Exploring the Relationship between Identity, Mental Health, and Community Involvement among Canadian Adults 55+

by

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Abstract

Background: Mental health and social connection are closely intertwined and contribute to resilient aging in later life. While socio-demographic and ability factors have been associated with mental health, social participation, and access to mental health services, a notable gap in this research is the use of an intersectional lens. As such, intersectionality was important to consider in the study team's implementation of the CONNECT Program, a community-based group therapy intervention for adults 55+ targeting mental health and social connection. Our team has partnered with three community organizations across Canada to facilitate its' implementation, which necessitated additional research to understand the mental health support needs of older adults at each community organization.

Aims: The goal of this study was to employ a mixed method, intersectional approach to characterize the perspectives of adults 55+ on: (1) their experiences with mental health challenges and accessing supports, and (2) their opinions on the acceptability, appropriateness, and feasibility of the CONNECT Program.

Method: 13 women aged 62-90 enrolled, each of whom expressed interest in participating in the CONNECT Program and felt comfortable conversing in English. Participants completed a semi-structured focus group (two focus groups of $n = 3$ and $n = 4$) or individual interview ($n = 6$) addressing the study aims, which were transcribed naturalistically. Interviews were analyzed using Interpretive Description, creating a narrative that explores patterns and variations among participants' experiences. To characterize the sample, participants also completed questionnaires assessing background information, depression, anxiety, social connection, loneliness, and program implementation outcomes. Questionnaire data were descriptively summarized and integrated into qualitative findings using a narrative weaving approach, to deepen analysis and provide richer context.

Results: The overarching theme that emerged from focus groups and individual interviews was participants' evolving identity in response to loss, life transitions and aging, which impacted their mental health. Participants highlighted how their intersecting identities (e.g., older woman with low income) influenced their connection with community and use of mental health services. In relation to their identity, participants described two themes: their mental health as a journey, impacted by formal supports and coping strategies; and connection to community as a form of resiliency. Qualitative results converged with quantitative data to demonstrate that participants were at different stages in their mental health journeys. Participants viewed the CONNECT Program positively and shared recommendations regarding facilitation and mode of delivery, and qualitative and quantitative data converged to support that the majority of participants viewed the CONNECT Program as acceptable, feasible, and appropriate.

Discussion & Implications: Results highlight the significance of identity and community connection to mental health, the impacts of compounding marginalization on access to services and connection, and the resiliency of older adults. Findings shed light on the importance of identity-focused and person-centered care for older adults, which has implications for future research, clinical care and policy. In addition, findings provide timely guidance for the implementation of the CONNECT Program.

Keywords: adults 55+; mental health; intersectionality; program implementation; Interpretive Description

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Introduction

Adults ages 65 years and older (termed *older adults*) comprise about 19% of Canada's population, and this proportion is expected to rise to 22-30% by 2068 (Statistics Canada, 2023). As this population grows, it is critical to develop supports to promote resilient aging. An important aspect of mental health in later life is connection – with family, friends, and community. Social isolation and loneliness can be distressing, leading to depression or anxiety symptoms (Courtin & Knapp, 2017; Donovan & Blazer, 2020; Wister et al., 2023). In parallel, depression and/or anxiety can lead to withdrawal from social activities, thus leading to isolation and/or loneliness (Courtin & Knapp, 2017; Donovan & Blazer, 2020; Wister et al., 2023). As such, there is a specific need to develop interventions targeting social disconnection and mental health challenges. Furthermore, there are an array of internal, logistical, identity and ability related, and system-level factors that impact mental health service use and social participation in older adults. Therefore, treatment options must be designed to overcome these barriers, in order to better serve the growing Canadian older adult population. Using an intersectional framework in aging research will enhance our understanding of how to best support older adults seeking support for their mental health (Holman & Walker, 2021; Thomas Tobin et al., 2023).

An opportunity to further this line of investigation has arisen through the development of the CONNECT Program, a telephone-based mental health intervention for older adults co-developed by Dr. Kristin Reynolds (advisor) and collaborators from the University of Manitoba, Brandon University, and the community organization *A&O: Support Services for Older Adults*. This 6-week program aims to support older adults experiencing social isolation, loneliness and co-occurring depression or anxiety. Pilot research in Manitoba found that the program was effective (Reynolds et al., 2021). The CONNECT Program is now expanding to be offered in Manitoba, British Columbia, and Saskatchewan for adults ages 55 years and older (termed *adults 55+*), thus necessitating additional research to understand how to tailor the program to each new setting. This pre-implementation research is a critical step when bringing programs to new setting to promote intervention effectiveness and sustainability (Graham et al., 2006). As such, this master's thesis research aimed to understand the mental health support needs of adults 55+ at each partnered organization, and how the CONNECT Program can meet those needs. This study provides unique insight into the mental health needs of Canadian adults ages 55+ and how to implement the CONNECT Program in each organization.

Aging, Social Connection, and Mental Health

As we age, we gain experience and wisdom, and this serves to improve well-being in later life. In one of the largest studies on well-being to date, Stone et al. (2010) assessed several dimensions well-being across adults ages 18-85. They found that, from middle-adulthood onwards, positive components of well-being (such as enjoyment, happiness, and life satisfaction) increased whereas negative aspects (such as anger, stress, worry) decreased. While this finding might contradict the generally negative societal expectations of aging, this shift in well-being is accounted for by the socio-emotional selectivity theory (SST; Carstensen, 1993, 2006). This is a well-supported developmental theory that describes changes in goals and emotion regulation over the lifespan as a function of changes in future time perspective and motivation. SST posits that, as time becomes more limited with age, it becomes more valuable, leading to motivational shifts. While younger adults tend to focus on novelty and exploration, middle-aged and older

adults favour emotionally-meaningful goals in order to make the best use of their remaining time (Carstensen, 1993, 2006; Carstensen et al., 1999). These shifts in motivation influence behaviour, such that older adults preferentially attend to positive information (Carstensen & DeLiema, 2018a) and prune their social networks to focus on meaningful connections (Carstensen, 2021; Charles & Carstensen, 2010), thus fostering observed improvements in well-being.

Close relationships and connection are common emotionally-meaningful goals in later life (Löckenhoff & Carstensen, 2004) that positively impact well-being (Stone et al., 2020) and mental health. Research investigating the interrelation of connection and mental health often focuses on social participation, defined as a component of social connection that involves participation in social activities that are meaningful to the individual (Levasseur et al., 2022). Using data from the Canadian Longitudinal Study on Aging (CLSA), a large observational study of Canadian adults ages 45-85, social participation was associated with reduced likelihood of self-reported mood and anxiety disorders as well as fewer symptoms of depression among middle-aged and older adults (Reynolds, Sommer, et al., 2022). Social participation has also been negatively associated with psychological distress in a large sample of Canadian older adults, and this association was mediated by the degree to which they felt connected to those in their social network (Mackenzie & Abdulrazaq, 2021). Further, among adults ages 50+, higher social participation was associated with lower risk of developing major depressive disorder, independent of age and gender (Ryu et al., 2023). Evidence-based theories of successful aging provide further support for the positive association of mental health, well-being and social connection. Activity Theory posits that maintaining participation in physical and social activities from middle age onwards helps preserve well-being (Havighurst, 1961; Lemon et al., 1972; Longino & Kart, 1982). Additionally, the Continuity Theory of Normal Aging suggests that middle-aged and older adults will continue to engage in the activities and roles as they did in their past. This promotes normal aging (e.g., no significant disease, able to meet one's needs) and results in a satisfying life that involves networks of social relationships (Atchley, 1989). Altogether, these theories and studies highlight the importance of maintaining social participation for mental health as well as well-being throughout older adulthood.

Inversely, and consistent with the outlined research, social isolation and loneliness are associated with mental health challenges. Here, social isolation is defined as the quantitative lack of social connections (Holt-Lunstad, 2021) whereas loneliness is the subjective, emotional experience of dissatisfaction with social relationships (Cacioppo et al., 2002). These constructs are related yet distinct (e.g., one can be "lonely in a crowd," or isolated but not lonely; Newall & Menec, 2019). Based on pre-COVID-19 pandemic data from the CLSA, about 25% of participants were socially isolated and/or lonely, whereas 75% reported no feelings of loneliness or isolation (Menec et al., 2020). Social isolation and loneliness can be distressing, leading to the experience of depression or anxiety symptoms. In parallel, depression and/or anxiety can lead to withdrawal from social activities, thus leading to isolation and/or loneliness (Courtin & Knapp, 2017; Donovan & Blazer, 2020; Wister et al., 2023). In Canada and the United States prior to the COVID-19 pandemic, about 6% of older adults experienced diagnosable depression and 11% experienced diagnosable anxiety (Reynolds, Pietrzak, El-Gabalawy, et al., 2015). One possible pathway between social disconnection and mental health challenges was identified using a large sample of adults ages 57-85. Social isolation was found to predict loneliness, and this predicted

increased depressive and anxiety symptoms. The reverse pathways were also statistically supported (Santini et al., 2020). In sum, there is extensive research backing to support the close relationship between social disconnection and mental health challenges.

Notably, social isolation, loneliness, anxiety and depression rates are not uniformly distributed among adults 55+; sex, income, marital status, and ability have been associated with differing rates of these concerns. For example, in the United States, older adults who identified as female, had lower income, or were widowed, separated, or divorced had higher rates of depression (Reynolds, Pietrzak, El-Gabalawy, et al., 2015). Further, when comparing older adults who were isolated/lonely to those with neither, those who were not isolated or lonely were younger and had higher income; those who were only lonely were more likely to be women; and those who were isolated and lonely were more likely to have lower income (Menec et al., 2020). In terms of ability, sensory loss and functional disability have been associated with isolation and loneliness, as they limit one's ability to connect with others (Donovan & Blazer, 2020). Further, hearing loss has been associated with increased symptoms of depression and anxiety among older adults (Cosh et al., 2019), and vision impairment has been associated with increased risk of having a depression diagnosis (Crews et al., 2017; Frank et al., 2019). These statistics serve to exemplify that, while social disconnection and mental health challenges are prevalent across older adults, demographic characteristics and declines in ability have been associated with increased experiences of mental health challenges.

Impacts of the COVID-19 Pandemic

The COVID-19 pandemic had historic impacts on the economy, society, and our health, and the nature of the social distancing guidelines led to an increased research focus on mental health challenges, loneliness and social isolation. In a Canadian convenience sample of adults 55+, 19% had persistent depression symptoms and 16% had persistent anxiety symptoms throughout the pandemic (May 2020 – January 2021), and having persistent depression or anxiety symptoms was associated with identifying as a woman, living with multi-morbidity, and having pre-existing depression and pre-existing anxiety (Siddhpuria et al., 2023). Using data from the CLSA, the prevalence of depressive symptoms increased from 16% to 21% pre-to-peri pandemic (2012-2015 vs. April 2020). Further, those who had an income under $50,000 were three times more likely to experience depressive symptoms relative to those with an income of $150,000 or more (Raina et al., 2021).

Loneliness also increased substantially from the onset of the pandemic. Among older adults who were surveyed pre- and peri-pandemic, loneliness increased (Kirkland et al., 2023; Macdonald & Hülür, 2021; Van Tilburg et al., 2021), and was negatively associated with a larger social network and available social support (Macdonald & Hülür, 2021). Among Canadian older adults, identifying as a women, younger age (on the older adult spectrum), and lower self-rated physical health status were associated with increased loneliness during the pandemic (Kirkland et al., 2023; Savage, Wu, et al., 2021). In sum, social isolation, loneliness, and mental health challenges are prevalent among adults 55+. Several socio-demographic and ability-related factors have been associated with higher rates of mental health symptoms and loneliness, highlighting the increased need for the development of mental health services that are suitable for a broad range of adults 55+.

Mental Health Service Use

Given the prevalence of social isolation, loneliness and mental health challenges among adults 55+, it is essential that adults 55+ have access to mental health supports. From a review of the limited literature on this topic, common sources of support for adults 55+ are their primary care physician, mental health professional, friends or family. For example, one Canadian study noted that 31% of adults 55+ with at least one DSM-IV diagnosis saw their primary care physician to discuss their mental health or substance use, and almost 25% saw a mental health specialist (Cairney et al., 2010). Echoing this, when adults 50+ were asked about their preferences regarding sources of mental health information, over half indicated they would be very likely to ask their family doctor, spouse or partner, or a mental health professional (Reynolds, Mackenzie, et al., 2022). However, over 60% of adults 55+ with mood or anxiety disorders do not seek mental health services (Byers et al., 2012; Cairney et al., 2010). For example, older adults with generalized anxiety disorder, major depression or dysthymia were less likely to seek treatment as compared to middle-aged adults (35-64), both before and after controlling for sex, marital status, household income, and race/ethnicity (Mackenzie et al., 2012).

Assessing the social factors associated with mental health service use provides insight into the groups of middle-aged and older adults who may or may not be accessing services. Older age on the spectrum of older adults has been associated with less service use (Mackenzie et al., 2012; Mackenzie & Pankratz, 2022; Vasiliadis et al., 2023). Female sex has been associated with seeking mental health services, with Canadian studies showing that female older adults are more likely to seek mental health services for anxiety or mood disorders as compared to men (Mackenzie et al., 2012; Public Health Agency of Canada, 2020). Although, it has been observed that this sex difference becomes non-significant after adjusting for other demographic, psychological, enabling and need factors (Mackenzie & Pankratz, 2022). Research has also shown inconsistent associations of ethnicity and/or race (Byers et al., 2012, 2017), marital status and income level (Byers et al., 2012, 2017; Mackenzie & Pankratz, 2022) with service use.

In contrast, other research has shown that mental health-related characteristics are associated more closely with mental health service use. For example, a study of older adults in Canada found that perceived need for mental health services and mental health literacy (i.e., knowledge and beliefs about mental health; Jorm, 2012) were the strongest predictors of using mental health services (Mackenzie & Pankratz, 2022). Further, among Canadian older adults with a past-year anxiety disorder, self-rated mental health and having a comorbid mood disorder were the strongest positive predictors of past-year mental health service use, whereas age, sex, education, marital status, and income were not predictive of service use (Scott et al., 2010). In relation to the present study, this literature shows the importance of considering socio-demographic-related factors when developing and delivering mental health services for adults 55+.

Barriers to Mental Health Services

In addition to examining the characteristics associated with mental health service use, researchers have directly investigated barriers to mental health services that adults 55+ may encounter. These barriers are related to internal, external, and system-level factors. Internal barriers include limited perceived need for care, a desire to manage their mental health independently, internalized stigma, and low mental health literacy (Lavingia et al., 2020;

Mackenzie et al., 2010; Mackenzie & Pankratz, 2022; Nair et al., 2019; Reynolds et al., 2020; Volkert et al., 2018). Stigma related to seeking help is a complex and pervasive barrier (Mackenzie & Pankratz, 2022; Nair et al., 2019; Reynolds et al., 2020) that is associated with living in rural areas and different culture-specific norms surrounding mental health (Lavingia et al., 2020). Common external barriers are logistical, such as cost, transportation, or need for caregiver support. These logistical barriers pose exceptional challenges for adults who are already experiencing mobility challenges (Weinberger, 2009). At the system-level, the shortage of suitable healthcare professionals (e.g., psychiatrists, providers with expertise in geriatric mental health) and challenges navigating the mental healthcare system hinder mental health service use (Lavingia et al., 2020; K. A. Reynolds et al., 2020; Solway et al., 2010; Van Der Aa et al., 2015). A clear implication of this body of research is the need for collaborative research to develop mental health services in partnership with adults 55+, as they could provide recommendations to make services accessible based on lived experience. Furthermore, creating community-based mental health services that are offered via pathways familiar to this population may help mitigate barriers related to stigma, logistics and system navigation.

Barriers to Social Participation in the Community

A common source of social connection is in the community, with middle-aged and older Canadians commonly participating in various activities outside of the house with family/friends, church or religious activities, sport/physical activities, and other recreational activities (Naud et al., 2021). However, adults 55+ can encounter barriers that impede their ability to participate in social activities in their communities. Among Canadian middle-aged and older adults (45-85), the most common barriers to social participation were being too busy, having a health condition or limitation, personal or family responsibility, and the timing of the activities (Gopinath et al., unpublished; Jones et al., 2023; Naud et al., 2021). Furthermore, a review paper summarized four categories of barriers to social activities experienced by adults 60 years or older:, individual factors, environmental or infrastructure factors, and social network characteristics (Townsend et al., 2021). These categories are similar to the barriers to mental health services reviewed earlier. Individual barriers included poorer health (e.g., age-related vision loss, chronic conditions), less motivation to participate, and challenges accessing and using technology (Townsend et al., 2021). For example, among older adults, self-reported visual impairment and hearing loss have been associated with reduced participation in social activities (Jin et al., 2019; Prieur Chaintré et al., 2024). Environmental and infrastructure-related barriers included low proximity to and accessibility of social activities, reduced neighbourhood cohesion, living rurally, and living alone or living in care facilities with features that limited participation (e.g., poor building design; Townsend et al., 2021). Lack or loss of social networks also limited social participation (Townsend et al., 2021). In sum, demographic characteristics, individual factors, environmental or infrastructure factors, and social network characteristics can act as barriers to social participation.

In addition to directly examining the types of barriers to social participation, research has examined the socio-demographic factors associated with experiencing these barriers. Older age has been inconsistently associated with experiencing barriers to participation; associations are dependent on other aspects of the participants' identities. Some studies found that older adults with lower income or living in rural areas may be more likely face transport-related barriers to social participation (Lamanna et al., 2020; Rozynek & Lanzendorf, 2021). Other research has

found that barriers to social participation did not differ among older adults living in urban or rural areas, although the barrier of transportation was not examined (Jones et al., 2023). Sex can also impact the experience of barriers to participation. For example, in a study of Canadians aged 45-85, the experience of barriers differed by age and sex (Naud et al., 2021). Older adults reported that health conditions were the most common barrier, and women ages 45-64 more frequently reported transportation or not wanting to go alone as barriers, as compared to men (Naud et al., 2021). Research from our group found that female sex was the most consistent predictor of increased odds of facing barriers to social participation, followed by lower income (<$100,000), being separated/divorced, and younger age (Gopinath et al., unpublished). Overall, prior literature has revealed that common barriers to social participation include demographic characteristics, individual factors, environmental/infrastructure factors, and social network factors, In addition, several socio-demographic and ability-related characteristics can impact social participation and barriers to social participation. This suggests that middle-aged and older adults may benefit from community-based initiatives that mitigate common external or infrastructure barriers (e.g., lack of accessibility). This demographic may also benefit from social connection strategies targeted towards those at risk of facing more barriers to social participation, thus reducing internal and demographic-related barriers.

The CONNECT Program

Given the intertwinement of social connection, depression and anxiety, treatments targeting these domains could be particularly impactful for the mental health of adults 55+. Further, in a recent study where researchers partnered with Canadian older adults, caregivers to older adults, and clinicians to older adults, they highlighted mental health supports for those who are experiencing loneliness and isolation as a top research priority (Giosa et al., 2025). To address this need, The CONNECT program was co-developed by Dr. Kristin Reynolds in collaboration with faculty and graduate students from the University of Manitoba and Brandon University, as well as volunteers and staff from a prominent community organization in Manitoba (A&O: Support Services for Older Adults).

This 6-week program involves weekly, 90-minute sessions of group therapy delivered over the telephone. Overall, the CONNECT Program aims to reduce older adults' social isolation and loneliness, improve mental health, and promote coping strategies. CONNECT stands for: **C**reating **O**pportunities to build social **N**etworks, learn **N**ew skills to manage challenging emotions, **E**nhance mindful awareness and acceptance of emotions, and increase self-**C**ompassion, through **T**elephone-based group programming. The program was informed by Acceptance and Commitment Therapy (ACT; Hayes & Strosahl, 2005), self-compassion (Neff, 2011), and psychosocial theories of successful aging (e.g., SST; Carstensen, 1993). ACT is a third-wave cognitive behavioural therapy that aims to foster psychological flexibility by promoting mindful awareness of the present moment, openness to one's experiences, a core sense of self that is unaffected by thoughts, feelings or circumstances, acceptance of and flexible responding to painful thoughts and emotions, and increased value-oriented action (Harris & Hayes, 2009). The group format of the CONNECT program was selected to promote social connection. The program was also developed based on focus groups with staff and volunteers from *A&O: Support Services for Older Adults*, mental health professionals working with older adults, and older adults experiencing social isolation, loneliness, low mood, and anxiety in Manitoba.

Pilot research in Manitoba was completed, involving seven intervention groups and 34 participants in total (Reynolds et al., 2021). Post-intervention, participants showed a significant reduction in self-reported depressive symptoms, had improved knowledge of how to care for mental health problems, and increased psychological flexibility. Reductions in self-reported loneliness, social isolation, and anxiety were observed and approached significance. Qualitative interviews with participants revealed that they found the program to be feasible and acceptable, they found connections within their group, and they observed emotional, behavioural and cognitive benefits. Overall, pilot research suggests that the CONNECT Program is a beneficial support for older adults seeking to improve their mental health and reduce isolation and loneliness.

Pre-implementation Research

The CONNECT program is expanding outside of Manitoba to be offered to adults 55+ in British Columbia and Saskatchewan. The age cut-off was lowered from 65 to 55 at the request of collaborating community organizations. Before this stage of program implementation, an "adaptation phase" (Chambers et al., 2013) is critical, as this promotes the effectiveness and sustainability of an intervention in a new setting (Chambers et al., 2013; Fernandez et al., 2023). This is supported by the knowledge-to-action process, a dynamic framework that describes how to move research knowledge into an intervention that is then implemented. The framework outlines that, when bringing an intervention to a new setting, the knowledge that forms the basis of the intervention needs to be tailored to the local context, barriers to the intervention need to be assessed, and then this information should be used to tailor the intervention (Graham et al., 2006). Therefore, when bringing the CONNECT Program to these organizations, it is important to examine older adults' mental health needs, experiences with social isolation and loneliness, and access to services and supports. In addition, the perceived acceptability, appropriateness, and feasibility of the CONNECT Program are relevant to assess at this stage of pre-implementation research because they inform adaptation (Proctor et al., 2011). Appropriateness refers to the perceived fit or relevance of the intervention in the new setting. Acceptability describes whether the stakeholders involved in the intervention view it as agreeable or satisfactory as-is (e.g., with regards to delivery, format). Feasibility relates to how successfully the intervention can be implemented within the new setting (e.g., accessibility of the program). These concepts guided the methods of this study.

Aging Research with an Intersectional Lens

There is a critical need for mental health supports designed to overcome these barriers, in order to better serve the growing and diversifying Canadian older adult population. Using an intersectional lens in research can deepen our understanding of the help-seeking barriers that exist and how to overcome them. Intersectionality focuses on how multiple identities can intersect to differentially impact experiences within social contexts and systems of power, and can disproportionately disadvantage individuals. The concept stems from seminal work by feminist scholars and critical race theorists, and the term was first coined by Kimberlé Crenshaw, (Crenshaw, 1989). To meaningfully conceptualize intersectionality in clinical practice in psychology, the ADDRESSING model was developed (Hays, 1996, 2008, 2016). This model summarizes nine key aspects of identity, specifically: Age and generational differences; Developmental or other Disability, Religion and spiritual orientation; Ethnic and racial identity; Socioeconomic status; Sexual orientation; Indigenous heritage; National origin; and Gender

(Hays, 1996, 2008, 2016). While psychological research has typically considered aspects of identity independently, intersectionality posits that the impact of the identities one holds are most accurately understood by looking at their synergistic effect.

Specific to the context of aging research, taking an intersectional approach is necessary to comprehensively understand the experiences of Canada's heterogenous older adult population. There are about two times more females than males among older adults 85+ (Hallman et al., 2022). More older women were living below low-income cut-offs than men in 2018 (5% vs. 3%), which might be an underestimation since the cut-off was based on 1992 norms (Public Health Agency of Canada, 2020). Furthermore, the number of older adults who identify as non-White is expected to nearly triple from 2021 to 2041 (1,020,000 to 2,950,000; Statistics Canada, 2022b). In 2018, about 29% of older adults were immigrants or non-permanent residents (Public Health Agency of Canada, 2020). Additionally, as of 2021, older adults comprise more of the rural population (23%) than urban (18%; Statistics Canada, 2022). Mobility challenges affect about 24% of older adults (Statistics Canada, 2020), and declines in mobility, hearing and vision have been shown to increase from middle age onwards (Mick et al., 2021; Statistics Canada, 2020). As these statistics highlight, older adults in Canada can hold a variety of social identities that interact with systems of power. Taking an intersectional approach in research will enhance our understanding of how social factors impact adults' 55+ mental health and access to mental health services and social opportunities (Holman & Walker, 2021; Thomas Tobin et al., 2023). Further, to minimize identity and ability related barriers, interventions for socially isolated older adults should take into account the system-level or structural challenges they face as well as intersectional discrimination they may experience (Dassieu & Sourial, 2021).

Study Purpose, Rationale, and Aims

In summary, prior literature has indicated that socio-demographic and ability factors are differentially associated with rates of mental health challenges and social participation. Further, socio-demographic, ability, and system-level factors impact access to mental health services. Yet, a notable gap is the use of an intersectional lens in this work. An opportunity to further this line of investigation this has arisen through the expansion of the CONNECT Program across Canada, and this necessitates additional research to characterize the mental health support needs of older adults across the three Canadian provinces, which aligns with the knowledge-to-action framework (Graham et al., 2006). Therefore, the overarching goal of this study was to characterize the mental health needs of community organization members and their views on the CONNECT Program. Specifically, the study employed a mixed method, intersectional approach to characterize the perspectives of adults 55+ on: (1) their experiences with mental health challenges and accessing supports, and (2) their opinions on the acceptability, appropriateness, and feasibility of the CONNECT Program.

Method

Research Design Overview

To address these objectives, this study employed a mixed-method design to gain in-depth insight that is grounded in participants' voices. A mixed methods research design involves the collection and integration of qualitative and quantitative data to deepen the research findings beyond what one method alone can provide (Creswell & Creswell, 2018, pp. 51-52). Relevant to

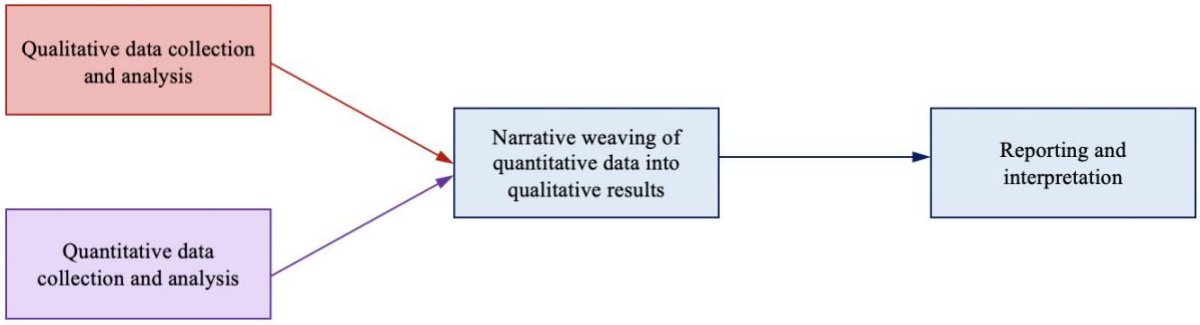
this study was a convergent mixed methods approach, involving the parallel collection and data analysis of qualitative and quantitative data, followed by integration of the two (see Figure 1). This approach allowed for the examination of participants' mental health experiences and views on the CONNECT Program in comprehensive manner, facilitating triangulation of results. This was appropriate given the potential challenges anticipated in qualitative interviews, namely self- and public stigma surrounding mental health (Holm & Severinsson, 2014; Reynolds et al., 2020) that may limit discussion, and the potential impact of discussing the CONNECT Program with researchers involved in the intervention's development. Quantitative data was integrated into qualitative data to provide further richness to analysis and interpretation of results (as explained further in *Data Analysis*).

The qualitative approach employed in this study was Interpretive Description (ID), an inductive method derived from nursing epistemology, grounded theory, naturalistic enquiry, ethnography and phenomenology (Thorne et al., 1997, 2004). ID aims to deepen a field's understanding of a clinical phenomenon, with the ultimate goal of producing practical findings that can inform clinical practice. The approach is constructivist in nature, acknowledging that experiences are subjective and contextually-bound. Findings take the form of a coherent narrative that provides rich insight into a phenomenon, noting both patterns and variation within the data (Thorne et al., 1997, 2004). In this method, researchers are encouraged to gain insight into the specific population of focus using research and clinical insights to inform sampling procedures (Thorne et al., 2004). This ensures that the study findings "seem reasonable to the intended audience" (Thorne, 2008, p. 91). Further, ID recognizes that there can be infinite variation in experiences and outliers may exist, so the concept of data saturation is not relied upon (Thompson Burdine et al., 2021). Rather, researchers are encouraged to reflect on the meaning of their data in the context of how much exposure they have had to the phenomenon (Thorne, 2008, p. 98), and consider whether they have enough information to support their findings.

ID was a relevant method for this study due to the alignment in theoretical approach and goals. First, ID's constructivist and clinically-oriented approach aligns with a central aim underpinning this project and the overarching CONNECT research program: to ensure the CONNECT Program is a relevant and clinically-effective support for adults 55+. Second, with this study's focus on intersectionality, the ability to maintain individual narratives while also creating themes across stories by using ID was a notable strength. Third, using ID, I was able to incorporate pre-existing knowledge about the community organization characteristics into the sampling process, and use prior research on aging, mental health, social participation, and intersectionality to inform the interview/focus group questions. This allowed for greater ease in recruitment and precision in study materials. Thus, given the strong alignment in aims and benefits of this qualitative method, ID was selected as a relevant approach for this study.

I also included quantitative measures to assess the sample's socio-demographic characteristics, and contextualize participants' mental health and views on the CONNECT Program. To address objective 1, I used quantitative measures to further characterize the sample in terms of their socio-demographics, well-being, and experiences of anxiety, depression, loneliness and social isolation. To address objective 2, I used a quantitative measure to explore participants views on the CONNECT Program.

Figure 1
Convergent Mixed Methods Procedure



Intersectionality in Qualitative Health Research

Abrams and colleagues (2020) described how an intersectional lens can be incorporated into qualitative health research to produce more holistic and rich understandings of a phenomenon and health disparities experienced by marginalized populations. With guidance from this paper, I considered intersectionality in this study throughout study conceptualization, design, data collection, analysis, and the write-up. Throughout the project, I reflected on my identity, biases and assumptions, and how those may impact the study. In conceptualization and study design, I reflected and read literature on how participants may be impacted by marginalization based on their social identities and, and how this may impact their experiences with mental health, mental health service use, and social participation. The interview guides and socio-demographic questionnaires were developed with the aim of exploring intersectionality in analysis. The incorporation of intersectionality in data analysis and the write-up are discussed in more depth in *Data Analysis.*

Participants and Recruitment

Using an integrated knowledge translation approach, my study team partnered with three community organizations who offer social programs for older adults: *A&O: Support Services for Older Adults* in Manitoba (MB), *Senior Centre Without Walls* in Saskatchewan (SK), and *Brella Community Services Society* in British Columbia (BC). In a Zoom meeting with partners from each site, we discussed the goals of my study, the demographic characteristics of their organization members, and the best recruitment methods to reach the intended audience (i.e., prospective CONNECT program participants). In line with recommendations from partners at the BC, SK and MB organizations, the study was advertised via an email sent out to their community organization email list (see Appendix A-B for poster and email). For MB, organization staff also verbally read the recruitment materials to participants of the study in a meeting of Seniors Center Without Walls. A convenience sampling strategy was used, per study partners' guidance, in order to minimize the burden placed on the providers and maximize opportunities for recruitment. The inclusion/exclusion criteria included: age 55+; able to converse in and read English; competent to provide consent; sufficient hearing ability such that they can attend to conversation; and self-reported interest in the CONNECT Program.

Recruitment and data collection occurred from November 2024 – April 2025. I aimed to recruit five to eight participants from each site (15-24 total), in line with best practices in focus group research (Krueger & Casey, 2009). Interested individuals reached out to our study team

directly via email or phone. The screening process is outlined in the *Procedures* section and Appendix C. A total of 13 participants were recruited, including: six from BC (three individual interviews, one focus group), four from SK (one focus group), and three from MB (three individual interviews). Participants indicated their preference for an individual interview or focus group. Only one participant in MB expressed interest in a focus group and the other participants preferred an individual interview, thus only individual interviews were completed. Across sites, those who preferred the individual interview expressed hesitancy around sharing their feelings in a group of new people. To note, while the CONNECT Program has been offered in MB, participants from MB in this study had not participated in the CONNECT Program. As the CONNECT Program has not been offered in BC or SK yet, these participants had not completed the intervention.

Measures

Lubben Social Network Scale-6

The Lubben Social Network Scale-6 (LSNS-6) is a six-item self-report scale that assesses the degree of social connection with family and friends (Lubben et al., 2006; Appendix D). The items are rated with a 5-point scale (0 = *none*, 1 = *one*, 2 = *two*, 3 = *three or four*, 4 = *five through eight*, 5 = *nine or more*). The total score is the sum of the items. Higher scores reflect more connection (range: 0-30). Lubben and colleagues (2006) examined the scale's validity among community-dwelling older adults in three European countries, which supported the scale's internal consistency (Cronbach's alpha = 0.83 across countries). A cut-off score of 12 was found to identify individuals who have low social connection, with the score reflecting having on average less than two meaningful social connections (Lubben et al., 2006).

UCLA Three Item Loneliness Scale

The UCLA Three-Item Loneliness Scale is a three-item self-report scale that assesses aspects of loneliness and isolation (Hughes et al., 2004; Appendix E). The items are rated with a three-point Likert scale (1 = *hardly ever*, 2 = *some of the time*, 3 = *often*). The total score is the sum of the items. Higher scores reflect more loneliness (range: 3-9). Hughes and colleagues (2004) examined the scale's validity is supported by a study of community-dwelling older adults, showing convergent validity with the long-form of the scale (r = 0.82). In a large sample of adults, a cut-off score of 6 or higher was found to be most sensitive and comparable to the longer version of this scale (Gosling et al., 2024).

PROMIS Emotional Support – Depression 8a

The Patient-Reported Outcomes Measurement Information System (PROMIS) Depression 8a is an eight-item self-report scale that assesses depression symptoms (Cella et al., 2010, 2019; Appendix F). The items are rated with a five-point Likert scale (1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *usually*, 5 = *always*). The total score is the sum of the items, and this raw score is converted to a T-score based on a normative sample of adults. T-scores have an average of 50 and a standard deviation of 10. Higher scores reflect greater depression severity. The scale's validity is supported by a study of community-dwelling older adults, indicating convergent validity with the Geriatric Depression Scale and the Montgomery-Asberg Depression Rating Scale (Levin et al., 2015).

Geriatric Anxiety Inventory Short-Form

The Geriatric Anxiety Inventory Short-Form (GAI-SF) is a five-item self-report scale that assesses the presence of anxiety symptoms (Byrne & Pachana, 2011). The response format for each item is "agree/disagree", scored as 1 = *agree*, 0 = *disagree*. The total score is the sum of all the items (range: 0-5). Byrne & Pachana (2011) examined the scale's psychometric properties among community-dwelling older women, supporting its internal consistency (Cronbach's alpha = 0.81), convergent validity with the scale's long-form (r = 0.88), and discriminatory ability with General Anxiety Disorder (AUC = 0.80). A cut-point of three was optimal for identifying Generalized Anxiety Disorder , and had high sensitivity and specificity (Byrne & Pachana, 2011).

World Health Organization Five Well-Being Index

The World Health Organization Five Well-Being Index (WHO-5) is a five-item self-report scale that assesses subjective well-being over the past two weeks (Appendix G; World Health Organization, 2024). The items are rated with a six-point Likert scale (5 = *All of the time*, 4 = *Most of the time*, 3 = *More than half of the time*, 2 = *Less than half of the time*, 1 = *Some of the time*, 0 = *At no time*). The total score is the sum of all the items (range: 0-25). The scale's psychometric properties were investigated in a study of community-dwelling older adults, supporting its internal validity using item-response theory and discriminatory ability with depression symptoms (AUC = 0.88) (Lucas-Carrasco et al., 2012)

Socio-Demographic Characteristics

This questionnaire assessed socio-demographic characteristics and background information to characterize the sample (Appendix H). Participants were asked about their age, sex assigned at birth, gender identity, sexual orientation, primary language, country of origin, ethnicity, race, highest level of education, level of income, area of residence, marital status, employment status, impairment in vision, hearing, and mobility, and prior mental health service use.

Focus Group or Individual Interview

Participants completed a semi-structured individual interview or organization-specific semi-structured focus group, dependent on their preference and number of interested individuals (Appendix I). Participants were asked about their involvement in their community organization, their sense of connection, their identities, current mental health challenges, as well as their mental health service needs. Following a description of the CONNECT Program (Appendix J), participants were asked about the program's accessibility, acceptability, feasibility, and appropriateness, as well as suggestions to tailor the program to meet their needs. Participants were asked reflect on their identities and how they may impact their service needs. Questions remained the same throughout interviews. After one focus group and two individual interviews, I consulted with my advisor to add additional probes about identity and intersectionality to improve the richness of the data. These included exploring difficulties discussing identity, describing a vignette of an older adult with intersecting identities, and framing identity as aspects of ourselves that can be new or held with us from youth.

Implementation Outcomes Assessment

Participants completed a 6-item assessment designed by the study team (Appendix K). The first four items address one key implementation outcome outlined by Proctor and colleagues (2011): feasibility, appropriateness, and acceptability. Participants were asked to indicate their agreement with each item using a five-point rating scale (1 = *disagree strongly*, 2 = *disagree*, 3 = *neither agree nor disagree*, 4 = *agree*, 5 = *agree strongly*). Participants were asked to provide a brief qualitative response to contextualize their quantitative rating. The last two items were open-ended, and addressed appropriateness and feasibility. This tool was developed in line with other implementation outcome questionnaires (Milosevic et al., 2015; Weiner et al., 2017).

Procedures

Ethics approval was obtained from the University of Manitoba Research Ethics board prior to recruitment. I screened interested individuals for eligibility via telephone following the screening script and questionnaire (Appendix C). The calls took about 10-15 minutes. For eligible and interested individuals, the consent form was signed via REDCap (an online survey management system), or, if the individual did not have access to the Internet, I obtained their verbal consent, documented it in REDCap, and sent the signed consent form via mail for their records. See Appendix L for the consent form. After consent was provided, I scheduled a time to complete the questionnaires via the telephone for those who requested it, as well as the focus group or individual interview. Prior to the focus group or individual interview, participants completed questionnaires assessing socio-demographics, depression, anxiety, social connection, and loneliness. These questionnaires were completed either via REDCap or over the phone with myself and documented in REDCap. Completing questionnaires themselves took on average 12.5 minutes, and completing questionnaires on the phone took about 15-20 minutes. After, participants completed one focus group or individual interview via Zoom Professional, led by myself. A research assistant attended and co-facilitated focus groups and took field notes. Focus groups ranged from 88-121 minutes to complete, and individual interviews took 74-93 minutes to complete. The interviews were audio-recorded for transcription. After the interview, participants completed the Implementation Outcomes Assessment either via REDCap or over the phone in the same manner described above. Completing this questionnaire themselves took on average 17.9 minutes, and completing it on the phone took about 5-15 minutes. Participants were compensated with a $50.00 gift card (i.e., about $25 per hour of participation), shared either via email or mail dependent on their preference. Focus group and individual interview audio-recordings were transcribed naturalistically using Trint, a transcription software. Transcripts were copy-edited and de-identified by two research assistants and myself. Data were analyzed as described below.

Data Analysis

Per the convergent mixed methods approach employed in this study, qualitative and quantitative data were analyzed separately, and then integrated based on a match of theme. This analytic plan is detailed below and in Figure 1.

Qualitative Analysis

For the transcripts, myself and a research assistant independently coded the data, compared our results, and reviewed discrepancies as an analytic team with the support of my advisor. The focus of analysis was at the participant-level, centering on the experiences and

perspectives shared by participants rather than group dynamics or consensus formation (Kidd & Parshall, 2000). Thus, the same approach was able to be applied to the analysis of focus groups and individual interviews. Overall, analysis involved moving from "pieces to patterns" (Thorne, 2008, p. 142) through coding and identifying potential patterns, and from "patterns to relationships" (Thorne, 2008, p. 149) through thoughtful comparison of these codes and patterns. More specifically, we read the full transcript multiple times to become familiar with it. Next, we coded the transcript by grouping data bits that were similar, with key quotes being identified for potential inclusion in the final narrative. Codes were used to organize the data but were not too specific, as they were refined throughout analysis. Then, we assessed tentative patterns by comparing and contrasting the codes, and identified relationships among them. Interpretation of these relationships occurred through iterative synthesis to find overarching relationships using the data and pre-existing literature. Interpretations were recontextualized within the relevant setting (Thorne, 2008, pp. 141-150).

Throughout, we documented analytic memos and created visual diagrams of codes and themes to foster deeper analysis of the data. Additionally, we continually reminded ourselves of the following: (1) the purpose of the study, (2) what findings are expected or unexpected, (3) the similarities and differences observed between cases, and (4) how the results can be translated into clinically-meaningful findings (Thorne, 2022, 2023). In addition, to incorporate intersectionality, we continually reflected on the impact of participants' identities and societal contexts on their experiences, as well as the system-level factors relevant to participants' experiences (Abrams et al., 2020). Ultimately, analysis generated a coherent narrative, influenced by our perceptions of the data. While writing the results, I was mindful of recommendation from ID that the degree of interpretation and implications drawn from the results should be proportional the amount of data there is to support findings (Thorne, 2008, p. 94). In line with the ID approach, and to account for the integration of focus groups and individual interview data, I considered both the individual stories presented within focus groups as well as the focus group codes when developing the framework. For quotes included in the results, participant IDs include the site/provincial abbreviation (MB, SK, or BC) and participants' abbreviated study number.

Regarding the process, qualitative analysis started during data collection. We decided to create one qualitative framework that represented all participants experiences, rather than one framework per site, given the similarities in content across sites as well as the smaller sample sizes for MB and SK. Content on the CONNECT Program was initially integrated with the rest of the qualitative data. However, given the unique study aim of characterizing views on the intervention, data specific to the CONNECT Program was included in a separate framework.

Quantitative Analysis

Across the full sample, descriptive statistics were used to summarize socio-demographic variables and the questionnaire scores in RStudio. One individual with missing responses on a subset of socio-demographic variables was excluded from analysis of those variables.

Mixed Method Integration

I integrated quantitative and qualitative data at the stages of interpretation and results using a narrative weaving approach, per Fetters and colleagues' guidelines (2013). This involved

integrating quantitative findings into the qualitative results based on a match of themes or concepts (e.g., mental health, connection). In bringing the data together, I looked for confirmation of results, opportunities to expand what is known about participants' experiences, and any discordance. Data was integrated separately for each study objective. To reduce repetition, only the integrated results for objective two (evaluation of the CONNECT Program) are presented in this thesis.

Rigor

In line with recommendations by the ID literature (Thompson Burdine et al., 2021; Thorne, 2008), we engaged in reflexive practices, sought independent scrutiny, and created an audit trail to ensure analytic rigor. These practices are relevant to the ID approach given its constructivist nature, and serve to promote "well-founded" interpretations of participants' experiences (Thompson Burdine et al., 2021). *Reflexivity* involved bringing awareness to how my beliefs, values and experiences were impacting my views of the research. Engaging in reflexive practices served to minimize *over-inscription of self* in the results (Thorne, 2008, p. 157). As the lead researcher, I acknowledge how my background, perspectives and beliefs have shaped all aspects of this project. I acknowledge that I am an able-bodied, cis-gender female of mixed ethnicity (South Asian and White). I am highly privileged to be engaged in post-secondary education, and am currently a Master's student in a clinical psychology program. My position as a clinical psychology trainee and my positive attitudes towards older adulthood and aging have influenced my overarching research goals: to promote psychological health in older adulthood by improving access to mental health services. Further, my role as a clinician biases the way I interpret descriptions of mental health challenges and symptoms. As a 26-year-old, I acknowledge that I am an outsider to the population of study and therefore I may not be able to fully comprehend participants' experiences. This study's conceptualization was inspired by my experiences being of mixed ethnicity and my passion for providing accessible mental health services. From this, I recognize that one's experiences are impacted by their socio-political identities, and that mental health services or programs are not "one size fits all." I approach this study with constructivist and pragmatic worldviews: I recognize that I will be constructing meaning from the data based on my perceptions and understandings, and my hope is to generate practical findings to help tailor the CONNECT program. To practice reflexivity, I reflected on the impact of my biases as well as my personal reactions to and opinions on the data by journaling and engaging in open discussions with study team members throughout data collection, analysis, and interpretation. Study team members (research assistant and advisor) also wrote positionality statements as part of their self-reflexivity practices. The research advisor acknowledged the influence of her perspectives as a clinical psychologist and a qualitative methodologist, with deep admiration of and respect for adults ages 55+. She noted that her identity as a young-to-middle-aged woman was prominent and notable, in addition to her positive valuation for community-based mental health programming. The research assistant acknowledged that her perspectives were shaped by intersectional, feminist, constructivist thought learned throughout her undergraduate degree. She noted that, as a young adult early in her career, much of her perspective on adults aged 55+ was formed from the experiences and respect for her parents and late grandparents. She acknowledged the importance of accessibility and cultural competency to mental health interventions, and the value of community engagement in their development, and implementation.

Independent scrutiny involved discussing emerging findings with other experts, as well as reflecting on the results with respect to what is known about the phenomenon of study, to see whether the interpretations of the data were appropriate. I discussed initial findings and developments with the study team, and reflected on how the results compared to what is known about adults' 55+ mental health challenges, experiences with social isolation and loneliness, and barriers to mental health services and social participation. For expert opinion, I sought feedback on the appropriateness and relevance of the emergent results from my thesis committee and advisor, who have expertise in the areas of aging, mental health, and the CONNECT program. To create an *audit trail*, I recorded my decisions regarding coding and interpretation to track my analytic logic (Thompson Burdine et al., 2021). In addition, I avoided *premature closure* of emerging patterns and relationships by keeping an open mind, expanding on and challenging the emerging narrative, and challenging patterns and relationships in the data. To further this, I *capitalized on outliers* by considering potential variation in the data that was not captured within this sample (Thorne, 2008, p. 156-161). This is aligned with ID's disassociation from the concept of saturation.

Results

Participant Characteristics

The sample was comprised of 13 participants, including six from BC, three from MB, and four from SK. Two focus groups (BC: $n = 3$; SK: $n = 4$), and six individual interviews (BC: $n = 3$, MB: $n = 3$) were completed. Participants were on average 71.5 years old (range: 62-90), all women, and majority identified as Canadian (69.2%) and racially White (76.9%). The most frequent marital status was separated or divorced (46.2%). The majority of participants had an annual income under $50,000 (61.5%), and all were retired or on disability leave. Most participants lived in urban areas (84.6%). Impairment in mobility and vision were commonly reported by participants (46.2% and 61.5% respectively), and 46.2% of participants reported experiencing impairment in multiple domains of ability (i.e., mobility, hearing, and/or vision). Most participants reported prior use of mental health services (84.6%), most commonly from a counsellor (62%). Services were primarily sought to cope with depression, anxiety, and relationship challenges (e.g., with children).

The mean score on the LSNS-6 was 11.8 ± 7.6, indicating that participants were socially connected to less than two individuals across family and friends on average, although individual scores ranged from 3 to 26. About half of the sample (46%) fell below the cut-off score, indicating that they had less than two meaningful social connections on average. The average score on the UCLA-3 was 6.1 ± 2.2, with seven participants falling above the cut-off indicating loneliness Importantly, the majority of participants (77%) endorsed experiencing aspects of loneliness (i.e., endorsed at least one item on the measure). On the PROMIS Depression 8a, the average score was 59.2 ± 8.7, indicating that the sample reported an average level of depression symptoms relative to a normative sample of adults, though individual scores ranged from average to high average (total score range: 38.2 – 68.7). The average score on the GAI-SF was 2.5 ± 1.9, with individual scores ranging from 0 to 5. Six participants' anxiety levels fell in the clinically-significant range. Participants' level of well-being was, on average, 12.4 ± 6.2, which falls at about halfway point on the questionnaire's scale (potential scores range from 0-25). Although, scores ranged from 5 to 22.

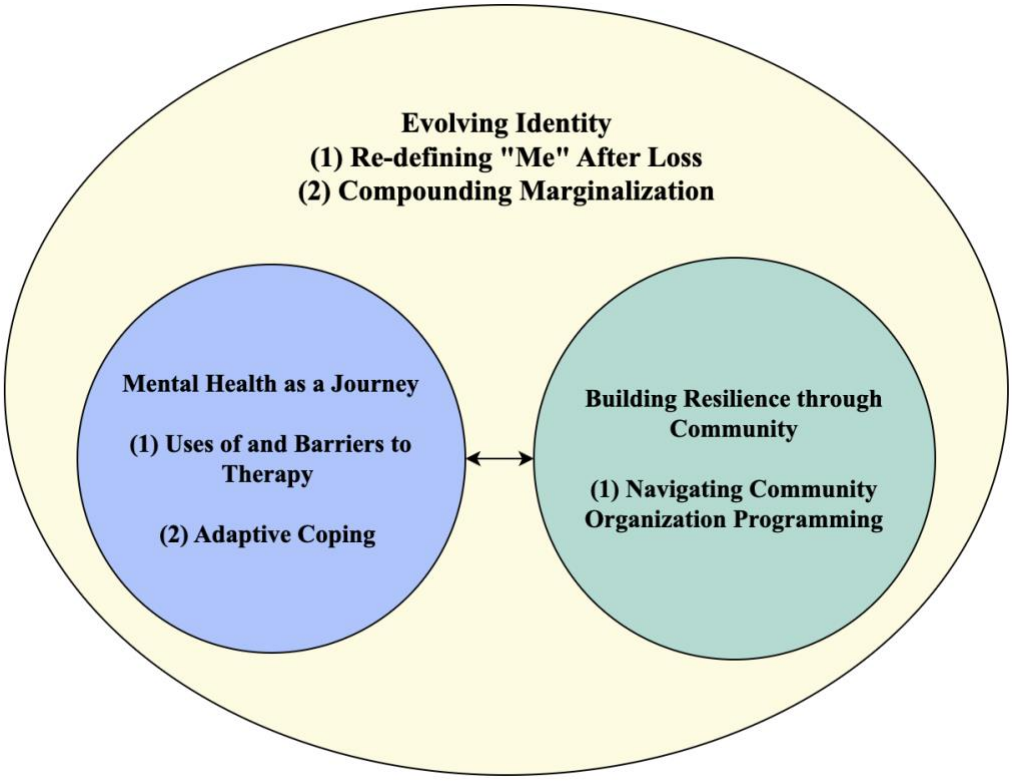
In sum, the perspectives heard in this work were primarily from older women who had used mental health services before and experienced symptoms of depression, anxiety, loneliness, and social isolation. See Table 1 for a full list of demographic characteristics and questionnaire scores for the total sample (Appendix M).

Qualitative Results

The overarching theme that emerged was participants' experiences navigating loss related to life transitions, major events, and aging. Specifically, participants highlighted how they are processing changes in their inner sense of self (*Re-defining "Me" After Loss)* and their intersecting identities (*Compounding Marginalization*). In relation to their identities, participants described two themes: their *mental health as a journey*, influenced by formal supports and informal coping strategies; and *building resilience through community*, through meaningful community-based connections and organizational programming. Participants described how their identities can be experienced as connecting or isolating, and have impacted their access to mental health and community-based supports. Figure 2 provides a visual representation of this framework.

Figure 2

Qualitative Framework



Evolving Identity

Participants' evolving identity was a central theme that related to all aspects of their experiences. They described both their inner sense of self, as they sought to understand their own identity after transitions, and their intersecting identities, as they discussed how marginalization impacts their ability to connect with others and seek services.

Re-defining "Me" After Loss. Participants described how loss related to life transitions (i.e., loss of a loved one, disconnection from family, retirement, health decline) and significant events (e.g., COVID-19 pandemic) contrasted with their expectations of aging and impacted their sense of self as an older adult. Most participants recounted the loss of loved ones and grief, which they resigned to accept as a part of later life. One participant described how her mental health had fluctuated over time in relation to retirement, COVID-19 pandemic restrictions and subsequent easing of restrictions, decline in health, and the loss of loved ones. She stated: "…Up to about 50, I'd say or 55 even, like I never thought about this kind of loss, you know? And now I think that's, that's a big part of our lives as well" (MB2, individual interview). Losing a loved one was commonly experienced as traumatic and permanently life-altering, resulting in the loss of imagined future with their loved one and altered sense of self. Another participant recounted how she has been struggling to adjust to the passing of her sister, which occurred a few years prior to the interview. She stated: "The [name] that I was is not the [name] that I am right now" (MB3, individual interview). Retirement also posed a significant transition that created a shift in identity. Some participants outlined how taking disability leave due to mental health challenges turned into unexpected retirement or a chosen career change to avoid encountering mental health stigma at work. One participant described the impact of unexpected retirement, which occurred after going on disability due to her mental health: "Just maybe my existence doesn't matter as much anymore, um, because I'm not in the work force" (MB1, individual interview). Other participants retired due to physical health declines that impaired their mobility and vision, and struggled with what it meant to no longer be able to pursue their meaningful career or engage in activities that they used to. One woman described how her mobility has declined significantly over the past years due to a medical condition, resulting in the need to use a walker. She described how this change in mobility not only impacted her ability to participate in social activities, but more saliently impacted her identity: "But, still inside of me, it's like, you know, I'm only [mid 60s] and jeepers I have to use a, a walker and, you know, how I see myself, um, is kind of negative" (SK2, focus group).

Participants also discussed the COVID-19 pandemic as a turning point in their lives, impacting their ability to engage in planned activities like travel or socialization. These life transitions and events often stacked together, further contrasting participants' expectations of their lives as older adults. One participant started to describe how retirement was a more challenging transition than she expected, by contextualizing her experience within the changes and transitions she moved through over time:

> At first [retirement] was really exciting, you know, because you had all this free time. And you felt alive. But then I think it kinda wore off after a while. And then actually, unfortunately, we had some... Illnesses in the family and then COVID hit. So, it, it kind of um, yeah, I have to say, it kind of put us in a darker spot and like, yeah, it, it really hasn't improved that much really I have to say, things are... Not the thing I expected. But uh, you know what, that's what life throws you and you've got to just deal with it, so. (MB2, individual interview).

While grappling with these unexpected losses in later life, participants' connection to pieces of their past-self created a sense of stability. This was salient in the way most participants discussed their hobbies and pastimes not just as enjoyable but also as an important through line in their identities. While discussing our hobbies at the start of the interview, one woman

described how her identity and roles have changed, but not the activity: “I started out as a crafty, um, person, a crafty mom, and now I graduated into a crafty senior” (BC2, focus group). Another participant exemplified how hobbies can create a sense of normalcy in unexpected times, following the loss of her mother and sister: “I'm restarting, I guess, but still walking” (SK3, focus group, with mall-walking being one of her pastimes).

Compounding Marginalization. Age, being a woman, mobility challenges, and low income were key aspects of participants’ identities that impacted how they navigated their worlds. Most saliently, many participants described how being viewed as an older person or an older woman in society resulted in feeling invisible or judged, which some participants labeled as ageism (e.g., “Ageism is alive and well,” BC4, focus group). For example, one woman described disconnection from society as an older woman with mobility challenges:

> …What I find as you get older, you almost, you become invisible… So as soon as your hair turns grey and you, you get, you walk a little slower and you have to use a cane. You um... Yeah, people buzz by you a lot. (BC1, individual interview)

In focus groups, participants took turns telling their experiences of ageism, forming a point of laughter and connection. In focus groups and individual interviews, many participants described these occurrences with resistance. For example, one participant described frustration that her outward appearance as an older woman led others to make assumptions about her inability to use technology: “Sometimes it just makes me want to prove them wrong, I'll put it that way. *Laughs* You know. I will answer those questions and say, of course I do. I'm always polite, but…” (SK3, focus group). Importantly, participants’ identities intersected to uniquely shape their experiences. For instance, one participant described how, as an older retired woman, she encountered challenges accessing mental health services due to financial limitations, as well as ageism and sexism in everyday life and the healthcare system. These experiences distanced her from supports, however, she was eventually able to find a supportive mental health clinician (BC2, focus group). Another woman described how, as a retired older adult with mobility challenges, she encountered both financial and accessibility-related barriers to mental health services and community programs. In one instance, she recounted how her walker could not fit through the entryway of a community-based mental health service. This participant described feeling distanced from connection and support and is still navigating services (MB1, individual interview).

In contrast, two participants did not experience their identities as negatively impacting their experiences in the world. One woman identified that her neighbours viewed her as less capable of doing physical labour due to her age, but that it resulted in connection as they assisted with household tasks that she did not want to do (BC3, focus group). Another woman identified that while she felt hesitant to share her culture with others due to concerns of discrimination, it facilitated connection with people who shared her cultural background (MB2, individual interview).

Mental Health as a Journey

Participants described their mental health as a journey, influenced by their view on mental health, life transitions and changes in identity, as well as the use of formal therapeutic supports and a diversity of coping strategies. Participants’ mental health challenges fluctuated over their adult lives, and they highlighted critical moments to their mental health. Several

participants described past depression and anxiety in early-mid adulthood as a result of work stressors, conflicts with their spouse, disconnection from their children, loss of a loved one, or change in ability level. In more recent years, participants noticed the connection between isolation and mental health challenges as a consequence of life transitions impacting their relationships (e.g., loss of a loved one) and the COVID-19 pandemic restrictions, leading to increased loneliness, depression and anxiety. One woman described how she experienced increased depression and isolation following the passing of her husband, however, she did not realize the extent to which these symptoms impacted her until the COVID-19 pandemic. She stated: "I think COVID really brought... my feelings and my emotions about being isolated to the forefront because I never felt isolated before" (BC1, individual interview). The majority of participants described current experiences of grief, depression and anxiety as a result of the loss of loved ones, disconnection from children, or decline in health or ability. Closely intertwined with these life transitions was a subsequent loss of identity that increased mental health challenges. One participant expressed hopelessness and devaluation of herself when describing the connection between social support and her mental health:

> Sometimes, more times, that I just feel, you know, why am I around? You know, my, my kids aren't nearby, I don't have grandchildren you know, I... If I went, there wouldn't be... um, or when I go, there, there won't be a hole in anybody's life. Um, you know. So just like, what's the purpose? (BC6, individual interview)

In another instance, a participant described how her reduction in mobility due to a medical condition led to early retirement and becoming "a shut-in kind of a person" (SK2, focus group). As a result, she described: "What's happening with my mental health around that, is, because I see myself as, uh, the person with the disability, rather, and, and I allow that disability to define me" (SK2, focus group). For a subset of participants, in response to traumatic events or the unexpected or sudden loss of a loved one, they described re-experiencing the events (e.g., through nightmares), self-blame, negative cognitions, despair, sleep disturbances and distrust of others. Overall, participants' mental health has fluctuated over time, impacted by life transitions and changes in identity. At the time of interviews, participants were at different stages of their journeys, reflected by different severity of mental health challenges. For example, one participant described past challenges with depression and anxiety that no longer impacted her: "I went through, um, some mental health issues a number of years ago but work, did a lot of work on that. Um, and so I'd say that I'm no longer depressed or have anxiety" (BC5, individual interview). The two sub-themes further describe how engaging in formal support and coping strategies helped participants to cope with mental health challenges.

Uses of and Barriers to Therapy. In discussing their mental health and views on the CONNECT Program, participants described the uses of therapy. Therapists provided someone to "bounce things off of" (BC6, individual interview) and discuss topics that they were not comfortable discussing with friends or family. One woman described this when talking about the end of a positive experience with short-term therapy from a community mental health counsellor:

> So I knew I had someone, um. Sort of on my shoulder, right. And sort of I can uh dump on her a bit, uh. And not having that sort of. Yeah, its uh, makes me feel like empty, right? Because I don't have anyone to talk to. Because all this stuff is, like, so personal (MB1, individual interview).

Therapy also provided the opportunity to gain insight into oneself and process traumatic experiences. Across participants, the utility of therapy was contingent on the therapist implementing active listening and providing suggestions, solutions, or advice. While therapy was viewed positively, participants highlighted several barriers to services that connected to their identities. A common barrier was the financial cost of services, made more prominent by loss of income through retirement. At the system-level, participants recounted difficulty navigating services, feeling stuck on waitlists, and finding limited options targeted towards older adults. One participant described hesitancy to seek mental health services due to past experiences muddling through the physical healthcare system: "It would be another journey that I would have to, go on. And, struggle to find my way through it" (BC1, individual interview). Mental health stigma acted as another barrier, in multiple ways. Participants described mental health stigma drawn from their generation's upbringing as a factor that impacted their understanding of mental health and comfort accessing services. By growing up post-World War II, participants felt that emotions and mental health were not a priority nor discussed, for example: "We were told, uh, to suppress emotions and, um, we just had to work through everything" (BC1, individual interview). Further, when accessing mental health services, one woman described how she felt stigmatized: "I don't have a problem with saying I need to talk to someone. However, there still is that same thing from the mid 80s, where if it's known that I'm going, then I'm the one with the mental illness" (BC2, focus group). Participants described their family doctor as a key point of access or as a barrier, depending on their relationship. Some participants felt unheard or dismissed by their doctor, and as a result felt they had to work hard to get referred to needed supports. Other participants described positive relationships with their family doctor, who helped them to navigate the system and provided more holistic supports.

Adaptive Coping. Participants engaged in hobbies and strategies, social connection, and community programming to maintain their mental health, prevent cognitive decline, and fill their time. These included both new and familiar activities or strategies, developed through lived expertise. Hobbies and strategies included crafts, reading, engaging in activities that promote learning, gardening, yoga, spiritual and religious activities, and breathwork. Meaningful social connection with friends and family was a root form of support that was a point of gratitude for those who had it, and a point of yearning and loneliness for those who did not. Notably, participants who were socially connected described increased effort and management to maintain their relationships. For example, one woman described how social connection was an important aspect of coping with mental health challenges, and how she works hard to do so:

> You have to, it, it's almost like a, a job because if you don't talk to these people, to talk to your friends all the time or talk to uh, family all the time, um, your relationship with them can disappear a lot quicker than when you were younger. (BC1, individual interview)

For two participants who were more isolated through intersections of age, loss of income, and mobility challenges, their pets provided mental health support through distraction, companionship and facilitators for social interaction. One participant described the life-changing impact of her dog on her mental health:

> My son got her about seven years ago. And before that point, I was always in and out of the hospital just just 'cuz of the mental health and and having her, um. Sort of changed my life that way. And, um. Yeah. Made me more responsible, right. And sort of, um. Yeah. So she keeps my mind occupied, too. (MB1, individual interview)

Throughout discussion, participants also highlighted the benefits of tuning out negativity (e.g., not watching the news) and instead focusing on positively-valanced information as a way to manage their mood and anxiety. A unique aspect of coping for participants in BC, as well as one participant in MB, was the importance of nature. Participants described how connecting with nature was restorative, grounding, and commonplace in their neighbourhood cultures. Another unique topic of discussion within participants from BC was an emphasis on the value of intergenerational contact, which would provide the opportunity for socialization and reciprocal learning. In sum, participants described a wide range of coping strategies and hobbies, reflecting beneficial adaptation to life transitions and their mental health.

Building Resilience Through Community

Creating connection to their community, whether through friends, family, or community organizations, were acts of resiliency that participants took while facing of life transitions and shifting identities. In response to the loss of social connections (e.g., through the death of a loved one, loss of a relationship, moving, loss of mobility due to health decline), participants joined community-based organizations and programs, forged new social connections based on shared interests or experiences, and continued to engage in pastimes that brought meaning to their lives (e.g., going to church, going to a walking group). One participant described how she sought to form connections after losing loved ones, and how joining a community-based group of women has been an important part of healing:

> …But lonely is um, I've lost a lot of friends. Some have moved away, like long term friends. Some have died. And so, what I find at this age, it's hard. And you don't ever replace anyone. I know that. But it's hard to fill that space with um, and it takes time with people you don't really connect with. That's part of the reason why I'm in sorority. (BC4, focus group)

For one participant who lost her husband, she began volunteering at the hospice that supported him as a way to give back to her community. Through this opportunity, she established a small circle of close friends who she connects with daily. In the early days of the COVID-19 pandemic, she also joined Brella to foster more social connection and have activities to look forward to (BC1, individual interview). For participants who had family and friends in their lives, they worked hard to ensure they connected with their loved ones regularly by scheduling phone calls or outings. For one participant whose decline in mobility impacted her ability to engage in activities and whose relationship with her children was distanced, she coordinated a pet group within her apartment building, which provided both an opportunity to connect with others and a support network (BC6, individual interview). Across participants, establishing and working hard to maintain connection to community positively impacted their mental health and perspective, as one participant described when talking about connecting with her sister and friend: “It means it's going to be a good day” (BC6, individual interview). For another participant who had retired from a meaningful career of teaching people who have disabilities due to her own decline in health, she continued to volunteer with the same population. She described that volunteering positively impacts her mental health: “Going to [organization] helps me, to show that people are happy. And to heal me… [it] takes my depression up. Because I'm making somebody else happy and I'm happy that they're happy” (MB3, individual interview).

Navigating Community Organization Programming. Within this subtheme, participants described their pathways to involvement with our partnered community organizations and their experiences with programming. Most participants joined community programs at times of change in their lives. Five participants were referred by a healthcare provider, support worker, or friend when they were in need of social connection or support. The remaining participants sought the organization themselves for entertainment and connection during COVID-19 pandemic, to seek assistance with housing, or to generally connect with other older adults and learn. Participants were engaged in a variety of programs that involved art, reminiscing, education, and socialization. Many participants in BC reported taking part in day trips. All participants had engaged in telephone-based programming, through which they enjoyed learning and hearing others' voices and stories. Participants commonly shared that these programs fill the gap in their social lives. One participant described how she valued telephone-based programming as a way to fill her time and to open the door to connection, without leaving the safety of her home. She said: "Sometimes you could go through the whole day. The phone doesn't ring. You know, you have no connection. Like I mean, I don't think that's very healthy" (MB2, individual interview). Another participant described how community programs and the friendships she has formed through programs help her cope with the grief of losing her child:

> …They've all become really good friends to me, in the sense that they take me outside of myself so that I'm not grieving, uh, my losses so much anymore. And I jump in on a lot of the speakers in that because believe it or not, I learn lots from them. Stuff that I can even pass on to my family members too. (SK2, focus group)

Participants distinguished between attending and engaging in programs, and degree of engagement ranged across participants from minimal to moderate to high. Participants who were minimally engaged described feeling uncomfortable to share, or too low in mood to share. These participants had joined in challenging life transitions such as grief, and described benefits to listening to others and gaining familiarity with the programming without feeling pressured to join conversation. Participants who were moderately engaged joined community programs in a preventative manner, recognizing it would be helpful to have these programs set-up for when they need help. On the other side, some participants were highly engaged in their programs. These individuals had been involved in their organization for a long time, which allowed them to establish a degree of comfort and familiarity needed to participate. Further, while community organization programming was appreciated by all, participants also noted some limitations of programming that they have come to accept. Participants expressed mixed views around the group format, with some viewing it as an opportunity to connect with and learn from peers. However, many described challenges with group dynamics and feeling silenced when individuals dominate a group conversation. Regardless, participants still attended these group programs. Notably group programming was not the preferred option for three participants who completed individual interviews, but they still attended group programs as there were few other options.

Overall, throughout the theme of *Building Resilience Through Community*, participants highlighted the importance of community involvement and organizational programming to filling a gap in their social networks and providing opportunity for connection and learning. While these programs were generally found to be accessible and beneficial, participants also described challenges entering group programs.

Mixed Method Integration: Experiences with Mental Health Challenges and Accessing Supports (Objective 1)

Participants described their *Mental Health as a Journey*, impacted by loss related to life transitions, aging and significant events (e.g., loss of a loved one). They also described how loss and *Compounding Marginalization* contributed to isolation and loneliness. Individuals were at different stages of their journey, dependent on their use of psychotherapy, *Adaptive Coping* skills and community connection (as described in the theme *Building Resilience through Community*). This aligns with quantitative measures of mental health symptoms, on which participants endorsed a wide range of depression symptom burden (total score range: 38.2 – 68.7, 7/13 participants scored above average), anxiety symptom burden (total score range: 0-5, 6/13 participants met clinically-significant cut-off score), loneliness (total score range: 3-9), and social connection (total score range: 2-26). Participants' reported subjective well-being also aligns with these findings. While participants' average level of well-being fell at the halfway point on the questionnaire's scale, demonstrating their resilience, individual scores ranged greatly (total score range: 5-22), reflecting individuals different positions on their mental health journeys. Interesting, while the majority of participants (77%) endorsed experiencing aspects of loneliness, about half of the sample (46%) were engaged in, on average, fewer than two meaningful social connections. Together, these questionnaires reveal that loneliness was a common sentiment across participants, whereas isolation from meaningful social connections varied. This might be explained by participants' description that it required more effort and management to maintain their social connections (*Adaptive Coping* subtheme). As such, some participants may have been able to coordinate more regular connection resulting in lower isolation. In conclusion, the integration of qualitative and quantitative data pertaining to Objective 1 revealed a convergence in findings: participants were at different stages of their mental health journeys, likely related to differences in coping skills, engagement in psychotherapy for their current challenges, and community connection.

Mixed Method Integration: Pre-Implementation Assessment of The CONNECT Program (Objective 2)

Overall, participants viewed the CONNECT Program positively and shared recommendations for improvement within individual interviews, focus groups, and the follow-up implementation questionnaire. Participants were eager to be involved in this process, which was a driving force for their involvement in the study, as one woman described: "I appreciate this opportunity because I want this program to be the best it can be because I think mental health is important' (BC5, individual interview). Below, interview and questionnaire data were integrated to address the three implementation outcomes of focus: appropriateness (i.e., perceived fit and relevance), feasibility (i.e., ease of accessing and participating in the CONNECT Program), and acceptability (i.e., satisfaction with the program). See Tables 2 and 3 for a summary of implementation measures and recommendations for the CONNECT Program.

Appropriateness

The aims of the program were viewed by most as relevant to participants' experiences and the needs of older adults, and addressing a gap in organizational programming. For example, one woman reflected on how the content of the CONNECT Program might help herself and others going through changes in one's sense of self:

> We really need a chance to get outside of, to quit defining ourselves by what's happening with us, and to learn to be. Uh, just be, and be with others, and be ourselves around others, uh, without having to feel like we're our, uh, challenge (SK2, focus group).

A subset of participants noted that they look forward to learning new information in the program that they can share with family and friends. Another participant described how the CONNECT Program addressed her questions about mental health:

> Because you sort of flounder with your emotions because you don't, I don't understand what they are. Because sometimes I'm happy, sometimes I'm sad. Does that mean that I'm a happy-sad person? Or, or how long do you measure an emotion? (BC1, individual interview).

On the other hand, one participant in BC noted concern about the CONNECT Program overlap with other hospital or organizational-based programs that were not specific to older adults. As well, three participants indicated they would ideally prefer more specialized mental health services (e.g., grief, trauma focus, exploring specific emotional conflicts). However, two stated they would be open to trying to participate in the program. For example, one participant described looking for a program that addressed trauma, and when asked if the CONNECT Program would meet her needs for support she stated: “Yeah, it would be helpful to a certain degree. Um. All we can do is just try, right?” (MB1, individual interview). This aligns with quantitative data, where the majority (69.2%) of participants agreed that the CONNECT Program is appropriate and would recommend the CONNECT Program to other adults 55+. Of remaining participants, 23.1% neither agreed or disagreed with this item, due to questions around scheduling and group size, and general uncertainty around their participation. One participant did not view CONNECT as appropriate due to uncertainty around the program’s effectiveness. Overall, the CONNECT Program was perceived as appropriate by most participants based on the aims, content and perceived benefits.

Feasibility

Participants described the CONNECT Program as low-barrier and feasible to join. They identified that telephone delivery mitigates health, mobility, vision and transportation barriers to services and program use that they have experienced in past. Although, for those with vision loss, they identified a need for audio-workbooks to enhance their program engagement, as the current workbooks are only in written form. Further, with the program being free to access, financial barriers that have particularly hindered their mental health service use are minimized. Participants voiced no perceived identity-related barriers to CONNECT. This aligns with questionnaire data, where the majority of participants (84.6%) indicated they could participate in the CONNECT Program without many challenges or barriers. For those who disagreed (15.4%), their reasons pertained to a dislike of telephone programming or distrust of organizational staff. Participants noted that, with the potential offering of CONNECT over videoconferencing in the randomized trial, technology use may be a potential barrier. Although, one participant with hearing loss highlighted that Zoom delivery would be beneficial because she could read lips. Other potential barriers included inconsistent scheduling and timing, which requires further discussion with partnered organizations. Overall, participants highlighted that there were few barriers to accessing the CONNECT Program.

Acceptability

Overall, participants generally viewed the program as acceptable. Most participants viewed the CONNECT Program as a "first step" (BC4, focus group) to self-discovery and healing. For participants who were actively seeking mental health support, they saw the CONNECT Program as an opportunity to be supported, to learn about themselves and about mental health, and to connect with others (n = 8). For participants who were not actively seeking mental health support, they viewed the CONNECT Program as an appropriate introduction to mental health services for those who may be less familiar with mental health or less comfortable talking about their feelings. These participants shared that the best way to support this demographic would be in-person programming, to foster trust and connection (n = 3). One participant, who was seeking mental health services and completed an individual interview, did not anticipate participating in the program due to discomfort sharing in groups and distrust of organizational staff. With regards to the format of the CONNECT Program, majority (61.5%) indicated that it was acceptable. For those who were neutral or did not agree, their reasons included: viewing the session length as too long, uncertainty due to lack of personal involvement in the program, and uncertainty around whether it will fill the gap in programming.

Central points of discussion were the group format, facilitation, and the mode of delivery. With regard to the group format, there were perceived benefits and challenges. The opportunity for normalization and peer connection were identified as important aspects of both the CONNECT Program and participation in this study, as one women described: "Like all of us are feeling the same, about different... things in our lives, I guess. It's amazing" (SK3, focus group). This aligns with responses on the questionnaire item assessing the acceptability of talking openly about emotions in the group, with the majority agreeing or strongly agreeing (84.6%). The remaining participants neither agreed nor disagreed with this statement (15.4%) due to uncertainty about sharing and questions around the emotion terminology that will be used within the group. Some participants indicated they would prefer individual mental health services or smaller group sizes to feel more comfortable sharing. In addition, a subset of participants also raised questions around the age inclusion criterion for the CONNECT Program, detailing that there is a difference between those who are younger or older, on the spectrum of older adulthood. One woman explained that the inclusion of all older adults above 55 in group programs has led her to participate less, as she does not feel a sense of peer connection (BC5, individual interview). Other participants were satisfied with the 55+ cut-off, as they expect to have shared experiences with people in this age bracket as well as opportunity to learn. One woman detailed the way she benefits from being in programs with the 'old-old': You know, I think, wow, that is good. Like, you know, they're. It's good for them at that age. You know, they're still strong and… It's kind of inspiring. (MB2, individual interview). However, most stated they would be open to trying to participate in the program as it is currently designed.

A common concern and area of recommendation for the CONNECT Program pertained to the program facilitators. As described above, from their experience in telephone-based group programs, participants highlighted the importance of having a facilitator who can manage group dynamics effectively and prevent individuals from dominating a conversation. Further, participants highlighted the importance of facilitators' level of training, which ideally involved training in mental health. For some participants, this necessitated a formal degree or certificate in a mental health-related program, and for others this meant facilitators should receive training

specific to the CONNECT Program. Another prominent focus of discussion was on the mode of delivery of program, with the debate between telephone, videocall (e.g., Zoom), and in-person. Telephone mode of delivery was recognized as a more accessible and suitable option for themselves and others in their community organization, and participants from MB and SK felt comfortable continuing with telephone programming. When asked about videocall, many expressed openness as it would facilitate closer connection to other group members. Participants from BC had mixed views on the mode of delivery, with two expressing a preference for in-person programming to promote connection, while also recognizing that telephone-formats would be most accessible to all and that programs need to support a wide audience.

Table 2

Recommendations for Implementation of the CONNECT Program

Implementation Construct	Recommendations from participants	Recommended next steps for our research team
Feasibility	Change length and frequency of session (n = 4)	Discuss ideal timing with each partnered organization
	Schedule the program at a consistent time each week (n = 4)	Discuss with each partnered organization
	Provide audio-recording of workbooks (n = 2)	Create this option when program materials are finalized, as a way to improve accessibility for those with vision impairment Discuss dissemination of audio-recordings with each partnered organization
	Address difficulty sharing in groups (n = 2)	Discuss what group therapy entails during screening (e.g., highlight that participants do not need to share anything they are not comfortable with)
Acceptability	Appropriate mental health and group facilitation training for facilitators (n = 8)	Transparently discuss the facilitator training process during screening of prospective CONNECT participants, so they can make an informed decision on their participation Discuss this plan with each partnered organization

	In-person follow-up session (n = 6) In-person delivery (n = 2, BC)	Discuss with each partnered organization
	Incorporate activities into the program, such as art (n = 2)	Further research to address the following question: how can activities effectively be integrated into mental health programming for older adults?
	Separate programs for age group (n = 2)	Further research to address the following question: what is the appropriate age cut-off to foster a sense of peer connection for older adults?
	Train facilitators to provide person-centered care (n = 1)	Discuss with study team to incorporate into facilitator training
Other	Title "The Mental Health CONNECT Program" (n =1, MB)	Discuss with MB partner organization

Table 3

Implementation Measures for the CONNECT Program

Item	Mean ± SD and Response Percentage
Feasibility: I can see myself participating in the CONNECT program without many challenges or barriers.	4.0 ± 1.0 Disagree strongly: 0% Disagree: 15.4% Neither agree nor disagree: 0% Agree: 53.8% Strongly agree: 30.8%
Appropriateness: CONNECT is appropriate for me.	3.9 ± 1.0 Disagree strongly: 0% Disagree: 7.7% Neither agree nor disagree: 23.1% Agree: 38.5% Strongly agree: 30.8%

Acceptability: We talk openly about difficult emotions, such as loneliness and depression, in this group. Would you be comfortable doing that?	4.2 ± 0.7 Disagree strongly: 0% Disagree: 0% Neither agree nor disagree: 15.4% Agree: 46.2% Strongly agree: 38.5%
Acceptability: The format of the CONNECT program is satisfactory.	3.6 ± 0.9 Disagree strongly: 0% Disagree: 15.4% Neither agree nor disagree: 15.4% Agree: 53.8% Strongly agree: 7.7%

Note. Participants rated their agreement with each statement using a five-point Likert scale (1 = *disagree strongly*, 2 = *disagree*, 3 = *neither agree nor disagree*, 4 = *agree*, 5 = *agree strongly*). See Appendix K for full questionnaire.

Discussion

In providing care as a clinical psychologist, we assess the symptoms of mental health challenges, diagnose, and provide treatments that aim to reduce symptoms. While this medicalized model of care can be effective, it does not account for the broader picture of our clients' lives that are pertinent to their mental health. This is particularly important when working with individuals who hold marginalized social identities, which result in different experiences within everyday life and systems of power and privilege. Important to the topic of study, prior literature has found that socio-demographic characteristics, level of ability, and system-level factors can impact access to mental health services and social opportunities in older adults, yet, a notable gap in this literature is the use of an intersectional lens. Therefore, this study aimed to understand the mental health challenges and supports of adults 55+ with consideration for intersectionality. The overarching theme that emerged from focus groups and individual interviews was participants' evolving identity in response to loss, life transitions, major events, and aging, which impacted their mental health. Participants highlighted how their intersecting identities (e.g., older woman with low income) influenced their connection with community and mental health services. In relation to their identities, participants described two themes: their mental health as a journey, influenced by formal supports and coping strategies; and connection to community as a form of resiliency. Participants described how their identities can be connecting or isolating, and impact access to mental health and community-based supports. Altogether, these results shed light onto the importance of identity and community connection to mental health in later life. Qualitative results converged with quantitative data, supporting that participants were at different stages in their mental health journey. A secondary aim of this master's thesis was to conduct a pre-implementation assessment of the CONNECT Program. Overall, participants viewed the program content positively and made

recommendations around facilitation and mode of delivery. Qualitative and quantitative data converged, and participants feedback will be discussed with our community partners to improve the perceived feasibility, acceptability and appropriateness in the current offering of the CONNECT Program, and will inform future research.

Mental Health As a Journey

A central theme that related to all aspects of participants' experiences was their sense of evolving identity, characterized by loss, life transitions and significant events that were often isolating (e.g., loss of a loved one, COVID-19 pandemic). In describing their identities, participants described shifts in their internal sense of self that impacted their mental health. Specifically, they were navigating their understanding of being an older adult, in light of life transitions that contrasted their expectations for older adulthood. For example, a common transition was retirement, which was hoped for but created financial strain and loneliness amplified by the COVID-19 pandemic restrictions. In reaction to these life transitions, participants described heightened mental health challenges, commonly loneliness, social isolation and related anxiety and depression. Participants were at different stages of coping with these transition, as supported by the range of symptom severity on questionnaires: the sample reported a wide range of depression symptoms, anxiety symptoms, degree of social connection, and subjective well-being. This aligns with other research citing anxiety and depression as the most common mental health challenges in older adults (World Health Organization, 2023), with about 1-6% of older adults who experienced clinically-significant depression (Reynolds, Pietrzak, El-Gabalawy, et al., 2015; Yang & D'Arcy, 2023) and 3-11% who experienced clinically-significant anxiety (Reynolds, Pietrzak, El-Gabalawy, et al., 2015; Scott et al., 2010). Research has shown that these mental health challenges often occur in tandem with social isolation and loneliness (Santini et al., 2020), and about 25% of Canadian adults aged 45-85 reporting social isolation and/or loneliness prior to the COVID-19 pandemic (Menec et al., 2020). Past qualitative research on older adults' experiences with mental health challenges has also identified the significance of life transitions and identity to mental health. Reynolds and colleagues (2020) employed narrative analysis to explore the experiences of older adults with mental health challenges. In one subtheme "Experiencing role conflict," older adults described their mental health challenges in relation to their identities, and desired to make sense of their identity after experiencing mental health challenges. Other research has reported how forms of loss contribute to mental health challenges, such as through retirement, physical health declines (Moult et al., 2020), "life-changing events" like illness (Stark et al., 2018) and death among family and friends (Moult et al., 2020; Stark et al., 2018), and estrangement from family (Holm et al., 2013). Similarly, in qualitative work exploring Canadian older adults' perceptions of ageing, change in self-image after physical health declines was described as unexpected and challenging (Savage, Hardacre, et al., 2021). In a study exploring older adults' understanding and management of distress, one woman described how the cumulative loss of friends was distressing and shocking:

> I went to erm two funerals recently and somebody said 'are you alright [Anne]?' to me when I was at the second one, and I said not really because I had a phone call just before I came out to say another friend had died. (Moult et al., 2020)

In another study, older adults described these losses as unexpected and against their expectations of growing old with their close friends and family, and highlighted the "traumatic"

nature of living through these losses (Savage, Hardacre, et al., 2021). These findings align with the Continuity Theory of Normal Aging, which highlights the importance of maintaining relationships and social roles in older adulthood to create continuity in sense of self (Atchley, 1989).

Impact of Intersecting Identities

Participants felt invisible as older adults, and commonly described intersections between age, gender, socio-economic status, and ability level that impacted their connections with others and ability to easily navigate everyday life. They described instances of stereotyping and infantilization in daily interactions with others (e.g., assumed to not be able to use technology), and felt stigmatized as undeserving of mental health support by their doctors and family. Everyday ageism, defined as discrimination based on age, has been found to be a common experience across older adults. In a large survey of adults ages 50-80, 65% agreed that they hear, see or read ageist messages in everyday life, and 45% reported experiencing ageism in their interpersonal interactions (Allen et al., 2022). Further, ageism has been proposed to be a barrier to social participation due to internalization of stereotypes impacting behaviour, perceived risk of conforming to negative stereotypes leading to increased stress, and discrimination (Swift et al., 2017).

The sense of invisibility that comes with the intersection of being older and a women has been well-documented in extant literature (Krekula et al., 2018; Merodio et al., 2024; Rochon et al., 2021; Westwood, 2023). This intersection has been termed ‘gendered ageism’ to highlight the double jeopardy experienced as an older adult and a woman (Krekula et al., 2018). For example, one study generated a thematic framework reflecting prominent forms of discrimination identified by older women: invisibility within the media and public spaces, and being stereotyped as sexual undesirable, a grandmother, or incompetent (Westwood, 2023). Participants in this study were further marginalized based on low income, often due to retirement or loss of spouse, and declines in mobility and vision, and/or hearing. These axes of marginalization posed barriers to mental health services and social participation, limiting their options. This aligns with the literature reviewed on barriers to mental health services and social participation (Lamanna et al., 2020; Naud et al., 2021; Townsend et al., 2021; Weinberger, 2009). For instance, in the study examining experiences of discrimination identified by older women, one woman identified the impact of the intersection of aging, disability, and invisibility as an older woman: “You find that people ask the able- bodied or younger person in your company the question.” (Westwood, 2023). Altogether, by employing an intersectional lens, this study provides deeper insight into lived experiences of compounding marginalization based on the intersections of age and other identities. These results hold relevance to the Continuity and Activity theories of aging. As demonstrated by these findings, the ‘how’ of engaging and maintaining in these activities is hindered by system-level ageism and societal marginalization of older adults. This highlights a need for significant change to ensure societies are set up to support older adults in their wellness, which is discussed further in the *Implications*. And yet, despite multiple layers of marginalization and challenges, participants demonstrated resilience and coping by using their lived expertise, accessing mental health supports, and community connections to cope.

Mental Health Supports and Community Connection

Navigating life transitions was a driving factors for participants' engagement in supports, including mental health services, coping strategies, and community programming. This was a high treatment-seeking sample, with majority having accessed mental health services. Mental health stigma was discussed as a product of generational differences, which appeared to impact mental health literacy and comfort accessing services. This is aligned with prior literature, which highlight limited perceived need for care, a desire to manage their mental health independently, internalized stigma, and low mental health literacy as factors that impact mental health service use (Lavingia et al., 2020; Mackenzie et al., 2010; Mackenzie & Pankratz, 2022; Nair et al., 2019; Reynolds et al., 2020; Volkert et al., 2018). However, a majority of participants had still accessed mental health services, indicating that stigma did not prevent service use. Participants described strategies that they engaged in to support their mental health, as well as prevent cognitive decline and fill their time. This included meditation, religious activities, and a wide range of hobbies, such as crafts and educational pursuits. For some, these hobbies served as a form of continuity and connection to their younger self. Interestingly, research has found that starting new hobbies or maintaining old hobbies are associated with fewer depressive symptoms in older adults (Fancourt et al., 2020). Several participants also coped by avoiding negative content (e.g., upsetting news on television), aligning with the well-documented positivity effect outlined in the SST (Carstensen & DeLiema, 2018b).

Social connection through family, friends, and community organization programming was integral to navigating their evolving identity and coping with mental health challenges. This aligns with past research showing that social participation was associated with fewer depressive symptoms (Reynolds et al., 2022) and lower psychological distress (Mackenzie & Abdulrazaq, 2021). Further, this result aligns with the SST, as it demonstrates older adults' prioritization of the emotionally-meaningful goal of social connection. For those who were more isolated, they described the benefits of having a pet, which created responsibility, connection, and facilitated conversation with others. This aligns with prior qualitative and quantitative research, which has demonstrated that pet ownership in older adults is associated with satisfaction with social participation (Toohey et al., 2018), increased well-being (Ikeuchi et al., 2021), reduced loneliness and a sense of purpose (Hui Gan et al., 2020). One study used a phenomenological approach to generate a framework reflecting older adults' experiences with pet ownership and its impact on their mental health: "comfort and safety", "social inclusion and participation", "purposeful routine and structure," and "a meaningful role." One participant described how her pet facilitated social connection: "…The dogs meet first, then you get to know the people." (Hui Gan et al., 2020).

Within participants' community organizations, they engaged in a range of social and education- or activity-based programs. Participants distinguished between attendance and engagement in programs, which ranged from low (when they felt uncertain or were experiencing low mood), to moderate (preventative), to high (i.e., felt comfortable and open to sharing). To the best of my knowledge, one study has also examined this spectrum of participation. Researchers in Singapore used qualitative methods to explore social participation trends in one neighbourhood, revealing the following continuum: marginalized, participating within their comfort level, active social participation, establishing new social connections, to volunteerism and giving back to their community. They noted that moving further up the continuum was

dependent on financial ability, managed health, building trust and resources to facilitate connection, and family support (Aw et al., 2017). This also aligns with findings from a systematic review of qualitative investigations into the effectiveness of community-based loneliness programs. Two key facilitators to program effectiveness include the ability for participants to exercise choice over the degree of engagement or sharing within the program, and a sense of belonging (Noone & Yang, 2022). This demonstrates the potential importance of designing community-based socialization programs in a manner responsive to older adults' continuum of needs.

All participants had engaged in telephone-based programming and highlighted that a key benefit is hearing others' voices and stories and filling a gap in their social networks, which has also been echoed in previous literature (Newall & Menec, 2015). With regards to barriers to community programs, participants reports were aligned with previous literature. They identified that in-person programming raised barriers of transportation (Lamanna et al., 2020; Rozynek & Lanzendorf, 2021), timing (Gopinath et al., unpublished; Jones et al., 2023; Naud et al., 2021), and mobility and health (Gopinath et al., unpublished; Li & Loo, 2017). In sum, participants described telephone programming as low-barrier and accessible, aligned with previous investigations (Newall & Menec, 2015; Reynolds et al., 2021).

Evaluation of The CONNECT Program

The CONNECT Program was appraised as appropriate, acceptable, and feasible by majority of participants. Overall, from the perspective of the knowledge-to-action framework, these findings provide support for the implementation of the CONNECT Program and provide guidance on important factors to inform the tailoring of the program for each site. Importantly, participants described the content as beneficial and something that generally addressed a gap in organizational programming, both among those who would join presently and those who may not. A minority of participants indicated they would prefer smaller groups or more tailored mental health services (e.g., trauma focus, exploring specific emotional conflicts), however, most stated they would be open to trying to participate in the program. Motivations for participants' interest and/or anticipated participation in CONNECT included: the opportunity for normalization and peer connection, increasing mental health literacy, and gaining skills and information to help them cope with their challenges. They also discussed the added benefit of being able to share their knowledge with their peers and family, which aligns with past research showing older adults provided altruistic reasons for joining a loneliness-focused program (Newbronner et al., 2025). Participants described the telephone delivery as feasible and low-barrier, both from the stance of logistical barriers and from consideration of their intersecting identities. These results align with findings in the preliminary development of the CONNECT Program, in which participants described the program as low barrier and accessible (Reynolds et al., 2021).

Three areas of concern pertained to the facilitator, the mode of delivery, and the age of group members. First, participants highlighted the importance of the facilitator's ability to manage group dynamics. This has been echoed in previous literature on the implementation of a wide variety of community-based group programming for older adults (Newall & Menec, 2015; Yeo et al., 2024). For example, in a hybrid-individual and group program to improve older adults' management of diabetes, in-person and virtual group sessions had low attendance rates due to challenges sharing in groups and personality differences (Fisher et al., 2025). Providers

and participants alike shared difficulty managing group conversation to balance group and individual foci (Markle-Reid et al., 2016). Further, participants emphasized the importance of facilitators having mental health training, which aligns with participants' preference for therapy that involves active work rather than passive listening. Similar issues have been raised in previous implementation studies of community-based programs for older adults (Petrescu-Prahova et al., 2016; Sims-Gould et al., 2019). Providers themselves have also shared concerns about their level of skill to support training in our partner meetings, as well as in previous literature (Sims-Gould et al., 2020). This area of concern may reflect older adults feeling that they need to advocate for a well-resourced mental health program, so they do not have to make programs fit based on what is available.

Second, the mode of delivery was discussed and debated. All agreed that telephone was accessible mode of delivery, but many voiced a preference for Zoom or in-person, which would facilitate deeper connections that are easier to establish. This may also reflect the nature of the sample, as majority were recruited via email thus likely had greater technology literacy. Research supports participants' insights. Specifically, a recent systematic review and meta-analysis of remote interventions for loneliness for older adults found video-conferencing programs were more effective at reducing loneliness than telephone delivered programs (Fu et al., 2022). However, as recognized by participants and research literature, technology still poses a barrier to virtual programming for older adults given the range of digital literacy (Gorenko et al., 2021). We raised this point of concern to our community partners in our quarterly meeting in April 2025, and each site plans to approach mode of delivery differently based on their memberships' needs. Third, while majority of participants seemed comfortable with the age 55+ cut-off, a minority voiced concern about a difference between the 'young-old' and 'old-old'. This discrepancy might reflect a desire to create a space where participants feel heard and understood in a world where, as older adults, that is not a guarantee. In the literature on social connection, to the best of my knowledge, there is no work qualitatively exploring older adults' opinions on their preferences for age cut-offs, indicating an area for future investigation.

The most common recommendation, voiced by six participants, was the need for an in-person follow-up session. This raises interesting questions for future investigation: how long are benefits from the CONNECT Program sustained, would CONNECT participants benefit from a booster session, and could an in-person follow-up be accessible and feasible from an implementation standpoint. From the limited psychotherapy literature in this area, it seems that the effects of short-term ACT interventions are sustained at various follow-up points. Specifically, 12-weeks of individual ACT delivered via internet/in-person reduced anxiety post-treatment and at 12-month follow-up (Witlox et al., 2021); a 12-week individual ACT intervention reduced depression that was sustained three months post-treatment (Davison et al., 2017); and a self-paced online ACT intervention reduced loneliness which was sustained one month post-treatment (Zarling et al., 2023). In sum, this is an important future direction that requires discussion with community partners per feasibility. Participants also provided several additional recommendations highlighted in Table 2, which will be implemented and discussed with partnered organizations to inform our offerings of the CONNECT Program.

Interestingly, this sample and the pilot study sample were both primarily older women who identified as White, suggesting that the CONNECT Program in its current form is most

accessible to this demographic. This has been a trend across health promotion and mental health programs (Howell et al., 2023; Newmark et al., 2020). Common barriers to inclusion of male older adults include: masculine gender roles, facilitators being primarily female, and lack of interest in program content (Howell et al., 2023). In addition, societal pressures for men to be strong and stoic increase stigma surrounding mental health (Newmark et al., 2020). In one study that was able to recruit male participants into a community-based health promotion program, a facilitating factor was male participants knowing that there were other males in the program (Sims-Gould et al., 2020). Similarly, in research on physical activity programs, older men identified a preference for programs that include similar proportions of men and women (Windt et al., 2023). Likewise, older men participating in a community-based social program Men's Sheds identified that the focus on the participation and needs of older men was a key factor contributing to program involvement (Reynolds, Mackenzie, et al., 2015). Further, older adults from marginalized ethnocultural and racial groups face additional barriers to mental health care, including language barriers, discomfort with a provider from a different race, and greater negative attitudes and stigma surrounding the need for mental health care (Lavingia et al., 2020; Sadavoy et al., 2004; Solway et al., 2010; Wang et al., 2019). Given the unique barriers and facilitators to care of older adults based on sociodemographic characteristics, there is a need for more widespread adoption of collaborative research models that integrate diverse older adults' lived expertise and guidance to increase program accessibility.

Strengths and Limitations

There are several strengths of this study, including the flexible mixed method approach and the representativeness of the sample. First, including qualitative interviews ensured the results were grounded in participants' voices and perspectives, which allowed us to understand participants' intersecting identities from their perspective rather than relying on quantitative demographic data. Assessing the convergence of qualitative data with standardized quantitative measures of mental health symptoms and well-being allowed for deeper understanding of participants' current mental health and support needs. Further, participants were provided with the option to complete an individual interview or focus group. As discussed by participants who completed individual interviews, the group setting can hinder their discussion of sensitive themes surrounding mental health and identity. Therefore, this study was able to include individuals who might not typically express their opinions in a group, which has expanded our understanding of the mental health needs of each community organization's membership. Second, the demographics of this study's sample are similar to the memberships of the community organizations we are partnering with. A partner from MB shared that their membership was primarily older females who lived in Winnipeg based on 2023-2024 polling. A partner from BC shared that their membership is primarily ages 65-75, female, Caucasian, low-income, and that many require assistance with mobility based on their personal opinion. The SK site did not provide demographic characteristics. This is important at the stage of pre-implementation, to ensure we are hearing from probable participants who would access the CONNECT Program.

There are several limitations of this study that should be acknowledged. First, the sample was limited to those who were already engaged in each community organization. As such, further tailoring of the CONNECT Program may be needed in the future in response to changing community organization needs or demographics. This aligns with the knowledge-to-action process, which proposes a cyclical process of tailoring and implementation (Graham et al.,

2006). Second, recruitment efforts in BC and SK were solely through email, thus limiting the sample to those who have internet access. And, while the sample appeared to be representative of the community organizations, participants were also all older White women. Future research on the CONNECT Program must prioritize broadening our recruitment to include a diverse range of older adults, to ensure the program can support the increasingly diverse older adult population in Canada. Recent statistics suggest that the Canadian older adult population is becoming more diverse with respect to race and ethnicity (Statistics Canada, 2022b), country of origin (Public Health Agency of Canada, 2020), and sexual orientation (Stinchcombe et al., 2018). Furthermore, given that older men less likely to seek mental health services (Mackenzie et al., 2012; Public Health Agency of Canada, 2020) and are one of the most at-risk groups of dying by suicide (Mental Health Commission of Canada, 2022), it is critical to represent their perspectives in the development of the CONNECT Program.

Future Research

In light of the study findings and the aforementioned limitations, there are several directions for future investigation. Findings indicate that life transitions are a crucial period for mental health support in older adulthood, including those traditionally viewed as positive such as retirement. While it has been established that psychosocial stressors, such as grieving the death of a loved one, are risk factors for mental health challenges (Husain-Krautter & Ellison, 2021), this study's findings suggest that processing life transitions and making meaning of identity could be an important component of mental health support. Three modalities of psychotherapy that move beyond symptom reduction to focus on identity and life stories are: narrative therapy, acceptance and commitment therapy (ACT), and reminiscence therapy. Narrative therapy aims to recapitulate life stories in an empowering manner that links past, present and future (Carr, 1998). Recent studies suggest narrative therapy can reduce loneliness and depression symptoms in older adults (Jiang et al., 2025; Zhu et al., 2025). ACT, a third-wave cognitive behavioural therapy, examines identity through identifying and re-defining one's self-narratives and aims to promote psychological flexibility and incorporation of values into life, rather than symptom reduction (Hayes & Strosahl, 2005). Pilot research on the CONNECT Program supports the effectiveness of ACT in reducing depression, loneliness and social isolation (Reynolds et al., 2021). Reminiscence therapy involves exploring and re-experiencing past memories to create new interpretations and promote a deeper understanding of themselves. A recent systematic review of community-based reminiscence programs for older adult found that they reduced depression, anxiety and loneliness (Laidlaw et al., 2023). Given that these three therapies have been shown to be effective at reducing mental health symptoms, future work should employ qualitative and quantitative approaches to explore the mechanisms of change underpinning treatment gains, and how identity-based work contributes to the gains. As well, future work should compare the modalities to examine differences in effectiveness.

A need for support processing the traumatic aspects of the death of loved ones, as well as past traumatic experiences, was also apparent in participants descriptions of loss and mental health challenges. Limited literature suggests that rates of past-year post-traumatic stress disorder are lower among older adults than middle-aged and younger adults (Reynolds, Pietrzak, Mackenzie, et al., 2015). Cumulative effects of significant losses of loved ones, declines in physical health, reduced independence due to functional limitations, and traumas in early adulthood can be viewed as "normal" in later life and dismissed, yet warrant psychological attention (Kusmaul & Anderson, 2018). Few studies have validated trauma-focused

psychotherapy for older adults (Dinnen et al., 2015), particularly with respect to older women and culturally-diverse older adults (Cook, 2022; Dinnen et al., 2015). Future research is needed to more comprehensively understand older adults' needs for trauma support, and to validate screening measures and trauma-focused psychotherapies for this population.

The combination of both ageism and compounding marginalization through other identities was a prevalent experience in this sample, highlighting the importance of interventions targeting both internalized and externalized ageism from an intersectional lens. Presently, majority of the literature has focused solely on ageism. A small subset of externalized ageism interventions have addressed both age and other axes of discrimination in the domain of workplace ageism interventions, with variable effects (Sinclair et al., 2024). To the best of my knowledge, no non-workplace interventions have been designed to address ageism from a broader, intersectional standpoint. As such, this is a clear gap and future direction for intervention development. Importantly, work in this area should be conducted in partnership with diverse older adults to ensure their experiences and needs are at the center of this work.

Several future directions stem from participants' discussion of the CONNECT Program and community organization programming. First, an important process identified by participants was the continuum of engagement in community programs, which could be used to inform step-wise community programming to increase program access and participation. Further work is needed to replicate and more comprehensively characterize this engagement continuum. Second, further work is needed to characterize the divide between 'young' and 'old' older adults, and how that impacts social connection. Qualitative and quantitative research is needed to understand the factors underlying participants' distinction, as well as the appropriate age cut-off to foster a sense of peer connection for older adults. Third, some participants identified that integrating activities into mental health programming could improve engagement and comfort discussing mental health, necessitating future research. Given the wide range of terminology that may be used to describe this work, an important first step would be to conduct a scoping literature review to synthesize prior work and inform future studies.

Implications

Research Approaches

These findings go beyond the quantitative factors associated with mental health symptoms to richly describe adults 55+ experiences with mental health challenges as well as barriers to supports. As such, researchers should strive to adopt collaborative research models and/or multi-method approaches, to ensure older adults' voices are uplifted and, ideally, prioritized equally with researchers. Not only is this a more equitable approach, but it also benefits the research process. A recent systematic review of collaborative research with older adults found that adopting such approaches resulted in more accurate understandings of their experiences, more appropriate policies and programs, and opportunity for growth and learning for researchers and older adults alike (James & Buffel, 2023). In sum, collaborative research holds promise as an important avenue forward to the field of gerontology.

Mental Health and Community-Based Care

This work has several implications for the provision of mental health and community-based care for adults 55+. First, intake of new clients should not only focus on presenting

problems, but also broader experiences of life transitions and identity. Doing so will provide a more holistic image of older adult clients, allowing providers to understand the life context that may be contributing to clients' presenting problems. Providers can achieve this by adding two questions to their intake form that ask about recent changes in their life (e.g., with family, employment, or health) and about the pieces of identity that define them (e.g., being a woman, being a grandmother, being from x ethnic background). This aligns with recent work with Canadian older adults, their caregivers, and clinicians, in which they highlighted person-centered mental health care as a priority for research and care (Giosa et al., 2025; Savage, Hardacre, et al., 2021). Relevantly, Mackenzie and Berard (2022) provide guidance on delivering individual psychotherapy to older adults with consideration for intersectionality. Second, community-based providers do an immense amount of work in facilitating large groups. To assist in the management of group dynamics, they may benefit from drawing upon Yalom's 11 principles for group therapy. These principles include a focus on development of social skills as well as ways to facilitate group cohesion (Yalom & Leszcz, 2020). Third, to improve the diversity of older adults involved in community-based interventions and mental health services, including the CONNECT Program, more active forms of older adult engagement are needed (Howell et al., 2023; Solway et al., 2010). Service providers should aim to partner directly with older adults from various subgroups, and seek their lived expertise to facilitate development of programs that are feasible, acceptable and appropriate for these groups, and to facilitate recruitment. Fourth, for mental health clinicians, social prescribing should be integrated into standard practice (South et al., 2008). This study highlights both the significance of community connection to mental health in later life, the significant amount of effort older adults must input to maintain social connections or increase social participation, and the system- and societal-level barriers to navigating care systems and daily life. Social prescribing involves connecting clients to non-clinical supports, such as community organizations, to promote clients' holistic wellness. Social prescribing can to help address the social determinants of health (e.g., ageism, loneliness) contributing to mental health challenges (Burnett & Beauchamp, 2025).

Knowledge Translation

Awareness about lived experiences of compounding marginalization based on the intersections of age and other identities, and dissemination of my study results, will be the foci of my knowledge translation efforts. With regards to awareness of aging through an intersectional lens, several efforts in Canada have already commenced. Focused on age and gender, Women's College Hospital and the Women's Age Lab in Toronto, Ontario have created a global campaign titled "End Gendered Ageism" (Women's College Hospital, n.d.). More broadly, the Ontario Human Rights Commission and RTOERO, a non-profit Canadian organization, have published works highlighting the experiences of marginalization among older adults resulting from intersections of age and other aspects of identity (Ontario Human Rights Commission, n.d.; RTOERO, 2021). These works hold promise for increasing awareness across Canada for the general population. In addition, I propose raising targeted awareness at a smaller-scale by connecting with mental health providers, aging community organizations and the University of Manitoba student body. I will create two infographics to do so: one highlighting participants' experiences and statistics on aging through an intersectional lens (for all groups), and one with a summary of study findings and clinical care recommendations (for providers and community organizations). I will distribute the infographics to mental health providers by requesting its inclusion in the Canadian Psychological Association's Aging and Geropsychology Section

newsletter, and more broadly via academic social media (e.g., LinkedIn, Health Information Exchange Lab Instagram). I will distribute the infographic to our community partners via email and by discussing the results in one of our partner meetings. To share these findings with the university student body, I will collaborate with the University of Manitoba's Center on Aging to discuss potential avenues of dissemination. I will also share a verbal summary of findings and key take-aways to each community partner's membership by presenting at one of their in-person or virtual community programs.

Policy

While this study had a relatively small sample size ($N = 13$), findings converge with existing research to suggest a need for systemic change to increase available mental health supports for older adults. Further work is needed with larger, diverse samples of older adults across Canada to fully inform policy recommendations. As discussed within the results and previous literature, older adults can encounter a wide variety of barriers to services that have compounding effects, underscoring the importance of bringing an intersectional, person-centered lens to care for older adults. At the system-level, difficulty navigating services, financial cost, and a shortage of appropriate providers or services (i.e., those tailored to older adults and/or specific mental health needs) hindered mental health service use. Older adults demonstrate resilience and adaptability on a regular basis by using the services that are accessible and offered, despite the programs not matching their exact needs for services. Taken together, older adults continue to experience inequity within systems of care due to well-documented barriers to care. As a trainee clinical psychologist and researcher dedicated to serving this population, I must advocate against this system-level passivity. This research highlights how mental health, physical health, and other aspects of life (e.g., change in finances) are intertwined. Hence, approaching mental health treatment from a medicalized, symptom-focused lens is not sufficient. Further, using a 'one size fits all' approach does not map onto the unique experiences of older adults. A clear implication of this research is the need for increased funding and mental health services dedicated to older adults, that incorporate a person-centered approach and are designed to mitigate system-navigation challenges. Policy change is needed to address the inequity in mental healthcare for older adults, and, given the growing older adult population and expected rise in healthcare costs (Gibbard, 2018), this should be prioritized. To promote policy change, I will distribute a summary of results and policy recommendations to Manitoba's Minister of Seniors and Long-term Care to inform development of person-centered supports for older adults in general and within Manitoba's Mature Women's Clinic, which is planned to be re-implemented.

Conclusion

In summary, this study provided unique insight into the mental health needs of adults 55+ from an intersectional lens, and collected feedback pertinent to the expansion and implementation of the CONNECT Program across Canada. Altogether, older adults' evolving identity in response to life transitions impacted their mental health, and their intersecting identities influenced their connection with community and mental health services. This work highlights future avenues for research, primarily focused on exploring the utility and mechanisms of change related to identity-focused psychotherapies, trauma supports for older adults, aging through an intersectional lens, and qualitative experiences of social participation in community organizations serving older adults. Key implications of this work include adoption of

collaborative research practices, incorporating identity and partnerships with older adults into service provision, increased awareness of aging through an intersectional lens, and policy to mitigate ageism within systems of care.

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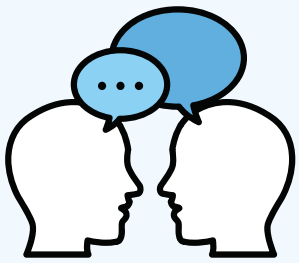
Appendix A

Recruitment Poster

Study Participants Needed

Help us learn more about the **mental health support needs** of adults 55+ in your community.

And, **share your opinions** on a new mental health support program that will be offered by this organization.



Eligibility:

- Age: 55+
- Comfortable speaking and reading English

What is involved?

- 25-minute survey
- One 60-90 minute focus group or individual interview

As a thank you for participating, participants will receive a $50 e-gift card.

For more information, please contact the study team:

connectprogram@umanitoba.ca **204-800-1411**

Principle Investigator: Dr. Kristin Reynolds, kristin.reynolds@umanitoba.ca

University of Manitoba REB Approval HE2024-0150

Appendix B

Recruitment Email

Subject line: Your Input Matters: Participate in Research on The CONNECT Program
Attachment: Recruitment poster

Dear [*organization name*] members,

We are glad to inform you about a new study being conducted through the University of Manitoba, titled "*The CONNECT Program: Engaging Community Organizations in the Implementation and Evaluation of a Group Telehealth Mental Health Program for Older Canadians*." This study is being conducted in partnership with community organizations in British Columbia, Manitoba, New Brunswick, Saskatchewan. The principal investigator is Georgia Gopinath, a Master's student at the University of Manitoba, who is supervised by Dr. Kristin Reynolds (Kristin.Reynolds@umanitoba.ca), Ph.D., C. Psych., Associate Professor in the Departments of Psychology and Psychiatry at the University of Manitoba. The study has been approved by Research Ethics Board 1 at the University of Manitoba.

The CONNECT program aims to support adults ages 55+ who are seeking to better understand their emotions, and to build connections with others and things that are important to them. The program was successfully piloted from 2019 to 2023 in Manitoba, so we are now expanding to offer it at [*organization name*]. At the initial stage of the program, we are inviting community members ages 55+ to participate in a study aiming to understand their mental health support needs, their opinions on the suitability CONNECT program, and how different aspects of their identity (e.g., sex assigned at birth, race, ethnicity, income, hearing ability) might inform their experiences and/or opinions. The results of the study will be used to tailor and improve the CONNECT program to enhance access to the program.

Participating will involve (a) completing a 60-90 minute interview or focus group, and (b) 25 minutes of surveys. Your valuable insights will assist us to tailor and improve the CONNECT program to enhance access to the program. As a thank you for participating in this study, you will receive a $50 electronic gift card. Please review the attached e-poster to learn more about the study and find our contact information.

Thank you for considering participating in this research project!

Best regards,
The CONNECT program team

Appendix C

Screening Interview

Introduction
Hello, my name is Georgia Gopinath, I am a master's student in Clinical Psychology at the University of Manitoba. Thank you for your interest in this research study.

Before we get started, I would like to confirm your name and the current address you are at for security purposes. I will temporarily record this information on a password-protected document and delete it when a decision about your eligibility has been made.

Today, I would like to provide an overview the study and what participating would involve. I'll also ask you some questions to check that you are eligible to participate. The call will take approximately 15 to 30 minutes. Do you have time for this and are you interested in continuing the call?

If no: Thank you for your time.
- *Re-schedule the appointment if they are willing.*
- *If they do not want to participate, ask if they would be willing to elaborate on why, so that we can understand if we need to modify how we are advertising our study or the screening process.*

If yes:
Thank you. Please let me know if you would like to take a break or have any questions at any point during this phone call.

This study is being conducted as a part of my master's thesis. My lab has developed a program called CONNECT that is going to be offered at [*organization name*] in the future. The CONNECT program aims to support adults who are 55 years and older who are seeking to better understand their emotions, and to build connections with others and things that are important to them.

The aim of my study is to explore the mental health support needs of community members like yourself, understand if the CONNECT program as a good fit for them, and to see if any changes are needed to improve the program before it is offered. This study will also specifically ask about how various aspects of one's identity (for example, gender, race, hearing ability) might impact your support needs and views on the program. We want to make sure that this program would be helpful, accessible and suitable for yourself and others in your community organization.

Participating would involve completing this phone call to check that you are eligible. If you are, we will review the consent form at a time that is convenient for you. We would then ask you to complete about 25 minutes of questionnaires. These could be completed online or together over the phone. The main part of the study will be participating in a 60-90 minute interview via Zoom, during which we would discuss your mental health, existing strategies and community supports for your mental health, and discuss whether the CONNECT program might be a

suitable support and if any changes are needed. You will be asked to reflect on how different aspects of your identity might inform your experiences and/or opinions.

This interview could be done as a focus group, which is essentially a group interview with 4 to 7 other people, or as a one-on-one interview with myself.

You would be compensated $50 to complete the whole study.

Do you have any questions?

Are you still interested in participating?

If no, ask if they would be willing to elaborate so that we can understand if we need to modify how we are advertising our study or the screening process, or if we can improve our delivery/study purpose/compensation/time commitment etc.

If yes: Thank you for your interest. I would like to ask you some questions about your background to check that you are eligible to participate. I will take some notes on a password protected document, and once we have determined your eligibility, these notes will be discarded securely.

Do you have any questions before I proceed?

Screening questions
Inclusion criterion – age 55+: How old are you? _____

Inclusion criterion – able to communicate in and read English:
- Do you feel comfortable having conversations in English? Yes or No
- Are you able to read English? Yes or No

To ensure the individual is able to provide consent for themselves:
Are you able to make legal decisions for yourself? Yes or No

To ensure the individual would be a CONNECT user (i.e., a relevant person to include in the adult 55+ focus group):
The aim of this program is to support older adults who are seeking to better understand their emotions, and to build connections with others and what is important to them. Does this sound like a program that you would be interested in participating in?
Yes or No

Notes for screener to consider, to ensure the individual would be a suitable participant:
- Is the individual having any challenges with hearing that might interfere with speaking over the phone or Zoom?
- Is the individual able to follow the conversation and remember what you are saying?

Eligibility

Thank you for your time and for answering these questions. Do you have any questions for me at this time?

If they are eligible:

I can confirm that you are eligible to participate in our study. Are you still interested in participating?

In terms of next steps, I would like to review the study consent form, which outlines in more detail what is involved in the study and what your rights and roles are as a participant.

- Discuss sharing the consent form with them for their review (either share via email, or can it over the phone)
- Schedule a time to review and sign the consent form together over the phone
- Discuss approximate timeline for participation
- Discuss their interest in participating in a focus group vs interview

If it is unclear if they are eligible:

I will review this information with our study team, and let you know whether you are eligible within one week. Would you like me to share this information with you via phone or email?

- Discuss communication plan

If they are not eligible:

You are not eligible to participate due to [*exclusion criterion*].

- Discuss ineligibility
- Refer to other studies in the lab if they are interested

Appendix D

Lubben Social Network Scale - 6

Instructions – Family: Considering the people to whom you are related by birth, marriage, adoption, etc…

Items:

1. How many relatives do you see or hear from at least once a month?
2. How many relatives do you feel at ease with that you can talk about private matters?
3. How many relatives do you feel close to such that you could call on them for help?

Instructions – Friendships: Considering all of your friendships including those who live in your neighborhood

Items:

4. How many of your friends do you see or hear from at least once a month?
5. How many friends do you feel at ease with that you can talk about private matters?
6. How many friends do you feel close to such that you could call on them for help?

Response options: None (0), One (1), Two (2), Three or four (3), Five thru eight (4), Nine or more (5)

Reference:

Lubben, J., Blozik, E., Gillmann, G., Iliffe, S., Von Renteln Kruse, W., Beck, J. C., & Stuck, A. E. (2006). Performance of an abbreviated version of the Lubben social network scale among three European community-dwelling older adult populations. *The Gerontologist*, *46*(4), 503–513. https://doi.org/10.1093/geront/46.4.503

Appendix E

UCLA 3-Item Loneliness Scale

Instructions: The next questions are about how you feel about different aspects of your life. For each one, select how often you feel that way.

Items:

1. First, how often do you feel that you lack companionship?
2. How often do you feel left out?
3. How often do you feel isolated from others?

Response options: Hardly ever (1), Some of the time (2), Often (3)

Reference:

Hughes, M. E., Waite, L. J., Hawkley, L. C., & Cacioppo, J. T. (2004). A short scale for measuring loneliness in large surveys: Results from two population-based studies. *Research on Aging*, *26*(6), 655–672. https://doi.org/10.1177/0164027504268574

Appendix F

PROMIS Depression Scale – Short form 8a

Instructions: Please respond to each question or statement by selecting one response. In the past 7 days…

Items:

1. I felt worthless
2. I felt helpless
3. I felt depressed
4. I felt hopeless
5. I felt like a failure
6. I felt unhappy
7. I felt that I had nothing to look forward to
8. I felt that nothing could cheer me up

Response options: Never (1), Rarely (2), Sometimes (3), Often (4), Always (5)

References:

Cella, D., Choi, S. W., Condon, D. M., Schalet, B., Hays, R. D., Rothrock, N. E., Yount, S., Cook, K. F., Gershon, R. C., Amtmann, D., DeWalt, D. A., Pilkonis, P. A., Stone, A. A., Weinfurt, K., & Reeve, B. B. (2019). PROMIS® adult health profiles: Efficient short-form measures of seven health domains. *Value in Health*, *22*(5), 537–544. https://doi.org/10.1016/j.jval.2019.02.004

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Appendix G

WHO-5 Well-being Index

Instructions: Please indicate for each of the five statements which is the closest to how you have been feeling over the last two weeks.

Items:

1. I have felt cheerful and in good spirits
2. I have felt calm and relaxed
3. I have felt active and vigorous
4. I woke up feeling fresh and rested
5. My daily life has been filled with things that interest me

Response options: All the time (5), Most of the time (4), More than half of the time (3), Less than half of the time (2), Some of the time (1), At no time (0)

Reference:

World Health Organization. (2024). *The World Health Organization-Five Well-Being Index (WHO-5)*.

Appendix H

Socio-Demographics Questionnaire

Community Organization: What community organization are you participating in?
- British Columbia: Brella Community Services Society
- Manitoba: A&O Support Services for Older Adults
- Saskatchewan: Senior Centre Without Walls
- New Brunswick: Senior Centre Without Walls

Age: What year were you born in? _____ (YYYY)

Sex Assigned at Birth: Please identify your sex as indicated on your birth certificate.
- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ Prefer not to answer

Gender identity: Please identify your gender identity. Gender identity refers to your sense of being a woman, man or other gender. This can be the same or different from your sex assigned at birth or sexual orientation.
- ☐ Woman
- ☐ Man
- ☐ I identify my gender as: _____ (please specify)
- ☐ Prefer not to answer

Sexual Orientation: Please identify your sexual orientation.
- ☐ Heterosexual/Straight
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Other (please specify): _____
- ☐ Prefer not to answer

Language: What is your primary language? _____

Country of Origin: Where were you born? _____
- ☐ Prefer not to answer
- ☐ *If relevant*: when did you immigrate to Canada? _____

Ethnicity: Please share the ethnic groups that you identify with. "Ethnic groups have a common identity, heritage, ancestry, or historical past, often with identifiable cultural, linguistic, and/or religious characteristics" (Public Health Ontario, 2021, p.2). Some examples include: Canadian, Chinese, East Indian, Jewish, etc. You may select multiple.
- ☐ _____

- ☐ Do not know
- ☐ Prefer not to answer

Race: Please identify your race by selecting all that apply. Race "may influence the way we are treated by individuals and institutions, and this may affect our health" (Canadian Institute for Health Information, 2022, p. 9).

- ☐ Black
- ☐ East Asian
- ☐ Indigenous (First Nations, Inuk/Inuit, Métis)
- ☐ Latin American
- ☐ Middle Eastern
- ☐ South Asian
- ☐ Southeast Asian
- ☐ White
- ☐ Other (please specify): _____
- ☐ Do not know
- ☐ Prefer not to answer

Education: What is your highest level of education?

- ☐ Less than high school
- ☐ High school or equivalent
- ☐ College degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate degree or other professional degree (law, MD)

Household Income: What was your approximate household income before taxes last year?

- ☐ Less than $30,000
- ☐ $30,000 - $49,999
- ☐ $50,000 - $69,999
- ☐ $70,000 - $99,999
- ☐ $100,000 - $149,999
- ☐ $150,000 or more
- ☐ Do not know
- ☐ Prefer not to answer

Area of Residence: Do you live in an urban or rural area? Rural areas have less than 10,000 inhabitants.

- ☐ Urban
- ☐ Rural
- ☐ Prefer not to answer

Marital Status: What is your marital status?

- ☐ Never married
- ☐ Separated/divorced

- ☐ Married
- ☐ Domestic partnership
- ☐ Widowed
- ☐ Other (please specify): _____
- ☐ Prefer not to answer

Employment status: Please identify your employment status.

- ☐ Working
- ☐ On Disability
- ☐ Retired
    - *If yes*, when did you retire? _____ (YYYY)
- ☐ Prefer not to answer

Health History: Do you experience challenges with any of the following (select all that apply)?

- ☐ Challenges with mobility: _____
- ☐ Vision impairment or loss: _____
- ☐ Hearing impairment or loss: _____
- ☐ Prefer not to answer

Mental Health Service Use

Have you ever sought support for your mental health? Yes or No or Prefer not to answer

If yes, For what concerns did you access mental health support (e.g., challenges with depression)? You may leave this field blank if you do not wish to answer this question.

_____

If yes, which services have you used (select all that apply)?

- ☐ Primary care physician / family doctor
- ☐ Counsellor
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Other (please specify): _____
- ☐ Prefer not to answer

Appendix I

Semi-Structured Focus Group or Individual Interview Protocol

Introduction:
Welcome and thank you for taking time to meet with me and participate in this study. The purpose of this focus group/interview is for me to learn more about your support needs and understand your perspectives on a new mental health support program that will be offered at [*community organization name*] called CONNECT. My goal is to deeply understand your perspectives and opinions, so that we can tailor this program to be suitable, accessible, and meet the support needs of community members like yourselves. The focus group/interview will take about 1 hour to 1 hour and a half, during which I will pose some questions to structure our conversation.

Review consent:
Just before we get started, I would like to emphasize that you can choose not to answer any questions you are uncomfortable with or choose to leave the focus group/interview at any time if you wish. [Also, I would like to give a gentle reminder of the oath of confidentiality you all signed, which states that you will not share anyone's name or personal information outside the context of this focus group.]

As you have read in your consent forms, this meeting will be audio-recorded. Your names and other identifying information will not be linked to any of the comments that you make throughout the meeting. I will be turning on the recorder now, any questions before I do so?

Ok, let's begin.

Rapport building:

It would be great if you could each introduce yourselves with your first name and something you'd like to share about yourselves. I can start…

- How are you involved in [*community organization name*]?
  - When and how did you become involved?
- What are the things you do within your community to feel connected, feel belongingness?

Needs assessment:
Something that brings us all together today is wanting to improve our mental health and our connections with others and build upon our existing strengths to learn how to better cope with challenging emotions, such as feeling lonely, isolated or low. These are feelings we all struggle with from time to time.

Thinking about connectedness, our identities can sometimes bring us together and sometimes they can distance us. I encourage you all to reflect on the different aspects of your identity that you connect to, for example your age, ethnicity, hearing ability or income level, and how your identity might impact your experiences. For example, when I think about myself, the pieces of

my identity that I connect to most are being a 25-year-old woman who is of South Asian and White ethnicity, and these identities uniquely affect my experiences. One of the things I want to hear about today is how your identity has impacted your participation in mental health supports. This information will help us make sure that the CONNECT program is accessible and a safe space for all.

Do you have any questions for me?

- How would you describe your mental health?
- If you have encountered mental health challenges, what has helped in managing these challenges?
- Are there any services offered by your organization to support you with these challenges?
    - If so, have they been helpful? Why/why not?
- How has your identity influenced your experiences with seeking mental health supports?
    - Are there challenges you've encountered that are unique to you and your identities?

CONNECT Program:
The CONNECT program aims to support adults 55 years and older who are seeking to better understand their emotions, and to build connections with others and what is important to them. *{Share screen to go over infographic}.* It involves six weeks of weekly group therapy sessions that focus on helping you better understand yourself and your emotions, increase your self-compassion, and help you connect with the present moment and with other people.

There are 6 sessions in total, and they are all offered over the phone. Along with the sessions, you would also receive workbooks that contain information, strategies, and resources.

Do you have any questions about the program before we continue our discussion?

- What are your thoughts on the program? Would it meet your needs for support (i.e., does it seem like it would be helpful)?
    - *Probes: content and structure of the program, accessibility and identity related factors*
- Do you feel welcome to participate?
    - What would make you feel more welcome or comfortable?
    - *Probes: content and structure of the program, accessibility and identity related factors*
- Earlier, we discussed some barriers that have impacted your ability to access or use mental health supports in the past, including {*identity-related barriers they shared*}. How can we alter the CONNECT program to minimize those barriers?
    - *Probes: content and structure of the program, advertisement, language used*

Conclusion:
- Are there any other thoughts before we conclude the focus group/interview?

Appendix J

The CONNECT Program Infographic

The CONNECT Program:

A telephone-based support to promote mental health and social connection

Goals

To help you...

- Better understand yourself, including your emotions and your values
- Connect with the present moment and other people

Format

- 6 weeks long (1 session per week)
- Telephone-based
- 4-8 participants

Each session, we will:

- Complete a mindfulness exercise
- Group check-in
- Discuss a topic related to the program goals (for example, defining your values)
- Learn techniques and coping strategies

University of Manitoba

Contact the study team: connectprogram@umanitoba.ca or 204-800-1411

Principle Investigator: Dr. Kristin Reynolds, kristin.reynolds@umanitoba.ca

Appendix K

Implementation Outcomes Assessment

Instructions: In our interview, we discussed the CONNECT program. To better understand your opinions on the program, please answer the questions below.

Here is a quick summary of the program: The CONNECT program is a telephone-based group program designed to support adults 55 years and older who are seeking to better understand their emotions, and to build connections with others and what is important to them. It involves six weeks of weekly group therapy sessions. Click this link to learn more about the program: {*link to infographic*}.

Feasibility – Item 1. I can see myself participating in the CONNECT program without many challenges or barriers.

1	2	3	4	5
Disagree strongly	Disagree	Neither agree nor disagree	Agree	Agree strongly

Feasibility – Item 1a. Please explain your answer: _____

Appropriateness – Item 2. The CONNECT program is an appropriate program for me.

1	2	3	4	5
Disagree strongly	Disagree	Neither agree nor disagree	Agree	Agree strongly

Appropriateness – Item 2a. Please explain your answer: _____

Acceptability – Item 3. We talk openly about difficult emotions, such as loneliness and depression, in this group. Would you be comfortable doing that?

1	2	3	4	5
Disagree strongly	Disagree	Neither agree nor disagree	Agree	Agree strongly

Acceptability – Item 3a. Please explain your answer: _____

Acceptability – Item 3b. What would help you to feel more comfortable/willing to talk openly about these topics?_____

Acceptability – Item 4. The format of the CONNECT program is satisfactory.

1	2	3	4	5
Disagree strongly	Disagree	Neither agree nor disagree	Agree	Agree strongly

Acceptability – Item 4a. Please explain your answer: _____

Acceptability and Feasibility – Item 5. Are there any aspects of the program that do not sit well with you or might make it difficult for you to participate? If so, how could we change that?

_____

Item 6. Do you think the CONNECT program would be helpful and suitable for your friends or family who are ages 55 and older?

_____

Appendix L

Informed Consent Form

Research Project Title: An Interpretive Description of the Mental Health Support Needs and Views on the CONNECT Program of Adults 55+ Across Canada

Principal Investigator: Georgia Gopinath, MA Student
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Telephone; (204) 800-1411
Email: connectprogram@umanitoba.ca

Research Coordinator: Dr. Kira Kudar, Ph.D.
Department of Psychology, University of Manitoba
Telephone: (204) 800-1511
Email: connectprogram@umanitoba.ca

Research Supervisor: Dr. Kristin Reynolds, Ph.D., C. Psych.
Department of Psychology, University of Manitoba
Telephone: (204) 474-9528
Email: Kristin.Reynolds@umanitoba.ca

This consent form, a copy of which can be downloaded, printed, and/or mailed to you for your records and reference (depending on your preference), 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:

Georgia Gopinath is conducting this study as part of her master's thesis, under the supervision of Dr. Kristin Reynolds. The CONNECT program is a 6-session telephone-based mental health program designed to support adults 55 years and older who are seeking to better understand their emotions, and to build connections with others and things that are important to them. CONNECT stands for: **C**reating **O**pportunities to build social **N**etworks, learn **N**ew skills to manage challenging emotions, **E**nhance mindful awareness and acceptance of emotions, and increase self-**C**ompassion, through **T**elephone-based group programming.

The CONNECT program will be offered by this community organization in the future. The purpose of this study is to better understand the perspectives of adults ages 55+ in this community, specifically: (a) their mental health, existing strengths and supports, and their mental health support needs; and (b) their opinions on the suitability of the CONNECT program. This study will also explore how aspects of one's identity (e.g., gender, race, hearing ability, mobility) might impact their support needs and views on the program. The results of the study will be used to tailor and improve the CONNECT program to enhance access to the program.

Your Participation:

As a participant in this study, you will first be invited to complete a survey that will take approximately 20 minutes to complete. Questions covered in the survey include socio-demographic information (e.g., age, sex, race, ethnicity, employment status, household income, hearing challenges), social support, loneliness, mental health challenges, and well-being. The survey can be completed online through REDCap, which is a secure web application for building and managing online surveys and databases. Secure Sockets Layer (SSL) encryption is configured for data transfer from online surveys to the database server, ensuring the protection of all transmitted data. Access to surveys and data is safeguarded through secure user authentication mechanisms and optional password protection features. Alternatively, the survey can be completed over the phone or virtually with the Principal Investigator.

You will be asked a 60–90 minute virtual interview or focus group, which will be conducted over University of Manitoba (UM) Zoom Professional and be audio-recorded. The focus group would involve a conversation with 4-7 additional participants, and you would first be asked to sign an oath of confidentiality to reflect your agreement to not share information about the other participants. During the meeting, you will be asked about your mental health, existing strategies and community supports for your mental health, whether the CONNECT program might be a suitable support, and if any changes to the program are needed. You will be asked to reflect on how your identity might inform your experiences and/or opinions. After, you will be asked to complete a 5-minute questionnaire asking more about the suitability of the CONNECT program.

Throughout this study, you may choose not to answer any questions you wish not to answer.

Potential Benefits and Risks of the Research:

There are no direct benefits to you for participating. The indirect benefit of participating is helping to refine this novel mental health intervention (the CONNECT program) to meet your community's needs, during a period of increased need for mental health interventions.

Discussing challenging emotions such as loneliness, anxiety, and depression may carry with it the risk of experiencing emotional distress. If you notice any feelings of distress after completing the virtual interview/focus group, please consult one of the resources on the last page of this document for assistance.

Participant Payment:
If you choose to participate, you will receive a $50 gift card as a small token of our appreciation. The gift card will be sent via mail or email, at the start of the study. You may retain this compensation even if you choose to withdraw from the study.

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. If you wish to withdraw while participating in the survey and are completing the survey online, please click through to the end of the survey to have your information discarded.

Interview:
If you wish to withdraw from participating during the interview, please inform the facilitator and they will ensure that your data is destroyed and that you are compensated.

Focus group:
If you wish to withdraw from participating during the focus group, please inform the group facilitators, and they will ensure that your data is destroyed and that you are compensated. Please note that if you have already completed your participation or begun participating in the focus group and have withdrawn, we will attempt to edit the full recording to remove your information. However, since your audio and feedback are combined with those of other participants in your focus group, the recording cannot be completely destroyed.

If you chose to withdraw after the interview/focus group, please let us know by emailing connectprogram@umanitoba.ca within 1 month of your participation. Beyond this point, data may have been analyzed and summarized and withdrawal will no longer be possible.

Confidentiality:
Information gathered in this research study may be published or presented in public forums in aggregate form. Quotations from interview/focus group dialogue may also be published or presented using general descriptors (e.g., "female participant"); your individual identifying information will not be used or revealed. As a participant in this research, you will identify yourself by first name during the interview/focus group. Once the interview/focus group is complete, your name will be removed and replaced by a pseudonym or number. If you do not wish to use your first name in the interview/focus group, you can choose to identify based on a pseudonym of your selection.

The virtual interview/focus group will be conducted on UM Zoom Professional, audio-recorded, transcribed, and analysed. All information collected will only be presented in aggregate form without your identifying information. All electronic data will be kept in a password-protected word document on a password protected computer. The audio recording of the interview/focus group will be deleted immediately after transcription. The de-identified interview/focus group transcript will be kept until this research has been published (approximately 7 years). Keeping

this data until March 2031 will ensures that we can fully analyze data, share our findings with participants and stakeholders, and disseminate the results within the research community.

If you chose to participate in this research, the PI (Georgia Gopinath), research supervisor (Dr. Kristin Reynolds), and research personnel from Dr. Reynolds' research team will have access to the recordings, transcripts and questionnaire data. Research data will be securely stored on UM One Drive cloud or on UM managed computers.

Focus group:
Please note that, due to the inclusion of other group members, confidentiality cannot be guaranteed for spoken information provided during virtual 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. Virtual focus groups will be conducted through the secure platform UM Zoom Professional, although complete privacy of the data collected cannot be guaranteed. We also cannot guarantee that other participants will refrain from recording the session in means external to Zoom. You and all other focus group participants will be required to sign an oath of confidentiality prior to your focus group participation.

Results Dissemination:
We plan for the results from this study to be published and presented in public forums in aggregate form, for example in thesis-related work, journal articles, in conference presentations, and other forums (e.g., colloquia). Direct quotes will be used when sharing this research, however, they will be attached to general descriptors (e.g., "female participant") to keep your identity confidential.

The summary results of this study will be available by roughly December 2025. If you would like to receive a summary of the results, please provide your contact information below. Please note that your individual results will never be shared.

Questions or Concerns:
If you have any questions about this study, please do not hesitate to contact the Principal Investigator, Georgia Gopinath (connectprogram@umanitoba.ca) or her supervisor, Dr. Kristin Reynolds (204-474-9528 or Kristin.Reynolds@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 verbal consent/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 subject. 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.

Do you consent to participate in this study? Your participation is voluntary, and you can withdraw at any time without penalty. Please state your full name and respond with 'yes' or 'no'.

_____ _____

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

Consent to be Recorded

☐ I consent to the interview/focus group being audio-recorded by the study team.

_____ _____

Participant's Initials Date (day/month/year)

Consent to be Receive Results Summary

☐ Yes, I wish to receive a summary of this research once it is completed.

☐ No, I do not wish to receive a summary of this research once it is completed.

If yes, please provide your contact information:
Phone: _____

Email: _____

Mailing address: _____

How would you like to receive the summary? Email or Physical copy by mail

Permission for Future Contact

Would you like to be contacted for future studies in relation to this study or other research being conducted by the Health Information Exchange Lab at the University of Manitoba? By agreeing, you are not required to participate in any future research. Should you select agree, your contact information will be stored in a password-protected document until this research has ended in 12/2025. Only the PI and the PI's supervisor will have access to your contact information. You may remove your name from the future studies contact list at any time by emailing connectprogram@umanitoba.ca.

☐ I consent to be contacted by Dr. Reynolds' research personnel by telephone, mail, or email for future follow-up in relation to this study or other research being conducted by the Health Information Exchange Lab at the University of Manitoba.

☐ I decline to be contacted by Dr. Reynolds' research personnel by telephone, mail, or email for future follow-up in relation to this study or other research being conducted by the Health Information Exchange Lab at the University of Manitoba.

_____ _____

Participant's Initials Date (day/month/year)

Resource List

Please refer to the following resources for Canada-wide and province-specific mental health supports.

National Online Resources

Canadian Coalition for Seniors'

Description: The CCSMH works to promote seniors' mental health by connecting people, ideas and resources.

Call: 1-888-214-7080 extension 102 (toll-free)

Website: https://ccsmh.ca/

Anxiety Canada

Description: Anxiety Canada is a leader in developing free online, self-help, and evidence-based resources

on anxiety.

Call: 604-620-0744

Website: https://www.anxietycanada.com/older-adults/

National Helplines

Suicide Crisis Helpline (24 hours/7 days a week)
Description: If you are thinking about suicide, or you're worried about someone else, we want to help.
Contact: call or text 9-8-8 toll free, any time
Website: https://988.ca/

First Nations and Inuit Hope for Wellness Helpline (24 hours/7 days a week)
Description: This number provides immediate mental health counselling and crisis intervention to all Indigenous peoples across Canada.
Call: 1-855-242-3310, or use the chat box.
Website: https://www.hopeforwellness.ca/

British Columbia - Community Resources

Brella Community Services Society
Description: Brella offers services under three banners: adult day program; community services; and dementia, caregiver and family services. The organization focuses on connecting isolated adults, fostering social skills, offering recreational activities, supporting independent living, and promoting emotional and physical well-being.
Call: 604-531-9400
Website: https://www.brellasociety.ca/

Services List from Surrey Libraries
Description: Discover a variety of low-cost and free counselling services available to support mental health and well-being.
Website: https://www.surreylibraries.ca/services/community-services/health-services/counselling

British Columbia - Helplines

BC Suicide Prevention and Intervention Line (24 hours/7 days a week)
Description: Support for people having thoughts of suicide.
Call: 1-800-SUICIDE / 1-800-784-2433

Seniors Distress Line (24 hours/7 days a week)
Description: Confidential, non-judgmental emotional support for people experiencing feelings of distress or despair.
Call: 604-872-1234

Saskatchewan - Community Resource

Seniors Centre Without Walls
Description: Educational, recreational and social connection programming over the telephone. For adults 55 years of age and older.

Call: 306-692-2242 to register
Website: https://scww.ca/scww/

Saskatchewan - Helplines

Mobile Crisis Regina (24 hours/7 days a week)
Description: 24/7 mental health and addictions crisis support
Contact: call 306-757-0127

Saskatchewan Healthline811 (24 hours/7 days a week)
Description: 24/7 mental health and addictions crisis support
Contact: call 306-933-6200
Website: https://www.saskhealthauthority.ca/your-health/conditions-illnesses-services-wellness/healthline-online

Manitoba - Community Resources

A&O Support Services for Older Adults
Description: Contact to get connected to a wide range of services for older adults, including counseling, support groups, immigrant settlement services, and safety and security services.
Call: 204-956-6440, info@aosupportservices.ca
Website:https://www.aosupportservices.ca

Manitoba - Helplines

Klinic Crisis Line (24 hours/7 days a week)
Description: This is a confidential counselling line. Call for support with any struggles you may be experiencing, including loneliness, sadness, and thoughts of suicide.
Call: (204) 786-8686, or toll free: 1-888-322-3019

Manitoba Suicide Prevention & Support Line (24 hours/7 days a week)
Description: Call this crisis line if you are struggling with suicidal thoughts or feelings, are concerned about a friend, family member or co-worker: or if you are impacted by a suicide loss or suicide attempt.
Call: 1-877-435-7170
Website: http://reasontolive.ca/

New Brunswick - Community Resource

Seniors Centre Without Walls
Description: Educational, recreational and social connection programming over the telephone. For adults 55 years of age and older.
Call: xxx-xxx-xxxx to register

New Brunswick - Helplines

New Brunswick Addiction and Mental Health Helpline (24 hours/7 days a week)
Description: This helpline is toll-free and bilingual, and offers confidential support related to mental health and addictions.

Call: 1-866-355-5550
Website:
https://www2.gnb.ca/content/gnb/en/departments/health/AddictionsandMentalHealth/helpline.html

New Brunswick Provincial Crisis Line
Description: A provincial crisis phone line, accessible 24 hours a day, 365 days a year to all residents of New Brunswick.
Call: 1-800-667-5005
Website: https://johnhowardfredericton.ca/

Appendix M

Table 1
Demographic Characteristics and Questionnaire Scores

	Full Sample (*N* = 13)
Age (years) *(mean ± SD, range)*	71.5 ± 8.2, 62-90
Sex *(%)*	Female: 100%
Gender *(%)*	Woman: 100%
Sexual Orientation *(%)*	Heterosexual: 84.6% Prefer not to answer: 15.4%
Primary Language *(%)*	English: 92.3% Other: 7.7%
Country of Origin *(%)*	Canada: 76.9% Other: 23.1%
Ethnicity *(N > 13, participants selected multiple ethnicities)*	Canadian: 9 Other: 7
Race	White: 76.9% Other or prefer not to answer: 23.1%
Education	High School or Equivalent, or less: 30.8% College, Bachelor's or Master's: 69.2%
Annual Income	< $50,000: 61.5% $50,000-99,999: 23.1% Don't know or prefer not to answer: 15.4%
Urban/Rural	Urban: 84.6% Rural: 15.4%
Marital Status	Domestic partnership or married: 23.1% Separated/divorced: 46.1% Widowed: 23.1% Other: 7.7%
Employment Status	Retired or on disability leave: 100%
Age at Retirement (years) *(n = 11, mean ± SD, range)*	54.7 ± 12.7, 28-75

Impairment in Ability *(N > 13, participants selected multiple)*	Mobility: 6 Vision: 8 Hearing: 4 Multiple: 6
Past Mental Health Service Use	Yes: 84.6% No: 15.4%
Mental Health Services Used [a] *(N > 11, participants selected multiple)*	Counsellor: 8 Primary Care Provider: 6 Psychiatrist: 5 Psychologist: 4 Other: 2
LSNS-6 – Total *(mean ± SD, range)*	11.8 ± 7.6, 2-26
UCLA 3-Item – Total *(mean ± SD, range)*	6.1 ± 2.3, 3-9
PROMIS Depression 8a – Total *(mean ± SD, range)*	59.3 ± 8.7, 38.2-68.7
GAI-SF – Total *(mean ± SD, range)*	2.5 ± 1.9, 0-5
WHO-5 Wellbeing – Total *(mean ± SD, range)*	12.4 ± 6.2, 5-22

Note: For identifying information, when n < 5, categories were collapsed or responses were reported as "other" to protect the privacy of participants.

[a] Data is missing from one participant who did not complete this question.