Help-seeking Behaviors among Older Adults and Minority Ethnic Sub-Groups: A Scoping Review

by

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Declaration of Committee

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Abstract

Background: Although older adults may experience health challenges requiring increased attention and care, they often do not ask for help. This behavior is complex and not completely understood; therefore, further research into help-seeking behaviors of older adults and minority ethnic sub-groups is warranted.

Methods: Guided by Arksey and O'Malley's scoping review framework and the PRISMA-Scoping Review guidelines, a scoping review was conducted. Data were analyzed using a qualitative meta-synthesis framework.

Results: Fifty-two studies meeting inclusion criteria were organized into six themes: interactions with formal healthcare providers, identity and independence, appraisal of symptoms and health, turning to social supports, accessibility and awareness, and cultural factors and lay/religious beliefs. A supplementary analysis of younger populations and Asian older adults was conducted to address the low number of minority studies captured by the inclusion criteria and to validate study themes.

Discussion: Identifying how factors, such as symptom appraisal and social support, impact older adults' help-seeking behaviors, may provide insights into how to address such barriers and how cultural dimensions of help-seeking contribute to unique challenges for minority ethnic populations.

Keywords: Older adults; Help-seeking; Healthcare utilization; Health

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Chapter 1.

Introduction

The complex health needs of the older adult population and the increasing number of older adults worldwide highlights important issues for caregivers, policy makers and healthcare providers (Kovner et al., 2002; Yao et al., 2019; World Health Organization, 2018). Due to issues, such as chronic illness, that require a greater need for health information and support (Yao et al., 2019), older adults account for one of the largest annual healthcare expenditures of any age group (Zayas et al., 2016). However, despite reports of high health service utilization, there are concerns regarding equity of access to care in this population (Woods et al., 2005). For example, older adults are less likely to access mental health services than their younger counterparts and even among those that do seek help, older adults are less likely to be offered treatment for their mental health challenges (Karlin et al., 2008; Lee et al., 2018; Mackenzie et al., 2008; Pless Kaiser et al., 2018; Wang et al., 2005; Woods et al., 2005). Furthermore, most of the existing research only focuses on the perspectives of current older adult service users (Woods et al., 2005). This shifts the focus to those who are already help-seekers, effectively excluding groups of older adults who experience the most need and yet do not seek consultation from healthcare providers or lack the resources to seek adequate help from others (Woods et al., 2005).

Recognizing that there are older adults who face disparities in healthcare access has led to efforts to support efficient and early help-seeking behavior among older adults (Porter & Markham, 2012). Efforts include the development of various personal emergency response systems and the introduction of health checks in general practice (Porter & Markham, 2012; Woods et al., 2005). However, despite such efforts, many older adults still do not seek help even while experiencing grave symptoms or harmful situations (Porter & Markham, 2012). For example, in a study of 40 older homebound women, 33 reported 139 incidents that they managed alone, which included falls, health problems and unwanted visitors (Porter & Markham, 2012). Help-seeking behavior is also a more salient issue amidst the ongoing COVID-19 pandemic, in which health system challenges are heightened and help-seeking behavior may be impacted due to fear, stigma and increased vulnerability of older adults (Centers for Disease Control and

Prevention, 2021). This is problematic as fear or failure to exhibit help-seeking behavior delays opportunities to diagnose or treat older patients in a timely manner, further exacerbating symptoms and potentially increasing future care costs (Arthur-Holmes et al., 2020; Blakemore et al., 2018). In a study estimating the number of deaths that could be prevented using clinical preventive services in the United States, the models suggested that 50,000-100,000 deaths could be prevented in those aged less than 80 years old (Farley et al., 2010). Not only that, but as Salkeld (1998) argues, the benefits of preventive healthcare not only need to be defined in terms of reducing future morbidity and mortality, but also in terms of attributes that are gained in the process, such as reassurance and awareness of risk for individuals. Evidently, efforts to improve preventative strategies and early help-seeking behavior is one way to improve health outcomes among older adults, over simply focusing on treatment and remediation strategies. However, current evidence on older adults' help-seeking behaviors, the barriers that they may face when accessing care, and alternative sources of support they may seek out in lieu of healthcare services, is complex and not completely understood.

1.1. Conceptualization of help-seeking behavior

Several conceptual models have been developed to describe how individuals may make decisions about how to address their health challenges and needs. For example, the health belief model suggests that there are six constructs influencing one's health decisions, behavior, and actions: 1) risk susceptibility, 2) risk severity, 3) benefits to action, 4) barriers to action, 5) self-efficacy, and 6) cues to action (Hochbaum, 1958; Rosenstock, 1974). In this model, one's beliefs and perceptions about the threat of illness and the benefits of the recommended health action can be used to predict the likelihood of their health behaviors (Hochbaum, 1958; Rosenstock, 1974). The theory of planned behavior extends beyond simply making health decisions and suggests that the decision to act or change behavior is influenced by one's intention to act, one's perception and attitude about the act, the view of others and one's perceived ability to perform that behavior (Ajzen, 1991). Andersen's behavioral model of health services utilization is widely used in understanding access to and use of healthcare. It suggests that service use is impacted by three variables; 1) predisposing variables, 2) enabling variables, and 3) need variables (Aday & Andersen, 2005). Predisposing variables are factors that relate to one's demographic and social structures, such as their race and

employment, as well as their existing health beliefs. Enabling variables relate to resources, for the individual (e.g. income, insurance coverage) and the community in which they live (e.g. availability of hospital beds). Finally, need variables relate to the necessity of care, and will depend upon the individual's self-perceptions or a healthcare provider's diagnosis of the health problem. It is noted that later versions of Andersen's model also include factors such as personal health practices, patient satisfaction, health outcomes and environmental forces (Aday & Andersen, 2005). In the context of help-seeking behavior, each of these models highlights the complexities involved in decision-making, and the varying influences of attitudes, beliefs, ability, and resources that individuals consider prior to changing their behaviors. Given this, it is necessary to determine which factors may be more relevant for older adults, so that their needs can be adequately addressed in a timely manner.

Help-seeking behavior has been conceptualized and defined in various manners, and as such, progress in this field has been hindered by a lack of consistent conceptual measures and an agreed upon definition (Rickwood & Thomas, 2012). For example, Mechanic was one of the first to describe help-seeking behavior in 1962, viewing help-seeking as 'illness behavior' and an adaptive way of coping (Rickwood & Thomas, 2012). Contemporary definitions of help-seeking more commonly focus on the active process of seeking help or the process of communicating one's needs to others (Rickwood & Thomas, 2012; Werner et al., 2014). As opposed to acute and infectious diseases that dominated the first half of the 20th century, the rise in chronic illnesses, disabilities, mental health challenges and living problems have posed significant challenges in recognizing symptoms and the need for medical attention (Rickwood & Thomas, 2012). As such, these later definitions are more useful in highlighting the voluntary and active process of help-seeking that more commonly occurs today, of which relies on receiving help (Rickwood & Thomas, 2012). In this case, help-seeking behavior encompasses various stages, such as the recognition of a problem or the experience of symptoms, the decision to seek help, an evaluation of the resources needed and contact with others for support (Lee et al., 2011; Werner et al., 2014). Through these conceptualizations, three types of support have been identified: 1) formal, 2) informal, and 3) self-help, with the latter on the rise due to the availability of technology that may not require communication with another individual at all (Rickwood & Thomas, 2012). Further to these definitions, several standardized measures have been developed, of

which the Attitudes Toward Seeking Professional Psychological Help Scale and the General Help-Seeking Questionnaire are more commonly used (Rickwood & Thomas, 2012).

For the purposes of this scoping review, a definition adapted from a World Health Organization report examining help-seeking behaviors of adolescents will be used (Barker, 2007). As there is no single definition of help-seeking that is routinely referred to throughout literature, this definition was chosen as it is one of the most broadly used and comprehensive attempts at defining help-seeking, including for older adults (Rickwood & Thomas, 2012). This definition is also useful due to its ability to expand beyond healthcare utilization, of which may not be a common or preferred avenue for older adults. As such, for this scoping review, help-seeking behavior is defined as the following: Any action taken by an older adult who perceives themselves as having a physical or mental health challenge, with the intent of finding an appropriate remedy (Barker, 2007; Latunji & Akinyemi, 2018; Rickwood & Thomas, 2012). The type of support that individuals pursue can include seeking formal support services (e.g. from physicians, psychologists, counselors) or seeking informal support services as a means of accessing health information and services (e.g. from family, friends, the Internet) (Barker, 2007; Latunji & Akinyemi, 2018; Rickwood & Thomas, 2012). Furthermore, this paper highlights the various barriers and facilitators to help-seeking for the older adult demographic. As such, the following definitions of barriers and facilitators are included, which were also adapted from a study on the examination of mental health-seeking behaviors among young athletes and chosen due to its explicit and comprehensive use in the study (Gulliver, Griffiths, & Christensen, 2012). Facilitators to help-seeking will be defined as any factor that has been shown to support or encourage an older adult to seek help for their mental and/or physical health challenges (Gulliver, Griffiths, & Christensen, 2012). An example of facilitators for adolescents includes positive perception of social supports, personal coping skills and self-agency (Barker, 2007). In contrast, barriers to help-seeking will be defined as any factor that has been shown to prevent or discourage an older adult from seeking help for their mental and/or physical health challenges (Gulliver, Griffiths, & Christensen, 2012).

1.2. Inclusion of minoritized ethnic groups

While it is evident that there needs to be more research on understanding the help-seeking behaviors of older adults as a whole, it is equally important to recognize the heterogeneity of this population and the various intersections of identity that individual older adults can occupy. The term intersectionality was first used by Crenshaw in 1989 to describe how characteristics such as race, gender, and class can overlap and influence the ways in which individuals experience the world. As the intersectionality theory suggests, such social locations interact and multiply to create power structures that result in privilege and/or oppression among individuals (Crenshaw, 1989; Hankivsky, 2014). In turn, this theory highlights how various inequalities such as racism and sexism influence and exacerbate one's lived experience and the way they interact with the world (Crenshaw, 1989; Hankivsky, 2014). In this way, the intersectionality theory provides a lens for understanding how structural and institutional forces privilege or oppress some groups over others with respect to accessing healthcare system resources and can disproportionately impact marginalized ethnic sub-groups in their help-seeking opportunities and behaviors. As models such as the health belief model and the theory of planned behavior are not focused on how cultural dimensions can impact the lived experiences of minority ethnic older adults, the inclusion of the intersectionality theory adds an important dimension of how intersections of age and ethnicity, and others such as gender, language, migration status and religion, can subsequently negatively affect help-seeking behavior.

Furthermore, understanding the relationship between ethnicity and age is even more important within the context of health, as health disparities continue to persist among these populations (Nelson, 2002). These groups underutilize healthcare services compared to mainstream older adults, despite demonstrating a greater need for health and support services (Greenwood & Smith, 2015; Walton & Anthony, 2017). Combined with racial and ethnic discrimination, ageism can compound the negative impacts on one's healthcare experience (Rogers et al., 2015). As Rogers et al. (2015) found in their study, healthcare discrimination was associated with new or worsened disability over four years. Furthermore, those who experience daily discrimination may be more likely to avoid care and subsequently be more likely to report poorer health outcomes, and can result in higher mortality (Rogers et al., 2015). For these reasons, the field of cultural

competency in healthcare is an emerging area that is also important to consider. Cultural competence can be defined as “a set of cultural behaviors and attitudes integrated into the practice methods of a system, agency, or its professionals that enables them to work effectively in cross cultural situations” (US Administration on Aging, 2011, p. 9). Cultural competency training can improve the knowledge, skills, and attitudes of professionals, where efforts towards practice that is critical, and reflexive can support the reduction of health inequalities for a diverse older adult population (Garneau & Pepin, 2015). Evidently, the continued underrepresentation of minority ethnic older adults in literature and in research (George et al., 2014; Korte et al., 2011) leads to a gap in our understanding of what strategies or programs may improve help-seeking behavior and subsequent health outcomes. Even among studies that examine ethnic or racial minorities, various racial/ethnic groups (e.g. Asian Americans) are often seen as one large entity, with no distinctions within them despite their varying cultures, languages and histories (McLaughlin & Braun, 1998; Hong, 2019). In addition, as seen among younger minority ethnic groups, there are a variety of help-seeking strategies that individuals may employ in place of formal healthcare services, or before using formal support services as a last resort. Alternative strategies or coping methods include various exercises and the use of traditional medicines, with reasons for this including traditional values, family obligations and stigma associated with the dominant group (Guo et al., 2015; Rüdell et al., 2008; Shefer et al., 2013; Taylor & Richards, 2019). Furthermore, in a glossary focusing on concepts and terms used within health research on minority ethnic and racial groups, Bhopal (2004) describes ethnicity as “a multi-faceted quality that refers to the group to which people belong, and/or are perceived to belong, as a result of certain shared characteristics, including geographical and ancestral origins, but particularly cultural traditions and languages” (p.1). As such, this scoping review also examined how factors such as culture, traditional beliefs, and immigration can influence help-seeking behaviors among a diverse older adult population.

Compared to systematic reviews, scoping reviews are an appropriate strategy to map and capture current knowledge in the literature as well as to identify existing gaps to identify rich areas for future research, investigation, and action (Munn et al., 2018; Tricco et al., 2018); therefore, to garner a more in-depth exploration of the help-seeking behaviors of older adults, with the inclusion of minority ethnic older adults, a scoping

review was conducted. The purpose of this review is to identify the ways in which older adults exhibit (or do not exhibit) help-seeking behaviors, and the ways in which they may experience barriers (or facilitators) from informal and formal supports. In understanding their help-seeking behavior, the most salient factors can be identified to support those most in need. The inclusion of minoritized ethnic groups will also allow for a discussion on how help-seeking behaviors may differ by populations, highlighting potential ways to move forward.

Chapter 2.

Methods

To understand the factors associated with the help-seeking behaviors of older adults, this scoping review adhered to the Preferred Reporting Items for Systematic Reviews and Meta-analysis Protocols Extension for Scoping Reviews (PRISMA-ScR) guidelines (Tricco et al., 2018). Due to a lack of consensus on conducting and reporting scoping reviews, the PRISMA-ScR guidelines were developed to improve methodological quality, transparency, and to ensure that core concepts and items are completely reported (Tricco et al., 2018). The final checklist was adapted from the original PRISMA statement (Tricco et al., 2018) and a detailed completion of the PRISMA-ScR checklist can be found in Appendix A. In addition, this scoping review was informed by the seminal work conducted by Arksey & O'Malley (2005), which was further built upon by Levac et al. (2010) and the Joanna Briggs Institute (Peters et al., 2020): 1) identifying the research question, 2) identifying relevant studies, 3) study selection, 4) charting the data, and 5) collating, summarizing, and reporting the results. This scoping review is registered with the Open Science Framework (https://osf.io/69kmx) and further methodological details are published and available online: Teo, K., Churchill, R., Riadi, I., Kervin, L., Cosco, T.D. (2021) Help-seeking behaviors among older adults: A scoping review protocol. BMJ Open.11: e043554.

2.1. Step 1: Identifying the research question

To better understand the salient barriers and facilitators to help-seeking among the older adult population, this scoping review was undertaken with one main research question: Which factors are associated with help-seeking behavior among older adults? This review also sought to answer an additional sub-question to specifically focus on the minority ethnic older adult population: How do cultural backgrounds, values, and differences impact help-seeking behavior among various older adult populations?

2.2. Step 2: Identifying relevant studies

To identify relevant studies, the following five databases were searched: MEDLINE/PubMed, Web of Science, PsycINFO, CINAHL, and Scopus. Articles published from January 2005 to the date of search commencement were included and no language restrictions were imposed. The five databases were searched using two main search strategies. To address the main research question, the following combination of terms were used: (“help seek*” OR “treatment seek*” OR “health information seek*” OR “healthcare seek*” OR “care seek*” OR “health seek*”) AND (“older adults” OR “older people” OR “elderly” OR “seniors” OR “geriatrics”). To answer the sub-question for minority ethnic older adults, an additional search string using a combination of these terms were used: (“help seek*” OR “treatment seek*” OR “health information seek*” OR “healthcare seek*” OR “care seek*” OR “health seek*”) AND (“older adults” OR “older people” OR “elderly” OR “seniors” OR “geriatrics”) AND ("immigrants" OR "ethnic minority" OR "minority populations"). For all databases, the default search string (e.g. [All Fields] in PubMed) was employed to ensure a comprehensive search that included all relevant articles. The search queries for each database can be found in Appendix B and further details of the search strategy are available in Teo, et al. (2021).

2.3. Step 3: Study selection

After exporting the search results into EndNote and removing duplicates, 50 random titles and abstracts were pilot screened by two independent reviewers and reconciled to ensure consistency. Following the pilot-screen, all titles and abstracts were reviewed by the same two reviewers independently. After reconciliation of the title and abstract searches, full texts were examined by two reviewers independently to create a final list of studies. From the included studies as well as any systematic reviews and scoping reviews that were captured in the search strategy, reference lists were hand-searched for potential missing articles. A third reviewer was available to consult and resolve any disagreements between the two reviewers when necessary.

2.3.1. Eligibility criteria

Inclusion and exclusion criteria for studies are highlighted in Table 1.

Table 1. Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Full-text and peer-reviewed studies • Address the help-seeking behaviors of older adults • Published from January 2005 to the date of search commencement in January 2021 • Participants aged 65 years old or older • Participants engaging in help-seeking behaviors or experiencing barriers to seeking help for their physical or mental health challenges	• Systematic reviews, scoping reviews, opinion letters, conference proceedings, and dissertations • Population dyads (e.g. includes both younger (<65) and older adults, or the perspectives of caregivers and healthcare providers) • Non-community dwelling older adults • Non-human studies

Studies involving older adults in which the factors associated with help-seeking were not a primary focus were excluded, for example: an intervention that aimed to increase an older adult's ability to find health information online (Campbell & Nolfi, 2005). In addition, while three articles on elder abuse were identified that met inclusion criteria, they fell outside of the scope of this review and comprise a separate sub-area, and thus excluded from the final analysis (Chokkanathan et al., 2014; Lafferty et al., 2013; Naughton et al., 2013).

2.4. Step 4: Charting the data

Charting the data in a scoping review is akin to the data extraction stage of a systematic review, where data are recorded and sorted according to key themes and categories (Arksey & O'Malley, 2005). To do so, an Excel data extraction spreadsheet was created that documented the following information: authorship, year and journal of publication, population characteristics (e.g. age range, ethnicity, gender), geographic location, language, study methodology, study limitations, the discussed barriers or facilitators to help-seeking as well as any notes. An example of this data extraction spreadsheet can be found in Appendix C.

2.5. Step 5: Collating, summarizing, and reporting the results

As a scoping review is only intended to provide an overview of the existing literature and not to appraise the quality of individual articles, a risk of bias assessment

was not performed (Tricco et al., 2018). However, a discussion of salient limitations found in the included studies as well as the continued knowledge gaps and opportunities for future research in this topic area will be discussed below.

To integrate and synthesize findings from the included studies, this review followed the components of a qualitative meta-synthesis framework. As opposed to a meta-analysis that aims to condense quantitative data into a value such as an effect size, a meta-synthesis is meant to interpret and construct greater meaning from the findings (Erwin et al., 2011). As the initial steps of a meta-synthesis are similar to the scoping review steps outlined by Arksey & O'Malley (2005) (e.g., formulating a clear research question, conducting a comprehensive literature search), this review specifically followed meta-synthesis techniques for this stage of the review (collating, summarizing, and reporting the results). To do so, each study was carefully read and re-read, with a focus on identifying any factors associated with help-seeking. As study findings and factors were identified, they were matched and compared with subsequent articles. They were then organized following a first-order, second-order, and third-order format. First-order constructs were recorded as direct factors, quotes and findings discussed from the studies themselves, second-order constructs were interpretive themes that formed the basis of each category, and third-order constructs were developed from the aggregation of multiple categories that led to the development of six new themes. To present these findings, study demographics and characteristics tables were created (Tables 2-5) and a narrative overview of the included articles are discussed below.

Chapter 3.

Results

3.1. Included studies

From the two search strings, a total of 4629 articles were identified. After duplicates were removed, 2824 title and abstracts were screened. While hand-searching of reference lists from the included full-text studies as well as from the systematic reviews and scoping reviews that were captured from the initial search strategy was conducted, no additional references were captured. At this stage, 2453 articles were excluded, and 371 articles went on to full-text screening. Eleven studies were unavailable to be retrieved from the Simon Fraser University Library and requests sent to the authors for full-texts (via ResearchGate) were not answered. A total of 52 articles met inclusion criteria (Figure 1).

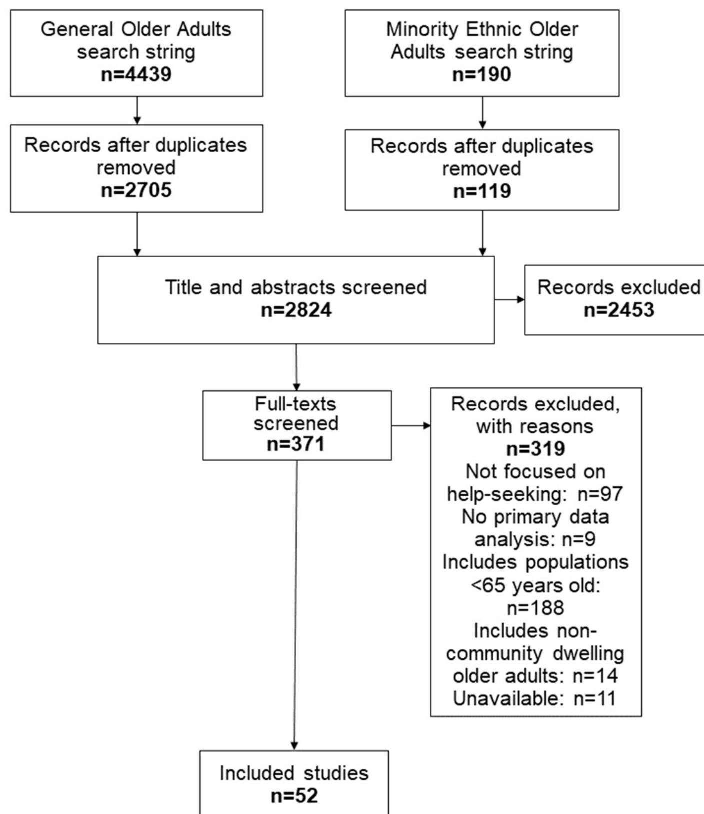

Figure 1. PRISMA flowchart: Screening process for study inclusion

3.2. Study characteristics

The number of studies was highest in Europe (n=18), followed by North America (n=16), Asia (n=12), Australia (n=5) and New Zealand (n=1). Most studies used qualitative methods (n=26; Table 2), followed by quantitative (n=24; Table 3) and mixed methods (n=2; Table 4). More papers focused on physical health challenges (e.g., chronic conditions and pain; n=28), over mental health challenges (e.g., depression; n=11). Thirteen studies discussed both physical and mental health challenges or discussed general health challenges. The types of help-seeking behavior exhibited varied, such as searching for health information on the internet, seeking support from friends and family, as well as seeking formal support from various healthcare providers, specialists, and religious leaders (Table 5). All articles were published in English.

Table 2. Qualitative Study Demographics

Author(s)	Year	Country	Study Population	Age
Altizer et al.	2014	United States	African American and White older adults in south-central North Carolina counties	≥65
Aubut et al.	2020	Canada	French-speaking Quebecers receiving treatment at a public addiction center	≥65
Begum et al.	2012	United Kingdom	Residents of southeast London	≥65
Canvin et al.	2018	United Kingdom	Older adults living in North West England and North Wales	68-95
Chen	2020	Taiwan	Older adults recruited from community day care centers, living in rural areas of Taiwan	≥65
Chung et al.	2017	United States	Older Korean immigrants living in the Seattle metropolitan area	67-79
Clarke et al.	2014	United Kingdom	Older adults in North-East Scotland	66-89
Dollard et al.	2014	Australia	Older women living in Adelaide, Australia	65-87
Elias and Lowton	2014	London	Older adults recruited from two day centers in South-East London	80-93
Frost et al.	2020	United Kingdom	Frail older people recruited from general practices in the United Kingdom	75-88
Gore-Gorszewska	2020	Poland	Polish residents	65-82
Hannaford et al.	2018	Australia	Older adults from New South Wales, Australia	65-89
Hurst et al.	2013	United Kingdom	Older people recruited from day centers, advertisements, or snowball recruitment	66-85
Johnston et al.	2010	Australia	Volunteers who had sustained a fall in the previous 6 months	≥65

Author(s)	Year	Country	Study Population	Age
Kelly et al.	2011	United States	Caucasian older adults living in the metropolitan areas of Phoenix and San Francisco	65-80
Kharicha et al.	2013	London	Patients from a general practice located in suburban London	≥65
Lawrence et al.	2006	United Kingdom	Black Caribbean, South Asian and white British older adults	≥65
Lee et al.	2020	Singapore	Older adults receiving public financial assistance and living in the Chin Swee residential estate	66-88
Makris et al.	2015	United States	Racially diverse population of older adults living in Connecticut or New York City	≥65
Miller et al.	2016	Canada	Canadian seniors who visited an Emergency Department in Ontario, because of a fall, but were not hospitalized	65-88
Mukherjee	2019	India	Migrant Bangladeshi elderly women living in North 24 Parganas, West Bengal, India	≥65
Polacsek et al.	2019	Australia	Older people receiving treatment and/or support for a formal diagnosis of moderate depression	65-82
Schaller et al.	2020	Norway	Native Norwegian adults of all sexual orientations, with or without partners	65-85
Stoller et al.	2011	United States	African American and White adults from 3 rural counties in south-central North Carolina	65-92
Tsai and Tsai	2007	Taiwan	Elders living alone in a remote area of eastern Taiwan	65-90
Waterworth et al.	2017	New Zealand	Older adults with multimorbidities, recruited from general practices in New Zealand	66-90

Table 3. Quantitative Study Demographics

Author(s)	Year	Country	Study Population	Age
Bonnewyn et al.	2009	Europe	Older adults living in Belgium, France, Germany, Italy, the Netherlands, and Spain	≥65
Djukanović et al.	2014	Sweden	Residents of Sweden	65-80
Eriksson-Backa et al.	2018	Finland	Finnish seniors	65-79
Garg et al.	2017	United States	Medicare beneficiaries	≥65
Garrido et al.	2011	United States	Older community-dwelling adults in the United States	≥65
Hartvigsen et al.	2006	Denmark	Danish twins	72-102
Hohls et al.	2020	Germany	Participants of the AgeQualiDe-Study (a German study on the oldest-old primary care patients)	≥85
Horng et al.	2014	Taiwan	Older Taiwanese people	≥65

Author(s)	Year	Country	Study Population	Age
Kagan et al.	2018	Israel	Older men in Israel who speak Hebrew	≥65
Krishnan and Lim	2012	Singapore	Single elderly Indian men who speak Tamil and receive state financial assistance	65-86
Lau et al.	2014	China	Chinese older adults recruited from health centers in Macao, China	65-91
Lee et al.	2005	Korea	Elderly males without prior prostate surgery, prostate cancer, or bladder disease	65-84
Lee et al.	2012	United States	Older adults who have health insurance and a usual source of care	≥65
Makam et al.	2016	United States	Patients hospitalized at medical centers in central Massachusetts	≥65
McCabe et al.	2017	United States	Patients living in the Midwestern United States, recruited from a primary care clinic	65-91
McGowan and Midlarsky	2012	United States	White and Black older adults of various religious affiliations	65-94
Mechakra-Tahiri et al.	2011	Canada	French-speaking older adults living in Quebec	≥65
Murata et al.	2010	Japan	Older adults who were literate and understood Japanese, living in 6 municipalities from 3 prefectures	65-100
Nurit et al.	2016	Israel	Older Jewish population in Israel	66-92
Pickard and Guo	2008	United States	Participants living in a Naturally Occurring Retirement Community (NORC) in Missouri	65-95
Pickard and Tang	2009	United States	Participants living in a Naturally Occurring Retirement Community (NORC) in Missouri	65-95
Schneider et al.	2014	Australia	Clients attending 3 low-vision clinics in Sydney, Australia	≥65
Stenzelius et al.	2006	Sweden	Older adults who reported having difficulties controlling urine and/or other urinary symptoms	≥75
Stenzelius et al.	2007	Sweden	Older adults who reported having difficulties controlling feces	75-96

Table 4. Mixed Methods Study Demographics

Author(s)	Year	Country	Study Population	Age
Horton and Dickinson	2011	England	Chinese older people based in central London, England	≥65
Hwang and Jeong	2012	South Korea	First-time AMI patients recruited from the cardiovascular unit of a national university hospital	65-89

3.3. Overview of findings

Key findings from each article regarding health challenges, help-seeking behaviors, barriers, and facilitators of help-seeking were recorded (Table 5). From these extracted data, the included articles were organized into six main themes according to the qualitative meta-synthesis framework: 1) interactions with formal healthcare providers, 2) identity and independence, 3) appraisal of symptoms and health, 4) turning to social supports, 5) accessibility and awareness, and 6) cultural factors and lay/religious beliefs.

Table 5. Help-Seeking Characteristics & Factors among Older Adults

Author(s)	Type of help-seeking behavior(s)	Health Challenge(s)	Help-seeking Barrier(s)	Help-seeking Facilitator(s)
Altizer et al. 2014	Health information seeking (e.g. from friends, healthcare providers & media sources)	General health challenges	-	Being confronted with unfamiliar/novel sumptoms or when a known treatment was not effective
Aubut et al. 2020	Asking for help from an addiction service centre	Substance use	Lack of knowledge about services and availability of services	Deteriorating health, desire to fill grandparent role, involvement of social supports, having a family doctor, available resources (e.g. addiction services)
Begum et al. 2013	Seeking help from a local specialist memory assessment service	Memory complaints	Viewing issues as not concerning, having causal beliefs that led to beliefs in lack of control, negative perceptions of general practitioners, stigma, pride, preference to cope alone or to use self-help strategies	Positive views of health system, having alternative pathways to care (e.g. medical surveillance through regular visits with general practitioner), available social supports, presence of comorbidities
Bonnewyn et al. 2009	Seeking mental health services, antidepressants, and benzodiazepines	Depression and chronic pain	-	Presence of major depressive episode or painful physical symptoms
Canvin et al. 2018	Various (e.g. medical and family-provided support, both paid or unpaid)	General health challenges	No perception of need, viewing decline as an inevitable consequence of age, viewing assistance as a threat to independence and inability to cope, not wanting to be a burden, passivity, lack of awareness	Reaching a point where deterioration could not be denied, impact of decline on usual activities and independence

Author(s)	Type of help-seeking behavior(s)	Health Challenge(s)	Help-seeking Barrier(s)	Help-seeking Facilitator(s)
Chen 2020	Medical treatment-seeking	Chronic conditions (e.g. diabetes, hypertension, arthritis, heart disease)	Low literacy, low awareness of illness and severity, cost, not wanting to be a bother to family, poor family living conditions, resignation to fate/folk remedies, poor doctor-patient communication	Availability of others for help and advice (e.g. family, neighbours, volunteers), having treatments close to home, increased seriousness of disease
Chung et al. 2018	Various (e.g. Health information seeking, complementary/alternative therapies, regular clinic visits)	Various (e.g. Chronic conditions, memory issues, mobility limitations)	Seeing oneself as healthy, mistrust, adapting to aging body, shorter immigration period, language barriers, lack of support and available information, cost, limited health insurance	Longer length of residency, community resources and organizations, social engagement, physicians motivating concerns about future falls and frailty, home care workers serving as source of health information, health coverage
Clarke et al. 2014	Seeking help from health professionals	Musculoskeletal chronic pain	Not wanting to bother or waste physician's time, the need to be really ill first, not wanting to be viewed as a 'complainer' or a 'fraud', issues associated with age, not getting a diagnosis for pain, assuming providers's dismissiveness	When pain becomes persistent/noticeable/repetitive, feeling listened to and heard
Djukanović et al. 2015	Seeking formal care (from a physician, district nurse, welfare officer, psychologist and physiotherapist)	Depression	Negative experiences from previous provider visits, difficulty getting through on the phone, symptoms got better on its own, cost, lack of awareness, time (e.g. had no time or waiting time too long)	-

Author(s)	Type of help-seeking behavior(s)	Health Challenge(s)	Help-seeking Barrier(s)	Help-seeking Facilitator(s)
Dollard et al. 2014	Seeking help from a general practitioner	Falls	Perceiving fall or fall-related injury as not serious, beliefs that general practitioner could not help, not wanting to "make a fuss", attribution of falls to extrinsic factors (e.g. uneven footpath, hurrying), discounting intrinsic risk factors (e.g. leg weakness, poor balance), not wanting to waste practitioners' time, untimely access to practitioner	Perceiving fall-related injury as serious (e.g. visible injuries or pain impairing mobility), persuasion/negotiation/coercion by others
Elias and Lowton 2014	Seeking medical care (e.g. from a general practitioner, at a hospital)	Various (e.g. severe pain, coughs)	Belief that doctors could not help, attributing problems to old age, desire not to burden others, valuing functional independence, negative accounts of receiving help when they did not seek it or being sent home despite seeking help at the hospital	Greatly impaired function, believing they were more vulnerable due to age, perceiving that physical access to the doctor was more difficult, being obliged by relatives
Eriksson-Backa et al. 2018	Health information seeking	General health challenges	-	Higher health information literacy, being female, higher education level
Frost et al. 2019	Various (e.g. from general practitioners, social workers, mental health professionals, adult children, support groups)	Frailty, depression and anxiety	Low expectations, normalizing decline and the aging experience, not experiencing improvement after seeking treatment, family conflict, finances, lack of awareness of available supports, threats to independence, fear of dependency on antidepressants, experiencing difficulties with telephone appointments or technology, being unable to access appointments, difficulty leaving homes	Moderate-to-severe symptoms, endorsement of treatments by others, face-to-face contact, delivery of services provided at home, locally or with transport provided

Author(s)	Type of help-seeking behavior(s)	Health Challenge(s)	Help-seeking Barrier(s)	Help-seeking Facilitator(s)
Garg et al. 2017	Seeing a doctor or other medical person	Various (e.g. chronic conditions, multimorbidity)	Low perceived severity of illness, costs, belief that doctors could not help, schedule or personal conflicts, trouble finding or getting to a doctor, high worry and fear of knowing the illness, and non-acceptance of insurance by the doctor	Higher age, non-smoking status, higher income, having a usual source of care, lower worry about personal health
Garrido et al. 2011	Seeking mental health care (e.g. from a physician, nurse, occupational therapist, psychiatrist, psychologist, social worker)	Various (e.g. mental illness, alcohol abuse, chronic conditions)	Problems went away by itself, desire to handle issues on their own, cost, low perceived seriousness, thinking treatment would not be useful, not knowing where to go for care, scheduling difficulties, limited insurance coverage, stigma	Perceiving a need for care, having a history of more chronic physical conditions, history of alcohol abuse or dependence, having private insurance
Gore-Gorszewska 2020	Seeking medical or psychological help	Sexual problems	Not recognizing symptoms or treating symptoms as part of aging, fear of doctors' disapproval or having problems dismissed, stigma, sexual problems considered less important than other medical conditions, lack of knowledge and awareness on how to access appropriate services	-
Hannaford et al. 2019	Seeking psychological services	Mental health challenges	Reluctance to disclose mental health concerns, short consultation times, passivity, a focus on physical symptoms, lack of enquiry by the GP, low mental health literacy, lack of familiarity with psychotherapy, feeling that challenges should be dealt with individually, stigma	Experiencing trust and the absence of judgement, practitioners providing advice/referral/initiating discussion of mental health problems, favorable help-seeking experiences in the past, access to social and professional networks linked with religious communities

Author(s)	Type of help-seeking behavior(s)	Health Challenge(s)	Help-seeking Barrier(s)	Help-seeking Facilitator(s)
Hartvigsen et al. 2006	Seeking medical care (e.g. from a general medical practitioner, medical specialist, chiropractor)	Neck and back pain	-	Higher duration and intensity of pain
Hohls et al. 2020	Receiving informal and/or formal support (e.g. from friends, relatives, or local services)	Psychological distress	-	Experiencing psychological distress or increased anxiety symptoms
Horng et al. 2014	Seeking medical attention	Fecal incontinence	-	Living in urban areas, mucous stool incontinence, frequent symptoms impacting social life/work life, anxiety, family interactions
Horton and Dickinson 2011	Various (e.g. using formal health services, telling adult children)	Falls	Embarassment, wanting to speak on positive events with friends, not wanting to worry adult children, belief in metaphysical explanations(e.g. fatalism) attribution of illness with age, self-judgement, lack of information about services, language & literacy barriers	Subsidized interventions, information presented via visual media (e.g. via television/DVD in Chinese, word of mouth), culturally appropriate interventions
Hurst et al. 2013	Health information-seeking (e.g. from newspapers, doctors, nurses, pharmacists, family, friends, internet)	General health challenges	Values and beliefs related to family history and superstition, perceiving the event as insignificant, viewing their condition as part of a normal aging process, fear, not wanting to bother the doctor	Change in health, the need for information around an actual or suspected diagnosis (self-assessment of symptoms usually done first), reading articles in the newspaper and having conversations with family/friends/health professionals, viewing event as serious, rising health concerns, past experiences and knowledge

Author(s)	Type of help-seeking behavior(s)	Health Challenge(s)	Help-seeking Barrier(s)	Help-seeking Facilitator(s)
Hwang and Jeong 2012	Going to the hospital	Acute myocardial infarction (AMI)	Lower education, non-ST-elevation MI, presence of preinfarction angina pain, attribution of symptoms to a non-cardiac origin, perceiving no heart attack threat, lack of knowledge/recognition of urgency of symptoms and risk, optimistic self-appraisal of symptoms, overconfidence about health, not wanting to bother or burden others	-
Johnston et al. 2010	Using a personal alarm to receive assistance	Falls	Performance of alarms not well understood, alarms viewed as obtrusive/uncomfortable/unnecessary, expressions of fatalism/resignation/denial of fall risk, cost, negative feelings of being a burden, threats to independence and identity, fear of going to the hospital and not being able to return home	Perceived benefits of personal alarms (e.g. personal safety, improved independence and reassurance), alarm use motivated by previously bad experiences (e.g. previous injury), positive experience of receiving quick medical attention after using the alarm, influence of family/health professionals
Kagan et al. 2018	Seeking help from a social worker	General health challenges	Stigma, higher education, lower self-rated health	Self-reported loneliness, better self-rated health, positive attitudes towards social workers, prior experience with receiving professional help
Kelly et al. 2011	Consulting hearing services	Hearing impairments	Not experiencing communication breakdowns or experiencing them in predictable ways (resulting in low cognitive anxiety and lack of consulting)	Being unable to make useful predictions about communication events, provision of hearing aids that reduced the number of communication breakdowns, knowing about communication strategies
Kharicha et al. 2013	Seeking medical care (e.g. from general practitioner, optician)	Vision loss	Denial, fear, viewing worsening vision as normal/part of aging, costs of buying and updating lenses/glasses, mistrust in the commercial motivation of optical industry	Seeking help depended on significant events and changes (e.g. experiencing difficulty in watching television/driving/reading bus numbers)

Author(s)	Type of help-seeking behavior(s)	Health Challenge(s)	Help-seeking Barrier(s)	Help-seeking Facilitator(s)
Krishnan and Lim 2012	Using subsidized healthcare facilities (e.g. government polyclinics and hospitals)	General health challenges	Low confidence in subsidized medical care providers, language disconcordance, difficulties communicating led to dissatisfication with the quality of healthcare received	Service awareness, financial resources, affordable services
Lau et al. 2014	Seeking help from healthcare professionals	Various (e.g. hypertension, diabetes, arthritis, osteoporosis)	Being married, valuing the idea of keeping personal matters within the family, low self-esteem, impaired body image, fear of intimacy with helping professionals	-
Lawrence et al. 2006	Various (e.g. seeking help from family or general practitioner, religion and self-management)	Depression	Not wanting to rely on family, past experiences of general practitioners not helping, belief that doctors were too busy/overly reliant on medication, limited consultation time, doctors dismissing their compliants, fear of medications creating dependency, concerns about side effects, confusion about the exact role of counsellors, belief one should not share personal problems with strangers, stigma	Being able to share without fear of boring others/becoming a burden/being judged, families providing advice or seeking help on their behalf, seeking friends as source of encouragement/advice/reassurance, access to day centres, not feeling well, belief that doctors could and should help, opportunity to speak to a professional who was distanced from the situation, regular contact with psychiatrists and subsequent experiences of reassurance
Lee et al. 2005	Various (e.g. consulting friends, spouses or health professionals)	Benign prostatic hyperplasia (BPH) and BPH-related symptoms	Attributing symptoms as part of a natural aging process and thus untreatable, feeling embarassed or fearful of cancer	-

Author(s)	Type of help-seeking behavior(s)	Health Challenge(s)	Help-seeking Barrier(s)	Help-seeking Facilitator(s)
Lee et al. 2012	Seeing a doctor	Disabilities	Minority status, marital status, lower education, living in Midwest regions/rural areas, older adults with disabilities had significantly higher odds of delaying seeing a doctor due to cost	-
Lee et al. 2020	Accessing healthcare services and financial assistance schemes	Chronic conditions	Low awareness, long wait times, perceived high costs of care, choosing to take personal responsibility over own health, fear of being a burden or receiving bad news, desire for independence, needs did not always match the services provided, perceived lack of medical expertise by community healthcare providers, low health literacy	Convenience and proximity, perceiving condition to be more serious
Makam et al. 2016	Going to the hospital	Acute myocardial infarction (AMI)	Onset of acute symptoms between 6 PM and 5:59 AM, presence of previously diagnosed multiple comorbidities, hospital presentation with atypical symptoms of AMI, diagnosis of an NSTEMI (non-ST-segment elevation myocardial infarction)	-
Makris et al. 2015	Seeking formal healthcare (e.g. talking to providers, having surgery)	Restricting back pain	Mistrust, negative relationships with providers, placing priority on other comorbidities, beliefs about the inevitability of restricting back pain, providers dismissing/minimizing participants' pain, ageist experiences, negative attitudes toward treatment	Positive relationships with providers

Author(s)	Type of help-seeking behavior(s)	Health Challenge(s)	Help-seeking Barrier(s)	Help-seeking Facilitator(s)
McCabe et al. 2017	Seeking medical attention	Atrial fibrillation (AF)	Inaccurate beliefs/misperceptions about AF, lack of knowledge about AF/symptoms, lack of confidence, unsure of when to seek treatment	Recognition that certain symptoms (e.g. shortness of breath, skipping heartbeats) should be evaluated, availability of family members
McGowan and Midlarsky 2012	Using psychotherapy/counselling	Mental health challenges	Limited openess to mental health interventions, viewing psychotherapists as outsiders, treatment seen as a threat to beliefs, lower stigma tolerance, fear	Perceived need, interpersonal openness, confidence in mental health practitioners
Mechakra-Tahiri et al. 2011	Seeking consultation from a health professional	Depression	Stigma, lack of accessibility, living in rural areas	Perceiving themselves as in poor health, presence of a confidant and emotional/instrumental support
Miller et al. 2016	Receiving informal support from spouses, family members, friends and neighbors	Falls	Wanting to remain independent and self-sufficient, pride, not wanting to owe someone in the future/becoming a burden, feeling devalued	Setting a routine/preset schedule where friends/family were available on specific days each week, mutual dependence/acceptance of help between friends
Mukherjee 2019	Various (e.g. using healthcare services, alternative medical amenities)	General health challenges	Language barriers, lack of accessible information, financial constraints, seeing age and illness as inseparable phenomena or a result of sins, stigma, no supports available, not wanting to move	Residential proximity of providers, only going to doctors when participants' situation deteriorated
Murata et al. 2010	Seeking medical and dental care	Various (e.g. hypertension, visual impairment, arthritis, heart disease, diabetes)	Costs/lower socioeconomic status, distance, lack of transportation, being too busy, conditions not serious enough, living in rural areas	-

Author(s)	Type of help-seeking behavior(s)	Health Challenge(s)	Help-seeking Barrier(s)	Help-seeking Facilitator(s)
Nurit et al. 2016	Using psychotherapy	Depressive symptoms	-	Perceived need, positive attitudes toward psychotherapy use, accessibility to services, recommendations from primary physicians
Pickard and Guo 2008	Seeking help from a clergy	Mental health challenges	-	Those with less social support/higher-reported levels of stress/reported more frequent religious attendance/engaged in more private religious activities/higher intrinsic religiosity scores more likely to have sought help from clergy
Pickard and Tang 2009	Help-seeking from a clergy compared to other formal sources (e.g. from psychiatrists, self-help groups, or other mental health specialists)	Mental health challenges	-	Religiosity and stress associated with help-seeking from clergy and other formal sources
Polacsek et al. 2019	Seeking formal support (e.g. from professional/private/public health providers, hospitals, community services)	Depression	Stigma, struggling to become self-motivated to seek help, associating aging with mental or physical decline, difficulty accessing formal supports (e.g. far geographical location/long waiting lists/financial cost), perceived low quality of formal support, low awareness of mental health nurses' role and no understanding of how to access them, experiencing ageism, difficulty obtaining an initial diagnosis, lack of informal support	Accepting personal responsibility for help-seeking, improved mental health literacy, access to online information, establishing a therapeutic alliance with a trusted health professional, being actively involved in the decision-making process, optimizing informal support

Author(s)	Type of help-seeking behavior(s)	Health Challenge(s)	Help-seeking Barrier(s)	Help-seeking Facilitator(s)
Schaller et al. 2020	Seeking formal clinical support (e.g. from general practitioners, specialists, or other healthcare personnel)	Sexual problems	Stigma, fear, unsatisfactory approaches by providers, lack of knowledge/competency, sexuality seen as less relevant in relation to other health issues, lack of sexual knowledge, ageism, possible homophobic attitudes/discrimination, healthcare atmosphere not able to provide a caring climate to discuss sensitive matters	Providers initiating the subject of sexuality from a professional standpoint, desire to express personal agency, believing they had a personal duty to ask their doctor, healthcare providers' explicit knowledge and competence (e.g. having a gay doctor)
Schneider et al. 2014	Various (e.g. seeing an audiologist, hearing aid provider, general practitioner, Ear, Nose and Throat specialist)	Dual sensory (vision and hearing) impairment	Being able to hear well enough, having more serious priorities, negative past experiences with hearing aids/service providers, wanting to only deal with vision loss and not hearing, no time	Being participants in the Vision-Hearing Project, hearing loss affecting day-to-day conversations/activities, encouragement from family/friends, hearing getting worse
Stenzelius et al. 2006	Seeking medical help	Urinary symptoms	-	Influence of issues on daily life, storage symptoms and pain symptoms
Stenzelius et al. 2007	Seeking medical help	Fecal incontinence	-	Discomfort and leakage problems
Stoller et al. 2011	Consulting a doctor	Various (e.g. chronic conditions, acute symptoms)	Regularly occurring symptoms	Perceiving a change in a symptom, experiencing uncertainty about the efficacy of management strategies, intolerable/intense pain, unknown cause of issues, new/unusual symptoms, persisting/recurring/worsening symptom, intending to use doctor as a gatekeeper
Tsai and Tsai 2007	Various (e.g. seeking help from significant others)	General health challenges	Lack of awareness, language barriers, self-perceived health status, having preventive coping strategies, being resigned to one's situation	Convenience of external environmental resources, more human resources, greater understanding of available resources

Author(s)	Type of help-seeking behavior(s)	Health Challenge(s)	Help-seeking Barrier(s)	Help-seeking Facilitator(s)
Waterworth et al. 2018	Contacting a primary nurse by telephone	Multimorbidity (e.g. cardiovascular diseases, diabetes)	Cost, short consultation times, having to make sense of symptoms amidst comorbidities, lack of knowledge, attributing symptoms to aging, feeling like nurses could not help as they had been referred to a doctor in the past	Being able to access a nurse by telephone, understanding the nurse's role, previous positive experiences, awareness that the nurse could be a positive link with the doctor if needed, trust and confidence, feeling heard

3.3.1. Interactions with formal healthcare providers

As the older adult demographic accounts for a large proportion of annual healthcare expenditures, formal healthcare providers can be one of the more frequent contacts among this population (Zayas et al., 2016). Among the articles that discussed this relationship, the more common healthcare provider roles discussed were general practitioners/physicians, nurses, psychologists, and opticians. Through the included studies, older adults highlighted the ways in which both positive and negative interactions and relationships with providers influenced their help-seeking behaviors in different ways.

Help-seeking barriers

Fifteen articles described how perceptions of a physician's role and past interactions with formal healthcare providers can negatively influence older adults' help-seeking behaviors. Among these articles, two perceptions were held; that the physician could either not help at all or any more than they already were helping (Dollard et al., 2014; Elias & Lowton, 2014; Garg et al., 2017), and that general practitioners are limited to only providing aid for physical issues (Begum et al., 2012). These notions were reinforced by past experiences of help-seeking, where misdiagnosis or non-diagnosis occurred (Clarke et al., 2015; Polacsek et al., 2019). For example, older adults that presented physical symptoms to their physician expressed significant issues in obtaining a correct diagnosis of depression (Polacsek et al., 2019). As Canvin et al. (2018) reiterates, continued unmet need after seeking assistance led to older adults seeking out other services or engaging in self-management strategies instead. Examples of self-management strategies included older adults purchasing their own assistance aids or using bedside tables for support when standing (Canvin et al., 2018). Furthermore, dismissal of health concerns and a lack of respect exhibited by the healthcare provider reinforced older adults' reluctance to share any new health challenges at subsequent consultations (Gore-Gorszewska, 2020; Lawrence et al., 2006; Makris et al., 2015). In this way, both perceived ineffectiveness or actual lack of aid from a provider impacted subsequent help-seeking behaviors of older adults in negative ways (Canvin et al., 2018; Djukanović et al., 2015; Elias & Lowton, 2014; Frost et al., 2020; Lawrence et al., 2006; Makris et al., 2015; Schneider et al., 2014).

Mistrust in healthcare providers was also noted as a barrier to help-seeking. This was emphasized in Schaller et al.'s (2016) study, where participants preferred discussing sexual problems with providers that would have more personal knowledge, where a provider's competence was measured by their age and gender. This mistrust also extended to the services and treatments that physicians would recommend; Kharicha et al. (2013) describes older adults weighing decisions between trusting the optician's professionalism when it came to their vision problems, with the commercialization of the vision industry.

Help-seeking facilitators

Conversely, 12 articles discussed how a positive relationship with healthcare providers was a facilitator to help-seeking among older adults, where Polacsek et al. (2019) highlights the term 'therapeutic alliance' to describe a mutually respectful relationship between the older adult and the provider. For example, despite continuing back pain, older adults in Makris et al.'s (2015) study expressed a willingness to seek care due to the positive relationship they had with their provider. Furthermore, Begum et al. (2012) found that positive views of the healthcare system were more likely to be true among formal help-seekers compared to non-seekers, while Nurit et al. (2016) found that positive attitudes with psychological treatment were associated with higher odds of seeking such treatment. Feeling heard by the providers, gaining a sense of security and being given practical information and assistance were deemed to be important components of this relationship (Clarke et al., 2015; Waterworth et al., 2018), as was older adults being a part of the decision-making process to allow for greater agreement with treatment plans (Polacsek et al., 2019). In this way, inquiry by and involvement of a primary care provider also increased opportunities for issues to be raised (e.g. memory problems during a routine check-up) (Begum et al., 2012; Elias & Lowton, 2014; Garrido et al., 2011; Hannaford et al., 2019; Waterworth et al., 2018), as was the opportunity for the provider to act as a gatekeeper to prescriptions or other services (Aubut et al., 2020; Frost et al., 2020; Hannaford et al., 2019; Nurit et al., 2016; Stoller et al., 2011).

3.3.2. Identity and independence

As individuals age, life transitions and life changes are inevitable. As such, an older adult's ideas of their identity and independence can be challenged and

transformed. As Johnston et al. (2010) describes, participants grappled with previously held notions of being independent to now facing new realities of being at risk for falls and injuries. The studies that discussed the relationship between help-seeking and notions of identity and independence suggest that these views can both hinder and encourage older adults' help-seeking behaviors.

Help-seeking barriers

Twenty articles discussed the desire of older adults to uphold their identities and independence as a barrier to help-seeking. This was true despite the availability of support, where older adults indicated the preference to not want others involved in their health challenges as a means of preserving their own independence (Aubut et al., 2020; Canvin et al., 2018; Elias & Lowton, 2014; Frost et al., 2020; Lee et al., 2020). Help-seeking was viewed as a threat to older adults' independence and identity (Johnston et al., 2010), as they often measured their self-worth and value in the ability to be independent and manage without help from others (Lee et al., 2020; Miller et al., 2016). Similarly, a frail elderly woman in Johnston et al.'s (2010) study expressed the fear that seeking help would result in hospitalization and the inability to return home only precipitated the fear of losing one's independence. In this way, avoiding embarrassment and stigma also contributed as barriers to help-seeking (Dollard et al., 2014; Hannaford et al., 2019; Horton & Dickinson, 2011; Kagan et al., 2018; Krishnan & Lim, 2012; Lee et al., 2005; Polacsek et al., 2019).

Furthermore, several older adults expressed notions of not wanting to bother others or be a burden, both to loved ones and healthcare providers (Begum et al., 2012; Canvin et al., 2018; Chen, 2020; Clarke et al., 2015; Elias & Lowton, 2014; Gore-Gorszewska, 2020; Horton & Dickinson, 2011; Hurst et al., 2013; Johnston et al., 2010; Lawrence et al., 2006; Lee et al., 2020; Miller et al., 2016). Here, there were concerns with worrying family with a diagnosis or relying on loved ones, of which was not desired unless their conditions were serious enough (Begum et al., 2012; Chen, 2020; Horton & Dickinson, 2011; Lawrence et al., 2006; Lee et al., 2020; Miller et al., 2016). Similarly, Dollard et al.'s (2014) sample expressed the desire to be seen in a positive light, and that a lack of help-seeking after a fall was due to not wanting 'to make a fuss' (p.226).

Help-seeking facilitators

For help-seeking to occur, older adults had to view this behavior as a functional way of increasing their own independence. For example, Johnston et al.'s (2010) study found that effective alarm users were more likely to be positive about using such aids and appliances, as a means of increasing their independence. These views demonstrated their resilience in adapting to the changes associated with age, where the authors suggest that use of a personal alarm in the event of falls could improve older adults' confidence to both live alone and provide reassurance to their families (Johnston et al. 2010). Similarly, friends were often cited as a preferred source of support (especially among those living in rural areas; Altizer et al., 2014; Horton & Dickinson, 2011), as they shared similar life experiences and had a shared understanding that help would be provided to the other when needed (Miller et al., 2016). This preference and desire to seek help from those with whom they could reciprocate was also seen in Tsai & Tsai's (2007) study, where a key decision point to help-seeking was whether the older adult was willing to return help from neighbors. Furthermore, being active in the help-seeking process and taking responsibility provided an opportunity for some participants to gain control and choice in Polacsek et al.'s (2019) study.

Further ways for help-seeking to occur without threats to identity or independence included friends and family setting a routine and pre-set schedule with the older adult (Miller et al., 2016). By communicating when loved ones were available, older adults could make plans and appointments accordingly without feeling like they were imposing on another's schedule and ensuring that they had transportation available (Miller et al., 2016). In examining ways to promote independence, Frost et al. (2019) also describes talking therapies as less threatening to independence compared to taking antidepressants, as it supports participants while allowing them to come to their own solutions. Being provided practical advice and support was also beneficial, in helping older adults resolve their issues and improve their self-esteem (Frost et al., 2019).

3.3.3. Appraisal of symptoms and health

Thirty-four articles highlighted the symptom appraisal process that older adults conduct to decide whether they will seek help or not. In this way, when confronted with a symptom, older adults would first self-assess to determine whether help was necessary

(Hurst et al., 2013; Hwang & Jeong, 2012; Tsai & Tsai, 2007; Waterworth et al., 2018). This appraisal would often occur within the context of an older adult's comorbidities (Makam et al., 2016), and a determination of whether the symptoms aligned with a previous diagnosis or condition (Hwang & Jeong, 2012; Waterworth et al., 2018).

Help-seeking barriers

As several articles highlighted, there was often a delay in help-seeking as many underestimated the seriousness of their conditions (Garg et al., 2017; Murata et al., 2010) and would subsequently wait to see if the problems went away on its own, attempt to self-manage their conditions, or informally reach out to family or friends first (Altizer et al., 2014; Begum et al., 2012; Canvin et al., 2018; Djukanović et al., 2015; Frost et al., 2020; Garrido et al., 2011; Hurst et al., 2013; Hwang & Jeong, 2012; Johnston et al., 2010; Lee et al., 2020; McCabe et al., 2017; Tsai & Tsai, 2007). For example, Kelly et al. (2011) found that despite acknowledgment of hearing impairment, those in the non-consulting group did not experience communication breakdowns or experienced them in predictable ways, resulting in lower levels of anxiety and a lack of seeking for evaluation or treatment. Furthermore, a barrier to seeking help was viewing other comorbidities or issues that older adults had as more important to address (Schneider et al., 2014). For example, issues such as restricting back pain (Makris et al., 2015) or sexual problems (Schaller et al., 2020) were deemed less of a health priority. Within this context, older adults expressed not wanting to bother the physician with their sexual problems because they felt that physicians had other more ill patients to take care of (Gore-Gorszewska, 2020).

Several articles also highlighted how during this symptom appraisal process, older adults would often attribute their health challenges to age (Canvin et al., 2018; Clarke et al., 2015; Elias & Lowton, 2014; Frost et al., 2020; Hwang & Jeong, 2012; Lee et al., 2005; Makris et al., 2015; Mukherjee, 2019; Waterworth et al., 2018). Using terms such as 'normal' or 'inevitable' to describe their health issues, further help was prevented (Canvin et al., 2018; Clarke et al., 2015; Elias & Lowton, 2014; Frost et al., 2020; Gore-Gorszewska, 2020; Hurst et al., 2013; Hwang & Jeong, 2012; Kharicha et al., 2013; Lee et al., 2005; Makris et al., 2015; Mukherjee, 2019; Polacsek et al., 2019). Denial and fears of knowing the illness (Garg et al., 2017; Hwang & Jeong, 2012; Johnston et al., 2010; Lee et al., 2005), also contributed to worsening symptoms being described as

normal (Kharicha et al., 2013). Furthermore, this ‘demedicalization of health problems’ (Elias & Lowton, 2014, p.977-978) was further exacerbated and reinforced when older adults did present these issues to health professionals, only to be met with dismissal, limited treatment options, patronizing comments or ageist statements (Frost et al., 2020; Gore-Gorszewska, 2020; Makris et al., 2015; Polacsek et al., 2019). Not only that, but even without the actual experience of ageism, the presumption or anticipation that this would occur was a barrier to bringing issues up with a physician (Clarke et al., 2015; Gore-Gorszewska, 2020; Schaller et al., 2020).

Help-seeking facilitators

On the contrary, the decision to seek help from health professionals was based on several determinations, such as whether symptoms were more serious or noticeable, and whether symptoms impacted their daily lives to the point that they could no longer ignore them (Altizer et al., 2014; Begum et al., 2012; Canvin et al., 2018; Clarke et al., 2015; Dollard et al., 2014; Elias & Lowton, 2014; Frost et al., 2020; Horng et al., 2014; Hurst et al., 2013; Hwang & Jeong, 2012; Kharicha et al., 2013; Lee et al., 2020; Mukherjee, 2019; Schneider et al., 2014; Stenzelius et al., 2006; Stenzelius et al., 2007; Stoller et al., 2011; Waterworth et al., 2018). For example, one study found that those with painful physical symptoms were more likely to seek help than those without (Bonnewyn et al., 2009), while another study found that the duration and intensity of pain were associated with seeking help (Hartvigsen et al., 2006). Similarly, it was often the change in one’s health or the presence of unfamiliar or novel symptoms that would spark the decision to seek help, as opposed to symptoms that were deemed a regular occurrence (Altizer et al., 2014; Hurst et al., 2013; Makam et al., 2016; Stoller et al., 2011). One study also reported older adults stating that they would not wait to seek help in the event of atrial fibrillation symptoms, of which McCabe (2017) suggests is due to the sample having an assigned primary care provider, the ability to access care and a higher level of education.

3.3.4. Turning to social supports

When seeking help was deemed necessary, reaching out to an older adult’s social network was a common avenue. For many, social support served as an opportunity to exchange health information, for disclosure, to seek

advice/encouragement, and to receive endorsements and recommendations for treatments (Aubut et al., 2020; Begum et al., 2012; Chen, 2020; Chung et al., 2018; Frost et al., 2020; Hurst et al., 2013; Lawrence et al., 2006; McCabe et al., 2017; Mechakra-Tahiri et al., 2011; Polacsek et al., 2019; Schneider et al., 2014). However, the presence of social supports had both negative and positive impacts on help-seeking.

Help-seeking barriers

While reaching out to informal support networks can be an effective avenue for older adults to receive help, it can serve as a barrier if the help received is inadequate or inappropriate. As Begum et al. (2012) suggests, the use of informal supports may reduce the need for formal support completely, as the older adult's concerns are already alleviated by those around them. This was also evident for mental health challenges, where children and spouses acted as substitutes to health professionals among men with depression (Mechakra-Tahiri et al., 2011). Other studies also demonstrated negative attitudes towards seeking help from healthcare professionals among married older adults (Lau et al., 2014) and a majority of those reporting psychological distress in Hohls et al.'s (2020) study received informal support. This was also evident on the opposite end, where those with less social support were found to be more likely to seek mental health support from a clergy (Pickard & Guo, 2008).

Furthermore, help from social networks was not always a plausible avenue. In some cases, family would be excused from helping. This rationalization is described in Miller et al.'s (2016) paper, where older adults excused their children from helping because they felt that their children had their own responsibilities to take care of. Work, caring for children and illness were seen as legitimate reasons for loved ones to not be able to help, and thus why friends and neighbors were contacted instead (Miller et al. 2016).

Help-seeking facilitators

Unsolicited social support appeared to serve a facilitating role in older adults' help-seeking. For example, there were situations in which decisions for the older adult were made on their behalf by others (e.g. spouse, provider) (Begum et al., 2012; Canvin et al., 2018; Lawrence et al., 2006), simply offered or given (Miller et al., 2016) or where family and friends would influence, persuade, negotiate or coerce the older adult in

question to seek help (Dollard et al., 2014; Elias & Lowton, 2014; Hurst et al., 2013; Johnston et al., 2010). In this way, passivity was also a factor to help-seeking (Hannaford et al., 2019), in which some older adults expected to be told if action was necessary (Canvin et al., 2018), or were simply open to health information without actively seeking it themselves (Altizer et al., 2014). While this influence could lead to subsequent help-seeking, there were cases where interventions by social networks were unwelcomed if they were deemed obtrusive or made the older adult feel pressured, disempowered or threatened their identity (Canvin et al., 2018; Elias & Lowton, 2014; Johnston et al., 2010).

3.3.5. Accessibility and awareness

Formal support services such as meal and transportation services, as well as home health services can be potential ways for governments and organizations to support older adults' functioning and enhance their quality of life (Miller et al., 2016). However, when making such programs available, access and awareness are important components for service providers to address. Here, 32 articles highlight how factors such as time, costs, knowledge, and literacy can influence the help-seeking behaviors of this population.

Help-seeking barriers

Among accessibility and awareness barriers that prevented older adults from seeking help, time was a key barrier. In various studies, older adults expressed related issues such as long wait times, not getting an appointment to their physician in a timely manner or not having time at all in their schedules to pursue help (Djukanović et al., 2015; Dollard et al., 2014; Frost et al., 2020; Garg et al., 2017; Garrido et al., 2011; Lee et al., 2020; Murata et al., 2010; Polacsek et al., 2019; Schneider et al., 2014; Waterworth et al., 2018). Wasting a physician's time was also a concern (Clarke et al., 2015), where some older adults expressed that they did not want to have to wait to see their physician, only to find that the problem had resolved on its own (Dollard et al., 2014). In addition, some older adults also highlighted short consultation times as a barrier, in which there was not enough time to disclose and discuss several issues that the older adults may have had (Frost et al., 2020; Hannaford et al., 2019; Lawrence et al., 2006; Waterworth et al., 2018). For particular issues like sexual problems, the

healthcare environment was also not seen as a safe space to discuss such issues (Schaller et al., 2020).

Additional access barriers included issues of cost and limited insurance/health benefits, as well as location and transportation (Chen, 2020; Chung et al., 2018; Djukanović et al., 2015; Frost et al., 2020; Garg et al., 2017; Garrido et al., 2011; Johnston et al., 2010; Kharicha et al., 2013; Krishnan & Lim, 2012; Lee et al., 2012; Lee et al., 2020; Mukherjee, 2019; Murata et al., 2010; Polacsek et al., 2019; Waterworth et al., 2018). For example, the delay in seeing a doctor due to cost was higher among those with disabilities in Lee et al.'s (2012) study. Far service locations and lack of available transportation were also influencing factors, especially when considering the physical constraints of older adults, those living in rural areas and the difficulty some experienced leaving their homes (Chen, 2020; Chung et al., 2018; Frost et al., 2020; Garg et al., 2017; Garrido et al., 2011; Mukherjee, 2019; Murata et al., 2010; Nurit et al., 2016; Polacsek et al., 2019; Waterworth et al., 2018).

Furthermore, a lack of available information, awareness and knowledge of available services was evident in several studies (Aubut et al., 2020; Chung et al., 2018; Djukanović et al., 2015; Garrido et al., 2011; Gore-Gorszewska, 2020; Horton & Dickinson, 2011; Lee et al., 2020; Mukherjee, 2019; Polacsek et al., 2019; Tsai & Tsai, 2007). This was especially true when it came to mental health services and who to seek for help in such cases (Hannaford et al., 2019; Polacsek et al., 2019; Waterworth et al., 2018). Furthermore, limited knowledge impacted perceptions of what a general practitioner could help with (Gore-Gorszewska, 2020), as well as understanding the severity of their symptoms (Chen, 2020; Hwang & Jeong, 2012; McCabe et al., 2017). This was particularly true for symptoms related to heart issues (Hwang & Jeong, 2012; McCabe et al., 2017). This unawareness was also further exacerbated among older adults with low health literacy (Chen, 2020; Hannaford et al., 2019; Horton & Dickinson, 2011; Lee et al., 2020), of which had older adults relying on other's assistance or a poor adherence to medications/treatments (Chen, 2020; Chung et al., 2018). Among those that did know where to seek help, some also found that the limited scope or availability of services to match their needs was a barrier (Gore-Gorszewska, 2020; Lee et al., 2020; Mukherjee, 2019).

Help-seeking facilitators

To facilitate resource use and seeking activity, a greater understanding, convenience of service use and higher literacy were notable factors (Eriksson-Backa et al., 2018; Polacsek et al., 2019; Tsai & Tsai, 2007). In contrast to above, the perception that access to a doctor was difficult actually acted as a facilitator in Elias & Lowton's (2014) study. Here, the authors highlighted an older adult that chose to seek help earlier, in case she would not be able to see a physician when she became sicker in the future. Furthermore, issues of location and transportation led to the importance of being able to speak to someone on the phone, especially for those living in rural areas (Waterworth et al., 2018). However, the adoption of telephone consultations varied, with some experiencing challenges due to hearing problems or invoking fears of not knowing who they were speaking to (Frost et al., 2020). Finally, while costs were a commonly described barrier, the older adults in Horton & Dickinson's (2011) study highlighted cost as not a barrier so long as services were priced reasonably or subsidized to keep costs low.

3.3.6. Cultural factors and lay/religious beliefs

Cultural dimensions of help-seeking were also considered within a sub-analysis, due to unique elements. Among the included studies, nine included diverse samples of minority ethnic older adults, while 10 articles did not specifically reference or distinguish various racially minoritized groups, but did refer to cultural factors and beliefs impacting help-seeking behavior. These 10 articles also encompass studies of diverse populations living in their homeland and thereby not considered a minority ethnic by definition (e.g. the help-seeking behaviors of Chinese older adults living in China; Lau et al., 2014).

Help-seeking barriers

Similar to the general older adult population, issues of knowledge and awareness were evident among these groups. Several articles listed language as a barrier to help-seeking (Chung et al., 2018; Horton & Dickinson, 2011; Krishnan & Lim, 2012; Mukherjee, 2019; Tsai & Tsai, 2007). As Chung et al. (2018) describes, a lack of English proficiency and lack of information provided in Korean limited older Korean immigrants' social activities, enhanced their preference for a Korean-speaking doctor, and increased

their reliance on others for support. Similarly, Krishnan & Lim's (2012) study on elderly Indian men living in Singapore found that those who experienced language discordance were more likely to be dissatisfied with care. Language barriers were further compounded by literacy barriers, where some could not only be unable to read in the dominant language of the country, but also in their own language (Horton & Dickinson, 2011).

Additional factors that were compounded by one's immigration status included cost and familial values. Cost was further exacerbated by limited health coverage due to immigration, where older adults compared the discrepancy between what the same help-seeking would have cost in their home country (Chung et al., 2018). Others expressed the notion that it would be inappropriate to share personal problems with strangers, particularly when it came to family matters (Lau et al., 2014; Lawrence et al., 2006). Not only that, but the theme of independence was further enhanced here, where older immigrants expressed pride in having always been able to take care of themselves and not bother others (Miller et al., 2016).

Lay and metaphysical beliefs, religion and alternative health strategies were also discussed as barriers to help-seeking. For example, older adults held beliefs such as fatalism, in which health challenges were deemed out of their control or as a result of luck, superstition, punishment/sin, karma, or fate/destiny (Horton & Dickinson, 2011; McGowan & Midlarsky, 2012; Mukherjee, 2019; Tsai & Tsai, 2007). These beliefs led to seeing help-seeking as futile, and in this way, minority ethnic groups also expressed the use of religion as a means of coping (Lawrence et al., 2006), particularly for mental health challenges (McGowan & Midlarsky, 2012). However, this did not seem specific to minority ethnic groups only, as there were also a few studies that did not discuss specific groups, yet still highlighted older adults' values and beliefs related to superstition, fatalism and the seeking of help from religious leaders over other formal sources (Hannaford et al., 2019; Hurst et al., 2013; Johnston et al., 2010; Pickard & Guo, 2008; Pickard & Tang, 2009). Furthermore, alternative medicines was associated with cultural mistrust of American providers and Western medicines (Chung et al., 2018), as was cultural beliefs and stigma associated with seeing a male doctor among migrant Bangladeshi women living in India (Mukherjee, 2019). Additional alternatives to formal care included belief in traditional medicines, holy foods, and spiritual healing (Chung et al., 2018; Lawrence et al., 2006; Lee et al., 2020; McGowan & Midlarsky, 2012;

Mukherjee, 2019). Poverty and the inability to seek proper treatments also led to the use of folk remedies (Chen, 2020).

Help-seeking facilitators

Facilitators to help-seeking among minority ethnic older adults included a longer length of residency in the country where one immigrated, which led to an improved ability to communicate with healthcare providers in English and a greater familiarity with how to navigate the healthcare system among older Korean immigrants living in the United States (Chung et al., 2018). In addition, the availability of community organizations that offered services such as translation or home care helpers enhanced opportunities to access healthcare and programs, find information and network with others (Chung et al., 2018). The value of family was also an important concept, where changing and redefining of cultural norms and values as a result of immigration were described. Here, expectations of filial piety (an East Asian virtue that values honor, respect and care for one's parents) were revealed (Mukherjee, 2019), with some anticipating these values to not be followed as highly as the older adult might have expected if they were in Korea (Chung et al., 2018). Because of their changing values, older adults described seeking support from peers, church members or senior associations, highlighting the potential for community-based organizations to support older immigrants in remaining healthy and independent (Chung et al., 2018).

3.4. Supplemental findings

In addition to the 52 articles included in this review, there were several articles identified by the search strategy that included individuals who were aged 65 years and older, but were excluded because participants from younger age groups were included in the sample and therefore did not meet the strict criteria used in this review. Despite falling outside of the inclusion criteria, these articles are useful comparisons between older and younger age groups, particularly when considering the low number of articles that focused on minority ethnic older adults. As such, a supplementary analysis of 1) younger populations and 2) Asian older adults was conducted. This comparative analysis identified similarities and enhanced the six themes identified from the scoping review itself.

3.4.1. Younger vs. older populations

In comparing older adults aged 65 years or older to younger populations, several similarities and differences were identified (Table 6). Common barriers to help-seeking for both younger and older groups include a low perceived need for treatment, treatment costs, negative perceptions of providers or treatments and the likelihood of help-seeking being impacted by the severity of one's condition or being married (Andrade et al., 2014; Choi et al., 2014; Mackenzie et al., 2012). These two populations appear to differ in the extent to which they delay help-seeking and the reasons for this delay. For example, among the evaluated studies, younger participants were found to be more likely to report structural barriers, stigma/confidentiality concerns and lack of knowledge about treatment venues as barriers to help-seeking, while older participants were more likely to report a low perceived need for help and were less likely to use treatment of any kind (Andrade et al., 2014; Choi et al., 2014). More specifically, Mackenzie et al. (2012) found that older populations were almost two times less likely to seek help for a mood disorder and almost three times less likely to seek help for an anxiety disorder, compared to the younger participants in the sample. Evidently, these studies that compare younger and older participants demonstrate that while younger populations also experience barriers to seeking care, older adults are more likely to delay seeking care and less likely to consult a professional for their mental health needs (Choi et al., 2014; Mackenzie et al., 2012; McDonald et al., 2017; Nguyen et al., 2010). In addition, despite Fisher & Goldney (2003) finding that the older adults in their sample were more likely to have seen a medical practitioner in the last 12 months and to be taking antidepressants, they continued to demonstrate low levels of mental health literacy. Much of the barriers discussed in this analysis match the findings from the scoping review, bringing to light how help-seeking barriers may be even more persistent for the older adult population when compared to other age groups.

Table 6. Comparing the Help-Seeking Behaviors of Younger (<65) and Older (≥65) Populations

Author(s)	Type of help-seeking behavior(s)	Health challenge(s)	Similarities	Differences
Andrade et al. 2014	Mental health service use	Mental health challenges	Common barriers to help-seeking: ▪Low perceived need, wanting to handle problems on one's own, perceived need (belief that problem was not severe or would get better on its own), perceived ineffectiveness of treatment, negative experience with a treatment provider, financial barriers, lack of availability	Younger populations: ▪More likely to report structural barriers (e.g., financial barriers and time) Older populations: ▪More likely to report low perceived need for help
Choi et al. 2014	Treatment use	Substance use disorders & mental health challenges	Barriers: ▪Thinking treatment was not needed, self-sufficiency beliefs, and doubts about treatment effectiveness ▪Treatment cost was the most frequently reported barrier to mental health treatment among those with perceived need	Younger populations: ▪26-34 age group more likely to report stigma/confidentiality concerns and lack of knowledge about treatment venues ▪26-34,35-49, and 50-64 age groups most frequently reported treatment cost/limited insurance as a barrier Older populations: ▪Least likely to use treatment and perceive treatment need ▪Least likely to report stigma/confidentiality concerns, treatment cost, not knowing where to go for treatment, lack of time, and lack of transportation/inconvenience as barriers ▪Frequently mentioned lack of readiness to stop using substances, lack of knowledge about treatment services and/or lack of openings in a program

Author(s)	Type of help-seeking behavior(s)	Health challenge(s)	Similarities	Differences
Fisher and Goldney 2003	Service utilization (eg. visiting a medical practitioner, psychiatrist, psychologist, social work or other counsellor)	Mental health challenges	▪No significant differences in the use of mental health practitioners or counsellors ▪Greater proportions of each group considered antidepressants harmful	Older populations: ▪Did not report greater levels of current depression but were more likely to have seen a medical practitioner in the last 12 months and be taking antidepressants ▪More likely to demonstrate lower levels of mental health literacy ▪Less likely to recommend seeing a counsellor and less likely to rate counsellors, social workers, psychiatrists, psychologists, help from family and friends as helpful or even rate them as harmful ▪Fewer saw herbal medicines/vitamins as helpful and more saw pain relievers/tranquilizers as helpful
Mackenzie et al. 2012	Mental health service use (e.g., professional help from a counselor)	Mental health challenges	▪Panic disorder and dysthymia are the psychiatric diagnoses most likely to lead individuals to seek professional help (likely due to their chronic and severe nature)	Older populations: ▪Nearly two times less likely to seek help for any mood disorder and nearly three times less likely to seek help for any anxiety disorder
McDonald et al. 2017	Mental health service use	Mental health challenges	▪Marital status has a significant effect on the likelihood of consulting a health professional, with married individuals being least likely to consult ▪Presence of a chronic condition and rating mental health as poor/fair/good are strong predictors of mental health service use	Younger populations: ▪Higher odds of reporting mental health status as poor/fair/good (particularly the 25-44 group) ▪Higher odds of consulting a mental health professional Older populations: ▪Highest odds of reporting their mental health status as excellent/very good ▪Least likely to consult a mental health professional

Author(s)	Type of help-seeking behavior(s)	Health challenge(s)	Similarities	Differences
Nguyen et al. 2010	Hospital presentation	Acute myocardial infarction (AMI)	▪Those delaying seeking medical care were more likely to have a history of comorbidities, present from 6AM-6PM with higher heart rates and systolic pressure, and least likely to report symptoms such as chest pain ▪Age and sex differences in duration of prehospital delay have narrowed with time and is largely due to changes in one's comorbidity profile or AMI symptoms	Older populations: ▪More likely to delay seeking medical care and wait ≥2 hours to seek medical care after the onset of symptoms suggestive of AMI ▪More likely to have atypical AMI symptoms and comorbidities

3.4.2. Asian older adults

In addition to a supplementary analysis on younger and older populations, another analysis on Asian older adults with no age limit imposed was conducted due to the limited number of minority articles identified in the review and to more fully understand the factors that impact the help-seeking behaviors of minority ethnic groups. As immigrants from Asia are among the fastest growing groups in North America (Na et al., 2016) and to make the hand-searching of supplementary articles a more focused process, only articles on Asian immigrant older adults were included in this analysis. Table 7 compares 11 additional articles with the original six themes of the scoping review and highlights supplementary findings that further enhances an understanding of how minority populations may exhibit help-seeking behaviors.

Table 7. Supplemental Findings on the Help-Seeking Behaviors of Asian Immigrant Populations

Supplemental Articles			Themes from Included Studies	Supplemental Findings
Author(s)	Study Population	Age		
Jang et al. 2008	Korean Americans	Compares 20-45 with 60+ age groups	Accessibility and awareness: ▪Substantial proportion of younger & older populations reported being uninsured Cultural factors and lay/religious beliefs: ▪Older adults more likely to believe that depression is a sign of personal weakness and that having a mentally ill family member brings shame to the whole family (in contrast to younger populations that were more likely to accept the medical conceptualization of depression) ▪Among older adults, this stigma and cultural misconceptions predicted negative attitudes toward mental health services	▪Both younger and older populations demonstrated the high levels of mental health problems yet low utilization of mental health services ▪Compared with older adults, younger immigrants may be more prone to education or job-related stressors, family conflict and discriminatory experiences
Koehn 2009	Punjabi, Vietnamese, and Hispanic communities in Canada	N/A	Interactions with formal healthcare providers: ▪Feeling like their issues are not taken seriously by their general practitioner or specialist or feeling like they were being treated as a "guinea pig" Identity and independence: ▪Desire not to increase burden of family members, fear that help-seeking would lead to being taken to the hospital/nursing home ▪Need for services that allow choice Appraisal of symptoms and health: ▪Fear leads to reluctance to ask unless one is seriously ill Turning to social supports: ▪Intergenerational tensions can make living together difficult ▪While participants often rely on family/friends/those in the community, this is not always reliable or acceptable Accessibility and awareness: ▪Financial dependence on sponsors ▪Many unaware of available health and interpretation services and ways to contact one's health authority	▪Priority access clause of long-term care homes disproportionately disadvantages minority ethnic older adults if they are placed in facilities far from those that can provide interpretation services or culturally appropriate food

Supplemental Articles			Themes from Included Studies	Supplemental Findings
Author(s)	Study Population	Age		
Koehn 2009 (Continued)	Punjabi, Vietnamese, and Hispanic communities in Canada	N/A	Accessibility and awareness: ▪Navigating public transportation is difficult ▪Language barriers and low literacy in own language, lack of knowledge of medical terminology (where family interpreters can also be imprecise) ▪Low permeability of services Cultural factors and lay/religious beliefs: ▪Shame, family honor, filial duty and respect for elders impacts the way some may interpret being provided care from outsiders (e.g., refusing home care because of stigma; conveys to others that they are in poor health, have family problems, have a lack of status/respect within their families) ▪Language compatibility with services and staff with similar cultural/social backgrounds as participants is crucial	-
Lai & Chau 2007	Older Chinese immigrants in Canada	55-101	Interactions with formal healthcare providers: ▪Cultural incompatibility: professionals not speaking users' language, programs not specialized for Chinese populations, professionals not understanding users' culture ▪Personal attitudes: believing that professionals cannot help Identity and independence: ▪Personal attitudes: feeling ashamed/uncomfortable with asking for help Accessibility and awareness: ▪Long waitlists, inconvenient office hours, complicated procedures ▪Circumstantial challenges: lacking transportation, weather being too cold to go out, lack of knowledge of existing health services	-

Supplemental Articles			Themes from Included Studies	Supplemental Findings
Author(s)	Study Population	Age		
Lai & Chau 2007 (Continued)	Older Chinese immigrants in Canada	55-101	Cultural factors and lay/religious beliefs: ▪Predictors of experiencing service barriers: being female, single, an immigrant from Hong Kong (compared to those from mainland China), shorter residency in Canada, less financially adequate, not having someone to trust or confide in, having stronger identification with Chinese health beliefs, and considering oneself as Chinese or Chinese-Canadian, but not Canadian ▪Length of residency affects level of acculturation	-
Lai & Chau 2007	Older Chinese immigrants in Canada	55-101	Interactions with formal healthcare providers: ▪Professionals who do not speak the same language/understand their culture or who are not Chinese serve as barriers to participants accessing care Turning to social supports: ▪Higher social support, living with others and better self-rated financial adequacy were significant predictors of one's mental health Accessibility and awareness: ▪Long waitlists, lack of knowledge about existing health services, programs not specialized for Chinese populations Cultural factors and lay/religious beliefs: ▪Cultural incompatibility with services	▪Having more administrative problems, personal attitudes, and circumstantial challenges were significant in predicting decreased mental health
Liu et al. 2012	First-generation Chinese elders from the North West of England	60-84	Appraisal of symptoms and health: ▪Aging acknowledged as inevitable; rather than seek causes for health problems or information/advice, they exercised ▪Situations where this could go to extremes (e.g., believing exercise could speed up one's recovery process, undertaking vigorous exercise to test whether potential heart problems could be beared, choosing exercise over medication) Accessibility and awareness: ▪Despite long residency and assumptions that participants would be able to navigate the healthcare system, participants demonstrated low levels of literacy ▪Lacked appropriate information from professionals	-

Supplemental Articles			Themes from Included Studies	Supplemental Findings
Author(s)	Study Population	Age		
Liu et al. 2012 (Continued)	First-generation Chinese elders from the North West of England	60-84	Cultural factors and lay/religious beliefs: ▪Common exercises included Tai Chi & walking ▪Participants believed that their approach to exercise was firmly rooted in Traditional Chinese Medicine and Chinese medical practice ▪Exercise as a self-management strategy; considered key to preventing disease/healing/promoting health	-
Liu et al. 2014	Chinese elders living in the United Kingdom	60-84	Interactions with formal healthcare providers: ▪Being "cured" is directly translated from Chinese meaning that symptoms are relieved, but the root cause is not eradicated - thus was one of the major barriers for participants seeking subsequent care (e.g., seeing doctors as not doing well) ▪Lack of 'understandable' health-related information from doctors also led to dissatisfaction and distrust ▪Negative views of British professionals and medicine ▪Feelings led to some making the decision not to bother and seeking a cure elsewhere Appraisal of symptoms and health: ▪Ultimate aim of Chinese participants was to maintain health via management of daily routines (e.g., diet, sleep, exercise) and self-assessment/self-management ▪Tendency to normalize/minimize health issues ▪Help-seeking behavior mainly a form of self-management and non help-seeking until necessary Turning to social supports: ▪Family both promoted and hindered help-seeking: often they were the primary source of support (e.g., for transportation, translation, information) but participants also often chose to follow their children's suggestions to not seek help	-

Supplemental Articles			Themes from Included Studies	Supplemental Findings
Author(s)	Study Population	Age		
Mukadam et al. 2015	United Kingdom-based South Asians	18-83	Appraisal of symptoms and health: ▪Seeing memory problems as an inevitable and normal part of illness, seeing memory problems as not an illness ▪Having a threshold for help-seeking (e.g., when symptoms are more frequent/troubling or severe/risky) Turning to social supports: ▪Believing individuals or families can make memory problems better Accessibility and awareness: ▪Lack of knowledge of help available ▪Ways to overcome barriers: normalizing help-seeking and breaking down stigma, emphasizing dementia as having a physical cause, using a trusted source, targeting the audience, reducing barriers due to language/literacy, including important information (e.g., symptom progression, benefits of help-seeking) Cultural factors and lay/religious beliefs: ▪Stigma of diagnosis (although contextually, would be lesser in the United Kingdom than back home)	-
Pang et al. 2003	Elderly Chinese Americans	60+	Interactions with formal healthcare providers: ▪Would only seek help from doctors when all other options have been exhausted Identity and independence: ▪Preference to take care of themselves first ▪Common for participants to not want to bother others Appraisal of symptoms and health: ▪Second choice was to seek help from spouses, then friends/neighbors or sons/daughters and would only go to the doctor when things become serious	-

Supplemental Articles			Themes from Included Studies	Supplemental Findings
Author(s)	Study Population	Age		
Pang et al. 2003 (Continued)	Elderly Chinese Americans	60+	Turning to social supports: ▪Change in family dynamics: modernized relationship where sons/daughters are not practicing filial piety and thus a shift in participants' expectations and shift in family and friend support networks ▪Relatives, neighbors, and friends were important informal supports, especially if immediate family members were absent ▪Use of self-care and home remedies recommended by friends ▪Positive influences of informal support networks: language/transportation assistance and decision-making Accessibility and awareness: ▪Lacking English proficiency, finding the American healthcare system confusing/intimidating, lack of understanding of Medicare/Medicaid benefits ▪Inability to predict the costs of doctor's visits, need to arrange transportation or navigate transportation system, long wait times Cultural factors and lay/religious beliefs: ▪Cultural reluctance to seek help from outsiders ▪Mixed strategy of Chinese and Western medicines	-
Sadavoy et al. 2004	Chinese and Tamil older adults in Canada	55+	Interactions with formal healthcare providers: ▪Lack of ethnic professionals in mainstream institutions who can provide linguistically and culturally appropriate services ▪Belief that family doctors cannot be consulted for only emotional/psychological problems and that participants need to present with a physical complaint to justify a physician visit ▪Valued service provider attributes: trustworthiness, respect, empathy, taking time, expressing a willingness to talk about emotional problems, conveying understanding/awareness of mental health challenges Identity and independence: ▪Fears of dependency, self-esteem, and self-sufficiency	▪At time of study, no services that combined ethnic specific and mental health expertise with geriatric knowledge/focus ▪Some preferred to seek someone outside the community for privacy and confidentiality concerns ▪Burden of distress found to be greater on lower socioeconomic subgroups

Supplemental Articles			Themes from Included Studies	Supplemental Findings
Author(s)	Study Population	Age		
Sadavoy et al. 2004 (Continued)	Chinese and Tamil older adults in Canada	55+	Identity and independence: ▪Not wanting to further burden family members Appraisal of symptoms and health: ▪Only in most severe cases would participants consider turning to the emergency department or psychiatry services Turning to social supports: ▪Preferred to contact a close friend first, then family (due to fear that family would not understand/reject their complaints while peers are in similar situations) ▪Potential exploitation (unpaid housekeeping/childcare), because of family stressors ▪Referral barriers also prevalent: participants often have to rely on their family to recognize or acknowledge their needs and then have them be willing to accompany them to receive care Accessibility and awareness: ▪Language barriers, lack of knowledge of how to negotiate the healthcare system, low level of awareness of available/appropriate formal mental health services ▪Access impeded by geographic barriers Cultural factors and lay/religious beliefs: ▪Migration exacerbating reactions to loss of prior positions/assets ▪Emotional distress produced by family issues (e.g., intergenerational conflicts over traditional Chinese/Tamil and Western-based values, disappointment in children for failing traditional filial piety values, humiliation over loss of power/status in family)	

Supplemental Articles			Themes from Included Studies	Supplemental Findings
Author(s)	Study Population	Age		
Sadavoy et al. 2004 (Continued)	Chinese and Tamil older adults in Canada	55+	Cultural factors and lay/religious beliefs: ▪Cultural beliefs (e.g., reluctance of participants/families to acknowledge programs), stigma impacting a family's reputation ▪Immigration and settlement issues produce family stresses that may disrupt traditional family values, structures, and loyalties ▪Involuntary migration/emotional isolation is further fostered by feelings of an impoverished spiritual life/longing for their homeland/being in prolonged exile	
Surood & Lai 2010	Older South Asian immigrants in Canada	55+	Cultural factors and lay/religious beliefs: ▪Use of traditional medicines not related to the use of Western health services, suggesting the choice between Western and traditional health service does not have to be a choice of one over the other ▪Being a Hindu, having resided in Canada longer, having fewer barriers in cultural incompatibility, and having a lower level of agreement with South Asian health belief, but a stronger South Asian ethnic identity was related to using more types of Western health services ▪Length of residency is a significant correlate	▪Discussions of the “healthy immigrant effect”

Supplemental Articles			Themes from Included Studies	Supplemental Findings
Author(s)	Study Population	Age		
Tieu & Konnert 2014	Chinese adults living in Canada	55-95	Interactions with formal healthcare providers: ▪Preference to seek help from a general practitioner more favorable than seeking help from close friends or a psychologist Identity and independence: ▪Preference to take care of oneself rather than seek help from close friends Turning to social supports: ▪Intentions to seek help from close family members were more favorable than intentions to seek help from a psychologist ▪Those with greater perceived social support, who had greater physical health and endorsed lower levels of Chinese cultural beliefs and values exhibited more positive mental health help-seeking attitudes ▪Those who were single had lesser positive attitudes than those who were married Cultural factors and lay/religious beliefs: ▪Negative relationship between Chinese cultural values and help-seeking attitudes reported in the current study, likely due to cultural beliefs/values, and stigma ▪Many Chinese adults see the use of psychiatric services as a loss of face, and stigma is a major barrier to accepting information about mental health ▪A need to consider cultural variations (e.g., differences among those who immigrate from China or Hong Kong or Taiwan)	▪Increasing age associated with less positive help-seeking attitudes

As demonstrated in Table 7, most of the findings from the additional articles are similar to the findings from the scoping review. This provides greater validity to the six themes discussed, while also highlighting further details and important points. For example, similar notions of Asian older adults not wanting to seek help unless they are seriously ill, and structural barriers such as costs, lack of knowledge and language/literacy barriers were evident for these groups (Jang et al. 2008; Koehn, 2009; Lai & Chau, 2007; Lai & Chau, 2007; Liu et al., 2012; Liu et al., 2014; Mukadam et al., 2015; Pang et al., 2003; Sadavoy et al., 2004; Tieu & Konnert, 2014). Further, these additional articles help enhance discussions of self-management, familial tensions and how cultural misconceptions/beliefs can impact various aspects of an Asian older adult's life. For example, exercise was a common self-management tool that was considered crucial to preventing disease and promoting health (Liu et al., 2012; Liu et al., 2014). Exercise was extensively studied in Liu et al's (2012) study, in which researchers found that exercise was often used by older participants to slow the aging process or to speed up one's recovery. While beneficial to one's health, the authors discussed situations in which this was taken to extreme levels amongst the Chinese elders, such as when they would undertake vigorous exercise to test whether their potential heart problems were serious, or when they would forego prescribed medication and choose to exercise instead (Liu et al., 2012). Similar to initial themes of symptom appraisal and preferring traditional self-management strategies, this supplementary analysis brings to light how dangerous such decisions can be.

In addition, while a discussion on the value of family among minority ethnic populations was briefly touched on in the results of the scoping review, these additional articles highlight the tensions that can exist due to intergenerational differences and emphasize the impacts that shame and filial piety can exert on help-seeking. While family were often relied on to provide transportation or translation, they can potentially hinder the help-seeking efforts of older adults in cases in which there was a tendency for Chinese elders to follow their children's advice to not seek help (Liu et al., 2014). Furthermore, because of the emphasis placed on familial honor and duty linked to filial piety, there was a common cultural reluctance to seek help from 'outsiders' (Koehn, 2009; Pang et al., 2003). These notions were further fostered when considering the stigma and shame that help-seeking, particularly for mental health challenges, would

bring to families and their reputations (Jang et al., 2008; Koehn, 2009; Mukadam et al., 2015; Sadavoy et al., 2004; Tieu & Konnert, 2014).

Finally, there were additional supplementary findings identified that warrant future research and exploration. For example, one study expressed Chinese and Tamil older adults' preference to seek help outside of the community due to privacy and confidentiality concerns (Sadavoy et al., 2004), while another compared older adults with younger immigrants, with the latter potentially being more vulnerable to education or job-related stressors and conflict (Jang et al., 2008). In addition, the "healthy immigrant effect", a phenomenon whereby the health of immigrants is high upon arrival to a new country and slowly deteriorates over time, is briefly mentioned in Surood & Lai's (2010) study, and warrants further exploration on whether this has a significant impact on minority populations and their potential change in help-seeking behaviors over time. Finally, while outside the scope of this review, Koehn (2009) highlights how policies in long term care homes can disproportionately impact minority ethnic older adults and result in their placement in homes that are not adequate to meet their needs.

Evidently, a supplementary analysis of Asian populations highlights further nuances and complexities in the help-seeking behaviors of minority ethnic populations. As demonstrated, there is a need to both address service barriers that all older adults experience when seeking care, such as long wait times and the provision of information/resources, as well as barriers that specifically prevent minority ethnic older adults from receiving the care that they need. This involves addressing language and literacy barriers, and providing culturally compatible services and resources, which are tailored and provided by professionals that speak the same language or at a minimum, understand their cultural needs. Through greater efforts and recognition in research and practice, minority ethnic populations such as Asian older adults can be supported to exhibit help-seeking behaviors, despite their unfamiliarity with healthcare surroundings.

Chapter 4.

Discussion

By systematically reviewing the factors associated with the help-seeking behaviors of older adults, with a sub-focus on minority ethnic older adults, this scoping review demonstrates older adults' tendency to avoid help-seeking when health challenges arise. Older adults' reasons for this behavior include past negative interactions of disclosure (Canvin et al., 2018; Clarke et al., 2015; Gore-Gorszewska, 2020; Lawrence et al., 2006; Makris et al., 2015; Polacsek et al., 2019) and perceived threats to the individual's identity and independence (Aubut et al., 2020; Canvin et al., 2018; Elias & Lowton, 2014; Frost et al., 2020; Johnston et al., 2010; Lee et al., 2020; Miller et al., 2016). Consistent with reviews studying the help-seeking behaviors of other populations, such as Indigenous communities (Fiolet et al., 2021), women with urinary incontinence (Koch, 2006), and men (Yousaf et al., 2015), avoiding help was linked to barriers such as inappropriate responses from service providers, the need for independence and control, and embarrassment/fear. The fear of being hospitalized and mistrust/past negative experiences has also been reported as a barrier to disclosing suicidal ideation among adolescents (Hom et al., 2015). Furthermore, the aforementioned reviews on Indigenous populations (Fiolet et al., 2021) and women with urinary incontinence (Koch, 2006), as well as a systematic review on women with breast cancer symptoms in Europe (Grimley et al., 2020), highlighted perceived seriousness and the feeling like a crisis had been reached, as a turning point in the decision to seek help. This is also seen among the older adults in this review, whereby the appraisal of symptoms as serious or novel prompted help-seeking. However, while other populations have expressed the similar tendency to minimize and normalize symptoms as a means of avoiding help-seeking (Koch, 2006; Yousaf et al., 2015), what is unique to the older adults in this review is the tendency to attribute their health challenges to age (Canvin et al., 2018; Clarke et al., 2015; Elias & Lowton, 2014; Frost et al., 2020; Hwang & Jeong, 2012; Lee et al., 2005; Makris et al., 2015; Mukherjee, 2019; Waterworth et al., 2018). This notion was reinforced when healthcare providers addressed older adult issues with dismissal, limited treatment options or patronizing remarks (Frost et al., 2020; Gore-Gorszewska, 2020; Makris et al., 2015; Polacsek et al., 2019). In this way, the compounding experiences of stigma and negative relations with others, along with

judging one's own health within the context of age and identity prove to be prevalent challenges for aging adults and their decision to ask for help.

Once a decision to seek help has been made, results from this review support the finding that informal supports such as friends and family are a common first choice of help among older adults. However, tension between wanting informal support and advice, and not wanting to bother or rely on others, may increase the delay between the onset of symptoms and accessing necessary care (Pang et al., 2003). In addition, while informal support was an available avenue among the older adults in the populations of these included studies, it is worthwhile also exploring the issue of dwindling social circles as an older adult ages (Morgan & Kunkel, 2007). Here, exploring the help-seeking experiences of isolated older adults who do not have friends or family to turn to could highlight additional barriers and facilitators.

Upon turning to informal supports, help-seeking can either end when needs are adequately met by these individuals or continue to more formal supports such as healthcare professionals. However, another significant theme that arose in this review was issues of access and awareness. Here, even if older adults are at a stage where they are willing to seek help from formal avenues, there are several structural barriers in place that can prevent them from doing so. As identified in the review, these barriers include high costs of services, far locations, lack of transportation options, and long wait times (Chen, 2020; Chung et al., 2018; Djukanović et al., 2015; Dollard et al., 2014; Frost et al., 2020; Garg et al., 2017; Garrido et al., 2011; Johnston et al., 2010; Kharicha et al., 2013; Krishnan & Lim, 2012; Lee et al., 2012; Lee et al., 2020; Mukherjee, 2019; Murata et al., 2010; Polacsek et al., 2019; Schneider et al., 2014; Waterworth et al., 2018). This was especially true for those living in rural areas or in countries where health insurance could be limited (Chen, 2020; Chung et al., 2018; Frost et al., 2020; Garg et al., 2017; Garrido et al., 2011; Mukherjee, 2019; Murata et al., 2010; Nurit et al., 2016; Polacsek et al., 2019; Waterworth et al., 2018). Not only that, but issues of low awareness, knowledge and literacy further exacerbated the inability to use available services (Chen, 2020; Chung et al., 2018; Djukanović et al., 2015; Frost et al., 2020; Garg et al., 2017; Garrido et al., 2011; Hannaford et al., 2019; Horton & Dickinson, 2011; Johnston et al., 2010; Kharicha et al., 2013; Krishnan & Lim, 2012; Lee et al., 2012; Lee et al., 2020; Mukherjee, 2019; Murata et al., 2010; Polacsek et al., 2019; Waterworth et al., 2018). Here, poor understanding of how serious one's symptoms could be as well as

a lack of clarity of who could help them prevented services from being used in the way they were intended to (Chen, 2020; Gore-Gorszewska, 2020; Hannaford et al., 2019; Hwang & Jeong, 2012; McCabe et al., 2017; Polacsek et al., 2019; Waterworth et al., 2018). Evidently, these issues of access and awareness imply the need for services and programs to understand the needs of the population they are intending to serve and tailor accordingly.

A sub-focus on minority ethnic older adults highlights additional barriers that further inhibit this population's ability to adequately seek help for their needs. The cultural factors identified in this review include language, literacy, immigration, cultural values, beliefs, and costs of care in relation to limited health insurance (Chung et al., 2018; Horton & Dickinson, 2011; Krishnan & Lim, 2012; Mukherjee, 2019; Tsai & Tsai, 2007). This pattern amongst older adults is similar to findings among younger minority ethnic populations, where traditional/cultural beliefs, family obligations and the employing of alternative strategies is invoked (Guo et al., 2015; Rüdell et al., 2008; Shefer et al., 2013; Taylor & Richards, 2019). In a study of Turkish and Moroccan immigrants, healthcare utilization was associated with measures of need (e.g. self-reported health status, number of chronic conditions), and higher levels of acculturation (Fassaert et al., 2009), where language, age of immigration and length of residence in the host country were considered the strongest predictors of acculturation (Schubert et al., 2019). This is consistent with what was found in Chung et al.'s (2018) study, where a longer length of residency was associated with an improved ability to navigate the healthcare system and communicate with doctors in English. Among older adults who may have immigrated later in life then, this suggests the need for greater interpretation and translation services, language classes or the availability of staff/providers that can speak multiple languages (Chung et al., 2018; Dong et al., 2012). Pang et al. (2003) also describes how acculturation and adaptation can lead to the changing of traditional values, such as from filial piety to filial autonomy. This was briefly touched on in Chung et al.'s (2018) study, who described older adults in their sample as redefining their cultural norms within the context of their new countries and warrants further exploration. Finally, among Somali migrants in Finland and New Zealand, cultural norms surrounding mental health issues can prevent help-seeking, where illness is understood as part of God's will or as punishment (Guerin et al., 2004; Koehn & Tiilikainen, 2007). This is consistent with the cultural and religious beliefs found in this review, leading to older

adults believing that seeking help is futile or a part of their destiny (Horton & Dickinson, 2011; McGowan & Midlarsky, 2012; Mukherjee, 2019; Tsai & Tsai, 2007).

Many of the factors within the six themes in this review overlap, highlighting how intricate and complicated a decision to seek help can be for an older adult. For example, an older adult's desire to remain independent is mixed with desires to not bother family or waste a healthcare provider's time, while symptom appraisal is also related to ageist experiences with healthcare providers. This is even more true for minority ethnic older adults, where issues of cultural beliefs, immigration and language are intermixed with issues of literacy, limited health insurance and the conflicting feelings towards family support. Due to the many factors that influence an older adult's decision to seek help, there is potential for long delays between an older adult's experience of symptoms or illness and help-seeking, which can be detrimental to their health outcomes (Arthur-Holmes et al., 2020; Blakemore et al., 2018; Pang et al., 2003).

4.1. Application of findings to conceptual models

As previously discussed, there are multiple theories that can be applied when exploring the help-seeking behaviors of older adults. In re-examining these models considering the scoping review's findings, there are several connections and additions worth noting. Of the models, Andersen's behavioral model of health services utilization is particularly useful for understanding how service use can be impacted by predisposing variables, enabling variables, and need variables (Aday & Andersen, 2005). Within the context of this review, there are several themes that align with these variables. For predisposing variables, an older adult's ethnicity and cultural beliefs were a prominent factor, in which minority ethnic older adults experienced language/literacy barriers and cultural incompatibility with services. Furthermore, age was a leading predisposing variable that impacts all older adults, resulting in the normalizing of symptoms or experiences of ageism exhibited by healthcare providers. In addition, the theme of access and awareness aligns well with enabling resources, in which one's individual and community resources can impact healthcare access. Here, the included articles identified several structural barriers such as unavailable resources, costs of services, transportation and far locations that prevent older adults from seeking help or require them to rely on their social support networks. Finally, in regard to need variables, the interplay between an older adult's perceptions of their own health and how healthcare

providers responded to their health problems was evident. Here, older adults regularly engaged in self-appraisal of their health and symptoms, choosing only to seek help when it was absolutely necessary. These feelings were reinforced when they sought help from professionals, only to be met with inadequate help or ageist/patronizing remarks.

The health belief model also further enhances our understanding of how the symptom appraisal process occurs, with older adults taking into account the severity of their symptoms, the barriers in place, their desires to be independent, and the benefits to help-seeking (Hochbaum, 1958; Rosenstock, 1974). Finally, the theory of planned behavior also helps justify why older adults may or may not turn to social supports. As the theory suggests that changing one's behavior can be influenced by the view of others, help-seeking can be hindered or encouraged by recommendations or advice from older adults' social networks (Ajzen, 1991).

For minority ethnic older adults, taking an intersectional approach highlights how older adults' help-seeking experiences are shaped by their social locations, which include their age, ethnicity, migration experiences and disability/ability (Hankivsky, 2014). As discussed in the review's findings, minority ethnic older adults are faced with language barriers, low literacy, and limited health insurance due to recent immigration. Cultural values, such as the importance of family, and the use of traditional remedies occur within connected systems that include policies, healthcare institutions and media. Through these processes, minority ethnic older adults experience cultural incompatibility with Western services or medicines, leading to further reliance on their informal supports or a complete lack of help-seeking behavior. Additionally, the cumulative advantage/disadvantage theory as well as the intersectional life course approach can further contextualize older adults' health experiences. The disadvantage/advantage theory describes how the gap between those with initial advantages and disadvantages continues to grow with age (Dannefer, 2003), while the intersectional life course approach combines concepts from intersectionality and the life course perspective to examine how diverse populations are impacted by their histories and key life events (Ferrer et al, 2017b). Within the context of this review's themes, these two theories highlight how a minority older adult's individual narrative, family history and migration experience can interact and impact their help-seeking behaviors within existing systems

in negative ways. This highlights the importance of cultural competency efforts, to help overcome such barriers and inequities.

4.2. Limitations and gaps

Because a scoping review is not meant to critically appraise and is subject to the findings of the included studies (Tricco et al., 2018), there are limitations to this methodology and review. Among the included studies, common limitations included studies that were cross-sectional in nature, and thus were unable to make causal conclusions or generalize their conclusions beyond their included samples. Furthermore, because these studies only capture findings at one point in time using specific measures, it is possible that there were confounding variables not discussed, inaccurate associations described and limited breadth in the measures used. Many studies used self-reported measures of help-seeking behavior, which may not always be indicative of actual help-seeking behavior and outcomes. This could have skewed the findings and resulted in the addressing of barriers and facilitators that do not actually impact help-seeking behavior. To avoid this, articles that only discussed future care preferences or desires for help were excluded. Among the qualitative studies, purposive sampling and the small samples used also prevented large generalizations. In addition, some studies discussed issues of underrepresentation of harder-to-reach groups, such as the oldest-old or frail adults. This results in a similar lack of underrepresentation of these populations in this review, where the most salient help-seeking barriers or facilitators that are relevant to these groups may be different and require specific attention in future research, particularly when considering the greater health challenges that they may have (Kawas et al., 2015; Ebrahimi et al., 2013).

The design of this scoping review itself also had limitations. For one, it is possible that there are other studies that should have been captured in this search but were not, due to the search strategy, the lack of standardization of terminologies for help-seeking or the indirect ways that help-seeking may have been addressed in excluded studies. Hand-searching the reference lists of included studies and reviews captured by the search strategy was undertaken to reduce the likelihood of excluding relevant studies. Outcome reporting bias is a possible limitation, but was reduced by following a protocol where the research question and methods were developed a priori to the data extraction and results stage (Teo et al., 2021). It is also possible that these findings are

underestimated due to the tendency for studies to evaluate samples of older adults who had sought help in the past or were already in the process of seeking help, thereby excluding very vulnerable groups who do not choose to seek help or participate in studies at all. In addition, due to the broad aims of this review, the data analysis and overview of findings could not discuss the findings of each included study in detail, of which could have prevented a discussion of further nuances and complexities of help-seeking among older adults.

The findings could have also been limited by the inclusion criteria, whereby articles excluding perspectives of stakeholders such as caregivers, policy makers or healthcare providers could have prevented the discussion of valuable insights from those who work closely with older adults and may identity factors that older adults are not conscientious of. Excluding studies that included populations of both younger and older adults also prevented the ability to discuss similarities or differences between populations, where in doing so, there could have been a discussion surrounding rationale for why help-seeking interventions may or may not need to be tailored by age. However, this criterion was implemented with the aim of understanding the help-seeking behaviors of older adults and how they alone interpret their health and subsequent care decisions. Furthermore, a supplementary analysis of such comparisons was discussed in section 3.4.1 to mitigate this gap. Non-community dwelling older adults were also excluded from the study, preventing an understanding of how those in long-term care exhibit help-seeking behaviors. While exploration of this population should also be explored due to possible differing factors and the greater health challenges that they may experience, this review was undertaken to explore the ways in which this population may experience barriers to care, and how this may influence early institutionalization.

A review of the global literature means that the available services will vary, of which likely impact help-seeking, allowing for commonalties and differences among countries to be explored. However, despite a secondary focus and desire to explore the help-seeking behaviors of minority ethnic older adult populations, only nine out of the 52 included articles focused on such populations. This in part, was likely due to the eligibility criteria and age cut-off of only including older adults aged 65 years and older, where lower life expectancies among ethnic populations in various countries should be a future consideration. Due to the inclusion of a general topic of help-seeking behaviors among older adults and a sub-focus on minority older adults, a restricted age criterion was

necessary to make this scoping review manageable. However, this may have introduced a selection bias that subsequently limits the relevance of these findings to countries outside of North America/Europe and older adults younger than 65. To mitigate this issue, a comparative analysis via the hand-searching of additional articles was discussed in Section 3.4.2. This step validated the themes identified from the scoping review itself and highlighted additional findings that warrant future exploration.

Furthermore, despite the inclusion criteria allowing for languages published in any language, all studies meeting inclusion criteria were published in English. This is likely due to the specific search terms and databases used, thereby preventing a wider understanding of various cultural differences and nuances in the help-seeking behaviors of minority ethnic older adults. In addition, due to the ways in which language is constantly evolving, the search terms used could have also prevented the capturing of articles that used terms such as people of color, Black, Asian and Minority Ethnic (BAME), Black and Minority Ethnic (BME), minoritized ethnic or racially minoritized (Advance HE, 2020; Milner & Jumbe, 2020; The Law Society, 2020). However, while the terms ‘minority ethnic’ or ‘minoritized ethnic’ are recently being preferred over ‘ethnic minority’ (Advance HE, 2020; Milner & Jumbe, 2020; The Law Society, 2020), the term ‘ethnic minority’ was chosen to be kept in the initial search strategy to capture the more common language of studies from 2005 onwards.

Additionally, delineation of the minority ethnic groups discussed was limited. For example, in one of the included studies, despite the direct acknowledgement that the authors were exploring care-seeking of a racially diverse sample, all those not categorized as White, Hispanic or Black were categorized as other or unknown (Makris et al., 2015). In this way, there was a lack of breadth in regard to cultural factors that may impact the help-seeking behaviors of diverse populations differently. As such, the cultural factors discussed in this review should be met with caution, in consideration of the heterogeneity and intersections of identity of various minority ethnic groups, who differ in factors such as language, culture, history and geographic location.

Finally, in discussing the importance of taking an intersectional approach to understanding the help-seeking behavior of older adults, discussions of gender were evidently lacking. While some of the included studies discussed some associations of gender (e.g., Altizer et al. (2014) found that a larger proportion of men were passive

consumers of health information than women in their study, citing pride as a reason, while formal help-seekers were almost exclusively women in Begum et al.'s (2012) study), there was a lack of articles in this area that prevented a greater focus on the topic. Additionally, while Dollard et al.'s (2014) article exclusively focuses on women and reasons that this is because some help-seeking is gendered, no influences due to gender were discussed. Furthermore, a literature review on the help-seeking behaviors of men finds that the literature is contradictory in its ability to conclude whether men are less likely to ask for help than women (Galdas et al., 2005). In these ways, further exploration on how and if gender roles, identities, and differences impact help-seeking among older adults should be considered. As the literature is already limited in its ability to examine specific groups within minoritized ethnic groups due to the ways in which they are often seen as one homogenous group (McLaughlin & Braun, 1998; Hong, 2019), so is the literature in its ability to understand the gendered experiences of older adults and minority ethnic older adults.

4.3. Implications for research and practice

As discussed in the limitations section, future research considerations should include a greater focus on minority ethnic populations, as well as on specific ethnic groups to begin to understand the cultural differences and nuances within populations. In addition, given the findings of this review, prospective scoping reviews can begin to take a more detailed and specific look at various populations and aspects of help-seeking. This could include a consideration of how gender may influence help-seeking behavior as one ages, how help-seeking may differ when comparing physical health with mental health challenges, and how family and social networks can impact the help-seeking behaviors of older adults in both positive and negative ways. Furthermore, future consideration of differences across countries and healthcare systems can be valuable in highlighting existing systemic gaps that prevent older adults from seeking adequate help. Future reviews including grey literature could also bring insights from documents such as government briefings and dissertations.

With the identified factors, interventions to improve help-seeking behaviors can also be developed. Much like a systematic review that was conducted on help-seeking interventions among mostly young adults (Gulliver, Griffiths, Christensen, et al., 2012), a systematic review of this nature could be beneficial in reviewing existing interventions for

older adults. This could include studies such as one implementing a training tool for public library staff to help meet the health information needs of elderly and their caregivers (Dieterle & Becker, 2011), a program teaching older adults how to use the internet to access health information (Campbell & Nolfi, 2005), or another on education and counselling for older adults at risk for acute myocardial infarction (Tullmann et al., 2007). Doing so could allow for a discussion of what may be most effective in influencing this population's help-seeking behaviors. Furthermore, as COVID-19 disproportionately impacts older adults in many ways, understanding the help-seeking behaviors of older adults and how factors have changed in the midst of their vulnerability, fear, and isolation could also add greater depth to this topic (Shuja et al., 2020).

Furthermore, while the focus of a scoping review is not to recommend implications for policy and practice (Tricco et al., 2018; Peters et al., 2020), there are several considerations that can help inform this area. To encourage older adults to seek help for their physical and mental health challenges, change needs to occur at all levels, with an acknowledgement of the barriers that prevent help-seeking among this population. Among the older adults themselves, a change in attitudes and awareness is required. As described earlier, the health belief model suggests that one's decision to seek care is influenced by 1) risk susceptibility, 2) risk severity, 3) benefits to action, 4) barriers to action, 5) self-efficacy, and 6) cues to action (Hochbaum, 1958; Rosenstock, 1974). Furthermore, the transtheoretical model of change describes how individuals go through various stages of readiness when changing their health behaviors, and thus suggests that health promotion or health approaches should be tailored according to an individual's or family's stage of readiness (Prochaska & Velicer, 1997). The finding that a lack of awareness and knowledge of services and symptoms are barriers, as well as the finding that older adults may inappropriately appraise their own symptoms as non-serious, highlights that greater education is necessary to foster positive changes to their behaviors. For example, widely inaccurate beliefs and misperceptions about atrial fibrillation were held in McCabe et al.'s study (2017), where older adults lacked the confidence to recognize relevant symptoms, thereby risking complications from untreated atrial fibrillation. As Altizer et al. (2014) highlights, friends, family, and media sources were the key sources of health information for the older adults in this sample. In this way, knowledge dissemination efforts are needed, where the use of media sources such as television programming, newspaper, books and magazines can be more

relevant and useful for both older adults and their support networks (Altizer et al., 2014). Locations for print media should also be strategically considered, where at-risk older adults commonly go and can be connected with appropriate resources. For example, the emergency department was cited as one place where at-risk individuals could be connected with mental health services (Hom et al., 2015), and can reasonably be considered true for older adults as well. Such efforts could increase the agency and decision-making abilities of older adults, allowing them to take proactive steps in their own health to avoid delaying help-seeking.

Furthermore, this review highlighted how an older adult's relationship with their social supports can greatly influence their care decisions. As such, initiatives looking to improve the help-seeking behaviors of older adults should be cognizant of the reach they have with not only the older adults themselves, but those in their circle. In situations where family or friends may act as a proxy for health decisions, greater reach and education must also be provided to caregivers and those who are close to an elderly in need, through additional avenues such as word of mouth, the Internet, and social media. Initiatives that focus on improving family dynamics and support has also been suggested in a study on Chinese Americans aged 55 years and older (Sun et al., 2018), in recognition of the finding that many older adults prefer to resolve their health challenges behind closed doors. A few articles in this review also highlighted the preference for older adults to seek out their peers for support, as this was viewed as a more reciprocal relationship that did not threaten their identity. In this way, peer support networks may also be an important way for older adults to share health information, such as via religious or other community groups.

The relationship and perceptions that an older adult has with healthcare providers also proves to be an important factor. While healthcare providers are a great source of health information, particularly in the event of serious symptoms, mistrust and negative experiences in the past have acted as a large barrier to improving older adults' health outcomes and subsequent formal help-seeking behaviors (Clarke et al., 2015; Gore-Gorszewska, 2020; Kharicha et al., 2013; Lawrence et al., 2006; Makris et al., 2015; Polacsek et al., 2019;). In contrast, opportunities where providers recognized other issues in passing at a visit for another reason, or who inquired about the older adults' wellbeing were viewed as positive (Begum et al., 2012; Elias & Lowton, 2014; Garrido et al., 2011; Hannaford et al., 2019; Waterworth et al., 2018). In this way, greater

awareness, and education for healthcare providers on older adult issues and ways to build rapport is also necessary. As a systematic review on strategies to engage the oldest old, black or other minority ethnic older adults and older adults in deprived areas found, home visits and referrals from trusted practitioners and gatekeepers are one way of improving engagement for these hard-to-reach groups (Liljas et al., 2017). Other reviews reiterate this, where initiatives that focused on improving community knowledge and networking with others and gatekeepers facilitated access and connection to help and services (Hom et al., 2015; Poscia et al., 2018). Including the older adult when making healthcare decisions may also curb threats to their identity and independence (Polacsek et al., 2019), further empowering them to take proactive steps in preventing poor health outcomes.

While the findings of minority ethnic older adults were limited in this review, this evident gap also signifies the need for greater representation of these populations in research and practice. As such, it is not only important for such voices to be prioritized in research, but also in practice. As described earlier, older Koreans lacking English proficiency had a preference for a Korean-speaking doctor (Chung et al., 2018) and thus various providers and community services that have staff able to speak multiple languages is important. Furthermore, cultural competency training for healthcare and service providers may be beneficial, where respect for diversity, awareness of one's own background, understanding of the history/values/beliefs of the population one is working with and knowledge of how to help are inherent factors (Mokuau & Tomioka, 2010; Mokuau, 2011). However, again, a lack of literature on specific minority ethnic groups also warrants further research, where recognition of ethnocultural variations and inclusion of culture-specific remedies, terms and understandings is necessary. As one study found, a common "one-size-fits-all" approach to address the health-seeking behaviors of East Asian immigrants is inadequate (Na et al., 2016), and thus requires greater prioritization and understanding by researchers and service providers alike.

Finally, in regard to knowledge translation and strategies to disseminate the findings of this scoping review itself, a condensed version of this review will be submitted for potential publication in a peer-reviewed journal. Furthermore, given the resources and opportunities to do so, presentations at various conferences and events as well as consultations with various stakeholders can be made possible. As this review highlights the complexities involved in older adults' help-seeking behaviors and the need for

collaborative and holistic strategies, local conversations between governments, healthcare providers, community organizations, loved ones and older adults are one important way we can begin to support the health and well-being of older adults in our communities.

Chapter 5.

Conclusion

Evidently, the help-seeking behaviors of older adults is a complex interaction of various factors, considerations, and experiences. This scoping review has indicated a need to address the barriers that older adults experience when a need for help arises, of which includes past interactions with providers, inadequate appraisal of symptoms and health and accessibility and awareness. Furthermore, issues of identity and independence, the tendency for older adults to turn to social supports first, and various cultural factors and lay/religious beliefs indicate the need for comprehensive changes that involves the older adult themselves in decision-making when possible, and considers their relationships, values, and beliefs in a holistic way. Finally, despite the low number of studies examining minority ethnic older adults in this review, there are several cultural factors discussed that warrant further exploration. Through addressing and recognizing these barriers in practice, as well as additional education efforts, training, and research, older adults can be better empowered and prepared to seek help and be helped when a physical or mental health challenge arises, without delay or exacerbation of symptoms.

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Appendix A. PRISMA-ScR Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	i
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	iii
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	1-7
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	7-8
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	8
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	9-10
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	9
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	9, 87-89
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	9-10
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	10

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	10
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	N/A
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	10-11
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	12
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	13-15
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	N/A
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	16-28
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	29-40
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	57-62
Limitations	20	Discuss the limitations of the scoping review process.	62-65
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	65-70
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	N/A

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMAScR): Checklist and Explanation. Ann Intern Med. 2018;169:467–473. doi: 10.7326/M18-0850.

Appendix B. Database Search Queries

MEDLINE/PubMed

1. Search: ("help seek*" OR "treatment seek*" OR "health information seek*" OR "healthcare seek*" OR "care seek*" OR "health seek*") AND ("older adults" OR "older people" OR "elderly" OR "seniors" OR "geriatrics")

("help seek*"[All Fields] OR "treatment seek*"[All Fields] OR "health information seek*"[All Fields] OR "healthcare seek*"[All Fields] OR "care seek*"[All Fields] OR "health seek*"[All Fields]) AND ("older adults"[All Fields] OR "older people"[All Fields] OR "elderly"[All Fields] OR "seniors"[All Fields] OR "geriatrics"[All Fields])

2. Search: ("help seek*" OR "treatment seek*" OR "health information seek*" OR "healthcare seek*" OR "care seek*" OR "health seek*") AND ("older adults" OR "older people" OR "elderly" OR "seniors" OR "geriatrics") AND ("immigrants" OR "ethnic minority" OR "minority populations")

("help seek*"[All Fields] OR "treatment seek*"[All Fields] OR "health information seek*"[All Fields] OR "healthcare seek*"[All Fields] OR "care seek*"[All Fields] OR "health seek*"[All Fields]) AND ("older adults"[All Fields] OR "older people"[All Fields] OR "elderly"[All Fields] OR "seniors"[All Fields] OR "geriatrics"[All Fields]) AND ("immigrants"[All Fields] OR "ethnic minority"[All Fields] OR "minority populations"[All Fields])

Web of Science

1. Search: ("help seek*" OR "treatment seek*" OR "health information seek*" OR "healthcare seek*" OR "care seek*" OR "health seek*") AND ("older adults" OR "older people" OR "elderly" OR "seniors" OR "geriatrics"); 2005-2021

ALL FIELDS: ((“help seek*” OR “treatment seek*” OR “health information seek*” OR “healthcare seek*” OR “care seek*” OR “health seek*”) AND (“older adults” OR “older people” OR “elderly” OR “seniors” OR “geriatrics”))

2. Search: ("help seek*" OR "treatment seek*" OR "health information seek*" OR "healthcare seek*" OR "care seek*" OR "health seek*") AND ("older adults" OR "older people" OR "elderly" OR "seniors" OR "geriatrics") AND ("immigrants" OR "ethnic minority" OR "minority populations"); 2005-2021

ALL FIELDS: (("help seek*" OR "treatment seek*" OR "health information seek*" OR "healthcare seek*" OR "care seek*" OR "health seek*") AND ("older adults" OR "older people" OR "elderly" OR "seniors" OR "geriatrics") AND ("immigrants" OR "ethnic minority" OR "minority populations"))

PsycInfo

1. Search: ("help seek*" OR "treatment seek*" OR "health information seek*" OR "healthcare seek*" OR "care seek*" OR "health seek*") AND ("older adults" OR "older people" OR "elderly" OR "seniors" OR "geriatrics"); 2005-2021

((“help seek*” OR “treatment seek*” OR “health information seek*” OR “healthcare seek*” OR “care seek*” OR “health seek*”)) AND ((“older adults” OR “older people” OR “elderly” OR “seniors” OR “geriatrics”))

2. Search: ("help seek*" OR "treatment seek*" OR "health information seek*" OR "healthcare seek*" OR "care seek*" OR "health seek*") AND ("older adults" OR "older people" OR "elderly" OR "seniors" OR "geriatrics") AND ("immigrants" OR "ethnic minority" OR "minority populations"); 2005-2021

((“help seek*” OR “treatment seek*” OR “health information seek*” OR “healthcare seek*” OR “care seek*” OR “health seek*”)) AND ((“older adults” OR “older people” OR “elderly” OR “seniors” OR “geriatrics”)) AND ((“immigrants” OR “ethnic minority” OR “minority populations”))

CINAHL

1. Search: ("help seek*" OR "treatment seek*" OR "health information seek*" OR "healthcare seek*" OR "care seek*" OR "health seek*") AND ("older adults" OR "older people" OR "elderly" OR "seniors" OR "geriatrics"); 2005-2021

((“help seek*” OR “treatment seek*” OR “health information seek*” OR “healthcare seek*” OR “care seek*” OR “health seek*”)) AND ((“older adults” OR “older people” OR “elderly” OR “seniors” OR “geriatrics”))

2. Search: ("help seek*" OR "treatment seek*" OR "health information seek*" OR "healthcare seek*" OR "care seek*" OR "health seek*") AND ("older adults" OR "older people" OR "elderly" OR "seniors" OR "geriatrics") AND ("immigrants" OR "ethnic minority" OR "minority populations"); 2005-2021

((“help seek*” OR “treatment seek*” OR “health information seek*” OR “healthcare seek*” OR “care seek*” OR “health seek*”)) AND ((“older adults” OR “older people” OR “elderly” OR “seniors” OR “geriatrics”)) AND ((“immigrants” OR “ethnic minority” OR “minority populations”))

Scopus

1. Search: ("help seek*" OR "treatment seek*" OR "health information seek*" OR "healthcare seek*" OR "care seek*" OR "health seek*") AND ("older adults" OR "older people" OR "elderly" OR "seniors" OR "geriatrics")

TITLE-ABS-KEY ("help seek*" OR "treatment seek*" OR "health information seek*" OR "healthcare seek*" OR "care seek*" OR "health seek*") AND TITLE-ABS-KEY ("older adults" OR "older people" OR "elderly" OR "seniors" OR "geriatrics")

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Appendix C. Data Extraction Spreadsheet Example

Article Title	Author(s)	Journal	Year	Country	Methodology	Study objectives	Study population	Age
Using the socioecological model to explore factors	Chung et al.	International Journal of Older	2017	USA (Seattle, Washington)	Qualititative interview data	To explore multilevel factors that affect	Community-dwelling (convenience	67-79, 68-79
Ageism, negative attitudes, and competing	Makris et al.	BMC Geriatrics	2015	USA (FG held in New tork	Qualititative	Assesses the experience of back	English-speaking, community-dwelling	65-85+
A Qualitative Analysis of How Elders Seek and	Altizer et al.	Gerontology & Geriatrics	2014	USA (North Carolina)	Qualitative	Documents OA's sources of health	North Carolina counties which vary	65-80+
Problematic Substance Use, Help-Seeking, and	Aubut et al.	Journal of Psychoactive	2020	Canada (Quebec)	Qualitative interviews	This study explores seniors' views of	65+, in treatment for problematic	N/A
Help-seeking Response to Subjective Memory	Begum et al.	The Gerontologist	2012	United Kingdom	Qualitative	To explore the reasons as to why	Residents of southeast London,	
Pain and depression in older people: Comorbidity	Bonnewyn et al.	Journal of Affective	2009	Belgium	Cross-sectional	To examine the relationship	Non-institutionalized	65-75+
Seeking assistance in later life: how do older	Canvin et al.	Age and Ageing	2018	United Kingdom	Qualitative interviews	To explore older adults' accounts of	65+, living in North West England and	68-95
Self-Care and Medical Treatment-Seeking	Chen, S	International Quaterly of	2020	Taiwan	Qualitative - semi-	To understand the self-care and	65+ with a primary school education or	
"I Try and Smile, I Try and Be Cheery, I Try Not to Be	Clarke et al.	PLOS ONE	2014	United Kingdom	Qualitative	To gain more insight into how older	Community-dwelling older adults in	66-89
Association between depressive symptoms and	Djukanovic I, Sorjonen K,	Aging and Mental Health	2014	Sweden	Cross-sectional	To examine the prevalence of and	Residents of Sweden	65-80
Why older women do or do not seek help from the	Dollard J, Braunack-	Family Practice	2014	Australia	Qualitative	To explore why older women do or do not	Community-dwelling women aged 65+,	65-87
Do those over 80 years of age seek more or less	Elias & Lowton	Sociology of Health and	2014	London	Qualitative interviews	To inform theoretical development of how	80-95 years old recruited from two	80-93
Health information seeking, beliefs about	Eriksson-Backa K,	Journal of Librarianship	2018	Finland	Questionnaire	To present results relating to health	65-79 year old Finns	65-79
Supporting frail older people with depression	Frost et al.	Aging and Mental Health	2020	London	Qualitative interviews	To explore frail older adults' experiences	OA in the UK, with frailty and	75-88

Type of help-seeking behavior	Health challenges	Barriers (prevent, discourages help-seeking)	Facilitators (supports, encourages help-seeking)	Cultural factors (e.g. traditions, values)	Other key findings	Study limitations
Health-information-seeking, health talk, physical activity,	Chronic disease (e.g. diabetes,	Intrapersonal factors (intrinsic):	Intrapersonal factors (extrinsic): current	Intrapersonal factors	Study utilizes the socioecological	Recruited from one geographical
Many had tried or were currently using an oral pain	Restricting back pain (pain severe	Mistrust, negative relationships with	Positive relationships with provider (patient-	N/A	Intro discusses how racial/ethnic	Despite aim for diversity, they did
Sources of health information: friends were the dominant	General health challenges		Many OA engaged in health information	Found no differences	Assesses breadth (the number and	Uses a small sample of rural
Hospital, addiction centres	Substance use (almost one had	Lack of knowledge about, and	1) Awareness: the onset of various	N/A	Extra themes: 1) experiences	Involved only 2 addiction
Formal help seekers at memory clinics vs. those who	Memory complaints, one	Informal help seeking may	More likely to seek help when people	N/A		In addition to help-seeking,
Use of mental health services, antidepressants,	Depression					Cross-sectional making it
Interviews included any type of support, advice,	General health challenges	Some refused offers of			Some bypassed asserting a need	Transferability limited by
Medical	89.3% had more than one chronic	OA tended to delay their medical	Participants relied on others' assisance to		Low literacy led to participants not	N/A
GPs	Musculoskeletal chronic pain	Concern not "to bother" physicians	Being listened to and being heard		The importance of diagnosis	N/A
Medical care (physician, district nurse, welfare officer,	Depression	Reasons for not seeking care			Found an association	Loneliness was measured with
Medical	Fall	1) Perceived fall or fall-related injury	1) Perceived fall-related injury as		Sanctioning - the role it plays in	Small, gender-specific sample
	1) Serious illnesses -	1) For non-illness health	Most would only seek help only if their		Increased age led to fewer normal	All were volunteers,
Health information seeking	General				Those who have a better confidence	Based on self-reported
General: mentions GP, social workers, mental health	Depression, anxiety or both	Low expectations in potential for	Preferred pathway was to seek help with		6 main themes emerged re: their	Could only provide limited