Treatment Engagement with Geriatric Psychiatry and Geropsychology Hospital Services: Patient Perspectives, Psychoeducational Pamphlet Development, and Patient Feedback

by

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ABSTRACT

Many Canadians, and older adults especially, do not seek mental health services when they need them. Older adults seeking mental health services face numerous psychological, social, and structural barriers. Not only are older adults less likely to utilize mental health services, but they are also less likely to accept and engage in offered interventions. Raue and Sirey (2011) proposed a theoretical treatment engagement model for older adults with steps including identifying mental health problems, referral to specialty care, and involvement in treatment. The overarching goal of this dissertation was to explore how engaged older adults felt during the process of referral to and treatment within specialty geriatric mental health services, to identify ways this process could have been improved, and to use the suggestions made by persons with lived experience to develop a brief method of enhancing treatment engagement. In Study 1, I conducted interviews with 13 individuals 65+ with depression, anxiety, and/or stress, who had been recently referred to specialty geriatric mental health services regarding how engaged they felt during this process and how engagement could have been improved. I analyzed the data using the framework analytic method and found four main themes of background factors, modifiable individual factors, social influences on treatment engagement, and opportunities for improvement. These themes supported and expanded Raue and Sirey's model to emphasize the role of mental health literacy, nuance concerning treatment preferences, and the dynamic and social aspects of the engagement process. Participants identified a number of opportunities to enhance engagement by improving mental health literacy. In Study 2, I employed a logic model to guide the development of a psychoeducational pamphlet for older adults referred to hospital-based geriatric mental health services. The pamphlet's content was guided by Raue and Sirey's treatment engagement model, interviews from Study 1, and psychoeducational resource recommendations. Finally, to ensure that patients' needs and preferences were accurately

translated into practice, Study 3 aimed to gather feedback from patients on this newly created pamphlet. In this third study, I conducted interviews (n=12) to explore patient feedback on the novel psychoeducational pamphlet and ways it may be improved. Using the framework analytic method, I coded themes of understandability, presentation, and accessibility of the pamphlet as well as themes related to overall usefulness and background factors influencing the perception of the pamphlet. Participants noted opportunities to improve the pamphlet's content and visual presentation. Notably, participants expressed positive reactions to the pamphlet while highlighting their preference that primary care providers share this information. Overall, findings from this research provide important and additive insight on treatment engagement in older adults and ways to improve this as expressed by individuals with lived experience.

Keywords: treatment engagement, aging, program development, psychoeducation, qualitative

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AUTHOR CONTRIBUTIONS

I, Ms. Del Rosario, M.A., am the primary contributor to Studies 1, 2, and 3. With respect to Study 1, in collaboration with my supervisor, Dr. Corey S. Mackenzie, I was responsible for the study design, literature searches, interviews, data analysis, and manuscript preparation. Dr. Mackenzie, along with Malissa Mailey, assisted with data analysis. Drs. Koven, Reynolds, and Furer provided feedback on the manuscript and gave valuable conceptual input. Geropsychologists Drs. Koven and Sexton, as well as geriatric psychiatrists Drs. Kaushik and Ramkissoon, assisted with recruitment. With respect to Study 2, I created the logic model, developed the pamphlet, and wrote the final manuscript. Drs. Mackenzie and Reynolds provided feedback on the manuscript and gave valuable conceptual input. With respect to Study 3, in collaboration with Dr. Mackenzie, I was responsible for the study design, literature searches, interviews, data analysis and manuscript preparation. Dr. Mackenzie and Dr. Krysanski assisted with data analysis. Geropsychologist Dr. Koven, as well as geriatric psychiatrists Drs. Kaushik, Bhangoo, and Ramkissoon, assisted with the recruitment of new participants. This work was supported by a Research Manitoba – Victoria General Hospital Foundation Research Operating Grant (Dr. Mackenzie) and a Social Sciences and Humanities Research Council (SSHRC) Doctoral Fellowship (Ms. Del Rosario).

Table of Contents

ABSTRACT ii
ACKNOWLEDGEMENTS iv
AUTHOR CONTRIBUTIONS v
LIST OF TABLES ix
LIST OF FIGURES x
CHAPTER ONE: General Introduction 11
Mental Health in Older Adults 11
Mental Health Service Use in Older Adults 13
Treatment Engagement 14
Theoretical Individual Factors of Treatment Engagement 16
Treatment Engagement Interventions 19
Limitations of Current Treatment Engagement Interventions 19
Overview of the Current Research 20
Positionality Statement 21
References 24
CHAPTER TWO: "Mental Health is a Mystery": Patient Perspectives on Treatment Engagement in the Referral Process to Specialty Geriatric Mental Health Services 33
Abstract 34
Introduction 35
Barriers to Accessing Mental Health Services for Older Adults 35
Barriers to Treatment Engagement 36
Research Objective 38
Methods 38
Participants and Recruitment 38
Data Collection Procedure 39
Analytic Procedure 39
Results 40
Sample Characteristics 40
Overview 41
Background Factors 42
Social Influences 44
Modifiable Individual Factors 47
Opportunities for Improvement 53
Discussion 54
Conclusions 58

References 59

CHAPTER THREE: Development and Description of a Psychoeducational Pamphlet for Older Adults Referred to Specialty Geriatric Mental Health Services 66

Abstract 66

Introduction 67

Methods 70
Participants 70

Logic Model 70

Discussion 79

Conclusion 81

References 83

CHAPTER FOUR: Feedback on a Psychoeducational Pamphlet about Geriatric Mental Health Services: A Qualitative Study 89

Introduction 90
Aims 93

Materials and methods 93
Participants and Recruitment 93
Procedures 94
Analytic Procedure 97

Results 98
Sample characteristics 98
Overview 99
Usefulness 100
Understandability 101
Presentation 102
Accessibility 103
Background Factors Influencing Perception of the Pamphlet 104

Discussion and Implications 106

References 113

CHAPTER FIVE: General Discussion 121

Research Summary 121

Impact of Positionality on Results 123

Clinical Implications 124

Limitations and Future Directions 133

Conclusion 137

References 139

Appendix A: Study 1 Request for Assent Script 147

Appendix B: Study 1 Recruitment Script 148
Appendix C: Study 1 Informed Consent Form 150
Appendix D: Study 1 Questionnaire 155
Appendix E: Study 1 Interview Protocol 157
Appendix F: Study 2 Request for Assent Script 159
Appendix G: Study 2 Recruitment Script – New Patients 160
Appendix H: Study 2 Recruitment Script – Previous Participants 162
Appendix I: Study 2 Informed Consent Form 164
Appendix J: Study 2 Questionnaire 169
Appendix K: Study 2 Interview Protocol – Previous Participants 175
Appendix L: Study 2 Interview Protocol – New Patients 177

LIST OF TABLES

CHAPTER TWO

Table 1. Sample Characteristics……41

CHAPTER THREE

Table 1. Overview of Pamphlet Content and Rational for Inclusion……74

CHAPTER FOUR

Table 1. Sample Characteristics……98

LIST OF FIGURES

CHAPTER ONE

Figure 1. Theoretical Treatment Engagement Model (Raue and Sirey, 2011) 15

CHAPTER TWO

Figure 1. Visual Representation of Geropsychology and Geriatric Psychology Patient Engagement ……...……43

CHAPTER THREE

Figure 1. Logic Model of Psychoeducational Pamphlet Development….……71

Figure 2. Psychoeducational Pamphlet for Older Adults Referred to Specialty Geriatric Mental Health Services……..78

CHAPTER FOUR

Figure 1. Psychoeducational Pamphlet for Older Adults Referred to Specialty Geriatric Mental Health Services…….96

Figure 2. Visual Representation of Patient Feedback on Novel Psychoeducational Pamphlet...100

CHAPTER ONE: General Introduction

Older adults, individuals aged 65 years and up, are a growing age group in Canada. The number of older adults in Canada is expected to increase from 4.7 million in 2010 to 9.9-10.9 million by 2036 (Statistics Canada, 2010). In fact, in 2016, the number of seniors surpassed the number of children aged 14 and younger in Canada (Statistics Canada, 2020). Of concern, mental disorders are the second leading cause of the global burden of disease, just behind cardiovascular disease (Vigo et al., 2016) and mental health concerns remain prevalent in later life (Almeida et al., 2012; Beekman et al., 2000; WHO, 2023). Given the growing number of older adults and the burden of mental health concerns, support for mental healthcare access and utilization is warranted.

Mental Health in Older Adults

Mental health is dynamic, changing in response to life stressors and, notably, with age. As the below dissertation often focuses on the sequela of mental health challenges in older adults, I first wish to place this in context, as research suggests many positive impacts on well-being with increasing age. In essence, I do not wish to present an unbalanced view of mental health in older adults but to provide a context to these difficulties within a greater pattern of increased well-being. Examining well-being across the adult lifespan, Blanchflower (2021) found a recurrent U-shaped pattern across participants from 145 countries. This "happiness curve" reflects a drop in life satisfaction occurring during mid-life that then improves with older age. In support of this pattern, Blanchflower and Graham (2022) re-examined data from 409 studies to find the support for this U-shaped trend. In line with these findings, several epidemiologic studies have reported a lower prevalence of mental disorders in older adults (Byers et al., 2010; Hasin et al., 2005; Reynolds et al., 2015). This trend has been

described as a "paradox" in that aging is generally associated with better mental health at the population level despite the loss of physical and cognitive functioning typically emphasized with aging (Thomas et al., 2016). Mackenzie and colleagues (2018) provide additional support for this pattern and suggest that despite multiple losses that are common in later life, aging is also associated with emotional benefits related to positive, eudemonic ways of living.

The trend of aging as being associated with improvements in mental health and well-being may be understood using the Strength and Vulnerability Integration (SAVI) theory (Charles, 2010; Charles & Piazza 2024). SAVI suggests that emotion regulation outcomes differ with age. Attentional strategies, appraisals, and behaviours to regulate emotional experiences are employed more frequently and successfully with age. These age-related strengths arise from changes in perspective gained from life experience and also from perspective of time left to live shaped by socioemotional selectivity theory (Carstensen et al., 2003). SAVI predicts that older adults are more likely to avoid or withdraw from stressful situations (Charles & Piazza, 2024). However, the theory posits that in the face of unavoidable stressors, strengths of aging are not able to mitigate these stressors and can result in decreased well-being. Charles and Piazza highlight three common age-related vulnerabilities which may lead to distress and psychopathology: social loss, exposure to chronic stressors, and neurological dysregulation. It would seem that older adults become more experienced and expert with emotion regulation strategies with age, and yet, the physiology of aging combined with life circumstances can impact their ability to utilize these strategies successfully.

SAVI (Charles, 2010; Charles & Piazza 2024) predicts that although mental health tends to improve across the adult lifespan, cumulative stress may outweigh the strengths in emotion regulation typically associated with aging. Consequently, depression and anxiety disorders

(Almeida et al., 2012; Beekman et al., 2000) and subsyndromal depression and anxiety (Laborde-Lahoz et al., 2015; Witlox et al., 2021) remain common in later life. The research literature therefore suggests that although older age tends to be associated with improved mental health, a subset of older adults who experience vulnerabilities in the form of chronic stressors will experience clinically significant mental health problems. These older adults tend to experience further mental health challenges with respect to seeking professional help.

Mental Health Service Use in Older Adults

Most individuals struggling with mood, anxiety, and substance use disorders do not seek professional treatment (Wang et al., 2007; Wang et al., 2023) and low service utilization becomes more prominent in later life (Crabb & Hunsley, 2006; Mackenzie et al., 2012; Volkert et al., 2018). Older adults are especially unlikely to seek mental health services as a result of a complex set of psychological, social, and structural factors (Eden et al., 2012; Lavingia et al., 2020). Many of these barriers prevent older adults with mental health problems from having those problems identified or treated. These include structural barriers that are especially likely to affect older adults, such as difficulty accessing and affording services (Pepin, 2009). Primary care physicians are often the first point of contact for individuals struggling with their mental health, but poor detection and low referral rates are notable for older adults seeking help for mental health problems in primary care (Park & Unützer, 2011). This trend may be related to the challenges of working with complicated comorbid physical and mental health concerns in a time-pressured environment (Bartels & Drake, 2005). Another factor affecting detection of mental health problems in primary care is that mental disorders often present differently in late life; older adults report a higher likelihood of worrying about the health and welfare of loved ones compared to younger adults (Gonçalves & Byrne, 2013). Furthermore, older adults are less likely

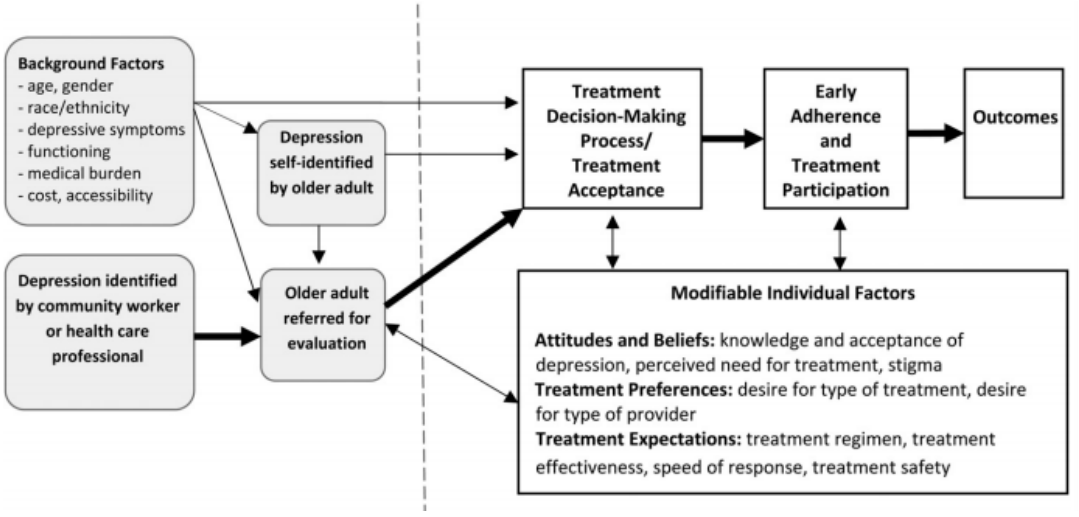
to report depressed mood but instead present with concerns of irritability, worry, somatic complaints, cognitive impairment, deterioration of self-care, social withdrawal, and paranoia (Sable et al., 2002). This is likely one reason why older adults describe their mental health symptoms as "mysterious, uncontrollable, dualistic, and somatic" (Reynolds et al., 2020; p.1525).

Treatment Engagement

Even for those fortunate to navigate the numerous barriers to mental health services (e.g., accessibility, cost, poor detection, low referral rates), treatment engagement emerges as another barrier to receiving evidence-based mental health care. The literature does not consistently define engagement in mental health treatment (Kim et al., 2012) although it often includes elements of client dropout, skipping sessions, attrition, and/or premature termination (Kim et al., 2012; Moore, 2018). Some researchers have also included a multifaceted definition beyond behavioural outcomes such as affective, cognitive, and social aspects that take into account emotional involvement and alliance with the clinician as impacting engagement (Lakind et al., 2022). Moore (2018) posits that evidence-based treatment protocols assume complete and active participation in treatment, and thus, should a client not fully be involved in treatment, this interferes with potential benefits. Indeed, poor treatment engagement may lead to "exacerbation of symptoms, rehospitalization, and not fully realizing the potential benefits of treatment" (Dixon et al., 2016; p. 13). McKay and colleagues (1998) divide treatment engagement into two steps of initial attendance and ongoing treatment. Similarly, treatment engagement consist of multiple stages of "promoting initial treatment seeking, consistent attendance, and adherence to the treatment plan" (Moore, 2018; p.1064). Furthermore, engagement in treatment is dynamic over time (McKay & Bannon, 2004; Staudt 2007; Lakind et al., 2022). Most research regarding the

impact of disengagement on client outcomes focus on adult (Dixon et al., 2016), youth (Kim et al, 2012), and marginalized populations (Interian et al., 2013). Interestingly, older adults are a marginalized group that have received relatively less attention. Raue and Sirey (2011) addressed the need for greater attention to treatment engagement among older adults by developing a theoretical model of treatment engagement in later life. This model (*Figure 1*) identifies steps beginning with a decision-making process in which older adults agree to treatment, followed by decisions to begin and participate in treatment, and ends with treatment outcomes that are impacted by the previous steps. Raue and Sirey's model focuses on the components to the right of the dashed line. An aim of the current dissertation is to expand this focus to include the referral process. This attention to referral in treatment engagement aligns with McKay and colleagues (1998) initial stage of treatment engagement. Raue and Sirey's model suggests that older patients may be better engaged in treatment if their attitudes, preferences, and expectations regarding treatment are considered. Essentially, by reducing psychological barriers to treatment, patients will be more engaged in the process of decision-making and subsequent treatment.

Figure 1. Theoretical Treatment Engagement Model (Raue & Sirey, 2011)



Theoretical Individual Factors of Treatment Engagement

In their theory, Raue and Sirey (2011) focus explicitly on modifiable individual factors, which may also be conceptualized as psychological barriers to mental health service use. The first category of individual factors in the model is attitudes and beliefs, which includes "knowledge", which the academic literature refers to as mental health literacy. Mental health literacy (MHL) describes knowledge and beliefs that can improve the recognition, management, and prevention of mental health disorders (Jorm et al., 1997). This is especially relevant in later life as older adults reported feeling less confident and knowledgeable about mental health problems and treatment compared to younger adults (Robb et al., 2003). Wetherell and colleagues (2009) found that older adults were less accurate at identifying symptoms of anxiety and depression compared to younger adults. Overall, older adults are less able to recognize mental health challenges and also demonstrate poorer knowledge of these issues (Malkin et al., 2019). Mackenzie and Pankratz (2022) found that low MHL was a strong negative predictor of mental health service use in older adults. MHL serves as a barrier to mental health service use in that inadequate health literacy is associated with impaired healthcare choices leading to poor quality of care and patient satisfaction (MacLeod et al., 2017).

The attitudes and beliefs category in Raue & Sirey's (2011) model also refers to stigma. Public stigma associated with help-seeking involves the perception that an individual seeking mental health treatment is socially unacceptable or undesirable. Self-stigma occurs when an individual with these traits internalizes negative public attitudes and stereotypes into their self-identity (Corrigan, 2004). Vogel and colleagues (2007) have conceptualized the mechanisms through which stigma acts as a barrier for seeking mental health services. According to the internalized stigma model, public stigma is internalized into self-stigma which then negatively

impacts attitudes toward seeking help, which consequently negatively affects intentions and willingness to seek help. Considering Vogel and colleagues' (2007) model, stigma and attitudes toward treatment and help-seeking may impact treatment engagement. Older adults, for whom public stigma is significant, are especially likely to internalize this into self-stigma, which negatively influences help-seeking attitudes (Mackenzie et al., 2019). In this way, considering stigma as a barrier to treatment may be especially important for older adults who internalize stigma. Mackenzie and Pankratz (2022) provide further evidence for self-stigma of seeking help as a significant negative predictor of mental health service use among older Canadians. In addition to the stigma of seeking help, individuals may also experience the stigma of having a mental illness which also contributes to treatment engagement when considering modifiable factors (Tucker et al. 2013). Being perceived as a help-seeker may be an additional threat to one's self-concept that is separate from the threat of being perceived as mentally ill (Tucker et al., 2013).

The second category of modifiable individual factors in Raue and Sirey's (2011) model is treatment preference as a patient attitude influencing treatment engagement. Treatment preference in this context often relates to factors such as receiving psychological versus pharmacological care. Kwan and colleagues (2010) provide support for the role of treatment preference in treatment outcomes in a study in which participants with major depressive disorder were randomized into receiving psychotherapy or antidepressant medication. Before randomization, participants were asked to report whether they preferred psychotherapy, medication, or had no preference. A mismatch between the preferred treatment modality and actual treatment was associated with a greater likelihood of attrition, fewer appointments attended, and poorer working alliance. What is more, the researchers found a significant indirect

effect of treatment preference on depression outcomes. Attendance, which was influenced by treatment preference, accounted for 16% of the variance in depressive severity improvement. When considering ways to maximize treatment engagement, a patient may not adhere to or complete treatment protocols that are perceived as unacceptable, underscoring the need to investigate treatment preferences (Diller et al., 2013). Although research suggests that many older adults prefer psychological treatment compared to pharmacological treatment (Gum et al., 2006; Mohlman, 2012), research also suggests a trend of decreasing psychotherapy treatment for older adults and increasing use of antidepressants as a mental health intervention (Alvidrez & Areán, 2002; Eden et al., 2012). It seems that it may not be common practice to match individuals to their preferred treatment modality given these trends. Accordingly, exploring treatment preference is an important consideration of individual factors related to treatment engagement.

The third and final category of modifiable individual factors that Raue and Sirey (2011) suggest affect treatment engagement is treatment expectations. Treatment expectancy is the perception of the likelihood of success if one were to engage in a treatment (Constantino et al., 2011). Swift and colleagues (2012) note that expectations of treatment length is a factor in premature treatment termination. Unsurprisingly, how effective patients expect treatment to be is related to dropout, with higher dropout rates correlated with lower perceived effectiveness if engaging in therapy (Edlund et al., 2002). Of note, treatment expectations encompass both a patient's attitudes toward and knowledge of the treatment, as expectations of efficacy may be informed by MHL.

Treatment Engagement Interventions

Following the development of Raue and Sirey's (2011) theoretical engagement model, a small body of research has begun to explore treatment engagement interventions for older adults. Many of these interventions target treatment engagement by providing information regarding treatment and expectations to patients. In one intervention, older adults were twice as likely (39% vs. 21%) to initiate and adhere to psychotherapy when engaged in a 30-40 minute in-person meeting and two 10-minute phone calls with a primary care nurse who discussed treatment preferences and concerns about psychotherapy and antidepressants (Raue et al., 2019). In another intervention, patients receiving three 30-minute in-person meetings and two telephone follow-ups with a counsellor discussing antidepressant recommendations, goals, and adherence demonstrated decreased depressive symptoms and greater adherence to treatment following the intervention (Sirey et al., 2010). These interventions may be conceptualized as methods of enhancing MHL. Providing mental health information to patients can also affect attitudes toward treatment and stigma. In this way, psychoeducational programs have been identified as a potential method to reduce stigma by way of improving MHL (Cook et al., 2014; Corrigan et al., 2012; Thornicroft et al., 2016). This may be seen as distinct from solely public stigma-reduction interventions, which often focus on reducing discrimination as a behavioural consequence of stigma (Corrigan et al., 2012).

Limitations of Current Treatment Engagement Interventions

Although preliminary research suggests that patient treatment engagement interventions for older adults may be effective, it is limited in several respects. First, the interventions noted above focused exclusively on patients with depression (Raue et al., 2019; Sirey et al., 2010). As well, neither study was conducted in Canada: participants may experience different accessibility

barriers with services covered under Canadian public health plans. Further, as the theoretical model is focused on modifiable individual factors, it does not address social processes of treatment engagement. In fact, older adults also face social barriers to care as help-seeking is inherently a dynamic and social process. Berard and colleagues' (2020) interviews with older patients described nuanced and complex social processes related to help seeking which referenced Pescosolido and colleagues' (1998; 2013) network episode model (NEM). According to NEM, individuals interact with their social support networks and healthcare system as they navigate the process of seeking treatment. In this manner, help seeking is shaped by social systems. Lastly, a significant limitation of the current research is the lack of patient input in understanding problem areas and intervention development. Including patient perspectives in research supports enhanced relevance for its intended audience, and improved knowledge translation (Pauly et al., 2019; Veldmeijer et al., 2023). My dissertation research seeks to address these gaps in knowledge by further exploring modifiable individual-level and social factors involved in treatment engagement and incorporating patient perspectives to better understand and optimize referral to geriatric mental health specialty services in two Winnipeg hospitals.

Overview of the Current Research

The current dissertation research follows the process of involving persons with lived experience to explore expressed barriers to treatment engagement and subsequent suggestions for improvement (Study 1), outlines the development of a psychoeducational pamphlet (Study 2), and seeking feedback on this novel resource (Study 3). The primary goal of Study 1 was to identify opportunities to enhance patient engagement in the referral process to geriatric mental health services by exploring the experiences and preferences of persons with lived experience of this process. The primary goal for Study 2 was to describe the development of a novel

psychoeducational pamphlet aimed at increasing MHL in order to promote treatment engagement based on previous patient interviews. Finally, the goal of Study 3 was to gather patient feedback on the co-created psychoeducational pamphlet intended to increase MHL in older adults referred to geriatric mental health services. While all manuscripts are stand-alone, they present the chronological nature of this research process. Each of the studies employ qualitative methods in which I was an active participant in participant interviews and brought my own life experiences into the process of data analysis and interpretation. As such, it is important that I reflect on how my position in the world and as a researcher may have affected this process.

Positionality Statement

I am a doctoral clinical psychology candidate at the University of Manitoba. I have completed training in program evaluation and research methods. I also have experience conducting interviews with adults and older adults throughout my clinical training. Throughout this dissertation, I held the roles of interviewer and interpreter, and in these roles, I sought to be aware of the lens through which I approached this work. I have found my clinical lens being influenced by my research lens, and vice versa. I identify as an integrative clinician, drawing from predominantly psychodynamic and cognitive models. My bias for often understanding conflict as intrapsychic was challenged by hearing participants share the predominant social nature of their experience. As a clinician and researcher, whether I am in a consultation room or study interview, I am interested in hearing life experiences and fostering an environment where the changes an individual wishes to see may hopefully occur. I view the construction of meaning as something that is co-created by clinician and client, or by researcher and participant. This perspective influenced my approach throughout this work, as I viewed the participant as a partner in this endeavour. My psychodynamic background also influenced me to pay close

attention to and value the process of interaction in interviews. While not meant to be therapeutic, I was touched by the response to follow-up interviews in which participants shared their gratitude for participation. Honouring these brief relationships, I was also saddened to hear of the death of one participant and the declining health of other individuals who so graciously shared their time with me and courageously shared their stories.

Personal life experiences have also shaped my position and lens. I acknowledge that while from a psychology background, my partner is a trained psychiatrist. On account of this, I am somewhat more familiar with the training and roles of these two professions. This is contrasted by my experience of growing up with immigrant parents and finding myself often repeating the differences in my husband's and my training. Through this life experience, I aimed to approach interviews nonjudgmentally holding the perspective that this knowledge is not guaranteed but a privilege. What is more, growing up in a biracial family, I often faced assumptions about my upbringing as I do not look like my father. I found explaining my heritage to often well-meaning, curious strangers exhausting and, at times, intrusive. Through this life experience, I aimed to approach interviews unassumingly in terms of how participants' unique positions may have impacted their experience and what they wished to share with me. My strong family ties have also influenced my interest in working with older adults. I remember eagerly asking to hear the stories of my Oma and Opa, often interwoven with tales of hardship and resilience that I took as life lessons. In a similar manner, hearing the immigration stories of my parents held wisdom for me. As a younger adult, I continue to view life experience as a teacher and value the wisdom older adults may share. Lastly, this work stems from my growing interest in the navigation of healthcare systems. I have personal experience seeing loved ones navigate through this process with ambivalence, and seeing others who I wished had pursued a referral for

mental health support. Through it all, I recognize that I approach this topic with a hope for change.

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CHAPTER TWO: "Mental Health is a Mystery": Patient Perspectives on Treatment Engagement in the Referral Process to Specialty Geriatric Mental Health Services

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1. Del Rosario, N., Mackenzie C.S., Koven, L., Reynolds, K., Furer, P. (in press). "Mental Health is a Mystery": Patient Perspectives on Treatment Engagement in the Referral Process to Specialty Geriatric Mental Health Services. *Aging & Mental Health.*

Abstract

Objective: Raue and Sirey (2011) proposed a theoretical treatment engagement model for older adults outlining steps from identifying mental health problems, referral to specialty care, and involvement in treatment. Using this model as a guide, the current study aimed to explore patient perspectives of their experience in the process of referral and first meeting with geriatric mental health services. Furthermore, the current study aimed to identify opportunities to enhance patient engagement in these beginning steps of the treatment engagement process.

Method: Thirteen geriatric outpatients (7 psychology, 6 psychiatry) presenting with concerns of anxiety, depression, and/or stress were interviewed. Interviews were analyzed using the framework method.

Results: Themes emerged as suggested by Raue and Sirey's model, including attitudes toward treatment (e.g., stigma), treatment expectations, and treatment preferences. In addition, new themes emerged related to modifiable individual factors (the patient as a passive recipient of healthcare, mental health literacy, and ageism) as well as social influences on treatment engagement. Participants primarily noted opportunities for psychoeducation as a potential treatment engagement intervention to implement within the current referral system.

Conclusions: This is the first study to examine the applicability of Raue and Sirey's theoretical engagement model in a clinical sample. Findings both support and expand the model and offer several recommendations for improving treatment engagement for older patients.

Keywords: *treatment engagement, aging, access to health care, users' experiences, Framework Method*

Introduction

Although mental health tends to improve across the adult lifespan (Charles, 2010), depression and anxiety remain common and tend to co-occur in later life (Almeida et al., 2012). Mental health supports are paramount as mental disorders are the second leading cause of global burden of disease, behind cardiovascular disease (Vigo et al., 2016). Despite their prevalence, most individuals struggling with diagnosable mental disorders do not seek professional treatment (Wang et al., 2007). Of concern, low service utilization becomes even more prominent in later-life (Crabb & Hunsley, 2006; Eden et al., 2012; Mackenzie et al., 2012; Mackenzie et al., 2022). Given that older adults, individuals aged 65 years and older, are a growing age group (Beard et al., 2016), support for mental health care access in later life is warranted.

Barriers to Accessing Mental Health Services for Older Adults

Older adults experience many barriers to accessing specialty mental health services such as geropsychology and geriatric psychiatry, starting with broad structural barriers of accessibility and financial cost (Pepin et al., 2009). Mental health concerns may go undetected due to the challenges of working with complicated comorbid physical and mental health concerns in a time-pressured environment (Bartels & Drake, 2005). Consequently, poor detection and low referral rates are notable for older adults seeking help for mental health problems in primary care (Park & Unützer, 2011).

In addition to structural barriers, older adults may also experience psychological barriers when seeking mental health treatment and research suggests that they are more impactful than structural barriers (Andrade et al., 2014; Sirey & Marino, 2020). Research examining barriers to older adults' mental health service use frequently identify stigma and knowledge about symptoms and treatment (Andrade et al., 2014; Mackenzie et al., 2022; Reynolds, et al., 2020;

Sirey et al., 2001). Concerns about how others might react if an older adult were to seek mental health services (i.e., public stigma) can hinder access to care, although a more significant barrier occurs when public stigma is internalized as self-stigma (Mackenzie & Pankratz, 2022). Another key psychological barrier includes mental health literacy (MHL), which refers to knowledge and beliefs that can improve the recognition, management, or prevention of mental health disorders (Jorm et al., 1997). Research has indicated that older adults feel less confident and knowledgeable about mental health problems and treatment when compared to younger adults (Hadjimina & Furnham, 2017; Malkin et al., 2019). As such, lower MHL may contribute to older adults not recognizing symptoms and also having less knowledge of potential treatments. Given these findings, older adults, relative to younger age groups, are vulnerable to experiencing MHL as a barrier to accessing treatment.

In addition to structural and individual psychological barriers to accessing treatment, challenges to accessing mental health services can occur due to the fact that seeking treatment is a dynamic and social process. According to Pescosolido and colleagues' (1998; 2013) network episode model (NEM), individuals interact with their social support networks and healthcare system as they navigate the process of seeking treatment. Berard and colleagues' (2020) interviews with older patients underscored the nuanced and complex social processes involved in help-seeking and the numerous barriers for older adults seeking specialty mental health treatment.

Barriers to Treatment Engagement

If the act of seeking mental health services is indeed a social process, the degree to which older adults are actively engaged with their referral sources and service providers can help or hinder treatment outcomes. Raue and Sirey (2011) define treatment engagement broadly as "a

process beginning with identification of depression in community settings; moving to a referral for mental health evaluation; making decisions on treatment and acceptance of treatment recommendations and early adherence and participation in care" (p.490). Even if older adults overcome notable structural barriers (e.g., accessibility, cost, poor detection, low referral rates) and are successful in accessing specialty mental health services, research suggests that limited engagement in treatment decision-making is associated with worse clinical outcomes (Dixon et al., 2016). For instance, accommodating client preference in psychotherapy has been associated with fewer treatment dropouts and more positive outcomes (Swift et al., 2018). Kwan and colleagues (2010) note that assessing and accommodating patient preferences may be especially important for specific populations vulnerable to disengagement.

Raue and Sirey (2011) developed a theoretical model of patient engagement for older adults. This model outlines the above noted steps of treatment engagement. This helpful model of mental health treatment engagement in later life is limited in several ways that the current study will address. First, although Raue and Sirey acknowledge structural and social influences on treatment engagement, their model focuses on modifiable individual-level factors, suggesting that older patients may be better engaged in treatment if their attitudes, preferences, and expectations regarding treatment are considered. Their individual-level focus fails to take into consideration that these factors take place within the context of interactions with referral sources and treatment providers. Second, their work using this model has been limited to depressed older patients within the U.S. healthcare system (Sirey et al., 2010; Sirey et al., 2016; Raue & Sirey, 2011) calling into question its generalizability. Finally, research has not yet examined the applicability of this model from the perspective of patients.

Research Objective

The primary aim of the current study is to build on Raue and Sirey's (2011) theoretical model in the following ways. First, by exploring the perspectives on treatment engagement of geriatric psychiatry and geropsychology patients with a broad range of mental health concerns within a Canadian healthcare context. As treatment engagement involves many steps, the current study focuses on treatment engagement related to the process of referral and initial appointment with the geriatric mental health specialist. Second, to explicitly identify opportunities to improve treatment engagement as expressed by patients.

Methods

Participants and Recruitment

We obtained ethics approval for this study before commencing data collection (University of Manitoba HS24738, H2021:104). Two clinical geropsychologists and four geriatric psychiatrists working in two tertiary-care hospital settings in a large Canadian city facilitated recruitment by describing the study to patients in geriatric psychiatry and geropsychology outpatient clinics. To be considered for this study, participants needed to be at least 65 years old, fluent in English, and seen for the consultation appointment within six months of the time of recruitment. Participants were eligible if presenting with anxiety, depression, or adjustment concerns without a primary diagnosis of cognitive impairment. Clinicians assessed presenting concerns and obvious cognitive impairment during the initial appointment with patients using their clinical judgement. Recruitment, interviews, and data analysis occurred concurrently.

Data Collection Procedure

Study participants had no prior relationship with the interviewer (first author and doctoral student). After providing informed consent, they participated in a single-session semi-structured individual interview by telephone (n = 9) or Zoom (n = 4). The study team developed the semi-structured interview guide based on topics suggested by the theoretical engagement model (Raue & Sirey, 2011). Specifically, interviews explored the process of patient referral to specialty geriatric mental health services and patient factors affecting this process, including patient attitudes, treatment preferences, and treatment expectations. Interviews ranged in length from 42 to 113 minutes with an average length of 71 minutes. Data saturation was evident, with no new themes arising from the final interview (Miles & Huberman, 1994). Participants received a $20 gift card as an honorarium.

Analytic Procedure

Interviews were audio-recorded, professionally transcribed, checked for accuracy, and anonymized. Interviews were analyzed using the framework analytic method (Pope et al., 2000; Ritchie et al., 2013). In this method, a thematic framework is identified both deductively based on themes theorized to be relevant from prior research (i.e., Raue & Sirey's 2011 model) and inductively based on novel information that emerges from the data. The analysis involved a series of phases: familiarization, identification of a thematic framework, indexing, charting, and finally, mapping and interpretation (Pope et al., 2000). During familiarization, the interviewer (first author) reviewed interview transcripts and made notes to identify key themes and emerging concepts. To approach the data with reflexivity, the interviewer made field notes of immediate impressions and thoughts following the interviews which included potential biases (Tracy, 2010). These field notes also documented participants' strong reactions to particular questions,

unexpected moments that arose, and perspectives that contrasted with other data. Upholding dependability, the first author kept a research diary that documented analysis steps and decisions made throughout the analysis process (Levitt et al., 2018; Tracy, 2010). NVivo12 was used when coding transcripts and assisted in organizing the framework. The analysis team (N. Del Rosario, C. Mackenzie, M. Mailey) independently and then collectively reviewed transcripts line by line and reviewed codes assigned to each passage of text. Consistent with framework analysis, the process of interviewing and analysis was continuous, flexible, and iterative, resulting in revisions to the initial framework throughout (Hackett & Strickland, 2018). By consulting with the team when analyzing data, the findings underwent cross-checks for rival explanations in keeping with previously established standards for rigorous qualitative research (Malterud, 2001). Furthermore, the research team included diverse educational levels and occupational specialties to provide multiple perspectives on the analysis and framework development to buffer potential biases.

Results

Sample Characteristics

Between December 2021 and December 2022, 24 individuals were approached for participation. Of those, 13 participants provided informed consent and completed the study (response rate of 54%). Six individuals were contacted but declined participation due to passive refusal ($n = 4$) or lack of interest ($n = 2$), while two individuals did not respond to attempts for contact. Characteristics for the final sample of 13 are reported in Table 1. Seven participants met criteria for at least moderate distress (5+) using the Kessler distress scale (K6) (Prochaska et al., 2012).

Table 1. Sample characteristics (N = 13)

Age (mean & range)	72.9 (66-85)
Gender, *n (%)*	
Female	9(69%)
Male	4(31%)
Service Accessed, *n (%)*	
Psychiatry	6(46%)
Psychology	7(54%)
Employment status	
Retired, *n (%)*	12(92%)
Part-time, *n (%)*	1(8%)
Marital status	
Married/Common-law, *n (%)*	8(62%)
Separated/Divorced, *n (%)*	2(15%)
Widowed, *n (%)*	3(23%)
Ethnicity, *n (%)*	
White	13(100%)
Education, *n (%)*	
Less than high school	1(8%)
High school or GED	3(23%)
Some college	4(31%)
Completed college	4(31%)
Post graduate degree	1(8%)
Household Income, *n (%)*	
10,000-29,000	2(15%)
30,000-59,999	4(31%)
60,000-89,999	3(23%)
90,000-110,999	3(23%)
150,000+	1(8%)
Self-Rated Physical Health, *n (%)*	
Poor	2(15%)
Fair	9(69%)
Good	0
Very Good	2(15%)
Self-Report Wait Time in Months (mean & range)	3.8 (1-11)

Overview

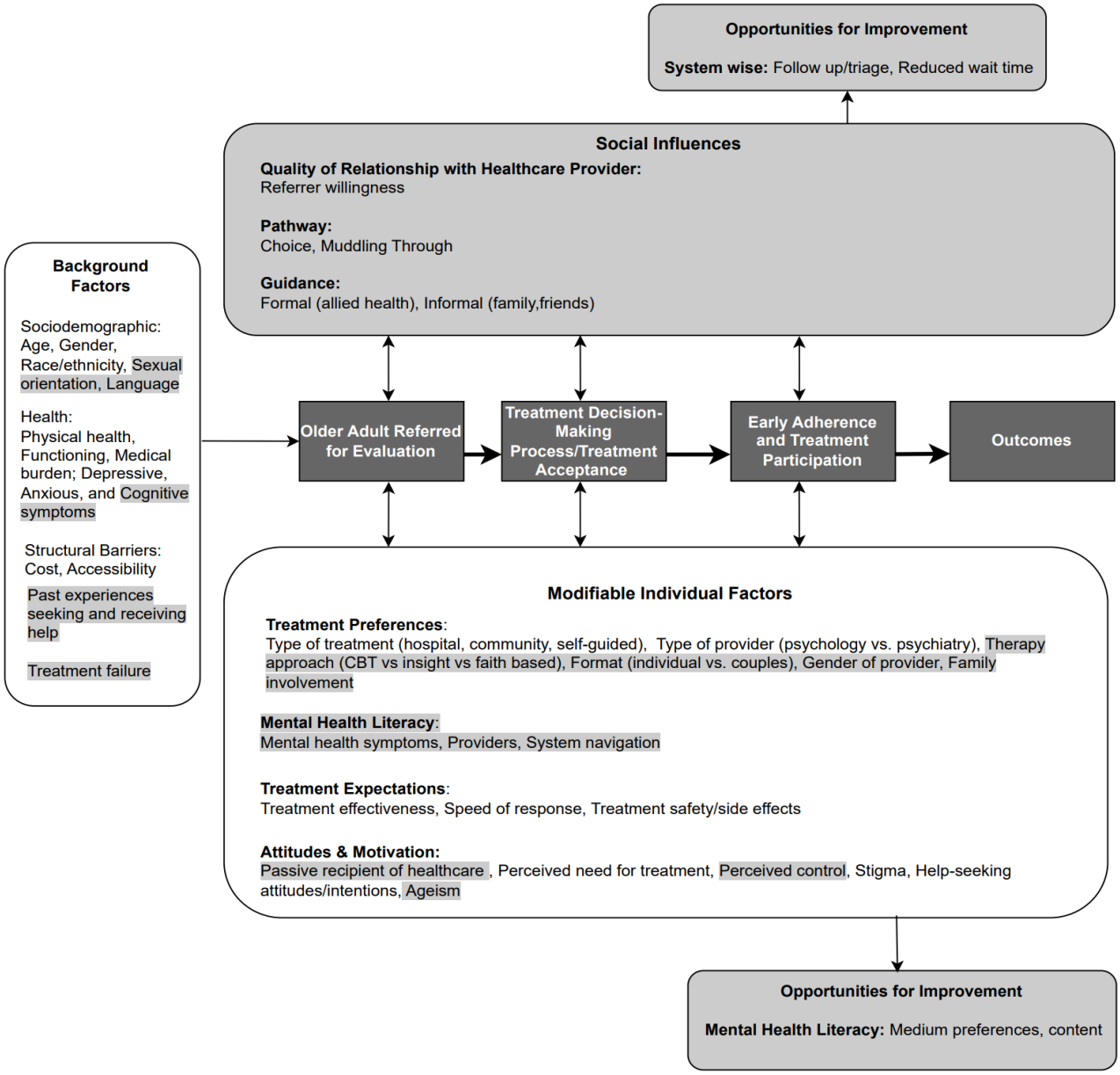
Figure 1 displays the steps in the process of treatment engagement as outlined by Raue and Sirey (2011) as dark grey shaded boxes (i.e., older adult referred for evaluation, treatment decision-making process/treatment acceptance, early adherence and treatment participation, and outcomes). The final framework included four main themes with corresponding sub-themes that

affect the treatment engagement process (Figure 1). Light grey shaded text and sections indicate themes and subthemes that were novel to the current study compared to Raue and Sirey's (2011) theoretical model. The four major themes are discussed below.

Background Factors

The first main theme, which was also in Raue and Sirey's (2011) model, included various background factors influencing participants' referral experience and subsequent engagement in treatment. These factors included sociodemographic factors (e.g., language and sexual orientation), structural barriers (e.g. cost), health (e.g., influencing comorbid physical concerns), past experiences of seeking and receiving help, and treatment failure. Some participants expressed that sociodemographic factors impacted their experience of the referral process in which they shared a preference to see information related to the referral in their first language (e.g., French). Another participant shared that their openness to discussing their difficulties was impacted by their sexual identity, which they had not shared with their primary healthcare provider. Overall, participants expressed that many of these factors added to the referral's complexity or posed a barrier to referral. For instance, many participants initially expressed seeing their primary care provider for physical health concerns rather than for their mental health: "I really didn't believe that whatever I had…had anything to do with mental health" (Participant 13). Participants also described past experiences seeking and receiving mental health treatment as providing context and familiarity to their current experience. Participant 1 described past experiences navigating the mental health system as a way of gaining knowledge of what to expect, "maybe if I haven't been through this before I might have had more questions, but I've been through quite a bit of counselling and stuff in the past, so I knew what was coming."

Figure 1. Visual Representation of Geropsychology and Geriatric Psychology Patient Engagement



Note: Grey shaded boxes represent steps of treatment engagement

Grey shaded content represent novel themes to Raue and Sirey's (2011) model

Similarly, Participant 10 shared that due to their past mental health treatment experiences, they could "trust in the process" when faced with the uncertainty of the wait time and follow-up. Participants also shared that past experiences of anxiety and depression helped shape their understanding of symptoms themselves. The treatment failure subtheme reflected participant experiences where referrals resulted from failure to respond to pharmacological treatments prescribed by their primary care physician. One participant expressed the desire that their family doctor had referred them sooner rather than attempting to manage her increasing anxiety despite her lack of response to medication and worsening symptoms (Participant 1).

Social Influences

Throughout analysis, the team coded a second main theme that was not part of Raue and Sirey's (2011) model. This novel theme resulted from participants sharing social influences that impacted their treatment engagement. This theme included three subthemes involving the quality of communication with their referral sources and providers, their willingness to refer, the directness of the pathway, and guidance from allied health professionals or family.

Quality of Relationship with Healthcare Providers

Participants spoke of the importance of the quality of the relationship with their healthcare providers, both their referral source, often their family doctor, and their specialty mental health provider. Participants expressed the importance of the quality of communication, regardless of whether their experience was a consultation appointment or a longstanding healthcare-provider relationship. One participant stated that "It depends on the actual therapist. The patient and the therapist have to connect" (Participant 7). She and other participants expressed the benefits and consequences of a connection or lack of connection between parties. For instance, one participant spoke of their referring doctor as not establishing a level of trust, "I

don't know him from a hole in the ground" compared to a level of trust and collaboration he felt was conveyed in the initial specialist appointment; "I didn't feel like I was a rat in a cage being examined in that first interview" (Participant 11). He later spoke of the positive influence of the relationship with the specialist on treatment engagement; "If [provider] hadn't approached me and made me feel as comfortable as he did, I most likely wouldn't have gone anywhere."

Within the subtheme of quality of relationship with healthcare providers, participants spoke of referrer willingness which captured variability across participants in their provider's knowledge of mental health treatment and willingness to refer. Participants shared the vital influence of their primary care provider's knowledge and responsiveness to their concerns. Participant 8 noted their provider, acting as a gatekeeper, was unwilling to refer them to a program, to which they eventually were referred by a psychiatrist. Participant 5 described their referral as a response to their primary care provider's hesitancy to manage mental health concerns themselves, "He [family doctor] even admitted he didn't know much about the mental health issues, so that's probably why he referred me to somebody."

Pathway

While some participants described a straightforward referral process with a direct entry into specialty care in which they felt choice and autonomy in decision making, many described a more convoluted pathway to services such as seeing multiple health professionals. This second type of pathway is referred to as muddling through in prior literature (Berard et al., 2020; Pescosolido, 2013). For instance, one participant described a lack of treatment response to medication from her family doctor, being encouraged by her pharmacist to discuss re-evaluating medication, and then being referred to a psychiatrist who then referred to psychology. While this participant later described psychological services as an appropriate fit, she noted that getting to

this service was a “long process” (Participant 2). Other participants indicated that it was challenging to recall circumstances leading to their referral as they frequently saw specialists for various physical concerns. One participant explained that when his physician sent the referral to specialty mental health services, he had “no idea what was happening or what was going on” as referrals were often made in the context of other physical concerns (Participant 6).

Guidance

Participants emphasized the influence of allied health professionals (often pharmacists), family, and friends in their help-seeking, often supporting and encouraging treatment engagement. Two participants taking pharmacotherapy noted pharmacists as providing information about treatment side effects: “The druggist told me. He said, that’s one of the side effects of this medication, didn’t your doctor tell you? I said no” (Participant 7). Participant 2 noted that allied health also acted as a source of information in navigating services:

> she [pharmacist] wasn’t saying, don’t take it, but just talk to your doctor, and I said, there’s no point in talking to my doctor. So, she actually gave me a list of doctors… Because she said, as a pharmacist, she deals with them all the time, so she knows who might be a better fit. So, that was one person that really helped me in pointing me in a better direction.

Participant 8 shared frustration in trialling medications with little to no improvement, noting that “nothing was working” and upon sharing these experiences with his daughter, she shared her positive experience with certain medications and working with psychiatry. He noted the irony in that effective medication “…was recommended to me by my own children, not by my family doctor”. Other participants noted family and friends supporting and encouraging seeking specialty care.

Modifiable Individual Factors

We categorized a third main theme from participants discussing modifiable individual factors that may facilitate or inhibit each of the treatment engagement phases. Raue and Sirey's (2011) model included three categories: attitudes and beliefs, treatment preferences, and treatment expectations. We generally found support for these subthemes in our data, but chose to separate their "attitudes and beliefs" category into two separate subthemes. Attitudes are more evaluative in nature whereas beliefs are tied to knowledge (Connors & Halligan, 2015). Given the central role of knowledge, otherwise known as mental health literacy, in our data we felt it important to have it as a separate subtheme. We also added a motivational component to the attitude subtheme.

Treatment Preferences

Treatment preferences encompassed aspects such as type of treatment, gender of provider, format, and involvement of family. When speaking about preferences for family involvement, participants expressed a range of reactions to having family members involved in the referral and treatment process. One participant expressed the benefits of family involvement to encourage the implementation of recommendations. On the other hand, one participant described a sense of frustration that her daughter's involvement was "slowing down progress" (Participant 13). Another participant expressed that her spouse's involvement was unwelcome and felt like a threat to her independence:

> But I still have my mind…I can still speak for myself, because I don't need my husband to talk for me or ask him questions about my depression…..and it made me feel like I was old and needed someone to tell him [psychiatrist] what was going on in my life. (Participant 12)

Treatment preferences also captured preferences for providers (psychiatry versus psychology) and, as a consequence, whether pharmacological intervention was involved. While some participants expressed dissatisfaction with taking medication and a preference for psychological interventions, neutral responses to provider preferences were common. Many participants voiced flexibility about the path to feeling well. For instance, one participant expressed that, although she dislikes taking medication, she was "prepared to see whoever would be able to guide me to feeling better" (Participant 2). Another participant shared this flexibility, yet also highlighted a lack of information underlying their lack of preference, "I guess I'm open to whatever works. I don't know what works" (Participant 3).

Treatment Expectations

When reflecting on treatment expectations (including factors such as efficacy, side effects, and speed of response), three participants expressed in a joking manner the desire for a "magic pill/bullet." Participant 7 expressed concern about the side effects of medication and talk therapy, noting the annoyance of dry mouth from medication but also wishing to avoid the "dependency" on a counsellor she had observed in others. However, most participants described their expectations for treatment in a vague manner, capturing another facet of treatment expectations: knowledge of treatments. Participant 2 reflected that her lack of knowledge about treatments impacted her expectations of what they would involve and whether they would be effective, "I didn't have much expectation because I didn't know what to expect" (Participant 2).

Mental Health Literacy (MHL)

Flexible preferences and vague expectations of treatment were shared among many participants, most likely resulting from a lack of knowledge of providers and treatments. Participants discussed MHL in terms of knowledge of symptoms, providers, and system

navigation. Many participants reflected their surprise that physical symptoms they were experiencing and seeking treatment for were related to their mental health. Participant 1 shared a feeling of shock when discussing her diagnosis with the psychiatrist, “I just didn’t recognize it as depression. I recognized that I had anxiety. I was just a little bit shocked at that” (Participant 1). On a larger scale, when reflecting on mental health, Participant 7 mused, “Mental health…that’s a mystery.”

Most participants did not know the difference between a psychiatrist and a psychologist. In the minority of participants who endorsed knowing the difference, their understanding was not always accurate regarding cost and training. Several participants expressed not knowing what a psychologist does and having a limited understanding that psychiatrists prescribe medications, “I know the psychiatrist, but the psychologist, I’m vague on that one” (Participant 12).

An often under-emphasized component of MHL in the literature is the process of system navigation, in which the patient utilizes knowledge and awareness of services to navigate the mental health system. Participants were often confused about how to access services they sought within and outside of the hospital system, “If they don’t have what we’re looking for, where can we find it?” (Participant 9). Participant 12 expressed the emotional aspects of not knowing how to advocate for herself as she considered whether to ask her nurse practitioner for guidance or contact community programs directly. Ultimately, she described a sense of hopelessness in having “nowhere to go now.” Participant 10 highlighted the impact of lack of awareness of mental health services influencing the ability to navigate the system, noting that people cannot use services they are not aware of, “You can’t decide where you want to head if you don’t have the options and know what the options are.”

Attitudes and Motivation

Participants described a variety of attitudes related to engaging in all aspects of the treatment engagement process. These included the role of a patient as a passive recipient of healthcare, perceived need for treatment, perceived control, motivation for treatment, ageism, and stigma.

Participants often described a lack of agency in decision making, which included deferral to their referrers and treatment providers as professionals with expertise in the subject area, leading to passivity on the part of patients concerning health decisions. Participant 8 shared a sense of helplessness at being at the mercy of their family doctor in terms of referral, "I was just looking at my doctor and assuming the doctor was doing the right thing." Participant 2 shared her experience of lacking agency with respect to decision-making about referrals because doing so is impacted by the very nature of depression:

> I think, unfortunately, when a person is in that kind of situation, you don't think of asking the questions. You're just kind of, okay, for me anyway, I don't really question anything. Okay, you're sending me to do that. Well, okay, I'll do that. (Participant 2)

Lack of agency extended beyond conversations with referral sources to a lack of agency with geriatric specialists themselves. Participant 7 expressed that she did not have a prominent say in recommendations from the psychiatrist, noting "the average person is not qualified to decide which type of specialist he or she needs." On the other hand, Participant 12 shared feeling "intimidated" by professionals and the fear of being "brushed off" should she express her opinion.

A frequent response to seeing the specialist was fear of wasting the time of the specialist. Participant 2 noted ambivalence about engaging in services, doubting her need:

> So, there are all these conflicting thoughts going on, that, again, I guess, being a burden. Well, okay, I'm here, and I'm doing these things, but maybe he's [psychiatrist] got something better that he should be doing. Maybe I'm not that unwell that I should be taking up his time. So, there's all of that going on in my brain at the same time.

Many participants also described conflicted feelings about engaging in services that may be allocated to urgent cases; "I always have such a concern about … taking up other people's time" (Participant 10). Participants often rationalized their use of services, describing that a professional had assessed their needs but noting that this awareness did not allay their concern of being unworthy of treatment.

When navigating the referral process, participants shared a perceived sense of control as helpful in coping with uncertainties related to issues such as waitlist time and resource restrictions. Participant 10 noted that the severity of her mental health concerns and waiting times influenced her preference for certain treatments. She recalled that in the past, she may have been open to waiting longer to see her preferred service, but in terms of her most recent interaction with mental health services, she was interested in the soonest appointment possible. She described that knowing the options would have been helpful to feel more in control of her treatment:

> Whereas if you're offered different things, and you can make the decision of if I need to get in faster these are my options. Feeling good, I can wait eight months for that, or I can wait nine months for that. (Participant 10)

Other participants shared neutral reactions toward treatment options and a lack of motivation to engage even if offered treatment. Participant 10 shared her hesitation to engage in treatment because her symptoms had already improved. Participant 5, on the other hand,

questioned “what’s the point?” when considering whether to engage in treatment at her age. In this case, the participant described entering the specialist appointment out of “curiosity” but not having help-seeking intentions for various reasons, including her age.

As Participant 5 noted, her age was seen as a barrier to engaging in treatment due to the perceived lack of benefit from intervention at her age. Reactions to seeing a geriatric-specific mental health specialist emerged across interviews, with participants sharing a range of responses. While one participant shared a feeling of reassurance and comfort in seeing a professional with specialty training, many shared a feeling of shock to be placed in an older adult category; “I did not realize I would be termed as geriatric so that does hit a person a little bit hard” (Participant 1). On the other hand, Participant 10 shared a similar reaction of shock; “geriatric, kind of threw me” but she did not “dwell” on this. Participant 6 shared what he described as a reaction of his “ego” in which he initially resisted. He jokingly recalled that when offered an appointment, the caller “didn’t call it geriatric because if he had I would have told him to go to hell because I don’t feel like I’m in that category”.

Participants shared various experiences with public and self-stigmas related to having mental health problems and seeking help for them. Participants spoke of these different facets interchangeably. Many participants expressed their mental health struggles as a “weakness.” For instance, Participant 11 noted:

> You go to a doctor for something that’s physical and people can see you have a physical problem, and they can understand you’re going to a doctor. But going to a doctor because you have head problems? That’s a sign of weakness.

Some labelled their experience in this way and discussed it as a source of shame due to implicit messages from family. For instance, Participant 10 shared that while her mother never

said she was weak, “she gave me the impression that the stigma of if you’re depressed then you’re not a worthy person and you’re weak”. Similarly, Participant 12 shared feeling embarrassed with her husband’s involvement in the consultation appointment. She noted he “doesn’t really believe in mental health” and has shared the attitude that “pick yourself up and brush yourself off and get going.”

As a result of these messages from others, some participants discussed keeping these struggles private as much as possible, such as Participant 1 who said that her preference was to “deal with it on my own.” Additionally, participants expressed their own reactions to their mental health difficulties. Participant 9 shared their struggle with acknowledging the importance of mental health, “I guess I don’t really view mental health as equal to physical health…[I] understand that mental illness is an illness that deserves equal credibility…I have a ways to go on that.”

Opportunities for Improvement

A fourth novel main theme was categorized when reflecting on ways in which engagement in the process of referral to specialty geriatric mental health services could be improved. Many participants spoke of system-wise improvements involving the desire for reduced wait times and the value of a triaging process. Participants also described the benefits of follow-up during the waiting period, including the chance to re-evaluate the urgency of their referral and to reassure them while they are waiting for care, “If there’s no follow up, it just reinforces the feeling that you have that nobody gives a damn” (Participant 11).

Participants also noted opportunities to improve their referral experience and treatment engagement by having increased knowledge about what their appointments would entail. As noted previously, multiple participants shared an unclear understanding of the difference between

psychiatry and psychology and a desire for information that clarifies resources both within and outside of the hospital. One participant described a “lack of information” leading to seeking a specialist and compared the lack of preparation to a physical medical appointment. “When they send you for mammogram, they give you all this information: do this, do that, don’t do this. What to expect when you come in, things like that” (Participant 2). When speaking of the value of knowing what to expect during the specialist appointment, participants also shared the benefits of increasing MHL generally in understanding their symptoms and reducing shame in seeing a specialist.

When asked how participants would have liked to receive this desired information, participants endorsed preferences for physical pamphlets containing psychoeducational information, with mixed responses to instead obtaining this information online or via group sessions, commenting on the lack of accessibility of online resources and lack of enthusiasm for group sessions noting its inconvenience and feeling unable to share with a large group of individuals.

Discussion

The current study explores Raue and Sirey’s (2011) theoretical model from the perspectives of patients and extends its original focus on depression to include a broader variety of non-cognitive mental health presentations, including anxiety and stress-related issues, in a Canadian context and thus, expands its applicability. In addition, the current study expands the original model in several ways by (a) emphasizing the key role of mental health literacy, (b) highlighting additional nuance concerning treatment preferences, and (c) incorporating a novel theme that includes the dynamic and social aspects of the referral process from the perspective of

patients. Participants also identified opportunities for improvement that provide intervention opportunities focused on addressing mental health knowledge.

The current study is the first to explore treatment engagement, specifically in the preliminary steps of the referral process and initial appointment with a specialist, from the perspective of older adults with non-cognitive concerns. Many participants expressed confusion about mental health concerns because of comorbid and overlapping physical health problems. This finding highlights the importance of psychoeducation that incorporates information about symptoms, providers, and service navigation, as noted by participants. MHL promotion is especially important as MHL significantly lags behind physical health literacy (Jorm et al., 2006). MHL has been found to be particularly low in older adults. Previous research indicated that older adults feel less confident and knowledgeable about mental health problems and treatment compared to younger adults (Hadjimina & Furnham, 2017). Wetherell and colleagues (2009) found that older adults were less accurate in identifying symptoms of anxiety and depression compared to younger adults. Overall, older adults are less able to recognize mental health challenges and also demonstrate poorer knowledge of these issues (Malkin et al., 2019). These findings are striking, considering that inadequate health literacy is associated with impaired healthcare choices, leading to poor quality of care and patient satisfaction (MacLeod et al., 2017). Consequently, the need for improving MHL may be especially important for older adults, and participants in the present study expressed the desire for opportunities such as psychoeducation pamphlets to address this need. Future research in this domain should consider evidence-based recommendations for psychoeducational materials that emphasize the need for simple and accessible materials (Meppelink et al., 2015; Visscher et al., 2018). Specifically,

Muscat and colleagues (2021) note the need to consider readability scores and reducing cognitive load.

Regarding treatment preferences, the results of the current study suggest that older adults have nuanced and complex preferences. This is in contrast to previous research which tends to suggest clear preferences for psychological interventions compared to pharmacological treatment (Gum et al., 2006; Mohlman, 2012). Participants shared flexible preferences, often voicing a willingness to try effective treatments while also underscoring a lack of awareness of available resources. They also expressed difficulty making an informed choice, often because of limited MHL. For example, while participants shared flexible treatment preferences, many also assumed that psychiatry would provide talk therapy, which is often not the case. It may be that clearer preferences would have emerged if participants had a better understanding of what psychology and psychiatry services offer. It is also important to consider the availability of treatments impacting treatment preferences, as one participant shared that shorter wait times made psychiatry a more desirable option given the severity of her illness. Notably, at the two hospitals in which this study took place, there are two geropsychologists and seven geriatric psychiatrists. Research suggests a trend toward decreasing psychotherapy treatment for older adults and increasing use of antidepressants as mental health interventions (Eden et al., 2012; Yang et al., 2022). Results from this study support this trend in greater access to pharmacological interventions. While participants often expressed flexible treatment preferences, most emphasized the importance of the relationship quality with their care provider.

A key novel contribution of this study was the addition of social factors that Raue & Sirey (2011) acknowledged but excluded from their model because of their intentional focus on individual-level factors. While our study maintained a focus on older patients, without exception

each of them discussed the impact of social processes on treatment engagement. These social processes involve the patients' relationship with social support systems such as friends and family and with referral sources that affected their pathways into specialty geriatric mental healthcare, as well as with treatment providers. Previous studies have identified the importance of the relationship between patient and provider in treatment engagement (e.g., Martin et al., 2000). Our study's findings suggest that patients value the relationship in both referrer-patient and specialty provider-patient interactions, even if the latter may only be a brief consultation appointment. Participants noted that the dynamic of patient-provider relationships influenced multiple facets of their experience, including the comfort of having family members involved and sharing their treatment preferences. Furthermore, participants noted the guiding influence of informal consultation with family and friends when seeking treatment and even providing suggestions for treatment. Finally, participants shared experiences of 'muddling through' to care, neither seeking out nor actively resisting treatment. This inclusion helps to bridge the gap between Pescosolido and colleagues' NEM model (1998; 2013) and Raue and Sirey's (2011) theoretical engagement model by viewing treatment engagement as including both social and individual factors. Overall, our findings suggest the intertwined relationship of patient and provider when an older adult is seeking mental health services. As a result, the provider is also a key influencing factor and partially responsible for treatment engagement and may serve as an additional target of intervention. Rapaport (2024) explored healthcare professional perspectives on treatment engagement amoung older adults in tandem with the current study. That study highlighted challenges that referral sources and providers also face in terms of clear communication with one another and with patients, as well as with mental health system literacy, that may also benefit from psychoeducational interventions.

A key limitation that should be considered when interpreting our findings is the lack of diversity among participants, with all participants self-reporting European background. As such, exploring more diverse populations would be helpful in understanding the generalizability of these findings. The limited diversity of this study's participant sample may also reflect the documented trend of health disparities in mental health service use for racially and socioeconomically diverse patients (Jimenez et a., 2013).

Conclusions

The population of older adults is growing (Beard et al., 2016). While mental health concerns continue to be prevalent in older age, the number of older adults engaging in treatment is relatively low. The present study examined patient experiences with respect to engagement in the process of being referred to and treated by geropsychology and geriatric psychiatry services in two tertiary care hospitals and offers suggestions for improved treatment engagement. Patient interviews explored the extent to which participants were engaged in the referral process so that older adults with mental health problems may maximize the benefits of the initial mental health specialist consultation and future potential treatment. Our findings provide a more nuanced understanding of the factors that affect older adults' engagement throughout the process of accessing and initiating specialty mental health care. This nuance includes a greater understanding of patient attitudes, preferences, expectations, and knowledge towards treatment and an acknowledgment that individual-level patient factors must be considered alongside social influences. Our data also point to potential intervention targets, including waitlist management and psychoeducational efforts to improve communication and knowledge when referring older patients to specialty geriatric mental health services. Future research should explore and evaluate these possible interventions and their impact on treatment uptake, adherence, and outcomes.

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CHAPTER THREE: Development and Description of a Psychoeducational Pamphlet for Older Adults Referred to Specialty Geriatric Mental Health Services

Abstract

Mental health concerns are common and remain so in later life. Given the world's rapidly aging population, it is of increasing concern that older adults are the least likely age group to seek mental health services and that even when services are accessed, older adults are often not engaged in treatment. Recent qualitative research explored a theoretical model of late-life treatment engagement from the perspectives of 13 outpatients referred to geriatric psychiatry or geropsychology in two tertiary hospitals in Canada. These interviews supported and expanded the theoretical treatment engagement model and offered recommendations for improving engagement in the referral process to specialty mental health services. The aim of the current study is to describe how the original theoretical treatment engagement model, interview data, and psychoeducational resource recommendations were used to develop a brief psychoeducational pamphlet aimed at increasing mental health literacy in order to promote treatment engagement. We met this aim by describing the pamphlet's content, rationale, and logic model underlying the pamphlet. A psychoeducational pamphlet may serve to facilitate treatment engagement for older adults in the referral process to specialty mental health services. The potential long-term impacts of psychoeducation include improved treatment outcomes, which is a promising area of future study.

Keywords: *treatment engagement; program development; aging; psychoeducation*

Introduction

The world's population of older adults is growing (Beard et al., 2016). What is more, according to the World Health Organization, approximately 14% of adults 60+ live with a mental disorder (2023). Despite this high prevalence, older adults are especially unlikely to seek mental health services (Byers et al., 2012; Mackenzie et al., 2012; Mackenzie et al., 2022). Researchers have identified many barriers to mental health service utilization for older adults, including structural barriers, such as accessibility, availability, and cost (Pepin et al., 2009), social barriers of complex pathways to treatment (Reynolds et al., 2020), as well as psychological barriers, such as lack of perceived need for care (Mackenzie et al., 2022), poor mental health literacy (Mackenzie & Pankratz, 2022), and stigma (Mackenzie et al., 2022; Reynolds et al., 2020; Sirey et al., 2001.)

For those older adults who successfully navigate structural, social, and psychological barriers and receive a mental health referral, many face yet another barrier: limited treatment engagement. Raue and Sirey (2011) developed a theoretical model of treatment engagement for older adults, which suggests that older patients may be better engaged in treatment if individual-level barriers (e.g., mental health literacy, stigma, attitudes about treatment, treatment preferences) to treatment are considered. This model begins with the identification of a mental health concern and referral to specialty mental health services with a focus on individual-level factors that affect treatment decision-making, treatment participation, and treatment outcomes.

Recent research explored Raue and Sirey's (2011) model from the perspective of 13 outpatients referred to specialty geriatric mental health services in a large city in Canada (Del Rosario et al., in press). Data from these interviews provided support for and expanded Raue and Sirey's model. Four main themes emerged in the analysis including background factors (i.e.,

sociodemographic, health, structural barriers, and past experiences influencing the referral process), social influences (i.e., pathway of referral, quality of relationship with providers, guidance from others), modifiable individual factors (i.e., treatment preferences, mental health literacy, treatment expectations, attitudes and motivation), and opportunities for improvement (i.e., system-level improvements and increasing mental health literacy through psychoeducation). A key finding from this study was that participants expressed confusion and a desire for more information regarding their symptoms, who they might be referred to, and what to expect following a referral while waiting for their consultation appointment. Participants' suggestions for improvement are paramount as research indicates that limited engagement in treatment decision-making is associated with worse clinical outcomes (Dixon et al., 2016; Kwan et al., 2010). Accordingly, exploring opportunities to improve treatment engagement among older patients offers the potential to improve treatment outcomes.

A small body of research has begun to explore psychoeducational methods of enhancing treatment engagement for older adults with promising findings. Sirey, Raue and their colleagues at Cornell have developed several interventions aimed at enhancing depressed older adults' engagement in treatment using psychosocial interventions involving brief face-to-face and telephone sessions. In one intervention, primary care nurses discussed treatment preferences and concerns about psychotherapy and antidepressants in a 30-40-minute in-person meeting and two 10-minute telephone calls (Raue et al., 2010). Analysis of this intervention following additional recruitment demonstrated that older adults exposed to this intervention were twice as likely (39% vs. 21%) to initiate and adhere to psychotherapy (Raue et al., 2019). In another intervention, a counsellor and patient were involved in three 30-minute in-person meetings and two telephone follow-ups discussing antidepressant recommendations, goals, and adherence. Patients receiving

this intervention demonstrated decreased depressive symptoms and greater adherence to treatment following the intervention and at 6 and 12-week follow-ups (Sirey et al., 2010). Both interventions represent different methods which involve psychoeducation to optimize treatment engagement. Older adults may be especially likely to benefit from psychoeducational programs as they have been found to have poorer mental health literacy rates compared to younger adults (Fisher & Goldney, 2003; Farrer et al., 2008; Hadjimina & Furnham, 2017; Malkin et al., 2019).

Although the interventions described above are proven effective, they are also resource-intensive. As such, brief and easily accessible methods of enhancing engagement are worthwhile areas of future research. What is more, researchers have developed evidence-based recommendations for effective psychoeducational interventions. These recommendations emphasize using simple and accessible materials that mental health consumers can easily understand (Meppelink et al., 2015; Visscher et al., 2018). Evaluations of online resources suggest that many psychoeducational materials are at a higher than desirable reading level (Bernstein et al., 2021; Hardman et al., 2022). Researchers have suggested that lower reading level materials may reduce cognitive load (Muscat et al., 2021). For older adult populations specifically, research has indicated that older patients value information to be easily accessible in a brief format with options for where to find more information if they desired (Reynolds et al., 2023).

With these psychoeducational resource guidelines in mind, the aim of the current article is to describe how we used data and recommendations from interviews with patients (Del Rosario et al., in press) to develop a novel pamphlet. Specifically, this paper describes in detail a logic model which served as a guide and visual representation of how previous research and

interview data informed the pamphlet content and anticipated outcomes in terms of how it might be used to enhance treatment engagement.

Methods

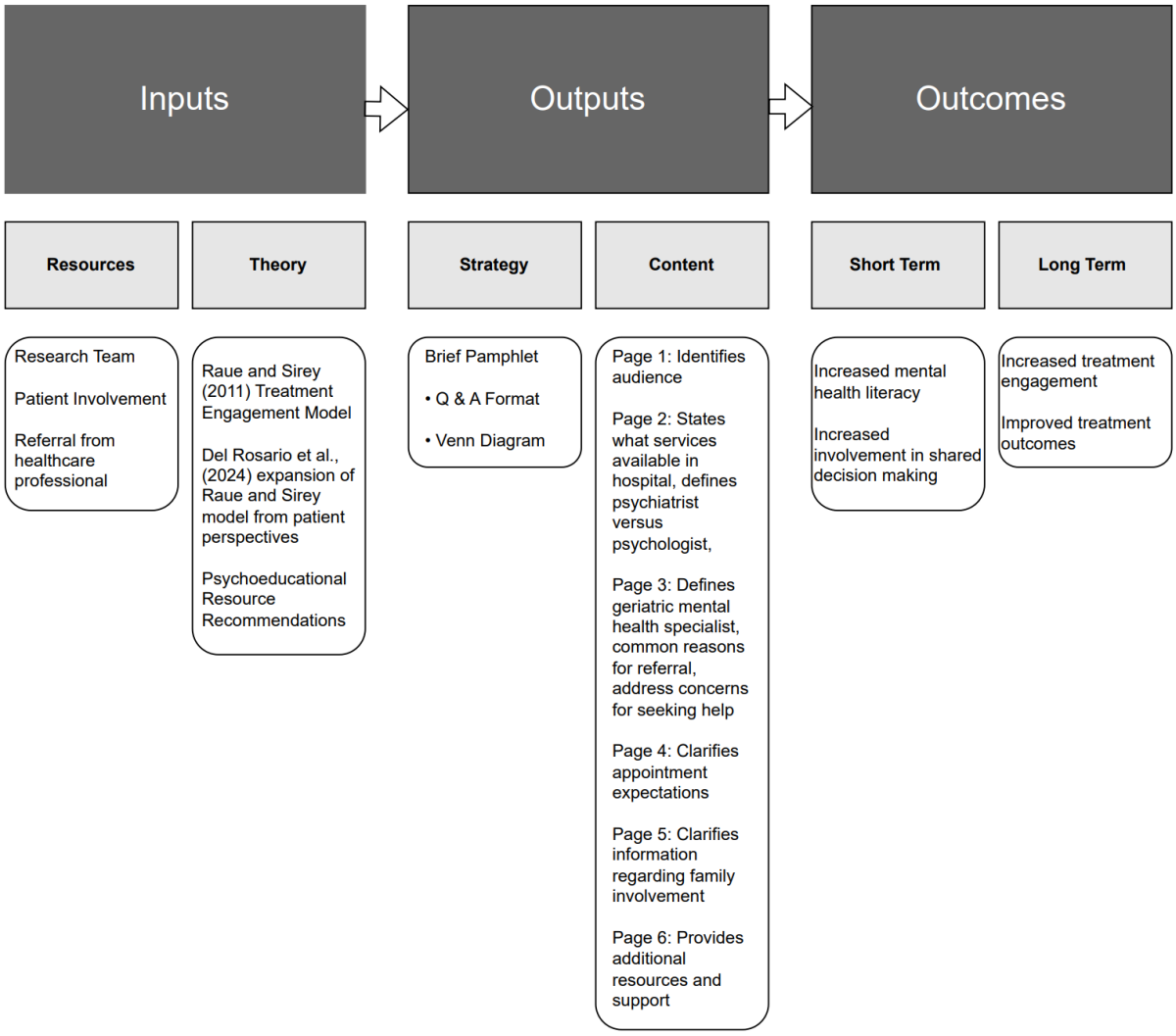
Participants

To be considered for this study, patients had to be at least 65 years old, fluent in English, and referred to specialty geriatric mental health services with primary anxiety, depression, or stress-related issues; we excluded patients where the primary reason for referral was cognitive impairment. Recruitment criteria mirrored the intended audience for the pamphlet: outpatient older adults referred to either geriatric psychiatry or geropsychology services at two tertiary-level hospitals in a large Canadian city for concerns of depression, anxiety or stress. Two clinical geropsychologists and four geriatric psychiatrists working in these settings facilitated recruitment (December 2021 –December 2022) by describing the study to patients who were recently referred to geriatric psychiatry and geropsychology outpatient clinics. Del Rosario and colleagues (in press) provide further information on data collection procedures and participant demographics.

Logic Model

As outlined in Figure 1, the logic model serves to visually display the underlying theory of using mental health psychoeducation to improve treatment engagement and subsequently guides the development of the psychoeducational pamphlet (Kaplan & Garret, 2005). The logic model below describes and visually presents the pamphlet's inputs, outputs, and outcomes. The aim of the psychoeducational pamphlet is to provide older adults with information that will promote their engagement in the referral process and discussions about treatment with the specialist they are being referred to.

Figure 1. Logic Model of Psychoeducational Pamphlet Development



Inputs

Resources

The logic model's inputs include the resources available to develop the pamphlet (i.e., research team and patient perspectives) and consideration of when to recruit participants within the treatment engagement process. The research team comprised of geriatric psychiatrists, hospital and university-based clinical psychologists, and a clinical psychology doctoral graduate student. This team provided diverse experience and relevant expertise in this project. An integral part of the resources leading to project development was also the 13 patients who were referred

to geriatric psychiatry or geropsychology services and participated in interviews. In terms of the broader context, the referral process to specialty mental health services is initiated by a healthcare provider, and the patient is then contacted regarding the appointment of a consultation. This particular time point was selected to capture an older adult's first contact with a geriatric mental health specialist. While situated in the same hospitals, geriatric psychiatry and geropsychology are part of different departments and do not share referral waitlists. By including inputs of the logic model, resources available for the pamphlet are considered.

Theory

A number of theories influenced the development of the pamphlet, including Raue and Sirey's (2011) theoretical treatment engagement model, Del Rosario and colleagues' (in press) extension of this model from the perspective of patients, and research recommendations regarding best practices in psychoeducational development (Meppelink et al., 2015; Muscat et al., 2021; Reynolds et al., 2023, Visscher et al., 2018). The foundational theory underlying the pamphlet is based on Raue and Sirey's theoretical treatment engagement model. While helpful, this theoretical model focused on depressed older adults and on individual-level factors influencing treatment engagement. The second primary influence on the development of the pamphlet was patient interviews from Del Rosario and colleagues (in press) which addressed many of these gaps. These interviews extended the previous theoretical model by expanding its applicability to a wider variety of non-cognitive concerns, such as anxiety and stress. Further, it incorporated a novel theme that included the dynamic and social aspects of the referral process. Regarding modifiable individual-level factors, themes were also expanded and highlighted the role of mental health literacy. Lastly, psychoeducational resource recommendations were incorporated into pamphlet development. Recommendations emphasize using simple and

accessible materials that mental health consumers can easily understand (Meppelink et al., 2015; Visscher et al., 2018). As such, a brief paper pamphlet without complex tables and figures aligned with these suggestions. The National Institute of Health recommends that health information has a reading level of Grades 6-8 (Skiekowski et al., 2019). To adhere to this recommendation, we used the Simple Measure of Gobbledegook (SMOG) evaluation (McLaughlin, 2008) as a measure of reading level regarding the years of education a reader would need to understand the material. SMOG, as a readability assessment tool, has been recommended for healthcare applications (Wang et al., 2013). The SMOG score was calculated by inputting the largest text page, "What can I expect from my appointment?" into the calculator. This page scored a readability index of Grade 8. This rating is in line with The National Institute of Health recommendations.

Outputs

Strategy

Participants recommended a paper-based pamphlet as the optimal delivery method for psychoeducation because they felt it was the most accessible and favourable option for enhancing engagement for most older patients (Del Rosario et al., in press). Despite research suggesting potential benefits (Berman et al., 2009) and increasing use of technology among older adults (Alsabeeha et al., 2023; Hong & Cho, 2017), the interviewed sample expressed the benefits of a paper pamphlet rather than an online resource. Some participants also shared the desire for telephone follow-up; from a resource perspective, this method may face potential limitations given the lack of personnel and resources to support a new program. Finally, participants also shared a preference for self-guided options. Taking into account these

preferences and limitations of telephone follow-up, a paper-based pamphlet was selected as the medium for this resource.

The pamphlet's layout was organized based on answers to questions that older adults shared about their geriatric mental health consultation appointment. For instance, a common theme during interviews was that participants shared unclear expectations of their appointment. The pamphlet addresses this with a page titled "What can I expect from my appointment?" followed by information patients described would have been helpful to know (e.g., screening for memory problems may take place). The pamphlet also employed the use of a Venn diagram to display differences and similarities between mental health specialists visually.

Content

Table 1 summarizes the pamphlet's contents. In addition, participants' guiding responses are described in the rationale for including content in the pamphlet. Figure 2 presents the novel pamphlet that was developed using the logic model.

Table 1. Overview of Pamphlet Content and Rationale for Inclusion

Content	**Summary and reason for inclusion**
Cover Page	Summary: • Identifies the intended audience (patients referred to specialty hospital mental health services) and outlines what information to expect from the pamphlet Rationale: Patients expressed frequently seeking care from a variety of specialists due to often complex comorbid physical concerns and not always being aware of what specialist appointment they were attending. As such, identifying the intended audience of the pamphlet provides information for the patient regarding both psychiatry and psychology referral options.
Page 1	
"What mental health services are	Summary

available through the hospital"	• Identifies that a primary care provider has made a referral to speciality mental health services and that psychiatry and psychology services are available through the hospital Rationale: Some patients expressed lack of knowledge that their primary care provider had made a referral. Many patients also lacked knowledge of what mental health resources were available in the hospital system.
"What is the difference between a psychiatrist and a clinical psychologist?"	Summary: • Venn diagram outlining the differences (training and specialization) and similarities (both specialize in assessing and treating mental health) between psychiatrists and clinical psychologists • External website link for further information Rationale: Patients expressed unclear and at times incorrect understanding of the differences between psychiatrists and psychologists. Delineating the differences in training and specialization can enhance mental health literacy regarding knowledge of providers. A link for more information was provided based on a minority of patients requesting resources for trusted information.
Page 2	
"What is a geriatric mental health specialist?"	Summary: • Provides a definition of a geriatric mental health specialist as a provider with specialized training for adults 65+ Rationale: Patients expressed a range of reactions in learning the consultation appointment was with a geriatric specialist. Patients shared not knowing there was specialty training dedicated to older adult mental health concerns. Some patients expressed a sense of comfort that providers would be well-versed in the concerns of older adults given their dedicated training while others expressed a sense of shock to be categorized as an older adult. Providing advanced knowledge of this specialty aims to enhance awareness of this subsection of providers.
"What are common reasons for referral?"	Summary: • Lists changes in mood, difficulty with coping, and cognitive changes as common reasons for referral Rationale: Many patients were unclear about mental health symptoms and reasons for referral. Providing common reasons for referral is aimed to introduce mental health concerns across a variety of referral reasons to future patients. Given the diversity of referral reasons, specific symptoms and diagnoses were avoided. Moreover, as geriatric-focused clinics often also provide support for cognitive changes, this was included as a potential referral possibility.

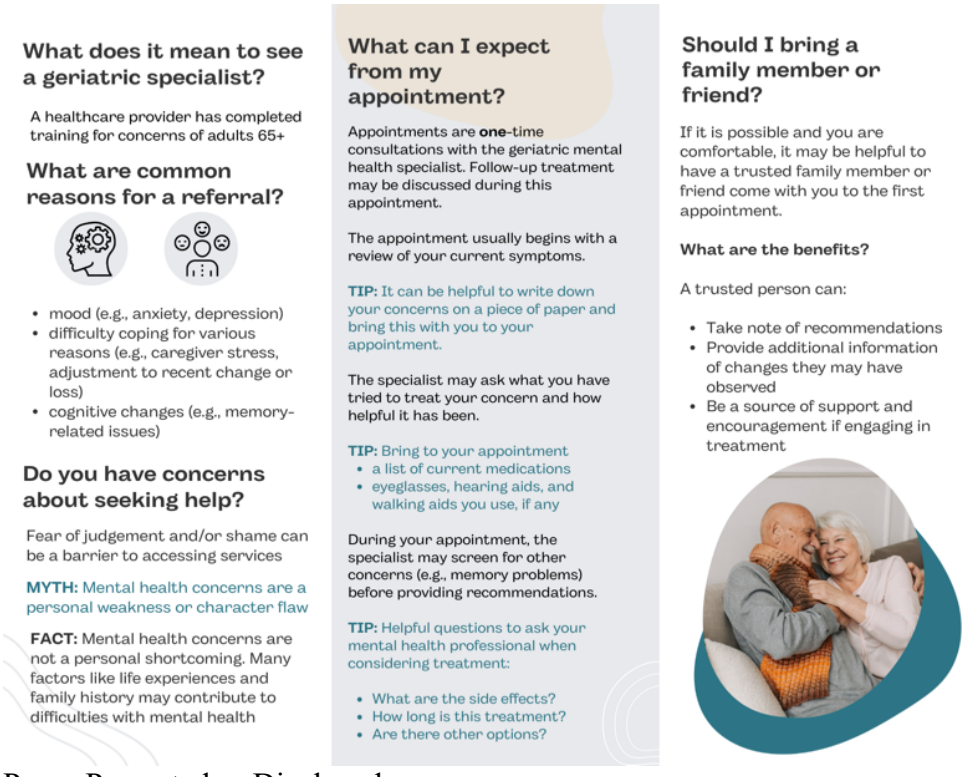
"Do you have concerns about seeking help?"	Summary: • Identifies fear of judgement and shame as potential barriers to accessing services • Presents "myth" that mental health concerns are a personal weakness or character flaw • "Fact" portion notes that life experiences and family history may contribute to difficulties with mental health. Rationale: Patients spoke of stigma related to having a mental illness as well as stigma related to help-seeking. Many patients discussed the perception that their struggles with mental health were a personal shortcoming. Patients also expressed the desire for understanding the etiology of mental health concerns. The stigma portion of the pamphlet includes phrases used by patients in expressing their fear of being seen as weak. The fact portion is aimed at providing a brief introduction that mental health concerns are multifaceted in development.
Page 3	
"What can I expect from my appointment"	Summary: • Appointments begin with one-time consultations that may lead to follow-up treatment • Cognitive screening may occur • Provides tips such as writing down concerns to discuss, bringing a list of medication and any mobility aids to the appointment, list of questions that may be asked to the providers (e.g., what are the side effects of treatment?) Rationale: Patients were surprised to learn that an appointment with the specialist did not immediately include follow-up care. This portion of the pamphlet aims to provide information regarding the expected time commitment of the appointment. Patients also shared surprise that cognitive screening often took place in appointments even if this was not perceived to be a concern. A list of questions was included in an effort to encourage patients to engage in shared-decision making for treatment. Many patients described their experience as a 'passive recipient of healthcare' and feeling uninformed or intimidated to ask questions regarding their treatment.
Page 4	
"Should I bring a family member or friend?"	Summary: • If appropriate, patients are encouraged to bring a trusted family member or friend to the first appointment • Lists benefits of family or friend attending appointment Rationale: Participants expressed varied preferences for family involvement. One participant described benefits of family taking note of

	recommendations and also providing collateral information and support. On the other hand, another participant expressed feeling that their independence was threatened with the provider's assumption that their spouse would be involved. The latter participant expressed the desire that spousal involvement was presented as a choice rather than assumed. This portion of the pamphlet aims to present familial involvement as a choice and noted benefits that some participants shared.
Page 5	
Additional Resources and Supports	Summary: • Encourages patients to speak with their referral source about information provided in the pamphlet • Lists self-guided resources for mood, anxiety, memory, and social programming • Provides community service navigation contact Rationale: Participants expressed unclear navigation of services. This portion of the pamphlet aims to redirect them to the primary care provider or a community contact for assistance in navigating potential resources. The list of resources was selected based on participants' preferences for self-guided resources concerning mood, anxiety, and memory concerns, as well broader social programming.

Figure 2. Psychoeducational Pamphlet for Older Adults Referred to Specialty Geriatric Mental Health Services



Inner Fold Back Cover Front Cover



Pages Presented as Displayed

Outcomes

The final column depicts the anticipated short and long-term outcomes for patients receiving the psychoeducational pamphlet. The psychoeducational pamphlet is proposed to have a positive impact on mental health literacy and shared decision-making for older adults by way of improving knowledge of treatment and encouragement to partake in informed discussions of their mental health care. It is assumed that with these improvements, patients may feel better engaged in the referral process to geriatric mental health services. Subsequently, with improved treatment engagement, patients are more likely to initiate and adhere to treatment and, as a result, have better treatment outcomes (Raue & Sirey, 2011).

Discussion

This paper aimed to describe the development of a psychoeducational intervention in the form of a pamphlet for older adults referred to specialty mental health services. As Cumming and colleagues (2022) note, the developmental process of new interventions is rarely reported but is important for understanding and future research. Using a logic model, the relationship between the setting, theory, use of pamphlet, content included, and intended outcomes is visually represented and served as a guide for its development. The pamphlet was developed using a rigorous approach based on theory (Del Rosario et al., in press; Raue & Sirey, 2011), psychoeducational recommendations (Meppelink et al., 2015; Muscat et al., 2021; Reynolds et al., 2023, Visscher et al., 2018) and patient perspectives with lived experience of the referral process. Notably, there has been a shift to recognizing patients as “co-pilots” to healthcare-oriented research (Anderson & McCleary, 2015). In this way, recent research has focused on ways of collaborating with patients to better understand their healthcare needs (Forsythe et al., 2018; Phoenix et al., 2018; Pushparajah, 2018).

The current study’s approach has a number of strengths, limitations, and challenges.

One of the strengths of the developed pamphlet was its collaboration with patients who have lived experience of the referral process. This way, the intervention is modelled to be relevant and appealing to its intended audience. While patient-oriented, it did not consider other stakeholder perspectives, such as providers and referral sources involved in the referral process. Future research would benefit from potentially modifying the pamphlet to include these perspectives. Another strength of the developed pamphlet is its format. As a pamphlet, information is presented in brief with directions to access further information if desired and with the flexibility of being viewed online or as a printed copy. This is in line with previous research findings suggesting that older adults desired mental health information to be presented in a brief format with options to find more information if desired (Reynolds et al., 2023). Lastly, the pamphlet has the potential for adaptation to different contexts and clinics. For instance, one participant noted wanting to have a Francophone version of the pamphlet. In the future, the pamphlet may be tailored to specific clinics and contexts, reaching a larger population of older adults.

A limitation of the current sample is its size, selection bias, and lack of diversity. While saturation was reached in interviews, it would benefit future research to explore perspectives from a greater number of people, including those less likely to engage in treatment. Those who participated in the current study may represent those who are more likely to embody greater treatment engagement as they had already attended their consultation appointment and were willing to speak about their suggestions for improvement. Less time-intensive participation, such as questionnaires rather than an interview, may enable more older adults to participate in such research. Furthermore, all participants self-identified as White and were generally well-educated. The lack of diversity in the current study's participant sample echoes and emphasizes trends of disparity in accessing services among racially and socioeconomically diverse patients and older

immigrants in Canada (Guruge et al., 2015; Jimenez et al., 2013). It would benefit future research to remove language exclusion criteria and collaborate with translators to explore treatment engagement in a wider sample of older adults.

A challenge we faced when developing a brief pamphlet was balancing the large amount of content that could be included and the depth and diversity of information presented. Further, practical implementation challenges exist for the use of this pamphlet in current referral systems. For instance, psychiatry and psychology departments are not unified in many hospital departments and often have different patient capacities dictated by staffing. A consequence of these varied resources across departments is that should patients feel empowered to advocate for certain services, the system may not be able to respond. Despite a documented preference for psychotherapy over pharmacotherapy for adults (McHugh et al., 2014), and older adults (Gum et al., 2006), there remains a relatively lower number of psychologists working in the public setting (Nicholson et al., 2004). Due to the extensive wait for public psychology services, most Canadians personally pay for psychotherapy (Bartram & Chodos, 2018). The number of psychiatrists is also less than desirable, and even more so geriatric psychiatrists (Aggarwal et al., 2022). The overall low number of psychiatrists and, even more so, psychologists in hospital settings may suggest to policymakers the need for increased funding in these mental health support sectors. Future research would benefit from exploring feedback on this pamphlet before its use and assessing its intended outputs delineated in the logic model, including treatment adherence and treatment outcomes.

Conclusion

Previous research supports the benefits of engaging patients throughout the process of referral and treatment. This paper presents a brief and low-cost resource developed in

conjunction with patients with lived experience with the referral process to geriatric mental health services to enhance treatment engagement. This paper could also support researchers and clinicians in psychiatry and psychology to develop or modify this intervention for older adults referred to these mental health services by providing in-depth descriptions of its development and theoretical rationale. The goal of such an intervention is to enhance older adults' treatment engagement, specifically at the point of first contact with a mental health specialist. The potential long-term impacts of psychoeducation include improved treatment outcomes for large and growing numbers of older adults with mental health challenges, a promising area of future study.

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CHAPTER FOUR: Feedback on a Psychoeducational Pamphlet about Geriatric Mental Health Services: A Qualitative Study

Abstract

Background and objectives: Older adults are less likely to access mental health services, have lower rates of mental health literacy, and often express a lack of active participation in treatment decision-making. Research suggests that taking into account patient preferences will improve how engaged they may feel during the referral and treatment process and, as a result, lead to better treatment outcomes. Despite older adults' desire for knowledge about mental health treatment options, deficits in mental health literacy remain. The current study aimed to gather patient feedback on a novel psychoeducational pamphlet to ensure that it was relevant and seen as useful for its intended audience. **Methods:** Twelve patients aged 65 and older (seven psychiatry, five psychology) presenting with concerns of anxiety, depression, or stress answered questions about the pamphlet. Interviews were analyzed using the framework analytic method. **Results:** Themes based on participant feedback included understandability, presentation, and accessibility of the pamphlet. In addition, themes related to overall usefulness and background factors influencing the perception of the pamphlet were coded. Participants noted opportunities to improve the pamphlet's content and visual presentation. **Implications:** Overall, participants expressed positive reactions to the pamphlet and suggested that it be implemented by their primary care providers. Enhancing mental health literacy in older adults is expected to improve engagement in treatment and subsequent treatment outcomes for growing numbers of older adults. Future research should evaluate whether this pamphlet effectively improves mental health literacy and treatment engagement in older adults.

Keywords: *psychoeducation; mental health; treatment engagement; aging; qualitative*

Introduction

The aging population faces several challenges in accessing and engaging with mental health services. These barriers include accessibility (Pepin et al., 2009), systemic barriers such as low rates of referral (Park & Unützer, 2011), social barriers of complex treatment pathways (Pescosolido et al., 2013; Berard et al., 2020) and psychological barriers, such as poor mental health literacy (Reynolds et al., 2020; Mackenzie & Pankratz, 2022). Even for those older adults who navigate these challenges, a lack of treatment engagement can be an additional barrier to successful patient outcomes. Raue and Sirey (2011) conceptualize treatment engagement as a process in which older patients remain involved in discussions and decisions around referral, treatment recommendations, treatment initiation, and treatment outcomes. Although many factors affect an older adult's ability and willingness to remain engaged in the referral and treatment process, a key factor is knowledge about that process, otherwise known as mental health literacy (MHL; Jorm et al. 1997). Improving MHL in older adults is paramount as research has found that they are less able to recognize mental health challenges and demonstrate poorer knowledge of these issues than younger adults (Robb et al., 2003; Hadjimina & Furnham, 2017; Malkin et al., 2019). This trend is striking, considering that inadequate health literacy is associated with reduced preventive service compliance leading to poor quality of care and patient satisfaction (MacLeod et al., 2017).

A growing body of qualitative literature has explored treatment decision-making and found that older adults often describe a a preference for a less active role in these decisions (Bastiaens et al., 2007; Cole et al., 2017; Reynolds et al., 2020; Williams-Roberts et al., 2018). Various factors likely influence older patients' willingness and ability to take an active role. For instance, Cole and colleagues (2017) presented older adults with a theoretical vignette and

explored preferences for decision-making in the scenario in which participants no longer had decision-making capacity. In these interviews, participants shared their preferences and the expectation of paternalistic care, with most older adults expressing their preference for physicians to make decisions on their behalf. Participants noted factors such as expertise and dependency and reliance on trusting their physicians's judgement due to their medical knowledge (Cole et al., 2017). Similarly, in qualitative research exploring older adults' narratives of seeking mental health treatment at a tertiary Canadian hospital, participants reflected on a form of system-induced passivity, with individuals neither resisting nor actively seeking out psychological treatment (Reynolds et al., 2020). Participants voiced a lack of understanding of psychological treatment once referred to psychological services. In both of these studies, participants experienced a sense of dependency or passivity stemming from a lack of medical knowledge. Thus, enhancing knowledge about mental health symptoms and treatment is a promising way to encourage older patients to take a more active role in medical decision-making (Jorm, 2012; Kim et al., 2017; Reynolds et al., 2020).

Given that low levels of MHL can have a detrimental impact on treatment engagement, it is fortunate that research supports the promising impact of psychoeducational interventions for increasing MHL (Jorm, 2012) and treatment engagement (Raue et al., 2019; Sirey et al., 2010; Sirey et al., 2016). However, two key limitations of many current psychoeducational interventions exist. First, many written psychoeducational resources do not meet recommendations of appropriate reading level, provide insufficient information, and lack visual aids (Hardman et al., 2022). Research suggests that psychoeducational information is most effective for consumers under certain conditions, such as when psychoeducational material uses language that is accessible to the public without providing too much detail that burdens the

consumer (Bernstein et al., 2021; Meppelink et al., 2015; Reynolds et al., 2023). Second, most psychoeducational resources are developed without patient input and may not meet their informational needs or preferences.

Including patient perspectives in resource development has many benefits, including the creation of relevant resources that are seen as more acceptable and, therefore, usable by the intended audience. Researchers note that seeking patient feedback lessens the gap between theoretical relevance and practice (Johnston et al., 2021). For instance, in a systematic review, Cosco and colleagues (2014) note that researchers and older adults viewed "successful aging" differently, either emphasizing physical functioning or psychosocial aspects respectively. Moreover, Sepucha and colleagues (2008) asked patients and providers to rank the importance of facts, goals, and concerns in healthcare decisions and found significant differences in how patients and providers ranked items. Consequently, the authors note the importance of including patient perspectives in developing healthcare informational tools. Bechtel and Ness (2010) argue that policymakers cannot understand what a healthcare user desires if there is a discrepancy between what providers treating their patients think they want and what the patient actually wants. Indeed, researchers tasked with developing an intervention face the same challenge and run the risk of devoting significant resources to an intervention that might ultimately be seen as unacceptable and unhelpful by patients (Swartz et al., 2022). Overall, the benefits of patient-oriented research are widespread and include the empowerment of patients, enhanced relevance for its intended audience, and improved knowledge translation (Pauly et al., 2019; Veldmeijer et al., 2023).

Considering the benefits of patient involvement, research has begun to explore patient feedback in the development of psychoeducational resources and interventions (Alvidrez et al.,

2010; Newman et al., 2021; Sibitz et al., 2007). With this in mind, we recently interviewed patients referred to specialty geriatric mental health services, asking them how their referral experience could have been improved and how they might have felt more engaged in this process (Del Rosario et al., in press). Those interviews were guided by Raue and Sirey's (2011) treatment engagement model for older adults, which suggests that older patients may be better engaged in treatment if their attitudes, preferences, and expectations regarding treatment are considered. Patients in that study expressed the desire for psychoeducation regarding aspects of the referral process that were unclear or confusing to them, and recommended that this information be delivered in a pamphlet format. Del Rosario and colleagues (in preparation) outline how patient preferences and informational needs guided the development of a psychoeducational pamphlet.

Aims

The current study aims to continue co-creating a brief MHL resource with patients by gathering additional patient feedback on a recently developed pamphlet to increase MHL in older adults referred to geriatric psychiatry and geropsychology hospital services.

Materials and methods

Participants and Recruitment

We obtained ethics approval for this study before commencing data collection (University of Manitoba HS25817, H2023:015). We recruited participants for the current study in two ways. First, we approached participants from a recently completed study where they provided suggestions for designing the MHL pamphlet (Del Rosario et al., in press). The first author recontacted individuals regarding their potential interest in participating in this second study to provide their feedback on the psychoeducational pamphlet that we created based on their

input. Of the initial thirteen individuals interviewed, seven (54%) participated in the feedback interview. Of the previous participants not successfully interviewed, one was deceased, one could not be contacted, and four declined, noting scheduling conflicts and/or worsening health. Second, we approached new patients recently referred to geriatric psychiatry and geropsychology services. Six participants were recruited this way, with five individuals providing consent and completing the interview. All participants were initially recruited by two clinical geropsychologists and four geriatric psychiatrists working in two tertiary-care hospital settings in a large Canadian city. These professionals facilitated recruitment by describing the study to geriatric psychiatry and geropsychology outpatient clinic patients.

To be considered for this study, participants needed to be at least 65 years old, fluent in English, and presenting with anxiety, depression, or adjustment concerns without a primary diagnosis of cognitive impairment. Clinicians assessed presenting concerns and level of cognitive impairment during the initial appointment with patients based on their clinical judgement. As is typical of qualitative research, participant recruitment, interviews, and data analysis occurred concurrently.

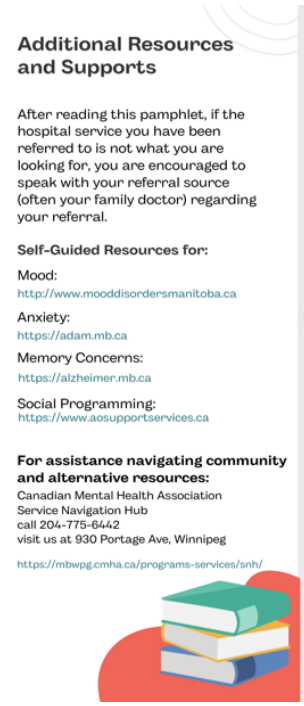
Procedures

Following assent, participants were mailed a packet of questionnaires and a printed version of the novel pamphlet. The pamphlet is presented in Figure 1. After providing informed consent, participants completed a sociodemographic questionnaire and the Patient Education Materials Assessment Tool for printed materials (PEMAT-P; Shoemaker et al., 2014). We collected basic demographic information at the beginning of the study (age, gender, ethnicity, marital status, education, occupational status, household income) as well as information on self-reported physical health, self-reported impact of physical health on functioning, and self-reported referral

wait-time. The PEMAT measures understandability (assesses aspects such as content, word choice, organization, and visual aids) and actionability (assesses the likelihood that the reader could use the information to take action). Each item is rated with either 0 (Disagree), 1 (Agree), or a non-applicable response (Don't know). For the PEMAT, participants were required to review the pamphlet and indicate their scores on each item. The scores are then averaged across participants to give a percentage ranging from 0 to 100% of each domain. Questionnaire responses were returned in a postage-paid return envelope. Participants then participated in a single-session semi-structured individual interview by telephone (n = 9) or Zoom (n = 3). At the beginning of the interview, all participants were prompted to reread the pamphlet. Interview times ranged from 40 to 81 minutes and lasted 55 minutes on average. A qualitative approach was selected for the current study to gather rich and thorough feedback regarding patient perspectives of the pamphlet that may then guide additional modifications prior to a larger dissemination. In brief, interviews solicited feedback page by page on the psychoeducational pamphlet with prompts regarding its content, presentation, accessibility, and overall usefulness. The research team developed the semi-structured clinical interview based on relevant topics outlined in the PEMAT (Shoemaker et al., 2014). Recruitment ended following the 12th interview, where saturation was reached, and no new themes emerged (Miles & Huberman, 1994). Participants received a $20 gift card as an honorarium.

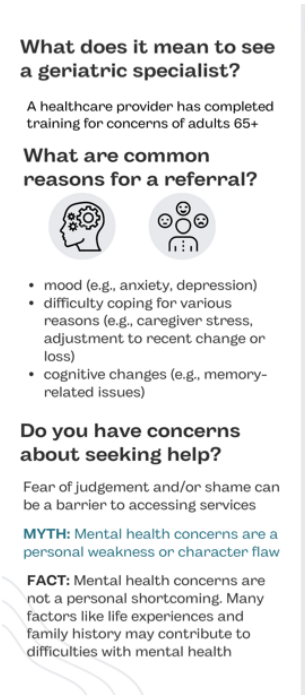
Figure 1. Psychoeducational Pamphlet for Older Adults Referred to Specialty Geriatric Mental Health Services

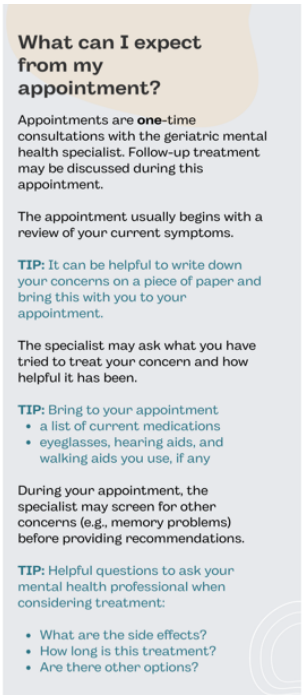


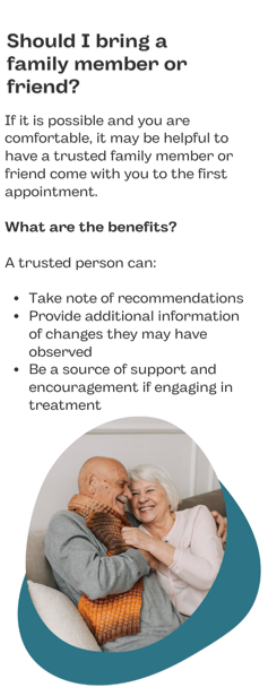




Inner Fold Back Cover Front Cover







Pages Presented as Displayed

Analytic Procedure

The interviews were audio-recorded and professionally transcribed. The interviewer then anonymized and reviewed transcripts for accuracy before importing files into NVivo12 for coding. Interviews were analyzed by the analysis team (N. Del Rosario, V. Krysanski, and C. Mackenzie) using the framework method (Pope et al., 2000; Ritchie et al., 2013). The research team was comprised of a clinical psychology doctoral student and two clinical psychologists holding a primarily clinical and academic role respectively. A thematic framework was identified deductively based on themes theorized to be relevant from prior research (i.e., PEMAT) and inductively based on novel information that emerged from the data. Accordingly, the framework method was appropriate for this study as it was guided by previous theories on psychoeducational materials (Shoemaker et al., 2014) and also allowed for new themes to be coded based on participant interviews. The team discussed coding and interpretation discrepancies allowing for discussion from multiple perspectives. As such, the findings underwent cross-checks for rival explanations and were consistent with previously established standards for rigorous qualitative research (Malterud, 2001). The decisions in the analysis were documented to uphold dependability (Levitt et al., 2018; Tracy, 2010). Furthermore, to support reflexivity, the interviewer made field notes of immediate impressions and thoughts following the interviews, which included potential biases (Tracy, 2010). As the researcher primarily responsible for developing the pamphlet from patient interviews and also the interviewer for feedback, N. Del Rosario attempted to be aware of her own potential bias to seek positive feedback and thus reflected on the purpose of the study prior to interviews. As well, she proactively welcomed critical feedback with open-ended interview probes.

Results

Sample characteristics

Between April 2023 and August 2023, nineteen individuals were approached for participation. Twelve participants provided informed consent and completed the study (response rate of 63%). Table 1 shows the characteristics of the sample.

Table 1. Sample Characteristics

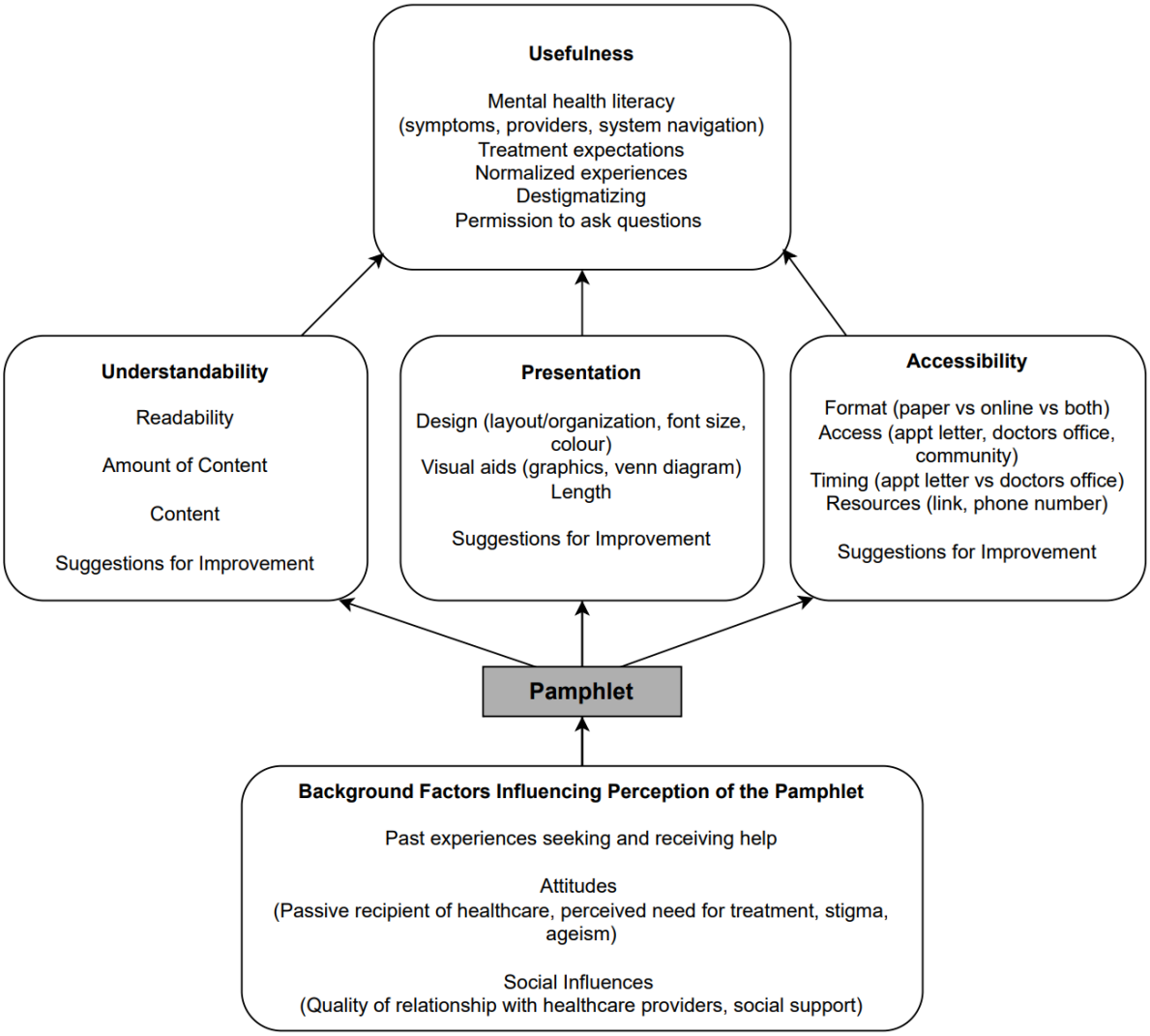
	Total Sample
N	12
Age (mean(range))	69.7(66-75)
Gender *n (%)*	
Female	7(58%)
Male	5(42%)
Service Accessed *n (%)*	
Psychiatry	7(58%)
Psychology	5(42%)
Retired	11
Married	11
Ethnicity	
White	10
Indigenous	1
South-Asian	1
Education	
High school or GED	2
Some college	5
Completed college	4
Post graduate degree	1
Household Income	
20,000-39,999	3
40,000-59,999	2
60,9999-79,999	1
80,000-99,999	3
100,000+	3
Self-Rated Physical Health	
Poor	1
Fair	5
Good	2
Very Good	4

Self-Rated Impact of Physical Health Concerns on Functioning	4
Not at all	5
A little	3
A great deal	
Self-Report Wait Time in Months (mean(range)	4.8 (2-9)
Patient Education Materials Assessment Tool (%)	
Understandability	91.3
Actionability	86.7

Overview

The final framework included five main themes with corresponding sub-themes that capture overall usefulness, perceptions of the pamphlet (understandability, presentation, accessibility), and background factors influencing perceptions of it. Throughout these main themes, participants generated suggestions for improvement. The five major themes are discussed below.

Figure 2. Visual Representation of Patient Feedback on Novel Psychoeducational Pamphlet



Usefulness

Participants spoke of various benefits of exposure to the pamphlet, categorized as the first main theme, usefulness. Specifically, participants spoke of the benefits of increased knowledge of symptoms, providers, and system navigation under the broader subtheme of MHL. Participants noted that the information also addressed questions they had regarding treatment expectations and provided a sense of permission to ask their provider questions.

Participants reported that the pamphlet helped normalize their experiences with respect to struggling with their mental health. Participant 5 shared, “When you see a pamphlet, you say to yourself, well, you know what, this is a thoughtful approach to mental health that I’m not alone; there’s a lot of us.” What is more, participants also shared that they received an anti-stigma message in addition to feelings of normalized experiences. For instance, Participant 1 shared,

> “The pamphlet is very good, and it makes you feel like you’re not alone. ….You’re not by yourself, and you’re not crazy. That’s the whole thing that a lot of elderly people feel that there’s something wrong with them, and there’s not.”

Participant 4 echoed the importance of including the “myth/fact” portion of the pamphlet, “I think that unfortunately…there’s still that feeling that, I don’t want to be referred to a psychiatrist because people will think I’m crazy, or that fear of the unknown or shame.”

Understandability

A second main theme that emerged, as expected from the PEMAT (Shoemaker et al., 2014), was understandability. Within this theme, participants spoke about the pamphlet’s readability, amount and type of content it included, and provided suggestions for additional content. Ten out of the twelve participants described the pamphlet as an appropriate reading level. Participant 10 described the pamphlet using “everyday language.” Similarly, Participants 1, 4, and 9 described the pamphlet as “easy to read.” Notably, two participants suggested that the pamphlet was at a higher than desired reading level, noting that while they understood the pamphlet, they did not feel others would. All participants also expressed that the amount of content was appropriate. Participant 7 spoke of a “fine line” between too much and too little content and described that the pamphlet “hits the balance.” When reviewing the pamphlet’s content, some participants suggested additional information to be included, such as clarification

about the cost of services and explicitly stating that patients may ask their providers what their diagnosis is or about biological factors related to their diagnosis. A few participants also shared the desire for additional versions of the pamphlet in French and braille.

Presentation

We categorized a third main theme, again as expected from the PEMAT (Shoemaker et al., 2014), as presentation. Within this theme, participants spoke about the pamphlet's design, use of visual aids, and provided suggestions for improvement. This theme elicited diverse responses, with some participants noting positive responses to certain graphics while others provided negative responses. Overall, all participants reacted positively to the pamphlet's font type and size (Body Grotesque, ranging from 11.5 – 17 size). Participant 10 noted that "the size of the text was very helpful, I don't know if that was intentional but that's great for people that are 65 and older." Reactions to the colours of the pamphlet ranged from neutral, "fine" (Participant 3) to the majority of participants expressing positive responses, such as "That really attracted me right away. I love the teal blue" (Participant 4) and "The colours are perfect" (Participant 7).

Interestingly, not all participants read the pamphlet in the same sequence; however, this did not appear to impact its flow. For instance, Participant 8 shared that he initially did not realize there was a back side of the pamphlet but that, in retrospect, "it could go both ways, you know." In terms of visual aids, Participant 11 shared the benefit of including visuals throughout the pamphlet; "It breaks it up. The visuals help that it's not too dry to read." All but one participant appreciated content explaining the differences between psychologists and psychiatrists using a Venn diagram. In terms of graphics, participants had varied reactions to the graphics. Participant responses to the cover photo, ranged from neutral "The graphics on the

front page was fine because what else are you going to put there, right?" (Participant 2) to negative "I thought your cover was pretty boring" (Participant 3). A common suggestion for the cover photo, as well as other graphics, was using a photograph instead of an abstract image when possible.

Accessibility

A fourth main theme that emerged from interviews was the accessibility issues related to the pamphlet. Participants were unanimous in their responses, preferring a paper copy of the pamphlet rather than an online resource; "It's something you can hold onto, you can look at it, you can put it away for a while, come back to it and refer to it" (Participant 9). However, some participants noted that a virtual option in addition to a physical copy might be helpful; "I'm old-school, I like it on paper, but it has the benefit of being able to access it online as well" (Participant 12). More specifically, Participant 7 shared that while they preferred a paper copy, having a paper version for themselves and an online copy he could share would be ideal.

Regarding additional information and resources in the pamphlet, participants suggested including phone numbers for community resources rather than a website, as this was viewed as more accessible. Many participants shared the potential of having this psychoeducational pamphlet shared in the community. For instance, Participant 1 shared the desire to see this displayed in older adult community group centers as well as in larger community spaces to share with family; "I think it's not only available to us, I think some family members would like to have this. To be able to get this information before they even talk to their mother or father, or whoever, their aunty or whoever they're looking after." Participant 10 shared a similar sentiment and suggested that the pamphlet be available at pharmacies, and Participant 2 added grocery stores as a potential distribution point.

While many participants shared the desire for greater distribution of the pamphlet, most participants expressed a strong preference that it be distributed mainly by their primary care provider; “First stop is your family doctor, that is my opinion, that’s where you start” (Participant 1). Participant 9 shared the advantage that if a primary care provider shares this with the patient when the referral is made, it allows the patient to ask questions and be aware that a referral is being made.

Background Factors Influencing Perception of the Pamphlet

Throughout the analysis, the team coded a fifth novel main background factors theme comprised of three subthemes that impacted how they engaged with the pamphlet: past experiences seeking help, attitudes (i.e., ageism, stigma, passive recipient of healthcare, and perceived need for treatment), and social influences (relationship with referral sources, social support). Some participants spoke of how their previous mental health help-seeking experiences have affected their willingness to seek services. For instance, Participant 1 shared that her prior negative experiences with medical professionals led her to feel very nervous about attending her first consultation. She later highlighted portions of the pamphlet that addressed her fears (e.g., myth and fact regarding seeking services) as most impactful. Another participant shared that the pamphlet served as a summary of her previous therapy experiences: “I’ve been in therapy for so long that I think it was all pretty much what I expected.”

Participants also described various attitudes influencing their perception of the pamphlet. These included the role of a patient as a passive recipient of healthcare, perceived need for treatment, ageism, and stigma. When reflecting on whether she would discuss her treatment preferences with a provider, Participant 2 shared, “Maybe other people might just speak up and say stuff, but I just sit and do as I’m told.” Another participant reflected on how she viewed the

pamphlet and how other older adults may view it, “it all depends on how depressed you are” (Participant 6). In this way, she spoke about how her perceived need for treatment influenced her openness to the pamphlet. Participant 12 shared a sense of unease viewing the term “geriatric”, he likened it to “It’s like being a juvenile, a delinquent, or something….it just has that connotation that, oh, gosh, I’m a worst-case scenario or something.” Similarly, Participant 6 expressed some hesitation that a pamphlet aimed at older adults indicated that “it makes you think that the seniors are the only ones with a problem.”

The most common attitudinal factors mentioned by participants were stigma towards seeking mental health services and the stigma of having a mental disorder. Many participants spoke of feeling ashamed of needing to seek mental health services. One participant described: “I think that unfortunately that’s still, even with all the talk out there, there’s still that feeling that I don’t want to be referred to a psychiatrist because people will think I’m crazy, or that fear of the unknown and shame” (Participant 4). Similarly, Participant 7 echoed, “you don’t want to say you’re going to a psychiatrist or a psychologist because that must mean I’m crazy.” Participant 9 expressed the fear of asking for help, which to him meant that he was in some way deficient as a person: “When I sat down with my doctor and told him what I was going through, I was very hesitant to do that. And again, because of the fears I have, showing a weakness that I have.” Participant 1 spoke about feeling the shame of having a diagnosis, “that they would be afraid of having a mental illness.” Lastly, Participants 1 and 3 were afraid that seeking services might lead to hospitalization. Participant 1 expressed, “You just feel shame, and you just feel embarrassed, and you feel that they are just going to lock me up.” Participant 3 reacted to the word hospital in the brochure as, “Hospital means, whoa, they might admit me. You know?”

The final subtheme within background factors captured social influences on how participants perceived the pamphlet. Participants 1 and 4 shared that knowing others in their social circle who have sought services made the process less scary. Participant 1 expressed, "Unless you've had friends that have been through it or whatever…it's scary." Participant 4 shared, "For me, I was lucky that most of my friends have seen counsellors or one of them was seeing a psychiatrist. So when I mentioned that I was going, everybody was really supportive." In addition to family and friends, participants also discussed the relationship with their primary care provider as influencing their perception of the pamphlet and its recommendations. For instance, Participant 4 shared a positive relationship with their family doctor and uncertainty about how other individuals navigate if this is not the case: "I have a great family doctor, so I wouldn't have any problems calling him back and discussing further with him. But I'm just wondering if some people who don't necessarily have or can't always get in touch with their doctor…" Overall, participants highlighted the role of relationships with providers or social support as influencing their reaction to the pamphlet.

Discussion and Implications

The psychoeducational pamphlet was developed based on suggestions by older adults regarding information they would have liked to receive prior to being referred to specialty geriatric mental health services to better engage them in the referral and treatment process (Del Rosario, et al., in press). By involving individuals with lived experience, the developed psychoeducational resource is situated to be relevant and useful to its intended audience (Veldmeijer et al., 2023). In line with previous research, older adults shared that they were unfamiliar and uncertain about treatment providers and treatment options (Reynolds et al., 2020). They also expressed feeling like passive recipients of healthcare as a result of this limited

knowledge and understanding of treatment. In this way, MHL emerged as a key component of treatment engagement and an opportunity for intervention. Consistent with principles of patient-oriented research (Novak-Pavlic et al., 2023), patients were involved throughout the intervention development process, not only in generating the content and format of the pamphlet but also in providing feedback after it was developed.

As expected, the themes that emerged as participants discussed the pamphlet were consistent with the assessment domains outlined in the PEMAT-P (Schoemaker et al., 2014). Perhaps most important was the theme of understandability, encompassing factors such as word choice and layout. Overall, participants reflected that the pamphlet's content was accessible to the everyday consumer, they appreciated the visual aids, and they had suggestions such as using photographs rather than abstract images.

The PEMAT also measures actionability, identifying what a consumer may do based on the information presented (Shoemaker et al., 2014). Participants in the current study did not speak of how the pamphlet may influence the next steps they might take in their treatment, likely because we interviewed them after they may have been engaged in treatment. When reflecting on the last page of the pamphlet, which states that individuals may discuss their preferences for the referral with their care provider, one participant described trust in their doctor's judgement of referral to a service (i.e., psychiatry versus psychology): "you're not in a position to decide whether you really need or don't need this service." Instead of actionability, participants spoke of the overall usefulness of the pamphlet, which focused on subthemes of normalized experiences and increased general knowledge of mental health.

Unexpectedly, participants also spoke of the role of background factors that impacted how they perceived the pamphlet. Some participants spoke of recommendations to see the

pamphlet in other languages. This is not surprising given that research has identified language barriers as an additional challenge to help-seeking for underrepresented populations (Teo et al., 2022). Participants frequently spoke of individual attitudes and social factors, such as the quality of their relationship with healthcare providers, as significantly influencing their engagement with the pamphlet. Including this theme is a key novel contribution of this study, highlighting potential moderating factors that could influence the impact of a brief psychoeducational intervention. Similar to previous research, participants shared experiences of paternalism or being passive recipients of healthcare (Del Rosario et al., in press; Cole et al., 2017; MacRae, 2018; Reynolds et al., 2020). Participants also shared concerns about ageism and stigma for seeking services that aligned with previous research (Del Rosario et al., in press; MacRae, 2018; Reynolds et al., 2020). In the current study, participants expressed variability in attitudinal factors such as passivity and stigma. This finding aligns with previous research suggesting that older adults vary in their preference to be involved in healthcare decisions, with some deferring to their doctor as expert (Cole et al., 2017). Findings by Bastiaens and colleagues (2007) note that older adults' preferences for involvement in their care span a spectrum, but often, the focus is on having a "caring relationship" with their healthcare provider rather than being an "active participant in decision making." These findings place the background factors participants voiced in context, such as the importance of the relationship with their primary care provider, attitudes towards seeking help, and stigma towards seeking help.

The current study's results have implications for research and practice. The pamphlet follows emerging research and intervention development recommendations of including patients with lived experience in research (Bechtel & Ness, 2010; Johnston et al., 2021; Mauer et al., 2021). By including patient perspectives in this research, the psychoeducational pamphlet is

tailored to meet the expressed needs of those it is meant to be relevant to. A reasonable next step in this iterative intervention development process would be a randomized control trial (RCT) to test whether exposure to such a pamphlet impacts MHL, attitudes towards seeking help, and stigma. Long-term outcome studies may also investigate whether this brief psychoeducational intervention impacts patients' treatment outcomes in domains such as symptom reduction, resiliency, and increased well-being. Certainly, resilience and well-being have been identified as worthwhile areas of focus for older adults, but may also have the extended benefit of decreasing demands on treating providers (Cosco et al., 2017). However, long-term outcome targets of relevant domains may also be decided in consultation with patient partners to determine what outcomes are most relevant to older adults engaging in treatment.

Practice implications also include the role of social processes in patient healthcare experiences. Participants expressed the desire for greater involvement of their referral sources, often their primary care providers. These results support previous research which suggests that relational continuity in healthcare is essential for older adults (Williams-Roberts et al., 2018). In qualitative research, older adults described the desire and preference for long-term relationships with their primary care providers, noting that they often sacrifice convenience for continuity with the same primary care provider. Results from the current study support this trend in that participants overwhelmingly provided feedback that they preferred to be presented with and had the opportunity to discuss the pamphlet with their primary care provider. These findings also support previous research, which has found that older adults reported healthcare professionals as a preferred source of mental health information (Reynolds et al., 2023). However, this may also present a significant practical challenge, given that a staggering number of individuals do not

have access to reliable primary care (Duong & Vogel, 2023) and a shortage of general practitioners is likely to be a growing concern (Dumesnil et al., 2024; Prunuske, 2020).

Findings from this study should be considered in light of a number of limitations. Some participants in the current study were previously interviewed regarding input on the creation of the pamphlet. It may be that some of these participants were reluctant to provide critical feedback due to their participation in its creation or follow-up interview with the original interviewer. However, participants appeared to be balanced and open in their feedback on the pamphlet. The interviewer noted that all participants were highly engaged in providing feedback, often coming to the interview appointment with notes and all participants having read the pamphlet prior to the interview. Furthermore, the effort was made to also seek feedback from newly recruited participants to address this potential bias. As such, the feedback provided during interviews did not appear to be unduly influenced. In fact, having prior interviews with some participants emerged to be a study strength that aligned with older adults' emphasis on the importance of building relationships, not unlike the social influences subtheme. It appeared that previous participants were more willing to share certain information (e.g., identifying with an ethnic minority in the demographics questionnaire), which may have been prompted by feeling a greater sense of trust within the researcher-participant relationship. Yet, a limitation remains that not all previous participants completed follow-up interviews. While the vast majority of this was related to declining health as a reason for the inability to participate, the current findings may neglect feedback from individuals who felt no longer engaged in treatment and, thus, less motivated to participate in follow-up. Again, less time-intensive feedback by way of questionnaires may support retention efforts in future studies. Second, while the involvement of individuals with lived experience was incorporated into research, greater involvement of patients

in research design and analysis would further align with patient-oriented research recommendations (Novak-Pavlic et al., 2023). Third, the current study does not address the majority of individuals who experience mental health challenges and do not seek services (Horackova et al., 2019; Wang et al., 2007; Wang et al., 2023). The present sample all were referred to specialty mental health services and attended a consultation appointment. It is not surprising that the sample was well-educated and predominately White, as this reflects greater trends in healthcare access (Guruge et al., 2015; Jimenez et al., 2015). Due to these selection biases, the pamphlet may overestimate the readability of the pamphlet. The current dissertation is also inherently selective for individuals who chose to participate in this research, perhaps having a greater interest or likelihood to engage in treatment than the general population. Future research would benefit from addressing the large number of individuals who do not seek or access mental health services, perhaps by utilizing broader MHL campaigns.

In conclusion, older adults are the least likely age group to access mental health services (Eden et al., 2012; Mackenzie et al., 2012) and have low rates of MHL (Hadjimina & Furnham, 2017; Malkin et al., 2019). The current study builds upon previous research in which we developed a pamphlet based on the expressed informational needs and preferences of older adults referred to geriatric specialty mental health services (Del Rosario et al., in press; Del Rosario et al., in preparation). Feedback from patients with recent lived experience being referred to specialty geriatric mental health services found the pamphlet to be helpful and effective. Results of the current study also highlight older adults' preferences for receiving such psychoeducation through their primary care providers. Before disseminating such a pamphlet into practice it will be important to assess its effectiveness, ideally using an RCT. Our new pamphlet was developed using a method that is both patient-oriented and evidence-based,

entwining practice and research. This approach is time-consuming but is better suited to meet the mental health needs of growing numbers of older adults with mental health concerns (Johnston et al., 2021; Maurer et al., 2021; Veldmeijer et al., 2023).

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CHAPTER FIVE: General Discussion

The aim of the current dissertation was to explore patient perspectives on the process of referral and treatment within geriatric mental health services, and to identify opportunities for improvement. This information then guided the development of a pamphlet based on participants' expressed desires. In this general discussion, I first provide a summary of the studies, discuss how my positionality influenced the current study, followed by a review of the clinical implications of my findings and future directions of this research.

Research Summary

The goal of Study 1 was to identify opportunities to enhance patient engagement in the referral process to geriatric mental health services by exploring, via qualitative interviews, the experiences and preferences of persons with lived experience of this process. My co-authors and I coded four main themes impacting the treatment engagement process: Background Factors, Social Influences, Modifiable Individual Factors, and Opportunities for Improvement. Results expanded Raue and Sirey's (2011) theoretical treatment engagement model in later life in several ways. First, it explored patient perspectives with a variety of mental health presentations, including anxiety and stress, to expand the model's applicability from its original focus on depression. Second, a novel main theme of social influences expanded the model's initial focus on individual-level factors affecting treatment engagement. Third, a number of novel subthemes emerged within factors that were originally in the model, such as MHL and nuanced treatment preferences. Overall, participant interviews highlighted the key role of MHL, flexibility of treatment preferences, and the dynamic social processes involved in their recent experiences being referred to specialty geriatric mental health services.

The goal of Study 2 was to describe the development of a novel psychoeducational pamphlet, created based on findings from Study 1, aimed at increasing MHL to promote

treatment engagement. A logic model was used to visually present how Raue and Sirey's (2011) theoretical treatment engagement model, interview data from Del Rosario and colleagues (in press), and psychoeducational resource recommendations (Meppelink et al., 2015; Skiekowski et al., 2019; Visscher et al., 2018) guided the development of this pamphlet. As noted by Cumming and colleagues (2022), developmental processes of new interventions are helpful to report in understanding the intervention and also guiding future research. By outlining the rationale and development of the pamphlet, it was apparent that this approach had many strengths as well as some limitations. For instance, the pamphlet's brief format was seen as feasible and preferred by patients. However, the pamphlet was limited in respect to the amount of information it could include, being a single page. It is also subject to implementation challenges in siloed specialist care.

The goal of Study 3 was to gather patient feedback on the co-created psychoeducational pamphlet intended to increase MHL in older adults referred to geriatric mental health services. By seeking additional feedback on this pamphlet from a selection of participants who were initially interviewed in the development phase, as well as patients more recently referred to these services, the pamphlet underwent scrutiny regarding its perceived usefulness. My co-authors and I coded five main themes that emerged from these feedback interviews: Background Factors Influencing Perception of the Pamphlet, Understandability, Presentation, Accessibility, and Usefulness. Overall, participants provided positive feedback on the pamphlet and noted some areas for improvement, such as increased use of photographs rather than abstract images and explicit prompts for questions such as, "What is my diagnosis?" Participants also universally recommended that this resource be distributed by primary care providers. An important next step will be to test the newly developed intervention in a clinical trial (Onken et al., 2014).

Taken together, the findings from my dissertation research provide a framework for patient involvement in the development of psychoeducational resources. The current line of research involves persons with lived experience in the innovation of a strategy, in this case, a psychoeducational pamphlet, to improve treatment engagement in specialty mental health services for older adults. This began with understanding patients' expressed barriers to treatment engagement and subsequent suggestions for improvement (Study 1), synthesizing this data into the desired format (Study 2), and presenting the developed pamphlet for feedback (Study 3) in the spirit of co-designing a strategy to improve treatment engagement. In this way, ideas shared in Study 1 shaped the research design and questions of subsequent studies. Findings emphasize the importance of seeking patient perspectives and feedback as a way to maximize strategies to improve treatment engagement. In essence, these findings provide nuanced information about patients' perspectives and experiences in the referral process to specialty mental health services as the preliminary steps involved in treatment engagement and the development of a resource approved by patients.

Impact of Positionality on Results

As noted at the beginning of this dissertation, an important part of qualitative research involves reflecting on how one's position may influence the research process. Below, I reflect on how my position may have also impacted the results of this research. Exploring geropsychology and geriatric psychiatry participants in tandem was heavily influenced by my training in Clinical Psychology but also my own personal relationships, as my husband is a geriatric psychiatrist. In this way, I occupy a unique position in that I am perhaps more familiar with these two referral processes than other trainees in Clinical Psychology. Exploring both of these services is also influenced by the collegial professional nature in Winnipeg, in which every specialist in these

services personally knows one another. Furthermore, as a resident at the University of Manitoba Clinical Health Psychology program, psychology residents are part of the medical union and are entitled to the same privileges as medical students, unlike other residency programs. The esteemed role of psychology in Winnipeg was also highlighted by my previous Master's training at the University of Regina, where psychologists often do not hold positions within hospital systems. Influenced by seeing ways in which psychology and psychiatry share space in Winnipeg hospitals fostered the exploration of both of these specialties in my dissertation, which may not have been as nurtured in other provinces. The dissertation's greater implications for collaboration within and across professions are influenced by my optimistic perspective regarding healthcare transformation. The results of the current study are also influenced by the context in which it took place and may not be generalizable to more rural settings where geriatric mental health specialists are not available.

Clinical Implications

There are several clinical implications that arise from this work extending to patients, clinicians, healthcare systems, and healthcare policymakers. Treatment engagement initiatives for older adults could have a significant benefit and impact on the large and growing number of older adults seeking mental health services locally, as well as beyond the local context in which these studies took place. The results from the present dissertation present a potential resource that may be implemented in specialty mental health care in Winnipeg, Manitoba. Arguably, the group most impacted by the implementation of such a resource would be the patients who would receive this pamphlet. The primary aim is that the pamphlet addresses questions that arise for many older adults when they are referred to a hospital-based mental health care specialist. By providing even brief amounts of highly relevant information, patients may benefit in at least

three ways. First, at the very least, the provision of information regarding an appointment may impact attendance at the first appointment (Kluger & Karras, 1983). Second, by providing information regarding the services available, the process involved, and direction for additional resources, my hope is that older adults are better informed regarding their mental health concerns, providers, and how to navigate these systems and, as a result, feel more engaged. In the current research, participants described the created pamphlet as useful and beneficial, which may impact satisfaction in their healthcare experience. Third, previous research suggests that older adults often have a less active role in treatment decision-making (Bastiaens et al., 2007; Cole et al., 2017; Reynolds et al., 2020; Williams-Roberts et al., 2018). Furthermore, experiences of seeking mental health treatment often involve a convoluted pathway of "muddling through" in which they neither seek out nor actively resist treatment (Berard et al., 2020; Pescosolido et al., 2013; Reynolds et al., 2020). Should exposure to the pamphlet increase knowledge of treatment options or destigmatize help-seeking, the implications of this resource may be greater treatment adherence, patients expressing their preference for certain treatments, and, in the long-term, better treatment outcomes.

The findings from this dissertation also offer several recommendations for current specialty providers on how to maximize treatment engagement when a patient attends their consultation appointment. First, specialist providers may benefit from explicitly including question prompts that patients noted were helpful. Consistent with prior research (Cole et al., 2017; MacRae, 2018; Reynolds et al., 2020), in Studies 1 and 3, participants described feeling like passive recipients of healthcare. When reviewing the pamphlet, participants noted it was helpful that specific questions they might ask their provider were listed. Many participants expressed feeling that this gave them a sense of permission to ask questions about their mental

health and treatment. Awareness on the part of specialty mental health care providers that many patients often leave their appointments with unanswered questions such as “What is my diagnosis?” and “What is the cost of appointments?” because they are hesitant to ask their providers, suggests that providers could and perhaps should address these common questions preemptively during their appointments. Further, participants also expressed appreciation for the pamphlet helping them feel less alone in their experiences, captured by the subtheme of “normalized experiences.” This research finding may support professionals sharing with their patients the prevalence of certain diagnoses. Armed with this knowledge, along with the recurring themes of importance in quality of patient-provider relationships across studies, providers may be prompted to emphasize validation and support when patients share concerns of feeling alone in their difficulties.

The dissertation findings also provide detailed information to providers of the factors that may be potential moderators to treatment engagement. In both Study 1 and Study 3, participants spoke about background factors related either to their treatment engagement or influencing their perception of the pamphlet. Across these studies, patients spoke of the influence of how their previous experiences seeking and receiving help might positively or negatively impact their current experience. With this information, specialty mental health care providers may pay special attention to learning more about these experiences in order to address any barriers that may be interfering with treatment engagement. Overall, for specialty providers, findings from this research might provide additional support for their current interview style or prompt reflection on how they might address these factors better in a consultation appointment. Not only do the research findings support specialty provider practices, they also complement current training. In a way, the themes arising from Study 1, in particular, may complement many professionals'

training in the biopsychosocial model and increased calls to recognize the dynamic nature of this model (Lehman et al., 2017). Components of the biopsychosocial model are represented in the current treatment engagement model with social factors reflected in the social influences theme, psychological factors reflected in the individual modifiable factors theme, and biological factors incorporated into the background factors theme. If anything, the current findings serve as a reminder to healthcare professionals to consider the many factors involved in treatment engagement and the benefits of exploring these factors during their consultation appointments.

The results from the present dissertation also have implications for current healthcare systems in terms of the demand and wait times for services. Although past research suggests that older adults prefer psychological compared to pharmacological treatment (Gum et al., 2006; McHugh et al., 2013), participants expressed nuance to these preferences in interviews. In particular, participants often described difficulty stating a preference due to a limited understanding of what psychiatry and psychology might offer. What these services offer may also be influenced by the clinicians themselves and not only outlined by specialty service. Despite geriatric psychiatry operating on a consultation model, with single session appointments and pharmacological recommendations provided and implemented by the referring doctor, in the current dissertation, some participants noted being followed by the geriatric psychiatrist following the consultation for medication management and supportive therapy. On the other hand, geropsychology typically offers psychological treatment over several individual therapy sessions and yet two participants noted they did not engage in follow-up appointments with the psychologist as their questions and concerns were addressed in the consultation appointment. Evidently, there is variability in the level of follow-up provided by the provider and also desired by the patient. Lack of understanding of treatment options informing preferences leads to delays

in care. For instance, one patient shared her preference for psychological therapy, but was not aware that her referral to psychiatry would most likely not include this treatment option. As a result, she waited months to see a psychiatrist under the expectation of receiving talk therapy only to be rereferred and to wait an additional several months for another appointment with a psychologist. By addressing the desire for more information regarding mental health treatment options, patients may be better informed about their treatment options and, as a result, be more likely to express their treatment preferences. A related challenge, however, is that a better understanding of mental health providers and their treatment options may lead to patients sharing potential treatment preferences with their referral source that health systems are unable to respond to due to clinician shortages. For instance, if the documented preference for psychological treatment compared to pharmacology (Gum et al., 2006; McHugh et al., 2013) emerges by enhancing older adults' awareness of treatment options, patients may experience longer wait times to access these services. For example, at the hospitals in which the current studies took place, there are 1.5 geropsychologists and 8 geriatric psychiatrists. This discrepancy was not lost on some participants. For example, one participant shared that wait times in relation to her severity of illness would dictate her preference for pharmacology versus psychological treatment. In this way, treatment preferences appear to be dynamic and flexible and, at times, based on systemic challenges.

Furthermore, participants also noted systemic challenges including long wait times and siloed care, in that psychiatry and psychology constitute separate referrals. Research has supported that confusion on how to access services, long wait times, and a shortage of clinicians serve as barriers to mental health needs (Moroz et al., 2020). In response to these challenges, participants in Study 1 identified system-level recommendations for improvement, including the

integration of services and triage, which necessitates greater integration and collaboration between services.

The current research also has implications for current healthcare systems by supporting greater collaboration between primary care providers and geriatric mental health specialists (i.e., psychiatrists and psychologists). Overwhelmingly, participants noted the importance of the relationship with their primary care providers in their healthcare experience, preferring that information about their referral to specialty services come from these providers. These findings are in line with previous research that suggests older adults prefer receiving health care information from their providers (Reynolds et al., 2023) and value continuation of care over convenience (Williams-Roberts et al., 2018). These preferences are at odds with the fact that many individuals do not have access to reliable primary care (Duong & Vogel, 2023). Indeed, the current research supports the need to improve access to primary care providers. However, a greater number of primary care providers does not resolve system challenges. Notably, primary care providers face challenges of working with older patients with often complicated comorbid physical and mental health concerns in a time-pressured environment (Bartels & Drake, 2005). Thus, ways of supporting primary care providers are warranted. Greater collaboration between primary care providers and geriatric mental health specialists may involve the creation of psychoeducational resources tailored to primary care providers and clarifying referral pathways and treatment services available. If patients are unclear about how to navigate the mental health system and look to their primary care providers for support, it would follow that supporting primary care providers by ensuring they are well-informed is paramount. It may be that additional information and questions are included in referral forms that clarify what services are available. Research has begun to explore using electronic referral methods with promising

outcomes including reduced wait times and improved coordination between primary and speciality services (Straus et al., 2011; Tuot et al., 2015).

Furthermore, armed with the knowledge that older adults value their relationships with primary care providers, integration into specialty services within these healthcare settings may be beneficial for treatment engagement (Gupta et al., 2019) and for underrepresented groups in particular (Ayalon et al., 2007). Past research has reported older patients were more likely to accept mental health treatment in primary settings than in a mental health specialty clinic and as such, integrated services would improve mental health service utilization (Bartels et al., 2004). It is important to note that research by Bartels and colleagues, now two decades old, has suggested the same policy reforms which the current dissertation supports, that coordinated and integrated mental health and primary care sectors would benefit older adult mental health care service utilization. This reform has been termed primary care transformation. Henderson and colleagues (2023) have examined various reform models across 15 countries. It is notable that all of these models used multiple components (e.g., group practice setting, multidisciplinary teams, community engagement) as strategies for transformation. Despite the growth in the literature examining patient perspectives, Henderson and colleagues note that many reviews of primary care transformation do not examine its impact from patient perspectives. Promising emerging research has identified case coordination as an effective way to engage outpatients of underserved communities in New York with positive feedback from both patients and clinicians (Ng et al., 2024). Overall, greater collaboration between primary care providers and geriatric mental health specialists spans a spectrum of communication relaying service information via psychoeducational resources to more active collaboration in sharing treatment spaces.

Finally, the potential dissemination of the novel psychoeducational pamphlet also impacts decision-makers involved in healthcare policy. As noted, one implication of this research is the call for greater collaboration between primary care providers and specialists, which might involve some degree of restructuring current systems, with the inclusion of a mental health care specialist within a primary care site. However, given that knowledge translation of research into healthcare systems has significant lags (Davis et al., 2003) capitalizing on the potential benefits of brief and feasible interventions is paramount. The pamphlet presents a brief and low-cost potential resource that may be adopted by current mental health care systems. In effect, the pamphlet represents the potential for low intensity-high volume impact. There has been a recent growth in the use of low intensity-high volume (LI-HV) interventions in the United Kingdom (Clark, 2018) and within Manitoba (Vincent et al., 2021). The primary principle of this approach to care is using a low amount of specialized provider time in a cost-effective way, such as seeing more than one patient at a time, seeing patients for fewer or shorter sessions, or supporting the use of self-help or other resources (Bower & Gilbody, 2005). In Manitoba, LI-HV interventions have been commonly used in a progressive stepped-care model by psychologists in tertiary hospital settings who are underfunded and pressed for resources (Vincent et al., 2021). From these clinician experiences, patients were not always aware of what their providers were referring them for. Similarly, some patients were seeking medication treatment and/or community-based services. Information provided in a LI-HV program such as QuickStart for Overcoming Anxiety, a 2-session psychoeducational introduction to anxiety and cognitive-behavioural therapy skills for anxiety, allowed patients to be redirected sooner to a preferred resource rather than waiting for an individual appointment to assess suitability for the psychology service. In a similar and yet even lower intensity way, the pamphlet serves as a

psychoeducational introduction to geriatric hospital services and provides redirection for additional resources. For instance, policymakers may have invested in an online psychoeducational program for older adults in an effort to meet the mental health needs of the aging population that, according to participants in the current dissertation, would not have been accessible. As such, the results of the current dissertation may support the funding decisions of policymakers in healthcare.

The current dissertation also highlights issues regarding access to services, considering the deficits in primary care providers and the discrepancy between geropsychology and geriatric psychiatry providers. These results are relevant to policymakers considering retention and training for these professions. On a broader level, the current dissertation supports previous research regarding policy recommendations for increasing health service accessibility for older adults. The World Health Organization (2007) developed a guide for policies that would support older adults within cities. This guide noted that a frequently mentioned barrier by older adults to accessing care is insufficient knowledge about the health services available, echoed by participants in the current dissertation. The guide suggests advertising local health services and educating adults on service options as potential strategies to address this barrier. The current dissertation aligns with the second suggestion of educating older adults by way of a pamphlet. Another noted possibility is funding a telephone support line that may serve as an informational directory for services (WHO, 2007).

Further, the pamphlet may serve as a template and guide for developing or modifying the pamphlet in a variety of contexts. For instance, it may be useful across Canadian mental health care sites. The method followed in developing the pamphlet may also serve as evidence of the benefits of involving individuals with lived experience in the adaptation of such a pamphlet to

novel contexts and patient populations. While the pamphlet may serve as a template and guide, it is important to note that it may not be immediately generalizable for different contexts. For instance, the collegiality and familiarity between geropsychology and geriatric psychiatry in Winnipeg and the inclusion of both of these separate services in the same pamphlet may not translate to other cities in which these services operate without familiarity. The current research is also impacted by accessibility to specialty training, and the created pamphlet would not be generalizable to other locations, such as rural Manitoba, that may not have access to these specialists. Despite these limitations, the pamphlet also presents to patients, clinicians, and policymakers an opportunity to provide a brief resource that spans mental health diagnoses. This may be especially important to older adults who may be experiencing comorbid concerns and as a result, has impact on a wider audience.

Limitations and Future Directions

While participants perceived the pamphlet as useful in its current form, it is important to assess its effectiveness prior to its dissemination in a larger sample. It may be that a less time-intensive feedback process would invite participation from more patients. For instance, a questionnaire measuring satisfaction alongside the pamphlet may be provided to every individual referred to services. In this way, feedback may also be potentially gathered from individuals who do not attend the consultation appointment and is less time-intensive than an interview. Broader recruitment efforts may also address the limitation of the current dissertation in that patients who participated in the current research are potentially inherently more engaged in treatment, having attended the consultation appointment and also willing to use their time to provide suggestions for improvement. Ideally, a randomized control trial would be used to assess the impact of exposure to the pamphlet on MHL, attitudes toward seeking treatment, and self-stigma. From a

service perspective, it would be interesting to measure whether exposure to this pamphlet impacts attendance rates for consultation appointments. Long-term outcomes could also be measured, including treatment adherence and overall treatment outcomes. In a broader context, another theoretically relevant outcome to measure is potential benefits for well-being (Cosco et al., 2017). It would also behoove researchers to consult with patient partners on any additional outcomes that may be relevant to assess. For instance, a recent study highlighted the discrepancy in mental health needs of older adults as expressed by older adults versus social organization leaders and government officers (Chen et al., 2023). The authors of that study noted that older adults placed greater emphasis on the need for social interaction. If patients in the Winnipeg catchment echo this sentiment, improvement in social interaction may be considered an important treatment outcome to assess in determining the usefulness of such a pamphlet. By using a randomized control trial to examine these potential impacts, the pamphlet would bridge the gap between evidence-based practice and patient-oriented research efforts. Future research could also explore more fully ways the pamphlet may also maximize engagement in the consultation appointment. Patients noted questions such as, “What is my diagnosis?” and where to go next for services following the consultation appointment. Perhaps a future iteration of the pamphlet would not only include these question prompts but also dedicate space for patients to not only ask these questions during the appointment but also record answers that they may revisit following the appointment. While the focus of the current dissertation was to answer questions patients had coming into their consultation appointment, it may be that also supporting questions that patients have following this appointment optimize treatment engagement in these services. Future studies may build on the current research findings by exploring whether these additions

impact treatment engagement operationally defined as medication adherence and/or psychotherapy attendance and participation in treatment.

The addition of a quantitative aspect of this research would also complement the qualitative focus of the present research. Qualitative methods were most appropriate to gain an in-depth understanding and capture the nuances in patient experiences in the preliminary steps of treatment engagement as they were referred to specialty mental health services. In Study 1, the aim was to explore patient perspectives in a process that was guided by theory (Raue & Sirey, 2011). Framework methodology was an appropriate approach for this analysis as it explored the inductive aim while also being influenced by theory. Qualitative methods were also used to obtain detailed feedback on the pamphlet, which facilitated opportunities for patients to share personal experiences with the pamphlet and express how their own lived experiences impacted their perceptions of the pamphlet. Given the detailed and rich feedback gained through qualitative interviews, it would be appropriate to extend this research by better understanding its impacts in a quantitative manner which may support implementation and policy change. Specifically, these policy recommendations may suggest primary care transformation, the need for greater integration of specialty services, and also the rising demand for specialty services.

While patient perspectives were a focus of this research, even greater patient involvement throughout the research process, including study design and analysis, would further align with patient-oriented research recommendations (Pushparajah, 2018). Though time-intensive, the benefits of more involved patient engagement are improving the relevance and usefulness of research (Maurer et al., 2022). As noted, patients may be consulted in future research on relevant outcomes. Furthermore, patients may also be consulted regarding implementation decisions should resources be unavailable with respect to their expressed preferences. For instance,

patients may be consulted if it would be reasonable to provide the pamphlet with their consultation appointment letter should resources not allow for larger implementation in primary care. While it is important to emphasize patient perspectives, future research would also benefit from exploring these perspectives alongside other relevant stakeholders in the treatment engagement process (e.g., geriatric mental health specialists and primary care providers). By engaging other stakeholders, greater collaboration across specialties may be fostered.

Finally, participants of the current dissertation are predominantly White and well-educated. The limitations of the current sample appear to reflect barriers to accessing mental health services in general. It is important to note that the current study does not address the majority of individuals who do not seek mental health services despite a need for treatment (Horackova et al., 2019; Wang et al., 2007; Wang et al., 2023). The current research provides some insight into factors that may impact this trend, such as perceived need and stigma related to seeking services. It would benefit future research to consider strategies to improve engagement in mental health treatment prior to the referral process. This larger outreach may be guided by findings from the current dissertation. Although participants preferred their primary care provider as the source of information regarding their referral, many participants also noted the benefits of having mental health information in more widespread community contexts, such as community centers and even grocery stores. Greater MHL efforts may also be of benefit and may reach individuals not already involved in the referral process. As well, it would be worthwhile to specifically target these MHL towards older adults facing unique barriers to help-seeking, such as newcomers to Canada. (Guruge et al., 2015). Further, many participants expressed satisfaction in participating in the current research as a way to share the wisdom gained from their experiences. It may be that greater patient involvement in these MHL efforts includes peer

support strategies that have been shown to have positive impacts on domains such as symptom severity, healthcare service satisfaction, service uptake, and reduction in self-stigma (Bellamy et al., 2017; Conner et al., 2015; Maunder & White, 2022). Overall, additional research on factors impacting access to mental health treatment prior to referral, as well as the outcomes of the use of this pamphlet, serve to better place this research in the context of mental health service use.

Conclusion

The population is aging (Beard et al., 2016). Alongside this fact are several trends supported by research, including that mental health concerns remain prevalent in later life (WHO, 2023) and that older adults are less likely to seek mental health services compared to their younger counterparts (Eden et al., 2012; Mackenzie et al., 2012). Contributing to lower mental health care utilization is poor MHL among older adults (Hadjimina & Furnham, 2017; Malkin et al., 2019). Taken together, these trends are concerning in that MHL often informs treatment preferences, that when met are related to better treatment outcomes (Dixon et al., 2016). Accordingly, the mental health care system faces the challenge of engaging older adults in treatment while also experiencing a shortage of providers and limited coordination across specialties and with primary care providers (Dumesnil et al., 2024; Moroz et al., 2020; Prunuske, 2020). Rather than assume what might be useful to patients in the waiting period between referral to specialty mental health services and the consultation appointment, patients in this dissertation research were asked to share their experiences and thoughts on how this process might be improved. Patients shared the desire for more information in brief and accessible formats, and spoke of the importance of the quality of the relationship with their healthcare providers. By hearing from patients themselves, potential change in the current system and overarching healthcare policy may be influenced arguably by those to whom it matters most: the

patients receiving care. Older adults face many barriers to mental health services, and in effect, their voices often go unheard in consultation rooms. On the other hand, there has been an increased call in research to create spaces for individuals with lived experiences to share their wisdom. It is my aspiration in conducting this dissertation research that the increasing space for patient voices in research be echoed in mental health consultation rooms. While at times it is a more laborious process for clinicians and researchers to collaborate with patients, the outcomes can be infinitely richer and more meaningful.

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Appendix A: Study 1 Request for Assent Script

Recruiting patients: Script for requesting assent

[To be used by the geriatric mental health provider when seeing new patients that they deem appropriate for the study. This script could be used in person or remotely, depending on how the clinical service is being provided.]

If it's okay with you, I'd like to very briefly describe a research study that you might be interested in taking part in?

[if yes, continue; if no "Okay, that's absolutely fine"]

The study is exploring patient perspectives on the process of being referred to geriatric mental health services. The goal is to look for ways of engaging patients in that process to improve treatment outcomes. Participants in this study complete a brief survey and a 60-minute interview with a Research Assistant, Ms. Nicole Del Rosario. The interviews can be conducted online using Zoom or by telephone, and participants in the study will be compensated for their time. I want to emphasize that you shouldn't feel any pressure from me to take part in this study, and the services you'll receive aren't affected by your decision. Would you be interested in hearing a bit more about the study?

[If no, thank the patient for their time and reassure them that it's fine not to take part]

[If yes] That's great. The next step would be for me to give Ms. Del Rosario your name and telephone number so that she can call you to describe the study in greater detail, and to book a time for the interview if you decide to continue at that point? How does that sound to you?

[If the patient is still okay moving forward at this point, the provider will ask for a preferred telephone number and tell the patient that Ms. Del Rosario will contact them soon]

Appendix B: Study 1 Recruitment Script

Recruiting patients: Telephone script patients who provide assent

[Conducted by Ms. Nicole Del Rosario, our study Research Assistant.]

Hi ***[patient's last name],*** this is Nicole Del Rosario. The reason for my call is that you had indicated to Dr. X at [Victoria General Hospital or St. Boniface General Hospital] that you were interested in hearing more about a study focusing on the process of referral of older patients into geriatric mental health services. Is this a good time to talk with me about this study?

[if yes, continue; if no "is there another time you would like me to call back, or have you changed you mind about hearing about this study?" If change of mind, thank them; If not a good time schedule a return call]

OK, great. I'll take about 10 minutes to describe the purpose of the study, what would be involved if you decide to take part, what the risks and benefits to you are, and how we will protect the confidentiality of the information you provide. As I go through this please interrupt me to ask questions or if something doesn't make sense. How does that sound?

[if yes, read through the informed consent sheet, pausing frequently to see if there are any questions.]

[After the section on Voluntary Participation] Thanks for your attention while we went through that. With this additional information, are you still interested in taking part in the study?

[If no] That's perfectly fine - I know how busy we all are these days. Thanks anyway for taking my call and I want to reassure you that your decision not to take part in this study will have absolutely no effect on the clinical services you'll receive at **[the Vic or St. B].** Have a great rest of your day.

[If yes] That's great. If you have a few more minutes, there are two additional things we need to decide on.

First, we have an informed consent sheet for you to sign; it is basically a form that describes what we just went through. And in addition, there is a brief sociodemographic survey we'll ask you to complete that we'll use to describe the study sample. It's easiest to complete these online. Do you have an email address and access to the Internet?

[If yes] Great, If you give me your email address I'll send you an email with a link to the consent form. Once you click on the consent button the next thing you'll see is the survey. It should take you 5 to 10 minutes to complete all of that. And once you've finished that the last thing we need to do is the interview. So if you have your calendar we can find a time to do the interview.

[If no] That's not a problem – in that case I'll mail you the form and the questionnaire and I'll include a postage-paid return envelope so that when you complete it you can just pop it in the mail at your convenience. What is your mailing address?

The second thing we need to decide is how you will complete the interview, and our options are to do it online using Zoom, or to do it on the phone. Do you have a preference? ***[schedule interview and end call]***

Appendix C: Study 1 Informed Consent Form

Patient Consent

Corey Mackenzie, Ph.D., C. Psych
Professor & Director of Clinical Training
Department of Psychology
Adjunct, Department of Psychiatry
Affiliate, Centre on Aging
P516 Duff Roblin Bldg, 190 Dysart Rd
Winnipeg, Manitoba, Canada R3T 2N2
P: 204-474-8260 F: 204-474-7599
W: http://www.coreymackenzie.com

***Note: This consent form will be read and completed online. For those patients without email or Internet access we will send a hard copy version with pagination and a spot for participant initials at the bottom of each page**

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM PATIENT VERSION

April 11/22

Title of Study: Opportunities to Promote Treatment Engagement Among Older Adults Referred to Specialty Mental Health Services

Principal Investigator:

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Dr. Vishal Kaushik, M.D., Department of Psychiatry, University of Manitoba. Ph (204) 477-3556 Email: vkaushik@sbgh.mb.ca

Dr. Reece Ramkissoon, M.D. Department of Psychiatry, University of Manitoba. Ph (204) 477-3556. Email: rramkissoon@manitoba-physicians.ca

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the study staff. You may take your time to make your decision about participating in this study and you may discuss it with your friends, family or your doctor before you make your decision. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of Study

Mental health problems in later life are common, burdensome, and associated with negative outcomes. When older patients are referred to specialty mental health services (e.g., a psychiatrist or psychologist) for treatment of problems such as anxiety and/or depression, those who are passive and unengaged in this process are less likely to accept, more likely to drop out, and less likely to benefit from treatment. Our goal is to better understand how to engage older patients referred to specialty geriatric mental health services. Our specific aims are to: (a) explore patient perspectives on how the referral process could be improved, with an eye to (b) identifying opportunities for novel interventions to enhance patient engagement that are feasible and sustainable, including remote access options.

Study procedures

We will recruit 10-15 patients referred to geriatric psychiatrists or psychologists. If you consent to take part in this study, you will provide sociodemographic information and descriptive information about your experience with the referral process. After that you will complete a 45- to 60-minute interview either online using Zoom Healthcare, or by telephone. In summary, this interview will explore: (1) your experiences with the referral process, (2) opportunities to engage patients by assessing their attitudes, preferences, and expectations about treatment, (3) ideas for feasible and sustainable novel interventions to enhance patient engagement, and (4) preferences for how these interventions could best be delivered, including in person and remote access options, and whether to involve family members in engagement efforts.

The interviews will be conducted by Ms. Nicole Del Rosario, a doctoral clinical psychology student at the University of Manitoba under the supervision of Dr. Corey Mackenzie. Ms. Del Rosario will also be happy to answer any questions or concerns you might have about participating after you read this form and consider whether to take part in our study. If you would like a summary of the results of this study, please check the appropriate box at the end of this consent form.

Risks and Discomforts

We anticipate that any risks to taking part in this study are minimal. It is possible that some discussions about aspects of the referral process may be uncomfortable, but we will try to make the interview as pleasant as possible. You may also discontinue participating at any time.

Benefits
Although there is little direct benefit to you in taking part in this study, our hope is that the results will enhance the geriatric mental health referral process so that patient outcomes are improved in the future.

Costs
There are no financial costs to you to participating in this study, although there is the cost of an hour of your time. The study investigators have received grant funding from Research Manitoba and the Victoria General Hospital Foundation to support this study.

Payment for participation
You will receive a $20 gift card for participation in the interview.

Confidentiality
You will provide two kinds of data for this study. First, you will complete a brief sociodemographic questionnaire where you will provide descriptive information about yourself and your experience being referred to geriatric mental health services. If you have access to a computer and the Internet you will complete this questionnaire online by clicking on a link in an email we will send you. If you do not have access to a computer and the Internet we will mail you a hard copy of this consent form and questionnaire, with a postage-paid return envelope so you can send it back to us at no cost to you. The study Principal Investigator and research team will have access to it. This information will be kept indefinitely and used only at an aggregate level to describe the study sample.

Second, you will provide rich data in the form of an interview that will be conducted online using Zoom Healthcare or over the telephone (whichever you prefer) and recorded. Recordings on Zoom will be downloaded onto Ms. Del Rosario's personal computer as soon as possible (ideally that same day and no longer than 2 days). Both the recorded file and her personal computer are password protected. All recordings will be double deleted from this computer at the end of the study. Please note that although Zoom Healthcare has the necessary (HIPPA) privacy protections in place, it is an externally hosted cloud-based service. A link to their privacy policy is available here (https://explore.zoom.us/trust/security). Although the University of Manitoba Health Research Ethics Board has approved using this platform to collect data for this study, there is a small risk of a privacy breath for data collected on external servers.

We will also use a professional Canadian company to transcribe the interviews. The process of sending the files to and from the company occurs online using secure encryption methods that are HIPAA compliant with respect to web security. In addition, data are stored on an encrypted server with secure access while with the company. For information about the company and its privacy policies and procedures see https://waywithwords.net/privacy-policy/. We will keep a master list of participants in which participant names are associated with a number. That number will be used instead of names in the sociodemographic survey data file, and in the interview transcripts. The master list will be password protected and only kept on Dr. Mackenzie's password protected computer. This is an added protection against breaches of confidentiality in the unlikely event that someone outside of our team should see the sociodemographic data or transcript files.

Once we receive the transcribed interview data our research team will analyze them by reading them carefully and coding them for themes that are evident across multiple participants. All members of our research team will have access to the verbatim transcripts, will access them from the secure server, and keep them on password-protected computers. Video of the interviews and original (unedited to remove identifying information) transcripts will be deleted when the study is complete (on or before January 2023).

For publication purposes, your de-identified study data may be shared with other researchers from other institutions for secondary analyses or other research purposes. Any information sent outside of the University of Manitoba or St. Boniface Hospital will not show your name or address, or any other identifiable personal information about you. However, despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed.

We intend to publish and present the results of this study, focusing on main themes that are found across multiple interviews and quotations from interviews that support those themes. We will be careful in ensuring that all quotes that we use will be de-identified and readers should not be able to identify you from those quotations. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

The University of Manitoba Health Research Ethics Board and St. Boniface Hospital may review research related records related to the study for quality assurance purposes.

No information revealing any personal information such as your name, address or telephone number will leave the care of the research team.

Records that contain your identity will be treated as confidential and in accordance with the Personal Health Information Act of Manitoba and the Freedom of Information and Protection of *Privacy Act* (FIPPA).

Voluntary Participation/Withdrawal from the Study

There are no reasons we can think of why we would need to stop your participation in this study. However, you are free to stop participating at any time. If you decide to stop participating part-way through the study, we encourage you to talk to Ms. Del Rosario first. If you have any concerns about this study, you are also welcome to contact the principal investigator (Dr. Corey Mackenzie). If you know any of the members of our research team, please be assured that your clinical care will not be affected if you decide not to participate.

Questions

You are free to ask Ms. Del Rosario any questions that you may have about your treatment and your rights as a research participant. If any questions come up during or after the study or if you have a research-related injury, feel free to contact the principal investigator: Dr. Corey Mackenzie (204) 474-8260. E-mail: corey.mackenzie@umanitoba.ca

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389

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

Statement of Assent:

We are currently recruiting participants for a study focusing on family members of patients referred to specialty geriatric mental health services. If you have a family member that we could contact to see if they are interested in hearing more about this study, please provide their name and contact information. Name:_____ Phone: _____Email: _____

Statements of Consent:

I have read this consent form and I understand my role as a participant. The risks and benefits have been explained to me. I have not been influenced by any study team member to participate in the study by any statements or implied statements. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

□YES □ NO

I understand that the information I provide concerning this study will be kept confidential, but that confidentiality is not guaranteed. I permit the inspection of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes.

□YES □ NO

I understand that quotations from my transcribed interview might be used in presentations and publications, that efforts to protect my identity will be taken by the research team, and that quotations in publications and presentations will have gender and age decade listed afterward (e.g., female, 50s).

□YES □ NO

By providing these consents, I have not waived any of the legal rights that I have as a participant in a research study.

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

□YES □ NO

If yes, please provide an email address where we can send it:

Appendix D: Study 1 Questionnaire

1) Patient Questionnaire

What is your age? (drop down menu)

What sex were you assigned at birth, meaning on your original birth certificate?
Male
Female
Intersex
Prefer not to answer

I identify my gender as:
Woman
Man
Or please specify: _____
Prefer not to answer

What is the highest level of education you have achieved?
( ) Less than high school
( ) high school diploma
( ) some college or university education
( ) a college diploma or undergraduate university degree
( ) a postgraduate degree (e.g., Master's degree, Ph.D., MD).

Current occupational status:
( ) Full-time
( ) Part-time
( ) Retired
( ) Unemployed/on Disability

**Only participants that respond Retired to the above question will also see:*
Approximately how many years ago did you retire? ____

Approximately what is your current household income before taxes?
(drop down menu starting with $0 - $9,999 and continuing in increments of $10,000 until $300,000+

Marital status:
( ) Single
( ) Married or Common law
( ) Widowed
( ) Separated or Divorced

Population Group:
_____ Arab

_____ Black
_____ Chinese
_____ Filipino
_____ Indigenous (First Nations, Métis, Inuit)
_____ Japanese
_____ Korean
_____ Latin American
_____ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
_____ Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian, etc.)
_____ West Asian (e.g., Iranian, Afghan, etc.)
_____ White
_____ Other – Specify: _____

Self-rated physical health:

How would you rate your overall health at the present time?
( ) Poor ( ) Fair ( ) Good ( ) Very Good ( ) Excellent

Do your health problems stand in the way of you doing things that you want to do?
( ) Not at all ( ) A little ( ) A great deal

How would you say your health compares with most people your age?
( ) Not as good ( ) About the same ( ) Better

Please list any significant chronic health problems you currently have:

Referrals to geriatric mental health might result in patients seeing either a psychiatrist or a psychologist. Do you understand the difference between these two groups?

1. I'm very confused about the difference
2. I'm somewhat confused about the difference
3. I'm somewhat clear about the difference
4. I'm very clear about the difference

Which service were you referred to?
( ) Psychology (i.e., Dr. Koven or Dr. Sexton)
( ) Psychiatry
( ) I'm not sure

Who referred you to this geriatric mental health professional?
( ) primary care / family physician
( ) hospital based physician: please specify what kind of doctor: _____
( ) other – please specify: _____

Approximately how long did you have to wait after being referred to see the geriatric mental health professional (drop down menu in months)?

Appendix E: Study 1 Interview Protocol

Protocol for Interviews with Patients

1. Introduction, reminder of purpose of interview – to hear your perspective on the process you recently went through where you were referred to geriatric mental health services.
    a. *[Throughout the interview 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", "Who else was involved in that decision?"]*
2. If it's okay with you, I'd like to start by hearing about what was going on for you at the time of the referral. Let's reflect back to when you were first referred to geriatric mental health services. What was going on and what emotional problems were you were struggling with?
    a. *[Note primary mental health complaint and emotional comorbidities, as well as contextual factors such as physical & cognitive health, other sources of stress]*
    b. Were you managing that problem and seeking professional help on your own, or did you have family and/or friends who were helping you? Who were they and how were they helping at that point, or after you were referred?
3. Now I would like to ask you to think about the different steps from the time that the original doctor referred you until you saw the psychiatrist/psychologist. I'm going to ask what each step looked like for you, and if there are things that could have been done to make each of steps better for you.
    a. Let's start at the beginning – at the time you received the referral. Tell me about that health care visit. Who referred you to the specialty geriatric mental health service? Why were you seeing that person – was it for emotional health, or for some other reason? What was your understanding of the reason for the referral?
        i. Aside from the logistical parts of the referral, what was it like for you? Could that part of the referral process have been improved? How so?
    b. Did you have a sense, when that referral was made, what might come of that referral? In other words, several months ago when you received the initial referral, did you have a good sense of what that first meeting with the geriatric mental health professional would look like, and what options might be offered?
        i. Could that part of the referral process have been improved? How so?
    c. Approximately how long were you waiting from the time you were referred until you were eventually seen by X? Can you talk a bit about what was happening during that waiting period?
        i. During that time if you had been invited to share your attitudes, expectations and preferences for treatment would you have done so? Why or why not?
    d. If you had a chance to have your attitudes and preferences for treatment taken into consideration, how do you think those could be assessed? Would you prefer to meet with someone to discuss these kinds of things? What if you had an option to go online to find out about treatment options, and to answer questions about your treatment preferences and expectations – is that something you would do? Why or why not?
    e. Often patients like to involve close family members or friends in decisions about treatment, discussion of what treatments might be preferred, etc. Is that something you would have liked? Why or why not? At what point in the process, starting with

the initial referral, and then waiting for treatment, and finally meeting the mental health professional, do you see a role for involving family or friends?

f. Now let's talk about the first time you saw the geriatric mental health professional you were referred to. I would like to hear about what happened during that first visit. What was that first appointment like? Was it what you expected? Were you offered treatment? Were you motivated to engage in that treatment? Did you start the treatment you were offered? Did you finish it or stop before it was completed? Did you get the type of treatment you were hoping for? Was the treatment effective?
    i. Could that part of the treatment process have been improved? How so?

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 process you recently went through where you were referred to geriatric mental health services? Are there any last thoughts you have about how that process could be improved for future

Appendix F: Study 2 Request for Assent Script

Recruiting new patients: Script for requesting assent

[To be used by the geriatric mental health provider when seeing new patients that they deem appropriate for the study. This script could be used in person or remotely, depending on how the clinical service is being provided.]

If it's okay with you, I'd like to very briefly describe a research study that you might be interested in taking part in?

[if yes, continue; if no "Okay, that's absolutely fine"]

A pamphlet was developed based on a previous study that explored patient perspectives on how the referral process to geriatric specialty mental health services could be improved. Before potentially using this pamphlet in our service, the study involves interviewing patients to get their perspective and feedback on the pamphlet.

Participants in this study complete a brief survey and a 60-minute interview with a Research Assistant, Ms. Nicole Del Rosario. The interviews can be conducted online using Zoom or by telephone, and participants in the study will be compensated for their time. I want to emphasize that you shouldn't feel any pressure from me to take part in this study, and the services you'll receive aren't affected by your decision. Would you be interested in hearing a bit more about the study?

[If no, thank the patient for their time and reassure them that it's fine not to take part]

[If yes] That's great. The next step would be for me to give Ms. Del Rosario your name and telephone number so that she can call you to describe the study in greater detail, and to book a time for the interview if you decide to continue at that point? How does that sound to you?

[If the patient is still okay moving forward at this point, the provider will ask for a preferred telephone number and tell the patient that Ms. Del Rosario will contact them soon]

Appendix G: Study 2 Recruitment Script – New Patients

Recruiting patients: Telephone script for new patients who provide assent

[Conducted by Ms. Nicole Del Rosario, our study Research Assistant.]

Hi ***[patient's last name],*** this is Nicole Del Rosario. The reason for my call is that you had indicated to Dr. X at [Victoria General Hospital or St. Boniface General Hospital] that you were interested in hearing more about a study focusing feedback regarding a pamphlet with information on the process of referral of older patients into geriatric mental health services. Is this a good time to talk with me about this study?

[if yes, continue; if no "is there another time you would like me to call back, or have you changed you mind about hearing about this study?" If change of mind, thank them; If not a good time schedule a return call]

OK, great. I'll take 5 or 10 minutes to describe the purpose of the study, what would be involved if you decide to take part, what the risks and benefits to you are, and how we will protect the confidentiality of the information you provide. As I go through this please interrupt me to ask questions or if something doesn't make sense. How does that sound?

[if yes, read through the informed consent sheet, pausing frequently to see if there are any questions.]

[After the section on Voluntary Participation] Thanks for your attention while we went through that. With this additional information, are you still interested in taking part in the study?

[If no] That's perfectly fine - I know how busy we all are these days. Thanks anyway for taking my call and I want to reassure you that your decision not to take part in this study will have absolutely no effect on the clinical services you'll receive at **[the Vic or St. B].** Have a great rest of your day.

[If yes] That's great. If you have a few more minutes, there are two additional things we need to decide on.

First, we have an informed consent sheet for you to sign; it is basically a form that describes what we just went through. And in addition, there is a brief sociodemographic survey we'll ask you to complete that we'll use to describe the study sample. It's easiest to complete these online. Do you have an email address and access to the Internet?

[If yes] Great, If you give me your email address I'll send you an email with a link to the consent form. Once you click on the consent button the next thing you'll see is the survey. It should take you 5 to 10 minutes to complete all of that. To complete the survey you will be asked to review the pamphlet, what is the best address I can mail that to? And once you've finished that the last thing we need to do is the interview. So if you have your calendar we can find a time to do the interview.

[If no] That's not a problem – in that case I'll mail you the form, the questionnaire, and the pamphlet and I'll include a postage-paid return envelope so that when you complete the questionnaire and consent form and you can just pop it in the mail at your convenience. I ask that you keep the pamphlet with you as we will be reviewing it during the interview. What is your mailing address?

The second thing we need to decide is how you will complete the interview, and our options are to do it online using Zoom, or to do it on the phone. Do you have a preference?

Would you prefer to do this study online, or by phone?

[schedule interview and end call]

Appendix H: Study 2 Recruitment Script – Previous Participants

Recruiting patients involved in HS24738: Telephone script

[Conducted by Ms. Nicole Del Rosario, our study Research Assistant.]

Hi ***[patient's last name],*** this is Nicole Del Rosario calling from the University of Manitoba. We last spoke when you took part in a research study where you completed an interview regarding your referral experience to geriatric mental health services. The reason for my call is that findings from interviews have informed the creation of a pamphlet. We are currently recruiting for a new study exploring feedback on this information pamphlet for individuals referred to geriatric specialty mental health services. This is a completely voluntary research study, I am wondering if is this a good time to talk with me about this study if you are interested in participating?

[if yes, continue; if no, "is there another time you would like me to call back,; If not a good time schedule a return call, if no thank for time]

OK, great. I'll take about 10 minutes to describe the purpose of the study, what would be involved if you decide to take part, what the risks and benefits to you are, and how we will protect the confidentiality of the information you provide. As I go through this please interrupt me to ask questions or if something doesn't make sense. How does that sound?

[if yes, read through the informed consent sheet, pausing frequently to see if there are any questions.]

[After the section on Voluntary Participation] Thanks for your attention while we went through that. With this additional information, are you still interested in taking part in the study?

[If no] That's perfectly fine - I know how busy we all are these days. Thanks anyway for taking my call and I want to reassure you that your decision not to take part in this study will have absolutely no effect on the clinical services you'll receive at **[the Vic or St. B].** Have a great rest of your day.

[If yes] That's great. If you have a few more minutes, there are two additional things we need to decide on.

First, we have an informed consent sheet for you to sign; it is basically a form that describes what we just went through. And in addition, there is a brief sociodemographic survey we'll ask you to complete that we'll use to describe the study sample. It's easiest to complete these online. Do you have an email address and access to the Internet?

[If yes] Great, If you give me your email address I'll send you an email with a link to the consent form. Once you click on the consent button the next thing you'll see is the survey. It should take you 5 to 10 minutes to complete all of that. To complete the survey you will be asked to review the pamphlet, what is the best address I can mail that to? And once you've finished that the last

thing we need to do is the interview. So if you have your calendar we can find a time to do the interview.

[If no] That's not a problem – in that case I'll mail you the form, the questionnaire, and the pamphlet and I'll include a postage-paid return envelope so that when you complete the questionnaire and consent form and you can just pop it in the mail at your convenience. I ask that you keep the pamphlet with you as we will be reviewing it during the interview. What is your mailing address?

The second thing we need to decide is how you will complete the interview, and our options are to do it online using Zoom, or to do it on the phone. Do you have a preference? ***[schedule interview and end call]***

Appendix I: Study 2 Informed Consent Form

Patient Consent

Corey Mackenzie, Ph.D., C. Psych
Professor & Director of Clinical Training
Department of Psychology
Adjunct, Department of Psychiatry
Affiliate, Centre on Aging
P516 Duff Roblin Bldg, 190 Dysart Rd
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W: http://www.coreymackenzie.com

***Note: This consent form will be read and completed online. For those patients without email or Internet access we will send a hard copy version with pagination and a spot for participant initials at the bottom of each page**

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM PATIENT VERSION

January 20, 2023

Title of Study: Evaluation of a Brief Pilot Psychoeducational Pamphlet to Promote Treatment Engagement Among Older Adults Referred to Speciality Mental Health Services

Principal Investigator:

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Research Co-Investigators:

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Dr. Kristin Reynolds, Ph.D., Department of Psychology, University of Manitoba Ph. (204) 474-9528 E-mail: kristin.reynolds@umanitoba.ca

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the study staff. You may take your time to make your decision about participating in this study and you may discuss it with your friends, family or your doctor before you make your decision. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of Study

Mental health problems in later life are common, burdensome, and associated with negative outcomes. When older patients are referred to specialty mental health services (e.g., a psychiatrist or psychologist) for treatment of problems such as anxiety or depression, those who are passive and unengaged in this process are less likely to accept, more likely to drop out, and less likely to benefit from treatment. A previous research study by our team explored patient perspectives on how the referral process could be improved, with an eye to identifying opportunities for novel interventions to enhance patient engagement that are feasible and sustainable, including remote access options. The current study builds on that first study to create a psychoeducational pamphlet informed by patient recommendations. The current study aims to explore patient feedback on this pamphlet.

Study procedures

We will recruit 10-15 patients referred to geriatric psychiatrists or psychologists, including new patients and those previously interviewed for our first study. If you consent to take part in this study, you will provide sociodemographic information and descriptive information about your experience with the referral process (2-3 mins), a brief 6-item measure of psychological distress (1-min), and the Patient Education Materials Assessment Tool (10-20 minutes). After that you will complete a 45- to 60-minute interview either online using Zoom Healthcare, or by telephone. In summary, if you agree to take part in this study you will read the psychoeducational pamphlet and give us feedback on its readability, clarity, usefulness, and potential areas of improvement.

The interviews will be conducted by Ms. Nicole Del Rosario, a doctoral clinical psychology student at the University of Manitoba under the supervision of Dr. Corey Mackenzie. Ms. Del Rosario will also be happy to answer any questions or concerns you might have about participating after you read this form and consider whether to take part in our study. If you would like a summary of the results of this study, please check the appropriate box at the end of this consent form.

Risks and Discomforts

We anticipate that any risks to taking part in this study are minimal. It is possible that recalling aspects of the referral process may be uncomfortable, but we will try to make the interview as pleasant as possible. You may also discontinue participating at any time.

Benefits
Although there is little direct benefit to you in taking part in this study, our hope is that the results will enhance the geriatric mental health referral process so that patient outcomes are improved in the future.

Costs
There are no financial costs to you to participating in this study, although there is the cost of an hour of your time. The study investigators have received grant funding from Research Manitoba and the Victoria General Hospital Foundation to support this study.

Payment for participation
You will receive a $20 gift card for participation in the interview.

Confidentiality
You will provide two kinds of data for this study. First, you will complete a brief sociodemographic questionnaire where you will provide descriptive information about yourself and your experience being referred to geriatric mental health services. If you have access to a computer and the Internet you will complete this questionnaire online by clicking on a link in an email we will send you. If you do not have access to a computer and the Internet we will mail you a hard copy of this consent form and questionnaire, with a postage-paid return envelope so you can send it back to us at no cost to you. The study Principal Investigator and research team will have access to it. This information will be kept indefinitely and used only at an aggregate level to describe the study sample.

Second, you will provide rich data in the form of an interview that will be conducted online using Zoom Healthcare or over the telephone (whichever you prefer) and recorded. Recordings on Zoom will be downloaded onto Ms. Del Rosario's personal computer as soon as possible (ideally that same day and no longer than 2 days). Both the recorded file and her personal computer are password protected. All recordings will be double deleted from this computer at the end of the study. Please note that Zoom Healthcare, it is an externally hosted cloud-based service. A link to their privacy policy is available here (https://explore.zoom.us/trust/security). Researchers will comply with University of Manitoba Research Ethics and Compliance guildlines to ensure data security and maintain participant confidentiality. Although the University of Manitoba Health Research Ethics Board has approved using this platform to collect data for this study, there is a small risk of a privacy breath for data collected on external servers.

We will also use a professional company to transcribe the interviews. The process of sending the files to and from the company occurs online using secure encryption methods . In addition, data are stored on an encrypted server in Canada. For information about the company and its privacy policies and procedures see https://waywithwords.net/privacy-policy/. We will keep a master list of participants in which participant names are associated with a number. That number will be used instead of names in the sociodemographic survey data file, and in the interview transcripts. The master list will be password protected and only kept on Dr. Mackenzie's password protected computer. This is an added protection against breaches of confidentiality in the unlikely event that someone outside of our team should see the sociodemographic data or transcript files.

Once we receive the transcribed interview data our research team will analyze them by reading them carefully and coding them for themes that are evident across multiple participants. All members of our research team will have access to the verbatim transcripts, will access them from the secure server, and keep them on password-protected computers. Video of the interviews and original (unedited to remove identifying information) transcripts will be deleted when the study is complete (on or before September 2023).

For publication purposes, your de-identified study data may be shared with other researchers from other institutions for secondary analyses or other research purposes. Any information sent outside of the University of Manitoba or St. Boniface Hospital will not show your name or address, or any other identifiable personal information about you. However, despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed.

We intend to publish and present the results of this study, focusing on main themes that are found across multiple interviews and quotations from interviews that support those themes. We will be careful in ensuring that all quotes that we use will be de-identified and readers should not be able to identify you from those quotations. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

The University of Manitoba Health Research Ethics Board and St. Boniface Hospital may review research related records related to the study for quality assurance purposes.

No information revealing any personal information such as your name, address or telephone number will leave the care of the research team.

Records that contain your identity will be treated as confidential and in accordance with the Personal Health Information Act of Manitoba and the Freedom of Information and Protection of *Privacy Act* (FIPPA).

Voluntary Participation/Withdrawal from the Study

There are no reasons we can think of why we would need to stop your participation in this study. However, you are free to stop participating at any time. If you decide to stop participating part-way through the study, we encourage you to talk to Ms. Del Rosario first. If you have any concerns about this study, you are also welcome to contact the principal investigator (Dr. Corey Mackenzie). If you know any of the members of our research team, please be assured that your clinical care will not be affected if you decide not to participate.

Questions

You are free to ask Ms. Del Rosario any questions you may have about your participation in the study. If any questions come up during or after the study or if you have a research-related injury, feel free to contact the principal investigator: Dr. Corey Mackenzie (204) 474-8260. E-mail: corey.mackenzie@umanitoba.ca

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389

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

Statements of Consent:

I have read this consent form and I understand my role as a participant. The risks and benefits have been explained to me. I have not been influenced by any study team member to participate in the study by any statements or implied statements. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

□YES □ NO

I understand that the information I provide concerning this study will be kept confidential, but that confidentiality is not guaranteed. I permit the inspection of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes.

□YES □ NO

I understand that quotations from my transcribed interview might be used in presentations and publications, that efforts to protect my identity will be taken by the research team, and that quotations in publications and presentations will have gender and age decade listed afterward (e.g., female, 50s).

Researchers may publish documents that contain quotations by me under the following conditions:	
□YES □ NO	I agree to be quoted directly if my name is not published

By providing these consents, I have not waived any of the legal rights that I have as a participant in a research study.

Signature: _____ Date: _____

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

□YES □ NO

If yes, please provide an email address or mailing address where we can send it:

Appendix J: Study 2 Questionnaire

2) Patient Questionnaire

What is your age?

What sex were you assigned at birth, meaning on your original birth certificate?
Male
Female
Intersex
Prefer not to answer

I identify my gender as:
Woman
Man
Other, please specify: _____
Prefer not to answer

What is the highest level of education you have achieved?
( ) Less than high school
( ) high school diploma
( ) some college or university education
( ) a college diploma or undergraduate university degree
( ) a postgraduate degree (e.g., Master's degree, Ph.D., MD).

Current occupational status:
( ) Full-time
( ) Part-time
( ) Retired
( ) Unemployed/on Disability

If retired, approximately how many years ago did you retire? ____

Approximately what is your current household income before taxes?
( ) $0-$9,999
( ) $10,000-$19,999
( ) $20,000-$29,999
( ) $30,000-$39,999
( ) $40,000-$49,999
( ) $50,000-$59,999
( ) $60,000-$69,999
( ) $70,000-$79,999
( ) $80,000-$89,999
( ) $90,000-$99,999
( ) $100,000-$109,999

( ) $110,000-$119,999
( ) $120,000-$129,999
( ) $130,000-$139,999
( ) $140,000-$149,999
( ) $150,000-$159,999
( ) $160,000-$169,999
( ) $170,000-$179,999
( ) $180,000-$189,999
( ) $190,000-$199,999
( ) $200,000-$209,999
( ) $210,000-$219,999
( ) $220,000-$229,999
( ) $230,000-$239,999
( ) $240,000-$249,999
( ) $250,000-$259,999
( ) $260,000-$269,999
( ) $270,000-$279,999
( ) $280,000-$289,999
( ) $290,000-$299,999
( ) $300,000+

Marital status:
( ) Single
( ) Married or Common law
( ) Widowed
( ) Separated or Divorced

Population Group:
_____ Arab
_____ Black
_____ Chinese
_____ Filipino
_____ Indigenous (First Nations, Métis, Inuit)
_____ Japanese
_____ Korean
_____ Latin American
_____ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
_____ Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian, etc.)
_____ West Asian (e.g., Iranian, Afghan, etc.)
_____ White
_____ Other – Specify: _____

Self-rated physical health:

How would you rate your overall health at the present time?
( ) Poor ( ) Fair ( ) Good ( ) Very Good ( ) Excellent

Do your health problems stand in the way of you doing things that you want to do?
( ) Not at all ( ) A little ( ) A great deal

How would you say your health compares with most people your age?
( ) Not as good ( ) About the same ( ) Better

Please list any significant chronic health problems you currently have:

Do you have any concerns about your cognitive functioning (e.g., memory, attention):

Referrals to geriatric mental health might result in patients seeing either a psychiatrist or a psychologist. Do you understand the difference between these two groups?

5. I'm very confused about the difference
6. I'm somewhat confused about the difference
7. I'm somewhat clear about the difference
8. I'm very clear about the difference

Which service were you referred to?
( ) Psychology (i.e., Dr. Koven or Dr. Sexton)
( ) Psychiatry
( ) I'm not sure

Who referred you to this geriatric mental health professional?
( ) primary care / family physician
( ) hospital based physician: please specify what kind of doctor: _____
( ) other – please specify: _____

Approximately how long did you have to wait after being referred to see the geriatric mental health professional?

( ) 1 month
( ) 2 months
( ) 3 months
( ) 4 months
( ) 5 months
( ) 6 months
( ) 7 months
( ) 8 months
( ) 9 months

( ) 10 months
( ) 11 months
( ) 12 months +

The following questions ask about how you have been feeling during the past 30 days.
For each question, please circle the number that best describes how often you had this feeling.

Q1. During the past 30 days, about how often did you feel …	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
a. …nervous?	**1**	**2**	**3**	**4**	**5**
b. …hopeless?	**1**	**2**	**3**	**4**	**5**
c. …restless or fidgety?	**1**	**2**	**3**	**4**	**5**
d. …so depressed that nothing could cheer you up?	**1**	**2**	**3**	**4**	**5**
e. …that everything was an effort?	**1**	**2**	**3**	**4**	**5**
f. …worthless?	**1**	**2**	**3**	**4**	**5**

For the next set of questions. Please refer to the "Specialty Geriatric Mental Health Services" Pamphlet included in your consent package.

For the following questions, all items will have the answer options "Disagree,", "Agree," and "Don't Know." Rate the material on each item as you go.

You may refer to the material at any time while you complete the form. You don't have to rely on your memory.

Item #	Item	Response Options		
1	The pamphlet makes its purpose completely evident.	Disagree	Agree	Don't Know
2	The material does not include information or content that distracts from its purpose.	Disagree	Agree	Don't Know
3	The pamphlet uses common, everyday language.	Disagree	Agree	Don't Know
4	Medical terms are used only to familiarize audience with the terms. When used, medical terms are defined.	Disagree	Agree	Don't Know
5	The pamphlet uses the active voice.	Disagree	Agree	Don't Know
7	The pamphlet does not expect the user to perform calculations.	Disagree	Agree	Don't Know
8	The pamphlet breaks or "chunks" information into short sections.	Disagree	Agree	Don't Know
9	The pamphlet's sections have informative headers.	Disagree	Agree	Don't Know
10	The pamphlet presents information in a logical sequence.	Disagree	Agree	Don't Know

11	The pamphlet provides a summary.	Disagree	Agree	Don't Know
12	The pamphlet uses visual cues (e.g., arrows, boxes, bullets, bold, larger font, highlighting) to draw attention to key points.	Disagree	Agree	Don't Know
15	The pamphlet uses visual aids whenever they could make content more easily understood (e.g., illustration of healthy portion size).	Disagree	Agree	Don't Know
16	The pamphlet's visual aids reinforce rather than distract from the content.	Disagree	Agree	Don't Know
17	The pamphlet's visual aids have clear titles or captions.	Disagree	Agree	Don't Know
18	The pamphlet uses illustrations and photographs that are clear and uncluttered.	Disagree	Agree	Don't Know

20	The pamphlet clearly identifies at least one action the user can take	Disagree	Agree	Don't Know
21	The pamphlet addresses the user directly when describing actions	Disagree	Agree	Don't Know
22	The pamphlet breaks down any action into manageable, explicit steps	Disagree	Agree	Don't Know
23	The pamphlet provides a tangible tool (e.g., menu planners, checklists) whenever it could help the user take action	Disagree	Agree	Don't Know
24	The pamphlet uses visual aids whenever they could make it easier to act on the instructions	Disagree	Agree	Don't Know

Appendix K: Study 2 Interview Protocol – Previous Participants

Protocol for Interviews with Patients – Study 1 Participants

4. Introduction, reminder of purpose of interview:
    a. Thank you for joining me again today. As a reminder, the previous study that you did with me focused on examining how engaged patients are throughout the process of being referred to specialty mental health services. Past research suggests that if patients are engaged in this process rather than feeling like passive recipients, they are more likely to have good treatment outcomes. We define patient engagement as the extent to which patients feel that their preferences and attitudes toward treatment are taken into consideration. In your previous interview you shared your perspectives on how engaged you felt during your recent referral and treatment experience, and how patient engagement could be improved. Based on your interview, and the interviews of several other patients referred to geriatric mental health services at St. Boniface and Victoria General Hospital, we developed a pamphlet that we hope will improve knowledge and engagement in the referral and treatment process. The aim of this current study is to get some feedback from you about this pamphlet. Our plan is to use this feedback to make changes and improvements to the pamphlet before we start sending it out to patients who are referred.

    b. I will ask that you have the pamphlet in front of you as I will be referring to specific sections throughout the interview. Before we begin, I ask that you read the pamphlet in its entirety. (Ask participant if this is their first review of the pamphlet or a re-read, proceed with interview when participant is ready).

    [Throughout the interview 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"]

5. First, I would like to ask about the content of the pamphlet. I'm interested in how do you find the pamphlet in terms of content. In addition, I am interested in how you think older adults in general might find the pamphlet in terms of content.

    i. ***Probe*** *for readability (common, everyday language? Medical terms defined?)*
    ii. ***Probe*** *for clarity (e.g., are the aims clear? Does it achieve it's aims?)*
        a. *Refer to cover page of pamphlet*
    iii. ***Probe*** *for mental health literacy factors (how, if at all, did the pamphlet address questions you may have had about services available to you? The difference between psychiatry vs psychology, geriatric specialist?)*
        a. *Refer to Q&A services, what it means to see a specialist page*
    iv. ***Probe*** *for stigma (e.g., how, if at all, did the pamphlet address concerns you had about seeking help?)*
        a. *Refer to Myth/Fact section of pamphlet*

v. ***Probe*** *for support of shared decision making (e.g., how, if at all, did the pamphlet address unanswered questions you may have had before the appointment, was your understanding on the collaborative process of treatment changed?)*
    a. *Refer to "what to expect", family, and alternative resources pages of pamphlet*
vi. ***Probe*** *for missing information (e.g., is there information you have would liked to have received or additional questions that were not addressed in this pamphlet?)*

6. Next, I would like to ask you about the visual presentation of the pamphlet. Again, I am interested in your personal perspective but will also ask about how you think older patients in general might find the visual presentation of the pamphlet.

    i. ***Probe*** *for layout, well structured? Clear order/logical sequence? Useful headers?*
    ii. ***Probe*** *for font readability, size*
    iii. ***Probe*** *for graphics, colour scheme*

7. I would like to ask you about the accessibility of the paper pamphlet. Again, I am interested in your personal perspective but will also ask about how you think older patients in general might find the accessibility of the pamphlet.

    i. ***Probe*** *for whether preferred paper pamphlet, online resource, both?*
    ii. ***Probe*** *for timing of pamphlet, at time of referral? With appointment letter?*

8. Lastly, I would like to ask you about your thoughts on whether this pamphlet is something you would have found helpful in enhancing knowledge and engagement in the referral and treatment process.

    i. *How the pamphlet could be improved?*
    ii. *Alternative engagement methods?*

9. 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 your impressions on the pamphlet regarding geriatric mental health services? As a reminder, 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 L: Study 2 Interview Protocol – New Patients

Protocol for Interviews with New Patients

10. Introduction, reminder of purpose of interview:
    a. Thank you for joining me today. A previous study conducted by our research team focused on examining how engaged patients are throughout the process of being referred to specialty mental health services. Past research suggests that if patients are engaged in this process rather than feeling like passive recipients, they are more likely to have good treatment outcomes. We define patient engagement as the extent to which patients feel that their preferences and attitudes toward treatment are taken into consideration. Based on previous interviews with patients referred to geriatric mental health services at St. Boniface and Victoria General Hospital, we developed a pamphlet that we hope will improve knowledge and engagement in the referral and treatment process. The aim of this current study is to get some feedback from you about this pamphlet. Our plan is to use this feedback to make changes and improvements to the pamphlet before we start sending it out to patients who are referred.

    b. I will ask that you have the pamphlet in front of you as I will be referring to specific sections throughout the interview. Before we begin, I ask that you read the pamphlet in its entirety. (Ask participant if this is their first review of the pamphlet or a re-read, proceed with interview when participant is ready).

       [Throughout the interview 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"]

11. First, I would like to ask about the content of the pamphlet. I'm interested in how do you find the pamphlet in terms of content. In addition, I am interested in how you think older adults in general might find the pamphlet in terms of content.

    vii. ***Probe*** *for readability (common, everyday language? Medical terms defined?)*
    viii. ***Probe*** *for clarity (e.g., are the aims clear? Does it achieve it's aims?)*
        a. *Refer to cover page of pamphlet*
    ix. ***Probe*** *for mental health literacy factors (how, if at all, did the pamphlet address questions you may have had about services available to you? The difference between psychiatry vs psychology, geriatric specialist?)*
        a. *Refer to Q&A services, what it means to see a specialist page*
    x. ***Probe*** *for stigma (e.g., how, if at all, did the pamphlet address concerns you had about seeking help?)*
        a. *Refer to Myth/Fact section of pamphlet*
    xi. ***Probe*** *for support of shared decision making (e.g., how, if at all, did the pamphlet address unanswered questions you may have had before*

the appointment, was your understanding on the collaborative process of treatment changed?)

   a. *Refer to "what to expect", family, and alternative resources pages of pamphlet*

xii. ***Probe*** *for missing information (e.g., is there information you have would liked to have received or additional questions that were not addressed in this pamphlet?)*

12. Next, I would like to ask you about the visual presentation of the pamphlet. Again, I am interested in your personal perspective but will also ask about how you think older patients in general might find the visual presentation of the pamphlet.

iv. ***Probe*** *for layout, well structured? Clear order/logical sequence? Useful headers?*

v. ***Probe*** *for font readability, size*

vi. ***Probe*** *for graphics, colour scheme*

13. I would like to ask you about the accessibility of the paper pamphlet. Again, I am interested in your personal perspective but will also ask about how you think older patients in general might find the accessibility of the pamphlet.

iii. ***Probe*** *for whether preferred paper pamphlet, online resource, both?*

iv. ***Probe*** *for timing of pamphlet, at time of referral? With appointment letter?*

14. Lastly, I would like to ask you about your thoughts on whether this pamphlet is something you would have found helpful in enhancing knowledge and engagement in the referral and treatment process.

iii. *How the pamphlet could be improved?*

iv. *Alternative engagement methods?*

15. 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 your impressions on the pamphlet regarding geriatric mental health services? As a reminder, 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.