SUA literacy that were not measured in the current study or analyzed as potential predictors due to homogenous sample characteristics. For example, race was measured as a sociodemographic variable but not included in the regression model as a potential predictor of SUA literacy. Then again, producing a simultaneously diverse and adequately sized sample for a valid evaluation of race as a predictor was not anticipated, nor did it occur, despite some success in building bridges with multi-cultural organizations during recruitment (e.g., Winnipeg Chinese Senior Association, Senior Immigrant Settlement Services). A similar limitation is that sex/gender identification was notably binary, with all survey respondents identifying as male or female, and homogenous in this respect. Finally, I acknowledge limitations related to the causal inferences drawn because of the cross-sectional study design.

### **Implications**

Despite these limitations, results of this mixed-methods research have expanded our understanding of the adult 65+ and service leader/provider perspectives on late-life mental health

and SUA service needs and priorities. Taken together, findings have numerous implications. My jurisdiction of interest was Manitoba, Canada. Accordingly, I expect that the research, clinical, and health services and policy implications discussed will be most relevant to this jurisdiction.

### **Research Implications**

The first major practical contribution of this research is that it provides numerous directions for future research that were obtained directly from people with lived experience of the issues I explored, and who are likewise most impacted by them. Typically, individuals whose lives are most directly affected by research do not have the opportunity to set or define research directions. As a result, many potentially important areas are likely to be neglected due to a mismatch between research carried out and the research evidence that would be most valued by those with lived experience. My research approach mitigated this outcome. However, although important themes for future research were broadly identified, there remains an opportunity to apply the NGT in future studies to set *specific* research priorities with the populations studied.

While several ideas for furthering research on improving access to late-life mental health and SUA services were identified, one research gap does stand out. Service leaders and providers illuminated the need for a formalized approach to hoarding problems, including development or expansion of services for hoarding behaviours in later life, clinical practice/policy changes (e.g., classification of hoarding as a mental health problem), and much more research. This research gap has also increasingly been acknowledged in the extant literature (e.g., Ayers et al., 2015; Postlethwaite et al., 2019; Thew & Salkovskis, 2016). Qualitative research with the aim of better understanding the development and trajectory of hoarding problems in later life, underlying reasons, impacts of hoarding on mental health, help-seeking for hoarding problems, and unmet service or support needs, should be considered. Quantitative methods could also be applied to

assess the population's level of need for hoarding-related services in later life. Specific program models such as The Multiagency Hoarding Teams may also be worth considering/adopting (Chapin et al., 2010). Such research could help inform interventions, clinical practice guidelines, service delivery standards, and policies for late-life hoarding problems. Notably, adults 65+ in the current study voiced a desire to stay involved in research that is of value to them. Continued use of patient-engagement methods with this population should accordingly be considered.

### **Clinical Implications**

The second major practical contribution of this research is that it provides much needed data on the clinical service needs of the individuals who use or deliver late-life mental health and SUA services, and their priorities when it comes to clinical and community-based service offerings. This information is important given how little research on the topic currently exists in the literature. There are implications for both clinical practice and clinical training.

First, from a clinical practice standpoint, mixing qualitative and quantitative findings underscores the relevance of mental health and SUA problems among Manitoba's aging population and, consistent with Virgo Report (2018) recommendations, points to the importance of increasing awareness and support for – and competency in working with – this population. The integration of psychoeducation interventions into clinical, population, and public health practices may be helpful to mitigate the risk of unrecognized and untreated problems.

Extant research shows that older adults' mental health literacy is much lower than younger age groups (e.g., Farrer et al., 2008). Results of the current study suggest that their self-reported SUA literacy may be even lower than mental health literacy, which makes it likely that both their mental health *and* SUA literacy are lowest of all age groups and would each benefit from clinical/public health interventions. A growing body of research shows that low literacy

levels can be improved over time with targeted educational interventions and tailored skill building, which in turn increase engagement with appropriate services and reduce severity of problems (Berkman et al., 2011; Edwards et al., 2012; Kelly et al., 2007; Nutbeam et al., 2018; Visscher et al., 2008). For low baseline levels, interventions that are customized to the population's specific literacy needs/topics are associated with greater improvements compared to general or nontargeted interventions. Results of the current study provide guidance on potential literacy needs/topics (e.g., types and how to access help/resources, safe medication use). Future research is needed to investigate whether strategies that are targeted to improving key components of older adults' SUA literacy are more effective than using interventions that combine components of mental health and SUA literacy together.

The voices of focus group participants also shine light on the need to consider experiences commonly encountered by older adults when delivering virtual services in clinical settings, as the application of virtual psychological assessment, consultation, and treatment, as well as other health and social services, increasingly becomes more mainstream (or even the preferred default). These considerations include screening for appropriate fit with interpersonal communication style (including retaining in-person options to provide optimal interpersonal connection when preferred), and use of appropriate accommodations for older adults exhibiting hearing difficulties, such as regular use of assisted listening devices.

Regarding clinical training implications, attention should be paid to increasing competency and confidence in the provision of SUA services by mental health professionals and service delivery organizations. Psychologists are ideally suited to bridge the gap in care for people experiencing SUA problems; however, there is limited training for psychologists in Canada to develop expertise in SUA diagnosis and treatment (Corace et al., 2022). Reducing

reluctance to address SUA in clinical practice will require skills-building during clinical training. Clinical psychology training programs should lead the way in introducing core curriculum on understanding, assessing, diagnosing, and treating SUA (and co-occurring) problems.

Clinical psychology training programs should also pay close attention to offering ample opportunity for graduate students and residents to build interest and expertise in geropsychology. Evidence suggests that interest in aging among trainees is decreasing, and aging/geriatric positions across all professional settings (graduate student, resident, clinician, and academic) are becoming less sought out. Health services will bear the consequences of this trend including the backfilling of aging/geriatric positions by those lacking relevant backgrounds or competence, difficulty securing funding for aging/geriatric positions, and loss of aging/geriatric positions (Ma et al., 2023). Consideration should be given to the introduction of aging/geriatric tracks within clinical psychology training programs as a declared area of focus, like child/adolescent tracks.

### **Health Services and Policy Implications**

The third major practical contribution of this research is that it contains helpful information for government and other policy/decision-makers to consider (alongside other evidence) to inform selection, funding, and delivery of health services that are targeted to the needs of an aging population. Between 2023 to 2026, Manitoba is set to receive \$65.2M for mental health and SUA services through new federal transfers, in addition to funding through the Working Together to Improve Health Care for Canadians initiative and Canada Health Transfer (Health Canada, 2024). Policy/decision-makers in Manitoba should prioritize and invest in the mental health of older adults, which also aligns with Virgo Report (2018) recommendations.

The thematic frameworks and lists of priorities provide numerous suggestions on service offerings to invest in, to close the current gap in services in Manitoba. As this research makes

evident that people who use and deliver services alike consider the mental health and SUA system to be complex and lacking sufficient coordination, investments to coordinate access to services that is based on an integrated stepped care model could be prioritized; older adults should never have to think that they will only get care if they are ‘bad enough’, and if not, that none will be available. More integration of mental health and SUA services is especially needed to address issues with these historically siloed service delivery approaches. Investment into standardizing the service user experience is also needed to provide older adults with consistent information on what to do and where to go when facing mental health and SUA challenges.

Attention should be paid to aligning staffing models, levels, and geographic distribution to the needs of older patients/clients, and to establishing an adequate workforce of mental health professionals who are specially trained to work with older adults. Aging/geriatric psychologists who understand the development and trajectory of mental health and SUA problems, who are trained in evidence-based psychological assessment and treatment, and who can impart coping skills for life transitions, are especially well-suited. Currently, the number of psychologists equipped to work with older adults falls far short of the demand and is predicted to only worsen in coming years (Ma et al., 2023). Now is the time to strengthen the workforce in Manitoba.

Finally, this research informs us that the way mental health and SUA service navigation is currently understood and managed is not optimal for adults 65+, which implies that a new approach to service navigation is needed. Formalizing a new approach also aligns with a focus in the Manitoba Seniors Strategy (2023) on establishing service navigation as a core part of service offerings for older Manitobans. Currently, service navigators are embedded within the Manitoba 211 service, and this service – like the Seniors Resource Guide (2023) – has compiled a list of resources for older adults (mental health, recreation, transportation, housing, and in-home

supports). Service providers and service delivery organizations are invited to share information about their service offerings directly into the 211database. While resource lists can be helpful, more formalized and ‘hands-on’ approaches (e.g., service navigation programs, advocacy support, and/or direct referrals to appropriate services) would help reduce the hardships associated with help-seeking in later life. Exploring how to make information contained in the 211database more readily available to service providers and service delivery organizations may be especially beneficial for improving their knowledge of resources and appropriate referrals.

### **Future Directions**

While this research offers an exploration of multi-level perspectives on late-life mental health and SUA service needs and priorities, it only begins to scratch the surface and a paucity of literature on these topics remains. Although generalizability was not part of this study's objectives, it would be beneficial for future studies to build on findings by engaging with a more diverse sample of adults 65+, especially emphasizing diversity of sex/gender and racial/cultural representation, geographic location, and SUA lived experience. It will be important for future research to pay close attention to the voices of people with lived experience in their own local jurisdictions, as differences may emerge. Future studies in different jurisdictions are needed to understand how relevant and far-reaching the service priorities identified in the current study are. It may also be of benefit for future studies to validate the list of service priorities obtained from service leaders and providers with a larger sample of providers/organizations.

Given the limited number of participants who use or deliver SUA services within this study, the unmet SUA service needs of adults 65+ remain largely unknown. Future research exploring experiences of finding and using SUA services in later life, including facilitators and barriers, and identifying service priorities among adults 65+ living with an SUA problem, is

needed to ensure nuances in late-life mental health and SUA service needs are met. Future studies are also needed to explore the service needs and priorities of adults 65+ living with co-occurring mental health *and* SUA problems (such as those with dual diagnoses).

Although I purposely integrated mental health and SUA in the current study, future studies may benefit from purposively recruiting individuals living with SUA problems (or co-occurring disorders) to prevent domination of mental health representation among the sample. It will be important to adopt additional/alternative sampling approaches and recruitment techniques to better reach this population, such as face-to-face rather than virtual communication, inclusion of supportive/trusted others, and offers of additional incentives such as allowing for discussion of concerns beyond the study's purpose (Kammerer et al., 2019; Liljas et al., 2017). Partnering with and involving SUA service delivery organizations to a greater extent and earlier in the research design stage may also be beneficial to allow for their influence over recruitment techniques and even aspects of data collection (e.g., trusted/familiar people linked with a SUA service delivery organization could be involved in organizing, attending, or co-facilitating focus group sessions).

Future research is needed to standardize and validate measurement of the mental health literacy construct, and possibly the SUA literacy construct as distinct from mental health literacy. Although the nature and design of this investigation of perceived SUA literacy was appropriate given the absence of extant research on the topic, future studies measuring actual (rather than perceived) SUA literacy, and examining predictors of SUA literacy over time and rates after completion of psychoeducation interventions, may be valuable. Finally, there is a program development opportunity to develop information/education resources on several topics explored in and highlighted through this research – that should be made readily available and accessible to adults 65+ and other stakeholders – as a consumer-driven strategy to improve their mental health

and SUA literacy, knowledge of mental health and SUA resources, and pathways into them. As an initial step, findings could inform the development and evaluation of a Manitoba-specific service map for older adults, caregivers, service providers, and organizations, which is a research aim that the Health Information Exchange Lab at the University of Manitoba is now pursuing.

### **Knowledge Mobilization of Findings**

I was motivated to undertake the current study as a means to communicate with and generate evidence for service providers, service delivery organizations, researchers, and policy/decision-makers on late-life mental health and SUA service needs in Manitoba. I wanted to raise awareness of and stimulate change in the way we currently support mental health and SUA in later life, to help address the needs of a population that is far too often underserved. Accordingly, knowledge mobilization – “the reciprocal and complementary flow and uptake of research knowledge between researchers, knowledge brokers and knowledge users” (SSHRC, 2021) – is a critical next step. I am eager to inform all who stand to benefit from this research.

Knowledge mobilization (KM) involves sharing research findings with knowledge users in ways that are relevant, accessible, and easily digestible (Greenhalgh et al., 2004; Ungar et al., 2015). I plan to share findings with older adults (and other impacted consumers of health services) through developing a ‘research snapshot’ (i.e., concise, plain-language 1-page research summary or poster for non-academic users that highlights real-world impacts/opportunities). During recruitment, I joined numerous community-based and aging networks as I sought to raise awareness of this participatory research opportunity (see examples in Appendix F). I plan to share the ‘research snapshot’, along with an offer of a brief virtual or in-person presentation, within these networks to jumpstart conversations and raise awareness within the community.

My planned KM activities are also intended to make sure that information amassed through this research can be acted upon by those who have the power and means to do so. I plan to develop a separate ‘research snapshot’ for service providers, service delivery organizations, and interested researchers, summarizing information about common mental health and SUA problems among older patients/clients, and their mental health and SUA service needs and priorities. KM activities will focus on informing these knowledge users about, (a) current gaps in the design, availability, and coordination of services in Manitoba, (b) opportunities to expand service offerings and integrate new ideas/approaches into existing services, (c) targets for psychoeducation/intervention, and (d) opportunities for clinical or service delivery practice changes including workforce capacity to meet the growing needs of an aging population. I will provide this same ‘research snapshot’ to policy/decision-makers in the Manitoba government to justify increased allocation of funding to geriatric mental health and SUA services. The Manitoba government may also find this research particularly useful for fulfilling their mandate to implement Virgo Report (2018) recommendations and the Manitoba Seniors Strategy (2023).

I laid the foundation for KM during the research design and data collection process, by building bridges with numerous local stakeholders/organizations. For example, I provided presentations about the study aims and goals to the Shared Health Mental Health and Addictions, and Addiction Foundation of Manitoba, leadership tables. I similarly plan to offer presentations of my findings, along with the accompanying ‘research snapshot’, locally through my collaborative relationships within research, healthcare, and broader government systems (for example, Shared Health Department of Clinical Health Psychology; Health Information Exchange Laboratory at the University of Manitoba; Manitoba Health, Seniors and Long-Term Care; and Manitoba Mental Health and Addictions Branch).

Finally, I will disseminate this research by submission to academic conferences and for publication in relevant peer-reviewed journals. The Liquor, Gaming and Cannabis Authority of Manitoba will also add a link to this completed dissertation to their website for service users, providers, delivery organizations, researchers, and government policy/decision-makers to access.

### **Concluding Remarks**

I set out to explore the experiences and understand the perspectives of adults 65+ and those who provide services to adults 65+ about late-life mental health and SUA service needs. I wanted to identify barriers and opportunities to enhance access to and navigation of services and obtain consensus on service priorities, with the intention to feed this information back to government and community stakeholders. Hearing the voices of the individuals who use and deliver mental health and SUA services, and whose experiences, expertise, and perceptions directly relate to the issues I explored, was a key philosophical underpinning of my work. This research collectively underscores how adults 65+ are greatly impacted by mental health and SUA problems, and the importance of enhancing awareness and management of these problems in later life. Practically, this research provides information on ways to better meet the service needs of aging populations. In Manitoba, commendable progress has been made in responding collaboratively to the mental health needs of the broad population. In completing this dissertation, I have learned that there is more to do. Moving forward, I encourage researchers, clinicians, service delivery organizations, and policy/decision-makers to work together to address the unmet needs of adults 65+ living with a mental health or SUA problem, or supporting someone else who is, to protect their quality of life, health, and longevity well into later life.

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**Table 1***Sample Characteristics of Focus Group A (Adults 65+) (n= 6)*

| Characteristics                  | n (%)              |
|----------------------------------|--------------------|
| Age <sup>a</sup>                 | 76.5 (7.42; 69-89) |
| Gender                           |                    |
| Female                           | 3 (50.0)           |
| Male                             | 3 (50.0)           |
| Education (years) <sup>a</sup>   | 15 (2.83)          |
| Racial background                |                    |
| White                            | 4 (66.6)           |
| Indigenous and White             | 1 (16.7)           |
| Other/Mixed Race and White       | 1 (16.7)           |
| Marital Status                   |                    |
| Married/Common-Law               | 3 (50.0)           |
| Divorced/Separated               | 1 (16.7)           |
| Single                           | 2 (33.3)           |
| Location of Residence            |                    |
| Urban                            | 6 (100.0)          |
| Occupational status              |                    |
| Retired                          | 4 (66.6)           |
| Employed                         | 1 (16.7)           |
| Unemployed                       | 1 (16.7)           |
| Annual household income          |                    |
| 0-29,999                         | 4 (66.6)           |
| 50,000-69,999                    | 1 (16.7)           |
| Undisclosed                      | 1 (16.7)           |
| General Physical Health          |                    |
| Fair                             | 2 (33.3)           |
| Good                             | 1 (16.7)           |
| Very good                        | 2 (33.3)           |
| Excellent                        | 1 (16.7)           |
| General Mental Health            |                    |
| Good                             | 3 (50.0)           |
| Very good                        | 2 (33.3)           |
| Excellent                        | 1 (16.7)           |
| Personal lived experience        |                    |
| Current mental health problem    | 3 (50.0)           |
| Lifetime mental health problem   | 6 (100.0)          |
| Current SUA problem              | 0 (0.0)            |
| Lifetime SUA problem             | 0 (0.0)            |
| Mental health service access     | 6 (100.0)          |
| SUA service access               | 2 (33.3)           |
| Mental health information access | 6 (100.0)          |
| SUA information access           | 2 (33.3)           |

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|                                                                                        |                     |
|----------------------------------------------------------------------------------------|---------------------|
| Mental Health and SUA Literacy                                                         |                     |
| Composite Mental Health Literacy <sup>a</sup>                                          | 14.83 (3.06; 13-19) |
| Composite SUA Literacy <sup>a</sup>                                                    | 12.16 (2.56; 9-16)  |
| Descriptive Mental Health Literacy (composite /4) <sup>b</sup>                         | 3.9 (3.7, 0.76)     |
| Descriptive SUA Literacy (composite /4) <sup>b</sup>                                   | 3.0 (3.0, 0.64)     |
| Knowledgeable about how to navigate mental health services <sup>b</sup>                | 4 (3.5, 1.38)       |
| Not at all                                                                             | 1 (16.7)            |
| Moderately                                                                             | 1 (16.7)            |
| Very                                                                                   | 3 (50.00)           |
| Extremely                                                                              | 1 (16.7)            |
| Knowledgeable about how to navigate SUA services <sup>b</sup>                          | 2.5 (2.33, 0.82)    |
| Not at all                                                                             | 1 (16.7)            |
| Somewhat                                                                               | 2 (33.3)            |
| Moderately                                                                             | 3 (50.00)           |
| Knowledgeable about how the mental health system in Manitoba is organized <sup>b</sup> | 4 (3.5, 1.64)       |
| Not at all                                                                             | 1 (16.7)            |
| Somewhat                                                                               | 1 (16.7)            |
| Very                                                                                   | 2 (33.3)            |
| Extremely                                                                              | 2 (33.33)           |
| Knowledge of mental health and SUA community resources <sup>b</sup>                    | 3 (3.17, 1.33)      |
| Poor                                                                                   | 1 (16.7)            |
| Good                                                                                   | 3 (50.0)            |
| Very good                                                                              | 1 (16.7)            |
| Excellent                                                                              | 1 (16.7)            |

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*Note.* <sup>a</sup>Value represents M (SD; *range*); <sup>b</sup>Value represents Mdn (M, SD); SUA=substance use and/or addiction.

**Table 2***Sample Characteristics of Focus Group B (Service Leaders and Service Providers) (n= 6)*

| Characteristics                                                                        | <i>n</i> (%)       |
|----------------------------------------------------------------------------------------|--------------------|
| Age <sup>a</sup>                                                                       | 48.7 (9.44; 33-59) |
| Gender                                                                                 |                    |
| Female                                                                                 | 5 (83.3)           |
| Male                                                                                   | 1 (16.7)           |
| Education (years) <sup>a</sup>                                                         | 17.2 (3.13)        |
| Racial background                                                                      |                    |
| White                                                                                  | 6 (100.0)          |
| Occupational status                                                                    |                    |
| Full-time employment                                                                   | 6 (100.0)          |
| Length of time in current role <sup>a</sup>                                            | 13.7 (4.68)        |
| Service delivery area                                                                  |                    |
| Mental health and SUA                                                                  | 1 (16.7)           |
| Mental health                                                                          | 5 (83.3)           |
| SUA                                                                                    | 0 (0.0)            |
| Service Location                                                                       |                    |
| Urban                                                                                  | 6 (100.0)          |
| Mental Health and SUA Literacy                                                         |                    |
| Composite Mental Health Literacy <sup>a</sup>                                          | 17.2 (2.71; 13-20) |
| Composite SUA Literacy <sup>a</sup>                                                    | 14.0 (3.16; 11-18) |
| Descriptive Mental Health Literacy (composite /4) <sup>b</sup>                         | 4.3 (4.3, 0.68)    |
| Descriptive SUA Literacy (composite /4) <sup>b</sup>                                   | 3.1 (3.5, 0.79)    |
| Knowledgeable about how to navigate mental health services <sup>b</sup>                | 4 (3.8, 0.41)      |
| Moderately                                                                             | 1 (16.7)           |
| Very                                                                                   | 5 (83.3)           |
| Knowledgeable about how to navigate SUA services <sup>b</sup>                          | 4 (4.0, 0.63)      |
| Moderately                                                                             | 1 (16.7)           |
| Very                                                                                   | 4 (66.7)           |
| Extremely                                                                              | 1 (16.7)           |
| Knowledgeable about how the mental health system in Manitoba is organized <sup>b</sup> | 3 (3.2, 1.17)      |
| Somewhat                                                                               | 2 (33.3)           |
| Moderately                                                                             | 2 (33.3)           |
| Very                                                                                   | 1 (16.7)           |
| Extremely                                                                              | 1 (16.7)           |

*Note.* <sup>a</sup>Value represents M(SD; range); <sup>b</sup>Value represents Mdn (M, SD); SUA=substance use and/or addiction.

**Table 3***Sample Characteristics of Adult 65+ Survey Respondents (n=138)*

| Characteristics                         | n (%)             |
|-----------------------------------------|-------------------|
| Age <sup>a</sup>                        | 71.5 (5.8; 65-92) |
| Gender                                  |                   |
| Female                                  | 103 (74.6)        |
| Male                                    | 35 (25.4)         |
| Education                               |                   |
| Doctorate (PhD)                         | 6 (4.3)           |
| Masters/Professional (M.D., J.D., etc.) | 24 (17.4)         |
| Bachelor's Degree                       | 37 (26.8)         |
| Post-Secondary Certificate/Diploma      | 49 (35.5)         |
| High School                             | 17 (12.3)         |
| Less than High School                   | 5 (3.6)           |
| Racial background                       |                   |
| White                                   | 130 (94.2)        |
| Indigenous                              | 3 (2.2)           |
| Metis                                   | 1 (0.7)           |
| Black and White                         | 1 (0.7)           |
| Other/Mixed Race                        | 3 (2.2)           |
| Marital Status                          |                   |
| Single, Widowed, Separated, Divorced    | 55 (39.9)         |
| Married, Common-Law                     | 83 (60.1)         |
| Occupational status                     |                   |
| Employed Full-time                      | 11 (8.0)          |
| Employed Part-time                      | 8 (5.8)           |
| Other                                   | 6 (4.3)           |
| Retired                                 | 113 (82)          |
| Number of years retired <sup>a</sup>    | 10.2 (7.7; 1-53)  |
| Annual household income                 |                   |
| 0-29,999                                | 14 (10.1)         |
| 30,000-49,999                           | 22 (15.9)         |
| 50,000-69,999                           | 30 (21.7)         |
| 70,000-99,000                           | 49 (35.5)         |
| 100,000-149,000                         | 19 (13.8)         |
| 150,000+                                | 4 (2.9)           |
| General Physical Health                 |                   |
| Poor                                    | 7 (5.1)           |
| Fair                                    | 23 (16.7)         |
| Good                                    | 49 (35.5)         |
| Very good                               | 48 (34.8)         |
| Excellent                               | 11 (8.0)          |
| General Mental Health                   |                   |
| Poor                                    | 2 (1.4)           |

|                                                                         |                  |
|-------------------------------------------------------------------------|------------------|
| Fair                                                                    | 21 (15.2)        |
| Good                                                                    | 43 (31.2)        |
| Very good                                                               | 53 (38.4)        |
| Excellent                                                               | 19 (13.8)        |
| Personal lived experience                                               |                  |
| Lifetime mental health problem                                          | 97 (70.3)        |
| Lifetime SUA problem                                                    | 21 (15.2)        |
| Current mental health service access                                    | 11 (8.0)         |
| Lifetime mental health service access                                   | 65 (47.1)        |
| Current SUA service access                                              | 2 (1.4)          |
| Lifetime SUA service access                                             | 13 (9.4)         |
| Lifetime mental health information access                               | 90 (65.2)        |
| Lifetime SUA information access                                         | 49 (35.5)        |
| Mental Health and SUA Literacy                                          |                  |
| Composite Mental Health Literacy <sup>a</sup>                           | 13.4 (3.6; 4-20) |
| Composite SUA Literacy <sup>a</sup>                                     | 12.6 (3.9; 4-20) |
| Descriptive Mental Health Literacy (composite /4) <sup>b</sup>          | 3.5 (3.3, 0.90)  |
| Descriptive SUA Literacy (composite /4) <sup>b</sup>                    | 3.0 (3.1, 0.97)  |
| Knowledgeable about how to navigate mental health services <sup>b</sup> | 3 (2.64, 1.1)    |
| Not at all                                                              | 23 (16.7)        |
| Somewhat                                                                | 37 (26.8)        |
| Moderately                                                              | 48 (34.8)        |
| Very                                                                    | 26 (18.8)        |
| Extremely                                                               | 4 (2.9)          |
| Knowledgeable about how to navigate SUA services <sup>b</sup>           | 2 (2.48, 1.1)    |
| Not at all                                                              | 29 (21.0)        |
| Somewhat                                                                | 43 (31.2)        |
| Moderately                                                              | 43 (31.2)        |
| Very                                                                    | 17 (12.3)        |
| Extremely                                                               | 6 (4.3)          |
| Knowledge of mental health and SUA community resources <sup>b</sup>     | 2 (2.41, 1.04)   |
| Poor                                                                    | 30 (21.7)        |
| Fair                                                                    | 46 (33.3)        |
| Good                                                                    | 41 (29.7)        |
| Very good                                                               | 18 (13.0)        |
| Excellent                                                               | 3 (2.2)          |
| GDS-SF M (SD; range) <sup>c</sup>                                       | 3.0 (3.3; 0-14)  |
| GAI M (SD; range) <sup>d</sup>                                          | 3.0 (4.3; 0-20)  |
| SMAS-T-G M (SD; range) <sup>e</sup>                                     | 0.7 (1.1; 0-6)   |
| CAGE-AID M (SD; range) <sup>f</sup>                                     | 0.2 (0.6; 0-4)   |
| LSNS-6 M (SD; range) <sup>g</sup>                                       | 16.0 (5.9; 1-29) |

*Note.* <sup>a</sup>Value represents M(SD; range); <sup>b</sup>Value represents Mdn (M, SD); <sup>c</sup>GDS-SF =Geriatric Depression Scale-Short Form; <sup>d</sup>GAI =Geriatric Anxiety Inventory; <sup>e</sup>SMAS-T-G =Short Michigan Alcohol Screening Test-Geriatric Version; <sup>f</sup>CAGE-AID =CAGE questionnaire Adapted to Include Drugs; <sup>g</sup>LSNS-6 =Lubben Social Network Scale; SUA = substance use and/or addiction.

**Table 4***Adults' 65+ Ranked List of Service Priorities from NGT Focus Group A*

| Ranked Position | Item (Service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1               | A service that provides wholistic and simultaneous support and education to people experiencing mental health, substance use, addiction, and/or physical health challenges together with their caregivers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 2               | Protection and advocacy services for adults living in care facilities who are experiencing severe mental health, substance use or addiction challenges.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 3               | A service to support cooperation and collaboration between healthcare providers and caregivers that allows for freer sharing of information about the person being cared for and their mental health, substance use or addiction challenges and treatment (i.e., expand the circle of privacy to include caregivers more easily).                                                                                                                                                                                                                                                                                                                                                                        |
| 4               | An educational service that provides information on interactions between over-the-counter drugs and prescription medications.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 5 <sup>a</sup>  | <p>i) An educational service that would support adults 65+ in knowing where to go and how to find the mental health, substance use or addiction services they need or are looking for.</p> <p>ii) Services designed to more wholistically address multiple overlapping conditions together including physical health concerns, mental health concerns, and substance use or addiction concerns.</p> <p>iii) Services and supports for adults 65+ whose difficulties fall outside of typical service categories and for adults 65+ who do not have diagnoses (e.g., do not meet full criteria for common mental health, substance use and addiction diagnoses but are still experiencing challenges).</p> |

*Note.* <sup>a</sup>Three items were tied for fifth place.

**Table 5***Service Leaders' and Providers' Ranked List of Service Priorities from NGT Focus Group B*

| Ranked Position | Item (Service)                                                                                                                                                                                                                    |
|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1               | Services and support for combating loneliness and finding connections, including peer and group support development (e.g., support for aiding in addressing addiction, lost spouses, transition to retirement, loss of children). |
| 2               | Access to timely comprehensive assessment of mental health issues and SUA issues to clearly identify and share needs in the context of a support system.                                                                          |
| 3               | An educational service on developing alternative coping skills in later-life, especially in addressing late onset of problematic substance use, to provide more education about different adaptive ways to cope.                  |
| 4               | Cost-free, one-on-one, evidence-based counselling or therapy services that are specialized/tailored to adults 65+ experiencing mental health and SUA challenges.                                                                  |
| 5               | Adult protection services for older adults with authority to implement safety measures (similar to child protective services) in instances of abuse or neglect.                                                                   |

**Table 6***Adults 65+ NGT Participant Quotations on Ranked Service Priorities from Focus Group A*

| Priority | Service                                                                                                                                                                                                    | Group A NGT Participant Quotations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1        | A service that provides wholistic and simultaneous support and education to people experiencing mental health, substance use, addiction, and/or physical health challenges together with their caregivers. | <p>And the obvious solution for my caregiver stress is if I could get my wife and daughter the care they need. But lots of people are giving me support, but they're not helping me get what we really need, which is help from my wife and daughter who have what I think are high priority needs, whereas it's easy to get help for the low priority needs like mine, but hard to get help for the high priority needs like my wife and my daughter. (GA3)</p> <p>I hear him saying that the high priority need is for his wife and daughter to get help, and they're not getting it. And he's the caregiver that's supporting them to keep them functioning and doing okay. And he's not getting support either. (GA6)</p> <p>People who either have the disease or are walking beside someone who has the disease, such as MS, Parkinson's, cancer, ALS, alcoholism, overweight. There are very high needs for the person with the health challenge or mental health challenge or physical challenge to get support in the context where your caregiver or the person who lives with them or loves them also gets the education and the support. They have different paths, but they are on the same road. And they need significant supports. (GA6)</p> <p>Okay, so what what's captured here is, this is support for caregivers. But I'm also saying simultaneously, there needs to be a circle of support for both the person who's walking the illness, living it and their caregiver. (GA6)</p> <p>And at times you split the group in half. The people who have a disease state, they go there and the people who are doing the caregiving over there, but then they come back together. I've seen it. It works. It's fantastic. It's not happening in Manitoba. (GA6)</p> |

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|---|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2 | Protection and advocacy services for adults living in care facilities who are experiencing severe mental health, substance use or addiction challenges.                                                                                                                                                                           | <p>It's the legislated institutions responsible to oversee the protection of persons in care is being careless. (GA6)</p> <p>I was told vulnerable persons was not the place to go. I was told protection of persons in care was the place to go. [<i>speaking in a frustrated tone</i>] And I was told, after telling all of the issues that this resident who's locked up is facing, that they would phone the nursing home and ask what was the care plan? I said, 'No, you need to go out and see this person for yourself' ... And they're saying that there's nothing wrong. (GA6)</p> <p>And how do we access really appropriate Ombudsmen in the hospital that have the ability and skill to intervene while somebody is in the hospital and experiencing a contest for survival with their doctors and nurses on delivery of service? I've found that the Ombudsman's office in the hospitals is not very proactive to really support a patient who is having a life-or-death challenge at the bedside. (GA6)</p> <p>I would say that better support in all, for better access to all mental health programs for seniors. (GA2)</p> |
| 3 | A service to support cooperation and collaboration between healthcare providers and caregivers that allows for freer sharing of information about the person being cared for and their mental health, substance use or addiction challenges and treatment (i.e., expand the circle of privacy to include caregivers more easily). | <p>I have a lot of trouble because family, friends, what I call the informal support network, want to help a patient. But we're left out. We're said, well, we can't talk about things for privacy reasons. And there's very little cooperation and collaboration for privacy reasons. (GA3)</p> <p>It seems to me it's very important to have close cooperation and collaboration with people in their support network, their family, and friends. And privacy is used to really shut out family. (GA3)</p> <p>So, I try to intervene. I try to help. And they say, well, we're sorry, we can't discuss that with you for privacy reasons. (GA3)</p> <p>And there are resources there in the family and friends who could be a help and who want to help, but they're basically shut out by these privacy things where you get no</p>                                                                                                                                                                                                                                                                                                       |

|                |                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|----------------|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                |                                                                                                                                    | meaningful discussion or cooperation or collaboration from the psychiatric services. (GA3)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 4              | An educational service that provides information on interactions between over-the-counter drugs and prescription medications.      | <p>Yes, I went kind of general with my first one, and that was programs dealing with the interaction of over-the-counter drugs with prescription drugs. And I, working in the field, I saw so many people taking over-the-counter drugs without letting their doctor or pharmacist know what they were, yeah. And so, I would like to see programs that educated people on the dangers of taking too many over-the-counter drugs when they're taking a lot of prescription drugs. (GA2)</p> <p>Huge. I think there's a huge over-prescription of drugs for seniors. (GA6)</p> <p>There's the challenge of interaction of prescription drugs. Many seniors that I know and work with and am related to and visit are taking four, five, six, seven, eight, nine, ten tablets at once. And I don't think there's any pharmacological studies that ever study what is the interaction between two drugs, let alone three or four or five or ten? (GA6)</p> <p>...we have a lot of adults that were using recreational substances and that can even include cigarette smoking and they get to personal care and now we're giving them medications for them to stop that because it can't be allowed within the personal care home setting or an assisted living place. There's just so many more constraints and policies and restrictions around the use than when they were in their own homes. And so, it's a complete lifestyle change for them. (GB2)</p> <p>And I see people drugged out of their minds because they got a prescription five years ago and it is being maintained now, whether the problem still exists or not. It's just part of their "throw it in your mouth" out of the bubble pack. (GA6)</p> |
| 5 <sup>a</sup> | i) An educational service that would support adults 65+ in knowing where to go and how to find the mental health, substance use or | <p>Education on 'know where to go'. (GA5)</p> <p>Yeah, which services? What? What are you looking for? People sometimes feel very lonely and alone. And that's different. (GA5)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| addiction services they need or are looking for.                                                                                                                                                                                                                                              | Like, who can you call? (GA5)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| ii) Services designed to more wholistically address multiple overlapping conditions together including physical health concerns, mental health concerns, and substance use or addiction concerns.                                                                                             | How we provide supports and services to people who are dealing with combinations of anxiety, fear, depression, grief, anger, continuous lack of restorative sleep, overweight addictions to cigarettes to sugar, to salt to meth to marijuana, to alcohol. Like, there's any amount of combinations, permutations and there's no place I've found that assists people very well with any one of those things, let alone any double combination or triple or whatever. It's just out to lunch support systems is what I call it. (GA6)                                                                                                                                                                                                                                                                                                                                   |
| iii) Services and supports for adults 65+ whose difficulties fall outside of typical service categories and for adults 65+ who do not have diagnoses (e.g., do not meet full criteria for common mental health, substance use and addiction diagnoses but are still experiencing challenges). | <p>More supports for seniors that fall into unslotted, that fall out of the slots that they have available for the services that exist. (GA2)</p> <p>And we may have kinda said that, but any services that are available, they fall outside of the listed slots. (GA2)</p> <p>One thing that's important to me is my addictions don't fall into what the Addictions Foundation helps with, and they do not deal with weight loss. And a lot of seniors have a problem with weight loss. And seniors face the challenge of maybe having to deal with heart attack, stroke. All of which can be prevented with weight loss. And I have struggled with it all my life. And food is one of my addictions. (GA2)</p> <p>Another example can be gambling, which is dealt with by the Addictions Foundation, but they do not deal with over shopping or overeating. (GA2)</p> |

*Note.* <sup>a</sup>Three items were tied for fifth place.

**Table 7**

*Service Leaders and Providers NGT Participant Quotations on Ranked Service Priorities from Focus Group B*

| Priority | Service                                                                                                                                                                                                                           | Group B NGT Participant Quotations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1        | Services and support for combating loneliness and finding connections, including peer and group support development (e.g., support for aiding in addressing addiction, lost spouses, transition to retirement, loss of children). | <p>It's kind of like if you address that, then the other things fall into place. (GB2)</p> <p>Yeah, I agree...just the meaningful connections are supremely important and like [participant number] said, could combat almost 99% of the rest of the list. (GB4)</p> <p>I would just put in that peer group development. So, finding a population of older adults who have dealt with their addiction and having them become peer mentors to people who are actively trying to break their addiction. So that was another way of finding connection. (GB6)</p> <p>I really like that, and I think it doesn't even need to be specific for substance use. I think any – [pauses], I think help with peer group development is really relevant no matter what the issues are as people are losing their peer groups to illness or death. Yeah, a service that can help kind of, help people get connected. I think it would be really valuable. (GB5)</p> <p>Groups for people who have lost spouses, groups for people who have lost children and groups for people who have suddenly retired and, you know, are feeling lost. (GB6)</p> <p>We sometimes think that we have people in our lives, but they're all paid workers. And so having unpaid people in our lives is just as important. And so, I think this will help build that. (GB6)</p> |

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|---|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|   |                                                                                                                                                          | And I will say, when I voted on this one, I thought about it in kind of a broader way, not only limited to groups, but other I mean, just sort of like visitors or volunteer phone calls, or some of the other ways that we know we can address loneliness as well. (GB5)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 2 | Access to timely comprehensive assessment of mental health issues and SUA issues to clearly identify and share needs in the context of a support system. | <p>So, I think that we already do have this service to some extent, although I don't know if it's, it could always be improved in terms of, you know, just accessibility, the wait list, that kind of thing. But I think it's important to have a clear assessment of what the issue is so that then you can go about putting in whatever plan for supports or services. So, you clearly need to identify what the needs are first...and the important thing that I thought of, that's maybe more so what I see with older folks, is to look at it in the context of their social support network. (GB3)</p> <p>I just wanted to mention that I know, like rurally we have, I guess what you could call access, but I know currently, it's over half a year wait to get into some specialties and even once you get a consultation, it can take another half a year. Like I heard, some places are backed up eight months and I'm still waiting for a synopsis of my client that went to the facility and the dictation is so backed up that, so, I'm winging it, until I find out what their findings are. And it's very frustrating then too, it's kind of like, 'Well, why did we send them to the other facility?' It was a waste of time because we're just muddling through it here anyways. And so, as a professional, it's very, very frustrating. The timely access. (GB2)</p> <p>I wonder if we could add to that the sharing of [sic]. Right. Because it is done. But often the smaller people providing services in the community do not have access to what the medical professionals might be saying. So, I don't know if everyone would agree to adding that the sharing of that information is equally important. (GB6)</p> <p>Yeah, I do agree with the timely, adding the timely in there, but the kind of the sharing of information and the access to the software and whatnot. To me, that's something a little bit different. (GB3)</p> |

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|---|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3 | An educational service on developing alternative coping skills in later-life, especially in addressing late onset of problematic substance use, to provide more education about different adaptive ways to cope. | <p>Well, a number of older adults who experience late onset of substance use and addiction, so they move into an apartment block. There's things that are available to them that wouldn't have otherwise been, and they partake. And suddenly that coping skill becomes a problem in their lives. And so just some more education on, you know, if you're suffering with depression, that these aren't the best. You know, they might have helped for a moment, for a bit. But just how many other coping skills are more effective at moving forward and having a healthier lifestyle, if that makes sense. (GB6)</p> <p>I'd like to make a comment on that, too. I see a lot of times where people come into personal care homes and their way of coping was going out for coffee and going for walks and they are now wheelchair bound or cannot transfer and ambulate on their own. And so now they have to learn something new. (GB3)</p> <p>I was just thinking from a delivery standpoint, it's probably a lot easier to deliver education on developing alternative coping skills as kind of a mass distribution than it is to have the one-to-one counseling, which is more time consuming and more resource consuming. (GB2)</p> |
| 4 | Cost-free, one-on-one, evidence-based counselling or therapy services that are specialized/tailored to adults 65+ experiencing mental health and SUA challenges.                                                 | <p>I think I think it would be beneficial. I think they would be more apt to go right. Because someone else talked about the stigma against mental health services that are available in Winnipeg. And that could be one of them is that this is for young people, or this is for people who are working, you know, the various mental health organizations that are out there. Some of them are frequented by older adults, but many may not be as eager to partake. But if there was a specialized mental health for older adults, then likely they would. (GB6)</p> <p>Yeah, it's sort of a stepped care kind of model. Like not everybody needs the one-on-one counseling. So, you know, having education for people for that, where that meets their needs. But then the one-on-one counseling to people who need a little bit more. (GB5)</p>                                                                                                                                                                                                                                                                                                                                                                                        |

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| 5 | Adult protection services for older adults with authority to implement safety measures (similar to child protective services) in instances of abuse or neglect. | So, similar to, say, child protection services. We don't have anything in Manitoba that I know of that implements the same safety measures and investigation that could be required for instances of elder abuse or neglect that would operate without consent other than the police. So, if there is an older adult in the community that is being abused where there might need more follow up or case management or access to shelter, the police don't always have the ability to carry on a case like that and provide that type of case management. Some other provinces in Canada have this, where if you are worried about an older adult in the community, you could call adult protection services and it would be similar to child protection services where they would go out and investigate without consent. (GB4) |
|---|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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**Table 8***Integration of Adult 65+ Survey Respondents' Final Ranked List of Service Priorities (n=138)*

| Ranked Position | Item (Service)                                                                                                                                                                                                                                                                                                                    | M <sup>w</sup> (SD <sup>w</sup> ) | [NGT Rank]        |
|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------|
| 1               | Protection and advocacy services for adults living in care facilities who are experiencing severe mental health, substance use or addiction challenges.                                                                                                                                                                           | 4.5 (4.5)                         | [2]               |
| 2               | A service that provides wholistic and simultaneous support and education to people experiencing mental health, substance use, addiction, and/or physical health challenges together with their caregivers.                                                                                                                        | 4.3 (4.4)                         | [1]               |
| 3               | A service to support cooperation and collaboration between healthcare providers and caregivers that allows for freer sharing of information about the person being cared for and their mental health, substance use or addiction challenges and treatment (i.e., expand the circle of privacy to include caregivers more easily). | 4.2 (4.1)                         | [3]               |
| 4               | An educational service that would support adults 65+ in knowing where to go and how to find the mental health, substance use or addiction services they need or are looking for.                                                                                                                                                  | 4.1 (4.1)                         | [5 <sup>a</sup> ] |
| 5               | Services designed to more wholistically address multiple overlapping conditions together including physical health concerns, mental health concerns, and substance use or addiction concerns.                                                                                                                                     | 3.8 (3.8)                         | [5 <sup>a</sup> ] |
| 6               | An educational service that provides information on interactions between over-the-counter drugs and prescription medications.                                                                                                                                                                                                     | 3.5 (3.6)                         | [4]               |
| 7               | Services and supports for adults 65+ whose difficulties fall outside of typical service categories and for adults 65+ who do not have diagnoses (e.g., do not meet full criteria for common mental health, substance use and addiction diagnoses but are still experiencing challenges).                                          | 3.5 (3.5)                         | [5 <sup>a</sup> ] |

*Note.* <sup>w</sup>Value represents weighted mean and standard deviation; <sup>a</sup>Three items were tied for fifth place.

**Table 9**

*Frequency of Adult 65+ Survey Respondents' Endorsement of Priority Items from Most Important to Least Important (n=138)*

| Choice<br>Selected <sup>a</sup> | 1st Choice<br>n (%) | 2 <sup>nd</sup> Choice<br>n (%) | 3 <sup>rd</sup> Choice<br>n (%) | 4 <sup>th</sup> Choice<br>n (%) | 5 <sup>th</sup> Choice<br>n (%) | 6 <sup>th</sup> Choice<br>n (%) | 7 <sup>th</sup> Choice<br>n (%) |
|---------------------------------|---------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Priority 1                      | 30 (21.7)           | 28 (20.3)                       | 17 (12.3)                       | 17 (12.3)                       | 11 (8.0)                        | 21 (15.2)                       | 14 (10.1)                       |
| Priority 2                      | 36 (26.1)           | 20 (14.5)                       | 13 (9.4)                        | 14 (10.1)                       | 15 (10.9)                       | 18 (13.0)                       | 22 (15.9)                       |
| Priority 3                      | 18 (13.0)           | 20 (14.5)                       | 29 (21.0)                       | 19 (13.8)                       | 26 (18.8)                       | 14 (10.1)                       | 12 (8.7)                        |
| Priority 4                      | 17 (12.3)           | 23 (16.7)                       | 19 (13.8)                       | 19 (13.8)                       | 31 (22.5)                       | 22 (15.9)                       | 7 (5.1)                         |
| Priority 5                      | 12 (8.7)            | 21 (15.2)                       | 20 (14.5)                       | 18 (13.0)                       | 21 (15.2)                       | 31 (22.5)                       | 15 (10.9)                       |
| Priority 6                      | 14 (10.1)           | 14 (10.1)                       | 17 (12.3)                       | 27 (19.6)                       | 14 (10.1)                       | 17 (12.3)                       | 35 (25.4)                       |
| Priority 7                      | 11 (8.0)            | 12 (8.7)                        | 23 (16.7)                       | 24 (17.4)                       | 20 (14.5)                       | 15 (10.9)                       | 33 (23.9)                       |

*Note.* <sup>a</sup>Respondents ranked each item from the list of seven items that was developed by adults 65+ during NGT focus groups in order of importance (1 = *Least important/Last choice*, to 7 = *Most important/First choice*).

**Table 10***Differences Between Adults' 65+ SUA Literacy and Mental Health Literacy by Composite Score (n=138)*

|                                        | Mean  | Std Dev | 95% C.I.    | Paired <i>t</i> test |           |             |          |
|----------------------------------------|-------|---------|-------------|----------------------|-----------|-------------|----------|
|                                        |       |         |             | <i>t</i> value       | <i>df</i> | <i>p</i>    | <i>d</i> |
| Composite SUA Literacy Score           | 12.59 | 3.87    | 11.94-13.25 | -3.30                | 137       | <b>.001</b> | 0.28     |
| Composite Mental Health Literacy Score | 13.40 | 3.61    | 12.79-14.01 |                      |           |             |          |

*Difference Between Adults' 65+ SUA Literacy and Mental Health Literacy by Item Score (n=138)*

|                                              | Mean | Std Dev | Sum of Ranks        | Wilcoxon matched-pairs signed-ranks test |           |               |          |
|----------------------------------------------|------|---------|---------------------|------------------------------------------|-----------|---------------|----------|
|                                              |      |         |                     | <i>z</i> value                           | <i>df</i> | <i>p</i>      | <i>r</i> |
| Signs and symptoms of SUA problems           | 3.25 | 1.07    | 1835 <sup>Neg</sup> | -2.88                                    | 137       | <b>.004</b>   | 0.17     |
| Signs and symptoms of mental health problems | 3.48 | .914    | 867 <sup>Pos</sup>  |                                          |           |               |          |
| Causes of SUA problems                       | 3.26 | .999    | 1041 <sup>Neg</sup> | -0.49                                    | 137       | .623          | 0.03     |
| Causes of mental health problems             | 3.30 | 1.01    | 912 <sup>Pos</sup>  |                                          |           |               |          |
| Professional help for SUA problems           | 3.04 | 1.06    | 1190 <sup>Neg</sup> | -3.12                                    | 137       | <b>.002</b>   | 0.19     |
| Professional help for mental health problems | 3.27 | 1.02    | 463 <sup>Pos</sup>  |                                          |           |               |          |
| How to seek help for SUA problems            | 3.05 | 1.15    | 1641 <sup>Neg</sup> | -4.01                                    | 137       | < <b>.001</b> | 0.24     |
| How to seek help for mental health problems  | 3.36 | 1.05    | 504 <sup>Pos</sup>  |                                          |           |               |          |
| How to navigate SUA services in MB           | 2.48 | 1.09    | 518 <sup>Neg</sup>  | -3.18                                    | 137       | <b>.001</b>   | 0.19     |
| How to navigate mental health services in MB | 2.64 | 1.06    | 149 <sup>Pos</sup>  |                                          |           |               |          |

*Note.* Mental health cues provided to respondents included anxiety and depression; SUA cues provided to respondents included misuse or dependence on alcohol, cannabis, sleeping pills, pain pills, other prescription or recreational drugs, and gambling problems

**Table 11***Regression of Sociodemographic and Psychosocial Characteristics on SUA Literacy (n=138)*

| Variable                   | $\beta$                    | $SE\beta$ | $R^2$                      | $\Delta R^2$               | $F$                        | $\Delta F$                 |
|----------------------------|----------------------------|-----------|----------------------------|----------------------------|----------------------------|----------------------------|
| Step 1                     |                            |           | <sup>*</sup> <b>0.06</b>   | -                          | <sup>*</sup> <b>2.72</b>   | -                          |
| Age                        | <sup>*</sup> <b>- 0.13</b> | 0.06      |                            |                            |                            |                            |
| Gender                     | 0.44                       | 0.74      |                            |                            |                            |                            |
| Education                  | 1.18                       | 0.65      |                            |                            |                            |                            |
| Step 2                     |                            |           | <sup>***</sup> <b>0.28</b> | <sup>***</sup> <b>0.22</b> | <sup>***</sup> <b>4.96</b> | <sup>***</sup> <b>5.64</b> |
| Age                        | - 0.10                     | 0.05      |                            |                            |                            |                            |
| Gender                     | 0.27                       | 0.69      |                            |                            |                            |                            |
| Education                  | 0.71                       | 0.60      |                            |                            |                            |                            |
| SUA Lived Experience       | <sup>***</sup> <b>3.02</b> | 0.64      |                            |                            |                            |                            |
| Self-rated mental health   | 0.66                       | 0.42      |                            |                            |                            |                            |
| Self-rated physical health | 0.47                       | 0.38      |                            |                            |                            |                            |
| GDS-SF                     | 0.09                       | 0.13      |                            |                            |                            |                            |
| SMASST-G                   | - 0.21                     | 0.27      |                            |                            |                            |                            |
| CAGE-AID                   | 0.42                       | 0.52      |                            |                            |                            |                            |
| LSNS-6                     | 0.04                       | 0.06      |                            |                            |                            |                            |

*Note:* SUA = substance use and/or addiction; Gender was coded Male = 0, Female = 1; Education was coded Less than University = 0, University degree = 1; SUA Lived Experience was coded No = 0, Yes = 1; Self-rated mental and physical health mean rating /5, ranging from 1 (poor), 2 (fair), 3 (good), 4 (very good), and 5 (excellent); <sup>a</sup>GDS-SF = Geriatric Depression Scale-Short Form; <sup>b</sup>GAI = Geriatric Anxiety Inventory; <sup>c</sup>SMASST-G = Short Michigan Alcohol Screening Test-Geriatric Version; <sup>d</sup>CAGE-AID = CAGE questionnaire Adapted to Include Drugs; <sup>e</sup>LSNS-6 = Lubben Social Network Scale.

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

**Figure 1**

*Depiction of the Exploratory Sequential Mixed-Methods Research Design and Process*

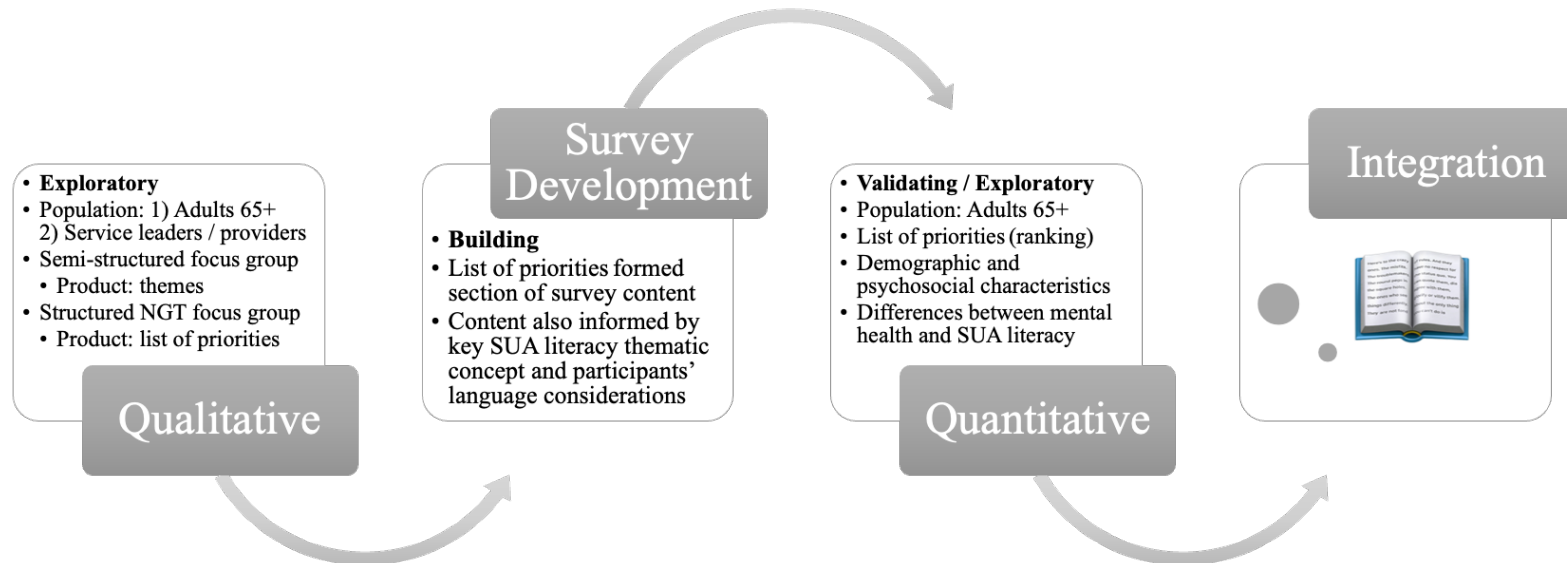


**Figure 2**

*Depiction of the Major Steps in Administering the NGT Adapted for a Virtual Environment*

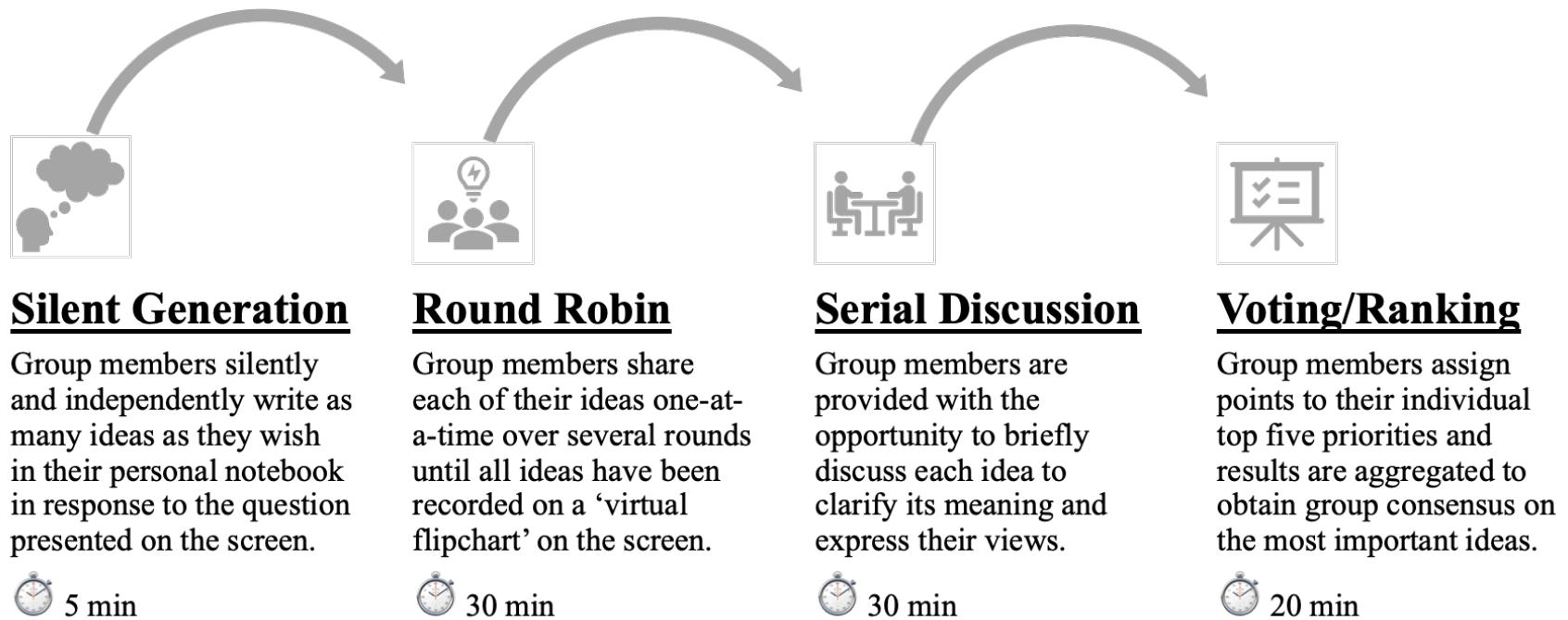


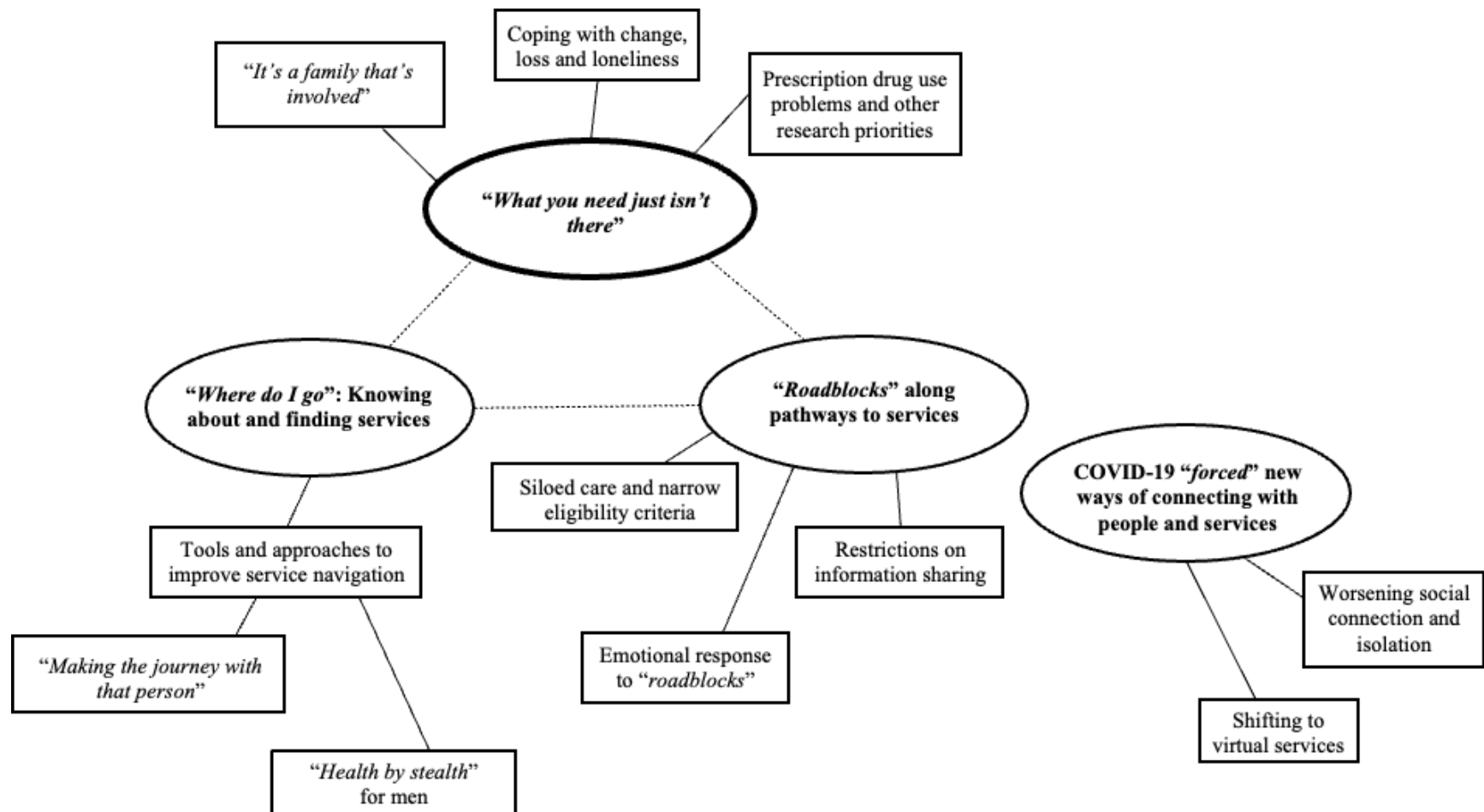
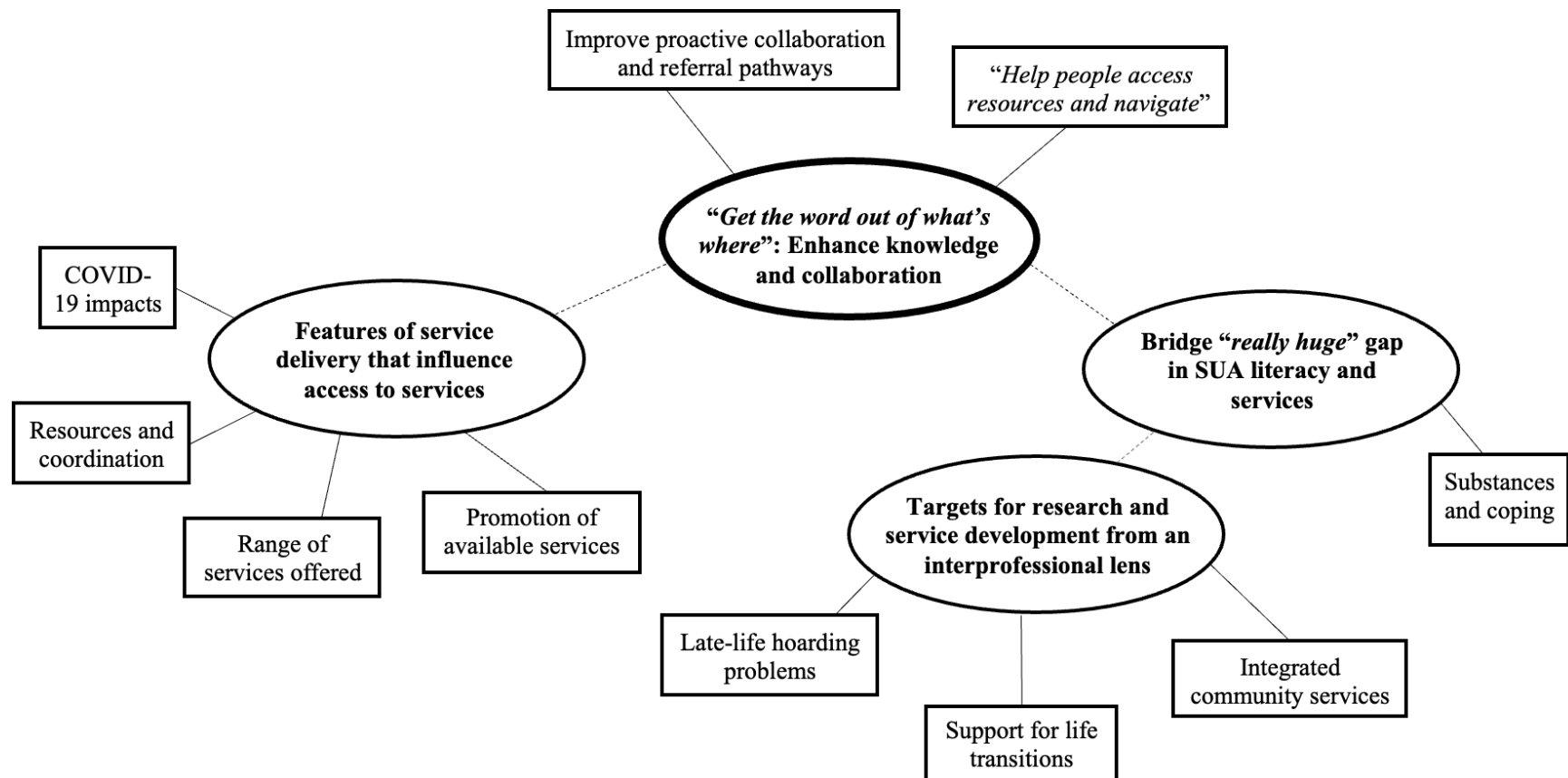
**Figure 3***Group A Thematic Framework (Adults 65+)*

**Figure 4***Group B Thematic Framework (Service Leaders and Providers)*

## Appendix A

### Series A Recruitment Poster (Adults 65+)

Led by Dr. Kristin Reynolds, C. Psych. and Ms. Stephanie Dudok, PhD Candidate, at the University of Manitoba (REB: HE2021-0196)

**IF YOU ARE AN ADULT AGED 65  
YEARS OR OLDER AND HAVE  
EXPERIENCED A MENTAL HEALTH,  
SUBSTANCE USE OR ADDICTION  
PROBLEM FOR WHICH YOU HAVE TRIED  
TO FIND HELP OR SERVICES ...**



We would like to hear from  
you about your experiences

Your stories, experiences and perspectives will help improve access to and navigation of late-life mental health, substance use and addiction services in Manitoba

**Research participants will attend:**

- Three virtual focus groups lasting 1.5 hours each
- Focus group meetings will each occur approximately 2-4 weeks apart
- Focus groups will take place virtually using Zoom videoconferencing
- Meetings will be audio-video recorded

**Research participants will complete:**

- Consent form and background survey before participating in the first focus group
- A link to the survey will be emailed to participants to complete online

**Participants will receive:**

- **\$25 e-gift card** for Amazon.ca each time they attend a focus group meeting **[total participation = \$75]**

Please contact the Study Coordinator if you are interested in hearing more or to participate in a short conversation to see if you are eligible to join a focus group:



**Dudoks3@myumanitoba.ca**

## Appendix B

### Series A Focus Group Recruitment Letter (Adults 65+)



**University  
of Manitoba**

Dr. Kristin Reynolds, Ph.D., C.Psych  
Email: [Kristin.Reynolds@umanitoba.ca](mailto:Kristin.Reynolds@umanitoba.ca)

Ms. Stephanie Dudok, MA., Ph.D. Candidate  
Email: [Dudoks3@myumanitoba.ca](mailto:Dudoks3@myumanitoba.ca)

University of Manitoba,  
Department of Psychology  
P404 Duff Roblin Building, 190 Dysart Rd.  
Winnipeg, MB, R3T 2N2

---

Date:

Organization:

We are pleased to inform you about an upcoming participatory research opportunity that is likely to be of interest to clients associated with your organization!

We are seeking the participation of community-dwelling adults ages 65+ for our study entitled *“Let’s Talk About Late-Life Mental Health: Multi-Systemic Collaboration to Inform Better Access to Care.”*

**Attached with this email is a recruitment poster** with information about the participants we are seeking, the focus groups we are conducting, and how interested participants can contact us. We hope that your organization will distribute this poster through the regular communication channels (e.g., newsletter, website, or other communication materials) that you use to stay in touch with clients or to inform clients about upcoming opportunities.

Please also find below an accompanying social media post, should you be willing to share through your organization’s social media platform:

“Are you an adult aged 65+? Have you experienced or are you currently experiencing a mental health, substance use or addiction problem, which you have tried to find help or services for? We want to hear from you! Join our upcoming “Let’s TALK” series of three focus groups and receive a \$25 e-gift card for Amazon.ca each time (**total participation = \$75**). Contact [dudoks3@myumanitoba.ca](mailto:dudoks3@myumanitoba.ca) to learn more! (U of M REB: HE2021-0196; Shared Health/WRHA REB: SH2022:029)”

Please reply to the Study Coordinator (Stephanie Dudok), via email at [dudoks3@myumanitoba.ca](mailto:dudoks3@myumanitoba.ca), if you will be distributing this opportunity to clients of your organization. We would also be happy to answer any questions you may have.

Sincerely,  
Kristin Reynolds, Ph.D., C. Psych.  
Assistant Professor  
Departments of Psychology and Psychiatry  
Research Affiliate, Centre on Aging  
University of Manitoba

Stephanie Dudok, MA., Ph.D. Candidate  
“Let’s TALK” Study Coordinator  
Department of Psychology  
University of Manitoba

REB Approval received from the U of M (HE2021-0196) and Shared Health/WRHA (SH2022:029)

## Appendix C

## Series B Recruitment Poster (Community/Government Organizations)

Led by Dr. Kristin Reynolds, C. Psych. and Ms. Stephanie Dudok, PhD Candidate, at the University of Manitoba (REB: HE2021-0196)

**IF YOU ARE PART OF AN  
ORGANIZATION THAT  
OVERSEES OR DELIVERS  
SERVICES TO ADULTS AGED  
65 YEARS OR OLDER IN THE  
AREAS OF AGING and/or MENTAL  
HEALTH and/or SUBSTANCE USE AND  
ADDICTIONS ...**



**We want to talk to you –  
and have you talk to each other!**

We are researchers interested in hearing about your needs and priorities related to the accessibility, availability, and navigation of late-life mental health, substance use and addiction services in Manitoba

**Research participants will attend:**

- Three virtual focus groups lasting 1.5 hours each
- Focus group meetings will each occur approximately 2-4 weeks apart
- Focus groups will take place virtually using Zoom videoconferencing
- Meetings will be audio-video recorded

**Research participants will complete:**

- Consent form and background survey before participating in the first focus group
- A link to the survey will be emailed to participants to complete online

Please contact the Study Coordinator if you are interested in hearing more or to participate in a short conversation to see if you are eligible to join a focus group:



**Dudoks3@myumanitoba.ca**

## Appendix D

### Series B Recruitment Poster (Service Providers)

Led by Dr. Kristin Reynolds, C. Psych. and Ms. Stephanie Dudok, PhD Candidate, at the University of Manitoba (REB: HE2021-0196)



**IF YOU ARE A CLINICIAN  
WHO PROVIDES SERVICES  
TO ADULTS AGED 65 YEARS  
OR OLDER IN THE AREAS OF  
MENTAL HEALTH and/or SUBSTANCE  
USE and/or ADDICTIONS ...**

**We want to talk to you –  
and have you talk to each other!**

We are researchers interested in hearing about your needs and priorities related to the accessibility, availability, and navigation of late-life mental health, substance use and addiction services in Manitoba

**Research participants will attend:**

- Three virtual focus groups lasting 1.5 hours each
- Focus group meetings will each occur approximately 2-4 weeks apart
- Focus groups will take place virtually using Zoom videoconferencing
- Meetings will be audio-video recorded

**Research participants will complete:**

- Consent form and background survey before participating in the first focus group
- A link to the survey will be emailed to participants to complete online

**Please contact the Study Coordinator if you are interested in hearing more or to participate in a short conversation to see if you are eligible to join a focus group:**



**Dudoks3@myumanitoba.ca**

## Appendix E

### Series B Focus Group Recruitment Letter (Organizations and Providers)



Dr. Kristin Reynolds, Ph.D., C.Psych  
Email: [Kristin.Reynolds@umanitoba.ca](mailto:Kristin.Reynolds@umanitoba.ca)

Ms. Stephanie Dudok, MA., Ph.D. Candidate  
Email: [Dudoks3@myumanitoba.ca](mailto:Dudoks3@myumanitoba.ca)

University of Manitoba,  
Department of Psychology  
P404 Duff Roblin Building, 190 Dysart Rd.  
Winnipeg, MB, R3T 2N2

---

Date:

Organization:

As you are aware, Manitoba's Provincial Mental Health and Addictions Strategy (i.e., 'Virgo Report') was developed to improve access to and coordination of mental health and substance use/addiction (SUA) services in the province. Recommendations in the Virgo Report highlight the need to enhance older adults' access to mental health and SUA services; to improve the public's mental health and SUA literacy; and for greater collaboration across community resources in enhancing mental health and SUA service access and navigation.

Inspired and guided by these particular findings and recommendations, we are launching a participatory research study entitled "*Let's Talk About Late-Life Mental Health: Multi-Systemic Collaboration to Inform Better Access to Care*" (poster attached).

**We have identified your organization as an important stakeholder for our Focus Group B series** (being held with community leaders, government leaders, and service providers combined, who work with adults 65+).

If you are interested in learning more or being involved, please reply to the Study Coordinator (Stephanie Dudok), via email at [dudoks3@myumanitoba.ca](mailto:dudoks3@myumanitoba.ca)

**We would be happy to further discuss our research aims and to share with you why we think your participation would be valuable.**

Sincerely,

Kristin Reynolds, Ph.D., C. Psych.  
Assistant Professor  
Departments of Psychology and Psychiatry  
Research Affiliate, Centre on Aging  
University of Manitoba

Stephanie Dudok, MA., Ph.D. Candidate  
'Let's TALK' Study Coordinator  
Department of Psychology  
University of Manitoba

REB Approval received from the U of M (HE2021-0196) and Shared Health/WRHA (SH2022:029)

## Appendix F

### Participant Recruitment Channels and Collaborations

#### Group A

Community-based aging, mental health, and SUA service organizations in Manitoba

Manitoba 55+ seniors centres and seniors councils

Residential 55+ complexes and retirement communities in Winnipeg, Manitoba

Seniors Scope newspaper advertisement targeted to older adults in Manitoba (<https://seniorscope.com/>)

The Pros Know 55+ Active Living and Resource Expos in Manitoba (<https://prosknowexpos.ca>)

Healthcare organizations in Manitoba (e.g., Access Centres, Rapid Access to Addictions Medicine (RAAM) clinics, Primary Care Clinics)

University of Manitoba Centre on Aging

#### Survey Respondents

Community-based aging, mental health, and SUA service organizations in Manitoba

Manitoba 55+ seniors centres and seniors councils

The Pros Know Expos 55+ Active Living and Resource Expos and community network (<https://prosknowexpos.ca>)

Active Aging community events targeted to adults 55+ in Manitoba (<https://activeagingmb.ca/55games/>)

Seniors Scope newspaper advertisement targeted to older adults in Manitoba (<https://seniorscope.com/>)

Facebook Meta advertisement targeted to adults 65+ living in Manitoba

University of Manitoba Centre on Aging

#### Group B

Shared Health – Soins Communs (Manitoba) Mental Health and Addictions Provincial Leadership Table

Addiction Foundation of Manitoba Provincial Leadership Table

Manitoba Department of Mental Health and Community Wellness

Mental Health and Addictions Community Network

Community-based aging, mental health, and SUA service organizations in Manitoba

Healthcare organizations in Manitoba (e.g., Access Centres, Rapid Access to Addictions Medicine (RAAM) clinics)

## Appendix G

### Series A Telephone Screening Checklist (Adults 65+)

*Interested participants will initially email the email address provided in the Recruitment Notice (dudoks3@myumanitoba.ca) to indicate their interest in participating. The Study Coordinator will then email the interested participant back to schedule a telephone meeting to discuss the project and eligibility and will also request a telephone number to contact for this purpose.*

- Hello, my name is (Stephanie Dudok), thank you for contacting me regarding the *Let's Talk About Late-Life Mental Health* project.
- How did you find out about our project? Did you have any questions?
- Our focus groups will be starting in [X] month. Before enrolling you into the research study, I have a checklist of questions for you, which will help us to determine whether you are a good fit for our focus groups.
- The checklist will take about 15 minutes of your time, do you have time for that right now, or would you like to be called back at a more convenient time?
- I will be taking notes as we speak, but these notes will not be used for research purposes. These notes will help me to better-understand your eligibility for participating in our research. I will record the notes electronically on my computer and will keep them in a password-protected Excel file.
- Once we have gone over this checklist and if it is determined whether you are a good fit to participate, these notes will be destroyed (deleted from my computer).
- Do you have any questions before I proceed?
- What drew you to this research study, was it of interest to you?
- Explain briefly about the virtual Focus Group format, online videoconferencing requirements, and time commitment.
  - Ensure that participants understand that the group will be 90-minutes in length; discuss any concerns that participants have with this time commitment.
  - Clarify that participants can leave the focus group prior to the 90-minute mark if they are feeling unwell.
- Now I will ask a few questions about you to see if you are able to participate in these focus groups. There may be services that exist that are better suited to you and your interests that we can discuss if this research study is not a good fit for you.
  - What is your age? (Looking for ages 65+ to meet inclusion criteria)
  - How would you describe your hearing (presence of severe hearing difficulties meets exclusion criteria)
  - Do you have any challenges when speaking to others virtually or using videoconferencing? Speaking or understanding the English language? (affirmative responses meet exclusion criteria)

- Do you have access to a private space in which to complete focus group participation? (Looking for affirmative response to meet inclusion criteria)
  - Have you ever or are you currently experiencing a mental health problem? Have you sought help or used services for this problem? (Looking for affirmative response to meet inclusion criteria)
    - Schizophrenia or other psychotic disorder (meets exclusion criteria)
    - Dementia or other major or mild neurocognitive disorder (meets exclusion criteria)
  - Have you ever or are you currently experiencing a substance use or addiction problem? Have you sought help or used services for this problem? (Looking for affirmative response to meet inclusion criteria)
    - Would you have any difficulty participating in the group due to current challenges with alcohol or substance use? (meets exclusion criteria)
  - How are you currently addressing or managing your mental health or substance use/addiction problem?
  - Do you have any issues providing consent? Do you provide consent independently?
  - Do you have access to the Internet and a technology device (computer, laptop, mobile phone)?
  - Thank you for answering my questions. Do you have any questions for me now? *(Based on the discussion, there are two possible options to relay):*
1. I am pleased to say that you will be a good fit for our research study, and I invite you to participate in our virtual focus groups. Would you like to participate?
    - [If no] Thank you for your time. Have a nice day.
    - [If yes] The following are options for our first focus group meeting: [X date], [X date], and [X date]. Of these options, can you let me know your preference? Are you unavailable for any of these options?
    - I will follow-up this phone call with an email (account dudoks3@myumanitoba.ca), which will include a link to an electronic consent form, which we will need you to review and sign prior to your participation. We will also require that you fill out a background questionnaire (to obtain socio-demographic information and information about your mental health background and literacy), which you can also access through a link that I email. *(Collect email preferred/additional email address if needed; send consent form by email through Qualtrics software).*
    - Feel free to contact me at by email (dudoks3@myumanitoba.ca provided) if you have further questions.
  2. It does not appear at this time that you are a good fit for our research study for these reasons (outline eligibility criteria that is not met).
    - There may be services that exist that are better suited to you and your interests, that we can briefly discuss. *(Resource list will be referred to during this discussion and provided through email to the individual if required).*

## Appendix H

### Series B Online Eligibility Checklist (Community Service Leaders)



**Dr. Kristin Reynolds, Ph.D., C.Psych**  
Email: [Kristin.Reynolds@Umanitoba.ca](mailto:Kristin.Reynolds@Umanitoba.ca)

**Ms. Stephanie Dudok, MA., Ph.D. Candidate**  
Email: [Dudoks3@myumanitoba.ca](mailto:Dudoks3@myumanitoba.ca)

University of Manitoba,  
Department of Psychology  
P404 Duff Roblin Building, 190 Dysart Rd.  
Winnipeg, MB, R3T 2N2

Dear X,

Thank you for getting in contact. We are glad to hear that you and your organization are interested in participating. I will first answer your questions about X: *(if relevant, respond to specific questions raised about research study).*

You have indicated your interest in participating in a virtual focus group to discuss needs and priorities related to the accessibility, availability, and navigation of late-life mental health, substance use and addiction services in Manitoba. Before enrolling you into the research study, we have a brief checklist of questions for you, which will help us to determine whether you are a good fit for our focus groups. The checklist is expected to take no more than 5 minutes of your time.

Please complete the checklist using the following link: *(provide link to Qualtrics platform - Checklist content outlined below):*

#### Eligibility Criteria Checklist (confirm affirmative response to each question)

- ☒ Hold a current leadership position (e.g., executive, managerial, supervisory) in a community organization in Manitoba that has responsibility for the delivery, planning or oversight of late-life aging, mental health, and/or substance use/addiction services.
- ☒ Able to give informed consent
- ☒ Fluent in the English language
- ☒ Have access to a computer or other electronic device
- ☒ Have access to an Internet connection
- ☒ Have an email address
- ☒ Able to participate in a virtual videoconference format without significant challenge
- ☒ Have access to a private space in which to complete focus group participation
- ☒ Able to complete a background survey online
- ☒ Absence of severe hearing difficulties

Availability poll for first focus group meeting date options: Option X, Option X, Option X.

Once you complete the checklist, we will email you back confirming whether you have met our eligibility requirements and will, at that time, invite you to complete an electronic participant consent form and background questionnaire, and join an upcoming focus group.

Sincerely, Stephanie Dudok, MA, PhD Candidate, and Kristin Reynolds, PhD, C. Psych.

## Appendix I

### Series B Online Eligibility Checklist (Service Providers)



**Dr. Kristin Reynolds, Ph.D., C.Psych**  
Email: [Kristin.Reynolds@Umanitoba.ca](mailto:Kristin.Reynolds@Umanitoba.ca)

**Ms. Stephanie Dudok, MA., Ph.D. Candidate**  
Email: [Dudoks3@myumanitoba.ca](mailto:Dudoks3@myumanitoba.ca)

University of Manitoba,  
Department of Psychology  
P404 Duff Roblin Building, 190 Dysart Rd.  
Winnipeg, MB, R3T 2N2

Dear X,

Thank you for getting in contact. We are glad to hear that you and your organization are interested in participating. I will first answer your questions about X: *(if relevant, respond to specific questions raised about research study).*

You have indicated your interest in participating in a virtual focus group to discuss needs and priorities related to the accessibility, availability, and navigation of late-life mental health, substance use and addiction services in Manitoba. Before enrolling you into the research study, we have a brief checklist of questions for you, which will help us to determine whether you are a good fit for our focus groups. The checklist is expected to take no more than 5 minutes of your time.

Please complete the checklist using the following link: *(provide link to Qualtrics platform - Checklist content outlined below):*

#### Eligibility Criteria Checklist (confirm affirmative response to each question)

- ☒ Be practicing geriatric mental health and/or substance use/addiction service providers in Manitoba (i.e., geriatric psychiatrists, psychologists, social workers, rehabilitation workers, or other clinicians)
- ☒ Able to give informed consent
- ☒ Fluent in the English language
- ☒ Have access to a computer or other electronic device
- ☒ Have access to an Internet connection
- ☒ Have an email address
- ☒ Able to participate in a virtual videoconference format without significant challenge
- ☒ Have access to a private space in which to complete focus group participation
- ☒ Able to complete a background survey online
- ☒ Absence of severe hearing difficulties

Availability poll for first focus group meeting date options: Option X, Option X, Option X.

Once you complete the checklist, we will email you back confirming whether you have met our eligibility requirements and will, at that time, invite you to complete an electronic participant consent form and background questionnaire, and join an upcoming focus group.

Sincerely, Stephanie Dudok, MA, PhD Candidate, and Kristin Reynolds, PhD, C. Psych.

## Appendix J

### Series A Informed Consent Form (Adults 65+)



**Dr. Kristin Reynolds, Ph.D., C.Psych**  
Email: [Kristin.Reynolds@Umanitoba.ca](mailto:Kristin.Reynolds@Umanitoba.ca)

**Ms. Stephanie Dudok, MA., Ph.D. Candidate**  
Email: [Dudoks3@myumanitoba.ca](mailto:Dudoks3@myumanitoba.ca)

University of Manitoba,  
Department of Psychology  
P404 Duff Roblin Building, 190 Dysart Rd.  
Winnipeg, MB, R3T 2N2

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**Title of Research:** Let's Talk About Late-Life Mental Health: Multi-Systemic Collaboration to Inform Better Access to Care

**Principal Investigator:** Dr. Kristin Reynolds, Ph.D., C. Psych., University of Manitoba, Department of Psychology

**Study Coordinator/PhD Student Researcher:** Stephanie Dudok, MA., Ph.D. Candidate, University of Manitoba, Department of Psychology

**Research Assistants:** Amanda Kristjanson and Samantha Steele-Mitchell, University of Manitoba, Department of Psychology

**This consent form, a copy of which can be downloaded and/or printed for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about, who is involved in the research, and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.**

**Purpose of the Study:**

The purpose of this study is to engage impacted individuals to understand and address their late-life mental health and substance use/addiction (SUA) service needs and priorities. Participants (adults ages 65+ who have experienced a mental health or SUA problem) will respond to a background survey and then participate in three focus groups with the following five aims: 1) to hear about participants' experiences with the accessibility and availability of late-life mental health and SUA services; 2) to hear about service needs/gaps and system navigation needs; 3) to hear about and set priorities concerning needed services; 4) to hear about and set future research priorities for improving access to and navigation of services; and 5) to hear perspectives on the development and evaluation of a service navigation tool (i.e., late-life mental health and SUA service map).

**Study Procedures:**

As a participant in this study, you will first respond to an online survey that will take approximately 25 minutes to complete. The survey can be accessed and completed online through Qualtrics software and will be made available following your completion of this online consent form. Questions covered on this survey will measure demographic information (i.e., community of residence, sex, population group, age, education, income, marital status); psychosocial information (i.e., self-reported mental health, self-reported physical health, personal experience with mental health or SUA problems, previous experiences accessing mental health or SUA information, and previous experiences accessing mental health or SUA services/programs); and self-rated mental health, substance use and addiction literacy. You can choose to skip a question if you prefer not to respond. Qualtrics is a secure platform that uses Transport Layer Security (TLS) encryption (also known as HTTPS) for all transmitted data. Surveys are protected with passwords.

You will then participate in a total of three virtual focus groups, with approximately 9 other participants in total. Each focus group meeting will take approximately 90 minutes. Participants can, however, leave the focus group prior to the 90-minute mark should they feel unwell. In order to complete the survey and participate in focus group meetings, you will have to have Internet access and be able to use an interactive videoconference software platform (Zoom). You will be required to take part in focus groups from a private space (e.g., a private room where the meeting will not be overheard). During the focus groups, you will be asked to discuss your experiences and perspectives on the accessibility and availability of late-life mental health and substance use/addiction services, your service needs, and your service and research priorities.

**Potential Benefits and Risks of the Research:**

Benefits of participating include learning about and sharing your experiences accessing and navigating services for late-life mental health and SUA problems; sharing your unmet late-life mental health and SUA service needs and priorities; and sharing your perspectives about how the accessibility and availability of late-life mental health and SUA services can be improved. Results of this study will contribute to enhancing access to mental health and SUA services and supports. For example, your responses may be used as a part of informing the development of an system/service navigation tool(s), such as a late-life mental health and SUA service map.

Discussing mental health and SUA problems (e.g., depression, anxiety, alcohol misuse, prescription drug misuse/dependency) may carry with it the risk of experiencing emotional distress. If you notice any feelings of distress after completing any of the focus groups, please speak with one of the focus group facilitators trained in Clinical Psychology and/or consult one of the attached resources for assistance.

**Participant Honourarium:**

If you choose to participate, you will receive a \$25 e-gift card for Amazon.ca your time and contributions for every focus group meeting you attend, accumulating to a total of \$75 in e-gift cards for participating in the entire study. Your gift cards will be provided to you via email, to the email address you provide, at the end of each focus group meeting.

**Voluntary Participation:**

**Participation in this research is voluntary and your decision to participate or not participate will NOT influence your involvement with the services or facilities through which you are being contacted.**

**Freedom to Withdraw:**

**It is your choice whether or not to participate in this study. Participation is voluntary and you may withdraw at any time with no penalty.** If you choose to withdraw during a scheduled focus group, you may click the red “leave meeting” button, which will end your participation in the virtual meeting. If you choose to withdraw at any time, please contact the Principal Investigator (Dr. Kristin Reynolds), at (204) 474-9528 or [Kristin.Reynolds@umanitoba.ca](mailto:Kristin.Reynolds@umanitoba.ca), or the Study Coordinator/PhD Student Researcher (Ms. Stephanie Dudok) at [dudoks3@myumanitoba.ca](mailto:dudoks3@myumanitoba.ca), within two weeks following each attended focus group meeting. Beyond this point, data may have been analyzed and summarized and withdrawal will no longer be possible. The Principal Investigator (Dr. Kristin Reynolds) or the Study Coordinator/PhD Student Researcher (Ms. Stephanie Dudok) may also contact you by telephone or email to confirm your intent to withdraw.

**Confidentiality:**

Information gathered in this research study may be published or presented in public forums in aggregate form such as, thesis-related work, journal article publications, and conference presentations. Quotations from focus group dialogue may also be published or presented using general descriptors (e.g., “74-year-old male participant”); your individual identifying information will not be used or revealed. If you do not wish to use your first name in the focus group, you can choose to identify based on a pseudonym of your selection. Each group meeting will be audio-video recorded by research personnel. You may choose to participate without video, by turning off your camera. Each group meeting will be transcribed using Trint Transcription and analysed by research personnel. All information collected will only be presented in aggregate form without your identifying information. Your information provided on the form requesting future contact regarding the research results will not be linked to the information and name/pseudonym (or ID code) you provide during the group meeting. **If you choose to participate in this research, the Principal Investigator (Dr. Kristin Reynolds), the Study Coordinator/PhD Student Researcher (Stephanie Dudok), and the Research Assistant will have access to research data. Research data will be securely stored off-campus due to COVID-19 restrictions on building access. Research data will be password-protected, and stored in secure, access-controlled University-provided individual file storage (University of Manitoba Outlook OneDrive). Please note that all data stored and shared using Office365 files tools is hosted in Microsoft Data Centres located in Toronto and Quebec City. All copies of this material will be permanently deleted after this research has been completed (within approximately 7 years).**

**Please note that, due to the inclusion of other group members, confidentiality cannot be guaranteed for spoken information provided during focus groups. Please be mindful of this before sharing any private or sensitive personal information to the group. Please also be respectful of others group members’ right to privacy and confidentiality and do not share information that they may provide within the context of the group meeting. You and all other focus group participants will be required to sign an oath of confidentiality prior to your focus group participation.**

A limit of confidentiality is the requirement of research personnel to disclose suspected abuse of vulnerable persons (children or persons in care) to appropriate authorities.

**Questions or Concerns:**

If you have any questions about this study, please do not hesitate to contact the Principal Investigator (Dr. Kristin Reynolds), at (204) 474-9528 or [Kristin.Reynolds@umanitoba.ca](mailto:Kristin.Reynolds@umanitoba.ca), or the PhD Student Researcher (Ms. Stephanie Dudok) at [dudoks3@myumanitoba.ca](mailto:dudoks3@myumanitoba.ca).

For questions about your rights as a research participant, you may contact The University of Manitoba Human Ethics Officer at 204-474-7122 or [HumanEthics@umanitoba.ca](mailto:HumanEthics@umanitoba.ca).

**Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.**

**Statement of Consent:**

**Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.**

**The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.**

**This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or [HumanEthics@umanitoba.ca](mailto:HumanEthics@umanitoba.ca). A copy of this consent form has been given to you to keep for your records and reference.**

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I, \_\_\_\_\_ (print name), have read the above information and hereby consent to participate in this study.

Participant's Signature \_\_\_\_\_ Date (day/month/year)

**Consent to audio and video record during the study:**

Yes \_\_\_\_ No \_\_\_\_ Participant Initials \_\_\_\_

**Oath of Confidentiality:**

**ALL focus group participants, including yourself, must sign this oath as confirmation that you will respect others' rights to privacy and confidentiality.**

I, \_\_\_\_\_ (print name), have read the above information and pledge to respect my fellow focus group members' rights to privacy and confidentiality by not disclosing their name, or the personal information that they share, outside the context of this focus group at any time, including during and after the study is completed.

Participant's Signature \_\_\_\_\_ Date (day/month/year) \_\_\_\_\_

**Permission for future contact:** I agree to be contacted by Ms. Stephanie Dudok or Dr. Kristin Reynolds by telephone, mail, or email for future follow-up in relation to this study (including mailing of e-gift card honoraria) or if any of the content from the focus groups is unclear to her (until research study completion, approximately Dec/2028).

Yes \_\_\_ No \_\_\_ Participant Initials \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**Would you like to receive a summary of the results of this study?**

\_\_\_ No

\_\_\_ Yes, I would like to receive the summary results.

If yes, please provide your contact information below:

Email: \_\_\_\_\_

Phone number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**Would you like to be contacted for future studies related to this work?**

\_\_\_ No

\_\_\_ Yes, I would like to be contacted for future studies by Ms. Stephanie Dudok or Dr. Kristin Reynolds:

If yes, please provide your contact information below:

Email: \_\_\_\_\_

Phone number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

## Appendix K

### Series B Informed Consent Form (Service Leaders and Providers)



**Dr. Kristin Reynolds, Ph.D., C.Psych**  
Email: [Kristin.Reynolds@Umanitoba.ca](mailto:Kristin.Reynolds@Umanitoba.ca)

**Ms. Stephanie Dudok, MA., Ph.D. Candidate**  
Email: [Dudoks3@myumanitoba.ca](mailto:Dudoks3@myumanitoba.ca)

University of Manitoba,  
Department of Psychology  
P404 Duff Roblin Building, 190 Dysart Rd.  
Winnipeg, MB, R3T 2N2

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**Title of Research:** Let's Talk About Late-Life Mental Health: Multi-Systemic Collaboration to Inform Better Access to Care

**Principal Investigator:** Dr. Kristin Reynolds, Ph.D., C. Psych., University of Manitoba, Department of Psychology

**Study Coordinator/PhD Student Researcher:** Stephanie Dudok, MA., Ph.D. Candidate, University of Manitoba, Department of Psychology

**Research Assistants:** Amanda Kristjanson and Samantha Steele-Mitchell, University of Manitoba, Department of Psychology

**This consent form, a copy of which can be downloaded and/or printed for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about, who is involved in the research, and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.**

**Purpose of the Study:**

The purpose of this study is to engage stakeholders in understanding and addressing their late-life mental health and substance use/addiction (SUA) service needs and priorities. Participants (leaders of community aging, mental health, and SUA services or government agencies; geriatric mental health service providers) will participate together in three focus groups with the following five aims: 1) to engage participants in open discussion about accessibility and availability of late-life mental health and SUA services; 2) to identify service needs/gaps and system navigation needs; 3) to define and set priorities concerning needed services or priorities related to needed 'bridges' or collaboration between organizations; 4) to define and set future research priorities for improving access to and navigation of services; and 5) to provide perspectives on the development and evaluation of a service navigation tool (i.e., late-life mental health and SUA service map).

**Study Procedures:**

As a participant in this study, you will first complete an online survey that will take approximately 10 minutes to complete. The survey can be accessed and completed online through Qualtrics, and is accessible following your completion of this online consent form. Questions covered in the survey include demographic information, information concerning your profession, and your self-rated mental health, substance use and addiction literacy. You can choose to skip a question if you prefer not to respond. Qualtrics is a secure platform that uses Transport Layer Security (TLS) encryption (also known as HTTPS) for all transmitted data. Surveys are protected with passwords.

You will participate in a total of three online focus groups, together with approximately 9 other representatives from other service or government organizations. Each focus group meeting will take approximately 90 minutes. In order to complete the survey and participate in focus group meetings, you will have to have internet or WIFI access and be able to use an interactive videoconference software platform (Zoom). You will be required to take part in focus groups from a private space (e.g., a private room where the meeting will not be overheard). During the focus group, you will be asked to discuss your experiences and perspectives about the accessibility and availability of late-life mental health and substance use/addiction services, gaps in services or needed bridges between service delivery organizations/providers, and your service and research priorities.

**Potential Benefits and Risks of the Research:**

Benefits of participating include learning about and collaboratively sharing with other organizations/care providers on improving access to and navigation of late-life mental health and SUA services, including service integration across different levels of care. Results of this study will contribute to enhancing access to late-life mental health and SUA services for patients/clients and their caregivers. For example, your responses may be used as a part of informing the development of an interactive system/service navigation tool(s), such as a late-life mental health and SUA service map. Additional benefits include the potential establishment of partnerships and collaborations with other stakeholders who are impacted by the research topic (i.e., the establishment of a network consisting of community or government organizations, service providers, and researchers in the area of late-life mental health and SUA).

Discussing mental health and SUA problems (e.g., depression, anxiety, alcohol misuse, prescription drug misuse/dependency) may carry with it the risk of experiencing emotional distress. If you notice any feelings of distress after completing any of the focus groups, please speak with one of the focus group facilitators trained in Clinical Psychology and/or consult one of the attached resources for assistance.

**Voluntary Participation:**

**Participation in this research is voluntary and your decision to participate or not participate will NOT influence your involvement with the services or facilities through which you are being contacted.**

**Freedom to Withdraw:**

**It is your choice whether or not to participate in this study. Participation is voluntary and you may withdraw at any time with no penalty. If you choose to withdraw during a scheduled**

focus group, you may click the red “leave meeting” button, which will end your participation in the virtual meeting. If you choose to withdraw at any time, please contact the Principal Investigator (Dr. Kristin Reynolds), at (204) 474-9528 or [Kristin.Reynolds@umanitoba.ca](mailto:Kristin.Reynolds@umanitoba.ca), or the Study Coordinator/PhD Student Researcher (Ms. Stephanie Dudok) at [dudoks3@myumanitoba.ca](mailto:dudoks3@myumanitoba.ca), within two weeks following each attended focus group meeting. Beyond this point, data may have been analyzed and summarized and withdrawal will no longer be possible. The Principal Investigator (Dr. Kristin Reynolds) or the Study Coordinator/PhD Student Researcher (Ms. Stephanie Dudok) may also contact you by telephone or email to confirm your intent to withdraw.

**Confidentiality:**

Information gathered in this research study may be published or presented in public forums in aggregate form such as, thesis-related work, journal article publications, and conference presentations. Quotations from focus group dialogue may also be published or presented using general descriptors (e.g., “community organization participant” or “geriatric mental health clinician”); your individual identifying information will not be used or revealed. If you do not wish to use your first name in the focus group, you can choose to identify based on a pseudonym of your selection. Each group meeting will be audio-video recorded. You may choose to participate without video, by turning off your camera. Each group meeting will be transcribed using Trint Transcription and analysed by research personnel. All information collected will only be presented in aggregate form without your identifying information. Your information provided on the form requesting future contact regarding the research results will not be linked to the information and name/pseudonym (or ID code) you provide during the group meeting. **If you choose to participate in this research, the Principal Investigator (Dr. Kristin Reynolds), the Study Coordinator/PhD Student Researcher (Stephanie Dudok), and the Research Assistant will have access to research data. Research data will be securely stored off-campus due to COVID-19 restrictions on building access. Research data will be password-protected, and stored in secure, access-controlled University-provided individual file storage (University of Manitoba Outlook OneDrive). Please note that all data stored and shared using Office365 files tools is hosted in Microsoft Data Centres located in Toronto and Quebec City. All copies of this material will be permanently deleted after this research has been completed (within approximately 7 years).**

**Please note that, due to the inclusion of other group members, confidentiality cannot be guaranteed for spoken information provided during focus groups. Please be mindful of this before sharing any private or sensitive personal information to the group. Please also be respectful of others group members’ right to privacy and confidentiality and do not share information that they may provide within the context of the group meeting. You and all other focus group participants will be required to sign an oath of confidentiality prior to your focus group participation.**

A limit of confidentiality is the requirement of research personnel to disclose suspected abuse of vulnerable persons (children or persons in care) to appropriate authorities.

**Questions or Concerns:**

If you have any questions about this study, please do not hesitate to contact the Principal Investigator (Dr. Kristin Reynolds), at (204) 474-9528 or [Kristin.Reynolds@umanitoba.ca](mailto:Kristin.Reynolds@umanitoba.ca), or the PhD Student Researcher (Ms. Stephanie Dudok) at [dudoks3@myumanitoba.ca](mailto:dudoks3@myumanitoba.ca).

For questions about your rights as a research participant, you may contact The University of Manitoba Human Ethics Officer at 204-474-7122 or [HumanEthics@umanitoba.ca](mailto:HumanEthics@umanitoba.ca).

**Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.**

**Statement of Consent:**

**Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.**

**The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.**

**This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or [HumanEthics@umanitoba.ca](mailto:HumanEthics@umanitoba.ca). A copy of this consent form has been given to you to keep for your records and reference.**

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I, \_\_\_\_\_ (print name), have read the above information and hereby consent to participate in this study.

Participant's Signature \_\_\_\_\_ Date (day/month/year)

**Consent to audio and video record during the study:**

Yes \_\_\_ No \_\_\_ Participant Initials \_\_\_

**Oath of Confidentiality:**

**ALL focus group participants, including yourself, must sign this oath as confirmation that you will respect others' rights to privacy and confidentiality.**

I, \_\_\_\_\_ (print name), have read the above information and pledge to respect my fellow focus group members' rights to privacy and confidentiality by not disclosing their name, or the personal information that they share, outside the context of this focus group at any time, including during and after the study is completed.

Participant's Signature \_\_\_\_\_ Date (day/month/year) \_\_\_\_\_

**Permission for future contact:** I agree to be contacted by Ms. Stephanie Dudok or Dr. Kristin Reynolds by telephone, mail, or email for future follow-up in relation to this study (including mailing of e-gift card honoraria) or if any of the content from the focus groups is unclear to her (until research study completion, approximately Dec/2028).

Yes \_\_\_ No \_\_\_ Participant Initials \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**Would you like to receive a summary of the results of this study?**

\_\_\_ No

\_\_\_ Yes, I would like to receive the summary results.

If yes, please provide your contact information below:

Email: \_\_\_\_\_

Phone number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**Would you like to be contacted for future studies related to this work?**

\_\_\_ No

\_\_\_ Yes, I would like to be contacted for future studies by Ms. Stephanie Dudok or Dr. Kristin Reynolds:

If yes, please provide your contact information below:

Email: \_\_\_\_\_

Phone number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**Appendix L****Series A Background Survey (Adults 65+)****Today's Date:** \_\_\_\_\_**Gender identification:** \_\_\_\_\_**Age:** \_\_\_\_\_**Highest Level of Education Completed:** \_\_\_\_\_**Occupational Status:** \_\_\_\_\_**Current household income per year (before taxes):** \_\_\_\_\_**Marital Status:** \_\_\_\_\_**Living Arrangement:** \_\_\_\_\_**Location of Residence:**

- ☐ Urban
- ☐ Rural

**Population Group (check all that apply):**

- ☐ White
- ☐ South Asian
- ☐ Chinese
- ☐ Black
- ☐ Filipino
- ☐ Latin American
- ☐ Arab
- ☐ Southeast Asian
- ☐ West Asian
- ☐ Korean
- ☐ Japanese
- ☐ Indigenous peoples
- ☐ Other: \_\_\_\_\_

**How would you describe your physical health in general (how are you feeling physically)?**

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very Good
- ☐ Excellent

**How would you describe your mental health in general (how are you feeling emotionally)?**

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very Good
- ☐ Excellent

Have you ever experienced a **mental health problem?** (for example: anxiety, depression)

- ☐ No
- ☐ Yes

Are you currently experiencing a **mental health problem?** (for example: anxiety, depression)

- ☐ No
- ☐ Yes

Have you ever experienced a **substance use or addiction problem?** (for example: misusing or being dependent on alcohol, cannabis, prescription drugs, or other drugs; gambling problems)

- ☐ No
- ☐ Yes

Are you currently experiencing a **substance use or addiction problem?** (for example: misusing or being dependent on alcohol, cannabis, prescription drugs, or other drugs; gambling problems)

- ☐ No
- ☐ Yes

Are you currently using or have you ever looked for **information about mental health problems** and how to get help for yourself or others?

- ☐ No
- ☐ Yes

If yes, please list the information you have accessed: \_\_\_\_\_

Are you currently using or have you ever looked for **information about substance use or addiction problems** and how to get help for yourself or others?

- ☐ No
- ☐ Yes

If yes, please list the information you have accessed: \_\_\_\_\_

Are you currently accessing, or have you ever sought or used, **mental health services or programs?**

- ☐ No
- ☐ Yes

If yes, please list the services/supports you have accessed: \_\_\_\_\_

Are you currently accessing, or have you ever sought or used, **substance use or addiction services or programs?**

- ☐ No
- ☐ Yes

If yes, please list the services/supports you have accessed: \_\_\_\_\_

How would you rate your knowledge of mental health, substance use and addiction-related resources **for adults ages 65+ in the community?**

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very Good
- ☐ Excellent

### **Brief Measure of Mental Health, Substance Use and Addiction Literacy**

Please read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely honest and open.

| Not at All | Somewhat | Moderate | Very | Extremely |
|------------|----------|----------|------|-----------|
| 1          | 2        | 3        | 4    | 5         |

How knowledgeable are you about:

- The signs and symptoms of mental health problems? (such as anxiety and depression)
- The possible causes of mental health problems?
- The types of professional help available for common mental health problems? (such as anxiety and depression)
- How to go about seeking professional help for mental health problems?

How knowledgeable are you about:

- The signs and symptoms of substance use or addiction problems? (such as alcohol, cannabis, or prescription drug misuse/dependency, or problem gambling)
- The possible causes of substance use or addiction problems?
- The types of professional help available for common substance use or addiction problems? (such as alcohol, cannabis, or prescription drug misuse/dependency, or problem gambling)
- How to go about seeking professional help for substance use or addiction problems?

How knowledgeable are you about:

- How the mental health system in Manitoba is organized?
- How to navigate the mental health services that you need?
- How to navigate the substance use or addiction services that you need?

**Appendix M****Series B Background Survey (Community Service Leaders)****Today's Date:** \_\_\_\_\_**Gender identification:** \_\_\_\_\_**Age:** \_\_\_\_\_**Population Group** (check all that apply):

- ☐ White
- ☐ South Asian
- ☐ Chinese
- ☐ Black
- ☐ Filipino
- ☐ Latin American
- ☐ Arab
- ☐ Southeast Asian
- ☐ West Asian
- ☐ Korean
- ☐ Japanese
- ☐ Indigenous peoples
- ☐ Other: \_\_\_\_\_

**Community/Government Organization (name):** \_\_\_\_\_**Community/Government Organization's Service Delivery area:**

- ☐ Mental Health
- ☐ Substance Use / Addictions
- ☐ Mental Health AND Substance Use / Addictions

**Location of Organization:**

- ☐ Urban
- ☐ Rural

**Highest Level of Education Completed:** \_\_\_\_\_**Current occupational status:**

- ☐ Full-time
- ☐ Part-time
- ☐ Casual

Current role within Community/Government Organization: \_\_\_\_\_

Length of time (years) involved within Community/Government Organization: \_\_\_\_\_

**Brief Measure of Mental Health, Substance Use and Addiction Literacy**

Please read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely honest and open.

| Not at All | Somewhat | Moderate | Very | Extremely |
|------------|----------|----------|------|-----------|
| 1          | 2        | 3        | 4    | 5         |

How knowledgeable are you about:

- The signs and symptoms of mental health problems (such as anxiety and depression)?
- The possible causes of mental health problems?
- The types of professional help available for common mental health problems (such as anxiety and depression)?
- How to go about seeking professional help for mental health problems?

How knowledgeable are you about:

- The signs and symptoms of substance use or addiction problems (such as alcohol, cannabis, or prescription drug misuse/dependency, or problem gambling)?
- The possible causes of substance use or addiction problems?
- The types of professional help available for common substance use or addiction problems? (such as alcohol, cannabis, or prescription drug misuse/dependency, or problem gambling)
- How to go about seeking professional help for substance use or addiction problems?

How knowledgeable are you about:

- How to navigate/refer to the mental health services that you need?
- How to navigate/refer to the substance use or addiction services that you need?
- How the mental health system in Manitoba is organized?

**Appendix N****Series B Background Survey (Service Providers)****Today's Date:** \_\_\_\_\_**Gender identification:** \_\_\_\_\_**Age:** \_\_\_\_\_**Population Group** (check all that apply):

- ☐ White
- ☐ South Asian
- ☐ Chinese
- ☐ Black
- ☐ Filipino
- ☐ Latin American
- ☐ Arab
- ☐ Southeast Asian
- ☐ West Asian
- ☐ Korean
- ☐ Japanese
- ☐ Indigenous peoples
- ☐ Other: \_\_\_\_\_

**Highest Level of Education Completed:** \_\_\_\_\_**Current occupational status:**

- ☐ Full-time
- ☐ Part-time
- ☐ Casual

**Current profession** within the area of geriatric mental health and/or substance use and addiction services: \_\_\_\_\_**Location of Service Delivery:**

- ☐ Urban
- ☐ Rural

**Service Delivery area:**

- ☐ Mental Health
- ☐ Substance Use / Addictions
- ☐ Mental Health AND Substance Use / Addictions

Length of time (years) in current position: \_\_\_\_\_

Prior experience within the area of geriatric mental health and/or addiction services (if current position differs from prior position): \_\_\_\_\_

### **Brief Measure of Mental Health, Substance Use and Addiction Literacy**

Please read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely honest and open.

| Not at All | Somewhat | Moderate | Very | Extremely |
|------------|----------|----------|------|-----------|
| 1          | 2        | 3        | 4    | 5         |

How knowledgeable are you about:

- the signs and symptoms of mental health problems? (such as anxiety and depression)
- the possible causes of mental health problems?
- the types of professional help available for common mental health problems? (such as anxiety and depression)
- how to go about seeking professional help for mental health problems?

How knowledgeable are you about:

- the signs and symptoms of substance use or addiction problems? (such as alcohol, cannabis, or prescription drug misuse/dependency, or problem gambling)
- the possible causes of substance use or addiction problems?
- the types of professional help available for common substance use or addiction problems? (such as alcohol, cannabis, or prescription drug misuse/dependency, or problem gambling)
- how to go about seeking professional help for substance use or addiction problems?

How knowledgeable are you about:

- how the mental health system in Manitoba is organized?
- how to navigate/refer to the mental health services that you need?
- how to navigate/refer to the substance use or addiction services that you need?

## Appendix O

### Focus Group 1 Semi-Structured Procedure

#### **Before the Focus Group**

Ask participants to complete background information questionnaire via secure survey link prior to attending the first focus group meeting.

#### **During the Focus Group**

##### **Introduction/Preamble:**

- Thank you very much for joining our virtual focus group meeting today.
- Facilitator introduces herself and the research team.
- Remind participants about the project aims.
  - The purpose of this focus group is to understand the perspectives of impacted individuals concerning their late-life mental health and substance use/addiction service (and service navigation) needs and priorities.
  - We will use our time to hear about your experiences accessing or attempting to access services and supports in the community for late-life mental health and substance use/addiction problems; and to learn about your needs when it comes to navigating services for these problems.
  - An expected outcome is improved access to and navigation of late-life mental health and substance use/addiction (SUA) services.
- Remind participants that the information they provide will remain confidential. Let the participants know that they can refuse to answer questions when preferred.
- Remind participants about the limits of confidentiality related to disclosure about the abuse of vulnerable persons (including children or other persons in care).
- Remind participants to refrain from mentioning any personal identifiable details during the focus group (e.g., refrain from saying their or others' name).
- Remind participants that transcripts of recorded information will be stored for 7 years and then destroyed.
- Remind participants that the focus group will be audio-video recorded, and that participants may choose to turn their cameras off.
- Remind participants not to record the focus group using any other devices (recording by participants will be disabled in Zoom).
  - Note: participants will not be able to participate if they do not agree to be recorded. (In this case, the facilitator/Zoom Host will ask the participant to leave the meeting and, if necessary, will virtually remove the participant from the Participant Menu).
- Verify that participants have each received and signed the consent form. If you do not have their electronic consent form, ask for their verbal consent to proceed with the interview before you get started.
  - For Group A only: remind participants that they will receive a \$25 e-gift for Amazon.ca per meeting for their participation.

- Finally, let participants know when you are turning on the recorder [get consent for this]. Then start the recorder.

**General probes to consider throughout (both groups):**

- Tell me more about that.
- Why/why not? How so?
- Can you give me an example of that?
- What did/does that mean to you?
- How did/does that impact/effect you?
- What did you do when that happened?
- Can you say anything else about that?
- Can you build on the point [Participant] just made? What about re. SUA?
- Who's had a similar experience to [Participant]?
- Who's had a different experience from [Participant]?

**Group A Probing Questions:**

1. Can you tell me about the mental health or SUA services or supports that you need or are/were looking for?

- How have you tried to access these services in the community?
- What was it like to for you to try to access the services you need?
- What mental health or SUA needs do you have that have not been addressed by existing services? (*Potential Probe:* where are the gaps? How would they be helpful to you?)
- When you were not able to get your service needs met, how did that impact your alcohol or cannabis use, or gambling (or contribute to other problems)?
- How has the COVID-19 pandemic affected your service use? As we come out of the pandemic, what services or ways of delivering services do you think will be important now and in the future (e.g., telehealth needs)?

2. Can you tell me about your knowledge of how the mental health and SUA system in Manitoba is organized and how you can find and navigate the services you need?

- What would help you navigate the system and services more easily?
- How would you like to receive information about services and how to access services?
- What formats would be best (e.g., accessible, facilitative? From whom or where would you like to receive such information?)

[Additional Group A follow-up probes as needed]:

- *What services have you accessed?*
- *How are you getting the services that you need or how did you find them?*
- *What was the process of getting into these services like for you?*
- *Can you describe the process of how you found or got into these services or supports?*
- *Assuming you were ready to get help, what barriers made it difficult to access the services (including exclusions due to current substance use)?*
- *What are the services and supports that don't exist (where are the gaps)?*
- *What about formats of service delivery?*

- What needs do you have in terms of mental health and/or SUA that have not been addressed by existing services? How important would these services be to you? How would they be helpful to you? How would you like to access these services?

### **Group B Probing Questions:**

1. How do you or your organization meet the service needs of older adults 65+ and how accessible are the services?

- How can people access these services? What are the entry/referral pathways? (What is entailed here)? What makes it hard for people to access or navigate the services?
- What do you find are the most common service needs identified by older adults living in the community, who are seeking mental health or SUA services? Which of these services exists and which do not? Which services are missing or needed that don't already exist?
- Thinking about the gaps discussed so far, which of these areas would be worth focusing on to create better access opportunities? Which areas would be the most challenging and why?

2. How important is service integration? How can services be better integrated or united? Is there interest?

- What is the nature of relationships between community-based programs and services addressing late-life mental health and SUA? (With the healthcare system)?
- What strategies/mechanisms do you and your organization use to build and sustain credible linkages to support the mental health and well-being of older adults living in the community? What strategies/mechanisms are missing or needed?

[Additional Group B follow-up probes as needed]:

- *Can you describe for me the late-life mental health or SUA services that you or your organization provides and how people can get to them (access them)?*
- *What do you find are the most challenging mental health and SUA concerns/needs for your organization to address and make available? (for older adults living in the community)?*
- *How do you or your organization help adults 65+ navigate the services they need?*
- *What happens if people need different services (e.g., for more severe cases)? What bridges or linkages exist between organizations and with the healthcare system so that people are able to get the right level of care?*
- *What is the nature of relationships between community-based programs and services addressing late-life mental health and SUA? With the healthcare system?*
- *What system navigation strategies/mechanisms does your organization or the system use (to support adults 65+ to access services)?*
- *What programs are needed in the community that could be helpful to alleviating the demand on the formal health system (e.g., Geriatric Mental Health Teams, Geriatric Psychiatry, Geriatric Psychology)?*

- *What referral processes do you use and how can community organizations more seamlessly refer to the formal health system and vice versa? (e.g., Geriatric Mental Health Teams, Geriatric Psychiatry, Geriatric Psychology)*
- *How has the COVID-19 pandemic and related restrictions affected services and service delivery? What is currently needed, or what will be needed in the future, as a result (e.g., telehealth needs)?*

**Closing:**

- Is there anything else that you would like to say before we end the meeting?
- Thank all participants for their time.
  - For Group A only: Remind participants that they will receive a \$25 e-gift card for their time and contributions. Explain that when you send the e-gift card, they will need to confirm with a return email that they have received it.
- Remind participants about the two-week deadline for withdrawing their data following this first focus group meeting.
- Remind participants of the date of the next focus group (if determined). Instruct participants to bring a notebook and five blank pieces of paper to next focus group.

## Appendix P

### Focus Group 2 Structured Procedure

#### Pre-Steps

- Instruct participants in Focus Group 1 to each bring their own notebook and five blank pieces of paper to Focus Group 2, emphasizing that we will require use of this notebook during the session.
- Before the session, the Facilitator should create a Field Note Template using Microsoft PowerPoint for use during the session.
- On the first and second slide, write the NGT Question.
- On the next slide, create a list with numbers and corresponding blank spaces for recording ideas during the round-robin listing ('virtual flipchart').
- On the next slide, create a Field Note Template tally sheet using Microsoft Excel auto-sum function with numbers down the left-hand side of the chart, which will be used during the session to correspond with the ideas from the round-robin listing. Purposely create more numbers than expected and then delete excess to match the actual numbers generated during the session.

#### Procedures

1. **Silent Generation:** Each group member silently and independently writes as many ideas as they wish in their personal notebook in response to the nominal question.
2. **Round Robin:** Group members shared each of their ideas one-at-a-time over several rounds until all ideas have been recorded on the 'virtual flipchart'.
3. **Serial Discussion:** Group members are provided with the opportunity to briefly discuss each idea to clarify its meaning and express their views.
4. **Voting/Ranking:** Group members assign points to their individual top five priorities and results are aggregated to obtain consensus on the most important ideas.

**Opening Script (Facilitator):** I would like to thank each of you for attending this meeting to identify the most important late-life mental health, substance use, and addiction service needs. I welcome you to this meeting and want you to know that I am very happy to have each of you with us today. Our objective is an important one. At the conclusion of this meeting, we will have together identified your service and research priorities. In our meeting, it is important that each of us fully participate. Success today will depend on our equal and full participation. Each of us is here as an important group member. There are no status differences between us in this particular meeting. Our success depends on every member fully sharing the insight from his or her own personal experience and perspective. I appreciate the willingness of every one of you to fully share your ideas and work intensely during the next 90 minutes that we are together. The ideas which you generate in this meeting will become a very important starting point for knowing more about how to improve access to and navigation of late-life mental health, substance use and addiction services. At this time, can you each make sure you have your notebook available and ready to use, as well as your 5 blank pieces of paper [do not begin until everyone has their notebook/blank papers available and ready to use].

We are going to list ourselves off now as participants 1 to 6 so that real names aren't used.... Who would like to be participant #1? Thank you. Participant #2? Thank you. Participant #3? Thank you. Participant #4? Thank you. #5?... #6...

[Facilitator and Research Assistant 1 record participants' numbers to ensure round-robin section goes in order without using participants' real name].

### **Conducting the Focus Group**

#### **Step 1, Question 1 (service priorities): Silent Generation of Ideas in Writing**

**Script (Facilitator):** The following is the first question for today's session. [Research Assistant 2 will display the Field Note Template created using PowerPoint with the question; Facilitator will then read the first question to the group]. I would like each of you to take five minutes to list your ideas in response to this question. Describe each idea in a brief phrase or a few words in the notebook that you brought along. Please work independently of other members. During this period of independent thinking, I ask that you not talk to other members or interrupt their thinking. Since this is an opportunity for each of us to prepare his or her contributions to the meeting, I would appreciate intense effort during the next five minutes. At the end of the five minutes, I will pass things to Research Assistant 1, who will call time and suggest how we proceed to share our ideas. Are there any questions? [pause]. Let's proceed then with our individual effort for the next five minutes.

#### **Step 2: Round-Robin Recording of Ideas**

**Script (Research Assistant 1):** During the last five minutes, each of us used our notebooks to list ideas in response to the question on the screen. Now I would like to have each of you share your ideas with the other members of the group. [At this point, Research Assistant 2 displays the Field Note Template with the 'virtual flipchart' blank list on the screen]. This is an important step because our list of ideas will guide our further discussion as a group, to help us understand the richness of ideas we have to work with and stimulate additional ideas. To accomplish this goal as quickly and efficiently as possible, I am going to go around one-at-a-time and ask each person to give me one idea from their notebook, summarized in a brief phrase or a few words. We will go around several times until each person has had a chance to provide all the responses they wanted to. If someone else in the group lists an idea which you also had in your notebook, you don't need to repeat the idea again. If, however, in your judgment the idea in your notebook contains a different emphasis or variation, then I would welcome it as a new idea. Variations on a theme are important and will help us to be creative. Also, if someone says an idea that causes you to think of a new idea that you hadn't already written down, you should just silently add your new idea into your own personal notebook to be presented to the rest of the group when your turn arrives. Finally, after the entire list is on the screen, we will have the opportunity to discuss, clarify and deliberate the ideas as a whole. Are there any questions? [Turning to the first person in the group, Research Assistant 1 now asks:] "Now [Participant #1], would you please give me one idea from your list?"

**Step 3: Serial Discussion**

**Script (Research Assistant 1):** Now that we have all our ideas listed on the screen, I want us to take time to go back and briefly discuss each idea. The purpose of this discussion is to clarify the meaning of each item on our list. It is also the opportunity to express our understanding of the logic behind the idea and the relative importance of the item. We should feel free to express varying points of view or to disagree. We will, however, want to pace ourselves so that each of the items on the chart receives the opportunity for some attention, so I may sometimes ask the group to move on to further items. Finally, let me point out that the creator of the idea being discussed need not feel obliged to clarify or explain an item. Any member of the group can play that role. [Referring to the Field Note Template on Research Assistant 2's screen, Research Assistant 1 points to the first item and says:] "Are there any questions or comments group members would like to make about this first item?" ... and so on.

**Step 4: Voting/Ranking**

**Script (a) (Facilitator):** We have now completed our discussion of the entire list of ideas, have clarified the meaning of each idea, and have discussed the areas of agreement and disagreement. I'm now going to guide us through having each group member identify the most important ideas on the list. To accomplish this step, you should each take out your five blank pieces of paper. Then, I would like you to select the five most important items from our list of items on the screen. This will require careful thought and effort on your part. As you look at the list on the screen and find an item which you feel is very important, please record the item on one of your pieces of paper. [At this point, Research Assistant 2 should flip to the Field Note Template PowerPoint slide with 7 written on a picture of a page in the upper left-hand corner]. Place the number of the item on our list in the upper left-hand corner of the card. For example, if you feel Item 7 is very important to you, you would write 7 in the upper left-hand corner like you see on the screen. Then, write the identifying words or phrase on the card. [At this point, Research Assistant 2 writes the generated phrase for Item 7 on the screen displayed]. Do this for each of the five most important items from our total list. When you have completed this task, you should have five pages, each with a separate phrase written on the page and with identifying numbers using the numbering system from our list of ideas. Do not rank-order the pages yet. Spend the next few minutes carefully selecting the five items. We will rank-order the cards together. Right now, you just have to make sure you choose five items. Are there any questions? [At this point the Facilitator gives the group time to study their pages]. [After each member of the group has selected five items and written them on separate pages, the Facilitator says the following]:

**Script (b) (Facilitator):** Please spread out your pages in front of you so you can see all five at once. Looking at your set of five pages, decide which idea is the most important to you. Which page is more important than the other four pages; which is the most important page? [At this point the facilitator gives the group time (2min) to study their pages]. Please write a number '5' in the lower right-hand corner of the page. Turn that page over now and look at the ideas on the remaining four pages. Of the remaining four pages, which is the least important? Write a number '1' in the lower right-hand corner. [At this point the facilitator gives the group time (2min) to study their pages]. Now choose the most important of the remaining three cards and write the number '4' in the lower right-hand corner. [At this point the facilitator gives the group time (2min) to study their pages]. Now choose the less important of the remaining two cards and write the number '2' in the lower right-hand corner. [At this point the facilitator gives the group time

(2min) to study their pages]. Now write the number '3' in the lower right-hand corner of the remaining card. [At this point the facilitator gives the group time (2min) to study their pages].

The remaining parts of Step 4 are as follows (adapted for virtual administration):

- The Facilitator pulls up the previously created Field Note Template tally sheet on a linked Excel sheet with numbers pre-populated that correspond to the ideas from the round-robin list.
- The Facilitator has participants place their pages into a pile.
- The Facilitator then asks each group member to read the idea (top left-hand corner) number and number of points (1 to 5; bottom right-hand corner) from each index card while Research Assistant 2 records the scores on the tally sheet.
- The Facilitator sums the scores for each of the ideas to identify those ideas which are most highly rated by the group as a whole. These constitute the priorities favoured by the group for dealing with the NGT question. [Research Assistants ensure accuracy].

**Script (c) (Facilitator):** [At this point, Research Assistant 2 should display the Field Note Template tally sheet on the screen share]. I am now going to ask each group member to please read the number in the upper left-hand side of your page, followed by the number of points you gave it in bottom right-hand corner of your page. We will do for each person's five pages. I will record the points on the tally sheet here on the screen for each of your five pages, before we move on to the next person. Are there any questions before we begin? [pause]. "Now \_\_\_\_, would you please start us off?"

### **Step 5: Post-Voting Discussion**

The final vote is tallied to identify the group's most favored priorities. Step 5 adds a brief discussion held after the group sees the ratings of the entire group. This discussion focuses on those ideas that were most highly rated during the voting and clarifies any issues.

### **Question 2 (Open-Ended)**

What research topics or questions do we need to learn more about to improve access to and navigation of late-life mental health, substance use and addiction services?

### **Closing**

- Thank all participants for their time. Remind participants that they will receive a \$25 e-gift card for their time and contributions.
- Remind participants about the two-week deadline for withdrawing their data following this second focus group meeting.

Script adapted from: Dunham, R. B. (1998). Nominal group technique: A users' guide. *Madison: Wisconsin School of Business*, 2.

**Appendix Q**

**NGT Field Note Template (Virtual Flipchart)**

**Series [x], Focus Group 2**

[date and time of meeting redacted]

Question 1:

What are the most important mental health, substance use or addiction services that are needed by adults 65+ ?

|    |     |     |
|----|-----|-----|
| 1. | 9.  | 17. |
| 2. | 10. | 18. |
| 3. | 11. | 19. |
| 4. | 12. | 20. |
| 5. | 13. | 21. |
| 6. | 14. | 22. |
| 7. | 15. | 23. |
| 8. | 16. | 24. |

|     |     |     |
|-----|-----|-----|
| 25. | 33. | 41. |
| 26. | 34. | 42. |
| 27. | 35. | 43. |
| 28. | 36. | 44. |
| 29. | 37. | 45. |
| 30. | 38. | 46. |
| 31. | 39. | 47. |
| 32. | 40. | 48. |

|     |     |     |
|-----|-----|-----|
| 49. | ... | ... |
| 50. | ... | ... |
| ... | ... | ... |
| ... | ... | ... |
| ... | ... | ... |
| ... | ... | ... |
| ... | ... | ... |
| ... | ... | ... |

7

*[insert item here...]*

[ ]

## NGT Field Note Template (Tally Sheet)

|                         |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|-------------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 1                       | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|                         |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                         |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                         |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 0                       | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
|                         |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 21                      | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 |
|                         |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                         |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                         |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 0                       | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
|                         |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| IDENTIFIED PRIORITY #1: |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| IDENTIFIED PRIORITY #2: |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| IDENTIFIED PRIORITY #3: |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| IDENTIFIED PRIORITY #4: |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| IDENTIFIED PRIORITY #5: |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

## Appendix S

## Recruitment Poster for Online Survey (Adults 65+)



 University of Manitoba

ARE YOU **AGED 65 YEARS OR OLDER** AND HAVE 20 MINUTES TO SHARE YOUR VIEWS?

## Adults 65+ Online Survey on Health, Wellness and Services

Spring/Summer 2023

- 1 WHO WE ARE LOOKING FOR**  
Any person aged 65 years or older living in Manitoba to respond to the survey.
- 2 WHAT YOU WILL DO**
  - Click the link or scan the QR code
  - Fill out the online consent form
  - Fill out the confidential survey
- 3 HOW TO WIN \$100**  
Enter a draw after completing the survey for a chance to win 1 of 3 \$100 e-gift cards for Amazon.ca

<https://bit.ly/Adults65Survey>



**Contact Us**

✉ [Dudoks3@myumanitoba.ca](mailto:Dudoks3@myumanitoba.ca)

Led by Ms. Stephanie Dudok, PhD Candidate and Dr. Kristin Reynolds, C. Psych., at the University of Manitoba (REB: HE2021-0196)

## Appendix T

### Recruitment Letter for Online Survey (Adults 65+)



Dr. Kristin Reynolds, Ph.D., C.Psych  
Email: [Kristin.Reynolds@Umanitoba.ca](mailto:Kristin.Reynolds@Umanitoba.ca)

Ms. Stephanie Dudok, MA., Ph.D. Candidate  
Email: [Dudoks3@myumanitoba.ca](mailto:Dudoks3@myumanitoba.ca)

University of Manitoba,  
Department of Psychology  
P404 Duff Roblin Building, 190 Dysart Rd.  
Winnipeg, MB, R3T 2N2

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Month [X, 2023]

Dear [XX Organization]:

We are very pleased to inform you about a new participatory research opportunity that is likely to be of interest to clients associated with your organization:

#### **ADULTS 65+ ONLINE SURVEY ON HEALTH, WELLNESS AND SERVICES**

As part of our “Let’s TALK” research project, we are inviting community-dwelling adults ages 65 years or older to complete the *Adults 65+ Online Survey on Health, Wellness and Services*. Attached with this email is a **recruitment poster** with information about the participants we are seeking, e-gift card opportunity, and hyperlink / QR code to the online consent form and confidential survey.

We hope that your organization will distribute the poster and SURVEY LINK / QR CODE through the regular communication channels (e.g., newsletter, website, emails, poster boards, other methods) that you use to stay in touch with clients or to inform clients about upcoming opportunities.

Please also find below an accompanying social media post, should you be willing to share through your social media platforms (e.g., Facebook, Twitter, etc.):

“Are you an adult aged 65+? We want to hear from you through the *Adults 65+ Online Survey on Health, Wellness and Services*. Click <https://bit.ly/Adults65Survey>. Enter your name for a chance to win \$100 e-gift card to Amazon.ca. Questions? Contact [dudoks3@myumanitoba.ca](mailto:dudoks3@myumanitoba.ca) (U of M REB Approval: HE2021-0196)”

Note: All survey responses will remain confidential with no client identifying information recorded.

Please inform the Study Coordinator via email at [dudoks3@myumanitoba.ca](mailto:dudoks3@myumanitoba.ca) if you will be distributing this opportunity to clients. We would also be happy to answer any questions you may have.

Kristin Reynolds, Ph.D., C. Psych.  
Associate Professor  
Departments of Psychology and Psychiatry  
Research Affiliate, Centre on Aging  
University of Manitoba

Stephanie Dudok, MA., Ph.D. Candidate  
‘Let’s TALK’ Study Coordinator  
Department of Psychology  
University of Manitoba

REB Approval received from the U of M (HE2021-0196)

## Appendix U

### Informed Consent Form for Online Survey (Adults 65+)



Dr. Kristin Reynolds, Ph.D., C.Psych  
Email: [Kristin.Reynolds@umanitoba.ca](mailto:Kristin.Reynolds@umanitoba.ca)

Ms. Stephanie Dudok, MA., Ph.D. Candidate  
Email: [Dudoks3@myumanitoba.ca](mailto:Dudoks3@myumanitoba.ca)

University of Manitoba,  
Department of Psychology  
P404 Duff Roblin Building, 190 Dysart Rd.  
Winnipeg, MB, R3T 2N2

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**Title of Research:** Let's Talk About Late-Life Mental Health: Multi-Systemic Collaboration to Inform Better Access to Care

**Principal Investigator:** Dr. Kristin Reynolds, Ph.D., C. Psych., University of Manitoba, Department of Psychology

**Study Coordinator/PhD Student Researcher:** Stephanie Dudok, MA., Ph.D. Candidate, University of Manitoba, Department of Psychology

**Undergraduate Research Assistant(s):** Amanda Kristjanson and Samantha Steele-Mitchell, University of Manitoba, Department of Psychology

**This consent form, a copy of which can be downloaded and/or printed for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about, who is involved in the research, and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask the principal investigator or her supervisor. Please take the time to read this document carefully and to understand any accompanying information.**

**Purpose of the Study:**

The purpose of this study is to engage adults ages 65 years or older (“adults 65+”) in understanding and addressing their late-life health and wellness service needs and priorities in the areas of mental health and substance use/addiction (SUA). Participants will identify and rank priorities concerning needed services and/or future research priorities. Participants will also share information about their mental health and SUA literacy (i.e., knowledge about how to recognize, manage, and find information or services for mental health and SUA challenges).

**Study Procedures:**

As a participant in this study, you will complete an online survey that will take approximately 15 – 20 minutes to complete. The survey can be accessed and completed online through Qualtrics software, and will be made available following your completion of this online consent form. Qualtrics is a secure platform that uses Transport Layer Security (TLS) encryption (also known

as HTTPS) for all transmitted data. Surveys are protected with passwords. In order to complete the online survey, you will have to have internet or WIFI access. Questions covered on this survey will measure demographic information (i.e., sex, race/ethnicity, age, education, income, and marital status); psychosocial wellness factors (i.e., self-reported mental health, self-reported physical health, experience with mental health or SUA challenges, experience accessing mental health or SUA information, and experience accessing mental health or SUA services or programs); mental health and SUA literacy; and your rankings on the importance of different mental health and SUA services and/or future research priorities. You may choose to skip a question if you prefer not to respond.

### **Potential Benefits and Risks of the Research:**

Benefits of participating in this study include having the opportunity to identify and share your mental health and SUA service needs and priorities. Benefits also include enhancing our understanding of your knowledge about mental health and SUA challenges, and your knowledge of how to access and navigate health and wellness services for mental health and SUA. As such, results of this study will contribute to improving access to mental health and SUA services and supports. For example, your responses may be used as a part of informing the development of an interactive service navigation tool(s), such as a late-life mental health and SUA service map, which would provide adults 65+ with education and support on how to find the services they (or someone they know) are looking for.

Reflecting on your health, wellness, mental health challenges (e.g., depression, anxiety), and SUA challenges (e.g., misusing or being dependent on alcohol, cannabis, sleeping pills, pain pills, or other prescription or recreational drugs, or problems with gambling) may carry with it the risk of experiencing emotional distress. If you notice any feelings of distress during or after completing the survey, please consult one of the attached resources for assistance.

### **Participant Payment:**

At the end of the survey, you will be asked if you would like to enter a random draw for a chance to receive one of three \$100 e-gift cards for Amazon.ca as compensation for your time and contributions. If you choose to opt-in, you will be asked to provide your name and email, which will be anonymized and entered into the draw. Should your name be randomly drawn, your e-gift card will be provided to you via email after you complete the survey, and after the survey has closed for all participants.

### **Voluntary Participation:**

**Participation in this research is voluntary and your decision to participate or not participate will NOT influence your involvement with the services or facilities through which you are being contacted.**

### **Freedom to Withdraw:**

**It is your choice whether or not to participate in this study. Participation is voluntary and you may withdraw at any time with no penalty.** If you choose to withdraw at any time, please contact the Principal Investigator (Dr. Kristin Reynolds), at (204) 474-9528 or [Kristin.Reynolds@umanitoba.ca](mailto:Kristin.Reynolds@umanitoba.ca), or the Study Coordinator/PhD Student Researcher (Ms. Stephanie Dudok) at [dudoks3@myumanitoba.ca](mailto:dudoks3@myumanitoba.ca), within two weeks of completing the survey.

Beyond this point, data may have been analyzed and summarized and withdrawal will no longer be possible.

**Confidentiality:**

Your individual identifying information will not be used or revealed in any study-related records. **All information collected will only be presented in aggregate form without your identifying information.** Information gathered in this research study may be published or presented in public forums in aggregate form such as, thesis-related work, journal article publications, and conference presentations. Your information provided on the form requesting future contact regarding the research results, as well as for opting-in to enter the random draw, will not be linked to the information you provide in the survey. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law. **If you choose to participate in this research, the Principal Investigator (Dr. Kristin Reynolds), the Study Coordinator/PhD Student Researcher (Stephanie Dudok), and the Research Assistant(s) will have access to research data. Research data will be password-protected, and stored in secure, access-controlled University-provided individual file storage (University of Manitoba Outlook OneDrive). Please note that all data stored and shared using Office365 files tools is hosted in Microsoft Data Centres located in Toronto and Quebec City. All copies of this material will be permanently deleted after this research has been completed (within approximately 7 years).**

**Questions or Concerns:**

If you have any questions about this study, please do not hesitate to contact the Principal Investigator (Dr. Kristin Reynolds), at (204) 474-9528 or [Kristin.Reynolds@umanitoba.ca](mailto:Kristin.Reynolds@umanitoba.ca), or the PhD Student Researcher (Ms. Stephanie Dudok) at [dudoks3@myumanitoba.ca](mailto:dudoks3@myumanitoba.ca).

For questions about your rights as a research participant, you may contact The University of Manitoba Human Ethics Officer at 204-474-7122 or [HumanEthics@umanitoba.ca](mailto:HumanEthics@umanitoba.ca).

**Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.**

**Statement of Consent:**

**Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.**

**The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.**

**This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project**

**you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or HumanEthics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.**

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I, \_\_\_\_\_ (print name), have read the above information and hereby consent to participate in this study.

Participant's Signature \_\_\_\_\_ Date (day/month/year)

**Permission for future contact:** I agree to be contacted by Ms. Stephanie Dudok or Dr. Kristin Reynolds by telephone, mail, or email for future follow-up in relation to this study (including mailing of e-gift card honoraria) or if any of the content from the focus groups is unclear to her (until research study completion, approximately Dec/2028).

Yes \_\_\_ No \_\_\_ Participant Initials \_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**Would you like to receive a summary of the results of this study?**

\_\_\_ No

\_\_\_ Yes, I would like to receive the summary results.

If yes, please provide your contact information below:

Email: \_\_\_\_\_

Phone number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**Would you like to be contacted for future studies related to this work?**

\_\_\_ No

\_\_\_ Yes, I would like to be contacted for future studies by Ms. Stephanie Dudok or Dr. Kristin Reynolds:

If yes, please provide your contact information below:

Email: \_\_\_\_\_

Phone number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**Appendix V****Adults 65+ Online Survey on Health, Wellness and Services****BACKGROUND INFORMATION****Today's Date:** \_\_\_\_\_**Age:** \_\_\_\_\_**Gender Identification:**

- ☐ Female  
☐ Male  
☐ Other: \_\_\_\_\_

**Highest Level of Education:**

- ☐ Doctorate                      ☐ Masters/Professional (MD, JD, etc.)  
☐ Bachelor's                      ☐ Post-secondary Certificate/Diploma  
☐ High school                      ☐ Less than high school

**Current occupational status:**

- ☐ Full-time  
☐ Part-time  
☐ Retired  
☐ Other: \_\_\_\_\_

If you are currently retired, how long have you been retired? \_\_\_\_\_

**Current household income (before taxes):**

- ☐ \$0-\$29,999                      ☐ \$70,000-\$99,000  
☐ \$30,000-\$49,999                      ☐ \$100,000-\$149,000  
☐ \$50,000-\$69,000                      ☐ \$150,000+

**Marital status:**

- ☐ Single                      ☐ Common Law                      ☐ Married  
☐ Widowed                      ☐ Separated                      ☐ Divorced

**Race**

- ☐ Indigenous      ☐ Black      ☐ White      ☐ Latino      ☐ South Asian  
☐ Middle Eastern      ☐ Southeast Asian      ☐ East Asian      ☐ Other: \_\_\_\_\_

**INFORMATION ABOUT HEALTH AND WELLNESS SERVICES**

Please read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely honest and open.

| Not at All | Somewhat | Moderate | Very | Extremely |
|------------|----------|----------|------|-----------|
| 1          | 2        | 3        | 4    | 5         |

How knowledgeable are you about:

1. the signs and symptoms of mental health problems? (such as anxiety and depression)
2. the possible causes of mental health problems?
3. the types of professional help available for common mental health problems? (such as anxiety and depression)
4. how to go about seeking professional help for mental health problems?

How knowledgeable are you about:

5. the signs and symptoms of substance use or addiction problems? (such as misusing or being dependent on alcohol, cannabis, sleeping pills, pain pills, or other prescription or recreational drugs, or problems with gambling)
6. the possible causes of substance use or addiction problems?
7. the types of professional help available for common substance use or addiction problems? (such as misusing or being dependent on alcohol, cannabis, sleeping pills, pain pills, or other prescription or recreational drugs, or problems with gambling)
8. how to go about seeking professional help for substance use or addiction problems?

How knowledgeable are you about:

9. how to navigate the mental health services that may be available in Manitoba?
10. how to navigate the substance use or addiction services that may be available in Manitoba?

Have you ever used or tried to access mental health services or programs?

- ☐ Yes    ☐ No

Have you ever used or tried to access substance use or addictions services or programs?

- ☐ Yes    ☐ No

Are you currently using mental health services or programs?

☐ Yes   ☐ No

Are you currently using substance use or addictions services or programs?

☐ Yes   ☐ No

### EMERGENT SERVICE PRIORITIES

Please rank the following services in **order of important to you, from 1 (least important) to 7 (most important)**. Select each number only once.

Rank: \_\_\_\_     A service that provides wholistic and simultaneous support and education to people experiencing mental health, substance use, addiction, and/or physical health challenges together with their caregivers.

Rank: \_\_\_\_     Protection and advocacy services for adults living in care facilities who are experiencing severe mental health, substance use or addition challenges.

Rank: \_\_\_\_     A service to support cooperation and collaboration between healthcare providers and caregivers that allows for freer sharing of information about the person being cared for and their mental health, substance use or addiction challenges and treatment (i.e., expand the circle of privacy to include caregivers more easily).

Rank: \_\_\_\_     An educational service that provides information on interactions between over-the-counter drugs and prescription medications.

Rank: \_\_\_\_     An educational service that would support adults 65+ in knowing where to go and how to find the mental health, substance use and addiction services they need or are looking for.

Rank: \_\_\_\_     Services designed to more holistically address multiple overlapping conditions together including physical health concerns, mental health concerns, and substance use or addiction concerns.

Rank: \_\_\_\_     Services and supports for adults 65+ whose difficulties fall outside of typical service categories and for adults 65+ who do not have diagnoses (e.g., do not meet full criteria for common mental health, substance use and addiction diagnoses but are still experiencing challenges)

Are other mental health, substance use or addiction services more important to you than the ones previously ranked? If so, please list what those services would be in the box below.

|                                          |
|------------------------------------------|
| <br><br><br><br><br><br><br><br><br><br> |
|------------------------------------------|

**INFORMATION ABOUT YOUR HEALTH AND WELLNESS**

In general, how would you say your mental health is (how are you feeling emotionally)?

☐ Poor      ☐ Fair      ☐ Good      ☐ Very good      ☐ Excellent

In general, how would you say your physical health is (how are you feeling physically)?

☐ Poor      ☐ Fair      ☐ Good      ☐ Very good      ☐ Excellent

Have you ever experienced challenges with your **mental health or emotional wellness?** (for example: anxiety, depression)

☐ Yes    ☐ No

Have you ever experienced **challenges with substance use or addictions?** (for example: misusing or being dependent on alcohol, cannabis, sleeping pills, pain pills, or other prescription drugs, or problems with gambling)

☐ Yes    ☐ No

Have you ever tried to find or use **information about mental health problems** and how to get help for yourself or others? (for example: anxiety, depression)

☐ Yes    ☐ No

Have you ever tried to find or use **information about substance use or addiction problems** and how to get help for yourself or others? (for example: misusing or being dependent on alcohol, cannabis, sleeping pills, pain pills, or other prescription drugs, or problems with gambling)

☐ Yes    ☐ No

**Please answer whether the following statements are generally true for you over the past week.**

**Check YES if it is true much, most, or all of the time.**

**Check NO if this is not true or does not happen or happens infrequently.**

Y N Are you basically satisfied with your life?

Y N Have you dropped many of your activities and interests?

Y N Do you feel that your life is empty?

Y N Do you often get bored?

Y N Are you in good spirits most of the time?

Y N Are you afraid that something bad is going to happen to you?

Y N Do you feel happy most of the time?

Y N Do you often feel helpless?

Y N Do you prefer to stay home rather than go out and do new things?

Y N Do you feel you have more problems with memory than most?

- Y N Do you think it is wonderful to be alive now?
- Y N Do you feel pretty worthless the way you are now?
- Y N Do you feel full of energy?
- Y N Do you feel that your situation is hopeless?
- Y N Do you think that most people are better off than you are?
- ~
- Y N I worry a lot of the time.
- Y N I find it difficult to make a decision.
- Y N I often feel jumpy.
- Y N I find it hard to relax.
- Y N I often cannot enjoy things because of my worries.
- Y N Little things bother me a lot.
- Y N I often feel like I have butterflies in my stomach.
- Y N I think of myself as a worrier.
- Y N I can't help worrying about even trivial things.
- Y N I often feel nervous.
- Y N My own thoughts often make me anxious.
- Y N I get an upset stomach due to my worrying.
- Y N I think of myself as a nervous person.
- Y N I always anticipate the worst will happen.
- Y N I often feel shaky inside.
- Y N I think that my worries interfere with my life.
- Y N My worries often overwhelm me.
- Y N I sometimes feel a great knot in my stomach.
- Y N I miss out on things because I worry too much.
- Y N I often feel upset.
- ~
- Y N When talking with others, do you ever underestimate how much you drink?
- Y N After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?
- Y N Does having a few drinks help decrease your shakiness or tremors?
- Y N Does alcohol sometimes make it hard for you to remember parts of the day or night?
- Y N Do you usually take a drink to relax or calm your nerves?
- Y N Do you drink to take your mind off your problems?
- Y N Have you ever increased your drinking after experiencing a loss in your life?
- Y N Has a doctor or nurse ever said they were worried or concerned about your drinking?
- Y N Have you ever made rules to manage your drinking?
- Y N When you feel lonely, does having a drink help?
- Y N Do you drink alcohol and take mood or mind altering drugs, including prescription tranquilizers, prescription sleeping pills, prescription pain pills, or any illicit drugs?

**Answer the following by considering cannabis, prescription tranquilizers, prescription sleeping pills, prescription pain pills, or any other prescription or recreational drugs:**

- Y N Have you ever felt you ought to cut down on your drug use?
- Y N Have people annoyed you by criticizing your drug use?
- Y N Have you ever felt bad or guilty about your drug use?
- Y N Have you ever used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

**Please read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely honest and open.**

| None | One | Two | Three to Four | Five to Eight | Nine or more |
|------|-----|-----|---------------|---------------|--------------|
| 0    | 1   | 2   | 3             | 5             | 5            |

1. How many relatives/family members do you see or hear from at least once a month?
2. How many friends do you see or hear from at least once a month?
3. How many relatives/family members do you feel at ease with that you can talk about private matters?
4. How many friends do you feel at ease with that you can talk about private matters?
5. How many relatives/family members do you feel close to such that you could call on them for help?
6. How many friends do you feel close to such that you could call on them for help?

## Appendix W

### Resource List Provided to All Participants

#### **IF YOU ARE HAVING THOUGHTS OF HARMING YOURSELF OR OTHERS, OR ARE IN CRISIS:**

- WRHA CRISIS RESPONSE CENTRE at 817 Bannatyne Avenue or WRHA Mobile Crisis Service at 204-940-1781 (24 hours/7 days a week)
- KLINIC COMMUNITY HEALTH CENTRE CRISIS LINE (24 hours/7 days a week) at 204-786-8686
- MANITOBA SUICIDE LINE (24 hours/7 days a week) at 1-877-435-7170

#### **MENTAL HEALTH, SUBSTANCE USE AND ADDICTION RESOURCES:**

- A & O SUPPORT SERVICES FOR OLDER ADULTS: 200-280 Smith Street; Phone: 204-946-5667; Website: <https://www.aosupportservices.ca>
- MANITOBA ASSOCIATION OF SENIOR CENTRES: 204-792-5838  
<https://www.manitobaseniorcentres.com>
- WINNIPEG REGIONAL HEALTH AUTHORITY PROGRAMS - GERIATRIC MENTAL HEALTH: <http://www.wrha.mb.ca/prog/gmh/index.php>; Phone: 204-982-0140
- MANITOBA ADDICTIONS HELPLINE (ADDICTIONS FOUNDATION OF MANITOBA): <http://mbaddictionhelp.ca>; Phone: 1-855-662-6605
- SALVATION ARMY ANCHORAGE PROGRAM: 204-946-9401;  
<https://www.wpgboothcentre.ca/Anchorage%20Brochure%202012.pdf>
- BEHAVIOURAL HEALTH FOUNDATION: 204-269-3430; <https://www.bhf.ca>
- ANXIETY DISORDERS ASSOCIATION OF MANITOBA: Suite 100 – 4 Fort Street; Phone: 204-925-0600; Website: <https://adam.mb.ca>
- MOOD DISORDERS ASSOCIATION OF MANITOBA:  
<http://mooddordersmanitoba.ca>; Phone: 204-786-0987
- KLINIC COMMUNITY HEALTH: <https://mbwpg.cmha.ca>; Phone: 204-784-4090
- CANADIAN MENTAL HEALTH ASSOCIATION: <https://klinik.mb.ca>; Phone: 204-982-6100
- PEER CONNECTIONS MANITOBA: 204-786-1616; <https://peerconnectionsmb.ca>
- MANITOBA PSYCHOLOGICAL SOCIETY – Find a psychologist online:  
<http://members.mps.ca>

## **Appendix X**

### **Disclaimer**

This research was supported by a scholarship from the Liquor, Gaming and Cannabis Authority of Manitoba; however, the findings and conclusions of this paper are those solely of the author and do not necessarily represent the views of the Liquor, Gaming and Cannabis Authority of Manitoba.