Healthcare Professionals' Perspectives on Patient Mental Health Treatment Engagement in Later Life

by
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Abstract

Older adults face complex challenges in seeking and receiving mental health treatment. While older adults access psychological services less frequently than other populations, strong engagement can predict better treatment outcomes. This study explores practitioners' perspectives on the treatment engagement of patients referred for specialty geriatric mental health services. Guided by Raue & Sirey's (2011) late-life treatment engagement model, 11 interviews were conducted with specialty geriatric mental health professionals (geriatric psychiatrists and gero-psychologists) and frequent referral sources such as general practitioners and other specialty health providers to assess their perspectives on patient treatment engagement barriers and potential improvement to the current referral process. The data were analyzed using the framework analytic approach, and summative content analysis was used to extract suggested treatment engagement interventions. Results from the framework analysis highlighted mental health literacy, attitudes, and beliefs as key influences on treatment decisions and the importance of patient-centered care, strong relationship dynamics, and collaboration among providers and older adults when navigating treatment systems. Streamlined communication between the referral source, specialists, and patients was also proposed with a call to educate family doctors, and patients, and their families about available services, referral processes, and how to openly discuss mental health. Findings from this study highlight the importance of considering provider and referrer factors in attempts to better engage patients and suggest a need for interventions to improve knowledge about mental health services.

Keywords: older adults, mental health, treatment engagement, practitioner perspectives, collaborative care

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Aging communities have grown rapidly in recent decades, with adults in later life (age 65+) facing new and diverse mental and physical health challenges (Li et al., 2019). As a result, older adults fill primary care waiting rooms, seeking care for their physical and mental health (MH) needs (Areán et al., 2001; Simning et al., 2010). More than 20% of older adults currently live with a neurological disorder or mental disorder, with anxiety, depression, and dementia being most prevalent (Conner et al., 2010; Sirey et al., 2020; WHO, 2015). Anxiety and depression are among the most common chronic conditions in older adults, and a diagnosis with one or both disorders is often associated with diminished well-being (DiMatteo et al., 2000; Gonçalves & Byrne, 2012; Olfson et al., 2016; Raue & Sirey, 2011; Simning et al., 2010). In addition to those who received a mental health diagnosis, more than 14% of older adults experience sub-threshold symptoms of depression, and many would benefit from psychological treatment (Biella et al., 2019). Older adults who do not receive treatment for these psychological issues are likely to experience poorer quality of life and health outcomes, and higher mortality risk (Conner et al., 2010). Despite their apparent need for care, older adults access psychological services significantly less than any other age group and they are especially unlikely to report having their MH needs met (Mackenzie et al., 2008; Mackenzie et al., 2010; Pescosolido & Boyer, 2010; Robb et al., 2003). Further, for those older adults whose MH problem is identified, many patients terminate treatment despite acknowledging their need for services (Robb et al., 2003).

There are many individual, social, and structural barriers for older adults accessing treatment; but even for older adults who do receive treatment, an additional barrier to positive psychological outcomes is their level of treatment engagement. Patient engagement is a complicated and often overlooked aspect of treatment which relies on patient and MH provider cooperation, and it impacts patient decisions to begin, continue, and complete treatment (Sirey et al., 2020; Kappelin et al., 2023). The current study explores patient treatment engagement through the lens of the late life treatment engagement model (Raue & Sirey, 2011), adding to the literature in this area by focusing on the under-studied influence that MH providers and referring physicians have on older adults' engagement.

Barriers to Accessing Specialty Mental Health Treatment

Two key challenges to receiving psychological treatment include the barriers to initially accessing MH services and the barriers to engaging with and adhering to treatment once services are accessed (Raue & Sirey, 2011). While both challenges are crucial to optimizing older adults' MH care, the current study focuses on exploring engagement in specialty geriatric MH treatment after the primary care referral. Because my focus is on treatment engagement, a thorough review of the literature related to initially accessing care is beyond the scope of this study. Thus, I will briefly discuss barriers to accessing care, followed by an exploration of barriers to patient engagement during the referral and treatment process. These barriers are conceptualized using Raue and Sirey's (2011) late life treatment engagement model. Currently, most of the literature on barriers and facilitators of treatment access and engagement has been from the perspective of patients.

Researchers have identified a variety of individual, social, and structural barriers that older adults face when accessing MH care (Bartels et al., 2004; Lavingia et al., 2020). Key individual and social factors which may impact access to treatment include gender, ethnicity, race, cultural upbringing, and religious affiliation (Bartels et al., 2004). Some structural barriers are attributed inaccessible transportation and limited geriatric MH providers. The literature suggests that attitudinal (i.e., individual) and social barriers most significantly deter older adults from seeking services (Mackenzie & Pankratz, 2022; Park et al., 2018; Robb et al., 2003).

Social and individual/attitudinal barriers to seeking care for older adults include perceived need for care, perceived public stigma, self-stigma, social isolation, and poor MH literacy (Conner et al., 2010; Corrigan et al., 2014; Mackenzie et al., 2010; Mackenzie et al., 2022; Mackenzie & Pankratz, 2022; Sirey et al., 2020; Veras, 2020). Many older adults who experience MH issues report feeling resistant to accessing care because they fear the label and embarrassment of having MH problems (Frost et al., 2019; Park et al. 2018; Reynolds et al., 2020). In a study assessing MH care utilization in distressed older adults, although over half reported discussing their MH with their primary care provider (i.e., general practitioner or GP), few reported following through with accessing psychological services (Simning et al., 2010). Internalized stigma and levels of perceived need for services highly influenced patients when accessing care (Corrigan et al., 2014; Mackenzie et al., 2010; Mackenzie & Pankratz, 2022). Thus, the most prevalent individual psychological barriers to older adults seeking help were wanting to handle their struggles alone, poor MH literacy, negative attitudes and beliefs, and low perceived need for support (Mackenzie et al., 2010; Mackenzie & Pankratz, 2022).

Barriers to Treatment Engagement

For the subset of older adults who overcome the barriers to accessing care, there are additional barriers to engaging in treatment. Treatment engagement refers to a patient’s efforts made during the treatment process to achieve certain outcomes or change. Definitions and assessments of engagement can include clients attending treatments or appointments, sustained attention during appointments, open interaction with the treatment provider, treatment understanding, active information-seeking, treatment motivation, confidence during treatment, and expressed trust in the treatment provider (Holdsworth et al., 2014; Raue and Sirey, 2011). Shared decision-making (i.e., a communication method focusing on patient-clinician collaboration, and patient participation in treatment decisions, which improves engagement and outcomes; Morán-Sánchez et al., 2019; Trusty et al., 2019; Zisman-Ilani et al., 2021) is another indication that a patient is engaged in treatment.

Barriers to engagement include: complex or poorly communicated treatment plans, poor MH literacy, insufficient communication between patients and care providers, providers' bias for using elderspeak (i.e., paternalistic, nurturing speech that communicates inadequate respect to older adults, usually occurring between younger adult practitioners and older adult patients; Williams et al., 2004), and psychosocial factors (e.g., lack of family involvement/social support; Aggarwal et al., 2016; Sirey et al., 2020). Factors such as chronic illness, mobility limitations, cognitive impairment, and disability also pose barriers to treatment engagement (Cristancho et al. 2018; Sirey et al., 2020). Older adults are far less likely to receive a referral from a primary care provider compared to younger adults (Frost et al., 2019). This is likely attributed to practitioner bias and a belief that MH treatment is not as effective for older adults (Mackenzie et al, 1999). It could also be due to some GPs' inability to understand or meet the specific psychological needs of their older patients due to training constraints or insufficient resources (Kappelin et al., 2023; Simning et al., 2010). It is apparent that GPs and MH practitioners influence barriers and facilitators to engagement during treatment. Because of the breadth of factors affecting treatment engagement, theory is needed to organize them.

Raue and Sirey's (2011) Late Life Treatment Engagement Model

Raue and Sirey's (2011) late life treatment engagement model provides a theoretical conceptualization of how patients navigate barriers to engagement during the referral and treatment process (see Figure 1). According to this model, patients face a myriad of barriers which inform the decisions they make while receiving care. Some of these barriers are not modifiable (i.e., background factors) while others are modifiable (i.e., attitudes, knowledge about MH, preferences for treatment type, treatment expectations; Raue & Sirey, 2011). Treatment engagement involves engaging older patients during discussions of referral to services, treatment options, and early receival of care. Successful treatment engagement is often assessed from the patient's perspective. The theoretical model focuses on individual-level factors such as negative beliefs and attitudes towards mental illness and other psychosocial factors (e.g., exclusion from treatment-related decisions), which ultimately also influence treatment adherence and outcomes.

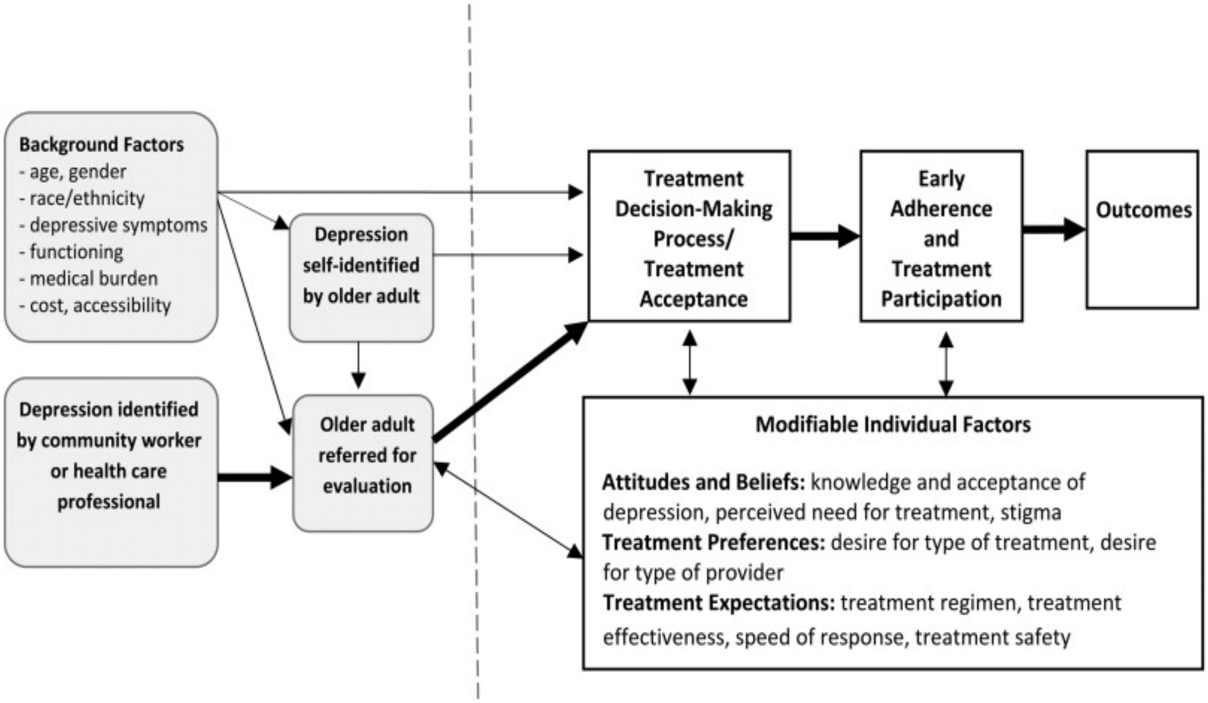

Figure 1. Patient Engagement in Mental Health Treatment Model (Raue & Sirey, 2011)

As this model would predict, poor treatment engagement is related to treatment refusal, early dropout, and overall suboptimal MH outcomes (Greene et al., 1989; Sirey et al., 2020). Making decisions about treatment can be highly influenced by beliefs about the services a patient is receiving, preferences for the structure of this process, and expectations about the treatments they were referred for (Raue & Sirey, 2011). If patients are not engaged during this process through efforts such as consistent communication and psychoeducation about the process, treatment refusal and premature termination are more likely. Treatment refusal can be defined as a patient failing to begin an offered intervention such as psychotherapy or pharmacotherapy (Swift & Greenberg, 2015; Swift et al., 2017). Alternatively, a client's premature termination of treatment can occur when a client unilaterally terminates an unfinished treatment before recovering from the targeted problem and against a specialist's recommendations (Swift & Greenberg, 2012). Approximately 20% of adult clients receiving psychotherapy, pharmacotherapy, or a combination choose to terminate their treatment early, and these clients are unlikely to see long-term symptom improvement (Swift & Greenberg, 2015; Swift et al., 2017). Premature termination can be partly attributed to lack of engagement with some aspect of treatment (Easter et al., 2016). Ensuring prompt treatment after a referral from a primary care provider is one way to better meet older adults' mental health needs and improve treatment engagement (Kappelin et al., 2023; Knight, 2010; Wang et al., 2007). In a study which explored older adults' commitment to treatment with external MH care providers after a diagnosis of major depressive disorder, fewer than half of patients referred to a psychologist followed through and sought treatment (Bartels et al., 2004). Follow-through rates were even lower (38%) among older adults with milder depressive symptoms (Sirey et al., 2020). In fact, patients with depression and related mood disorders are three times less likely to adhere to treatment plans, due to anhedonia and poor motivation, compared to non-depressed patients (DiMatteo et al., 2000). Considerations around MH care referrals and treatment delivery are complex for older adults. Crucial considerations to make when planning treatments for older adults should include methods to maximize treatment engagement and should involve collaboration between primary care providers (i.e., GPs) and specialty MH providers (Beck & Nielsen, 2022; Cleland et al., 2006; Kappelin et al., 2023; Younes et al., 2005).

When exploring what treatment engagement and refusal is attributed to, the most researched factor in Raue & Sirey's (2011) model is client preferences for their treatment plan and specialist (Swift et al., 2017). A meta-analysis including 34 studies analyzing adult patient preferences for psychotherapy and pharmacotherapy found that while 75% of adult clients preferred psychotherapy to treat their MH problems, the majority were receiving only pharmacological treatment (McHugh et al., 2013). Further, a diagnosis of anxiety or depressive disorder was linked to adult patients having more difficulty engaging with their treatment plans and led to higher refusal and dropout rates (Swift et al., 2017). In a similar meta-analysis exploring treatment outcomes among older adults, when comparing pharmacotherapy and psychotherapy dropout and treatment refusal rates, clients receiving pharmacotherapy were 20% more likely to terminate treatment compared with patients attending psychotherapy (Gonçalves & Byrne, 2012; Swift et al., 2017). Overall, many older adults prefer for care providers to be attentive to their needs, culturally sensitive to their values and experiences, and who consult with them when determining treatment plans. Preferences for treatments included humanistic treatment approaches (i.e., group counselling, social work, spiritual/religious consultation, psychotherapy, and natural remedies) compared to pharmacotherapy (Bastiaens et al., 2007; Jimenez et al., 2012). Therefore, despite their MH treatment preferences, it seems most older adults do not receive treatments that meet their preferences (Gonçalves & Byrne, 2012; Olfson et al. 2016; Sirey et al., 2020). It is important to explore how this finding impacts collaboration between providers and patients in treatment.

There are three main limitations to the late life treatment engagement model which should be considered in the scope of this study. First, the 2011 model was based on the authors' clinical work with depressed older adults referred for psychiatric care in the US, which is a small subgroup of older adults accessing MH services and these findings may not reflect Canadian treatment contexts. Second, the authors based their treatment engagement model on their own work and review of the literature, but they did not assess patient or provider perspectives on the model. Lastly, despite some of the literature suggesting the importance of exploring patient-provider collaboration in navigating treatment decisions and pathways, there is limited exploration of this factor in the authors' model (Raue & Sirey, 2011). This third limitation is explored below.

Mental Health Treatment and Collaborative Care

Positive engagement ideally requires a collaborative process between patients, social supports, primary care physicians or general practitioners, and specialty MH providers (Sirey et al., 2020). Engagement in care is greatly improved when interventions take place in settings where older adults are currently receiving treatment, such as a patient's primary care office, to avoid fragmented care (Sirey et al., 2020). Fragmented care, or healthcare that is not well-coordinated, poses significant barriers for patients and providers. Patients often feel overwhelmed by the information they receive after multiple visits to different practitioners. Communication between GPs and specialists can also be fragmented, leading to difficulty providing seamless care. This fragmentation negatively affects patient compliance with prescribed treatments and overall outcomes (Damarell et al., 2020).

Some treatments are now being embedded in primary care settings, using support teams with diverse specialties and innovative technology methods; this model is referred to as collaborative or shared care and involves two or more healthcare professionals working together to care for a patient with MH problems (Archer et al., 2012; Cleland et al., 2006; Rugkåsa et al., 2020; Shaw et al., 2019). Collaborative care models have been explored as effective approaches for addressing depression and anxiety (Archer et al., 2012). However, these models remain the exception rather than the norm, and in their absence collaboration between GPs or referral sources and specialty MH providers is crucial for providing adequate treatment.

But what happens when older adults do not have access to integrative care that promotes collaboration and communication? A key preventative measure against premature termination is maintaining communication and engagement between patients and health teams until referral appointments arrive (Williams et al., 2004). Research by Fredheim and colleagues (2011) pointed to poor collaboration and relationships between providers, leading to inefficient care, poor engagement, and patients falling through the cracks. A lack of shared knowledge between GPs and MH providers regarding patients' individual needs and familiarity with existing systems and resources further hindered collaboration (Fredheim et al., 2011). Addressing these challenges requires improved interprofessional communication, knowledge sharing, and specialized training for GPs and MH specialists. Additional factors may also act as facilitators to treatment engagement including engagement methods that might take place remotely online or by telephone. Although both patients and providers have roles in treatment engagement, this study focuses on the latter by exploring barriers and facilitators for providers attempting to engage patients. The literature provides guidance on providers’ specific roles in MH care to conceptualize how older patients are currently being engaged.

The Role of the Care Provider

Healthcare provision, and by extension, access to specialty MH treatment, is somewhat fragmented and difficult for patients to access (Doupe et al., 2022; Wait Times Reduction Task Force, 2017; Kappelin et al., 2023; Peachey et al., 2017). The key parties involved in geriatric patients' MH treatment include referring physicians (i.e., specialists in an unrelated medical field, or GPs in primary care) and specialty MH providers (i.e., generally psychiatrists or psychologists). This dynamic is consistent with the treatment engagement model and other research which focuses on those who refer to specialty MH and those who provide specialty MH care (Fredheim et al., 2011; Nymoen et al., 2020; Raine et al., 2005; Raue & Sirey, 2011).

General practitioner and referrer roles. General practitioner (GP) roles in the MH treatment process are crucial for providing comprehensive patient-centered care, often serving as the catch-all for older patients with MH concerns (Kappelin et al., 2023). A study on the management of MH by GPs in primary care revealed that MH-related concerns accounted for more than 20% of visits (Fleury et al., 2012). In Canada, GPs are often considered the first point of contact for patients who require MH treatment, and their role is central to treating these patients as they often diagnose, initiate, and follow-up on treatment, "gate keep" pathways to specialty MH providers, and act as knowledge carriers pertaining to available primary and specialty MH services (Berardi et al., 2007; Fredheim et al., 2011; Younes et al., 2005). Further, GPs are often relied on to provide follow-up to patients after they received specialty MH services, and to negotiate diagnoses with patients to foster a sense of collaboration, confidence, and patient buy-in (Stanners et al., 2012). In a recent study exploring the role of GPs in treatment navigation with patients with multimorbidity and MH problems, researchers found that GPs typically took on the pivotal role of "dancing" with their patients (Kappelin et al., 2023). GPs reported taking turns listening to and providing feedback to patients, which inevitably bolstered motivation for treatment and trust in the therapeutic relationship (Schöpf et al., 2018). However, treatment processes in primary care can be challenging due to limited resources and complicated presenting problems. The literature suggests that while GPs and other referring physicians tend to be comfortable managing common MH concerns, they are less confident addressing serious concerns alone (Fleury et al., 2012). In another study, GPs reported feeling challenged by insufficient evidence-based training and resources and the expectation that they must serve as "expert generalists" (i.e., provide care for a range of mental and physical health concerns; Reeve, 2015). Additional research suggested that GPs, acting as expert generalists, are responsible for helping patients navigate through complex fragmented systems and treatment plans, but that many GPs are not sufficiently familiar with treatment pathways themselves (Damarell et al., 2020; Ploeg et al., 2017; Reeve, 2015). One study also suggested that GPs' own biases and training experiences may impact their willingness to refer (Titzler et al., 2020). Thus, it is important to explore how providers may act as inhibiters or facilitators to patient engagement in older adult populations. Previous research suggests that overcoming these barriers requires a continuity of care providers and anchoring treatment decisions in patient values, goals, needs, and preferences, while lengthening consult times to effectively coordinate care planning. Educating patients about the importance of asking questions and actively involving them in treatment decisions was also suggested, since MH problems require additional time, flexibility, and emotional investment for GPs to address (Damarell et al. 2020; Fleury et al., 2012; Schöpf et al., 2018). It is still unclear what barriers and facilitators look like for older patients and providers during the referral, waiting, and specialty treatment process.

Referral to specialty mental health care. Although collaborative care models and research on shared decision-making highlight the importance of referrals to specialty care being a collaborative and streamlined process to promote patient engagement, shared understanding of this process still appears to be unclear. In one study, GPs found patients with MH concerns more difficult to refer than other patients due to non-existent or weak relationships with the MH providers they refer to, including psychiatrists and social workers (Younes et al., 2005). Another qualitative study explored the effects of referring patients from primary care into a centralized-intake model, similar to the model employed by the Winnipeg Regional Health Authority in Winnipeg, Manitoba (Raine et al., 2005). While there were benefits to having a single point of entry to specialty MH care, the study found that it impeded inter-provider communication, knowledge transfer, and professional relationships between primary and secondary/specialty care providers. GPs expressed concerns about accountability to their patients when referral into specialty MH care did not involve follow-up with the patient's GP. MH providers, on the other hand, reported being unaware of these barriers to the therapeutic process between patients and GPs (Raine et al., 2005). In terms of a shared understanding of when patients require referral to specialty MH care, a recent study highlighted an unclear definition of need for specialized MH care, leading to differing interpretations by GPs and specialty MH providers (Nymoen et al., 2020). This highlights the complexity of assessing patient needs based on symptoms, level of functioning, and available resources. The lack of clarity for GPs when making referral decisions may lead to unclear treatment protocols (Knight, 2010). Specialty MH providers likely also face barriers during the referral process, including long waitlists and managing stigma associated with MH treatments, especially among older adults (Frost et al., 2019). The literature suggests that referrals to specialty MH care can be more streamlined if GPs are aware of available resources and pathways to reach them, and if clear criteria for referral to specific services are established (Frost et al., 2019; Nymoen et al., 2020).

Specialty MH provider roles. Post-referral, specialty MH providers (i.e., geriatric psychiatrists and psychologists) play a crucial role in the MH treatment process (Beck & Nielsen, 2022; Easter et al., 2016; Liberman et al., 2022). Consistent with Raue and Sirey's (2011) late life treatment engagement model, one study noted that specialty providers' roles in treatment engagement were to prescribe treatments that promoted engagement and adherence which requires provider flexibility (Easter et al., 2016). Easter and colleagues (2016) also emphasized the importance of therapeutic relationships between specialty MH providers and clients. The study highlighted the need for both parties to be present during appointments and the divergence in treatment goals between practitioners and patients. Findings underscored the significance of treatment provider availability, client-focused goal setting, and trust and honesty in the therapeutic relationship, such that addressing client goals could enhance relationships between treatment providers and older patients with MH problems.

Another relevant study explored specialty MH professionals' perspectives on the complex needs of older patients with multimorbidity. Researchers suggested the need to improve communication and collaboration among healthcare professionals during the transition from primary to specialty MH care, including improved personal contact, effective communication, competent care, sensitive observation, and clarification of responsibilities among care providers (Beck & Nielsen, 2022). Thus, specialists providing MH treatment play a vital role in promoting treatment adherence, enhancing therapeutic relationships, and collaborating with other healthcare professionals to provide comprehensive care. Their expertise, support, and coordination contribute to improving treatment outcomes and addressing unique challenges faced by older adults with MH problems. However, primary care providers/GPs, other referring physicians, and specialty MH providers may be unfamiliar with complex pathways to MH care, specifically for geriatric patients requiring specialty MH care, a significant barrier which will be addressed in the current study.

In general, prior research suggests that strong patient engagement and overall successful treatment outcomes is dependent on effective collaboration between all providers within the care system and their patients (Beck & Nielsen, 2022). While GPs' roles are quite clear as "expert generalists" responsible for being a touchpoint for patients receiving treatment, specialty MH provider roles, while crucial to treatment engagement, are less clear (Ploeg et al., 2017; Raine et al., 2005). It is also still unclear how patient engagement processes translate to Canadian contexts as most research is conducted from a European or American-focused lens (Bastiaens et al., 2007; Berardi et al., 2007; Fredheim et al., 2011; Nymoen et al., 2020; Raine et al., 2005). Thus, it is important to explore perspectives on treatment engagement from practitioners pre- and post-referral. To address these gaps, the goal of this study was to explore primary and specialty practitioner perspectives on barriers to patient engagement, how older adults navigate pathways to treatment, and ideas to improve patient engagement during the referral and treatment process. This study also builds upon Raue and Sirey's late life treatment engagement model by addressing some of its limitations by (1) broadening the sample of depressed patients referred for psychiatric care in the US to Canadian older adults with a range of MH concerns referred to psychology or psychiatry; (2) obtaining provider perspectives on the current model; and (3) incorporating provider perspectives into the treatment engagement model to explore how patients and providers collaborate in treatment engagement.

Method

While conducting this study, I followed best practices with respect to guidelines for qualitative research (Schoenberg et al., 2011) and reporting standards for qualitative research (Levitt et al., 2018; Tong et al., 2007; see Appendix A).

Participants and Procedure

To address provider roles in older adults' MH treatment engagement, I collected data from 11 healthcare professionals. Participants consisted of nine geriatric MH providers based in two large general hospitals in a medium-sized metropolitan centre (i.e., six geriatric psychiatrists, two gero-psychologists, and one resident under their supervision) and two other physicians or providers who frequently refer to them (i.e., one GP and one neurologist; see Table 1). To be eligible for this study, participants had to be a practitioner who either refers to or specializes in providing geriatric MH treatment to older adults.

Eleven participants were recruited based on research using similar methods (Beatie et al., 2020; Caplan & Whittemore, 2013), and the sample size was determined when all possible novel themes were exhausted and the research question was adequately answered (i.e., saturation; O'Reilly & Parker, 2012; Sim et al., 2018). Saturation was noted during data collection between the eight and tenth interview, and I noted similarities in the content shared by psychiatrists, psychologists, and referrers. I used purposeful sampling to select practitioners who were interested in participating and represented a range of roles in the referral and treatment process to provide reliable and unique perspectives (i.e., identifying and selecting especially knowledgeable participants with rich experience with the phenomenon of interest; Palinkas et al., 2015). All possible geriatric psychologists and psychiatrists were recruited from two large hospitals in a medium-sized urban city. To reach and recruit common referring physicians (e.g., GPs), two

Table 1

Participant Demographics

ID	Occupation/ Specialty
P1	Specialty Medicine: Geriatric Psychiatrist
P2	Specialty Medicine: Geriatric Psychiatrist
P3	Specialty Medicine: Clinical Geriatric Psychologist
P4	Specialty Medicine: Geriatric Psychiatrist
P5	Specialty Medicine: Geriatric Psychiatrist
P6	Primary Care Physician
P7	Specialty Medicine: Geriatric Psychiatry Resident
P8	Specialty Medicine: Neurologist
P9	Specialty Medicine: Psychiatrist
P10	Specialty Medicine: Geriatric Psychiatrist
P11	Specialty Medicine: Clinical Geriatric Psychologist

geriatric psychiatrists provided the research team with the names and contact information of 14 providers who frequently refer to psychiatry.

After identifying potential participants, the research team sent out invitations to participate in the study via mail (to referring physicians) or via email (to specialty providers). Two waves of invitations were sent to participants between June and October 2022. Once interested participants responded to recruitment, participants were contacted by phone or email to discuss informed consent and select a time to meet for an online (Zoom Healthcare) or telephone (using WebEx Audio) interview. Participants completed an informed consent survey via an initial survey online using Qualtrics, a web-based platform. Consenting participants also provided sociodemographic and descriptive information (see Table 1) before completing approximately 60-minute interviews (ranging from 31 to 91 minutes). Eleven one-on-one semi-structured interviews were conducted by two researchers with consenting participants (see Appendix B). Participants were interviewed between July 2021 until March 2023, and interviews were held remotely to maintain accessibility and COVID-19 safety protocols. Following the interviews, participants received a 20-dollar e-gift card as compensation for their participation.

Interviews

Interviews followed a protocol informed by Raue and Sirey's (2011) treatment engagement model, previous literature on treatment engagement, and identified gaps in knowledge based on my review of the literature. The protocol explored (1) practitioners' impressions of the treatment engagement model and willingness to change referral practices to improve patient engagement; and overall perspectives on (2) the referral process, (3) engaging patients while assessing attitudes, preferences, and treatment expectations, (4) feasible and sustainable intervention ideas to improve engagement, and (5) preferences for how potential interventions would be delivered, such as in-person and remote methods, and the possibility of involving family in patient engagement. Each interview was audio recorded, transcribed using a professional Canadian transcription service, and analyzed using the Framework method (Ritchie & Spencer, 1994). Providers' impressions of the treatment engagement model, referral process, and patients' attitudes, preferences, and treatment expectations were analyzed using framework analysis, while data on intervention ideas and delivery methods were analyzed were analyzed using summative content analysis as described below.

Analytic Plan

The primary goal of the study was to gain insight into practitioner perspectives on treatment engagement, perceived barriers to engagement, and the role they see themselves playing in patients' treatment progress and overall understanding of the treatment plan. I explored this goal by analyzing the data for my framework using the framework analytic approach (Gale et al., 2013; Ritchie & Spencer, 1994; Srivastava & Thomson, 2009) and by using summative content analysis to summarize suggested interventions in the data (Hsieh & Shannon, 2005; Kleinheksel et al., 2020). Selecting framework analysis to create an initial theoretical framework for provider perspectives on treatment engagement allowed me to produce a novel model which was strongly guided by the original late life treatment engagement model. I selected summative content analysis for the second research question (i.e., exploring feasible engagement interventions) because it allows researchers to quantify themes based on their relevance. By quantifying suggested interventions and delivery methods, I can identify which interventions are most necessary to explore in future research. The research was conducted and analyzed using a social constructivist lens, which attributes the collected participant data to a synthesis of facilitator and participant experiences. This perspective views the final research product as a collaboration of how experiences were presented by participants and how I interpreted those experiences (Sutton & Austin, 2015). One way to achieve this synthesis was using Ritchie and Spencer's (1994) framework analysis (FA; Ritchie & Spencer, 1994).

FA is a commonly used form of thematic analysis, aimed at drawing specific conclusions based on clusters of themes and pre-existing theory, comparing data across and within individuals by identifying and categorizing related themes and patterns often in semi-structured interview transcripts (Gale et al., 2013; Ritchie & Spencer, 1994; Srivastava & Thomson, 2009). According to Braun and Clarke (2006), there are several schools of thematic analysis, ranging from reflexive thematic analysis that allows themes to be completely derived from meaning-based patterns in the data, to coding reliability thematic analysis in which data is coded into pre-determined, rigid, theme categories. FA, similar to codebook thematic analysis (i.e., analysis which coding maintains its structure, while also being informed by themes in the data), is in the middle of this spectrum, allowing researchers to deductively code data guided by established theory (e.g., treatment engagement model), while also remaining open and flexible to new themes arising inductively from the data (Braun et al., 2019; Braun & Clarke, 2006; Braun & Clarke, 2019; Braun & Clarke, 2021). I followed five stages of analysis in FA: (1) familiarization with transcripts; (2) identifying a working thematic framework based on key themes and recurring issues in the data; (3) indexing relevant portions of data into corresponding themes; (4) arranging all indexed qualitative data into charts with headings and subheadings derived from the framework; and (5) mapping and interpreting data based on key characteristics (see Appendix C; Ritchie & Spencer, 1994; Ritchie & Spencer, 2002). Because the research question is inductive while still being guided by theory, the framework approach was appropriate for analysis.

I used summative content analysis (CA) to identify key interventions suggested by participants in the data. Summative CA is a type of CA which systematically summarizes qualitative data by identifying essential keywords and counting their occurrences across the data (Hsieh & Shannon, 2005; Kleinheksel et al., 2020). This process is carried out by initially identifying keywords in each transcript, followed by counting their frequency in the textual data. Each keyword is then recontextualized and compared across transcripts to find the underlying context of the phenomenon (Hsieh & Shannon, 2005). The process is summarized in four key steps: decontextualization (i.e., pulling keywords from texts), recontextualization, categorization, and compilation (or summation; Bengtsson, 2016). Summative CA is deductive, meaning that keywords can be identified based on past literature, or by exploring the usage of specific language in the data (Kleinheksel et al., 2020). Because there is limited literature on feasible and sustainable treatment engagement interventions from practitioners' perspectives, I identified keywords deductively during the analysis based on the content in the data.

To facilitate my analysis, I followed a clear procedural process to ensure that analyses were organized and cohesive. Each transcript was first coded in Microsoft Word to allow for familiarization with the transcripts and to produce a preliminary thematic framework. Each transcript was then uploaded to QSR International's NVivo 12 qualitative data analysis software to index the data and pull meaningful quotations from each transcript. Keywords related to potential interventions were also highlighted and summed using the NVivo analysis software, with a log of each key word and number of occurrences kept in Microsoft Word.

Rigor

Upholding validity standards in this study included maintaining credibility, dependability, confirmability, and transferability (Levitt et al., 2018; Tracy, 2010). Credibility was achieved by developing a semi-structured interview protocol which allowed participants to elaborate or be prompted on their responses, and by ensuring awareness of personal biases as interviewers by seeking feedback from co-researchers (Forero et al., 2018). Dependability refers to the reliability and consistency of the data collection (Levitt et al., 2018; Tracy, 2010). Dependability was achieved by keeping a detailed codebook and research log detailing the important decisions made during the interview and analysis process. Confirmability entailed cross-checking data analysis and interpretation with my own biases and research roles (i.e., reflexivity), and multiple data sources (e.g., varied allied geriatric MH providers; Levitt et al., 2018). I approached reflexivity by noting thoughts and language of bias during the interview, analysis, and interpretation process, and by developing a positionality statement which addressed my biases as a researcher. I achieved triangulation (i.e., using multiple sources of data and methods to reduce biases in the data and strengthen validity of the results; Greene et al., 1989) during analysis through my transcripts and codebook and by working with a team of co-researchers, which provided multiple perspectives on the analysis and framework development to ensure that it was accurate and unbiased. Transferability, or ensuring that findings can be applied in multiple settings, was achieved by consistently tracking themes until data saturation was achieved, which was reached when novel codes or themes ceased in interviews (Forero et al., 2018).

Positionality Statement

The research was framed under constructivist and pragmatist lenses, acknowledging that while there are relevant guiding theories in this field which contribute to solving real-world barriers to care and treatment engagement, this research is still necessary to navigate the intersection between the relevant theories. I am an adult researcher who has not yet faced first-hand challenges seeking MH support as an older adult and has limited experience treating MH issues among older adults. Thus, I acknowledge that I may carry biases about older adults' and provider experiences of older adults. As a clinical psychology trainee, my clinical training experience to date follows a social model for treating MH disorders, and I am not being trained using a medical model to frame interventions. My research team is comprised of Dr. Corey Mackenzie, a clinical psychologist experienced in aging and mental health research and director of the Aging and Mental Health laboratory, Dr. Reece Ramkissoon, a geriatric psychiatrist with some experience administering qualitative interviews, Dr. Vishal Kaushik, a geriatric psychiatrist, and Dr. Lesley Koven, a gero-psychologist who works within the clinical health psychology sphere. I will also be supported by Drs. Valerie Krysanski and Kristin Reynolds, two figures in health and gerontology research and clinical practice. To buffer potential biases that the researchers hold, we worked collaboratively to analyze the data and to portray a balanced and nuanced view of provider perspectives on treatment engagement, while also ensuring that providers' unique views about the barriers they face are highlighted.

Results

The final framework included four main themes with corresponding sub-themes (see Figure 2; see Appendix E) that affect the treatment engagement process depicted in the shaded boxes in Figure 2. These themes build on Raue and Sirey's (2011) initial late life treatment engagement model (i.e., *Modifiable Individual Factors*, *Treatment Decision-Making Process/ Treatment Acceptance*, *Early Adherence and Treatment Participation*, *Outcomes*, and *Background Factors*). The four resulting major themes (i.e., (1) *Referral to Specialty MH*; (2) *Background Factors*; (3) *Pathway Navigation (modifiable)*; and (4) *Individual Patient Factors*) are discussed below. In addition, Table 2 provides a summary of the themes and subthemes along with sample quotes.

The current framework's themes and sub-themes act as barriers or facilitators to patient engagement depending on the presence or absence of the theme. The model, representing the treatment engagement process, begins before patients are referred to specialty care shown in the *Referral to Specialty MH* theme.

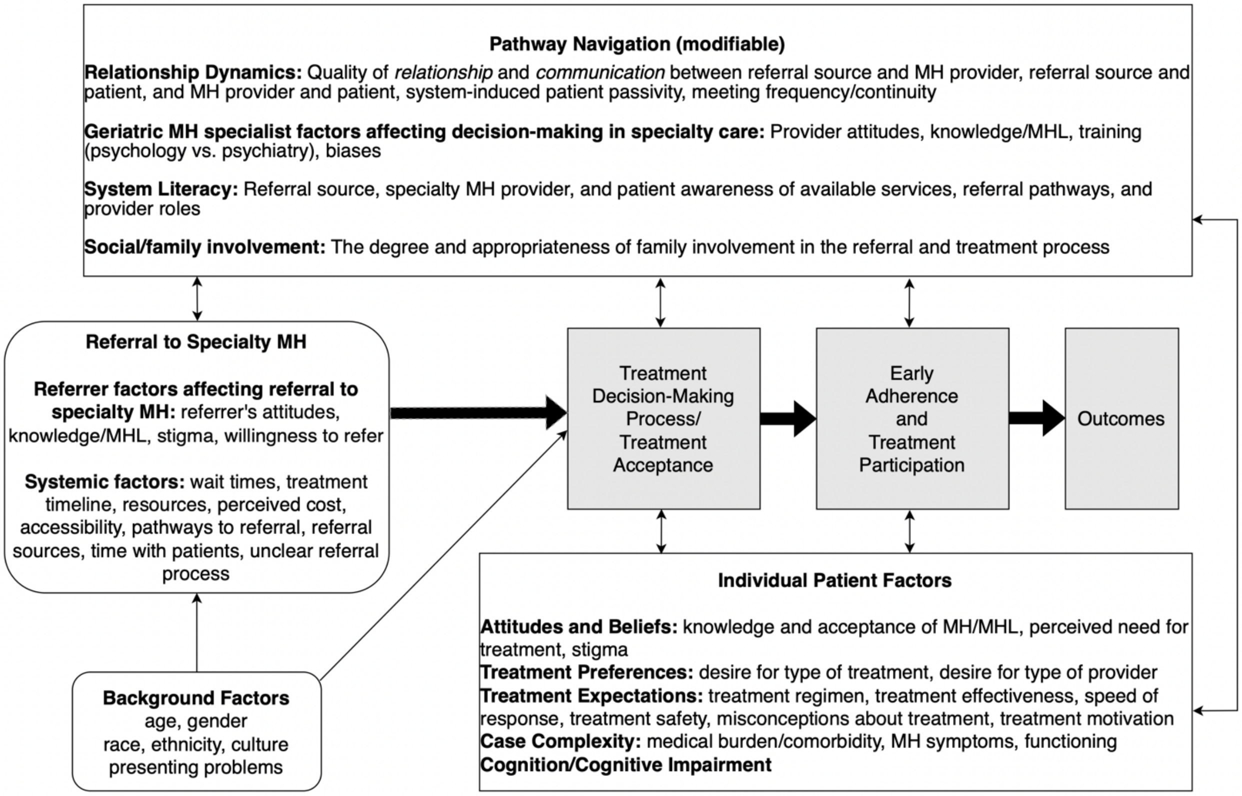

Figure 2. Provider Perspectives on Patient and Provider Roles in Mental Health Treatment Engagement Model

The model follows the process of treatment decision-making, treatment acceptance, early adherence to treatment, treatment participation, and overall treatment outcomes which are influenced by a patients' degree of treatment engagement, indicated by the bolded black arrows. The relationship between the four key themes and treatment decision-making, treatment acceptance, early adherence to treatment, and treatment participation are bi-directional, meaning that elements with bidirectional lines interact with one another during the treatment engagement process. It is important to note that saturation was also achieved in the model, meaning that the model represents all data from all participants, with referrer data focused more on the *Referral to Specialty MH* theme, specialty MH provider data focused more in the *Geriatric MH specialist* *factors affecting decision-making in specialty care* sub-theme, and participants contributing data fairly equally to the remaining themes and sub-themes.

Table 2

Emergent Themes and Corresponding Quotes

Theme	**Sample quotes**
1. Referral to Specialty MH	
1.1 Referrer factors affecting referral to specialty MH	
• 1.11 Referrer stigma and attitudes	P4 (Geri-Psychiatrist): “It's always better to refer if there is some kind of a concern regarding mental health, because I think that would hopefully eliminate some of that bias that some physicians may have that older adults don't improve, that they will not improve… There's a number of patients and families who say that their family doctor… just outright refuse to talk about it.”
• 1.12 Referrer knowledge/MHL	P2 (Geri-Psychiatrist): “Being available to the family doctor for questions is really important. I think that’s an important piece that providing just, in general, more psychoeducation regarding mental health in older adults will be good for family physicians as a whole.”
• 1.13 Willingness to refer	P4 (Geri-Psychiatrist): “Family physicians are sometimes very eager to send a referral to geriatric psychiatry, especially if there is some kind of primary mental health illness such as mood, anxiety, psychosis, things like that. Other times, I've heard some pretty heart-breaking stories that family doctors are not necessarily wanting to refer to psychiatry, or they think that it's not necessary to have a referral.”
1.2 Systemic Factors	
• 1.21 Wait times	P8 (Referrer: Neurologist): “Wait times are always a problem for people. They want to be seen sooner than later. Sometimes they forget about their referral, especially if they have cognitive problems.” P9 (Psychiatrist): “Probably for most of my career, our wait times were more like about four to six weeks, which was really an acceptable time. It only crept up… in the last year to what they are now.” P11 (Gero-psychologist): “In the geriatric world, if you can’t see somebody for a year, you are irrelevant. Older adults don’t buy green bananas for a good reason… I’m generally comfortable if my waitlist is around three months.”

• 1.22 System resources	P11 (Gero-psychologist): “The economic model is a barrier and will remain a barrier no matter what you do around it, as long as that doctor is motivated to spend no more than seven and a half minutes with the patient.” P7 (Geri-Psychiatry Resident): “You're talking more systemic, under-resourced, underfunding of mental health in general. Lack of, for example, mental health covering psychology, it’s outside of hospital setting.”
• 1.23 Accessibility	P10 (Geri-Psychiatrist; on patients accessing care via GP): “People who don’t have primary care providers are a potentially large unmet-need population… I think that would be a group that we wouldn’t be seeing because there’s no mechanism to capture them.” P11 (Gero-psychologist): “Better to continue to serve the geriatric network that knows how to get to us… Does that mean some patients might have less-ready access to us? Yes. Is that an ethical problem? Yes. Is opening the door and not being able to see anybody in less than three years, is that an ethical problem? Yes, as well. So, every decision you make is an ethical problem in terms of how you manage the availability.”
• 1.24 Pathways to referral	P10 (Geri-Psychiatrist): The [GP] is the anchor and is the most important part… If there is a strong [GP], … I think that referral system works pretty well. I think if you directly refer to a specialist, … the care is [fragmented] and not holistic.”
• 1.25 Time with patients	P6 (Referrer: GP): “I have an overstuffed practice… I try to give them the time, but there’s absolutely this thing going in my head about, well, I’ve got to get through this, to the next patient as soon as I can.” P7 (Geri-Psychiatry Resident): “Even if you allow for two hours, sometimes it might not be enough… the trade-off is less people get seen because you're putting all your resources toward one patient. It's a balance.”
• 1.26 Unclear referral process	P3 (Psychologist): “There's too many entry points. It can lead to confusion for referral sources, but also for patients, like patients who might be referred to me who are on [other geropsychologist]’s waiting list and they don’t even realize that we are part of the same service.” P8 (Referrer: Neurologist): “I don’t know. Tell me who to refer to and I’ll do it.”
2. Background Factors	
• 2.1 Demographic characteristics (i.e.,	P6 (Referrer: GP): “I have very few men who are looking for help for depression or anxiety. They’re just not open about it, in the geriatric population… referrals for the men tend to be more of a capacity question, whereas women are much more open.”

age, gender, race/ ethnicity)	P4 (Geri-Psychiatrist): “In terms of race… certain times, there's a level of [mistrust] with physicians, and I've had that a few times with patients who are First Nations, but they are open with me about it. They'll tell you like, doc, I don't trust you because of X, Y and Z, because of my background, my this and my that. But you talk to them about it and you're able to come to an understanding and able to have them engage in treatment.”
• 2.2 Culture	P2 (Geri-Psychiatrist): “Oftentimes, certain other cultures, often when they see a physician, … whatever the physician says, that they agree with it… They don’t want to question the physician.”
• 2.3 Presenting problems	P2 (Geri-Psychiatrist): “Things change when you actually see the patient, but it was helpful to know, just the stressor, the precipitants that could be interpreted into to the presentation.”
3. Pathways Navigation (modifiable)	
3.1 Relationship Dynamics: Quality of relationship and communication between:	
• 3.11 Referral source and MH provider	P4 (Geri-Psychiatrist): “There’s a [lack] of information that's provided by whoever is doing the referral. Sometimes a family physician may refer to psychiatry and give one sentence about what the issue might be, and may say something like, please assess anxiety and give no further history.” P11 (Gero-psychologist): “He feels free to just call me. So that’s optimal, right? It doesn’t have to be formalized. In fact, the informal is actually more useful to the patient. He’s an OT in a geriatric program assessment team, not even the mental health wing of it, but he feels free to call me and just say, what do you think? Would you be willing to see this person?”
• 3.12 Referral source and patient	P7 (Geri-Psychiatry Resident): “Sometimes referrals do happen in primary care where someone might do it because they're concerned about the patient. And perhaps it's not disclosed… And a patient might get a call… she really wasn't expecting psychiatry, wasn't sure why she was there.” P2 (Geri-Psychiatrist): “They’re the gatekeeper… a lot of these patients have long-term relationships with family physicians. I think that it’s important for the family physician to continue with that engagement too.”
• 3.13 MH provider and patient	P8 (Referrer: Neurologist): “I think you have to connect with the patient. If the patient didn’t feel like they connected with the psychiatrist, then they’re probably not going to follow their advice. They probably won’t see them again.”

• 3.14 System-induced patient passivity	P10 (Geri-Psychiatrist; on cognitive impairment): “They’re a passive passenger… things are said about them and things are done for them or to them without a lot of people wanting it done or seeing it as an issue.” P2 (Geri-Psychiatrist): “[Patients often say:] You're the expert and I’ll go along with whatever you say and my opinion doesn't matter as much as what you think… They want to be a good patient.”
• 3.15 Meeting frequency/continuity	P7 (Geri-Psychiatry Resident): “When you provide follow-up, there is that additional time to spend talking with them to engage them… a one-time consultation, there really isn’t engagement beyond that.”
3.2 Geriatric MH specialist factors affecting decision-making in specialty care	
• 3.21 Provider attitudes, knowledge, MHL	P10 (Geri-Psychiatrist; attitudes towards patient preferences and psychotherapy): “I think there’s stigma about psychotherapy. It’s seen as extra work, it’s seen as not as effective as pills, not as scientific, not as reliable.”
• 3.22 Provider training (psychology vs. psychiatry)	P11 (Gero-psychologist): “Psychology is a discipline, which means that you in graduate school are learning a way to think. And over there in medicine, they’re being taught a way to think. They both have their use, but they are dramatically different… my medical colleagues are much more fix-it and solution and prescriptive. And my psychology colleagues, a little more tentative, a little more qualitating.”
• 3.23 Provider biases	P10 (Geri-Psychiatrist): “It presupposes a fair amount of agency, and agency is variable with patients. As you age, there’s a certain… loss of [agency], a loss of the initiative, a loss of the ability to mentalize… If all you’ve got is a mood disorder, I think you’d be fine with it. If you were struggling with your executive function, you would be overwhelmed by the process.”
3.3 System Literacy	
Awareness of available services, referral pathways, and provider roles by the:	
• 3.31 Referral source	P7 (Geri-Psychiatry Resident): “…some people [just] reach out to certain psychiatrists they might have used in the past.” P8 (Referrer: Neurologist): “I’m sure a lot of my patients would benefit from psychological follow-up, but I’ve never done that, and I didn’t know that was an option and I wasn’t sure that there were the resources for that either.”

• 3.32 Specialty MH provider	P9 (Psychiatrist): "I don't think psychologists need referrals to see geriatric patients. Geriatric patients can call them directly and see them directly and pay their fees directly. There are people who do some geriatric psychology within the system. There're quite long waits for those."
• 3.33 Patient	P1 (Geri-Psychiatrist): "You'll have patients who come thinking they'll going to have a psychiatrist the rest of their lives and they'll see you weekly… at least in my practice, probably anywhere between 50% of them it's one-time consultations with recommendations for the family doctor, maybe a referral to other services."
3.4 Social/Family Involvement	
The degree and appropriateness of family involvement in referral and treatment process	P7 (Geri-Psychiatry Resident): "When people feel supported that they have someone on their side that comes to the appointment, that they'll support them to help them understand things to provide different perspectives. I think that can go a long way, especially if it is a healthy and supportive relationship, which may not always be the case." P2 (Geri-Psychiatrist): "Oftentimes, you see family members saying, hey Mom, hey Dad. You need to see a psychiatrist when the patient doesn't think that they need one."
4. Individual Patient Factors	
4.1 Attitudes and Beliefs	
• 4.11 Knowledge and acceptance of MH/MHL	P7 (Geri-Psychiatry Resident): "Knowledge is power… the more people know about something, … the more comfortable they'll be." P10 (Geri-Psychiatrist): "People who are psychologically minded are more likely to benefit from psychotherapy." P4 (Geri-Psychiatrist): "One of the things that pops up probably most frequently… 'I don't talk to people anymore. I don't talk to my friends anymore.' When I ask them, why don't you talk to your friends? 'Because they're going to find out that I'm really anxious or that I'm quite depressed.'"
• 4.12 Perceived need for treatment	P9 (Psychiatrist): "There're people that are advocating for themselves and asking for the service. Those ones are obviously very engaged and very motivated and trying to seek resources. And then at the other end of the spectrum… no matter what you do, you're not going to be able to engage them in a process where they don't see themselves as having a problem."
• 4.13 Patient stigma	P8 (Referrer: Neurologist): "I've offered psychiatry referrals to patients and they've said, no. I suspect that that's a stigma thing, where they don't want to be seen by a shrink."

	P11 (Gero-psychologist): “There has been so much done to destigmatise mental health… When I ask my colleagues, both in psychiatry and psychology, why do we get so many referrals now?... And the answer I get from every colleague is, we have actually managed to destigmatise this darn process.”
4.2 Treatment Preferences	
• 4.21 Desire for type of treatment or provider	P1 (Geri-Psychiatrist): “It depends on the severity of illness, whether or not you're going to incorporate preference or not, but if you can it's very important.” P2 (Geri-Psychiatrist): “Half the time we see patients that come in that just don’t want medication. They say, I’m here, but I just don’t want to take any medications.” P1 (Geri-Psychiatrist): “There are only one or two female geriatric psychiatrists I can think of. The supply-demand thing and access to care that would really impair it.”
4.3 Treatment Expectations	
• 4.31 Treatment regimen, Treatment effectiveness, Speed of response, Treatment safety	P10 (Geri-Psychiatrist): “I think it would be useful to temper people’s expectations maybe, temper their expectations of pills, and maybe try to improve the image the public has of what psychotherapy can do.” P6 (Referrer: GP): “I walk them through that, explain the pros and cons, the side effects, the expectation that it won’t be immediate, and then in five to six weeks, we’ll see.”
• 4.32 Misconceptions about treatment	P7 (Geri-Psychiatry Resident): “Some people might understand that it is generally meant to be a one-time consultation with recommendations. Some people think they're being referred for counseling, for example, or further follow-up. Perhaps there is some misunderstanding.” P1 (Geri-Psychiatrist): “A lot of them have ideas in their head about what a psychiatrist is, what a psychiatrist does, and that goes back to how psychiatrists can be portrayed in the moves and media. They see themselves lying on a couch. There are people who literally think you're going to talk to them once a week and do in-depth dynamic psychotherapy… Some people can be disappointed.”
• 4.33 Treatment motivation	P1 (Geri-Psychiatrist): “If they more engaged in their treatment, they're probably motivated to get better, and they probably are going to get better from a mental health standpoint.” P3 (Psychologist): “They're engaged because they understand what they're there for and they’ve opted to do that. They’ve made the choice to proceed with full understanding of what they were signing on for.”

4.4 Case Complexity	
4.41 Medical burden/comorbidity	P11 (Gero-psychologist): "Often, I can be helpful but in a way that's different from what the referral requests, and that's part of geriatric psychology too. This isn't really anxiety, it's Parkinson's."
4.42 MH symptoms	P11(Gero-psychologist): "Diagnosis of personality disorder. A lifetime of treatment that has been not effective for various reasons, whether it be patient-related reasons or system-related or clinician-related reasons."
4.43 Patient functioning	P10 (Geri-Psychiatrist): "It may look like psychosis or mood or some other psychiatric manifestation but at the core it's usually cognition in the people that will be coming your way if you're seeing my patients. But to be fair and give the person the benefit of the doubt, you try to fix the fixable."
4.5 Cognition/Cognitive Impairment	P8 (Referrer: Neurologist): "I tried to give them a clear idea but some of them are cognitively impaired. Sometimes it takes a long time for them to be seen, so they don't even remember what the problem was in the first place." P10 (Geri-Psychiatrist): "Most of the people that I see have cognitive issues, overwhelming, probably 95% of people."

1. Referral to Specialty MH

Most interviews included factors within referral sources and the healthcare system that affect whether patients are appropriately engaged in specialty MH treatment. Shown in Table 2, referrer factors (see 1.1) and systemic factors (see 1.2) capture these referral impacts on treatment engagement (i.e., factors which impact the referral process and patient engagement during referral). Regarding systemic factors impacting referral and treatment, participants reported that while many care providers could be referrers, most of those who refer were GPs in primary care, and GPs anchored the referral and treatment process (see 1.24). Providers agreed that specifically for geriatric patients, it is crucial for wait times to be minimal because both old age and cognitive abilities can contribute to time-sensitive patient needs and to a provider's ability to keep patients engaged in the process. At the same time, most agreed that geriatric referral wait times were reasonable across provider services (i.e., psychology, psychiatry, specialty providers) at around two to three months. Some providers suggested that wait times increased due to the COVID-19 pandemic and worried that wait times would continue to increase in the coming years; one noted that in the treatment timeline, engagement must take place as soon as possible, in some cases, even before the referral in the referrer's office (see 1.21). Many providers highlighted multiple pathways to referral (see 1.24), though many noted that knowledge of these pathways varied among patients and providers. Providers frequently discussed an unclear referral process for patients and providers, perpetuated by "too many entry points" (see 1.26) and unclear directions for referrers. While referrers agreed that geriatric psychology and psychiatry were easier to refer to compared to non-geriatric services (e.g., short waitlists, straightforward paperwork to navigate), a common worry among GPs/referrers and specialty MH providers surfaced pertaining to topics including resources, time with patients, perceived cost, and accessibility. Many agreed that the MH system is currently fragile, leading to a delicate balance between proliferating information to everyone which may lead to an influx of referrals and bloated wait times, or maintaining a somewhat inaccessible system (see 1.23). Some participants attributed this strain to insufficient care providers, limited resources and time with patients, and underfunded geriatric MH and primary care services (see 1.22, 1.25): "I… don't just indiscriminately [refer] people, because I don't want to be part of the problem of overloading the system until it breaks," – P6 (Referrer: GP).

Factors such as referrer knowledge, attitudes, stigma (e.g., ageism), and willingness to refer can either promote or impair appropriate referrals and engagement. Both referrers expressed attitudes which were mainly in favour of psychiatry rather than psychology referrals for their older patients:

> "I don't use the psychology component of the geriatric world as much as I would for the younger patients. I'll be completely honest. I almost never refer to psychology in the geriatric population. I probably should, but I don't." – P6 (Referrer: GP)

Meanwhile, one specialty MH provider emphasized the importance of providing additional psychoeducation for referrers to improve their MHL regarding mood-related presenting problems and interventions (see 1.12). Further, some MH providers shared mixed reports about referrers' stigma towards older adults' ability to overcome MH symptoms and their subsequential willingness to refer (see 1.11, 1.13). While some noted that GPs/referrers may be less willing to refer because they feel capable of treating symptoms in primary care, there was concern that some may have decided not to refer patients due to stigma.

2. Background Factors

The *Background Factors* theme, and corresponding subthemes (i.e., *age*, *gender*, *race/ethnicity*, *culture*, and *presenting problems*), describe how a patient's individual background factors may influence their ability to engage in treatment. Namely, many participants suggested a potential cohort effect for older adults related to knowing how to understand and express their MH (e.g., MHL; see 2.1), such that older patients' inexperience exploring and talking about their MH may act as a barrier to treatment engagement:

> "There's also definitely a cohort effect. Some generations are more open to the idea, the concept of health being in different spheres, including mental health. And then some are not." – P5 (Geri-Psychiatrist)

Providers also noted that presenting problems, including the nature of the symptoms, stressors, and precipitants should be considered when deciding how to engage patients (see 2.3). While providers had mixed perspectives on the influence of gender on treatment engagement (i.e., ranging from no influence to strong gender-specific experiences), most agreed that cultural context was a stronger predictor of engagement and treatment acceptance. Many participants also shared unique experiences treating minority cultural, ethnic, and racial groups (see 2.1, 2.2). They highlighted some groups' tendencies to be more passive in the decision-making process, potentially leading to poorer treatment engagement than more active patients and noted that there may be some degree of mistrust among BIPOC patients during treatment. Providers suggested the importance of patient-centred care to minimize barriers that background factors may pose (see 2.1).

3. Pathway Navigation (modifiable)

The *Pathway Navigation* theme includes subthemes which contribute to patient, referrer, or provider experiences navigating the referral and treatment process, and that contribute to the quality of patients' engagement. Across all participants, relationship dynamics and communication between parties were regarded as integral aspects of patient engagement with the referral and treatment process with strong influences on treatment outcomes (see 3.1). Most participants identified some shortcomings in these dynamics, between the referral source and MH provider (see 3.11), the referral source and patient (3.12), and the MH provider and patient (3.13). General findings were consistent, suggesting that weaker therapeutic alliances and communication between providers and patients led to less trust and motivation for treatment, and participants reported that patients were anxious and dissonant when they felt they were not informed of the process (see 3.13). Providers reiterated the important role of the GP in gatekeeping specialty treatment and in being a strong long-term support to patients (see 3.12). This role was reinforced by the consistent reported importance of continuity of care for treatment engagement and motivation among older patients (i.e., providing follow-up; see 3.15). Participants noted a key difference between referrals to psychiatry that are typically one-time consultations versus referrals to psychology that are typically for psychotherapy. The relationship and quality of communication between providers was compelling, as participants shared contradicting perspectives on provider relationships (see 3.11). The presence of strong relationships and communication between providers enhanced patient engagement, while the absence of strong relationship dynamics was a barrier to engagement. While one participant praised their strong informal communication within their hospital-based practice (i.e., strong collaboration and inter-provider relationships; see 3.11), most specialty MH providers and referrers reported not receiving sufficient communication from one another (i.e., poor communication in referral letters and reports). Thus, poor communication and relationship dynamics was largely a barrier to engaging patients across providers. Further, preferences for type of communication varied between a formal referral process and a more informal process. Overall, the subtheme, system-induced patient passivity, emerged subtly but frequently in the data. Participants cited this subtheme, sometimes referred to as paternalism in the data, as a major barrier to engagement because patients tended to expect and accept paternalistic care (i.e., the provider making expert decisions on behalf of the patient). Participants also highlighted paternalism in how patients responded to being engaged:

> “Especially in the geriatric world, is people who are used to a more, how do you say it, I guess parental… An expectation that they’re going to be told what to do, because that’s how it was when they were younger and that’s just how they’ve always operated. And when I ask them certain things, like, well, what do you think, they say, well, I don't know, you’re the doctor.” – P6 (GP)

Especially in the older age cohort, providers reported that their patients were less open to questioning their suggestions or engaging treatment discussions due to a culture of paternalism in healthcare throughout older patients’ lifetimes. Lastly, participants reported that paternalism was somewhat embedded into clinical and medical training in the past, leading to providers occasionally withholding information from patients or feeling compelled to make decisions without consulting older patients (see 3.14).

Geriatric MH specialist factors affecting decision-making in specialty care included their attitudes, knowledge/MHL, training (i.e., psychology or psychiatry), and biases (see 3.2). Overall, attitudes, knowledge, and biases tended to coincide with providers' training experiences and work environments. Across participants, providers' training tended to impact attitudes and knowledge/MHL (see 3.23). MH service providers tended to prefer interventions which they had the most training to provide. Participants suggested that psychiatrists take a solution-oriented approach to treatment and engagement with a tendency towards pharmacotherapy, and psychologists tend to lean towards longer-term interventions such as psychotherapy (see 3.22).

System literacy (i.e., referral source, specialty MH provider and patient awareness of available services, referral pathways, and provider roles) represents patients', referrers', or specialty MH providers' knowledge of and ability to interact with and navigate services (see 3.3). This subtheme emphasizes the part of MHL focusing on how patients (with the help of referrers and providers) navigate health systems (Jorm, 2000). System literacy reflects the system-level aspect of Jorm's MHL definition that is normally under-emphasized as it focuses on the crucial role that service awareness plays in one's sense of confidence interacting with the care system, as a provider or as a patient. Findings showed somewhat mixed beliefs about available services, referral pathways, and provider roles across referrers, specialty MH providers, and patients. Specifically, some specialty MH providers held inaccurate beliefs about geriatric psychology service availability and accessibility (e.g., patients can self-refer to geriatric psychology; see 3.32). Participants also shared that many patients were unsure of psychiatrist and psychologist roles, how to find providers, and what resources are available to them for support (see 3.33):

> "A lot of my patients have never seen a psychologist or mental health professional before. They muddled along to find me… They often don't know anything about what I'm going to do or what my role is, what differentiates me from a psychiatrist. I do spend a lot of time at the beginning… assessing what they do understand." – P3 (Psychologist)

Similarly, referring physicians/GPs had varied system literacy, but many were not provided with sufficient resources to navigate complicated MH systems with their patients (see 3.31). For example, one referrer was not aware of the possibility to refer to psychology or the referral pathway to psychology. Additionally, some participants observed that many GPs simply referred to specialists whom they were aware of despite centralized intake processes or provider fit.

Social/family involvement describes degree and appropriateness of family involvement in the referral and treatment process (see 3.4). Every participant emphasized the importance of assessing patient preference for family involvement, and most agreed that family involvement in treatment was positive for engagement when the relationship was supportive and loving. However, some providers highlighted the importance of confidentiality during family involvement, and that strained family relationships may present a barrier to positive engagement. Some participants also noted that family involvement was often expected in a caregiver capacity for patients with cognitive impairment (i.e., caregivers follow treatment progress, arrange medications, and help explain treatment to older adults), however, family involvement for patients with mood and anxiety issues required careful attention to confidentiality, as patients may want more independence and keep issues to themselves and not burden or worry family.

4. Individual Patient Factors

Participants discussed issues grouped into five subthemes related to patient factors that may facilitate or inhibit treatment engagement (i.e., *Attitudes and Beliefs*, *Treatment Preferences*, *Treatment Expectations*, *Case Complexity*, and *Cognition/Cognitive Impairment*). This theme includes both individual factors what are potentially modifiable (e.g., attitudes and beliefs), and those that may not be (e.g., cognition/cognitive impairment).

The attitudes and beliefs subtheme refers to evaluations about seeking help and treatments for MH problems (attitudes) that are affected by information that people have (beliefs; see 4.1; Fabrigar et al., 2005). The data highlighted MHL and patients' acceptance of their symptoms as strong influences on engagement and outcomes (see 4.11). Specifically, providers believed that MHL (i.e., "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention"; Jorm, 2000) influenced patients' sense of comfort in treatment, their ability to be psychologically minded during referral and treatment, and their willingness to accept and confide in loved ones about their symptoms. A patient's perceived need for treatment was commonly referred to in relation to MHL (see 4.12). Some providers explained that patients who were not psychologically minded, had poor MHL, or were cognitively impaired were the least likely to perceive a need for treatment. All providers shared at length about patients harbouring stigma about their own symptoms and about their providers' roles and treatments (see 4.13). Patients' internalized stigma often surfaced as self-criticism (e.g., "I am weak", "I am crazy", "I am a failure") or as embarrassment and shame around telling others, as exemplified by a geri-psychiatry resident's perspective on how their patients feel about needing to seek help:

> "The fact that I need to go to psychiatry. Especially going back to attitudes or perceived stigma, have I failed in something? Am I not strong enough? Those factors too that might

> be, perhaps in older generations, more strongly felt to some of those beliefs." – P7 (Geri-Psychiatry Resident)

Some participants shared that patients had stigmatized views about MH care (e.g., psychiatrists are "shrinks"). Conversely, one provider highlighted significant progress in relation to destigmatizing MH that has resulted in increased referrals to specialty MH care.

Pertaining to treatment preferences (see 4.2), providers generally agreed on the importance of respecting patients' preferences for treatment type; however, there was some dissonance between which treatments were preferred and which were provided. One psychiatrist cited the importance of respecting preferences until a patient's presenting problems became too severe, and about half of providers stated that patients preferred psychotherapy to pharmacotherapy for mood-related symptoms:

> "Some people don't want to take medications for depression. They're looking maybe for psychotherapy." – P9 (Psychiatrist)

However, most psychiatrists noted that they tended to prescribe medications for older adults with mood disorders as a first line of treatment. Regarding preferences for a type of treatment provider (e.g., specific gender, culture, race/ethnicity, etc.), most participants noted that preferences were not that common, and one provider explained that limited providers/resources may lead some difficulty honouring these preferences for certain providers (see 4.21).

Providers' perspectives on patients' treatment expectations were generally consistent (see. 4.3). While providers explained that most patients' preferences were in favour of consistent psychotherapy, some providers shared that patients still expected medications to be prescribed, and they often even expected their prescriptions to be a "magic bullet" for their mood-related symptoms (see 4.31). Thus, providers suggested clarifying expectations at the outset of treatment, and tempering patients' expectations about treatment regimens, effectiveness, response time, and safety to ensure these expectations do not become a barrier to engagement. Most participants also reported that patient misconceptions about treatment can pose a major barrier to patients attending and engaging in treatment (e.g., “if I'm going to see a psychiatrist, it must mean that I'm going to be hospitalized,” – P7). Lastly, most participants recognized motivation as a strong facilitator of patient treatment engagement, adherence, and overall outcomes (see 4.33; Jochems et al., 2012).

Case complexity (see 4.4) as an individual patient factor describes the complex clinical presentations that result in referrals to specialty MH, including medical burden or comorbidity (i.e., multiple chronic or complex conditions; see 4.41), the nature of patients’ MH symptoms (see 4.42), and how these presentations impact a patient’s overall functioning (see 4.43). Providers reported that among geriatric patients seeking treatment for mood-related problems, their symptoms may be attributed to other complex neurocognitive disorders such as dementia or Parkinson’s disease. One provider pointed out that regardless of these complex presentations, patients’ functioning is high priority, noting that providers have a responsibility to “try to fix the fixable” (see 4.43).

Cognitive impairment was regarded as a common and complex individual patient factor in treatment spaces (see 4.5), as providers explained that most of their patients have some degree of cognitive impairment. Across all providers, cognition was intertwined in most treatment and engagement considerations. Providers discussed the tendency for greater treatment engagement when cognition was not impaired, but that it is less common to see patients for mood-related disorders who have no degree of cognitive impairment:

> “I would say the ones that are cognitively well, are completely engaged. And the ones that are having troubles with cognitive impairment, they’re engaged in the extent that they’re capable of being engaged, but quite often they’re needing someone to assist them with the process.” – P9 (Psychiatrist)

Providers also reported that patients with cognitive impairment often struggle to understand why they were referred for treatment, and impairment sometimes led to different treatment expectations and misconceptions about treatment. Thus, assumptions were often that patients experiencing moderate to severe cognitive difficulties were not capable of being engaged in treatment or treatment-related decisions.

Potential Interventions

In addition to discussing their perspectives on the treatment engagement model, interviews ended with a discussion of ideas and opportunities related to interventions to enhance engagement with limited resources. Appendix D provides methodological information pertaining to interventions, as well as a summary of results from the summative content analysis quantifying the types and frequencies of interventions mentioned. The most widely suggested interventions were low-intensity psychoeducation interventions including handouts with eight suggestions (i.e., a pamphlet for patients about referral and treatment process with additional resources). Other forms of suggested psychoeducation included videos (two suggestions), MH education via media or radio show (two suggestions) and providing psychoeducational resources to help referrers engage and provide care to patients (five suggestions). Interventions which providers pitched to help mitigate the strain of resources in the care system included or at-home and virtual interventions (e.g., cognitive behavioural therapy groups with seven suggestions, or MH scales for patients to complete with one suggestion) or stepped care (e.g., single-session psychotherapy; three suggestions). Introducing a nurse practitioner liaison was also widely suggested (seven suggestions) specifically to complete pre-screenings or intakes for patients or take patient histories (seven suggestions), make phone call reminders about appointments (seven suggestions), and answer questions and follow-up with patients (four suggestions). While not as feasible as other suggestions, collaborative care interventions were suggested, including introducing collaborative care teams to treat patients with a range of presenting problems (two suggestions). One provider did report the difficulty of implementing a “team approach” due to strained resources, but that it would be worthwhile to advocate for this approach for patients’ overall engagement and streamlined communication between providers. Improving communication between allied health providers was also suggested (four suggestions) by sending letters on a timelier schedule or even introducing more multidisciplinary communication system, as well as ways to refine the current referral paperwork (three suggestions). Implications of these interventions will be discussed broadly in the context of the study.

Discussion

This study synthesized a range of perspectives from 11 care providers across the geriatric mental health treatment system. Findings supported past related research on barriers to treatment engagement including poor MHL (Jorm et al.,1997; Jorm, 2000; Wei et al., 2015), unawareness of service pathways and poor confidence navigating these pathways (Funk, 2019), tensions between paternalism and patient autonomy (Fernández-Ballesteros et al., 2019; McKinnon, 2014), the influence of a fragile care system on patient treatment (Fredheim et al., 2011) and poor provider-patient relations (McGilton et al., 2018), and the burden of tight resources on GPs and referring physicians (Reeve, 2015). The results also highlighted the pervasiveness of comorbidity and cognitive impairment in geriatric treatment spaces and the unique challenges that these complex symptoms present (Cristancho et al. 2018), and how providers’ training differences (Graham et al., 2014) and nuances in family involvement (Schulz, 2016; Thomas et al., 2017) may lead to varied treatment engagement and outcomes for patients. Further, the most widely suggested interventions methods that participants mentioned to address these issues were those that improved communication between parties (e.g., liaison/nurse-practitioner; Kappelin et al., 2023) and those that provided knowledge and education to all parties (e.g., handouts for GPs and patients, preventative programs, system literacy and MHL psychoeducation; Cleland et al., 2006; Fortuna et al., 2017). Noteworthy comparisons between the current theoretical framework and Raue and Sirey's (2011) original late life treatment engagement model are explored. Interpretations and implications of these key findings are also discussed below, as well as strengths, limitations, and future directions for this body of research.

MHL and System Literacy

Participants agreed that patients, referrers, and providers required strong MHL, which includes system literacy, to navigate referral and treatment pathways. MHL resides within each of the actors in the current model (i.e., the referrer, individual patient, and geriatric MH provider) but system literacy appears to be a neglected aspect of MHL since the data suggested that system literacy plays a crucial function in pathway navigation. As previously stated, Jorm's original definition of MHL is the "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" (Jorm et al., 1997). The definition includes (a) one's ability to recognize specific types of psychological distress or MH disorders; knowledge and beliefs about (b) symptom causes and risk factors; (c) interventions; and (d) available professional help, as well as one's (e) attitudes that facilitate recognition and help-seeking; and (f) knowledge about how to seek MH information (Sampaio et al., 2022). Jorm's definition focuses on knowledge and beliefs of psychological symptoms and about causes, risk factors, interventions, and how attitudes facilitate help-seeking. However, knowledge about what help is available and where to access this information tends to be minimized in the MHL literature.

Further, knowledge about how to navigate the care system once patients have already sought help is not addressed in the literature frequently (Wei et al., 2015).

System literacy is a term which encapsulates criteria (d) and (f) in Jorm and colleagues' original MHL definition (Jorm et al, 1997; Pereira, 2017). A case can be made to better define knowledge about the care access and navigation process within the original MHL definition. Though Jorm applied his original MHL definition in a follow-up article exploring help-seeking knowledge and awareness of available treatments (Jorm, 2012), the definition still did not include one's knowledge on how to navigate these service options beyond having knowledge of them. Both the results and supporting literature suggest that it is often challenging to navigate the care system for older adults with mental health problems even if they have some awareness of their options (Berard et al., 2020). Further, providers suggested in interviews that fragmentation in referral and treatment pathways has led to gaps in providers' system literacy, especially for referrers and GPs. Thus, when older patients transition between services, referrers, patients, and specialty providers may have difficulty navigating these systems together because of patients' complex presenting problems and challenges in communication between each party (Funk, 2019; Kappelin et al., 2023; Manderson et al., 2011; Ryvicker, 2018; Valaitis et al., 2020). The results suggest that access to geriatric psychology as a referral option was less well known to psychiatrists and referrers compared to geriatric psychiatry (Arai et al., 2012). The literature also supports participants' speculation that there is a lack of resources to address gaps in GPs' and referrers' knowledge about MH treatment options and pathways (Franz et al., 2010; Nymoen et al., 2020). However, there is currently limited research supporting participants' speculations about knowledge and accessibility within and outside of geriatric care.

Cognitive Impairment and Comorbidity

Study findings and supporting literature suggested that cognitive impairment and comorbidity are commonplace among older patients seeking healthcare (Cristancho et al. 2018; Frost et al., 2019; Sirey et al., 2020). Care providers reported that cognitive impairment and comorbid diagnoses can complicate the referral and treatment process especially among older adults, which can lead to confusion and poorer treatment engagement (Kappelin et al., 2023; Shippee et al., 2012). Some literature suggests a link between cognition and common MH symptoms such as anxiety (Maloney et al., 2014), meaning that a patient's cognitive abilities may further impact their treatment engagement due to elevated anxiety or other MH symptoms. Another study suggested that alternatively, older patients with anxiety and depressive symptoms reported more difficulty processing cognitive information (Beaudreau & O'Hara, 2009). There was a general belief among most study participants that cognitive impairment was the chief predictor of and barrier to patient engagement. Some providers also spoke about how it can be unproductive or too difficult to engage patients who are cognitively impaired in the decision-making process because they have difficulty following and remembering treatment conversations. The assumption that patients with cognitive impairment are more difficult to engage is supported by some literature (Choi & Twamley, 2013; Cubit, 2010). Thus, providers may approach treating mood symptoms among patients with cognitive impairment differently than patients without cognitive impairment.

It is important to explore how barriers to engaging patients with cognitive impairment can be overcome and the implications of this difference in engagement. First, various studies on involving patients with dementia in making care decisions suggest that despite having cognitive impairment, patients had better mood-related outcomes when their preferences were actively attended to (Fetherstonhaugh et al., 2013). Further, shared decision-making that involves collaboration between older patients, providers, and caregivers (e.g., speaking directly to the patient with cognitive impairment instead of to a caregiver) led to better quality of life and sense of personhood despite poor memory of the decision-making process (Groen-van de Ven et al., 2017). Therefore, engaging patients with cognitive impairment may have alternative utility in improving emotional well-being. Engaging patients with comorbidity or cognitive impairment requires additional effort, which may feel unrealistic to overburdened providers and poses additional challenges within a system with significant resource and time limitations (Damarell et al., 2020). However, doing so will likely lead to better treatment outcomes overall, so feasible and sustainable solutions are crucial. Patient cognitive impairment is also likely related to the push and pull between paternalism and patient autonomy described below, with paternalistic attitudes towards patients more evident when patient cognition was poorer.

Paternalism, Autonomy, and Provider-Patient Relations

Interviews portrayed the nuanced relationship between paternalism and autonomy, with participants reporting that patients' MHL informed their sense of autonomy and empowerment, preferences, involvement in decision-making, and a passive attitude toward treatment that likely engenders paternalism on the part of providers (e.g., "my doctor knows what is best"). It is important to note that this system-induced passivity is not an individual factor for patients or providers, but more often was presented as a result of earlier models of care which were internalized. Related literature on both health literacy and MHL support the notion that the more knowledge an individual has access to, the more confident and empowered they will feel to develop informed treatment preferences and make informed decisions (Fernández-Ballesteros et al., 2019; Jorm, 2012; Schulz et al., 2021). The move away from paternalism and towards patient-centred treatment with a shared decision-making approach is a trend which surfaced in the data and in the literature (McKinnon, 2014). Despite some research advocating that patient autonomy and empowerment leads to better treatment engagement, the perspectives in the literature and in the current data were more nuanced. One study suggested that in some situations where patients might not currently have the capacity to make informed treatment decisions (e.g., a patient in psychosis or with cognitive difficulties), taking a paternalistic approach may actually support future autonomy (Sjöstrand et al., 2013). Another study which analyzed the relationship between patient autonomy and paternalism suggested that the relationship between autonomy and paternalism is a spectrum. Exclusively promoting patient autonomy in decision-making can lead to poor treatment outcomes, similar to providers taking an exclusively paternalistic approach (Sandman & Munthe, 2010). Shared decision-making involves providers hearing and respecting patient preferences while maintaining a balance of what is best for treatment outcomes. Thus, the aim is to remain flexible on the autonomy-paternalism spectrum, sometimes leaning more toward the autonomy end of the spectrum and sometimes toward paternalism, a balance which takes time and can be difficult for providers with limited time and resources.

In terms of treatment adherence and outcomes, there was some contention about how and why patients adhered to treatments after beginning them. Providers speculated that only about 50% of patients adhered to pharmacotherapy, leading to poor treatment outcomes among those patients. Although pharmacological treatments can be provided more quickly and to a larger number of patients in comparison to individual psychotherapy, a large body of literature highlights that pharmacotherapy is generally less preferred, leading to treatment adherence problems (Bastiaens et al., 2007; McHugh et al., 2013; Wuthrich & Frei, 2015). Resource limitations in the system are at least partly responsible for why pharmacological treatments are much more accessible, in the context of the current study (i.e., the two hospitals that were recruited from have two gero-psychologists and five geri-psychiatrists). It is possible that providers' prescription of medications may be perpetuating a sense of passiveness because patients' preferences are not always considered like they had hoped.

Provider-patient relationships are complex and vary across the care system. It appears that the strongest relationships are fostered through continuity in care, attentive listening, and honouring patients' preferences or directly explaining to patients why preferences may not be honoured (Kappelin et al., 2023). It may be worthwhile to explore how providers navigate treatment and preferences for patients with severe MH and cognitive symptoms and in what circumstances it may be worthwhile to honour preferences despite symptom severity. While it is true that honouring patient preferences normally leads to elevated trust within the therapeutic relationship and improved treatment engagement and outcomes over time (i.e., shared decision-making among complex older patients; Drake et al., 2009), there are situations in which patient preferences should not or cannot be honoured.

Fragile System and GP Burden

The importance of continuity and shared decision-making on treatment engagement and outcomes speaks to the gravity of having a touchpoint for older adults, in this case, a primary care provider, referrer, or GP. Participants explained GP roles as the "home base" for patients receiving mental health treatment. For pharmacological treatment, primary care is typically where patients are referred back to with treatment plans, and most agreed that GPs hold some responsibility to work with their patients on adhering to these plans (Schöpf et al., 2018). While many specialty MH providers emphasized the importance of GPs in initiating and mediating the MH treatment process, the current results and past research reveal that GPs are burdened by strained resources (Bagayogo et al., 2018; Hermens et al., 2014; O'Neill, 2023). Most components of the referral and treatment process (e.g., systemic factors such as patients' access to stable GPs/family care, time with patients, wait times, pathways to referral, and pathway navigation factors such as meeting frequency/continuity) are driven by resource availability and supply and demand, and are impeded by the strained care system. Supporting literature suggests that GPs, acting as "expert generalists" (Reeve, 2015), often feel frustrated and overloaded, rarely having the ability to see their patients after their appointment with specialty MH (Damarell et al., 2020; Ploeg et al., 2017). Participants in this study reported a similar narrative, that not only do specialty providers rely on GPs assuming responsibility for their older patients' treatment, but GPs felt a similar sense of responsibility to not burden specialty MH providers with their difficult patients (e.g., "that would be unfair to put that on a group of people who've never met this person before" – P6, GP). Participants also spoke to the issue of GPs not being compensated enough for the management work that they do, considering the limited resources that they have access to (Ploeg et al., 2017). Likewise, current sources suggest that many patients cannot access GPs right now because primary care access is becoming increasingly limited to the public (Holloway et al., 2020; Tasker, 2023). Many providers also cited the fear of "breaking" the fragile care system if there was an increase in referral rates.

Provider Training and Shared Understanding via Communication

To mitigate the burden that strained resources places on GPs and other referrers, the literature recommends communication and collaboration between providers across the treatment system to improve knowledge about MHL and pathway navigation, and relationships between providers (Fredheim et al., 2013; Kappelin et al., 2023; Kates et al., 2011). Improved communication can lead to a shared understanding of what patients' needs are, the barriers to those needs, and how providers are faring with their complex older patients. Strong inter-disciplinary provider relationships/collaborative care is known to lead to better care for patients, and likely, improved treatment engagement (Fredheim et al., 2011; Goodrich et al., 2013). In a qualitative study exploring GPs' and hospital-based MH specialists' shared understanding about when patients require referral to specialized MH care (i.e., when MH concerns can no longer be addressed by the patient's GP), researchers found that a large portion of rejected referrals suggest that there is an unclear definition of 'need for specialized MH care' (Nymoen et al., 2020). Thus, it appears that although patient need is often assessed based on functioning and informal resources/supports that patients have access to, assessment based on these characteristics is often complex and open to varied interpretation by GPs and specialty MH providers (Nymoen et al., 2020). Further, strong collaboration and communication not only within the specialty MH system, but also between GPs and specialty providers is crucial to ensure shared understanding since participants suggested that GPs are currently left out of this communication loop. These findings also support the current results which call for streamlined communication about patient needs and where such resources (e.g., psychiatry versus psychology) should be allotted. While these calls for improved communication are sensible and important, it is important to acknowledge that they are difficult to implement within the currently strained care system.

One of the main utilities of communication across providers is to bridge the gap in knowledge and training that each type of provider has (i.e., psychologist, psychiatrist, GP, other specialty providers). Interviews with providers revealed clear differences in models of training between psychology and psychiatry that influenced patient engagement and treatment outcomes. One key distinction which arose was the different treatment approaches which providers took. Consistent with prior research, psychiatrist providers working within the biologically focused medical model tended to provide biological treatments, whereas psychologist providers working within a primarily psychosocial model tended to provide talk therapy (Hogan, 2019; Pingitore et al., 2002). There are several explanations for psychiatrists' medical treatment perspectives. With limited resources, sometimes the best line of defence is the cheapest and least time-intensive (i.e., diagnosing a disorder and prescribing medications with limited follow-ups). Further, one research team found that most psychiatrists in their qualitative study did not view their role as a psychotherapist as importantly as their role in diagnosing and prescribing medications (Mohtashemi et al., 2016). Therefore, it seems that although psychiatrists and referrers in the study understood that sometimes psychopharmacology is not optimal, demanding schedules and limited time with patients led to consistent prescribing. Participant preferences for type of referral and communication also varied based on training experience and the sector which providers worked in. For example, those who worked on a geriatric team were near other providers and may prefer an informal approach to consultation. Perspectives on what type of communication was best within the treatment system also differed (i.e., formal referral process through centralized intake, or a more informal, "call up a colleague" approach). It is possible that this preference varies based on training experiences, however some research suggests that GPs prefer formal referral and communication processes as they simplify the referral process, especially for those who do not know specialty providers personally (Chong et al., 2013). Though more research is required in this area, it is possible that elements of collaborative care involving informal, consistent communication between providers with a range of training experiences will increase the breadth of knowledge and improve attitudes for both psychiatrists and psychologists when treating older patients with comorbid physical and mood-related issues.

Family Involvement

Study results reflected the nuances in family involvement in pathways from referral to treatment, with cognitive impairment, overall patient functioning, and family members as caregivers or social supports playing a role in this involvement. Findings also showed that patients varied in the degree to which they wanted to have family involved. Most providers specified that patients with cognitive impairment normally had family members involved in the treatment process, often acting as a caregiver in addition to providing emotional support. Conversely, participants shared that patients who were more autonomous were more concerned with being independent and maintaining confidentiality, which is consistent with previous literature (Veras, 2020). Providers reported that patient preferences and individuals' relationships with family members determined their acceptance of family involvement. It appears that for both patients with and without cognitive impairment, self-sufficiency beliefs and internalized stigma about the diagnosis and seeking help for it pose a threat to treatment engagement and including family in the process (Cahill et al., 2009; Conner et al., 2010; Mackenzie et al., 2010; Robb et al., 2003). However, providers sometimes preferred having family members involved in treatment because they served a dual role of remembering and tracking the patient's treatment progress, explaining treatment decisions, and providing some comfort during treatment. Research suggests that complex family dynamics can have strong effects on patient treatment outcomes for mental health concerns (DiMatteo, 2004). Thus, the range of responses related to family involvement suggests that family involvement can either help or hinder patient engagement depending on the nature of the family relationship. This finding adds a layer of complexity for providers who, must remain mindful of family relationships to optimize patients' capacity to be engaged. Family members are often responsible for regulating one another's behaviours, and strained relationships may increase stress whereas supportive relationships may decrease it (Thomas et al., 2017). Past research suggests that social support is positively linked to both perceived effectiveness of the treatment and overall treatment engagement and satisfaction (Lippens & Mackenzie, 2011; Meis et al., 2013). There are apparent gaps in the family and MH literature relating to how family members provide emotional support separate from caregiving roles. Some providers suggested that patients who have strong support systems are less likely to develop mood disorders in late life, but more research is still required.

Comparing Theoretical Frameworks

The data in this study resulted in key changes to Raue and Sirey's (2011) original late life treatment engagement model. The original model involved background factors and modifiable individual factors as major facilitators of treatment engagement during treatment decision-making, treatment acceptance, early adherence and participation, and treatment outcomes. From the viewpoint of the providers in the current study, two themes required minor modifications (i.e., changes to the *Background Factors* and *Individual Patient Factors*, previously *Modifiable Individual Factors*) and two themes that were not part of the original model were added (i.e., *Referral to Specialty MH* and *Pathway Navigation (Modifiable)* themes). *Treatment Decision-Making Process/ Treatment Acceptance*, *Early Adherence and Treatment Participation*, and *Outcomes* are also de-emphasized in the new model as these original themes did not surface alone in the data, but rather they were part of the referral and treatment process and were influenced by other themes. An important distinction is that the original 2011 framework's perspective was specifically patient-centred, whereas the current model incorporates patient, referrer, and specialty MH provider factors.

Referral to specialty MH. The *Referral to Specialty MH* theme was expanded to encapsulate the systemic factors affecting referral (e.g., accessibility and cost) which were considered background factors in the original model. These elements were moved to this theme because background factors in the current model describe patient factors which provide context during referral and treatment (e.g., presenting problems, culture), while systemic factors reflect elements of the system which impact referral to and treatment in specialty MH (e.g., accessibility and cost). Additionally, the subtheme *Systemic Factors* also absorbed the pathways to referral which the original framework alluded to (e.g., depression identified by community worker or health care professional, depression self-identified by older adult), which are now pathways to referral and referral sources in the current model. The other prevalent subtheme which was added was *Referrer factors affecting referral to specialty MH*. Interviews from this study added nuance to this part of the process as participants described the complex experiences that referrers have relating to their own attitudes, MHL, stigma, and willingness/ability to refer their patients.

Pathway navigation (modifiable). The *Pathway Navigation* theme was one of the most noteworthy additions to the original 2011 model, including *Relationship Dynamics*, *Geriatric MH Specialist Factors*, *System Literacy*, and *Social/Family Involvement* subthemes, which are also entirely new additions to the model based on the data and past treatment engagement literature (Cristancho et al. 2018; Sirey et al., 2020). *Relationship Dynamics* was one of the most prevalent additions within pathway navigation as the data showed that it greatly impacts patients', referrers', and MH providers' experiences navigating treatment and service access together. Further, *System Literacy* was introduced as an extension of communication and shared understanding among patients, referrers, and MH providers, and is another novel subtheme. As previously discussed, the importance of highlighting system literacy in Jorm's MHL definition is useful for future interventions which should target referrers', patients', and specialty MH providers' system literacy specifically. Finally, considering the breadth of literature highlighting the complex roles of patients' family members and social supports during referral and treatment (i.e., older patients often do not navigate the treatment process alone; Beatie et al., 2020), the original 2011 model did not accommodate the family involvement piece. Thus, introducing family involvement as a key factor in facilitating pathway navigation and engagement during the pathway navigation process filled this gap in the original model. Further, literature such as the network episode model describes help-seeking as a dynamic social process which involves family and social supports as major collaborators with providers and patients (Pescosolido, 1991; Pescosolido et al., 1998; Pescosolido and Boyer, 2010). This research showed that patients' experiences often depended on the social relationships that the patient closely held. In the case of older adults receiving referrals for MH treatment, the network episode model conceptualizes treatment engagement as a process influenced by the older adult's social networks, rather than an isolated individualistic process. Adding the family involvement theme acknowledges the nuance of family involvement, as described in the network episode model, in a way that the original model missed. It also points to the need for both system-level interventions and individual-level interventions to address the problems with engagement in a comprehensive and meaningful way.

Individual patient factors. The *Individual Patient Factors* theme remains present in both the original and new frameworks, but the current integrates non-modifiable patient factors with the original modifiable factors. The original 2011 framework identified *Attitudes and Beliefs*, *Treatment Preferences*, and *Treatment Expectations* as modifiable factors because they can be largely changed with psychoeducation (Raue & Sirey, 2011). However, new individual factors added to the model (i.e., *Case Complexity* and *Cognition/Cognitive Impairment*) are non-modifiable individual factors which impact patient engagement greatly but are not easily improved using external means. Nonetheless, their addition to the current model provides a realistic representation of what many older individuals seeking MH treatment present with. Furthermore, both models include an *Attitudes and Beliefs* subtheme, however, while Raue and Sirey focused on attitudes and beliefs about depression, my subtheme incorporated MHL and expanded beyond depression to other common MH issues. There were some changes to the *Treatment Expectations* subtheme as well, including the addition of *Treatment Motivation* and *Treatment Misconceptions*. Both misconceptions and motivation consistently surfaced in participant interviews and in relevant literature, suggesting that they may significantly facilitate treatment engagement (Jochems et al., 2012; Jochems et al., 2017; Shields et al., 2014). Finally, *Case Complexity* and *Cognition/Cognitive Impairment* are new subthemes which importantly impact a patient's ability to engage in treatment. Nearly every participant in the current study spoke about the significance of patient functioning, often in the context of cognitive ability, and how one's functioning influences their degree of engagement in treatment decisions and ability to adhere to treatments (Cristancho et al. 2018). Further, cognitive impairment was one of the most commonly mentioned barriers to treatment engagement, emphasizing the addition of cognitive impairment as a critical change to the previous model based on the data. The likely assumption by Raue and Sirey was that their model focused on depression treatment among older adults without cognitive impairment. However, the data suggested that cognitive impairment surfaced as an issue that providers were mindful of even when the referral was not for cognitive impairment specifically. Thus, including these subthemes in the final model provides a comprehensive image of the most common barriers to patients and providers while navigating treatment. Additions and changes to the original model inform important potential interventions to address the barriers highlighted in these themes.

Treatment decision-making, acceptance, early adherence, participation, and outcomes. These factors which were presented as themes in the original Raue and Sirey (2011) framework were intertwined with, and determined by, the presence or absence of the four major themes in the model. Regarding treatment decision-making and acceptance, providers reported that some patients wanted to be more involved, and others simply were not interested in active decision-making either due to cohort-related beliefs about healthcare (i.e., paternalistic views; social influences on pathways to treatment: relationship dynamics), or because making decisions felt overwhelming and confusing due to cognitive impairment (i.e., individual patient factors). The time-consuming nature of engaging patients in decision-making (i.e., lack of time with patients; systemic factors) was also intertwined with engagement in decision-making. Treatment adherence and participation was often influenced by patient preferences (i.e., individual patient factors), the quality of the relationship and communication between MH providers and patients (i.e., social influences on pathways to treatment: relationship dynamics), and provider training (i.e., psychology versus psychiatry; social influences on pathways to treatment: geriatric MH specialist factors affecting decision-making in specialty care). The data suggested that psychiatrists tended to see patients for one-time medication consults, whereas psychologists tended to see patients for ongoing psychotherapy. Not surprisingly, these providers also stated greater adherence and participation in talk therapy. Treatment outcomes were strongly influenced by a patient's motivation for treatment (i.e., treatment expectations; individual patient factors), such that treatment outcomes were exceedingly positive when treatment motivation and patient buy-in was present.

Interventions

The issues raised by this study are rooted in a significant lack of mental health resources for providers and patients (systemic factors), combined with referrer, MH provider, and patient attitudes, beliefs, MHL, and system literacy. The focus of this study was on understanding factors that either facilitate or are barriers to treatment engagement. Although interventions to address these factors were not a focus of this study, many participants did discuss ideas for enhancing engagement. Most of the suggested interventions for addressing patient engagement highlighted the importance of options that were feasible and sustainable, focusing on maximizing limited resources to improve communication and system navigation for GPs, specialty MH providers, and patients. The most widely suggested interventions were those that improved communication between parties (e.g., liaison/nurse-practitioner) and those that provided knowledge and education to all parties (e.g., handouts for GPs and patients, preventative programs, system literacy and MHL psychoeducation). Providers also suggested versions of stepped care and prevention resources such as at-home interventions, single-session psychotherapy, cognitive behavioural therapy groups, and psychoeducation via the media to mitigate the burden that treatment has on healthcare resources (Boyd et al., 2019; Egan et al., 2021; Hermens et al., 2014).

A key suggestion which was consistent with supporting literature is the addition of psychoeducation for GPs, specialty providers, and patients about MHL and system literacy/navigation. Psychoeducation directly impacts MHL, attitudes, beliefs, and expectations (Brijnath et al., 2016). Previous studies found that not only did psychoeducation in the form of handouts, videos, and web-based applications improve patient stigma and attitudes towards mental health, it also reduced loneliness among older adults which often leads to improved mood-related symptoms (Al Mahmud et al., 2022; Amatrudo, 2018; Beaunoyer et al., 2019). Providers also suggested that psychoeducation could be delivered using multiple modes of information sharing to maximize patients' awareness, including radio shows and online courses. A similar psychoeducation intervention which was suggested by some participants was to implement a resource guide for GPs and specialty providers about common patient issues, how to navigate complex patient problems, and when or where to refer when GPs require added support. By providing this information, GPs will likely have the confidence and support needed to manage complex patients with mood-related disorders (Laufer et al., 2023).

The most widely suggested intervention to improve patient engagement and inter-provider communication was integrating a nurse-practitioner/liaison into the referral and treatment process. This suggestion was also popular in past literature (Kappelin et al., 2023; Knight, 2010; Sirey et al., 2020), serving as an additional support for patients and providers. The liaison could conduct intake meetings, take patient histories, provide brief, low-intensity interventions before patients are seen, and follow-up with patients. Participants also suggested using a liaison to help patients navigate through the treatment information that they received, to call patients with reminders about appointments, and to act as a go-between for providers across the care system. While this intervention is widely supported and the need for a liaison within the referral and treatment process is apparent, limited resources (e.g., no space in-clinic, too many patients, etc.) impede its implementation (Kumar et al., 2020; Spagnolo et al., 2022). Multiple psychiatrists mentioned that they once had a nurse-practitioner filling this liaison role, but the position ended due to funding cutbacks. This is one example of a necessary and effective treatment engagement intervention that can be sacrificed within strained systems.

Strengths and Limitations

Key strengths and limitations are present in the study. Namely, findings in this study advanced Raue & Sirey's model in several important ways including expanding on the definition of MHL with the definition of system literacy, acknowledging the important role of cognition in late-life specialty MH treatment engagement, expanding the framework to treatment for all mood-related disorders instead of only depression, and adding to the data on engagement during the referral process in primary care. A strength during data analysis was maintaining rigor. The analysis process included collaboration between four co-researchers at multiple time points to compare codebooks for half of the transcripts. These strengths and these novel participant perspectives provide an opportunity to translate this knowledge into interventions which benefits not only patients, but referrers and specialty MH providers too. One important limitation in this study was the narrow pool of GPs and referrers which were recruited (i.e., two out of 11). Although data was collected from a breadth of referrers, administering more interviews with GPs could have enriched the information about GPs' experiences navigating the referral process. Furthermore, there were barriers recruiting GPs to participate in this study such that it was difficult to contact and coordinate with GPs specifically, likely a testament to their overloaded schedules which the data alluded to. Another sample limitation may have been the distribution of psychologists and psychiatrists in the data. While having more psychiatrists than psychologists in the sample is a fair representation of the greater hospital-based care system, the data did reveal differences in training. These differences in training may have skewed participant responses related to knowledge, MHL, attitudes and beliefs within their practice. There were also potential limitations presented by the recruitment method used. Because the research team received contacts for referrers to psychiatry from psychiatrists and contacts were not collected from gero-psychologists due to resource constraints, the information collected on referrers' awareness of pathways to treatment may have been skewed towards psychiatry. For example, referrers may know more about referring to psychology if collecting contacts from psychologists had been possible.

Some methodological considerations may include limitations to data collection and analysis. Namely, two co-researchers conducted interviews for this study. While there are some benefits to using multiple interviewers to collect qualitative data (e.g., neutralizing potential biases that one interviewer may have; Boutain & Hitti, 2006; Matteson & Lincoln, 2009) and semi-structured interviews somewhat mitigate discrepancies in interviewing styles, multiple interviewers may still present some limitations. For example, the second interviewer did not have access to the first interviewer's field notes which detailed potential biases and impressions in the first half of interviews. I attempted to mitigate this limitation by keeping notes on potential biases present in the first set of interviews and by collaborating with co-researchers to ensure that the analysis was balanced and fair. Despite the potential limitations in this study, findings have strong implications on the treatment engagement literature. Implications and potential future directions for this research are discussed below.

Implications and Future Directions

Findings from this study highlight the importance of considering referrer, patient, and provider factors to better engage older patients with MH concerns that are significant or complex enough to warrant referral to specialty MH care. Focusing on older adults' relationships with providers while navigating the treatment process may expand treatment engagement research. Findings also answer important questions about how patients can best be supported and engaged during treatment, and how referrers and specialty MH providers can facilitate this support with limited resources. This study importantly underscored a lack of resources and psychoeducation for GPs and patients, and a generally limited supply of available MH providers to see older patients with complex concerns. Identifying gaps in knowledge about MH and service navigation for patients and providers highlights the need to create feasible and sustainable interventions to supplement the referral and treatment process. Another implication of the results points towards the importance of finding ways to meet older adults' preferences for psychological treatments when the resource balance swings heavily toward pharmacotherapy, such as low-intensity psychological treatments (this can be a future intervention; Boyd et al., 2019; Egan et al., 2021; Vincent et al., 2021).

Future studies can further investigate GP perspectives on engaging older adults before referring them to specialty MH providers. Exploring the impact of differences in training among psychiatrists and psychologists on older patients' treatment experiences and engagement would be an important future direction as well. Related to patient-provider relationships and the patient passiveness to autonomy spectrum, future research could explore ways of encouraging older patients to be less passive in the treatment process and potential moderators of patient passiveness in treatment spaces. After discovering varied perspectives on family relationships and involvement in older patients' treatment, the distinction between family involvement for emotional support and family involvement in the caregiver role is still unclear. Future studies could explore the nuances in family involvement in treatment by eliciting patient perspectives and preferences. Lastly, developing MH service navigation literacy tools for older adults and their GPs is a relatively unexplored future direction. Recent studies and the current findings stated the need to implement system navigation tools for older adults with complex mood-related and comorbid symptoms (Carter et al., 2018; Valaitis et al., 2020; Vos et al., 2018). Additional research is still needed to understand and address gaps in patients' and providers' knowledge of services being provided (Boling, 2009; Golden et al., 2010). Thus, exploring the feasibility of a system literacy intervention would be worthwhile for both older patients and their GPs. Reducing treatment barriers for older adults is crucial. By clarifying how providers support older adults and navigate treatment with them, we can translate this knowledge to feasible future interventions and be one step closer to minimizing barriers to engagement so patients can receive the treatment they desire and require.

Conclusion

Varying perspectives arose related to the barriers and facilitators to older patients' treatment engagement. Providers generally agreed that referrers were burdened by systemic barriers, that pathway navigation, system literacy, relationship dynamics, and family support were integral to engagement, and that all parties faced internalized stigma, poor MHL, and biases during the referral and treatment process which impacted decision-making. Overall, the *Patient and Provider Roles in Mental Health Treatment Engagement Model* is a sufficient framework to describe the complex barriers and facilitators to treatment engagement that patients and providers face. Implications of these findings call to the importance of creating accessible interventions for both patients and providers to improve communication and shared understanding across treatment. Implementing necessary interventions can ensure that patients remain engaged and confident in the treatment they receive. Implications of these findings highlight potential ways to improve access to effective MH care for large and growing numbers of older adults.

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Appendix A

Consolidated criteria for reporting qualitative studies (COREQ): 32-item list (Tong et al., 2007)

No Item	Guide Question/Description
<u>Domain 1: Research team and reflexivity</u>	
Personal Characteristics	
1. Interviewer/ facilitator	Which author/s conducted the interview or focus group?
2. Credentials	What were the researcher's credentials? E.g., PhD, MD
3. Occupation	What was their occupation at the time of the study?
4. Gender	Was the researcher male or female?
5. Experience and training	What experience or training did the researcher have?
Relationship with participants	
6. Relationship established	Was a relationship established prior to study commencement?
7. Participant knowledge of the interviewer	What did the participants know about the researcher? E.g., personal goals, reasons for doing the research
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? E.g., Bias, assumptions, reasons and interests in the research topic
<u>Domain 2: Study design</u>	
Theoretical framework	
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? E.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis
Participant selection	
10. Sampling	How were participants selected? E.g., purposive, convenience, consecutive, snowball
11. Method of approach	How were participants approached? E.g., face-to-face, telephone, mail, email
12. Sample size	How many participants were in the study?
13. Non-participation	How many people refused to participate or dropped out? Reasons?
Setting	
14. Setting of data collection	Where was the data collected? E.g., home, clinic, workplace

15. Presence of non-participants	Was anyone else present besides the participants and researchers?
16. Description of sample	What are the important characteristics of the sample? E.g., demographic data, date
Data collection	
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?
20. Field notes	Were field notes made during and/or after the interview or focus group?
21. Duration	What was the duration of the interviews or focus group?
22. Data saturation	Was data saturation discussed?
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?
Domain 3: analysis and findings	
Data analysis	
24. Number of data coders	How many data coders coded the data?
25. Description of the coding tree	Did authors provide a description of the coding tree?
26. Derivation of themes	Were themes identified in advance or derived from the data?
27. Software	What software, if applicable, was used to manage the data?
28. Participant checking	Did participants provide feedback on the findings?
Reporting	
29. Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? E.g., participant number
30. Data and findings consistent	Was there consistency between the data presented and the findings?
31. Clarity of major themes	Were major themes clearly presented in the findings?
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?

Appendix B

Interview Protocols

Protocol for Interviews with Health Care Professionals

1. Introduction, reminder of purpose of interview – to hear your perspective on whether it might be helpful to improve how we engage patients in the process of referral to geriatric psychiatry/psychology, and to see if you have ideas about whether and how we might do that.

2. I would like to begin by hearing about your understanding of the typical referral process into geriatric mental health services for patients struggling with a primary mood problem.
    a. Overall, what are your thoughts on how this process is working?
    b. How do you think patients are doing in terms of navigating this process?
    c. In what ways do you think this process is working well?
    d. What are some of the challenges that exist in the referral process? In what ways could this process work better?

3. I'm going to share a model of patient treatment engagement with you (share screen). I'll start by bringing your attention to the three boxes in grey with blue font at the top. These represent the typical steps when patients are first referred to specialty mental health services, they are then presented with treatments and need to decide whether to proceed, and the third box involves engagement with and adherence to the treatments that are started. [pause] I'll now bring your attention to the three boxes in white at the bottom that represent patient factors that could be assessed in order to enhance patient engagement in treatment decision making and treatment initiation. According to the model, engaging patients in terms of their attitudes, preferences, and expectations will affect the treatment decision-making process, enhance motivation and adherence to treatment. Importantly, engaged patients tend to have better treatment outcomes.

    [Throughout this next set of questions use probes to deepen the conversation, such as "What would that look like?", "Can you give me an example of that?", "Tell me more about that", "Have you seen that in other settings?"]

    a. Let me start with getting your initial impressions of this model before we get into specific about the various aspects of it?
    b. Now let me ask to what degree you think the patients you see are currently engaged in making decisions about treatment and starting them? Are patient attitudes, preferences, and expectations about treatment assessed and taken into consideration?
    c. Do you think that promoting patient engagement is something you, your colleagues, and others involved in the referral process here in your service would consider?
        i. Explore willingness & barriers.
    d. Now I'd like to walk through the various points in the process, beginning with referral and ending with the patient seeing the mental health professional.

i. Do you think patients have a clear idea of why they are referred? When do you think this might not happen? Are there things we could potentially do to improve that?
ii. Do you think patients have a sense of what might happen when they see the mental health professional? Can you discuss the potential benefits and drawback to patients in clarifying this? What about potential benefits and drawbacks for clinicians? How could this be improved?
iii. Most patients wait several months between being referred and being seen by a psychiatrist or psychologist. What are your thoughts on things that could be offered to patients during that wait time that could be helpful to them and to clinicians?

[Questions iv and v can be skipped for referring physicians]

iv. After the initial referral the model focuses on patient engagement in decisions about starting treatment by assessing their attitudes, preferences, and expectations for treatment. What do you think about this idea – what are the benefits and drawbacks to assessing this? Tell me your thoughts on when this might happen and how it could be implemented.
v. What about after treatment has started? The model suggests that engaging patients during treatment can lead to better adherence and participation. Are there things that could be done to enhance patient engagement at this point?
vi. Our research team is especially interested in methods of engaging patients that are feasible and sustainable. Of the various ideas we've discussed, are there some that seem more feasible and sustainable? What about in-person versus online or telephone methods of engagement? What about involving family members in this process?
vii. Finally, do you think that patient sex or gender needs to be taken into consideration with respect to treatment engagement efforts?

4. Thank you so much for your time and for your thoughtful approach to this interview. Before we close the interview, is there anything else you'd like to add concerning the referral process and ideas for engaging patients in this process? We are planning to do 10 to 15 of these interviews. Once they are completed and analyzed we will send you a summary if you requested that as part of the informed consent process. OK, thanks again for doing this.

Protocol for Interviews with Health Care Professionals
FAMILY DOCTOR VERSION

1. Introduction, reminder of purpose of interview – to hear your perspective on whether it might be helpful to improve how we engage patients in the process of referral to geriatric psychiatry/psychology, and to see if you have ideas about whether and how we might do that.

2. I would like to begin by hearing about your understanding of the typical referral process into geriatric mental health services for patients struggling with a primary mood problem.
    a. Overall, what are your thoughts on how this process is working?
    b. Is it clear that psychology and psychiatry referrals operate by separate streams?
    c. Do you consider certain criteria regarding whether you refer to either psychology or psychiatry?
    d. How do you think patients are doing in terms of navigating this process?
    e. In what ways do you think this process is working well?
    f. What are some of the challenges that exist in the referral process? In what ways could this process work better?

3. I'm going to share a model of patient treatment engagement with you (share screen). I'll start by bringing your attention to the three boxes in grey with blue font at the top. These represent the typical steps when patients are first referred to specialty mental health services, they are then presented with treatments and need to decide whether to proceed, and the third box involves engagement with and adherence to the treatments that are started. [pause] I'll now bring your attention to the three boxes in white at the bottom that represent patient factors that could be assessed in order to enhance patient engagement in treatment decision making and treatment initiation. According to the model, engaging patients in terms of their attitudes, preferences, and expectations will affect the treatment decision-making process, enhance motivation and adherence to treatment. Importantly, engaged patients tend to have better treatment outcomes.

    [Throughout this next set of questions use probes to deepen the conversation, such as "What would that look like?", "Can you give me an example of that?", "Tell me more about that", "Have you seen that in other settings?"]

    a. Let me start with getting your initial impressions of this model before we get into specific about the various aspects of it?
    b. Now let me ask to what degree you think the patients you see are currently engaged in making decisions about treatment and starting them? Are patient attitudes, preferences, and expectations about treatment assessed and taken into consideration?
    c. Do you think that promoting patient engagement is something you, your colleagues, and others involved in the referral process here in your service would consider?
        i. Explore willingness & barriers.
    d. Now I'd like to walk through the various points in the process, beginning with referral and ending with the patient seeing the mental health professional.

   i. Do you think patients have a clear idea of why they are referred? When do you think this might not happen? Are there things we could potentially do to improve that?
   ii. Do you think patients have a sense of what might happen when they see the mental health professional? Can you discuss the potential benefits and drawback to patients in clarifying this? What about potential benefits and drawbacks for clinicians? How could this be improved?
   iii. Most patients wait several months between being referred and being seen by a psychiatrist or psychologist. What are your thoughts on things that could be offered to patients during that wait time that could be helpful to them and to clinicians?

   [Questions iv and v can be skipped for referring physicians]

   iv. After the initial referral the model focuses on patient engagement in decisions about starting treatment by assessing their attitudes, preferences, and expectations for treatment. What do you think about this idea – what are the benefits and drawbacks to assessing this? Tell me your thoughts on when this might happen and how it could be implemented.
   v. What about after treatment has started? The model suggests that engaging patients during treatment can lead to better adherence and participation. Are there things that could be done to enhance patient engagement at this point?
   vi. Our research team is especially interested in methods of engaging patients that are feasible and sustainable. Of the various ideas we’ve discussed, are there some that seem more feasible and sustainable? What about in-person versus online or telephone methods of engagement? What about involving family members in this process?
   vii. Finally, do you think that patient sex or gender needs to be taken into consideration with respect to treatment engagement efforts?

4. Thank you so much for your time and for your thoughtful approach to this interview. Before we close the interview, is there anything else you’d like to add concerning the referral process and ideas for engaging patients in this process? We are planning to do 10 to 15 of these interviews. Once they are completed and analyzed we will send you a summary if you requested that as part of the informed consent process. OK, thanks again for doing this.

Appendix C

Five Stages of Framework Analysis (FA; Ritchie & Spencer, 1994)

(1) Familiarization

- Stage one consists of familiarization with each transcript and audio-recording to begin to search for developing themes. This stage ensures that researchers are knowledgeable of the data for the following stages.

(2) Identifying a thematic framework

- Stage two is identifying a working thematic framework based on recurring themes found in the data. Identifying themes and subthemes to construct a preliminary thematic framework can be done inductively (i.e., with novel themes which surfaced during familiarization) or deductively (i.e., based on an anchoring pre-existing framework and the related literature).

(3) Indexing

- Stage three, or indexing, involves using themes from the preliminary framework to qualitatively code the transcripts. This stage involves indexing the data into corresponding themes by assigning a code (i.e., a simple phrase/word) to lines within the transcript, then indexing each code into the preliminary themes and subthemes.

(4) Charting and summarizing

- Stage four involves arranging all indexed qualitative data into charts with headings and subheadings derived from the framework, including quotes and other related information in its original textual context. During this stage, themes are organized into a discernible order, and information from each theme is summarized.

(5) Mapping and interpretation

- Stage five involves mapping and interpreting the data based on key characteristics, such as grouping themes based on higher level similarities and analyzing how themes relate. Following this, themes and links between themes are interpreted with reference to the literature and a narrative is derived to explain relationships between themes.

Appendix D

Potential Interventions and Occurrences in the Data using Summative CA

Potential Interventions	Mentioned by X number of participants (N = 11)
1. Low-intensity Psychoeducation Options (on system literacy/MHL)	
• Pamphlets/handouts	8
• YouTube videos	2
• Radio/media marketing	2
• Resources for referrers	5
2. At-home/Virtual Interventions	
• Online CBT groups	7
• MH scales	1
3. Stepped Care	
• Single-session psychotherapy	3
4. Liaisons/Nurse-Practitioners	7
• Pre-screening/taking patient histories	7
• Appointment reminder calls	6
• Check-ins/follow-ups, answering questions	4
5. Collaborative Care/Improved Communication	
• Collaboration/teams treatment approach	2
• Improving comms between providers	4
• Refined referral forms	3

Appendix E

Patient and Provider Roles in Mental Health Treatment Engagement Themes

Referral to Specialty MH:

Referrer factors affecting referral to specialty MH

- Referrer's attitudes
- Referrer's knowledge/MHL
- Referrer's stigma
- Willingness to refer

Systemic Factors

- Wait times
- Treatment timeline
- Resources
- Perceived cost
- Accessibility
- Pathways to referral/Referral sources
- Unclear referral process

Background Factors

- Age
- Gender
- Race, ethnicity, culture
- Presenting problems

Pathway Navigation (modifiable):

Relationship Dynamics:

- Quality of relationship and communication between referral source and MH provider, referral source and patient, and MH provider and patient
- System-induced patient passivity
- Meeting frequency/continuity

Geriatric MH specialist factors affecting decision-making in specialty care:

- Provider attitudes
- Provider knowledge/MHL
- Provider training (psychology vs. psychiatry)
- Provider biases

System Literacy:

- Referral source, specialty MH provider, and patient awareness of available services and referral pathways, and provider roles

Social/Family Involvement:

- The degree and appropriateness of family involvement in referral and treatment process

Individual Patient Factors:

Attitudes and Beliefs:

- Knowledge and acceptance of MH/MHL

- Perceived need for treatment
- Patient stigma

Treatment Preferences:

- Desire for type of treatment
- Desire for type of provider

Treatment Expectations:

- Treatment regimen
- Treatment effectiveness
- Speed of response
- Treatment safety
- Misconceptions about treatment
- Treatment motivation

Case Complexity:

- Medical burden/comorbidity
- MH symptoms
- Patient functioning

Cognition/Cognitive Impairment

Treatment Decision-Making Process/Treatment Acceptance

Early Adherence and Treatment Participation

Outcomes