

**Outreach Psychotherapy: A Means to Bridging the Gap in Access to Mental Health
Services for Seniors in Care**

By

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Acknowledgments

The topic for this capstone was chosen in honour of two very special people in my life, my grandparents, Stan and Eleanor. I watched firsthand- before it was widely publicized due to the COVID-19 pandemic- how seniors in care were being left behind. Their needs are often neglected, both on the physical and mental health levels. Seniors are an overlooked and underserved part of our population. I hope to be part of a positive movement of change for our aging demographic. A picture of my grandpa and me sat on my desk throughout the writing process; thank you, Stan and Eleanor, for the inspiration for this capstone, as well as my passion for working with seniors in care.

I could not have made it through the workload and mental taxation of this degree without the unwavering support of both my partner, Findlay, and my mom, Jennifer. You both carried me through many moments of frustration, stress, and overwhelm. I look forward to celebrating the end of this academic chapter with you.

Abstract

This capstone project explores how outreach counselling programs may aid in greater access to mental health services (MHS) for the older adult population. It will specifically look at older adults (OA) in care facilities (ie. assisted living, long-term care, and palliative care). The objective of the literature review is to analyze the current data on this topic, and understand the information gathered/how well this answers the research question. As well, it will aim to see where there are gaps in the current literature and make informed suggestions for future clinical research and practice. A systematic literature review was conducted using Boolean methods with specific search parameters, inclusion and exclusion criteria. Scholarly databases were accessed, and only the use of peer-reviewed articles were included in the review. Major findings included age-related barriers that OA face, the prevalence of physical and mental health comorbidities, as well as common mental health concerns and methods of treatment for this population. This capstone project can be used as a guidepost for clinicians working in the field of geropsychology, in terms of future training for specialization with this population, future research to expand on the themes found, as well as understanding and developing new policies to advocate for the needs of OA adults and their mental health.

Keywords: older adults, mental health, care facilities, age-related comorbidities.

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Chapter One

By 2050, the percentage of adults aged 65+ will be nearly double the current level, bringing the number of OA to 2.1 billion (World Health Organization [WHO], 2025). This is the fastest-growing segment of our global population (Demmerle et al., 2023; Lind et al., 2022). This is important as the mental health needs of OA are currently being overlooked and underserved due to individual barriers such as issues with mobility, sensory deficits, stigma, etc. (Rabaioli-Fischer & Söder, 2021; Tegler et al., 2020). As the aging population increases, the need for mental health support will increase as well. This capstone project will examine how outreach psychotherapy can bridge the gap in access to MHS for seniors in care. It will look at both the ways this is already being done, as well as areas for growth.

Bringing counselling services into care facilities is uncommon, but not entirely new (Demmerle et al., 2023; Molinari et al., 2021). Current research identifies major themes, including the specific experiences clinicians specializing in geropsychology face (Demmerle et al., 2023; Merz et al., 2017; Molinari et al., 2021). Preliminary research indicates that outreach psychotherapy entails both benefits and challenges, a topic further explored in chapter three (Hansen, 2021). Another theme addresses how outreach counselling is currently conducted in care facilities. By focusing on meeting residents' individual needs, providers can offer access to support without many of the traditional barriers individuals in care face (Behrendt et al., 2023). This also supports the concept of "aging in place" and staying active in the aging process (Juthavantana et al., 2021). Stigma and a lack of awareness and education for OA populations is a common theme that deserves more attention. Current research lacks a clear understanding of this gap (i.e., its extent or which age groups and/or regions are most affected) (American Psychological Association [APA], 2020; Tegler et al., 2020). Additionally, current research

examines which modalities are most applicable for OA populations (Reynolds et al., 2022).

These themes are explored in greater detail in Chapter 3.

OA face a variety of challenges related to life stage transitions, cognitive decline, grief, and loss (Reynolds et al., 2022; Kim et al., 2023). The COVID-19 pandemic brings these issues to light, although the mental health struggles, abuse, and lack of sufficient care for OA exist in care facilities globally long before the pandemic (Botngård et al., 2021; Burnes et al., 2022; Yon et al., 2019). While this is a global issue, it raises serious concerns for North American populations due to the more common use of LTC facilities in Western versus Eastern contexts (Min & Huilan, 2020). Because the global population varies vastly in norms, values, and political policies regarding OA care, it is essential to conduct Canadian context-specific studies on this issue (Verbakel, 2018). Given these demographic shifts and ongoing barriers to care, it is crucial to examine how the field of counselling responds.

Research Problem Statement

This research will examine the current gap in access to MHS that exists for many, if not most, OA living in care. Many OA struggle with their mental health due to ongoing age-related concerns and the impending end of life (Reynolds et al., 2022). The research problem is that there is currently insufficient information on psychotherapy supports, specifically outreach supports, for seniors in care (Demmerle et al., 2023; Molinari et al., 2021; Carpenter et al., 2022). The question this capstone project proposes is, “How Does Outreach Psychotherapy Bridge the Gap in Availability of Mental Health Services for Seniors in Care Facilities?” Other research questions/variations of this would be, “What are the outreach services that are most effective for OA in care?”

This research study will examine how providing in-person outreach psychotherapy services to OA in care facilitates their access to adequate services (Demmerle et al., 2023; Molinari et al., 2021). As well, how outreach psychotherapy may or may not be a more effective method of counselling service for OA in care, due to mobility and other related limitations (Aisenberg-Shafran, 2022; Rabaioli-Fischer & Söder, 2021). Telehealth and other technology-based psychotherapy modalities are currently available to OA; however, there is limited research on in-person outreach options (Lind et al., 2022). The preferred interventions and delivery methods for MHS are essential for psychologists seeking to specialize in geropsychology (Merz et al., 2017; Lind et al., 2022). Currently, research on outreach services for OA in care, adapted service methods, and effective therapy modalities remains limited (Lederman & Shefler, 2023). There is also a gap in the literature about the possible stigma around mental health/accessing MHS for today's aging population (Rabaioli-Fischer & Söder, 2021). If these research gaps are left unaddressed, a large percentage of the population will be left with inadequate access to much-needed services, resulting in poor mental health, poor quality of life, and possibly higher rates of suicidality (Yang et al., 2021; Carpenter et al., 2022). To address these questions, it is essential to understand both what is already known and where gaps in the literature remain. The rationale for this research is taken from these considerations.

The primary research question guiding this study is: “How Does Outreach Psychotherapy Bridge the Gap in Availability of Mental Health Services for Seniors in Care Facilities?” Additionally, through this thematic literature analysis, I will attempt to uncover answers to the additional questions: “How Effective is Outreach Counselling for Seniors in Care?”, and, “What are the Preferred Counselling Modalities for OA Clients?”.

Rationale for Research

This literature review examines how outreach psychotherapy is currently being trialled and identifies areas requiring further research. Since outreach psychotherapy is rarely practiced, there is limited research on this topic (Demmerle et al., 2023; Molinari et al., 2021; Lederman & Shefler, 2023). This gap limits understanding about the mental health needs of this population, as well as which modalities are most effective to address the barriers OA face. This current limitation also relates to the lack of research specific to the Canadian context of OA. Having Canadian research is particularly applicable to the counselling spheres within Canada. This also pertains to provisional and registered psychologists under the College of Alberta Psychologists (CAP), Canadian Certified Counsellors (CCC), and Counselling Therapists within Canada. Additionally, this study aims to identify ways to potentially increase the entry of young practitioners into the field of geropsychology and/or the reasons for the current lack of interest (Merz et al., 2017; Molinari et al., 2021). Investigating these gaps allows for understanding the importance of evaluating not only the feasibility of outreach psychotherapy, but also how this method of service delivery may impact the broader field of counselling and the healthcare system. The significance of this research, therefore, extends beyond theory into both clinical practice and policy.

Significance of Research

As established, the rapid increase in the number of OA creates a higher demand for MHS. This study addresses how outreach psychotherapy responds to this demographic shift. Alongside this is the issue of understanding the impact this has on the healthcare system (i.e., system strain, caregiver burnout, etc.). The current healthcare system in Canada has been experiencing strain since the COVID-19 pandemic (Parsons et al., 2021; Baumann & Crea-Arsenio, 2023; Murphy

et al., 2025). This strain has been evidenced by a shortage of nurses and doctors to treat the number of patients, increased service wait times, and a lack of systemic-level support (Murphy et al., 2025). With the increase in OA populations, this strain is bound to increase unless wider system changes occur (Wyonch, 2024). In addition, having more culturally competent geropsychologists is important due to the diversity of current Canadian populations that will be entering OA age brackets in the near future (Joo et al, 2019; Arya & Tong, 2023). It is projected that this diversity will naturally shift into care homes in the future, therefore more culturally competent caregiving staff, nurses, and therapists are required to meet individual patient needs. Research is needed not only to gather this information but also to provide a better understanding of these topics, with the intention to therefore offer more effective care for OA populations. Addressing this gap helps inform new training programs in geropsychology, support culturally competent practices, and guide any system-level changes needed to address the demographic shift. To ground this literary investigation through a particular guiding lens, the following theoretical framework provides the ideology through which the issues are analyzed.

Theoretical Framework

The framework that guides this research is Social Justice Theory (SJT). SJT is a theoretical framework that places value on basic human rights; in the context of this research topic, this would relate to factors of equity, accessibility, fairness, and advocacy (Wu, 2024). This theory lends itself well to the notion of outreach psychotherapy for OA as it would be a way to provide more equitable access to MHS for them. Additionally, conducting this research is in itself a form of advocacy for the inequities OA in care face when it comes to this topic, as further research and discussion with a focus on inequities OA face advocates for just action to be taken.

The research question being asked speaks to the values of equity, accessibility, and advocacy of SJT. Because OA in care face specific age-related inequities and barriers to accessing psychotherapy services, a SJT lens is necessary when conducting research to make sure that research is analyzed through a lens of equity, accessibility and advocacy. SJT also helps to understand these barriers and inequities as a systemic issue rather than an individual one (Cosco et al., 2025; Banerjee et al., 2021). In turn, this theory then helps to better understand how outreach services can potentially address this systemic issue by focusing care on a currently marginalized community. This theory, due to its integral values, helps to understand the connection between access to MHS and human rights (World Health Organization [WHO], 2021). It looks at the reasons why outreach services matter in this context with OA, such as a more equitable way of approaching service design, a way to mitigate inequities OA face, and a way to maintain and/or restore health and wellbeing of OA (Tegler et al., 2020). A person centred framework would alternatively be a good theoretical framework for this topic. A SJT framework is superior though, as a person-centred framework alone would not address the aspect of advocacy for society that is needed for this topic.

SJT will also help guide the search process for the literature review. A SJT lens will be used when coming up with search terms (ie. equity, accessibility, and equality). Research focused on positive changes in the lives of OA individuals will be included. SJT will also guide the analysis process, where research with an emphasis on empowering OA and considering their intersectional identities will be chosen as part of the review. Societal issues of access to mental health support, stigma, and lack of community resources will also be featured. The purpose of this capstone project is to identify and understand more effective ways of providing counselling for OA in care, thereby advocating for society at large.

Definition of Key Terms

For the Systematic Literature Review (SLR), it will be important to define key search words. These search terms will be as follows: “seniors”, “care facilities”, “outreach”, “psychotherapy”, “assisted living”, “mental health”, “equity”, and “counselling”. Research will be done using Boolean operators such as (AND, OR, NOT) to connect key search terms in different sequential variations.

Positioning Statement

My motivation for this topic stems from both my personal caregiving experience and my current work in assisted living centers. This has shaped my commitment to geropsychology. My personal bias could interfere with the research via a confirmation bias. Being mindful of this bias throughout the research process will be crucial. Some of the ways I plan to manage this bias include consulting with colleagues and reflexive journaling.

My personal identity does not relate directly to the research, as I am not an OA. I am Canadian and will have a bias to the ways OA most commonly reside in care facilities once they reach a certain age/disability level in Western society. To mitigate this bias, I will check in with my supervisor throughout the process to be reflective and discuss the research. Additionally, I will plan to be open minded to the ways that other regions operate within an assisted living or long-term care setting, as this may differ from the Canadian context. As well, I plan to consult with fellow classmates and colleagues throughout the research process as a means of being reflective and mitigating bias in my research analysis and writing.

The place this research question is coming from is one where OA are less valued in society and agism plays a role (Ayalon & Roy, 2023). It is important to note that many eastern cultures do not have care facilities, rather aging adults will live independently for much longer,

or live with younger family members who are able to care for/integrate them into their own lives (Kan & Kolpashnikova, 2021). With my personal position accounted for, the structure of this capstone project will now be outlined.

Overview of Paper

This capstone project will comprise of four additional chapters. Chapter two will discuss the methods of the literature search, listing the databases accessed, key search parameters, and inclusion/exclusion criteria. It will also provide a brief evaluation of some of the key studies selected for inclusion in the larger literature review. Significant limitations of the search will also be acknowledged. Chapter three will provide the largest section of the study, showcasing the research selected to be discussed and analyzed. This will consist of 12-14 selected articles; these articles will derive from a broader list of 30-40 total articles read. The 12-14 selected articles will be selected due to having/overlapping on all important themes derived from the thematic analysis. Articles that only contained 1-2 themes from the thematic analysis will be used as supplementary material, but not the main articles for the critical analysis. The gaps in the literature will be discussed alongside important ethical considerations of the themes and subthemes.

Chapter four will focus on the clinical relevance and significance of the findings from chapter three, as they pertain to the field of psychology and practicing clinicians. Alongside this, important recommendations for the field will also be made. Finally, chapter five will formalize the ending of the capstone project with a summary conclusion focusing on the problem that was addressed. Future recommendations will be presented in this section, along with additional potential research questions. A reflection of my learning will coincide with this chapter.

Chapter Two: Methods of Literature Search

This chapter outlines the methods used to conduct and analyze peer reviewed research for the systematic literature review. This process involved selecting databases to retrieve scholarly research from and deciding which search terms were most meaningful and relevant to the topic. Research on outreach counselling for OA in care, as well as psychotherapy modalities for OA/common mental health challenges OA face was reviewed. A set of inclusion and exclusion criteria was used to determine which articles were most relevant to the topic and research question. This literature review was followed by a thematic analysis of the main articles selected.

Databases Accessed

This literature review was conducted using a systematic search of key terms and phrases through scholarly databases. Search engines used included PsychInfo, Google Scholar and the City University of Seattle's online library service. Databases accessed by both search engines included the following: EBSCO, PubMed Central, ProQuest, Research Network, Taylor & Francis, and Sage Journals.

Search Parameters

Key search terms included: ("nursing home" OR "assisted living" OR "long-term care") AND ("senior(s)" OR "older adult" OR "elderly") AND ("mental health") AND ("outreach psychotherapy"). These search terms were used to guide the initial literature search; the following combinations were used to filter the search further: ("outreach psychotherapy in palliative care" OR "outreach psychotherapy in nursing homes OR "psychotherapy services in senior homes") AND ("psychologists working in care facilities" OR "psychologists working in assisted living" OR "psychologists working in long-term care") AND ("mental health seniors in

care facilities” OR “seniors’ mental health overlooked” OR “seniors’ mental health issues” OR “geriatric mental health underserved” OR “aging population increase in mental health” OR “aging end of life mental health”).

Inclusion/Exclusion Criteria

Specific inclusion and exclusion criteria were used as search parameters for the literature review. Inclusion criteria specified that the year/date parameters of articles in the literature review would only be published between the years 2017-2025. As well, only scholarly, peer-reviewed articles would be used. These articles need to be available in full, without the need to purchase them. Additionally, research done during the COVID-19 pandemic and focused on the mental health experiences of seniors due to COVID-19 restrictions were only used for the purpose of the COVID-19 section within the review. Inclusion criteria specified that articles chosen would have related information to that of outreach counselling services geared towards the OA population (individuals 65+). These articles would then relate to any of the subtopics such as “mental health”, “aging”, and/or physical/mental health comorbidities”. Exclusion criteria were as follows: research published earlier than the year 2017, research that was unavailable in full, non-peer reviewed articles, and/or research not pertaining to the topic of mental health of OA/effective psychotherapy modalities for OA, and outreach psychotherapy. Initially, approximately 40 articles were selected and reviewed, this number was narrowed down to 14 chosen articles in which the main themes and subthemes derive from. Significance to the literature review was determined by how relevant the study was to the research questions, the population sample used being 65+, the setting of the study being in a care facility (if pertaining to outreach psychotherapy for seniors), and the clinical relevance for the field of counselling psychology.

Refinement Process

The literature review process started with searching for articles through the PsychInfo database. This search only yielded three-five articles relevant to the topic. A broader search using the defined search phrases mentioned above through Google Scholar was more impactful. Specifically, the switch from using the term “care facility” and “assisted living” to “nursing home” brought to light much more relevant research. When relevant seeming articles were discovered via Google Scholar, but a full text was not available, the City University database was used. If the article was available in full via the City University database, only then was that article deemed as meeting the outlined inclusion criteria. Both Google Scholar and the City University databases were then used for the remainder of the literature review search.

Thematic Analysis

In total, 43 articles were read and reviewed, which was paired down to 14 main articles to base the thematic analysis on. These 14 articles were chosen due to matching one or more main themes derived from the search, as well as a combination of subthemes. The thematic analysis was conducted using Braun and Clarke’s (2006) thematic analysis method. This involved doing multiple read throughs of the main articles, in which codes for different themes that were found. These codes were then grouped into broader themes and subthemes. The most prominent four themes were then selected to be discussed for the critical analysis (Braun & Clarke, 2006).

Literature Search: Challenges

The first challenge faced in conducting the review was the limited number of studies conducted on the mental health of seniors that were unrelated to the COVID-19 pandemic. This was in part due to the year/date search parameters. An extension from the original parameter of

articles within the last five years was granted due to the COVID-19 pandemic happening in 2020, resulting in much of the literature from the past five years being related to this phenomenon. As well, due to seniors in assisted living and long-term care facilities being disproportionately affected by the COVID-19 outbreaks, many studies related to/involving seniors in care were therefore related to COVID-19.

Another challenge was the general lack of research conducted with/for OA. There were very few studies of outreach counselling in nursing homes (assisted living or long-term care). The two studies chosen were from Germany; these were chosen due to the methods used and how these related the topic of outreach psychotherapy. Both used outreach psychotherapy as well as the notion of a collaborative care model. Collaborative care models became a theme mentioned throughout many studies. A study conducted in Thailand also used similar outreach methods and looked at the ways bringing counselling into their senior centres improved access to MHS for their residents. The relevance to the topic question was high for all three studies. As well, all three used similar populations. The differences between them was seen in their methods (Juthavantana et al. (2021) used a mixture of one-on-one and group counselling, whereas Behrandt et al. (2023) used only individual methods). Some studies were a literature review in themselves, providing important information for this review, but not firsthand data (ie. Tegler et al. (2020) and Rabaioli-Fischer & Söder (2021)). Overall, these limitations, while in doing the initial literature search, were valuable to show the gaps in the current literature and therefore the relevance this research would provide clinically.

The overall lack of research on outreach psychotherapy limited the available literature to include in the review but showed a large gap in the field of current research. These challenges were faced by adjusting the projected timeline for completing the research, alongside adjusting

the search terms and combination of terms used in the search phrasing. Notably, the terms “assisted living” and “care facility/facilities” were initially used more, but in adjustment process the term “nursing home” garnered more valuable/related articles.

Limitations of Methodology

One of the limitations incurred was the limited amount of research out of Canada for outreach counselling services provided to seniors. As of right now, there are not any Canadian studies being conducted on this topic. The closest counterpart culturally would be the studies based in the United States, although there were very clear differences such as medical system differences of privatisation and programs in use such as Medicaid and Medicare that Canada does not have and/or use. This made generalizability an issue with the findings.

Another limitation of the methodology was limited access to certain articles that may have been useful in the literature review. Access to these articles was restricted to organizations outside the normal access that City University of Seattle/me as an individual had through Google Scholar. This limitation created a necessary refinement in the search terms/phrases used. A switch from searching using terms such as “assisted living” and “long-term care” to “nursing homes” and “geriatric/geropsychology” was used. Some limitations were study specific, such as the reliance on self-report measures in Lederman & Shefler (2023), Merz et al. (2017), and Demmerle et al. (2023).

Chapter Three: Review of the Literature

This literature review looks at the current research that has been developed regarding outreach counselling services for OA. That is, psychotherapy services that are brought into the home (assisted living or long-term care (LTC)) for OA over the age of sixty-five. It will look to answer the question, “How Does Outreach Counselling Aide in Bridging the gap to Access MHS for OA in Care”. The scope of the literature involves looking specifically at OA in care, or those who are home-bound rather than community dwelling and mobile. The review is organized into thematic sections based on themes and subthemes from the literature. These include: Mental Health of OA, Barriers to Accessing MHS, Virtual Counselling Options, Therapist Experiences in Providing Outreach Counselling to OA, and Considerations for Providing Outreach Counselling. As well, ethical considerations are discussed alongside any gaps present in the current research. By investigating these themes, the intention of this review is to answer the research question and provide further insight for areas of growth in the mental health field.

Table 1

Themes From the Literature Review

Theme	Subtheme	Reference
1. Mental Health of OA	<ul style="list-style-type: none"> • OA face high rates of anxiety, depression, loneliness, and suicidality • COVID-19 pandemic- the impact this had on OA mental health 	<ul style="list-style-type: none"> • Behrendt et al., 2023; Carpenter et al., 2022; Demmerle et al., 2023; Reynolds et al., 2022; Tegler et al., 2020; Yang et al., 2021; Juthavantana et al., 2021; Lederman & Shefler, 2023; Merz et al., 2017; Carpenter et al., 2022
2. Barriers to Accessing MHS	<ul style="list-style-type: none"> • Mobility/transportation, independence, knowledge of MHS, financial means, sensory deficits, ageism/stigma 	<ul style="list-style-type: none"> • Aisenberg-Shafran, 2022; APA, 2020; Rabaioli-Fischer & Söder, 2021; Tegler et al., 2020
3. Outreach Psychotherapy with OA	<ul style="list-style-type: none"> • Collaborative care models • Effective modalities 	<ul style="list-style-type: none"> • Demmerle et al., 2023; Merz et al., 2017; Molinari et al., 2021; Lind et al., 2022; Reynolds et al., 2022; Rabaioli-Fischer & Söder, 2021;

4. Considerations for Providing Outreach Counselling for OA	<ul style="list-style-type: none"> • Need for trained/specialized therapists • Working with OA 	<ul style="list-style-type: none"> • Behrendt et al., 2023 ; Tegler et al., 2020 • Merz et al., 2017; APA, 2020 ; Carpenter et al., 2022; Demmerle et al., 2023
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Note. The left most column represents the main themes found in the literature, with following columns depicting subthemes. The farthest right column denotes the representing article citation in which the themes/subthemes derive from.

Mental Health of OA

When considering how outreach psychotherapy may bridge the gap in availability of MHS for OA, it would first and foremost be important to understand their mental health needs. OA face mental health challenges unique to their age and natural physical/mental decline (Luo et al., 2020). Rates of poor mental health were found to be higher in institutionalized (assisted living/LTC) individuals rather than OA living in their own homes (Tegler et al., 2020; Yang et al., 2021), yet in Canada there are no current in-centre psychotherapy treatment options. It should also be noted that OA who are considered home-bound- whether that be in a facility or their own home- are also at high risk for mental health challenges (Boamah et al., 2021). Those who are living in the community and are not home bound have the same access to psychotherapy/counselling options in the community that the rest of the public does. This is not the case for those who are home-bound, especially OA in assisted living or LTC facilities.

Both Tegler et al. (2020) and Yang et al. (2021) looked at the mental health rates of OA, specifically OA experiencing depression and suicidal ideation. Researchers found that being “home-bound” contributed to higher rates of depression in OA (Tegler et al., 2020). This could pertain to those living in their own homes as well as a facility; the criteria for the definition of home-bound is someone who is isolated with a lack of outside interaction (McManus, et al., 2025). Researchers noted that OA with physical health conditions reported even higher rates of

depression, meaning there is a correlation between physical and mental decline (Tegler et al., 2020). This study also discussed an important element to OA mental health care, which is the use of psychopharmacological drugs. Treating OA often involves the combined use of psychopharmacological drugs and psychotherapy (Reynolds et al., 2022). It was found that OA, like adults and adolescents, are often prescribed psychopharmacological drugs in addition to or instead of psychotherapy treatments; however, OA had lower compliance and drug response rates (Demmerle et al., 2023; Tegler et al., 2020). This could be due to many factors, but specifically an intolerance to the drugs, stigma about them, and/or negative interactions with other medications they were taking. Both Tegler et al. (2020) and Demmerle et al. (2023) noted that the OA in their studies preferred psychotherapeutic methods over and/or instead of medication. The physical and mental health correlation is especially important to understand with OA because of the comorbid conditions they statistically report having (Tegler et al., 2020). These comorbidities can be both/either the cause or the effect of poor mental and physical health (Lederman & Shefler, 2023). For example, an older adult who has suffered a stroke, leading them to have decreased motor function, which then leads them to be less able and likely to get around their community and become more isolated. This isolation could then lead to mental health concerns such as anxiety, depression, and/or suicidality. Alternatively, a senior experiencing grief and depression may then become less active and isolate themselves, leading to a decline in physical health and abilities such as muscle strength for walking. The integrated relationship between physical and mental health for OA will be explored further when discussing considerations for clinicians specializing in geriatric counselling work.

The life stage of becoming a senior is particularly important when we think about OA mental health challenges. These challenges are often due to life transitions that could

concurrently be seen as losses. For example, changes to one's sensory abilities, loss of previous independence and/or social connection, empty nest syndrome, retirement/loss of career, and cognitive decline (Rabaioli-Fischer & Söder, 2021; Blazer, 2020). When individuals go through these transitions, grief is often experienced (Mueller et al., 2021). Grief and loss do not just exist at the transitional period of moving into a care home, this is a common mental health challenge for OA in care due to ongoing losses of other residents, continuing decline in health and abilities overtime, and/or a loss in visitation frequency from family (Boamah et al., 2021). Creating a service that is accessible to this section of the population would be key to addressing the mental health needs of OA in care.

Visitation plays a large role in the mental and physical wellbeing of OA in care. For those who are home-bound in the facility, visits from outside friends and family are sometimes the only social interaction they have. Many homebound OA face high rates of loneliness- even in facility centres with hundreds of residents- due to being isolated. For OA like this, this is often a risk factor for further mental health challenges such as depression, grief, substance use, and suicidality (Boamah et al., 2021). Outreach counselling services brought into the facility, although not their main goal, could provide a piece of social connection with another human being that many of these OA are missing. Poor rates of mental health for OA is something that was already present in care homes prior to the COVID-19 pandemic, however, with mandated social isolation protocols the mental health of OA in care became even worse (Checkland et al., 2021).

Critical Analysis

All the above studies agree on the need for more mental health support designed for OA populations, and that OA have substantial unmet mental health needs (Demmerle et al., 2023;

Reynolds et al., 2022; Tegler et al., 2020; Yang et al., 2021; Lederman & Shefler, 2023). Tegler et al. (2020), Reynolds et al. (2022), and Demmerle et al. (2023) agree that the issue of access to better MHS for OA is a systemic problem due to lack of societal structures that are able to support their specific health needs. These studies differ from one another in terms of their research lens. Demmerle et al. (2023) and Lederman & Shelfer (2023) focus mainly on therapist experiences in providing psychotherapy to OA and the ethical dilemmas surrounding this. They note that with outreach models there is an increase in specific ethical considerations to be made and research further. Reynolds et al., 2022, Tegler et al., 2020, and Yang et al. (2021) have more of an outcome focus, in terms of patient outcomes and impact of psychotherapy on OA mental health.

These studies also differ in their methodology. Demmerle et al. (2023) used semi structured interviews, while Yang et al. (2021) interviewed care residents directly. Lederman & Shelfer (2023) interviewed psychotherapists on their experiences working with OA populations rather than the OA residents themselves. Having direct resident data is valuable due to the lived experience this provides researchers with. In opposition to that, an important aspect of this topic is understanding the implications for practitioners working with OA and what information is still lacking that future research can expand on. Data from psychotherapist experiences therefore is valuable as well. A limitation with this however is it is harder to generalize this data when the sample sizes are small; Demmerle et al. (2023) had a sample size of 16 therapists (supplemented with 10 client case studies), and Lederman & Shefler (2023) with 14 therapists. Yang et al. (2021) had a much larger sample size with 538 participants across 37 care facilities. Creswell & Poth (2018) depict ideal sample sizes based on the type of methodology used for a study. In the case of Demmerle et al. (2023) and Lederman & Shefler (2023)- which both used a grounded

approach- the sample size of 14 or 16 would be considered much smaller than the proposed ideal of 20-30 participants (Creswell & Poth, 2018). This makes the data less available for generalization.

Evidence found in these studies that is strong is the notion of an individual's lived experience. Both the experiences of OA and psychotherapists working with OA in outreach capacities is valuable to have to further insight on the topic (Demmerle et al., 2023; Lederman & Shefler, 2023). Demmerle et al. (2023) also shows high ecological validity with the outreach service taking place in OA's home settings. In contrast however, having data from lived experiences is subjective to those experiences and individual's intersectional life factors, making the data non-generalizable. A strength for Yang et al., 2021 was their large sample size (thus strength in the statistical factors) and their demonstration of loneliness leading to depression, leading then to suicidal ideation. This shows the effect and connection between structural systems on OA mental health (ie. isolation in a care facility without access to MHS).

Evidence that is still weak lies with the fact that this study was done in China, therefore aspects of the data could be culture specific, therefore not generalizable. As well, due to using self-reports from nursing home residents, there could be a recall bias which would not make the data as valid (Yang et al., 2021). Overall, there is strong evidence for a lack of MHS for OA populations, and the need for these services. The field of research remains limited to the cross-sectional designs explored above, small sample sizes and a lack of experimental designs with outreach modalities (Demmerle et al., 2023; Reynolds et al., 2022; Tegler et al., 2020; Yang et al., 2021; Lederman & Shefler, 2023).

COVID-19 Pandemic and Isolation Protocols

The COVID-19 pandemic alerted many to the grim reality of how OA in care require better MHS. It was seen that many residents were neglectfully cared for (on the level of basic personal needs) but also faced cognitive and physical decline due to loneliness, social isolation, and poor mental health (Webb & Chen, 2021; Carpenter et al., 2022; Holt-Lunstad, 2021). This was seen through various forms of elder abuse, self-isolation protocols, and general neglect (Chang & Levy, 2021). The unfortunate truth is that this occurred years prior to COVID-19, it was only televised and investigated due to the outbreaks disproportionately affecting elderly individuals (Chang & Levy, 2021). Much of the research that has been done in the last five years on OA and OA mental health is related to COVID-19. This is one of the gaps in the current literature. While the pandemic resulted in mass isolation protocols for OA in care, this isolation is a barrier many still face today.

Barriers to Accessing MHS

OA face exhaustive and unique barriers to accessing MHS. From the research, these barriers include but are not limited to issues with mobility, transportation, independence, knowledge of mental health systems, financial means, sensory deficits, ageism, and stigma surrounding mental health (Aisenberg-Shafran, 2022; Rabaioli-Fischer & Söder, 2021; Tegler et al., 2020).

Mobility/Transportation

Mobility barriers for OA derive from comorbid health conditions that decrease walking ability and/or leg function. Some individuals may be in wheelchairs or use walkers/canes. This makes getting into the community to a therapy office a challenge. Along with this is the fact that

many OA stop driving at a certain age/state of cognitive and physical decline (Savoie et al., 2024), especially those living in urban cities (Schouten et al., 2022). Many OA in assisted living, and most in LTC no longer own vehicles or a license to drive, adding another barrier to how they would get to a therapy office.

Independence

One of the major losses for OA is the loss of their independence; this can happen in many ways, one of which is moving into a care facility (Rabaioli-Fischer & Söder, 2021). While there are facility shuttle vans, they are limited to where they will take residents and must be prearranged/shared with others. This decreases a senior's level of independence, one they most likely previously had for the duration of their adult lives. This change can cause individuals to feel helpless in their ability to do things for themselves, as well as potentially reinforce the fact that someone else (or some other larger system) is taking care of them now. Of course, residents with full cognitive function still have their freewill/freedom for choice within the system they are a part of. However, the loss of independence, living on their own, and/or being able to drive can be a large mental hurdle to recover from and adjust to (Rabaioli-Fischer & Söder, 2021).

Knowledge of MHS

OA today may not have an in depth understanding of the MHS available to them. This could be due to a variety of factors, but the forefront of that being generationally, those 65+ in 2025 have not grown up with open conversations about mental wellbeing (Konstantinou & Attia, 2023). This is a generalization, where some individuals may have this knowledge and interact with mental health information daily, but overall, most do not. Understanding that there is a current barrier to OA access to information about MHS would be an important first step in reshaping a service that caters to the other barriers they face. The notion of normalizing mental

health conversations for OA in care would be key; this is a gap in the current field as of right now (Elshaikh et al., 2023). Understanding the mental health field and services available today usually involves the use of technology to access the internet. If OA are falling into a technological category of illiteracy (which is another generalization that does not apply to all, but many), this is part of the barrier to their knowledge of what help they could receive.

Financial Means

OA often fall into the low-income bracket (especially once they are residing in care) due to socioeconomic status, race, gender, no longer having employee benefits/a wage, and/or due to costs associated with aging (ie. Healthcare aides/devices) (Sibal & Raphael, 2022; Sogaolu & Sweetman, 2025). Many assisted living and LTC facilities are expensive due to being privatised (Molinari & Pratt, 2023). In the U.S. many LTC facilities are part of the Medicare system, but OA are reportedly still struggling to finance these costs due to not qualifying for coverage and high facility monthly fees (Werner & Konetzka, 2022). Taking this into account, having the financial means for MHS is often another barrier for OA.

Sensory Deficits

Providing MHS to OA would mean adapting the service to their sensory needs. Many OA face hearing, vision, and agility loss (Cavazzana et al., 2018). Accommodating these needs in sessions would be important. First and foremost, a need for addressing these factors as current barriers to accessing the service in the first place would be crucial. Today, intake appointments are often made online or over the phone; OA may face difficulty in doing this if they cannot hear sufficiently, or if they do not have access to/the knowledge of how to use a device. Many OA, especially those in care, need assistance with these sensory deficits, therefore they may end up waiting for a staff/family member to help them book an appointment (Ho & Chenoweth, 2021).

This adds to the time it takes for them to make an appointment, as well as the emotional and mental burden of having to ask someone else for help/feeling that sense of loss in their independence (Aisenberg-Shafran, 2022).

Ageism and Stigma

OA face internal and external stigma around aging and mental health (Carpenter et al., 2022). This is because many individuals in our western society have ageist beliefs, and therefore fuel stigma around being an OA; the stigma that exists around aging is that to age is considered adverse/something to avoid (American Psychological Association [APA], 2020). Societal stigma about aging and the decline that occurs with age can cause OA to internalize these beliefs themselves, which has been seen to correlate with poor mental and physical health outcomes. This is referred to as Stereotype Embodiment Theory (APA, 2020). Stigma around aging can be culture specific though, due to societal norms and beliefs of a particular region (ie. western vs. eastern perspectives on family, religion, individualism vs. collectivism, and aging).

Within the western context, things such as entertainment and mainstream media perpetuate negative aging stereotypes of elderly individuals being incapable, incurable, unimportant, and/or no longer contributing to society (APA, 2020). The APA (2020) article on Ageism mentions media in the United States as often viewing OA as individuals to ridicule or discriminate against. These attitudes also perpetuate the view for younger individuals to avoid aging at all costs. Ageism is not just something OA may internalize within themselves, but healthcare providers may adopt these negative views of aging and choose not to work with OA (Merz et al., 2017). This causes a shortage of workers in the field that specialize in geriatric psychology (Merz et al., 2017; Molinari et al., 2021). Although some practitioners have ageist views of OA, particularly the belief that OA will not benefit from therapy, Saunders et al. (2021)

found that OA benefitted from psychotherapy more than the working/younger aged adults in their study. This study noted that more research needed to be done with OA world-wide because of this, and because of the continued increase in the number of OA (Saunders et al., 2021). One potentially promising idea for combating these growing needs is to have counselling brought into an OA residence, also referred to as outreach psychotherapy.

Critical Analysis

All four articles discussed on the theme of barriers that OA face agree that psychotherapy is effective for OA populations, but currently underutilized by them (Aisenberg & Shafran, 2022; American Psychological Association [APA], 2020; Tegler et al., 2020; Rabaioli-Fischer & Söder 2021). This is in large part due to the various barriers they face in order to access a service like psychotherapy. Researchers also agree on the fact that these barriers are systemic/structural barriers, not individual. A pattern recognized by these researchers is noting that the problem is not about whether therapy works for OA populations but rather about the issue of access and why it is currently underutilized by them. Areas where the researchers disagree is their level of analysis on the topic of barriers OA populations face. The APA (2020) article on ageism looks at this from a macro/systems level lens, Tegler et al. (2020) use a literature review model looking at elements from both macro/systems and individual levels, and Rabaioli-Fischer & Söder (2021) look at specific outreach designs in German speaking countries. While these researchers' conclusions align, their lens of focus and direction for gathering the information differs.

The evidence for which barriers OA face is strong, as all studies agree and name the same core barriers of mobility, sensory deficits, and stigma (Aisenberg & Shafran, 2022; APA, 2020; Tegler et al., 2020; Rabaioli-Fischer & Söder, 2021). From the APA (2020) articles on ageism and throughout the other supplemented articles, it is also very clear in evidence that stigma and

ageism play a large role in OA mental health access. The data is weak when it comes to Canadian specific information (with the current data being from Germany, Israel and the U.S). When looking at what is missing from the current literature, the main factor is control trials/experimental designs of outreach psychotherapy in comparison to clinic-based MHS. While APA (2020) discusses the intersection of racism and sexism with ageism, there is limited discussion of how these barriers and inequities intersect with other identity factors for OA.

Outreach Psychotherapy in Practice with OA

Outreach psychotherapy is not currently being conducted in many nursing homes, it has however been done in a few countries such as Germany and Thailand. In Germany, two different studies were conducted, one in LTC (Rabaioli-Fischer & Söder, 2021) and one in palliative care (Behrendt et al., 2023). Palliative care- because it has not been mentioned in this review up until this point- is a form of LTC for end of life (Behrendt et al., 2023). The study by Behrendt et al. (2023) mentions the purpose of outreach programs being the ability to aide in service distribution to institutionalized settings (like nursing homes). All three studies showed a need for services to be delivered at the institutional setting level, whether it be a nursing home, LTC, or palliative care facility (Rabaioli-Fischer & Söder, 2021; Behrendt et al., 2023; Juthavantana et al., 2021). All three studies noted that whether it be a transition into retirement and late life, or the end of one's life, counselling would be beneficial for a range of challenges specific to aging. These factors include transition to a facility/adjustment, social isolation, behavioural issues, mental disorder, loss of meaning in life, and/or loss of independence and self-identity. Although they studied different life stages of older adulthood, both studies noted the involvement of care staff and/or family members of the resident was crucial to the psychotherapy process. This may not be a factor that could be automatically generalized to North American regions, as systems of care

can be country and culture specific. This was either seen with a staff member making the therapy referral for a resident, staff being part of a collaborative team approach to the counselling, or a family member being part of the therapy process (more so in palliative care) (Rabaioli-Fischer & Söder, 2021; Behrendt et al., 2023). Family members often play the role of a caregiver to loved ones in LTC and may help facilitate setting up therapy for the resident, or in the case of palliative care, work with the psychotherapist/counselling team to understand the end-of-life stage their loved one is in (Behrendt et al., 2023). This is another factor that would need to be studied in Canada specifically. Family involvement/the level of family involvement and general factors of healthy aging may be due to specific cultural elements (Bar-Tur, 2021).

With Juthavantana et al. (2021) in Thailand, the notion of aging in place or active aging was important. They noted the societal changes happening in Thailand, where previously most OA would live at home with family to take care of them, they were now moving into LTC facilities like in the west. With rising population numbers for OA and a shift in cultural norms around this, more OA were reported as moving into nursing homes (Juthavantana et al., 2021). From the information provided by all three outreach studies it could be questioned as to whether this may be a global trend across many nations in the years to come. This would only prove the points made in many of the articles stating the growing need for services dedicated to an aging population (Demmerle et al, 2023; Lind et al., 2021; Tegler et al., 2020). Across all three outreach studies, OA showed an increase in general wellbeing, fewer hospitalizations, reduction in psychopharmacological drug use, better quality of life, increase in self-worth/active aging, and adjustment to their new living situation (Rabaioli-Fischer & Söder, 2021; Juthavantana et al., 2021; Behrendt et al., 2023). Research into the generalizability of these findings to North American LTC facilities and systems of health would need to be conducted.

Collaborative Care Models

A recurring theme noted in the studies that had conducted versions of outreach psychotherapy, were the found benefits and possibilities for using a collaborative model of care (Demmerle et al., 2023; Rabaioli-Fischer & Söder, 2021; Behrendt et al., 2023; Reynolds et al., 2022). The suggestion these studies made was that in establishing future outreach psychotherapy programs in LTC, a collaborative team of nursing staff, case managers, caregivers, and a therapist may be a good model of care due to the specific, comorbid needs of OA. Behrendt et al. (2023) is the most comprehensive example of this model in place as they created a counselling program structured with a case manager (CM) and system of advance care planning (ACP). With this model, resident's situations were discussed amongst the care team. Staff in the LTC centre were talked to about the counselling service that residents would receive, and these staff members were tasked with assessing the needs of residents and relaying this to the care team. The care team then scored results into three categories of specific care needs to determine the best care plan for each resident (Behrendt et al., 2023). This would help with the referral process as without this model in place the only option for OA in care would be to self-refer or have a family member assist with a referral for counselling. Nursing home staff spend a lot of time around residents day-to-day and would be able to provide unique insight into what needs the resident may have, which could help with a psychologist's treatment plan. Having a collaborative model of care may be beneficial in breaking down barriers around knowledge about mental health systems, as well as the stigma many older generations feel about counselling. This model would not only bring counselling services into the home of the residents (breaking the barrier of mobility/transportation) but also by having the system in place at the care facility there would hopefully be more open information and potential conversation surrounding

MHS for OA. There are certain ethical implications of having more individuals involved in the counselling process rather than just the therapist and client; this will be discussed further in the ethics section of this review.

Effective Counselling Modalities

Multiple sources found psychotherapy to be an effective method for treating mental health issues in OA (Lind et al., 2022; Demmerle et al., 2023; Reynolds et al., 2022 Rabaioli-Fischer & Söder, 2021). Specific modalities such as Cognitive Behavioural Therapy (CBT), Life Review Therapy (LRT), Problem Solving Therapy (PST), Acceptance and Commitment Therapy (ACT), and Family Systems Therapy were found to be most effective with OA (Demmerle et al., 2023; Lind et al., 2022; Tegler et al., 2020; Reynolds et al., 2022). LRT was effective due to learning to reconnect with things that provide meaning in one's life (Reynolds et al., 2022). Reynolds et al. (2022) noted that having a purpose to one's life and/or finding their daily interactions as meaningful was a significant part of existing. LRT therefore assisted in combating depression and suicidality in OA. Demmerle et al. (2023) noted that most studies of effectiveness for CBT, LRT and PST have been done on "younger" OA aged 55-75 years old. They suggested that more research would be needed for those aged above 75 to gather reliable data for the bracket of adults most likely to reside in LTC. Overall, ACT was viewed as a good option for

Need for Trained Geropsychologists

In researching the way outreach psychotherapy may aide in better access to MHS for OA, understanding what is needed to conduct ethical and effective outreach psychotherapy would be crucial. Multiple studies in this review note the lack of psychotherapists who want to work with OA and who are trained to do so (Merz et al., 2017). It was found by Merz et al. (2017) that the shortage of specialized training and therefore certified geropsychologists starts at the community

and academic level. Graduate programs often do not have an aging or lifespan psychology course that discusses the issues pertaining to OA, or techniques for working with age related challenges. As well, many graduates simply lack the personal experience of being around OA/ lack family connections with any OA (Merz et al., 2017; Carpenter et al., 2022). These factors produce therapists without experience or training in working with this section of the population.

Another important factor is the stigma/bias many young clinicians showed towards the notion of aging and/or a fear of working with an aging population. This was seen due to existential fears of death and working with those much closer to death itself (Demmerle et al., 2023). As well, it was noted that many younger therapists had beliefs that OA could not benefit from therapy, that it was a waste of time to help those closer to end of life, and/or had imposter syndrome when working with a client who had more life experience (American Psychological Association [APA], 2020; Demmerle et al., 2023; Carpenter et al., 2022). Demmerle et al. (2023) noted an interesting theme in their study of clinician's experiences, where the notion of "caring" versus "curing" was a mindset many therapists fell into when working with OA. The idea of "caring" versus "curing" is that with OA there are some limitations to how much can be "cured" or improved upon symptom wise for them. Understanding that the goal of treatment was not to alleviate these challenges but to provide support as clients dealt with them/teach them ways of approaching challenges constructively was seen to be helpful to the therapists (Demmerle et al., 2023).

Additionally, due to the number of OA increasing in the next 30 years worldwide, there will be a need for more geropsychologists. The combined current need of OA today and the aging population increase creates a pressing demand for training in this area (Merz et al., 2017; Carpenter et al., 2022). For a statistical comparison, in the United States Merz et al. (2017) found

that roughly 3% of psychotherapists specialize in geropsychology, while 30% specialize in child and adolescent psychology. In their study, Merz et al. (2017) noted that the biggest deciding factors for therapists to choose to work with OA was when they had a personal connection/reason for working with OA (often something gained in early childhood) or were drawn to the life experience and wisdom of OA. These elements could be used as factors to increase entrance of psychotherapists in training to work with elderly populations. It should be mentioned however that their study also found there to be significant perceived cons to geropsychology, one being the extra personal burden (mostly referring to experiences of existentialism), and financial burden of extra driving/time to provide outreach counselling (Merz et al., 2017).

Working With OA

In working with OA, there are considerations that psychologists will need to reflect upon/incorporate into their practice of outreach counselling. The first being the complex comorbid symptomology that many OA will present with. Understanding this concept when treating an OA will be crucial for proper case conceptualization and treatment planning. This also aligns with the suggestion of collaborative models of care for OA in LTC, as nursing staff, physicians, or physical therapists may have more knowledge/training on how to deal with physical health concerns that intersect with the mental health issues the therapist is treating (Demmerle et al., 2023).

With the variety of sensory deficits OA commonly face, it would also be important for therapists to be willing and prepared to make sensory accommodations in the therapy space. This could include using a microphone/speaker aide to amplify their voice, sitting closer to a client for hearing purposes, adding in visual aids, enlarging the font on consent forms, assisting in helping

them get to and from their personal room to a designated therapy room in the centre, and/or having an emergency procedure plan in place. Some of these accommodations may require the therapist to purchase items out of pocket as well, as they would potentially be travelling between centres without a permanent office space.

Virtual Counselling

Telehealth

Outside of traditional in-person psychotherapy, telehealth became a widely used therapy option for many during the COVID-19 pandemic. By seeing a counsellor virtually, clients were able to distance and/or isolate when needed and continue their therapy work. Virtual sessions could be viewed as a way of mitigating the discussed barriers for OA accessing MHS. There are both pros and cons to this option for them, with the main pro being the accessibility factor. The cons of this method for OA are technology literacy, ability to form to a strong therapeutic alliance virtually, find therapy beneficial due to sensory limitations (ie. vision/hearing), as well as access to a device (Seifert & Cotten, 2023).

The ways in which telehealth may be a good option for OA needs to be studied further. There is research that has been done on telehealth use with OA for medical appointment purposes, with mixed results of both positive and negative attitudes towards this method. Specific research done on counselling through telehealth for OA would be good information to have going forward with the state of our aging population. It is possible with the advancement of technology in the future there could be another technological alternative for OA to attend therapy from a distance virtually, but that was adapted to the needs of OA.

Critical Analysis

There is strong evidence and agreement amongst these articles that there is both a large need for MHS for OA, and a current lack of service providers/outreach options (Merz et al., 2017; Reynolds et al., 2022; Lind et al., 2022). Alongside this workforce shortage, researchers noted a lack of specialized training options for psychotherapists interested in working with OA (Merz et al., 2017; Molinari et al., 2021). Researchers also agree with strong evidence that an outreach style service option is necessary for providing MHS to the OA population due to the age-related barriers they face (Merz et al., 2017; Reynolds et al., 2022; Lind et al., 2022; Rabaioli-Fischer & Söder, 2021). Areas where studies disagreed were with the methodological frameworks of the studies. Merz et al. (2017) conducted interviews

Evidence is limited, and therefore weak, when it comes to comparing outreach psychotherapy with standard practice psychotherapy. There is a need for experimental controlled trials comparing the two to have data comparing the effectiveness of both. Another factor missing from the research is mention of the cost/cost-effectiveness of outreach psychotherapy. Financial aspects of the research were not mentioned by the researchers. Another factor notably missing from the research is an in depth understanding of the intersectionality factors that pertain to the OA population in care. This is something that was not touched on but is critical to an intersection with health and wellbeing (Shannon et al., 2022). Lastly, through viewing the literature with a SJT lens, many of the articles use justice-based language when discussing outreach counselling but were limited in having a strong social justice lens to the design of the studies. In this sense, there is room for future research to explicitly operate from a social justice lens when working with OA populations.

Gaps in the Literature

Generalizability

The gaps found in the literature are vital to deriving the research question. When asking how outreach psychotherapy may bridge the gap in availability of MHS for OA, a significant gap is the lack of North American research on the topic. While much of the research found provides promising ideas for mitigating barriers to accessible MHS for OA, it cannot be assumed that the same or similar results would occur in North American (specifically Canadian) studies as there would be too many factors that could be specific to results found in Germany and Thailand (Behrendt et al, 2023; Rabaioli-Fischer & Söder 2021; Juthavantana et al., 2021). Some of the influencing factors could be due to a difference in other health care systems, cultural factors, government structuring/funding, societal values/norms, and/or difference in stereotypes around aging. The LTC facility structure could also be different than how it is set up in Canada, therefore results from those studies that implemented outreach programs cannot be generalized to our LTC centres here (Behrendt et al, 2023; Rabaioli-Fischer & Söder, 2021; Juthavantana et al., 2021).

Awareness and Funding

In general, OA being an underserved and overlooked part of the population means there is a lack of research with them as a centre focus or with them included as a participant population (Forsat et al., 2020). Because of things like stigma and ageism, there is a lack of interest in OA issues, therefore a lack of funding is provided for research on these topics to be done (Merz et al., 2017). With more awareness to the needs of the soon-to-be largest sector of the population, hopefully more funding will be provided for research to be conducted and/or programs like outreach counselling can start to be implemented more commonly.

Diversity Considerations

While there is the notion of diverse research due to many of the current outreach studies having been conducted in other countries (ie. Germany and Thailand), the diversity of participants (OA) in most of the mentioned studies was not a discussed factor. As the aging population increases, so will the diversity of the population (following the immigration patterns Canada has seen in the last 50 years) (Merz et al., 2017). This factor has implications not only for future work with OA, but also making sure to include diversity factors in specialized geropsychological training. Given that Canada already has a diverse senior population, understanding how OA intersectionality factors (such as sexuality, gender identity, race, and cultural values) interact with their views on mental health issues and counselling services would be important. Diversity is always an important factor to consider in therapy as it plays a critical role in each client's identity. Personal identity directly relates to how one manages emotions and psychological challenges in life, as things such as culture, values, norms, and family shape one's identity. Diversity could play a unique role in working with OA due to those very factors, as well as generationally how one's identity played a role in their life. For example, many OA today lived through large societal shifts such as world wars, racism, homophobia, changes to women's rights, etc. Keeping these generational factors in mind would be important for understanding not only a client's life experience, but also the way their identity factors intersect and have an impact on mental health issues.

Ethical Considerations

Working with OA means abiding by the ethical guidelines and laws laid out for psychologists, with special attention made to the factors that uniquely impact this population. For this literature review, the Canadian Code of Ethics (CPA), College of Alberta Psychologists

Standards of Practice (CAP), and the Government of Canada Tri-Council Policy Statement (Chapter 4, Fairness and Equity in Research Participation) (TCPS-2) will be referenced.

Autonomy and Consent

Respect for the dignity of the individual client is important with any population, this is the basis of all counselling (CPA, 2017). When working with OA, understanding and assessing for cognitive decline for the client to provide informed consent is where this may interfere with CPA guidelines. This is a crucial step as informed consent and assent for participating in services is needed to have integrity in the therapeutic relationship and maintain professional service standards (CPA, 2017; CAP, 2023). Having psychologists trained in working with OA would mean they have attained the knowledge needed to assess for cognitive ability/decline as well as working with supportive caregivers if cognitive impairment was present (Lind et al., 2022; Molinari, 2021). One's ability to provide informed consent means that they can learn from a therapist the important aspects of therapy such as risks/benefits, limits of confidentiality, reasons for reporting, role of supportive caregivers, session duration and cost, what insurance covers/does not cover, what therapy is/is not, etc. (CAP, 2023). Some of these factors fall outside the regular informed consent process as outlined by CAP (2023) but have been listed as important additional pieces to incorporate in therapy with OA (Lind et al., 2021; Demmerle et al., 2023).

When working with OA an adapted informed consent process may be necessary. This could take a variety of forms, all dependant on the unique needs of the client (Lind et al., 2022). Some examples of this could be taking more time in reading through the consent form aloud with clients, asking check-in questions about the client's understanding of therapy policies, having a family/support person present to assist the OA in understanding the consent process, and/or

having a support person present to provide consent (in cases of cognitive decline). It has also been suggested by Parmigiani et al. (2022) to rule out any medical reasons for cognitive impairment before reviewing consent (such as infection, fever, sedation, etc.), having the right setting (quiet, private space), and providing therapy at a time of day (such as the morning) when a client's capacity for thinking is higher. More research on strategies for therapists to manage the complexity of adapted informed consent processes needs to be conducted in the future (Parmigiani et al., 2022).

Tasks Outside of The Professional Role

An important element found in the literature review is the idea that working with OA comes with extra tasks placed on the therapist that would normally not fall under their professional role (Demmerle et al., 2023). This is because of the unique challenges that many OA in care face. Clinicians in both studies by Demmerle et al. (2023) and Merz et al. (2017) noted that by being in the home (or care facility) of the client, and in combination with the client having some age related difficulties, they often ended up helping with things such as sitting/standing, hydration needs, escorting them between locations within the facility, filling out paperwork, assisting in the case of a fall, etc. None of these things are very taxing, nor would they be considered inappropriate ethically, but do fall outside the normal boundaries of the therapeutic relationship (CAP, 2023). Assisting with tasks such as these could create future difficulties in sticking to strict boundaries. As well, it was reported that although each of these tasks seem small, they can add up, adding to the time and financial considerations of the job. Spending additional time outside of sessions takes away from additional sessions that could be held, therefore a decrease in potential income for the therapist. Having clear conversations about

boundaries and finding this balance personally for each therapist is the suggested route for mitigation.

Demmerle et al. (2023) commented in their study that with this change in the traditional therapy setting, the therapist could potentially fall into a “guest” role rather than the “host” of the session. This changes the power dynamic and is something therapists will need to navigate. Power dynamics are a normal issue therapists must navigate in session, but in the case of outreach work with OA this would be crucial to make sure the client does not fall into a hosting role. A hosting role would mean the client assumes the responsibility to ask about the therapist or attune to the needs/emotions of the therapist in session (CAP, 2023). Counselling sessions are to be focused on the client in every case for best professional practice (CAP, 2023).

Confidentiality

Confidentiality is another key area for balance on the part of the therapist. Family or designated caregivers may be more involved in an OA client’s life to support in the process of therapy (arranging appointments, paying for sessions, etc.) (Lind et al., 2022). This support could also come from LTC staff. This could be both positive and/or negative for OA clients as it borders on the line of breaching confidentiality in therapy and is possibly demeaning to the OA’s dignity (CAP, 2023; Lind et al., 2022; Molinari, 2021). Psychotherapists must protect the confidentiality of their client’s first and foremost, barring situations of risk/imminent harm (CAP, 2023). Lind et al. (2022) and Molinari (2021) both refer to this concept in their studies, mentioning that with OA in LTC elder abuse is something that falls into this category for therapists to be alert for and understand the limits to confidentiality when it comes to safety of their client/community members (CPA, 2017; CAP 2023).

Existentialism and Countertransference

As it was previously mentioned, Demmerle et al. (2023) found that working with OA caused therapists to face more instances of existentialism than when working with other populations. This was due to working with individuals who were closer to death than younger clients. This could potentially cause instances of countertransference to occur within the therapy session. The study noted that this was especially the case for younger therapists working with OA, therefore age plays a factor (Demmerle et al., 2023). It is important for countertransference to be reflected upon and mitigated at all costs so that sessions continue to be therapeutic and based on the needs of the client rather than any focus being placed on the therapist (CAP, 2023). One way of doing this is to have additional professional consultation in place for the therapist, to be able to identify the countertransference they are experiencing and come up with solutions with a fellow practitioner (Demmerle et al., 2023; CAP, 2023). This is often part of the important role that supervision plays in the field of psychotherapy. Discussing countertransference with one's supervisor is a way to process through emotions that have come up, review ethical guidelines with another practicing member, and come up with a plan of action (Prasko et al., 2022). Prasko et al. (2022) noted that two ways to have these discussions in supervision could be through guided discovery of one's feelings/thoughts, or using role play methods to work through session scenarios.

Responsible Caring and Responsibility to Society/TCPS-2

Principle II of the Canadian Code, Responsible Caring, refers to psychotherapists making sure they are competent in the models of therapy they practice to provide evidence based, professional care to clients (CPA, 2017). This will play a large role in the ethical duties of therapists working with OA due to the discussed factors of aging that therapists will need to be

aware of as these are comorbid with senior's mental health (Lind et al, 2022; Molinari et al., 2021). Having a high level of competence for working with OA could look like understanding certain medical conditions/medications that are common for persons in old age. Additionally, the ability to assess for cognitive decline and know how to navigate therapy sessions ethically and effectively for clients with dementia, mild cognitive impairment (MCI), Parkinson's, etc. Competency also refers to the modalities of counselling that are evidence based and empirically proven to work best with OA.

In working with OA populations there is a responsibility to society that therapists have (as per Principle IV of the Canadian Code) (CPA, 2017). This could refer to understanding the systems that OA are part of (ie. Health/old age benefits, community programs, etc.) (CPA, 2017; Lind et al., 2022). A therapist's responsibility to society refers to advocating for client's and the communities they belong to (CPA, 2017). With OA in care this could look like speaking to staff about workshops or MHS opportunities for residents, advocating in the community for MHS for OA populations, and/or participating in training future geropsychologists.

The TCPS-2, chapter 4 on protection of vulnerable persons is another important piece of legislation for Canadian therapists to understand when working with OA. This document refers to the need for more research to be done for the elderly, therefore with elderly persons as research participants (Government of Canada, 2023). In having vulnerable persons be a part of research the article makes sure to address the fact that some OA may be impaired cognitively and therefore unable to provide informed consent for the study. This must still be done, however special ethical provisions have been put in place to address this in a way that does not leave OA out of research, while also maintain ethical standards for safety and confidentiality (Government of Canada, 2023). This is done via a third-party person designated to make decisions on the

behalf of the OA, only after the individual has provided consent to the level of their ability. As well, risks and benefits of the study are considered; minimal risk with great benefit is always something researchers aim for as well as who the study will benefit the most. The idea is that studies using elderly participants or those with cognitive decline will benefit other individuals in the same age/ability category (Government of Canada, 2023).

All three pieces of ethical code/legislation pertain to the protection and care of OA and their mental health. Proper adherence is mandated for therapists, and it is possible that future additions to the Canadian Code of Ethics or CAP Standards of Practice may be necessary to accommodate specific ethical practices for working within OA systems of care.

Collaborative Models

The idea of a collaborative model of care was one of the main subthemes explored in chapter 3, under the theme of outreach work with OA. This subtheme requires an in depth look at the ethical considerations that would need to be implemented for services to maintain professional, safe standards (Demmerele et al., 2023; Lind et al., 2022). Some of the important factors would be informed consent and confidentiality- how does incorporating care staff, family, physical therapist/physicians into the counselling treatment plan impact this? It would be important to outline this in the informed consent process, so clients are aware as to what they are agreeing to when it comes to the treatment they are signing onto/the level of privacy and protection that is kept from other professionals on their care team (CAP, 2023). As well, the limits to a therapist's confidentiality would need to be considered as different to normal circumstances because of the team model. As it is now, therapists are bound to the current ethical guidelines, stating that all session information must be kept private within the confines of the therapeutic relationship unless there is risk of imminent harm toward the client or public (CPA,

2017; CAP, 2023). Working with a team approach would mean opening the boundaries of what is defined as the “therapeutic relationship”, including nursing staff, physicians and/or family at certain levels. Defining the role of each person on the care team would be crucial so that boundaries for professional service were clear, for both the client and the therapist providing the counselling service. Having clear boundaries and role descriptions aides in Principle III: Integrity in Relationships (CPA, 2017). It would be important for therapists to have guidance and an established understanding of their duty to report, and who to report to (levels of reporting) in the case of OA care. If collaborative care models were something chosen to be established for helping with the mental health service barriers OA currently face, many more ethical discussions would have to be made along these lines to ensure proper ethical service delivery (CPA, 2017; CAP, 2023). A revision of current codes of conduct for psychotherapists would also likely have to be amended to ensure guidance for therapists in care settings.

Ethical considerations for OA’s must include the vulnerability that OA present with due to their age-related comorbidities. As well, therapists looking to work with OA must consider things such as an adapted informed consent process, the ways confidentiality and limits of confidentiality may differ, and SJT ing sessions to include needed sensory supports. Additionally, noted challenges such as mitigating the “guest role” that can happen when seeing an OA client in their place of residence, interacting with family members/support persons of the client, and dealing with frequent existentialism should be considered. Collaborative care models are an interesting and potentially promising initiative that could be established in assisted-living centres, however specific ethical considerations between health systems and psychology will need to be accounted for in their implementation.

Conclusion

This literature review was conducted based on the research question, “How Does Outreach Psychotherapy Bridge the Gap in Availability of MHS for OA in Care Facilities?”. By way of attempting to answer this question, it looked at the current barriers OA, specifically those in LTC, face in trying to access mental health support. The research showed these barriers include, but are not limited to, issues with mobility and transportation, sensory deficits, lack of independence, and stigma around aging and being an OA (Rabaioli-Fischer & Söder, 2021; Tegler et al., 2020). This review also investigated the mental health issues that OA most commonly face, finding that rates of depression, anxiety, loneliness, and suicidality are reportedly high for those 65+. It was found that only a few select countries have tested outreach counselling in nursing homes and overall, there is a lack of research on this topic. From the research that has been conducted, outreach counselling was seen to be effective for OA, with specific modalities of psychotherapy being named. These modalities included CBT, PST, LRT, and Family Systems Therapy (Reynolds et al., 2022; Demmerle et al., 2023). This review touches on the fact that the world’s aging population is growing rapidly, and the needs of OA will become even more pressing in the near future (American Psychological Association [APA], 2020; Lederman & Shefler, 2023). This shows a need for future research and implementation of programs to facilitate in mitigating barriers to accessing mental health for these individuals. Gaps in the current literature and important ethical considerations for working with OA in care, as well as implementing future outreach counselling programs with OA was addressed.

Chapter Four: Application to Clinical Practice

From the literature review, there is strong evidence for the need for more accessible forms of MHS for OA in care (Demmerle et al., 2023; Tegler et al., 2020; Molinari et al., 2021). With this, there is a need for training programs to be established, focused on care specific to treating OA (Merz et al., 2017). The increase in demand for psychologists to work with OA highlights the importance of this research for the field of psychology and counselling at the institutional, educational, and professional levels (Merz et al., 2017; Lederman & Shefler, 2023; Demmerle et al., 2023). The literature revealed that while outreach psychotherapy for OA in care is not a common practice currently, the few experimental designs that have been conducted have been both positive and effective for OA mental health (Behrendt et al., 2023; Rabaioli-Fischer & Söder, 2021; Juthavantana et al., 2021). These findings align with the core aspects of SJT (equity, advocacy, and accessibility) by noting inequities in the forms of access barriers that OA face (Aisenberg-Shafran, 2022; American Psychological Association [APA], 2020). Researchers also noted the systemic issues that have led to OA being underserved in the mental health field, with the notion that outreach counselling methods would be an answer to a structural problem rather than an individual one (Aisenberg-Shafran, 2022; Rabaioli-Fischer & Söder, 2021; Molinari et al., 2021; Lind et al., 2022).

This chapter will focus on analyzing the information gathered from the literature in terms of its relevance to the field of counselling. The themes discovered in chapter three will be analyzed in further detail, specifically in terms of how they relate to the field of counselling/current and future practitioners. The clinical relevance of the following topics will be discussed: Adaptable Therapy Practices, Effective Therapy Modalities for OA, Collaborative Models of Care, and Geropsychological Training.

Clinical Relevance & Recommendations

Adaptable Therapy Practices and Adjustments

From the literature review, it was noted that part of the issue for OA accessing MHS is due to the various age-related barriers they face (Aisenberg-Shafran, 2022; American Psychological Association [APA], 2020; Tegler et al., 2020). A way to answer this issue could be the method of service delivery (ie. outreach psychotherapy), as well as adapting the therapy space (within the practice of an outreach service) to meet these needs in a more equitable way (Gréaux et al., 2023). This answers the research question, “How Does Outreach Psychotherapy Bridge the Gap in Access to MHS for OA”, by means of creating a therapy method (outreach service) that is also adapted for hearing, vision, and mobility impairments. This also connects with a SJT framework, by looking at the factors of inequity and underrepresentation of OA in the field of counselling and then create structural service changes to accommodate these individuals.

The research indicated a unique set of challenges associated with adapted counselling sessions (in a home setting for OA clients) (Demmerle et al., 2023; Molinari et al., 2021). While adjusting a therapy setting/style of conducting the session created challenges for therapists, it was also in line with the ethical standards of respecting a client’s dignity and unique life circumstances (CAP, 2023; CPA, 2017). Currently, there is minimal research on hearing/vision adaptations for therapists and their counselling spaces (Aisenberg-Shafran, 2022). Because of this, therapists are advised to adjust their communication style with clients (Cosh et al., 2019). Possible suggestions for visually impaired individuals include increasing the font size on consent forms, offering braille options, and incorporating visual aids (Braakman, & Sterkenburg, 2023). For sound adaptations, techniques such as the use of a microphone/speaker system and/or combining visual aids with verbal communication are effective (Warnicke et al., 2022). Even

environmental changes, such as lighting, soundproofing, and the spacing of seating, can have an impact on clients (Rodríguez-Labajos et al., 2024). An important factor for OA clients who are visually impaired is how comfortable they are in their home environment, or at least an environment they are familiar with. Having sessions in the centre may already be an advantageous adaptation for them due to this sense of familiarity, and from that, a sense of ability and independence in navigating the therapy space (Sim, 2020). Creating more familiarity with the therapy environment for the client might be another possible adaptation. This can be achieved by bringing small personal items to the session (e.g., a cushion, water bottle, blanket, sweater), the notion being that adding personalization and a home-like feeling creates comfort and ease in clients (Taiwo et al., 2023).

OA mobility is another factor that can be adapted for in the counselling space. Outreach psychotherapy essentially is the main adaptation itself by bringing counselling into a client's place of residence rather than requiring them to travel to an office (Rabaioli-Fischer & Söder, 2021). In addition to this, one suggestion would be to ensure the space used for sessions can accommodate wheelchairs/walkers, and any other mobility aids clients might be using. As well, assessing that the furniture used in the space is easy to get in and out of, is comfortable, and the appropriate size for the space (Mudrick et al., 2019). In addition to suitable furniture, having aids such as handrails or firm surfaces to assist with sitting and standing would be beneficial (Oberti & Plantamura, 2022). Conducting sessions in a room that is not too far to travel to within the building would also be helpful. In addition to this, having a staff member escort clients to and from sessions could also be a possible adaptation that would aid in mobility support (this will be discussed further in the section on collaborative models of care) (Tegler et al., 2020).

Cognitive decline may remain the most challenging of the factors to adapt for in the counselling space, due to being a unique experience that differs based on the individual (Mella et al., 2018). Cognitive decline is a condition that disproportionately affects OA and affects individuals to varying degrees (Tang et al., 2023). This being said, there are ways for therapists to adapt sessions to be more sensitive to this factor for clients, while maintaining the professional purpose of the sessions. These suggestions are as follows: tailoring therapy to the individual, including supportive persons to assist in therapy, slowing the pace of sessions to match client processing speed, understanding client-specific cognitive limitations, assessing for the client's levels of awareness and insight (with this, creating a baseline to compare to over time) (Tonga et al., 2016). Additionally, using memory aids, simplifying activities or therapy exercises, and understanding that treatment may require multiple sessions rather than just a few (Chow et al., 2021). Having more research on the effectiveness of these adaptations would be pertinent to policy making for therapists and guidance in geropsychological practice. With these adaptations, it is also key to note which therapy modalities are most efficacious with OA. A few of these empirically reviewed modalities will be discussed next.

These recommendations align with SJT as they are rooted in viewing OA populations as just as deserving of MHS access. By adapting the therapy service delivery and space, hopefully OA clients would feel represented and no longer underserved in the community. Further research on this as a subtopic of outreach psychotherapy would also align with the advocacy and social justice aspect of SJT theory (Wu, 2024).

Effective Modalities for OA

One of the sub-research questions for this capstone project was, "What are the Preferred Psychotherapy Modalities for OA". From the literature review, the specific modalities that have

proven to be efficacious with OA were LRT, PST, CBT, Family Systems Therapy and ACT (Demmerle et al., 2023; Lind et al., 2022; Reynolds et al., 2022; Tegler et al., 2020). For this recommendations section, LRT, PST, and ACT will be discussed. These modalities coming up as a sub-theme from the literature review answers the research question not only on the factor of which modalities, but also why it was seen to be effective for this population specifically (Demmerle et al., 2023; Lind et al., 2022; Reynolds et al., 2022; Tegler et al., 2020).

Life Review Therapy (LRT)

Understanding effective modalities for working with OA will be crucial for providing effective and efficient service. LRT (also referred to as “reminiscence therapy” (REM)) was one of the modalities mentioned in chapter three as an effective method with OA populations (Demmerle et al., 2023). LRT & REM look back on the memories one has of their life, usually focusing on positive memories that bring them joy or a sense of pride, but can also be used to revisit hardship and conflict (Demmerle et al., 2023; Lin et al., 2024). This method is based on psychodynamic, narrative and psychosocial practices, with the hope of building self-esteem, meaning in one’s life, and alleviating symptoms of loneliness and depression. From their study, Lin et al. (2024) found that LRT most effectively aided in alleviating anxiety for OA; a study done by Tam et al. (2021) found this modality also to be effective for OA facing depression. In counselling sessions that use LRT, tangible items can be brought in by the client (ie. photo albums, keepsakes, etc.) to aide in the reflective conversation. This modality can be seen to aid in connecting individuals, providing social engagement with others, enhancing cognitive well-being, and overall quality of life (Tam et al., 2021). LRT employs the ideology that while some individuals may be limited in creating new memories/achieving new life goals, reflecting on the past can be a way of coping with this change, understanding one’s emotions, and/or creating a

more profound sense of meaning and understanding through reflective practice. There is still a vast amount that OA can learn about themselves and the world around them, expanding their perspective that was previously limited.

Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT) is another effective modality for OA (Lind et al., 2022; Dinarvand et al., 2022). This is often because acceptance of the things we cannot change in old age is common with OA in care (ie. the barriers mentioned in chapter three). Due to the decline in physical and mental health in old age, having the space to feel heard, understood, and grapple with the emotions one is experiencing is an important step for OA. Practitioners who use ACT in session often take things back to the basics with clients by having them focus on/discover their values. ACT also focuses on mindfulness practices to help individuals accept unwanted feelings or thoughts and remain reflective (Harris, 2019). It was noted in one study with OA that ACT was an effective method for treating OA depression (Davison et al., 2017).

Additionally, ACT was seen to be effective in reducing symptoms of anxiety specific to the onset of one's death (as this is often a relevant worry for OA in care) (Dinarvand et al., 2022). While ACT has been proven to aid in alleviating anxiety and depression in OA, it may also assist with accepting the use of medical devices, loss of hearing/vision, the transition from owning a home to living in care, etc. More research would be needed on these topics, specifically to assist with the changing demographic culture.

Problem Solving Therapy (PST)

As previously mentioned, OA face many age-related challenges. Another modality for counselling with OA in care is problem-solving therapy (PST) (Tegler et al., 2020). This method

focuses on the problems that clients have and how to realistically “solve” them (Wu et al., 2023). This means of solving the problem is a way of alleviating symptoms such as depression, anxiety and loneliness in OA. For OA who are depressed, this modality can help them to identify root problems concretely. Coming up with solutions can provide a sense of hope; when these problems are resolved through problem-solving methods, this can also instill a sense of empowerment and ability in a previously hopeless client. This has also been seen as a way to develop a set of coping skills for clients to approach both current and future issues (Wu et al., 2023).

This modality is similar to solution focused therapy (SFT) methods, where a solution or “solve” to the problem is searched for (De Shazer et al., 2021). Attainable, realistic goals are often set to address the problem the client is currently facing (Wu et al., 2023). With OA this is often a feasible method because sometimes help solving concrete problems is something they need if faced with physical or mental challenges due to age. The key to this modality’s function is the achievable goal setting. Without this step in place, especially explaining how a goal can be determined as achievable, unrealistic expectations may be set on the part of the OA. When these expectations are not met in therapy, this could potentially exacerbate symptoms.

Understanding the most effective treatment modalities is part of a practitioner’s responsibility to their clients, as well as a responsibility for maintaining a competent level of professional care. With this in mind, understanding the model of care best suited for OA, given their high comorbidity rates with physical illnesses, the notion of collaborative/integrated models of care will be reviewed next. These modalities are most effective when combined with systemic supports, such as integrated models of care.

Collaborative Models of Care

An interesting sub-theme that emerged from the research was the notion of having interdisciplinary collaboration between a team of healthcare providers when it came to helping OA in care (Demmerle et al., 2023; Rabaioli-Fischer & Söder, 2021; Behrendt et al., 2023; Reynolds et al., 2022). This is due to a few noteworthy factors, the first being the complexity of care that seniors require. Due to the complexity of their care, the psychotherapist is required to understand the comorbidities of their illnesses and needs on a deeper level. As mentioned earlier, specialized training and a review of the ethical standards to which a therapist practices counselling will be necessary, along with an understanding of the connection to the medical field and other areas of health/health services. Given the significant responsibilities placed on geropsychologists, the idea of having a collaborative team (physician, physiotherapist, nursing staff, and/or family caregivers) working together is often suggested by many. This could be a way to approach the gap in access to MHS for OA, while also sharing the workload involved and making sure the care was at a high standard (by relying on experts in each field) (Lind et al., 2021).

This relates to the research question, “How Effective is Outreach Psychotherapy for OA”. Through a SJT lens, a solution for bridging the current gap in access, but also making that service delivery effective for OA, is essential. The idea of a collaborative team model does this by adapting the normal MHS delivery (in-office with one practitioner solely focused on patient mental health) to an interdisciplinary approach that takes into account OA comorbidity rates of physical and mental health (Demmerle et al., 2023; Rabaioli-Fischer & Söder, 2021; Behrendt et al., 2023; Reynolds et al., 2022). This connects to SJT factors of equity, accessibility, and advocating for marginalized populations. The following sections will provide examples of past

collaborative care models that a potential outreach model could be organized in a similar manner.

Program of All-Inclusive Care for the Elderly (PACE)

The PACE model was first established in the U.S. in the 1980s and then expanded nationwide by 2015. This is a collaborative model of care where a team of staff from different specializations are used to meet the care needs of OA in the community. These individuals must be 55 years or older and qualify for entrance into a care facility, but are still able to live in the community (Mukamel et al., 2007). This model of care assists OA by providing access to a team of care providers and community resources that are covered by a combination of Medicare and Medicaid (Cortes & Sullivan-Marx, 2016). These services can range from hospital visits and primary care to specialized services, rehabilitation, home care, medication, and social/recreation services (Cortes & Sullivan-Marx, 2016). The PACE program has demonstrated the ability to keep individuals with OA in the community setting and delay entrance to a care facility by two or more years (Cortes & Sullivan-Marx, 2016). PACE can also customize the benefits given to each individual based on their unique set of needs/level of disability (Mukamel et al., 2007).

The fact that these services are covered for the OA is key, as this removes the financial barrier many OA face with their care. Another positive aspect of this act is the range of services that are included for OA. Many benefit plans (in Canada specifically) are limited in what they provide full coverage for, especially for OA with various illnesses. The notion that a collaborative model of care, offering a wide range of benefits for OA, can delay entrance into LTC is positive. If a collaborative model of care were to be implemented for OA, specialized training would need to be developed and provided to current clinicians as well as students entering the field.

Geropsychology Training

To meet the growing need for accessible mental health care for OA, more clinicians will be needed to specialize in this area of psychology (Merz et al., 2017; Dzierzewski et al., 2023; American Psychological Association [APA], 2020). As discussed by Merz et al. (2017), school programs may need to incorporate classes that teach new therapists about aging/the end-of-life stage. This would be one way to introduce the aging population to students who may not have had any personal experiences with OA (Merz et al., 2017). Merz et al. (2017) noted that experience with OA was among the highest reported factors for wanting to work with OA as a professional. This is a way to increase interest in working with OA, especially among those in care. Increasing the number of practitioners who are able/willing to work with OA in care will be vital to our future population needs (Merz et al., 2017; Dzierzewski et al., 2023).

Education is not the only level to which this applies, as many psychotherapists must take continuing education and training courses to maintain their ongoing competence in treating patients (CAP, 2023). This is part of the Canadian Code section on responsible caring (CPA, 2017). Establishing courses to train psychologists in specialized methods for working with OA will be crucial, just as there are training courses for couples therapy, play therapy, family therapy, and a wide variety of condition-based concerns.

Lind et al. (2022) made many informative discoveries in their study on OA and Psychotherapy. They found that OA have been disregarded in psychological work. Much of the stigma OA face regarding their mental health is the preconceived notion that therapy would not be helpful/practical (Lind et al., 2022). However, researchers of this study found psychotherapy to be effective for both OA and OA with cognitive impairment (Lind et al., 2022). Notably, the

most effective modalities for OA were PST, LRT, CBT, and IFS (Reynolds et al., 2022; Molinari et al., 2021; Rabaioli-Fischer & Söder, 2021).

Job Opportunities

Due to the growing need for more specialized geropsychologists, job opportunities for clinicians in this field are expected to increase in the future (Dzierzewski et al., 2023; American Psychological Association [APA], 2020). It is likely that in the next 25-30 years, there will be a significant gap in the availability of clinicians who can work with OA (APA, 2020). Therefore, getting specialized training as a clinician will provide more opportunities for work, especially in care homes if outreach psychotherapy is established. With further research on outreach psychotherapy, hopefully, new insights will emerge, and effective programs can be established. Alongside this, future research requires an in-depth understanding of the cultural elements and societal changes that will occur in the near future (Merz et al., 2017). With this, the field will need to accommodate these shifts throughout the counselling process, training, and establishment of integrated care.

Cultural and Societal Changes

As noted by Merz et al. (2017), Canada, and the world at large, is changing demographically. This change is seen with a 130% increase in racialized populations in Canada between 2001 and 2021 (Statistics Canada, 2023). As well, Statistics Canada (2022) projected that by 2041 the minority/racialized population could represent a much larger portion than it ever has in the past. More people are immigrating to other parts of the world, and especially in areas of North America, societies are becoming much more multicultural and diverse than in years past (Statistics Canada, 2022). This trend is also expected to continue in the years to come (MacIsaac et al., 2017), underscoring the need for more information on the cultural systems of senior care.

This is important, as it can be foreseen that even more barriers may present themselves, specifically culture-specific barriers, for OA in care in the future. Some of these barriers may include language barriers between care staff and residents, family living overseas and not available as support for OA, differing cultural understandings, beliefs, and/or values surrounding retirement, end-of-life care, and/or death practices (Tong et al., 2022).

An example of this is the way Hindus believe in the afterlife and reincarnation (Chandratre & Soman, 2022). With this, certain cultural practices around death and dying involve family gatherings, ceremonies, and chants/prayers/songs (Moeke-Maxwell et al., 2025). It was noted by Lei et al. (2022) that many Chinese cultures find death to be a taboo topic, where OA do not want to be a burden on family or systems of care. On the other hand, many Indigenous cultures view death as a rite of passage into the next phase of life, something to be celebrated and honoured (Dawe et al., 2024; Dennis & Washington, 2018). Seeing how there can be vastly different cultural understandings of end-of-life stages and even death itself shows the need for culturally informed OA care.

Within the educational spheres and training courses clinicians are taking, culture will need to have a voice as it becomes more integrated into caring for OA (Tong et al., 2022; American Psychological Association [APA], 2020). A culture-informed lens will need to be taken with all clinicians, but specifically those working with OA as a way of adapting to their specific needs (such as the above-mentioned sensory deficits and/or comorbid health issues). As noted by Behrendt et al. (2023), and, Lind et al. (2021) geropsychologists often end up working with the family of clients in care; understanding the cultural landscape for the family and client will aide in making therapy more effective for the client and their caregivers, as well as aide in the success of the therapeutic alliance- an important aspect of every therapy session.

Understanding and respecting each client's unique identity, which includes their cultural identity factors, is a key aspect of the Canadian Code of Ethics, Principles I: Respect for the Dignity of Persons and People, and II: Responsible Care (CPA, 2017). Alongside the Canadian Code of Ethics, it is crucial to review and analyze other forms of legislation that impact OA and research within this topic.

OA Population Diversity

The OA population exhibits a vast variety and diversity within Canada specifically (Statistics Canada, 2021; Tong et al., 2022); with that in mind, it would be important to acknowledge how the research findings apply to specific contexts in which OA live, as well as the cultural subgroups of OA. With the increase in immigrant OA, it will be important for systems of care to have elements that specifically support this group of seniors (Tong et al., 2022). Within the sphere of assisted living and LTC, this could include things such as having a diverse staff (who speak various languages), cultural activities for residents, culturally specific food, spaces for prayer or other religious practices, social groups, etc. (Tong et al., 2022). Even the structural design of care facilities would adopt a more culturally diverse building design, rather than the standard Westernized units currently in use.

In the therapy space, there will need to be an intersection between each client's cultural identity and practices, the treatment modalities used, and the team of integrated care they are receiving (Dolberg & Lev, 2025; Rodríguez-Labajos et al., 2024; Taiwo et al., 2023). An example of this is the way ACT is adapted to incorporate the spiritual beliefs of Indigenous culture (Ward, 2024). This could intersect with the rest of this resident's care team in terms of how medical services are provided (i.e., language used, the level of involvement of supportive persons, and/or the resident's wishes regarding medical intervention). Part of this culture is the

spiritual significance attributed to dreams and their meanings (Ward, 2024). From a Western medical lens, if an OA was presenting in session by discussing prophecy, like dreams they were having, it could be misinterpreted as hallucinations, part of a larger DSM-5 diagnosis. It would be essential to have an understanding of this client's cultural identity to comprehend the spiritual significance dreams hold for them and incorporate this as a positive tool alongside the modalities being used (Tong et al., 2022; Ward, 2024).

OA Care Settings

With the diversity of the OA population, there is also a variety of settings in which OA individuals live. Some of the most common are in their own homes, in care facilities, in hospitals, or with family. The research found in the literature can pertain to any of these settings, as they are all outside of the typical office setting in which therapists usually work with clients. The home setting itself can mean a person's own home within a residential community, as well as in assisted living or LTC (Demmerle et al., 2023). Hospitals differ in that they have rules and regulations regarding who can visit, the hours available for visiting, and the areas where therapy is allowed/be conducted. Confidentiality would be a factor to consider, as well as any medical liability concerns that clinicians may or may not face by seeing clients in a hospital setting (Demmerle et al., 2023; Lind et al., 2022). Many considerations in this setting may warrant further research but fall outside the scope of this capstone project.

Legislation Considerations

Because the inequities that OA face within the sphere of mental healthcare are systemic, legislative considerations are crucial to include in the discussion of outreach psychotherapy. Further research and advocacy on OA mental health/outreach psychotherapy is needed on a systems level, which will involve both global, national, and provincial organizations (ie. the

World Health Organization, National Seniors Council, Government of Canada, etc.). This will be discussed in alignment with the SJT framework and themes derived from the literature review in chapter three.

World Health Organization (WHO)- Action Plan on Aging and Health

The WHO's policy for Aging and Health refers to the growing aging population, as mentioned throughout this capstone project. The policy states that OA have already outnumbered the number of youth aged five and younger (World Health Organization [WHO], 2020). This policy establishes a definition for the world's concept of healthy aging: the notion of developing and maintaining function into old age (WHO, 2020). The policy also emphasizes the importance of the environments in which people interact and/or inhabit. Our environments include the care systems and health services we use and participate in, which include care homes of any variety; these systems are vital to the ability to age healthily (WHO, 2020). The goals listed by the WHO were as follows: creating more positive attitudes around aging, developing positive communities that are "aging friendly", and delivering person-centred care that is integrated into primary care for OA (WHO, 2020). This is important because it potentially relates to the idea of collaborative models of care previously discussed. This depicts the WHO as understanding the increasing need for services and resources to be allocated for OA, as well as the current attitudes surrounding ageism (American Psychological Association [APA], 2020).

National Seniors Council (NSC)- Healthy Aging

Understanding the policies a global power controls is important, as is understanding local policy in each country. Looking specifically at Canada, the NSC is a council that advises the Canadian government on OA issues; in 2020, the NSC introduced legislation regarding a "Healthy Aging Lens" (NSC, 2020). This policy states that, first and foremost, basic needs must

be met for all OA. This relates to the framework of SJT, where basic human rights are at the core of its guiding principles (Wu, 2024). Within this policy statement four main principles are proposed. These are: changing the attitudes of the public to be more positive about aging, creating communities that celebrate OA abilities, delivering person-centred care that is integrative in the healthcare system, and providing LTC access for those who need it (NSC, 2020). A key point that this policy makes is the intention to remove the barriers that OA currently face and provide support to them in “age-friendly environments” (NSC, 2020). On the note of environments, the council emphasizes that an age-friendly environment is wherever an OA resides, meaning LTC facilities. This means that the care provided could be in a residential home or a facility (NSC, 2020).

Accessible Canada Act

The Accessible Canada Act was created to eradicate the barriers that people with disabilities commonly face. The council’s main goal was to “create a Canada without barriers by 2040 (Accessible Canada Act, 2019). As we know from the literature review, this aligns with the projected statistics on the number of OA there will be in the near future (American Psychological Association [APA], 2020). As well, this aligns with a SJT framework through a means of advocating for OA populations and the inequities they face. Unfortunately, this act only applies to government-run organizations and businesses, explicitly excluding LTC facilities (Accessible Canada Act, 2019). This is, unfortunately, because the act goes on to state that it intends to create laws, policies, and programs through a lens that prioritizes persons with disabilities and aims for a high level of accessibility in those services and programs. Specifically mentioned (aside from common aspects such as employment standards and transportation) are individuals’ “built environments” (*Accessible Canada Act, 2019*). This refers to any general physical space in a

government-run facility/business/or service that accommodates individuals with disabilities in these spaces. These disabilities are not confined to physical types only; instead, they can also include mental/cognitive or sensory disabilities. It is unfortunate that OA, especially those in care settings, have been excluded from this act. By being left out of this piece of legislation, OA in care settings face another barrier to assistance in their care needs, as well as feeling represented in policy.

Alternative Frameworks & Actions

Alternative Frameworks

SJT remains the best framework for this type of research, mainly due to the lack of representation and policy addressing the needs of OA in care. This gap in policy and gap in research on the topic of outreach psychotherapy aligns with the advocacy element of SJT (Wu, 2024). Adding elements of a Person-Centred framework would be helpful, but this framework alone would be limited. This is because both elements—social justice/equity for OA and a person-centred approach to care for each individual—are equally important at the intersection of OA, mental health, and the current underservicing in this area (Demmerle et al., 2023). By combining both frameworks, this approach would address areas of policy and legislation, as well as the direct care (including types of care, care models, etc.) being provided (Demmerle et al., 2023; Tegler et al., 2020; Lind et al., 2022). A person-centred framework would include elements such as understanding each individual as unique, creating a tailored care plan for that individual, and considering the individual's intersectionality and comorbidities across multiple health domains (Ebrahimi et al., 2021). In reference to OA in care, a person-centred approach may also coincide with the subtheme of collaborative models of care, where a team of various practitioners collaborates to cover multiple health domains in the name of care for the

patient/client (Ebrahimi et al., 2021; Behrendt et al., 2023). SJT would aid in viewing this topic/issue through a systems lens, whereas a person-centred framework would focus more on the individual (client). Together, these elements could create a stronger outlook on the issue of lack of access to MHS for OA in care, thereby potentially providing valuable research and insight into strategies to mitigate this.

Future Geropsychological Training

One area the field of counselling could implement in the near future is specialized training courses in geropsychology, seniors' care, OA mental and physical health comorbidities, and outreach psychotherapy in care facilities. Future research on these topics where there are currently gaps (as seen with the study conducted by Merz et al. (2017)) will allow for the creation of training courses for new and current therapists to take. This specialized training will be crucial for the ability to offer outreach psychotherapy programs in the future as a more common practice (Merz et al., 2017).

Future Outreach Psychotherapy Program

With more training in geropsychology, the creation of an outreach psychotherapy program that addresses the current and upcoming needs of OA in care in Canada could be possible. There are several models that could be adopted. The first is having an in-house team of therapists available to work with residents. This connects with the subtheme of collaborative models of care, as seen most clearly in Behrendt et al. (2023)'s study in Germany. There would either have to be a designated space for counselling sessions to take place, or therapists would work with clients one-on-one in their private residences. This version could also incorporate a collaborative model of care, where therapists were part of the staff roster and worked in an

integrated fashion with physicians, physical therapists, nurses, and general care staff. Payment for services may be included with residential fees or kept separate, depending on the model used.

Another model for a program could be that therapists in the community work as private contractors and come in to see residents who book appointments through their private counselling business. A designated space would still be needed for the counselling sessions, but these therapists would not be part of the staff at the care facility. Fees for services associated with this type of program would need to be kept private, where the resident paid out of pocket for sessions, or where the building itself hired a contractor to come in.

With either version of this idea for outreach psychotherapy, a thorough consideration of liability, safety, confidentiality, and general counselling ethics would be necessary (Demmerle et al., 2023; Molinari et al., 2021; Lind et al., 2022). This was noted in research by Demmerle et al. (2023), which examined therapist experiences working with OA clients in an outreach capacity. Additionally, both Molinari et al. (2021) and Lind et al. (2022) discussed the different ethical elements that need serious consideration when providing at-home counselling services. Having specific policies and procedures for therapists in this role, whether as part of a collaborative team of integrated care for OA or as privately hired contractors, would be crucial (Demmerle et al., 2023; Molinari et al., 2021).

Conclusion

A great deal can be gleaned from the literature that was reviewed. The first point being that future counselling practice with OA will need to have the flexibility for adaptations to be made. These adaptations can include attuning to sensory changes, such as using visual aids, microphones, and/or increasing font size on forms and handouts. Additionally, understanding the mobility needs of clients and how this relates to the therapy space/furniture layout is crucial. It

may be necessary for therapists to be seated closer to clients or even in non-traditional settings. Understanding the ethical nuances of having a support person present during sessions will also be critical, as clients with any level of cognitive impairment may require this.

Alongside these adaptations, it will be necessary for clinicians to have proper training in these areas. A recommendation would be to develop new training programs tailored specifically to the demographic shift of increasing OA clients in the coming years. The possibility that collaborative models of care will not only provide more specialized practitioners with jobs but also create an interdisciplinary style of care that will hopefully alleviate strain on the medical system is promising. This, in turn, would help reduce pressure on individual therapists and lead to a higher quality of care for OA.

Chapter Five: Recommendations and Conclusion

This capstone project investigated current research on outreach psychotherapy for OA in care, examining what has already been discovered and where research gaps remain. Within the topic of outreach psychotherapy, themes of barriers that OA face, the need for more geropsychological training, collaborative models of care, and effective therapy modalities for OA were explored (Demmerele et al., 2023; Reynolds et al., 2022; Rabaioli-Fischer & Söder, 2021; Behrendt et al., 2023; Carpenter et al., 2022; Merz et al., 2017). Learning this through the literature review process has provided an understanding of how OA are impacted on a day-to-day basis. The barriers in place for OA make it challenging to interact with their communities and systems of care, including the counselling field (Aisenberg-Shafran, 2022). The literature indicates this is a systemic problem, rather than an individual one, and is only going to increase in severity over time unless changes are made (American Psychological Association [APA], 2020; Statistics Canada, 2021). Combined, the findings suggest that because of these barriers, in addition to factors such as financial means, stigma, and ageism, many OA do not access MHS (APA, 2020). Despite not accessing services, many OA, especially those in LTC or assisted living, still need them (Yang et al., 2021; Carpenter et al., 2022). These findings contribute to a deeper understanding of what it is like to be an OA in our system of care right now, specifically the systems pertaining to mental health care.

Overall, the literature depicts that OA patients face unique mental health challenges due to the aging process (Rabaioli-Fischer & Söder, 2021; Tegler et al., 2020). Understanding this correlation is important, as it underscores the need for targeted research and knowledge on age-related treatments for this population. While many current modalities and therapies for children, adolescents, and even young adults may be generalized to this age group, there will also be age-

specific factors (e.g., barriers) (Aisenberg-Shafran, 2022). This is something the literature analysis has taught- the complexity and interconnectedness of physical health for this population. The level of comorbidity between physical and mental health issues is much higher for OA. This is where the intrigue of collaborative models of care emerges as a surprising theme in the literature (Behrendt et al., 2023; Tegler et al., 2020; Reynolds et al., 2022; Rabaioli-Fischer & Söder, 2021). Collaborative models integrated with outreach counselling options may offer a more accessible service for this population (Behrendt et al., 2023). The literature revealed collaborative models as an option that is able to deal with the complexity of OA health on a multidisciplinary level (Behrendt et al., 2023; Reynolds et al., 2022). That said, more research is needed on the ethical implications of a model that involves or intersects different health services. These findings demonstrate that accessibility is not only a logistical concern but also relates to ethical considerations for therapy grounded in the dignity and equity of the person (CPA, 2017; CAP, 2023).

This brings us to the primary research problem of this capstone project: how the use of outreach psychotherapy might help to bridge the current gap in access to MHS for OA. This question was investigated through a SJT lens. This refers to examining the issues faced by OA through the lens of equity and just action (Wu, 2024). This is an important topic for practitioners in the field to be aware of, given the demographic shifts predicted for the near future (Statistics Canada, 2022). There will be more OA in the population; therefore, it can be presumed and understood that more counselling clients will be part of this population (Reynolds et al., 2022; APA, 2020). From the literature reviewed, themes and subthemes were identified and subsequently analyzed. These themes were: Mental Health of OA, Barriers to accessing MHS,

Outreach Psychotherapy with OA, and Considerations for Providing Outreach Counselling with OA.

Combining the results analyzed, the literature indicates that outreach psychotherapy is an effective way to improve the mental health and well-being of OA in care, as well as a possible means to bridge the current gap in access to MHS for this population (Demmerle et al., 2023; Rabaioli-Fischer & Söder, 2021; Lederman & Shefler, 2023; Juthavantana et al., 2021). It does this by providing a needed service in a format that accommodates common barriers faced by OA, adapting to their abilities and situations while maintaining a respectful level of dignity in the professional service (Behrendt et al., 2023; Rabaioli-Fischer & Söder, 2021; Lederman & Shefler, 2023). This aligns with the SJT lens, using a perspective of equity and respect for each client, and advocating for this population in general to have better access to MHS.

In the previous chapter, these themes were further analyzed in relation to the field of counselling. Relevant findings were: Adaptable Therapy Practices, Effective Therapy Modalities for OA, Collaborative Models of Care, and Geropsychological Training. Based on the information gathered, interpreted, and analyzed, this chapter will present the study's conclusions, future recommendations, and reflection on the professional learning. This capstone project can serve as an opener for further research on these topics and as a basis for clinicians looking to work with OA populations. It can also be used to highlight gaps in current policy and to emphasize the need for new, protective legislation for OA care.

Research Limitations

While there was much to gain from the literature reviewed, significant gaps remain within this research topic. Looking first at study populations, Merz et al. (2017), for example, only interviewed graduate students from counselling programs with a focus on geropsychology.

This means these students already had an inclination to work with OA populations, rather than interviewing individuals from both geropsychology programs and other fields of counselling study (Merz et al., 2017). Something like this could be viewed as a sample bias, therefore rendering the data less valid. Despite substantial work on common ethical dilemmas encountered in outreach counselling, Demmerle et al. (2023) was limited by its small sample size. Only 16 psychotherapists were interviewed, and data was collected based on 10 cases (Demmerle et al., 2023). This is comparable to research conducted by Lederman & Shefler (2023) where there was a sample size of 14. While the information presented is valuable, it still represents a very small sample size. With a small sample size, the data cannot be generalized as effectively as a large sample would.

Additionally, the lack of generalizable data was a limitation of this research topic. Many studies can be considered country-specific, as there are very few experimental designs on outreach counselling for OA. The following three studies were unfortunately the only relevant experimental designs of outreach psychotherapy that met the inclusion/exclusion criteria: Behrendt et al. (2023), Rabaioli-Fischer & Söder, (2021), and Juthvantana et al. (2021). These studies were conducted in Germany (Behrendt et al., 2023; Rabaioli-Fischer & Söder, 2021) and Thailand (Juthavantana et al., 2021). Significant differences were observed across studies due to cultural norms and practices (e.g., Thailand versus Germany). Juthavantana et al. (2021) was based on collectivistic values/norms (including a higher value placed on family involvement with OA in care), healthy/active aging and personal growth in old age. In Germany, Behrendt et al. (2023) and Rabaioli-Fischer & Söder (2021) focused on individual autonomy and the use of a professional interdisciplinary team (collaborative models of care). This is in contrast to the reliance more on family (Thailand) rather than professional support (Germany). As well, the way

mental health is viewed (ageism and stigma), the mental health concerns that are most prevalent in society, and the use/implementation of nursing homes can also be country-specific (Yang et al., 2021). If one were to look at the differences between the studies in Germany specifically, Behrendt et al. (2023) researched outreach counselling in the palliative care setting. In contrast, Rabaioli-Fischer & Söder (2021) conducted their experimental design in an assisted living facility. The populations of participants exhibit vast differences between the different settings, particularly in factors such as the ability to walk, talk, and feed oneself (Behrendt et al., 2023; Rabaioli-Fischer & Söder, 2021). Additionally, cognitive impairment and the need for a third-party decision-maker are typically higher in palliative settings, as these are placements for end-of-life care (Behrendt et al., 2023).

In terms of other limitations within this literature review, studies such as Yang et al. (2021) and Demmerle et al. (2023) had exclusion criteria for any individual with acute or terminal illnesses, as well as factors such as cognitive impairment and sensory deficits. This is limiting due to the prevalence of these issues within the OA population. Understanding how to support individuals, including individuals with cognitive impairment, is part of the research question being asked. Future research would need to include and account for these factors.

Future Recommendations

Research Recommendations

A significant purpose of conducting research is the opportunity to learn something new and gain an understanding of what remains unknown. Based on the findings gathered in the literature review, significant gaps remain for future research to address. The first aspect of this is the lack of research done on outreach counselling programs in assisted living and LTC. Given the current lack of research on outreach counselling in care facilities, a first step for future

researchers would be to conduct experimental studies within care centres where individual counselling is provided to residents. This was noted as a limitation by many studies throughout the literature review (Demmerle et al., 2023; Rabaioli-Fischer & Söder, 2021, Tegler et al., 2020; Lind et al., 2022). For future research, comparison groups could be made for individual versus group therapy, specific types of therapy (ACT, CBT, LRT, etc.), and/or in combination with psychopharmacological medication. Experimental designs like this would require a team of researchers and clinicians to work hands-on with clients/participants. As well, funding, potential government approval if set in a government-run facility, as well as the consent of residents and staff participating. This type of experimental design matters in learning the effectiveness of outreach (to potentially become a widespread practice if successful), as well as it would provide further knowledge on the current needs and concerns of the aging population for the field of counselling.

Additional research could also be done on the barriers faced by OA in the future (potentially increasing due to demographic shifts, changes in the political landscape, and/or technological advancements) (Aisenberg-Shafran, 2022; APA, 2020, Statistics Canada, 2022). Similar resources to those for outreach experimental designs would be required for this kind of research; however, self-reports or surveys could be used, with less financial resources needed to obtain data (Creswell & Poth, 2018). This research could also be conducted in the community, as OA face barriers across many settings, not just LTC (Aisenberg-Sharan, 2022; Yang et al., 2021). As well, understanding how to best support those at end-of-life stages is crucial (Behrendt et al., 2023). Death is often a topic faced with stigma and fear (Kang, 2021; Quintiens et al., 2023). Death and planning one's end-of-life stage are equally important steps in the lifespan; this would be research that needs to be done in LTC or palliative care settings (Behrendt et al., 2023).

Research like this is likely to involve family members, staff, and residents (Behrendt et al., 2023).

With future research on outreach programs, specific studies on mitigating the ethical dilemmas outreach counselling creates for practitioners will be key, as this was a theme revealed by the literature (Demmerle et al., 2023; Molinari et al., 2021; Lind et al., 2022). The current ethical dilemmas may be part of the reason that outreach counselling is not yet commonplace in care facilities (Demmerle et al., 2023). Having a more in-depth understanding of these ethical considerations will provide policymakers with information to create new legislation for practitioners to follow (Lind et al., 2022). This will potentially alleviate clinicians' current wariness about undertaking outreach work with OA (Demmerle et al., 2023; Merz et al., 2017). These ethical practices relate to confidentiality, consent to services, safety, dual relationships, power dynamics, working in a home setting, and cultural competency. This relates to principles of the Canadian Code of Ethics and Alberta Standards of Practice (CPA, 2017; CAP, 2023).

Because collaborative models of care was another recurring theme from the literature, further research on this model, integrated with outreach counselling, would also be helpful to explore (Behrendt et al., 2023; Tegler et al., 2020; Rabaioli-Fischer & Söder, 2021). It would be necessary to know how the different health services interact, how service providers would/would not communicate about a patient's care, and the role/service division of each provider. Again, these would intersect with the powers responsible for new policy creation and the Board of Regulatory Ethics (Demmerle et al., 2023; Molinari et al., 2021; Lind et al., 2022). Resources required would be the most involved with this type of research study, due to the intersection of multiple health disciplines, the number of potential people involved in patient care, legislation/policy needed to be in place prior, and the financial cost of carrying out the data

collection and analysis. Additionally, consideration of intersectionality and the social identities of OA will be necessary for these future studies. This is because issues such as ageism and stigma intersect with identity factors (ie. race, gender, ethnicity, cultural practices, etc.). For example, ageism interacts with gender by way of being more prevalent for female OA than male (Sanghvi & Frank, 2022). Different cultures have different ideas around aging/ageism, which also intersects with one's race and ethnicity (Chen et al., 2025). Another factor of intersectionality that had been found to relate to ageism and/or stigma is socioeconomic status (Allen et al., 2023). Keeping these factors in mind when designing future research studies will ensure the necessary inclusivity.

In terms of next steps for future research, determining which factor is most urgent is key. From the information gathered in this literature review, discourse and change around the ethical parameters of outreach services would be crucial. This would inherently lead to more successful experimental designs for outreach counselling. Having clear policies in place, as well as government-supported legislation for OA care, will cause future experimental designs to follow these policies for ethical standards of care (CPA, 2017; CAP, 2023). This will instigate better experimental designs grounded in advocacy for OA mental health needs.

Additional Research Questions

1. "How do collaborative care models meet the mental health needs of OA in care?"
 - a. This question would help address whether a collaborative model is enough for OA/if this form of care meets all of their mental health needs, or if there is still something missing for them. It may help to identify which factors are not being met if this is the case.
2. "What policy changes are needed to meet the increasing mental health needs of OA?"

- a. A study that conducts a literature review specifically on the current legislation regarding the mental health/mental health needs of OA would allow researchers to identify current gaps in policy. This would then help create new policies with OA MHS in mind. Research on this would also coincide with outreach counselling programs (as it was mentioned that policy and ethical standards would need to be updated to reflect new ethical dilemmas with outreach care).
3. “How do specialized training programs aid in the increase of new clinicians entering the field of geropsychology?”
 - a. As noted in Merz et al. (2017), there is a sense of unease and/or hesitation among new clinicians entering the field of geropsychology. Further research on whether this is due to a lack of specialized training could inform a new approach to encouraging new therapists to join this part of the field. Due to the future demographic shift, importance should be placed on having enough geropsychologists available to meet the demand that will be placed upon the field of counselling.

Practice Recommendations

Specialized Training

For clinicians wanting to work with OA, training/specialization will be the first priority, as it was noted from the literature that there is a current shortage of practitioners (Merz et al., 2017; Lind et al., 2022; Molinari et al., 2021; Aisenberg & Shafran, 2022). Having additional training in a counselling theory or strategy is often seen as providing the clinician with a greater sense of competence, empowerment, and the ability to help their clients (Frank et al., 2020). This is part of every clinician’s ethical duty- responsible caring as per principle II of the Canadian

Code (CPA, 2017). A key factor in gaining competence through training is direct clinical practice and feedback to achieve a higher level of competency (Frank et al., 2020). While online training would be helpful, in-person options with practical applications would raise overall understanding and, therefore, the outcome for clients.

Having additional training both outside and within the master's curriculum would be helpful, as noted by Merz et al. (2017) regarding exposure to OA populations. Within the curriculum taught in Master of Counselling programs, this could look like courses on lifespan development and/or counselling techniques for OA. It could also focus on typical age and health-related barriers OA face, and how to adapt to these within the counselling practice. Just as learning the difference between working with adults and children is beneficial, so is understanding and gaining valuable practice experience within the classroom setting for sessions with OA. Additionally, incorporating any new ethical standards and guidelines that pertain to working with OA in care settings could be incorporated into ethical practice courses (Demmerle et al., 2023; Lind et al., 2022). As seen with Merz et al. (2017), many clinicians currently have reservations about working with OA populations. Reasons included additional time commitments and financial burdens on therapists, and a lack of specialized training led some clinicians to move away from working with OA populations (Merz et al., 2017). It was also noted that for many participants in the study, the decision to enter the field of geropsychology was based on positive personal experiences with OA. An additional suggestion from the study itself was to create more opportunities for students and young clinicians to gain experience with OA, whether through a practicum experience, a volunteer position, or a community program (Merz et al., 2017).

Student Reflection

This section is written for the purpose of reflecting on the specific things learned throughout the research and writing process. The following factors will be discussed: Research Skills Obtained and Impact on Clinical Practice.

Research Skills Obtained

The research process for this capstone project has taught me valuable skills for conducting an analytical literature review. It has given me a better understanding of the pieces of connection and analysis that go into truly understanding the literature being reviewed and how to gather information in a meaningful way. The notion of clinical relevance has broadened my view on research as well, in terms of the process of a thematic analysis and retrieving themes that correlate to one another in the data. In doing this, the process has taught me a greater understanding of the importance of clinical competence in research settings and in client work. Researchers are held to high levels of clinical responsibility both when conducting research and when analyzing it. This aligns with ethical competence; I have a deeper understanding of the ethical considerations researchers and clinicians consider when working with participants/clients.

Impact on Clinical Practice

This capstone project has a direct impact on my future clinical practice as I plan to work with OA in care home settings. This will most likely involve clients in assisted living, but will not be limited to that. The literature review specifically highlighted several themes for me that will impact how I work with OA. An example of this is the notion of the different adaptations that can be made in the therapy space to accommodate each OA's physical and cognitive limitations. Understanding how elements such as text on consent forms, the use of visual aids

alongside verbal communication, adapting therapy styles, and even adjusting the physical setup of the room can help clients has been impactful.

Additionally, knowing which modalities have been tested and proven effective with OA populations is very valuable knowledge to have. This will make my practice with OA more effective, and therefore successful for both me as the practitioner and for each client. This information has helped me know which additional trainings I may wish to take before working with OA populations, such as ACT training. Reviewing additional research, specifically on LRT and PST, will also enhance my overall competence in specializing in work with OA. Having completed this capstone project, I now have greater insight into the specific advocacy and ethical responsibilities that underserved populations, such as OA, require in the therapeutic space. This will impact the adaptations I make to work with OA, such as possibly providing outreach services, offering sliding-scale options, taking geropsychological training, and participating in advocacy efforts on their behalf.

This personal and professional growth also aligns with the Canadian Code of Ethics values of Respect for the Dignity of Persons and People, Responsible Caring, and Responsibility to Society (CPA, 2017). Researching relevant client-related topics is a way to enhance one's competency in their practice. This process has taught me the importance of continuing competency and the value of a curious outlook on ever-changing information. As well, specific takeaways, such as adaptable therapy methods, are a way to both responsibly care for a client and respect their dignity in each unique situation (CPA, 2017). Advocating for clients and making a lifelong commitment to advocating for MHS for OA aligns with Principle IV: Responsibility to Society (CPA, 2017).

Overall, this capstone project has brought new information to light on a topic I already care deeply about. These research findings have further inspired me to work with OA populations and to embark on a career that continues to integrate training and research to foster greater competence in my clinical practice.

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