Guest editorial

Alisoun Milne and Toby Williamson

Alisoun Milne is Professor in Social Gerontology and Social Work at the School of Sociology, Social Policy and Social Research, University of Kent, Kent, UK.

Toby Williamson is Head of Development and Later Life at the Mental Health Foundation, London, UK.

Mental health and wellbeing in later life is not only an important issue for older people but for all of us. It is an opaque and under-researched field and one that is routinely eclipsed by concerns about “mental illness” especially dementia. This tendency not only presents later life as a time of “inevitable” deterioration in mental wellbeing but also marginalises the potential of older people, policy makers, researchers and practitioners to explore the meaning, nature and promotion of mental health in later life.

This special issue aims to provide a counterweight to this dominant, rather negative, discourse by offering a mix of papers each taking a different perspective on mental health and wellbeing in later life. As later life incorporates a long, varied and heterogeneous stage(s) of life the papers – rightly – represent a spread of issues, views and settings. The papers illustrate not only the breadth of the topic but the number of “ways in” to extending knowledge and understanding about mental health and wellbeing in later life.

Dr Tanner’s research paper is based on a diachronic case study of a 97-year-old woman, Harriet, who had originally been interviewed for a previous study 15 years ago. The author explores the factors that both promote and undermine Harriet’s mental wellbeing. Findings suggest that her life is characterised by both continuity and change. Although her world has narrowed and she is physically more dependent than she was in her “third age”; she retains long-term connections and employs cognitive strategies that help her feel content. Of particular note are the themes of: keeping going (keeping active, keeping stable and keeping balance); staying me (continuity and self-affirmation); and slippery slope (threats and resources). One of Harriet’s most important resources is the support she receives from her family and paid carer. Her previous efforts to “retain independence” have been replaced by an acceptance of her changed situation and deteriorating health. Harriet accepts her reliance on others; she acknowledges her losses but does not dwell on them.

Harriet employs strategies to retain a positive emotional state and a continuous sense of self. Dr Tanner notes that the “essence of her subjective well-being seems to reside in the threads of continuity she is able to preserve”; these include her home, routines, social interaction and identity derived from her key relationships. Although this research is based on only one case study it highlights a number of important issues. The findings challenge existing narrow constructions of the “fourth age” highlighting, in particular, a need not to assume agency is lost at this stage of life but that it takes a different form. Work on the fourth age needs to be more nuanced, capturing evidence about how identity is preserved, relationships maintained and difficulties negotiated. Dr Tanner’s findings challenge the dominant view that the fourth age is a state of abjection and absence. This case study not only offers us unique insights into an older woman’s management of change through time but it also provides lessons about methods when working with a frail elderly respondent. The fact that Dr Tanner has known Harriet previously is pivotal and her patient, time rich and empathic approach to “having a conversation” with Harriet ensured that she gathered rich data about sustaining the self in the fourth age.

Dr Sullivan, Professor Victor and Dr Thomas’s paper explores older people’s perspectives on the meaning of loneliness in their daily lives. Despite a significant emphasis in policy, research and services on the nature and alleviation of loneliness in later life, there is a limited focus on the views of older people themselves. Research also tends to define loneliness as a linear construct whose dimensions are fixed and universal, rather than a more complex, dynamic and multi-dimensional one. The paper draws on qualitative data from two separate samples of older people who identified as either “lonely” or “sometimes lonely” in earlier survey research. A number of key themes emerged. An overriding issue relates to the challenge of describing and capturing “loneliness”.

In part this reflects its association with shame and stigma and in part it relates to its opaque nature. Some participants described it as a physical sensation such as “cold” whilst others referred to it more philosophically, e.g. “the soul being alone”. Participants viewed loneliness as a subjective individual experience that has both internal and external dimensions. The notion of loss was a key theme; loss of spouse, work and health. The co-existence of adversity, i.e. feeling lonely, alongside strength, i.e. overcoming feelings of loneliness, was also identified.

Vulnerabilities to loneliness generated via meso- and macro-level factors also emerged. The nature of a person’s community, reduced access to social capital and societal attitudes to older people are all examples. The intersection of these with individual lifecourse experiences such as widowhood and ill health contribute to the development of loneliness. These findings bring a new lens to the loneliness discourse, highlighting the role played by contextual factors in creating or amplifying risk.

In terms of use of agency and mechanisms participants themselves could deploy to mitigate the impact of loneliness, “keeping busy”, routines, taking up new interests and maintaining or seeking out new social opportunities were all identified. Dr Sullivan, Professor Victor and Dr Thomas’s research suggests that loneliness is a complex phenomenon that may need to be understood differently. Its construction as a “social problem” to be resolved by investing in an “initiative” or a community service fails to appreciate the fact that it is a subjective, dynamic and temporal experience and one that may be a response to both individual and structural issues. These findings may have implications for the way loneliness is conceptualised, explored and responded to by researchers, policy makers and practitioners working with older people.

The involvement of older people in decisions about their lives, in services they may need, and how involvement can benefit their mental health is the focus of Dr Crepaz-Keay’s position paper. The author rightly identifies that most conversations about older people’s mental health quickly turn into discussions about mental illness and services for people with dementia. Far less attention is paid to the maintenance of mental health in later life and what promotes it. The fact that current (and future) generations of older people will have grown up in a culture of involvement is also relevant.

The author explores involvement through three lenses: strategic, operational and individual, drawing out key themes. The Commission for Patient and Public Involvement in Health (CPPIH), service users delivering training for professionals, and self-management and peer support are described as successful examples in these three areas, with benefits for older people’s mental health. He characterises the historical journey from service user as passive patient, through self-management, to a community-based model of relationship-related support as mirroring the three states dependency, independence and interdependence.

In the second half of his paper the author reviews the impact of involvement on older people’s mental health, clustering them under the five headings of: physical health, poverty, discrimination, participation in meaningful activity, relationships. There is evidence that the involvement of older people on the CPPIH fora influenced an emphasis on the connections between physical and mental health for both “sets” of services, and at individual-level involvement in peer support activities has been evidenced as benefiting users’ overall health. In relation to poverty the author give examples of how handyperson services and older service users pooling knowledge about benefits and entitlements are examples of providing services with the whole adult lifecourse in mind. This can ensure that older people can remain in their communities and are not be obliged to incur additional expenses for adaptations. Involvement can challenge discrimination, through increasing the visibility and roles of older people with longer term experience of involvement, and highlighting their contribution to service development and as educators. The peer support role can provide a sense of purpose and improve confidence. The development and enrichment of relationships is also (often) a by-product of involvement activities. The author concludes that although later life often contains a number of challenges, active involvement at the strategic, operational and individual levels offers significant opportunities to protect and improve older people’s mental health.

Mr Tarran Macmillan’s research paper focuses on hospital discharge of older people and the ways in which opportunities to promote mental health and wellbeing may be missed. It is based

on a Healthwatch England Special Inquiry, drawing on the experiences of 1,300 older people. Hospital discharge, the author reflects, has received a great deal of coverage in policy, research and practice literature. It represents a transition and sits on the intersection of primary and secondary healthcare and social care. The Healthwatch project identified a number of generic findings about hospital discharge. These were: a lack of continuity of services, perception of stigmatised treatment, lack of patient involvement and older people – and their carers – feeling they were leaving hospital without the full range of needs being considered or appropriate post discharge support.

Four themes were identified relating specifically to mental health and wellbeing. First, there were very polarised views about the impact on mental health of hospital discharge settings. Negative experiences related to older patients feeling totally disempowered during their hospital stay, e.g. having little control over when they ate or used the toilet. These patients described lengthy delays, lack of medical advice, uncertainty and confusion, and unclear post discharge arrangements; this caused anxiety for them and their families and engendered feelings of helplessness. Impaired physical ability and reduced capacity to perform activities of daily living was a key issue highlighted under the second theme – coping after being discharged home. Many participants felt they had been discharged “too early” creating worry and stress and threatening the older person’s sense of independence. Implications of discharge for carer stress is the third theme. Carers, often elderly themselves, are placed under enormous pressure to accept their relative back home and support them, even if their needs have significantly worsened. What helps carers manage is information, advice and signposting to support services, and consideration of their needs alongside those of the older patient. The final theme – care and involvement of older people with dementia – highlights particular concerns about this vulnerable group of patients. As hospitals can often be disorienting for people with dementia and their needs are often complex, special care needs to be given to discharge planning. The study suggests that people with dementia are often discharged home without any information being shared with the carer; this creates high levels of stress and distress for both. The author concludes by arguing for a much more person centred integrated model of care around hospital discharge that appreciates both the physical and mental health of older people and their carers.

Ms Rasa Mykelye and Professor Milne’s paper offers a scoping review of the role played by micro-cultures in long-term care in shaping residents’ mental health and wellbeing. This is an under-researched issue despite the fact that there are a growing number of older people living in long-term care and that many residents have mental health problems, especially dementia and depression. The review followed the framework developed by Arksey and O’Malley (2005). It offers a rigorous approach to reviewing literature in areas that are uncharted, complex and broad. Overall 24 papers were identified.

Although varied and complex, the evidence base is characterised by: multiple or qualitative methods (mainly ethnographical or observational methods); a focus on residents’ or staff and residents’ experiences; significant differences between studies in conceptualising and investigating “mental health” (most looked at either “wellbeing” or “quality of life”); and exploration of “care culture” or “organisational culture” in place of micro-culture. In terms of aims most studies intended to enhance understanding of the topic and regarding focus a third of studies looked at one specific dimension of a micro-culture (e.g. abuse, staff knowledge of depression) while two-thirds explored more than one dimension.

The review identified factors within a micro-culture that enhance, or undermine, resident mental health and/or wellbeing. Factors that enhance it are: dignity, spiritual wellbeing, enjoyment of food, offering choice, empowerment of residents, flexibility within routines, welcoming atmosphere, a sense of community, the care home being part of the wider community, higher levels of staff commitment, staff being present and engaged, homeliness and a culture that promotes a sense of belonging. Factors that undermine resident mental health are: lack of individualised care and support, staff being absent and disengaged, staff lacking knowledge about depression, a task-centred approach to care, nursing home setting (vs residential care and assisted living), staff not seeking to understand residents’ perspective, and moving through “staged care” (i.e. different levels of care), both residents and staff striving to uphold order, apathetic staff approach, rural location, large care home, and low staffing levels.

Overall, the review found that micro-cultures in long-term care are complex, multi-faceted and multi-directional; they include social dynamics as well as structural and environmental factors. Initiatives to promote the mental health and wellbeing of residents rarely consider micro-cultures in any holistic way. If we are to develop interventions, it is important to invest in research that explores the nature and systemic influence of the whole micro-culture, rather than one aspect of it, on mental health.

The parameters of both mental health and later life are extremely broad. As such, identifying the focus of work relating to the intersection of mental health and later life is a challenge. This is in contrast to work on dementia where the focus is much clearer. It also lacks the sense of urgency that issues such as children's mental health tend to attract. Ensuring good mental health in later life is a complex task for researchers, policy makers and practitioners and realistically, cannot be achieved for everyone, all of the time. Although different in their approaches and topics, the papers in this special issue capture some of the key themes that characterise this complex terrain and raise some searching questions. Where does responsibility for addressing mental health in later life lie? How can it be equitably shared between individuals, families, communities, services and wider society? How do we ensure each has the resources or capabilities to achieve this task? And while services working with older people may never be perfect, in the twenty-first century it cannot be right that they directly contribute to undermining mental wellbeing. Good mental health in later life is experienced, and achieved, by many older people, and the positive roles played by others is often a crucial factor. The authors hope this special issue will contribute to the developing public narrative about the importance of mental health in later life and fuel interest and investment in both individual and collective action to promote and sustain it.