

Tackling the inescapable: Mental ill health in later life. Report on a series of conversations.



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1 Executive Summary

Background to the project

Older people with mental health problems (OPMHP) are a sub group of both mental health service users and older people service users. The specific voice OPMHP is therefore diluted within these general groups and there is little evidence to inform our understanding of the experiences of OPMHP.

Project aims and objectives

This project aimed to engage in conversation with older people who have experienced mental health problems with a view to hearing OPMHP perspectives and identifying priorities for future research.

Methodology & methods

Twelve people met through contacts with local services and community contacts contributed. Their ages ranged from 52-86 and there were 7 men and 5 women. Six meetings/conversations were held (individually or in small groups) during a three month period April-July 2017. Each conversation built on findings from the previous meeting/conversation. The conversations were shaped by the questions: What does 'older person' mean to you? 'What matters in mental health care for older people'? (Including discussion about what was meant by 'age appropriate') and 'What should be researched'? Conversations about preliminary findings were continued at a feedback event on 3rd July 2017 attended by seven of the contributors.

Analysis & Findings

The predefined categories 'older people', mental health care and age appropriateness' and 'research' shaped the conversations. The older people category found mixed and contradictory ideas about what older person meant. A content analysis of the categories 'mental health care and age appropriateness', and 'research' was conducted by 'within' and 'across' analysis of the transcribed notes from the six meetings/conversations and found eight themes: Mutuality, Sensitivity, Carers, Exclusion, Meaning and purpose, Politics, Physical and mental health integration, and Mortality.

Discussion

Although limitations include: a small number of people, lack of diversity, and took place in only one location, the depth of the discussions was wide ranging. The themes overlapped somewhat but some new insights emerged which are perhaps not well explored in literature or policy. The idea of age appropriateness was confusing and was not defined but was conflated with illness and frailty. There was an emphasis on ageism that is in contrast with mental health policy that does not address the complexity of (indirect) discrimination on the basis of age for OPMH.

Conclusion & Next steps.

Although this report only includes the views of twelve people it raises a number of important issues that are worthy of further exploration. This is particularly important for policy and commissioners who need to progress on the basis of up to date evidence. The consultation will inform development for research proposals and bids following exploratory literature reviews on topics raised.

2 Report structure

The report is structured in the following way: first we present the aims and objectives followed by an introduction and background section. Current literature is then outlined and also the mental health services and (English) policy context. We then outline the methods, analysis and findings. This is followed by a short discussion, conclusion and plans for further action. Photographs illustrating some of our activities will be included throughout for which permission has been given.

3 Aim & Objectives

Aim

The aim of the project was to engage in conversation with older people who have experienced mental health problems (OPMHP) with a view to identifying ideas for future research.

Objectives

- I. To define what matters in mental health care for older people
- II. To discover how older adults perceive and experience being 'older'
- III. To define the concept of 'age appropriate'
- IV. To list research priorities identified by older adults

4 Introduction & background

This project reports on conversations with older people (OP) experiencing what is sometimes called 'functional' mental illness such as clinical depression, anxiety disorders (including post-traumatic stress disorder), psychosis and personality disorder. It is not about people living with dementia. This is a common assumption when talking about older people's mental health (OPMH) and this assumption is a key driver in trying to redress the balance with this project, to talk to OPMHP about what matters to them; people who do not have dementia and whose voices are far more neglected, despite greater prevalence. The title of the report uses Joanna Latimer's idea that singling out a category of 'older people' is 'absurd but inescapable' (¹ p143). Absurd because people who are older are not a single group and treating 'them' as such is potentially damaging and colludes with discriminatory attitudes; but 'inescapable' because there are some unique issues that require consideration when organising or delivering care, for example, life stage and its implications and

biological change. OP generally are well represented in public involvement initiatives. However, OPMHP are a subgroup of both OP groups and mental health (MH) services user groups. They are invisible in the former and often absent or nominally present in the latter. The absence or dilution of voices such as these is an important omission from evidence informing policy particularly for people have lived long term from early life to older age with ongoing mental health problems (MHP).

Although recent emphasis on public health and mental wellbeing for all in national policy has great value, the well documented exclusion of people with 'mental illness' from social life and the stigma they experience, as well as the sometimes disabling effects of mental illness are special features that require specific consideration (NB The term mental health problems or mental illness will be used interchangeably throughout. This is intended to distinguish between challenges to mental wellbeing that affect us all and the severity of degree by which MHPs, which may meet thresholds for a mental illness diagnostic name, affect people's ability to function in everyday life). Although mental wellbeing campaigns offer excellent initiatives aimed at preventing mental ill health, for example the Age UK campaign to end loneliness, such initiatives are not necessarily reaching or supporting people who are older and experience functional mental illnesses.

5 Current literature

Research that addresses issues relating to OPMH is relatively under developed compared to 'adults of working age'. There is a reasonably robust evidence base relating to medical concepts of mental illness for example, the course of schizophrenia in older people, but there is little that explores people's experiences. The literature on older people's mental health is defined by its age category, that is, older people, usually defined as over the age of 65. There is a wide range of topics explored, but no one subject, for example, self-harm, has a particularly robust qualitative evidence base in relation to 'older people', unlike literature on younger adults. The three systematic reviews available in the Cochrane Library focused specifically on older people/older life and mental health are: treatments for depression, prescribing in care homes and antipsychotic medication in schizophrenia. . Of 132 papers located in a search of the database CINAHL on 28th Sept 2017 on 'older people and mental disorders and qualitative research' (to focus on subjective voice) from 2007-present, the majority of these appeared to focus on carer issues, with a wide ranging list

including veterans, stigma, medication, screening, culture and resilience.

The voice of older people with mental health problems is not well heard². There appear to be only four research studies on the experience of long term or severe mental illness and older people³; Hedelin & Strandmark, 2001⁴; Hedelin & Jonsson, 2003⁵ Martinsson et al 2012⁶; Allan & Dixon 2009⁷. The first three of these are focused on women and depression, the last on the life situation for older people with mental disorder. Although comparisons of these papers give limited information by which to gather themes, they appear overall to indicate an idea about ‘tension between two poles’⁴ shown in figure 1 below:

Figure 1 Tension between two poles

<ul style="list-style-type: none">• Maintain hope/decrease worry• Look back with pride/face future with hope• Desire to be part of something• Maintain sense of security and being human	<ul style="list-style-type: none">• Stigma and fear• Excluded• Powerlessness• Vulnerability• Everyday struggles• Misunderstood and misinterpret others
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5.1 Mental Health services

Mental health services are largely delivered across primary care, secondary care (specialist mental health services) and third sector organisations. Primary care and third sector services tend not to have age divisions, and rely on staff skills to address the diverse range of needs. OP has been defined by the department of health (DH) as from age of 50⁸ though traditionally it has been age 65, a cut off that still commonly distinguishes (but not always) between ‘working age adults’ and ‘older people’ in mental health services.

Secondary inpatient and community mental health services tend to be organised around ‘working age adults’ and ‘older people’, with OP often not having the same access to some services as younger adults, for example, Mitford et al 2010⁹ found that OP with first episode psychosis did not have the same access to services or treatments as younger people. However, recent developments such as MH liaison and crisis services require a diverse range of skills and knowledge in their staff in order to address the needs of all adults of any age (though how far such staff are

prepared and trained in understanding later life issues is questionable).

5.2 The [English] policy context and rationale for the project

Until 2001 the influential National Service frameworks guided health care provision. The National Service Framework for Mental Health (NSFMH) introduced a framework for creative and innovative approaches to mental health care¹⁰. However, this was focused on adults of ‘working age’. Care for OP was governed largely by the National Service Framework for Older people (NSFOP) which had only one standard on mental health: improved recognition of depression and dementia, but which ironically also included a standard on challenging age discrimination¹¹. This arrangement appeared to be based on an assumption that being older was of primary importance in care organisation, and mental health secondary. This was later recognised to be a discriminatory approach and the exclusion of OP in MH care has been well recognised by the DH with a renewed focus on ‘needs not age’ in the implementation of policy (not least because the Equality Act published in 2010 made age a protected factor¹²). Nevertheless, in 2011 ageism was still identified as an ‘urgent priority’ by the National Mental Health Development Unit^{13, 14}.

The publication of the National Dementia Strategy for England in 2009¹⁵ recognised the unique needs of people of all ages with dementia and essentially created a division of service organisation for those serving people with organic illness (dementia) and those with functional mental illness. In relation to services for people with functional mental illness, the will to tackle ageism was evident but in practice solutions have been inconsistent and perhaps chaotic. One approach was to introduce what was called ‘ageless’ services. Ageless services aimed to class all over 18s as ‘adults’. In practice this model appears to have faced insurmountable problems due to the need to address the specialism of old age psychiatry (which was introduced in 1988). Addressing the special needs of OPMHP are not only undermined by ‘ageless’ services, but create worse outcomes for older people¹⁶.

The recent Mental Health policy ‘for all ages’, ‘No health without mental health’¹⁷ adopts a life course approach, though in reality this remains an age group approach. It also makes reference to ‘age appropriate’ services for everyone with no definition of what this means. In 2013 the Joint Commissioning Panel (JCP) guidance for OP Mental Health services¹⁸ also adopted the notion of age appropriateness and, with slight revisions to the no health without mental health objectives,

includes discrimination on the basis of age as well as MH. The panel objectives are:

More (older) people with MHP:

1. will have good mental health
2. will recover
3. will have good physical health
4. will have a positive experience of care and support

Fewer people:

- 5 will suffer avoidable harm
- 6 will experience stigma and age discrimination

On presenting this to the OPMH who contributed to this project, they were not at all impressed and some felt quite angry that what they felt were such unrealistic goals would be articulated in such an important document. However, this is probably the first time that discrimination borne out of being older alongside recognition of discrimination associated with mental illness has been acknowledged in official documents (though discrimination on basis of mental illness is not made entirely explicit in the document). This is a complex issue and there is little evidence that successfully addresses this complexity. The JCP report also notes the need to '*...consider data and outcomes for older people's mental health, and not data aggregated simply for mental health with no accompanying age information*' (¹⁸ p10), which is historically very poor.

The commitment to tackling ageism has not been reflected in current policy, that is the Five Year Forward for Mental Health strategy (Mental Health Taskforce, 2016¹⁹) which retains a focus on eliminating stigma in mental illness; there is no mention of ageism or the complex intersectionality. This is despite indirect recognition implicated in recommendation 21 that:

'...bespoke older adult services should be the preferred model until general adult mental health service can be shown to provide age appropriate care' (p33).

Therefore, to reiterate, the aim of the project was to engage in conversation with OP who have experienced MHPs to discover their perspectives on OPMH care.

The underpinning need for this project rests on the premise that:

- People with mental health problems are heard
- People with dementia are heard
- Older people are generally heard

But...

Older people with mental health problems are not heard

6 Methods

The original idea was to have a large listening event for the local community, but on reflection this didn't feel feasible given the potential sensitive nature of the conversations and the potential needs of the contributors. Therefore, contacts were made in local community groups (see page 2) and twelve people came forward to take part. The ages of the contributors ranged from 52-86 and there were 7 men and 5 women. Conversations were held individually or in small groups during a three month period April-July 2017. J, one of the authors of this report played a critical role as a community contact and put us in touch with most of the contributors. Although not an 'older' person himself, he took part in some of the discussions, stimulating debate and offering reflections.

A small group approach happened iteratively and responsive to need as follows:

- One conversation was held over the phone
- One conversation was held at the persons home
- One conversation was had with one person within the university
- Three meetings with a total of nine people were held in small groups within university.

Celia and Kit Kat



The people who contributed self-selected on the basis of identifying themselves as having experience of MHP. No diagnostic information was sought, though reference was made in conversation to a range of specific diagnoses experienced. All the contributors agreed that they wanted to be identified by name, that use of photographs was permitted and could be used in

dissemination, and that their opinions could be used for future research purposes and that they could be contacted again (all signed consent to this). However, they were promised that no specific quote would be attributed to any single person, therefore the quotes shown in this report are identified by randomly assigning meetings on different dates to a category, a, b, c, d, or e, and then showing the page number of the meeting notes where the quote appears e.g. Mbp1 (meeting b, page 1).

For meetings within the university, rooms were booked and these were planned around an hour for conversation, followed by a funded lunch, and then the opportunity to revisit the conversation.



J, Winifred and Keith

The conversations were organised around three main categories of interest:

- 1 What does the term 'older person' mean to you?
- 2 What do you think matters in mental health care for older people?
 - i. including discussion about what was meant by 'age appropriate'
- 3 What should be researched?

For every conversation, written notes were made then typed up, with an effort to document as much detail of responses as possible. All but one meeting was facilitated by EC (see page 3 for key); one meeting was facilitated by EC & GL.

Emails and phone calls from J and EC kept contributors informed and engaged over the time of the project.

A feedback event shown in the photographs below was held on 3rd July 2017 to present the preliminary findings and to explore further possibilities for developing the work. A welcome by Prof. Ormandy was given to the six people who attended (plus EC, GL, JA and AT). At this event, a

summary of preliminary findings was presented and discussed. The issues were revisited in two small facilitated groups with a view to agreeing what the most important issues were.

Feedback event



7 Analysis and Findings

Firstly comments relating to defining OP were extracted from transcripts of notes and written into a coherent text. For the remaining conversations that focus on age appropriateness, what matters in mental health care and research, content analysis principles were applied where meeting notes were coded for recurring themes (within) then compared to each other to identify commonalities (across) as follows;

1. Starting with the first meeting and coding (Celia only),
2. coding second meeting (Winifred) against Celia's notes
3. coding third meeting (Andrew) against Celia and Winifred
4. Coding fourth meeting (Phil, Dave, Bernard) against Andrew, Celia & Winifred
5. Coding the fifth meeting (Martin, Erica, Margaretmary & John) against all previous meeting notes coding.

This process resulted in identification of eight themes: Mutuality, Sensitivity, Carers, Exclusion, Meaning and purpose, Politics, Physical and mental health integration, and Mortality.

There was some overlap between the themes and the following discussion attempt to illustrate

where this occurs (shown in bold type). First the findings from the category 'older people' will be presented followed by the themes from 'What happens in mental health care and age appropriateness' and 'research'.

Category 1: 'Older Person'

In relation to defining OP, this resulted in a comprehensive pattern over all meetings whereby old age was defined by feelings, looks, perceptions, frailty, dependence, dementia and illness. Only one person identified as having significant physical health issues and therefore 'old' but as one person put it, *'it is everyone else but you'* (Mep1).

There was no agreement about a number that might define old age, and a range were suggested - 50, 60, 65, 70-100, 80, 80s, over 70, 80-90. There was recognition that it was relative to your perception of others and your self-concept, which confirmed an individually constructed idea, whilst grappling with how this might not fit with parameters of old age as communicated in popular culture and stereotypical societal constructions. Comments included:

*'...only body getting old..., the mind doesn't get old'
'You're not old until the nail is put in the coffin'
(MBp1)*

The difficulty articulating a definition of old was creatively described as it being *'like asking how to define a piece of art, it's the space around it. Your relationship with it'* (Map1), as it depended on your own self-concept.

Most of what was said about perceptions of old age is probably consistent with what has been found in the gerontology literature. However, one unique aspect here was that the issues of mental illness were thought to be important when defining older in this particular group of people. It was suggested that in research with people with MHP the definition of old age should be reduced to a much lower number than the traditional 65. This was because of awareness that people with long term mental illnesses are statistically more likely to die much younger than the general population, and are therefore relatively 'old' (**mortality**).

The sense of being older at younger age was also likened to the length of time in the mental health system *'I'm an older person (57) because I've been in the system since I was 17'* (Mdp1), and the wisdom that this bought which could be used for the benefit of younger people within the system. The sense of being older at a younger age also related to the fact that you were *'written off', 'on the scrap heap, can't get a job'* (Map1) and that you feel/grow old before your time if you feel isolated or can't achieve your goals. Exclusion from work makes you *'feel old'*.

Reflections on the long term nature of MHP and accompanying experiences of ageing and personal identity were evident:

'Age is irrelevant, growing up with it (caring too much for others). I've stopped worrying more recently. Is it mental health? Maybe I was worn out. Maybe mental exhaustion' (Mep1).

It was:

'Not necessarily to do with age I've been like that all my life... it isn't my age, it is because I am me' (Mep2)

Discussions also referred to how professionals might treat older people differently, to define them by their age and therefore behave differently towards them which they should not.

Category 2: What Matters in Mental Health Care, & Age appropriateness.

The idea of age appropriateness was largely met with confusion, and there were different opinions explored though it was considered *'a big question'*. If you were older within the MH system there shouldn't be *'separate services for older people. If you've survived – they are stronger – can help younger ones'* (Mdp1). In contrast it was *'Not right to be with young ones. Different needs. Toilet needs, etc. my mum, husbands mum, Alzheimer's when all that's going on it's not for young ones'* (Mep1). One person said they *'can't see of an age appropriate service'* (Mbp2) but said that people with dementia need age appropriate service. However these latter comments relate to ideas of old age being related to people who are very physically dependent and or frail.

Despite the views on age appropriateness, this concept was also reflected within the discussions which are presented in the themes below.

Mutuality

The theme of mutuality was about how contributors saw beyond their own needs and reflected on

mental health for all. They indicated that staff need looking after and there was worry about the stress the staff might experience.

'Support workers are a good idea – they get distraught I worry about them because they take it home at night. Staff used to be supervised' (Mdp1)

Mutuality also included the idea that we should protect younger people by having separate services for younger and OP, though as mentioned earlier, this largely appeared to be conceptualised in relation to dementia: that exposing younger people to seeing people with dementia was not *'fair'*.

Also implicated in mutuality was being a **carer**, which is presented within a separate theme, where people were cared for and were also carers themselves.

Sensitivity

This theme was about the fact that strain and stress was harder to deal with when you are older, so everything was that bit more difficult;

*'...you're affected more when you're older (Mbp1),
'The way things work day to day older you get harder it gets. (Mbp1)*

This was also felt to be related to the cumulative effect of added problems as you:

'...face different things in old age as go through life different things (Mbp1)

For example, being a **carer** (which was also more likely to happen):

'I am a carer for my wife....More likely in 60s – more likely to lose partner'. (Mbp1)

Also included in this theme was not getting diagnosed properly when young and being left with confusion. In addition, worry was increased if things are not explained properly. For example, if you did not know what 'normal ageing' was, you could worry about things that happened to you and you couldn't make a judgement about whether you should go to the doctor.

Carers

It was understood that becoming a carer was more likely when you were older, and that this was

likely to be more difficult because of **sensitivity** to strain. Experiences of long term caring were discussed that had resulted in mental health strain, both as a mental health issues in itself and also as a mental health issues added to already existing MHP where the 'Cared for (us) becomes carer' (**mutuality**).

Being a carer resulted in 'Loneliness and isolation' (**exclusion**)

'...carer for wife – I am lonely – no emotional partner. More likely in 60s – more likely to lose partner. (Mbp1)

And the over 65s:

'... should be given more support with their care. Should be assessed to see if they are a carer for someone else. Look after your own MH and being a carer is never taken into account. This is more likely for older people. (Map1)

This extra support should be enough so that:

'...older carers can circumnavigate what their giving up (Mbp2).

Because they were being 'robbed of choice'

Exclusion

Exclusion was conceptualised as cultural, social and health exclusion and included experiences and perceptions of ageism. There was agreement that as OP they didn't see images relevant to self in popular culture and news:

'Newspaper – all for teenagers – nothing for older people, feel excluded. Health – you are excluded – same sense of priority, Dr might think had it all her life so why bother – attitude problem by doctors (Mbp1)

MH appropriate for – setting where can meet together with OP. similar aged people, it's a forgotten time. All young people in adverts. (Mbp2)

They felt that:

'No one was talking about it' [ageism] (Mbp1).

And that they had become invisible' and as one person said, 'I've disappeared' (Mbp2).

In addition, there was a sense that they did not '...get the same attention as younger people for

health issues'

Overall, the individual nature of problems was important as they didn't want to be categorised, but to consider ability and needs individually.

Meaning and purpose

Meaning and purpose reflected the need for work and occupation, the need to be working towards a goal and that you were '*Not old*' if you were active and for example:

'...education keeps you young' (Mbp2).

The organisation START was mentioned as it had become:

'... raison d'être, makes life worthwhile, you can learn something (Mdp1).

Also, attendance at Art College was '*...working toward a goal purpose and passion.*' (Mbp2)

However, despite this recognition of the need for a sense of purpose, occupation however was not always achievable as an OPMHP as you were:

'... on the scrap heap' (exclusion)

Some specific experiences were described where people had attempted to attend services, but had felt unwelcome. It was felt (perhaps reflecting one idea around 'age appropriateness'), a place to meet similar aged people was needed.

Politics

Although this did not specifically come up in all the conversations, there were a number of questions about policy rhetoric; was what is written in policy actually done.

Cost was acknowledged but experiences of the system were described in terms of red tape in restricting flexibility and help and that often it was all about:

'Politics not betterment of patients' (Mdp2)

And that, in one experience of going for surgery;

'...the NHS charter is not worth paper it is written on'

Physical and mental health integration

This reflected the special needs that OPMHP encounter when seeking physical health interventions. For example, one person diagnosed with post-traumatic stress disorder experienced complete lack of understanding of the condition and its implications for impending surgery. In addition, recognition of mental illness earlier in life, for example PTSD and personality disorder, and its effect on physical care access was an important but unrecognised issue.

'Experience of NHS charter with surgery – not worth paper it is written on just words prostate surgery – link back to PTSD age 15 –they just wanted reduced chance of infection – didn't take account of past PTSD (Mcp2)

In addition, there was a mismatch between *'...perception of age; perception of services'*. (Mcp2)

As indicated within the **sensitivity** theme, the need to understand normal biological ageing was important, but never taught, and this could contribute to improved mental health by reducing worry.

Loneliness was also mentioned and perceived as *'...a changing ocean'* (Mbp2);

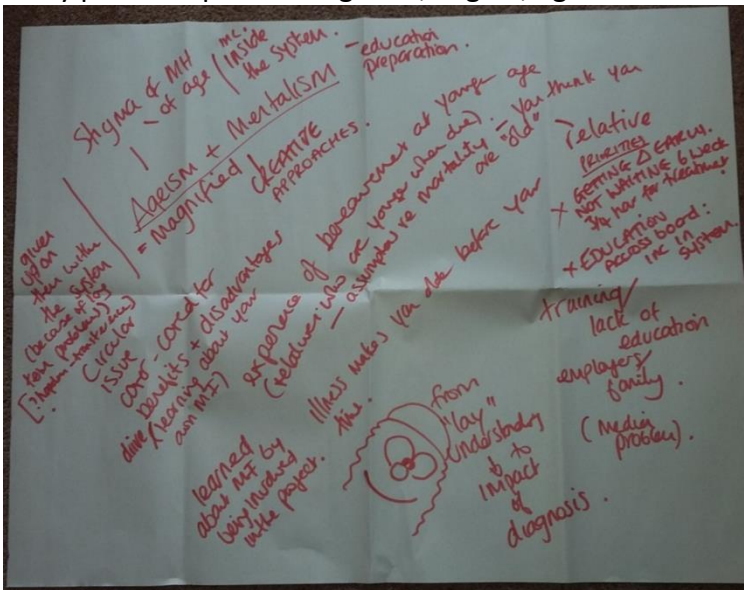
'...if I break my hip – mental state will change'.

Mortality.

There were quite differing views about mortality, and referred to in different ways e.g. life now was a *'Race against time'*. Also, *'...I'm waiting to die – not good for anything'*. (Mbp1) which was a long standing feeling, and in addition ageing without children was implicated *'...when I die I'm dead as don't have children'* (Mbp1).

The reduced life expectancy for people with long term MHP was known about and therefore, **old age** should be defined as lower for OPMHP. It was acknowledged that this in itself affected the number of OP in the population, as there were many people who had had MHP since early life who had *'...already died'* (Mfp1) and therefore were missing.

2 Key points Impact of diagnosis, stigma, ageism and mentalism magnified



The relative nature of 'old' was reiterated and of particular resonance was described as '*illness makes you older before your time*'. As can be seen from the notes shown in the images, there was a focus on ageism. There was particular discussion about ageism combined with discrimination on basis of MHP. The need for creative approaches to resolving this was also raised such as the need for education, training and access to treatments. This was not just an understanding of mental illness by the public and others but also for professionals, in physical health care environments in particular to understand the impact of a diagnosis, the 'label for life' and take its impact and relevance into account during consultations for physical health.

8 Discussion

The objectives of the project were met to a certain extent (though we cannot claim to have defined age appropriate) that is:

- I. To define what matters in mental health care for older people
- II. To discover how older adults perceive and experience being 'older'
- III. To define the concept of 'age appropriate'
- IV. To list research priorities identified by older adults

Although there were only twelve people involved in this project, this in itself is interesting given the richness of information shared and the resonance with other literature and policy as outlined earlier as well as introducing some new ideas, even with such small numbers. However, other

limitations include only including one locality and a lack of diversity in the contributors.

One particular area of interest is the discussion about ageism combined with discrimination on basis of MHP. Although this issue is reflected in the commissioner report¹⁸ to some extent, the point arguably needs to be more robustly made and integrated clearly into national strategy. This is particularly important as the five year forward recommendations make no mention of ageism for OPMH at all²⁰. Some direct discriminatory issues are potentially addressed as one year on the Five Year Forward for Mental Health report says that:

'NHS England has supported Age UK to run a campaign to encourage older people to access services supported further by the new mental health Quality Premium, which asks CCGs to focus on outcomes for people from black and minority ethnic groups, and access to services for older people'²⁰ (p14).

Recommendation 12 is to establish a MH champion to contribute to improving attitudes to MH, but what about ageism? This does not further the issues of direct or indirect age discrimination relayed in attitudes and the general cultural environment found in this project.

The finding about being educated in what to expect in 'normal ageing' is an interesting one, particularly given that the five year forward document²⁰ acknowledges that depression is not recognised in OP for example because it is seen as a normal part of ageing. However, the development of a CQUIN (Commissioning for Quality and Innovation-these are quality standards set by commissioning body's) on recognition of depression therefore only addresses one side of this issue. Educating the public on what to expect in relation to ageing could not only contribute to personal recognition of depression, but also help combat age discrimination. There is clearly a need for more in-depth exploration and explication of this area of practice, as the themes here add further information to the tentative themes suggested regarding the little literature on experience of mental illness in OP outlined earlier such as desire to be part of something, decrease worry. The issue of age appropriateness in particular would benefit from exploration given that policy basis itself on the undefined concept but it has only been shown here to be understood in relation to people with frailty and illness such as dementia. The findings also prompt the following questions:

- 1 What training do staff who see older people in 'ageless' services have in relation to their attitudes, perceptions and knowledge of later life issues?
- 2 How far is the wealth of knowledge that OPMHP hold acknowledged?
- 3 How far is the wealth of knowledge treated as an asset for younger people?

The latter two issues listed above are particularly important for recovery focused services and approaches, perhaps not always well implemented in later life contexts.

There are clearly specific considerations needed with regard to OPMH context as found in this project (which was not about wellbeing in the general population but perspectives of OP with existing MHP). The mental health foundation ²¹, includes discrimination, physical health, relationships and participation in meaningful activities in their infographic on mental health and wellbeing in OP and these issues resonate with our conversations.

9 Conclusion

The literature and policy mentioned earlier makes direct age discrimination a clear issue, but the indirect age discrimination that was talked about in our conversations needs more exploration. The interface between mental and age discrimination also needs further investigation as there is little acknowledgement or evidence of this as a complex problem.

No firm conclusions were drawn in the feedback event regarding what the research priorities would be. However the key issues from our conversations that seem to be potential areas for future work are:

1. the cared for becoming the carer
2. defining old age earlier for OPMH
3. the interface between age discrimination and mental illness discrimination
4. the rhetoric and reality of policy objectives
5. need for useful/meaningful connections

10 Plans: what next?

The findings of this project will first be disseminated through publication on Salford university information repository (USIR), and made accessible to the public. Health Watch in Salford will be made aware of the report. An abstract will also be submitted to the International Mental Health

Nursing Research conference 2018.

The possibility of repeating this consultation project in another area will be considered. In addition, the potential for a research project to build on this 'service user' consultation will be explored, firstly by conducting a series of literature reviews on the topics identified as important in this project. This will lead to development of research proposals and searches for appropriate funding.

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