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An interpretive descriptive study: the exploration of the determinants influencing the use and provision of services for older people with functional mental illness.

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An interpretive descriptive study:

The exploration of the determinants influencing the use and provision of services for older people with Functional Mental Illness

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A thesis submitted in partial fulfilment of the requirements of The Robert Gordon University, for the award of Doctor of Philosophy (PhD)
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Declaration

I declare that this thesis is my own work, and that no material contained in it has been submitted for another academic award.

Julia Wells

March 2023

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I wish to dedicate this study to the memory of my late Grandparents.

Douglas J. S. Henderson and Mariette Henderson

Abstract

Abstract

Author: Julia Wells

Title: An Interpretive Descriptive Study; The exploration of the determinants influencing the use and provision of services for older people with Functional Mental Illness

Aim: The overall aim of this research study was to explore the determinants influencing the use and provision of services for older people with functional mental illness.

Background: The prevalence of functional mental illness (functional mental illness encompasses illnesses such as depression, bipolar disorder, schizophrenia, personality disorder and anxiety disorders) in older adults is notable but, to date, has received less research and attention in national and international policy than dementia. Globally, depression is the leading cause of illness burden in older people, affecting one in five people over age 60. Older adults with functional mental illness may have a life expectancy of up to twenty years less than the rest of the population. There is little qualitative research exploring the use and provision of services for older people with functional mental illness. Therefore, further exploration is required.

Design and Methodology: An interpretive descriptive qualitative study was conducted with two phases of data collection and underpinned by an integrative review of literature between the timeframe of 31st of October 2017 to 31st of October 2022. The review findings underpinned two phases of data collection and analysis for this interpretive study. Phase one comprised of a focus group of three healthcare professionals and three individual interviews with healthcare professionals. Phase Two consisted of four older people with functional mental illness, one family carer and two healthcare professionals. Data was collected using semi-structured interviews between the 18th November 2019, and the 19th of June 2020. Reflexive thematic analysis was used to analyse and synthesise data.

Main Findings: During the thematic analysis process the Availability, Accessibility, Acceptability & Quality Framework (United Nations International Children's Emergency Fund 2019), was used as a framework and lens to interpret this study's findings. This framework was selected and justified in its use given its focus on accessibility and barriers to health services and therefore relevant to an exploration of the determinants influencing the use and provision of services for older people with functional mental illness.

Three key concepts were generated from this study;

1) *Impact of "place" on the person with Functional Mental Illness,*

2) *Relationship building with the person with Functional Mental Illness, and*

3) *Managing Functional Mental Illness in everyday life.*

It emerged that older people with functional mental illness living in remote and rural areas, at times choose not to access support for their mental health even if these services were perceived to be accessible and available to them. This was due to travel, and acceptability of functional mental illness in the context of stigma, stoicism and being independent. However, general practitioners were also perceived by healthcare professionals to treat older people with functional mental illness in remote and rural areas preventing onward referral to secondary care. Older people with functional mental illness living in urban areas were perceived by healthcare professionals to be more likely to access secondary services for their mental health.

Furthermore, relationship building with healthcare professionals was found beneficial by older people in their self-recovery, as they found talking particularly

beneficial towards their recovery. This speaks to the importance of taking time to build relationships as a component of quality care and older people with FMI felt accepted and healthcare professionals accessible to them. To healthcare professionals, relationship building was more complex, and enabled robust assessment and management of risk of self-harm or risk of others.

Finally, it emerged that to manage functional mental illness in everyday life healthcare professionals introduced several quality, available interventions to older people with functional mental illness. This included guided discovery, goal setting, distraction techniques and use of the Wellness and Recovery Plan. This highlights how healthcare professionals can provide, accessible, quality interventions to older people with functional mental illness to improve their resilience and recovery journey.

Contribution to Knowledge: the findings of this study add to understanding FMI and older people with three significant considerations which help to illuminate experiences of older people with FMI. 1). the connections between the *place* where people experience FMI and those who offer support. 2). *relationship building* emerged as important to the management and recovery of FMI. Taking time to build relationships was viewed as essential to HCPs who saw these as critical to interventions which would help them support older people with FMI. 3). *managing FMI in everyday life,* was a key outcome for older people, carers and HCPs. How people manage and live with FMI are components affecting how each older person experiences their recovery journey. HCPs in this study used a range of strategies and interventions to assist in this endeavour.

Combined these three concepts impact on decisions older people with FMI and their family carers, make about accessing mental health services. Likewise, these concepts influence HCPs decision making when planning interventions and delivering services. Therefore these key concepts help to provide an in-depth understanding of perceptions and experiences of FMI in older people within the context of this study.

Recommendations for Practice:

- Educators should highlight the benefits of *relationship building* to a person's recovery, and the importance of preparing healthcare professionals to undertake complex risk assessments.
- Commissioners and service designers should consider the impact that place has on for the experiences of older people with functional mental illness living in remote and rural areas, compared to urban areas when designing services. Services should be designed for people based upon accessibility and availability regardless of location.
- Healthcare professionals should recognise that face-to-face first assessments contribute to relationship building with older people with functional mental illness and their family carers before virtual follow up by telehealth.
- Policymakers and service commissioners need to consider and establish pathways to support the needs of older people with functional mental illness who are in crisis to ensure quality care and support.
- Healthcare professionals have a key role as educators to older people with functional mental illness and their family carers by highlighting the interventions that older people with functional mental illness, family carers and healthcare professionals use to aid recovery.

- HCPs and service planners to consider the contextual importance of availability, acceptability, accessibility and quality issues in services for those experiencing and supporting FMI in older people.

Keywords: older people, functional mental illness, place, relationships, access, availability, family carer, healthcare professionals.

Contents

Abbreviations

AAAQ	Availability, Accessibility, Acceptably and Quality
CASP	Critical Appraisal Skills Programme
CBT	Cognitive Behavioural Therapy
CMHN	Community Mental Health Nurse
CMHT	Community Mental Health Team
ECT	Electroconvulsive Treatment
FMI	Functional Mental Illness
GP	General Practitioner
HCP’s	Healthcare Professionals
HSCP’s	Health and Social Care Professionals
IRAS	Integrated Research Application System
IT	Information Technology
MDT	Multi-Disciplinary Team
NICE	National Institute Clinical Excellence
OAMH	Older Adult Mental Health
OAMHT	Older Adult Mental Health Team
OT	Occupational Therapist
SCN	Senior Charge Nurse
SERP	School Ethic’s Research Panel
SIGN	Scottish Intercollegiate Guidelines Network
VC	Video Conference
WHO	World Health Organisation
WRAP	Wellness Recovery Action Plan

Glossary of Terms

Adult Mental Health Services	Mental health services for those aged between 18 and 64
Decider skills	Training that uses aspects of Cognitive Behavioural Therapy
Family Carer	Family member who provides care and support, unpaid due to an illness
Formulation	Attempts to examine a patient’s problems, how they arose, and what causes them to continue
Functional Mental illness	Applies to mental illness other than Dementia
Mindfulness	The practice of bringing one’s attention to the present moment
Older Adult Mental Health Services	Mental health services for those aged over 65
Primary Care	First point of contact for NHS, includes General Practice, Community Pharmacy, Dentist and Optometry
Secondary Mental Health Services	Usually require referral from a GP and are a specialist mental health service
STORM	Suicide prevention training

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Chapter 1: Introduction

1.1 Introduction

This study was an exploration of the determinants influencing the use and provision of services for older people with Functional Mental Illness (FMI).

This chapter describes firstly, my interest in FMI and older people from my own experience as a mental health nurse. Next, an historical overview of mental health services within the United Kingdom (UK) is provided and then, the epidemiology of FMI in older people. This is followed by Older Adult Mental Health (OAMH) symptomology and treatment. I then highlight differences between age defined and ageless services. I follow this with an overview of International, UK and National policy and then a brief overview of this study. Finally, I provide an outline of the chapters in this thesis.

I have chosen to write in the first person in this thesis. This is justified as qualitative research represents lived experience and perceptions, including that of the researchers (Wertz et al. 2011).

1.2 My Professional Background and Interest in Older People with FMI

In the interest of trustworthiness, it is important I acknowledge my position within this study. I have a nursing background of 23 years, which is predominantly in OAMH. During my career to date, I have undertaken numerous roles such as a Community Mental Health Nurse (CMHN), Senior Charge Nurse (SCN), Liaison Nurse in Acute Hospital Services, Nurse Consultant and Clinical Director, all in OAMH services within one area in Scotland, UK. At the outset of this study, I was Nurse Consultant and then took on the additional role as Clinical Director. Four years later I moved into a Service Manager role for Mental Health and Learning Disability Services in the same geographical area. My current role is

Chief Nurse for Mental Health and Learning Disabilities Services in the same area, a post I started in May 2022.

My past professional experience instigated my interest in certain areas, for example, age defined versus ageless services, risk assessment and risk management, and person-centred care. This experience led me to have some preconceived ideas at the outset of this study, particularly around how services within mental health are designed (discussed in greater detail in Chapter 3; Section 3.2.2).

I was always intrigued why people in my area of work in Scotland upon reaching age 65 are transferred from Adult Mental Health Services to OAMH services (Chapter 3; Section 3.3.4). This appears to be an arbitrary decision, not informed by research or policy.

Furthermore, I recall many people in my caseload were offended to be transferred to an OAMH service upon turning that age- not considering themselves to be an older adult. Some also described a sense of loss, and a sense of insignificance and abandonment, that a service which had cared for them for years suddenly abandoned them, with no real rationale as to why.

This view appears more predominant in recent years as people are living longer and some still work at and beyond 65 years of age. I've had many discussions with peers over the years around this, with colleagues having mixed views. Some felt OAMH services have specialist skills that relate to the complexity of ageing and co-morbid mental health and physical health needs, and people should be transferred at 65 to receive specialist support. In contrast, others viewed that services should be more person-centred and flexible, dependent on the needs of the individual and that age was of no significance.

I became interested in undertaking research when I did my Master's degree course in 2008 - which focused on self-harm and risk management. I chose to focus on risk management because at that time I had started a post in a Department of Psychological Medicine which was predominantly around self-harm assessments. Prior to this, I had worked in OAMH and was struck that in comparison to OAMH, no evidenced-based assessment tools were used in the department. I was keen to understand if the use of evidence-based tools versus tacit knowledge made a difference to patient outcomes.

It is useful for this section to define what evidence-based practice is. Straus et al. (2011), describe it as a process which integrates the best available research evidence in consultation with the patient. It is viewed as the gold standard in delivering safe, person-centred care (Kumah et al. 2022). However, there is current debate within the world of nursing around the useability of evidence-based practice with some preferring evidence informed practice, with some viewing that it gives more flexibility regarding the nature of evidence including nursing expertise and patient experiences (Kumah et al. 2022; Woodbury et al. 2014). Within this study, I have elected to use the term evidence-based practice as exploring and generating knowledge from practice and for practice fits with the interpretive descriptive design of this study. Furthermore, evidence-based practice is linked to drawing on different sources of evidence, reflecting on experiences of practice and the learning which occurs. Applying evidence to practice is a complex and context specific activity and essential for decision making.

Since undertaking my Master's course and learning more about research, delivering evidenced-based care has become more important to me as it is fundamental to clinical outcomes. In addition, I strive to advance in my career to a Director of Nursing position and consider the ability to undertake and analyse research pivotal to professional credibility, my personal development, and necessary for such a senior professional position.

I’ve long had a desire to undertake a PhD and when I secured my Nurse Consultant post within OAMH, it was the opportunity I had been waiting for. Undertaking research formulated one quarter of the role specification, in line with the four pillars of advanced nursing practice (NHS Education Scotland 2023). A further pillar relating to the four pillars of practice is leadership, and in both my previous nurse consultant role and current chief nurse role, the use of evidence-based practice to underpin practice was essential to these posts to support nursing staff. I applied for a PhD at Robert Gordon University and was successful in being offered a place.

This study has been undertaken on a part time basis, over six years, whilst continuing to work full time. The next section of this chapter provides an historical overview of mental health services within the UK.

1.3 Mental Illness: An Historical Perspective in the UK

Mental health services have advanced over the past one hundred years within the UK. It is almost inconceivable to consider it was in 1930 that the Mental Treatment Act amended the 1890 Lunacy Act (Hilton 2020). Until 1930 people with mental health illnesses had to wait until their condition worsened enough for them to be “certified” and admitted to a mental health facility under the Lunacy Act.

The new legislation in 1930 made some attempt to address stigmatism associated with mental illness by introducing two categories for enabling admission to a mental health hospital - “voluntary” and “temporary”. If a voluntary patient wished to leave hospital, they were required to give 72 hours’ notice and a support plan was put in place following discussion with family members (Hilton 2020).

Throughout the Victorian era, people with mental illness continued to be cared for in large style asylums that were often placed far away from communities and public view, adding to further stigmatisation of mental illness (Hilton 2020). Some interest began to build around mental health in the second war world with servicemen returning with Post Traumatic Stress Disorder (Hilton 2020).

In 1959, The Mental Health Act was passed which stated that entry to a mental health hospital was a medical decision, not a legal decision (Parliament of the United Kingdom 1959). In 1961, there was a further shift around mental health care with Minister for Health, Enoch Powell's government advocating that asylums should be closed and people with mental illness should be cared for in general hospitals or in the community (Houston 2019). In tandem with this paradigm shift in care, there were great advances in psychotropic medication meaning people with mental illness could be treated more effectively (National Institute for Health and Care Excellence (NICE) 2022).

In 1971, the government proposed a seismic shift in mental health service provision with a vision to abolish all mental health services and where general primary care were to offer care to this population group. This vision was not realised. However, in 1990, the Community Care Act came to fruition, advocating community-based care for all people, including those with mental illness (particularly younger people), with a shift away from institutional care (Thornicroft 2018).

Simmonds et al. (2001), undertook a systematic review to evaluate community mental health services researching literature between 1980 and 1997. They concluded from the 5 relevant studies to their review question, that CMHT management was effective in relation to accepted treatment, reduction in hospital admission and reduction in suicide.

A review of mental health history by Hilton (2020), documents the shift towards community care for mental illness focused largely on the needs of younger people, meaning services for older people were left behind and largely under resourced. The demarcation between Adult Mental Health Services and Older Adult Mental Health began around the 1990's with the view there was a need for separate older mental health services, as people are more likely to develop dementia and have physical health co-morbidities in later years (Hilton 2020; Warner 2014).

A further paradigm shift - particularly in mental health practice - was the introduction of the recovery model which came into play in the early 1990's. This model challenged traditional psychiatric approaches with a move away from the medical model towards a focus on enabling the patient to build resilience and be empowered to make choices about their treatment (Jacob 2015). Mental health nursing has embraced the values of recovery-focused practice and led the recovery movement in the UK (Buchanan-Barker & Barker 2008; Santangelo et al. 2018).

The next section of this chapter gives an overview of how contemporary OAMH services are configured in Scotland.

1.4 OAMH Symptomology and Treatment

OAMH services are categorised into two specialities; organic illness (e.g., dementia and delirium) and FMI. FMI is described as a mental illness, other than dementia and is an umbrella terms for illnesses such as schizophrenia, bipolar disorder, personality disorder, anxiety, and depression. Symptoms of these illnesses usually persist into old age (Denning & Milne 2011). As highlighted earlier in this introduction FMI is an umbrella term for mental disorder distinct from dementia.

Psychotic illness (e.g., Schizophrenia, Bipolar) has two main symptoms;

Hallucinations: where a person may hear, see, or feel something that does not exist out with their mind, but feels very real to the person who is experiencing this. An example of this would be a person hearing voices (Meriam-Webster 2023). These symptoms can be extremely distressing for people and may influence their engagement in treatment and therapies (Hayward 2018).

Delusions: where a person has strong beliefs that are not shared by others, for example, someone may believe there is a conspiracy to harm them (Meriam-Webster 2023). Furthermore, Skelton et al. (2015), suggest people can also experience delusions of grandeur where the person believes they are in a high position of authority or famous. Delusions can also manifest as the person experiencing strange beliefs about their body image or that they have something wrong with their body.

The treatment for psychosis typically is anti-psychotic medication in conjunction with psychological therapies and health education (NHS 2022). Depression symptoms may present as loss of enjoyment, no hope for the future, loss of appetite and poor sleep patterns (NHS 2022). For depression and anxiety, treatment is typically anti-depressant medication and / or psychological therapies such as cognitive behavioural therapy (CBT). In very rare cases some people may require electro convulsive treatment (ECT) (NICE 2009).

There are illness specific clinical guidelines that span across the adult lifespan (Age 18+) for bipolar affective disorder; schizophrenia; depression; anxiety or personality disorder. The National Institute for Health and Care Excellence (NICE) have evidence based guidelines and recommendations for health and social care professionals in England but applicable in Scotland. These guidelines are intended to inform health and social care professional’s decision making in relation to care and treatment. The following NICE guidelines relate to this study; NICE guidelines (2022) for depression in adults [NG 222], NICE guidelines (2020) for generalised anxiety and panic disorder in adults [CG 113], NICE guidelines (2009) for Borderline Personality Disorder: recognition and management [CG78] and finally NICE guidelines (2014) for Psychosis and schizophrenia in adults: prevention and management [CG178]. In very brief summary these guidelines all highlight the importance of relationship building, awareness of stigma associated with mental illness and involving the patient and where appropriate family carer in decisions about their care and treatment.

The next section of this chapter gives an overview of epidemiology in FMI.

1.5 Functional Mental Illness: Epidemiology

Currently, FMI is estimated to affect one in four people in the general adult population and 15% of people aged over 60, worldwide (WHO 2017). This is likely to cause unmet need in the population of older people with mental illness as mental health services are challenged by increasing need (Abdi et al. 2019).

Globally, it is predicted depression was the leading cause of illness burden in older people by 2020 and will affect one in five people aged over 60, with severe depression expected to increase from present day by 49% by 2026 (Royal College of Psychiatrists (RCP) 2018). A systematic review by Hu et al. (2022), identified that depression is becoming more prevalent in older adults due to poor overall health in this population group and a lack of social support.

The prevalence of FMI in older people is now discussed.

Schizophrenia is estimated to affect 0.5% of the world's population aged over 60 (Loebach-Wetherhell & Jeste 2017). A systematic review undertaken by Charlson et al. (2018), illuminated that population growth and ageing has led to an increased disease burden caused by schizophrenia. Anxiety disorders are reported to affect one in twenty older people (Royal College of Psychiatrists 2018; Creighton et al. 2015; Kan et al. 2021). A literature review undertaken by Ljubic et al. (2021), revealed that 25% of all patients with bipolar disorder are aged over 65. Additionally, a literature review by Penders et al. (2020), revealed that there is limited research into the prevalence of personality disorders in older people. However, in studies they reviewed, a prevalence rate of approximately 10% of older adults were found to have a personality disorder.

As people with FMI become older, they are also more likely to develop a physical illness (Government UK 2018). Physical co-morbidity is one reason why, historically, Older Adult has been an age-defined service. With more of a focus in contemporary times on equality, it could be argued whether age-defined services are now appropriate (Saad & Bangash 2016).

There exists a tension currently as the population of older people continues to grow and it is anticipated that for the UK, that there will be an additional 8.6 million people aged over 65 in the next 50 years (Storey 2018). However, the imbalance in resources in England alone would cost £2.4 billion a year to redress the issue (Warner 2015).

Underfunding of OAMH services means there are gaps and a lack of services being provided (Age UK 2016). In Scotland, the Scottish Government have committed £13 million to mental health services in Scotland, it is unclear how much of this is aligned to OAMH services (Scottish Government 2022).

1.6 Ageless Versus Age Defined Services

There is much debate about ageless services versus age defined services, with limited research informing this. Arguments in favour for age defined services are that a large number older people with FMI will go on to develop dementia (Saad 2016; Warner 2018).

The mix of elderly and young people in a mental health ward places elderly people at risk from unwell fitter younger people and finally many older people will go on to develop a physical co-morbidity (Saad 2016; Warner 2018; Abdul - Hamid et al. 2016). Others argue that ageless services offer a more person-centred approach to care and treatment of this population group (Katona et al. 2009), and a significant driver for service commissioners to develop this model of care is the UK Government Equality Act (2010), which states that people regardless of age should be entitled to the same access of health support. Age UK (2019), advocate that older people should have the same access to health care as younger people. They highlight that treatment rates drop disproportionately for the over 70 age group. They argue services should be delivered according to need not age.

At the outset of this study, I attempted to find in the literature - to no avail - more detail as to how mental health services are configured in Scotland. I therefore emailed all health boards and discovered that twelve (out of fourteen) had age defined OAMH services.

A variety of services exist to meet the needs of older people. Primary Care general practitioners (GPs) will provide support to older people for milder symptoms of mental illness, for example, mild anxiety and mild depression. Secondary Mental Health Services, which usually require a referral from Primary Care can be hospital or community based. These services will support people with mental illnesses such as severe depression, severe anxiety, psychotic illnesses, dementia, and people experiencing suicidal thoughts (RCP 2018).

The referral criteria for OAMH services are defined by the Royal College of Psychiatrists (2015) thus:

Primary dementia, regardless of person's age

- Mental disorder and physical illness or frailty that contributes to, or complicates the management of the person's mental illness, regardless of their age.

- Psychological or social difficulties related to the ageing process, or end of life issues, or the person's opinion that their needs may be best met by a service for older people; this would normally include people over 70 years of age.

OAMH secondary services typically consist of a Consultant Psychiatrist, Mental Health Nurses, Community Mental Health Nurses, Occupational Therapists, Social Workers, and Psychologists.

1.7 Policy

International Policy

There is little international focus on older people with FMI. In general terms internationally, Article 25, under the Human Rights Act, states "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (Office of Human Commissioner for Human Rights (OHCHR) 2023).

Furthermore, Article 25 states that where possible, health services will be community based and where possible planned and delivered in co-operation with the people concerned (OHCHR 2023). This is important in relation to equity of accessible services to older people with FMI.

The World Health Organisation (2017) factsheet, recognises the challenge of the ageing population. It highlights that mental health is as important in older years as it is at any point across the lifespan and suggests the following strategic needs for the older adult population.

“Training for health professionals in providing care for older people.

Preventing and managing age-associated chronic diseases including mental and neurological and substance disorders

Designing sustainable long term and palliative care and

Developing age friendly services and settings.” (WHO 2017).

The next section of this thesis highlights UK policy relevant to OAMH.

UK Policy

Health and Social Care is a devolved power from the UK Government to the Scottish Government (Scottish Parliament 2023). NHS Scotland is comprised of fourteen territorial health boards; these health boards are responsible for delivering acute and primary healthcare to meet the populations needs (NHS 2023). In 2016, the Scottish Government developed 31 Integration Authorities who have delegated responsibility for local health and social care services, previously managed by Council and NHS Boards (Scottish Government 2016). Councils are defined in Scotland as being local government, which work independently from central government. They are responsible for the provision of public services including education, social care, waste management, libraries, and planning (Scottish Government 2023).

In terms of mental health, the UK government’s mental health and wellbeing strategy has a strong focus on early intervention and getting children’s mental health right. Furthermore, there is a strong focus on supporting people in crisis. Arguably, there is no focus on older people mental health despite the challenges of the ageing population (Department of health and Social Care 2022). However, the English NHS have a mental health delivery plan which has a specified section on older people’s mental health, including those with functional illness. This is absent in Scottish policy as discussed in the next section.

The Delivery Plan highlights that CMHTs will work closely with Primary Care to deliver “multi-morbidity” care. This focus is important as many people with severe mental illness will also have a co-morbid physical illness at any given time (Public Health England 2018). Furthermore, community-based crisis teams will deliver rapid responses to prevent unnecessary admission, and in-patient care will be encouraged to have a greater focus on physical health needs (NHS 2019-2014).

The UK introduced the equality act in 2010, which legally protected people from discrimination in both the workplace and wider society (UK Government 2015). The UK Government has also published research briefings on Mental Health Policy in England which focuses on the response to the COVID-19 pandemic, and for mental health, particularly highlighting that known patients should continue to receive support and addressing any inequalities (UK Government 2022).

The paper then highlights the ongoing consultation of the ten-year mental health and wellbeing plan which builds upon the previous five-year strategy for mental health (UK parliament 2022). This plan is aimed at people with lived experience, society, policymakers, and health providers. The mental health and wellbeing strategy incorporates, for the first time, mental health and wellbeing in one strategy (UK parliament 2022).

The next section of this chapter focuses on Scottish national policy on mental health.

Scottish Policy

In terms of national strategy and guidance, much work has focused on dementia, in part due to The Banerjee report (2009), which strongly advocated that non-pharmacological approaches should be utilised in managing what was referred to at the time as ‘challenging behaviour’, for example verbal and physical aggression, irritability and apathy. Also, Scottish Intercollegiate Guidelines Network (SIGN) 86 - managing people with dementia (under review) - advised strongly against the use of antipsychotics for challenging behaviour as the first route of treatment preferring non-pharmacological approaches be used instead, such as engaging in activities, and aromatherapy.

In addition to this, the Mental Welfare Commission (MWC) undertook themed visits to a selection of specialist dementia wards across Scotland and published their findings in their 2014 document Dignity and Respect (MWC 2014). This paper was highly critical of care delivered to people with dementia in relation to the management of stress and distress, carer involvement, the environment and rights-based care. The combination of these three papers led to The Scotland's National Dementia Strategy (Scottish Government 2014) with a strong focus on positive language and renaming challenging behaviour, stress, and distress. Commitment eleven of the strategy focused purely on improving care and treatment for people with dementia.

In addition, Alzheimer's Scotland were commissioned by the Scottish Government to create a Dementia Nurse Consultant post for each health board whose focus was to improve standards of care for people with dementia in both in-patient and out-patient settings. The focus on dementia at a national level has been welcomed.

The Scottish Government have also developed their draft mental health and wellbeing strategy, which is out for consultation, and mirrors the English strategy with the addition of adding a workforce chapter (Scottish Government 2022). Again, like England, this strategy does not have a focus on older people. This being likely because the strategy has consideration to cover all age groups under one umbrella. However, unlike England, which has a separate section – the English Mental Health Delivery Plan (NHS 2019-2014) - in my view, there are a lack of strategies in Scotland which focus on FMI in older people. The Scottish policy does not appear to have a specific mental health delivery plan for older people with FMI.

In addition to the development of the mental health and wellbeing strategy, Scotland has undertaken a review of mental health law. The *Scot Review* makes several recommendations including that all people should be treated equally and fairly. This includes sex, disability, race, and age. They also suggest the term "mental disorder" should change to "people with a mental or intellectual disability". Furthermore, peoples' human rights should be respected and people with mental illness should be treated without stigma (Scott 2022).

In response to addressing inequalities, the Scottish Government have introduced the Fairer Scotland Duty: Guidance for Public Bodies (2022), which provides statutory guidance for public sector bodies to address inequalities caused by socio-economic disadvantage, including age.

In Scotland, the Scottish Patient Safety Programme (SPSP 2019), have done much work to improve mental health practice. In 2019 they published "From Observation to Intervention" which was a paradigm shift in mental health care, as it moved away from a restrictive close-observation based approach to increased interventions as and when people needed this. The guidance focuses on continuum based person-centred care, where people with mental illness and families are considered equal partners. The paper focuses on early recognition of deterioration in patients and potential triggers of harm. Then, considering early recognition of deterioration in mental state, HCPs will use personalised responses all patients using a relational-based approach to care and treatment (Scottish Patient Safety Programme 2019).

Local Policy and Context

On a more local level, one of the health boards in Scotland was the subject of an independent review of their mental health services. The review made ten recommendations and focused on all staff working in mental health services being given the opportunity to contribute to decisions relating to; service design, staff raising concerns being listened to and that there be systems and process in place to support staff- with a focus on relationship building and empowerment.

On a more detailed level, people admitted to in-patient areas did not feel that the process of the ward environment was explained to them, leading to unease (Strang 2020). This review reinforced the importance of high-quality, person-centred care and resonates with the argument that older adult services should be delivered in a person-centred way, not delivered by arbitrary age restrictions. It further builds the case around the importance of relationship-building in mental health care.

On a wider, more general national basis; in 2013 the Scottish Government developed their 2020 vision which focused on a plan to deliver, safe, effective, and person-centred care. The vision was to embed a culture of care and compassion, dignity and respect, openness, honesty and responsibility, quality, and teamwork. The paper highlighted the workforce of NHS Scotland numbers over 150, 000 people (Scottish Government 2013). Since the development of that 2020 vision, The Scottish Government (following an independent review of adult social care) have introduced the National Care Service (Scotland) Bill. The Bill focuses on all health and social care in Scotland including mental health and proposes that Scottish Ministers will be able to transfer the responsibility of social care from the Local Authority to the National Care Service and, likewise, healthcare functions from the NHS (Scottish Parliament 2023).

These policies and strategies are all relevant to this study in relation to the importance of delivering the right care in the right place, without discrimination due to either location or age. The National Care Service will enable decision making about Health and Social Care to be delivered in a local context.

Also, within Scotland, the Digital Health Care Strategy (Digital Health and Care Scotland 2021), has been published. This strategy focuses on improving the wellbeing of people by making the best use of digital solutions. It strives to enable people to have access to digital services that will support their health and wellbeing, with the aim of giving people greater choice and control. The strategy recognises there are digital inequalities and is working to address this, recognising digital support is essential in shifting models of care from crisis support to early intervention (Scottish Government 2021).

Finally, it is helpful for the purpose of context, to give a brief overview of the COVID-19 pandemic and the impact this had on healthcare delivery in the UK. The pandemic hit the UK in March 2020. I was just about to start phase two of my data collection at that time. The country was placed in lockdown, with older people (people aged over 67) identified as being at greater risk. The impact of the pandemic on older people led to increased loneliness and depression in this age group (Kasar & Karaman 2021).

The next section of this chapter gives an overview of national guidance for mental health.

National Guidance on Mental Health

Scottish Intercollegiate Guidelines Network does not have any specific guidance for OAMH. Instead, their guidance is illness focused i.e., there is specific guidance for depression or dementia. This is almost mirrored by NICE (National Institute Clinical Excellence), except for NICE guideline NG32 (2015), which provides guidance for maintaining mental well-being in older people. Mental wellbeing is more around proactive strategies to stay healthy as opposed to a diagnosed mental disorder.

NICE [CG 90], advocates that people with moderate to severe depression should be offered psychological therapy plus an anti-depressant. The following is an extract of guidance from the Psychological Therapies Matrix for OAMH (2011).

Table 1: Psychological Therapies Matrix

Depression in Later life				
Level of severity	Level of service	Intensity of intervention	What intervention	Recommendation
Mild	Primary care	Low - moderate	• Bibliotherapy • Life review therapy • Counselling	• A • C • C
Moderate	Primary and secondary care	Low-high	• Problem - solving (PST) • Individual CBT • Psychodynamic psychotherapy • Group based CBT • IPT maintenance post recovery • Behaviour therapy	• A • A • A • A • A • A
Severe	Primary care and secondary care/ CMHT	High	• Individual CBT • CBT with medication may be more effective than just medication	• A
Chronic or treatment resistant	Secondary care/ Highly specialised specialist service. In-patient care	High	• Individual CBT	• C

1.8 This Study

The overall aim of this research study was to explore the determinants influencing the use and provision of services for older people with FMI. This was timely, given the complex and varied landscape outlined above, in particular, the lack of policy and guidance around the needs and choices of older people with FMI. This research aim was informed (as discussed in Chapter 2), by an integrative review of the literature. The Availability, Accessibility, Acceptability and Quality (AAAQ) (UNICEF (United Nations International Children's Emergency Fund) 2019) Framework was used following thematic analysis of data to interpret and understand the findings of this study.

1.9 Chapter Summary

This chapter provides a context and background of mental health policies and services, with a particular focus on older people with FMI. It has also defined FMI, scoped the scale of the problem, and described service delivery models. My own personal interest in older peoples' mental health services was also explored. The purpose of the study is explained with, finally, an overview of this thesis provided.

Within Scotland, there was a rapid change in how older people with FMI were assessed, treated, and offered support for their mental health, with all support being offered *virtually* by Attend Anywhere (tele-conference) or by phone. Only exceptional, (urgent), cases were seen face-to-face during lockdown. This meant I had to adapt to an unprecedented situation-as described further in Chapter 3 of this thesis.

This thesis comprises eight chapters. In Chapter 1, I present the context and background to FMI. Chapter 2 incorporates the integrative literature review which has been published (Wells et al. 2020), and an update of new literature since 31st of October 2017. The focus of Chapter 3 is the description of and justification for the methodology, data collection methods, analysis and ethical considerations. The findings from the phase one focus and individual interviews are presented in Chapter 4. The key themes and concepts which emerged from phase 2 are detailed in Chapter 5. A narrative synthesis of the phase 1 and 2 findings are detailed in Chapter 6. Chapter 7 comprises the discussion, underpinned by a theoretical framework and Chapter 8 presents the findings, specific contribution to knowledge and recommendations for future research and policy. Chapter 2 will present the findings of an integrative review which informed the research aims of this study.

Chapter 2: Integrative Review

2.1 Introduction

In this chapter, I embed a critical integrative review of relevant literature including one published in the Journal of Clinical Nursing (Wells et al. 2020), which underpins this study. That review focused on the experiences of older people with a diagnosed FMI, their family carers and healthcare professionals in relation to mental health service delivery. Given that paper was published in 2020, an updated search was undertaken in October 2022 and two new papers included. The new papers are reported following the published review.

In planning this review, several designs were considered, including a systematic review, narrative review, and integrative review (Noble and Smith 2018). The primary method of systematic review and meta-analysis was conducted according to criteria such as those developed by Cochrane, considered by many to be the "gold standard" of reviews (Noble and Smith 2018). Systematic reviews attempt to collate all empirical evidence fitting pre-specified eligibility criteria in order to answer a specific research question. A systematic process is conducted where transparency of methods and approaches designed to minimise bias are key (Cochrane 2023).

Systematic reviews focus on one specific question and focus primarily on experimental studies such as randomised controlled trials (RCTs). However, a limitation of systematic reviews is the rigour of the inclusion criteria which do not explore experiences and perspectives of people using services, their family carers and service providers (Souza et al. 2010). Narrative reviews describe and appraise published literature. However, the methods for selecting articles may not be discussed and therefore narrative reviews are not always reproducible (Noble and Smith 2019).

An integrative literature review- the approach chosen here- encompasses diverse research designs within its scope, ensuring no research findings are excluded from review (Whittemore & Knafl 2005). An integrative review was chosen, therefore, as the design for this study to provide a holistic understanding of older adults with FMI, their carers' and healthcare professionals' experiences of mental health services (Souza et al. 2010).

For this review, it is helpful to define the following terms:

Recovery: Anthony (1993), describes recovery as a personal and unique way of changing one's own attitudes, values, feelings, goals, and /or roles and a way of living a satisfying, hopeful life, despite the limitations caused by illness.

Mental Health: The WHO (2022), describe mental health as a state of wellbeing where an individual realises their own abilities, can cope with the normal stresses in life, can work productively and contribute to their community.

Mental Illness: The WHO (2022), define mental illness as a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour which impacts upon their functioning.

Mental Health Services: Secondary mental health services are defined by the Scottish Government (2022), as services which are there to meet the needs of individuals who have complex or longer-term mental health needs that cannot be met by their GP or Primary Care.

Sections 2.2 to 2.14 of this thesis detail the published review (Wells et al. 2020). In addition, Section 2.15 highlights findings which have emerged from the rerun of the October 2022 literature search. The two new papers found in October 2022 have been added to the table of evidence in Appendix 2.

Start of Published Article;

WELLS, J. et al., 2020. The experiences of older adults with a diagnosed functional mental illness, their carers and healthcare professionals in relation to mental health service delivery: An integrative review. Journal of Clinical Nursing, *29(1–2), pp. 31–52. Available from: http://dx.doi.org/10.1111/jocn.15067.* (Appendix 1).

2.2 Review Introduction

In many healthcare systems around the world, mental illness in older adult mental health services is classified into two main groups: organic or functional FMI (Collier 2008). Organic mental illness is defined as a mental illness caused by a physical change in brain tissue; these changes are often degenerative in nature, as in dementia (Logsdon 2018). In contrast, FMI is not degenerative in nature and encompasses illnesses such as depression, bipolar disorder, schizophrenia, and anxiety disorders (Collier 2008).

Worldwide, care and support for older people with FMI is provided primarily by informal carers such as spouses, other family, and friends (Broady & Stone 2015). However, caregiving can have a negative impact on carers' own psychological and physical health (McCann et al. 2016). This negative impact, termed 'carer burden,' can be exacerbated by the need to be available to an older person with FMI to provide support, monitor symptoms and navigate professional support when required, often at the cost of the carer's own health (Broady & Stone 2015). Carers of people with FMI are reported to have a higher prevalence of depression (including feelings of guilt and sadness) in comparison to those who do not provide care for people with FMI (McCann et al. 2016). Additionally, carers can experience feelings of loss and grief when caring for a person who was once independent in their role as the carer's spouse or parent (McCann et al. 2016). Meeting the needs of older people with FMI is, therefore, important, and significant.

Broady & Stone's (2015) study in New Zealand illustrated that the caring role can also be a positive intervention with carers describing experiences of love, support, fulfilment, and a sense of achievement (Broady & Stone 2015). Others describe how caring for a family member can provide a sense of purpose and fulfilment. Furthermore, providing care as a family member – as opposed to hiring a stranger – may be comforting, as highlighted by McCann et al. (2015), in their Australian study. A number of factors contribute to informal carers being the biggest source of care provision; these include an ageing population, increasing costs of care and limited availability of services.

Worldwide, the ageing population is growing. In 2017, the global population of people aged over 60 was 382 million and this figure is projected to almost double by 2050 (World Data Bank 2015). This ageing population presents a major challenge to health and social care services, now and in the coming decades (Anderson 2011). The growth of the ageing population seems to suggest that the incidence of FMI in older people will also increase, and for some illnesses such as depression and anxiety, it will. However, a dichotomy currently exists as some older people with FMI (those with severe and enduring mental illness such as schizophrenia and bipolar disorder) have an expected life expectancy of up to twenty years shorter than the general population (WHO 2018).

Worldwide, the number of people living with FMI in the general population is significant. Whilst this number is lower amongst older adults than younger ones, it is still notable and projected to increase in incidence (Anderson 2011). Currently, FMI is estimated to affect one in four people in the general adult population and 15% of people aged over sixty worldwide (WHO 2018). Globally, it was predicted depression will be the leading cause of illness burden in older people by 2020 and would affect one in five people over 60, with severe depression expected to increase by 49% by 2026 (Royal College of Psychiatrists 2018). Schizophrenia is estimated to affect 0.5% of the world’s population aged over sixty (Loebach-Wetherhell & Jeste 2017), and anxiety disorders are reported to affect one in twenty older people (Royal College of Psychiatrists 2018). As people with FMI become older, they are also more likely to develop a physical illness (Government UK 2018).

Older people with FMI have complex needs. In addition to coping with specific symptoms relating to their FMI (including delusions, hallucinations, and agitation), they are also likely to develop a physical comorbidity (Government UK 2018). Reasons for this might be that some older adults with FMI are more likely to have experienced years of economic deprivation, poor diet, significant alcohol intake, and heavy smoking (Government UK 2018), all of which are contributory factors to their poor life expectancy and place this population at increased risk of diabetes, stroke, cardiac problems, and vascular illness (Government UK 2018).

In older adults with FMI, physical and mental health needs impact one another and rarely appear singularly (WHO 2018). Generally, the physical health needs of an older adult present as general functional decline, accompanied by pain, physical frailty, sensory impairment, and multiple medication use (WHO 2018). These complex needs may inhibit the ability of an older person to seek appropriate support. Furthermore, the complexity of both physical and mental health needs poses a potential challenge to healthcare professionals who may work in silos, focusing on either physical or mental health (Hilton 2012). This may contribute to a potential lack of the skills and knowledge needed to holistically meet the needs of this population.

Care and treatment of older people with FMI can be offered across a spectrum of services, depending on the severity of the person’s symptoms. Whilst many older adults with mild symptoms of FMI will be managed by their physician, those with more severe and enduring symptoms, mainly psychosis or severe depression, are likely to need specialist mental health input in both hospital and community settings (Warner & Jenkinson 2013). Given the ageing population, increasing costs and limited services, care for older people with FMI worldwide is primarily provided by family members and other informal carers (Broady & Stone 2015).

Globally, little attention is paid to older adults with FMI and their carers’, leading to a large research gap (McCormack & Skatvedt 2017). In contrast, dementia has been a key priority in health and social care policy and in research internationally (Saad et al. 2016).

In 2014, The Glasgow Declaration called for a European dementia strategy leading to many European countries producing their own strategies. In contrast, there are no specific clinical guidelines relating to older adults with FMI. The emergence of different service delivery models for older people with FMI has evolved with minimal supporting evidence. Therefore, this review fills an important gap- exploring the experiences of older people with FMI, their carers' and healthcare professionals in relation to mental health services.

2.3 Aims

The aims of this integrative review were a) to analyse the experiences of older people with a diagnosed FMI and their carers' in relation to mental health service delivery and b) to analyse the experiences of healthcare professionals who care for and treat older people who have a diagnosed FMI.

Consequently, the following review questions were developed;

- What are the experiences of older people with FMI, their carers', and healthcare professionals providing mental health services?
- How are the physical and mental health needs of older people with FMI, their carers', and healthcare professionals identified and met?

2.4 Methods

A review protocol was registered with the International Prospective Register for Systematic Reviews (PROSPERO) 2017 CRD42017080576 crd.york.ac.uk/PROSPERO/display_record.php?RecordID=80576

2.5 Design

An integrative literature review was chosen as this approach encompasses diverse research designs, ensuring no research findings were excluded (Whittemore & Knafl 2005). An integrative review can provide a holistic understanding of how older adults with FMI, their carers' and healthcare professionals experience mental health services. The methodological approach includes five stages described by Whittemore and Knafl (2005): (i) problem identification, (ii) literature search, (iii) data evaluation, (iv) data analysis and (v) presentation.

2.6 Literature Search

Search strategy

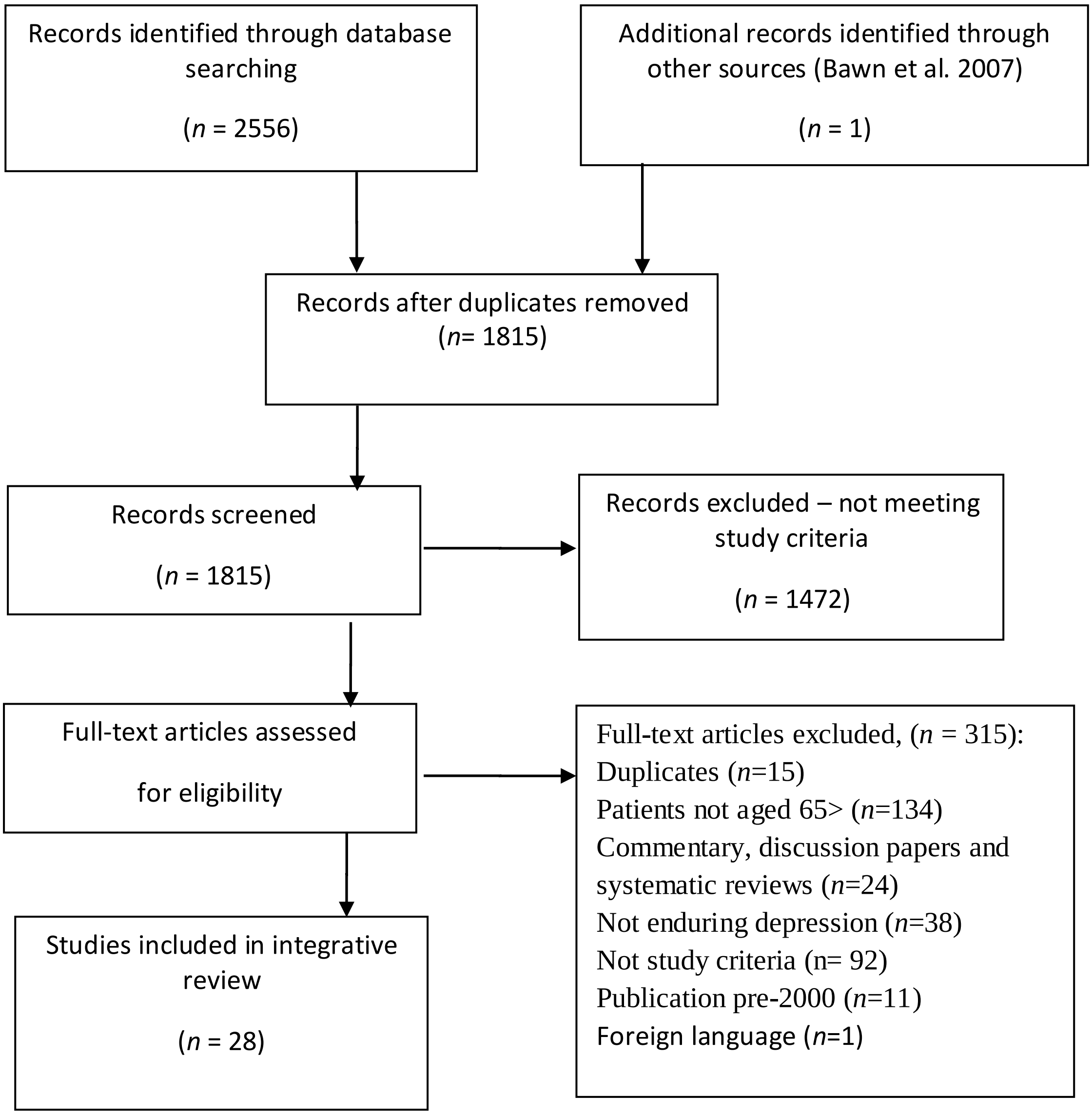
For the purpose of this integrative review, the focus was on FMI in older people (older than age 65). Inclusion and exclusion criteria were applied (See Table 3). Six international electronic databases were searched: MEDLINE, CINAHL, Cochrane Library, PsycINFO, EMBASE, AMED, and grey literature. Reference lists of included studies were scanned to identify articles which might be eligible for the review. MeSH and search terms were used (Table 2). The search was piloted in MEDLINE and adapted to other databases (Appendix 2).

Table 2: Search terms	
Functional mental illness	(MH "Mental Disorders"), (MH "Anxiety Disorders"), (MH "Depressive Disorders"), "serious mental illness", "psychotic illness", (MH "Personality Disorders"), (MH "Schizophrenia"), "functional mental illness" "mental illness"

People with functional mental illness, family carers and health care professionals	(MH “Patients”), “clients”, “carers”, “service users” “older adult mental health”, “older people”, “family carers”, “families”, “family caregivers”, “family carers”, “healthcare professionals”
Mental health services	“old age psychiatry”, “psychiatric services”, (MH “Mental Health Services”), “older adult mental health services”, (MH “Community Mental Health Services”)

The early part of the millennium saw key legislative reviews and the introduction of new legislative acts which impacted this population group. Hence, the search was limited to the years 2000–2017. The articles included were published in English and were from Europe, New Zealand, Australasia, and North America. All articles were exported to Refworks, allowing duplicates to be documented and then deleted. The Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) guided the audit trail (PRISMA checklist) (Moher et al. 2009).

Figure 1: PRISMA flow chart (Moher et al. 1999)



Study selection

Two reviewers (JW and SHL) independently screened the titles and abstracts. The reviewers used Rayyan QCRI software (2018), which allows the process of screening titles and abstracts to be ‘blinded’ to reviewers. Potential full texts were retrieved, assessed, and any doubts were discussed between the two reviewers. If agreement was not reached, then a third reviewer made the final decision (CK).

Inclusion Criteria

Table 3: Inclusion Criteria
Types of study included.
• Empirical research, including quantitative, qualitative, and mixed methods studies, was included in this review. • Editorial, commentary, discussion, opinion papers, and systematic reviews were excluded. • Papers on dementia, substance misuse, eating disorders, and alcohol use were excluded. Papers with a primary focus on physical health were also excluded.
Types of population/participants included.

- People aged over 65, with a diagnosed FMI were included in this review.
- Carers/families aged 18 and above. Carers or family members are defined in this review as a person who provides unpaid care to another person (Broady & Stone 2015)
- Healthcare professionals (including nurses, support workers, social workers, medical staff, allied health professionals, and those working in third sector organisations) working in mental health service, for those aged over 65 who have a diagnosed FMI.

2.7 Data Evaluation and Quality Appraisal

Data were extracted using a predetermined format. Key information was extracted; the author, year, country of study, type of study design, aims of the study, characteristics of participants, methods of data collection, key stakeholders' experiences in relation to mental health service delivery, and accessibility of mental health services for older people with FMI. Key findings were also documented. Data extraction forms were used to produce summary (Appendix 3).

Quality appraisal of included studies

Qualitative and quantitative articles were appraised using the recognised Critical Appraisal Skills Programme tools (CASP 2017), and cross-sectional studies appraised using the NHLBI (National Heart Lung Blood Institute) appraisal tool (2018) (Appendix 4). No mixed method studies were yielded in this review. Appraisal of literature in this review was not intended to exclude articles on the basis of quality but rather to draw on all available evidence.

2.7.1 Data Analysis

Whittemore and Knafl (2005) suggest that data analysis be ordered, coded, categorised, and summarised to allow the drawing of conclusions regarding the research problem. Therefore, the narrative synthesis framework by Popay et al. (2006) was used to theme data in this review. This approach was chosen as it can synthesise multiple studies by focusing on words and text (Popay et al. 2006). Using the framework of narrative synthesis, key findings were tabulated from a summary table (Appendix 3). Next, key findings were coded and grouped into similar concepts by the PhD student. These concepts were then checked and refined via reflective discussion at supervision, thus ensuring the validity and reliability of results by minimising any potential bias of the reviewers. This process ultimately led to the development of one overarching theme and two main themes.

2.8 Results

Search results

The search yielded a total of 2,556 articles. In total, 741 of these articles were duplicates, resulting in 1,815 titles and abstracts being screened. A total of 342 articles (PRISMA flow chart: Figure 1) were identified as potentially relevant to the literature review question. The inclusion and exclusion criteria were then applied to the 342 articles remaining; this revealed 27 articles which were considered relevant for this review. One additional appropriate paper (Bawn et al. 2007) was revealed by screening the reference lists of included articles. No articles were included from the grey literature. Therefore, 28 studies were included in this review.

Study characteristics

There were 23 quantitative studies and five qualitative studies. Thirteen studies were conducted in the USA (*n*=13), the remainder conducted in the UK (*n*=5), Canada *(n*=3), Australia (*n*=2), Holland (*n*=2), Ireland (*n*=1), Norway (*n=1*) and New Zealand *(n*=1).

Study quality

The overall quality of the included studies appeared to be moderate. Of the five qualitative studies, four did not discuss the relationship between the researcher and participants, and in two studies ethical considerations were not documented. Of the five cross-sectional studies, all aspects of the appraisal tool were met.

2.9 Themes

Thematic analysis of the literature illuminated an overarching theme: 'determinants influencing the use of services among older people with FMI'.

This overarching theme illustrates a number of factors which influence this population's decisions whether to use mental health services. The theme 'inevitable consequence of ageing' highlights that older adults with FMI often do not access mental health services because they perceive their FMI needs as related to the ageing process. This perspective was shared by family carers and healthcare professionals. Other factors, including stigma and ageism, were also found to influence the use of services by older adults with FMI.

The second theme, 'variations in availability of healthcare services for older people with FMI,' highlights that the cost and availability of services may influence older people to seek support for their mental health needs. This theme also highlights that service delivery models may influence a healthcare professional's decision making when offering support.

2.9.1. Inevitable Consequences of Ageing

Seventeen studies (eleven quantitative and six qualitative) supported the theme ‘inevitable consequences of ageing’. These studies were from the United States (*n*=8), Australia (*n*=2), Holland (*n*=2), the United Kingdom (*n* =1), Ireland (*n*=1), New Zealand (*n*=1), Canada (*n*=1) and Norway (*n*=1).

2.9.2 Perceived Need

The literature yielded in this review illustrated that perceived need was a factor influencing what support and mental health services older people with FMI received. Nine studies from two countries (USA *n* = 7; Holland *n* =2) illustrated that older people with FMI and their healthcare professionals shared the perception that mental health needs decline as people age. Mackenzie et al. (2010), in their quantitative study, demonstrated that 47.1% of older people (*n* =3017) were less likely to perceive they had a mental health need compared to younger people. Crabb and Hunsley (2006), demonstrated that low perceived need in older people correlated with lower use of mental health services, with those aged over 65 (N=23,364) found to be half as likely to seek mental health support compared to those aged 45-64 (N =35,958). Cummings (2009), in a study of (*n*= 75) older people, found that 70% felt they did not receive the support they required for their mental health and therefore had unmet needs in relation to chronic illness, functional disability (with impairment in four or more activities of daily living), and decreased social support, including home care. Houtjes et al. (2011) suggest this situation occurs because mental health needs are not always discussed by healthcare professionals during assessments in specialist services. This finding was corroborated by Muir et al. (2014), who revealed that older people and their carers shared the perception that healthcare professionals believed older peoples’ mental health illnesses were due to dementia and therefore overlooked.

Several studies revealed that physicians can see depression as an inevitable consequence of the ageing process (Holvast et al. 2012; Arean et al. 2007; Palinkas et al. 2007; Muir et al. 2014). Arean et al. (2007) conducted a randomised controlled trial of older people (*n* = 1801), examining older adults' use of mental healthcare. Within this study, collaborative care for depression was compared with the usual care for depression in primary care. This study illustrated that physicians generally did not routinely screen for depression in older adults, which resulted in under-treatment of depressive symptoms. Muir et al. (2014) demonstrated that healthcare professionals focused more on the physical needs of older people rather than their mental health needs.

Another factor in the reluctance of older people to seek attention for FMI was that healthcare professionals did not always recognise that older people with FMI required mental health support, even when the healthcare professional was a specialist mental healthcare professional (psychiatrist, community mental health nurse, or psychologist) (Houtjes et al. 2011).

Two studies revealed that older people with FMI often do not recognise they have a mental health need (Muir et al. 2014; Mackenzie et al. 2010). Muir et al. (2014) explored health and social care barriers for older people with mental health issues in rural Australia. These studies do not specify why older people with FMI often fail to recognise they need support. However, Crabb and Hunsley (2006), propose that older people with FMI often felt that younger people were more in need of services than were they.

Several studies have identified that the use of mental health services decreases as people age (Mackenzie 2008; Crabb & Hunsley 2006). Holvast et al. (2012) found people aged over 65 were less likely to seek mental health services than younger people because they utilised their social support networks instead. Mackenzie et al.'s (2008) study revealed similar findings. They examined the variables between older people and younger people who sought mental health services and found people aged over 75 were four times less likely to seek mental health services than those aged between 65 and 74.

In contrast, two studies found older people were more likely to use mental health services than their younger counterparts. Mackenzie et al. (2008), surveyed adults in community living (N=5692) on the attitudes of younger people compared to older people (N=1341) and their use of mental health services. They found that 80% of older adults were more likely than younger people to access mental health services. Another study by Nelson and Park (2006), found that older people had fewer unmet mental health needs and experienced fewer barriers when accessing services compared to younger people. This study demonstrated that most people who experienced unmet needs did so because they preferred to manage their needs themselves.

2.9.3 Stigma

The literature included in this review highlighted that stigma influenced the decision making of older people with FMIs when they considered seeking mental health support or services. Three American studies (Byers et al. 2012; Crabb & Hunsley 2006; Mackenzie 2006) illustrated that older people with FMI were more forthcoming in seeking support if they had a comorbid physical illness. Crabb and Hunsley (2006) revealed that the tangible aspects of physical ill health were often easier for older people with FMI to recognise (examples include diabetes, chronic cardiovascular disorders, and chronic pain). However, the study failed to address whether it was a physical or mental health condition that propelled them to seek support from a physician or if the mental health issue was secondary to their physical illness.

Four studies from a range of countries (Canada *n*=1; Holland *n* =1; USA; *n*= 2) found that older people with FMI preferred to see their physician rather than specialist services about their mental health, particularly about psychological distress (Preville et al. 2009; Holvast et al. 2009; Crabb & Hunsley 2006; Mackenzie et al. 2010). Older people with FMI found it easier to confide in their physician about their mental health needs compared to a mental healthcare professional. This decision largely stemmed from the stigma older people projected onto mental health services (Mackenzie 2010).

Byers et al.'s (2012) study found that physical health conditions correlated with higher use of mental health services in older people. Crabb and Hunsley (2006) found 95% of older people seeking support from mental health services to have co-existing medical comorbidity. People who experienced cardiovascular illness, chronic pain or any medical condition were far more likely to seek mental health support because they had the tangible reason of physical ill health accompanying their less-tangible mental health needs (Byers et al. 2012; Crabb & Hunsley 2006).

Several studies highlighted that stigma and ageism were determinants of the usage of mental health support in older people with FMI (Byers et al. 2016; Muir et al. 2014; Palinkas et al. 2007; McCormack & Skatvedt 2017). Byers et al.'s (2012) study revealed some older people with FMI reported being embarrassed to discuss their mental health needs and therefore did not access mental health services. Furthermore, some did not access mental health services out of concern their friends might find out (Muir et al. 2014). Muir et al. (2014) found that access to mental health services can be associated with stigma; this was sometimes perceived as a generational issue, with an apparent lack of understanding regarding mental health in the older age group.

A number of studies found older people with FMI want to remain self-sufficient, independent, and self-reliant as well as being seen as resilient (Byers et al. 2012; Crabb & Hunsley 2006; Muir et al. 2014). In addition, older people took pride in their ability to manage and wanted to be perceived by others as stoic (Muir et al. 2014). However, this sense of pride had a negative impact; Byers et al.’s (2012) study found 70% of older people were embarrassed to acknowledge they needed help. Older men in particular viewed seeking mental health support as a sign of weakness (Muir et al. 2014).

Another barrier to seeking support could be that people of some ethnic origins are less likely to seek help for their mental health needs (Byers et al. 2016). One explanation is they may be uncomfortable discussing mental health needs which they view as personal problems, with healthcare professionals. In contrast, Sarkin et al. (2015) found older people (*n*=1237) felt less stigmatised than younger people and were more likely to access mental health services. That study focused on people living in San Diego, which may offer some explanation for these diametric findings. However, it was the only paper to use a validated tool (the stigma scale) when assessing stigma.

2.9.4 Ageism

This review illustrated that ageist attitudes, or perceived ageist attitudes, from healthcare professionals influenced the decisions of older people with FMIs regarding accessing mental health services or mental health support. Some older people with FMI perceived ageist attitudes amongst healthcare professionals and reported they had experienced ageism (Palinkas et al. 2007; McCormack & Skatvedt 2017). Ageism is defined by Palinkas et al. (2007) as negative attitudes towards older people from service providers and has influenced older peoples’ desire to seek mental health support (Palinkas et al. 2007). Healthcare professionals also reported a lack of available mental health services appropriate for older people (Bawn et al. 2007; Palinkas et al. 2007; Muir et al. 2014).

Muir et al. (2014) suggest services for older people are set up to meet physical needs and do not focus on mental health. Bawn et al. (2007), in a UK survey, reported there is less financial investment in older adult services compared to ageless services, meaning there are fewer services available to older people with FMI.

A study by McCormack and Skatvedt (2017), explored the experiences of older people with FMI who received mental health services and had carers living at home. That study highlighted that some family carers perceived their loved ones did not always receive the standard of mental healthcare they expected from mental health nurses. In a qualitative study, McCann et al. (2016) aimed to understand the lived experiences of carers of older people with FMI (aged over 60 (*n*=30)); it was reported older people and their carers had expected mutual respect with their healthcare professionals, which they perceived they did not always receive.

2.9.5 Impact of caring

The literature gathered in this review highlighted older people with FMI rely heavily on family carers for mental health support and that family carers play an important role. However, playing that role impacted significantly on the health of family carers. Cummings et al. (2009) found 75% of older people with FMI relied heavily on family members for support with their physical needs and highlighted that family carers often are a main and essential source of care. One study illustrated family members were expected by society to support elderly relatives with their mental health needs (Broady & Stone 2015). This expectation was heightened if the carer was a spouse, as support was considered to be part of the marital role (Molyneux et al. 2008). Some family carers expressed the view healthcare professionals were unaware of the impact their caring role had on their own health (Muir et al. 2014). Other family carers reported their caring role impacted their own mental and physical health; some had depressive symptoms which increased a need for prescribed medication as a means to cope with their caring role (Broady & Stone 2015). Healthcare professionals often focused on the needs of the older person with FMI and did not consider the carer’s needs and how the caring role affected their health (Muir et al. 2014).

Evidence gathered under this theme identified several factors considered to be inevitable consequences of ageing which impacted the use of services by older people with FMI. For example, older people with FMI often did not perceive they had a mental health need and strove to remain independent in their daily living. Men in particular viewed support for mental health as a sign of weakness. Stigma and ageist attitudes were a deterrent to seeking support among older people with FMI. Older people found it easier to confide in their physicians about their mental health, using the guise of a physical health need.

However, support from physicians was not always available, as many viewed FMI as an inevitable consequence of ageing. Finally, there was an identified societal expectation that older people would receive support for mental health from their family, particularly a spouse. The caring role often impacted the health of the caregiver, who may receive little support when performing their caring role.

2.10.1 Variations in the Availability of Healthcare Services for Older People with FMI.

Eighteen papers relating to this theme were identified: fifteen were quantitative and three qualitative. The studies were conducted in the United States (*n*=10), UK (*n*=3), Canada (*n*=2), New Zealand (*n*=1), Australia (*n*=1) and Norway (*n*=1).

2.10.2 Affordability

This review found that affordability of mental health services influenced the decision to seek support, not only by older people with FMIs, but also by their family carers. Four studies from two countries reported that the cost of mental health services was an influencing factor in service usage by older people with FMI (USA *n*=3; New Zealand *n*=1). Two studies found older people were often unable to afford medical insurance, which in turn affected the mental health services they could access (Karlin & Norris 2006; Broady & Stone 2015).

An American survey conducted by Karlin and Norris (2016) of people aged over 18 (*n*= 12, 810) revealed that only 5% of older adults accessed mental health services. The authors attributed this finding to older people often being restricted financially, lacking healthcare insurance and being unable to fund the services they required. This is corroborated by Palinkas et al.'s (2007) and (*n*=16) and Robb et al.'s (2003) studies of older people (*n*= 474), which also found older people are less likely than younger people to have healthcare insurance.

Broady and Stone (2015), discovered financial restrictions affected not only older people with FMI but also their carers'. That study demonstrated that only one in four carers accessed the support they need to effectively deliver their caring role. Carers' decisions to access services were affected by cost implications, with many not having medical insurance due to reduced income from being retired. Furthermore, the caring role itself was time consuming and carers often simply did not have time to access services because their time was occupied with caring for their family member (Broady & Stone 2015).

2.10.3 Accessibility

The literature analysed in this review highlighted that a number of issues affected the accessibility of mental health services and their use by older people with FMI. One such issue was poor knowledge regarding available services and referrals to mental health services by a physician. Two studies from the United States found that accessing mental health services was more challenging for older adults with FMI, compared to younger people who are more adept at identifying their needs (Byers et al. 2012; Mackenzie et al. 2010), as, according to Byers et al. (2012), older people received insufficient information about mental health services. This finding was also highlighted by Robb et al. (2003), who discovered older adults were found to be less confident in their knowledge about services available to them in comparison to younger counterparts, and this was a barrier to accessing support.

Older people with FMI also faced challenges in accessing mental health services, as they often found they had to be referred by their physicians to specialist mental health services which they perceived as a barrier to accessing specialist support (Muir et al. 2014). However, in primary care services which had an integrated mental healthcare professional (such as a Community Mental Health Nurse or Psychologist), the experience for the older person was reported to be more positive because these healthcare professionals would assess for FMI and make referrals to the appropriate specialist services (Arean et al. 2007).

Another barrier to accessing specialist mental health services, identified in Australia, was that older people with FMI felt some local mental health services were unable to meet their mental health needs because they were already stretched and at full capacity (Muir et al. 2014). With contrasting findings, a study by Nelson and Park (2006), examined unmet need in Ontario, Canada in people aged 65+ (*n*= 2752) and in people aged 15-64 (*n*=10,432). They report older people have fewer unmet needs than younger people; older people accessed support, whereas younger people reported challenges around the availability of services (professionals unavailable in area, professionals unavailable when required and waiting times being too long).

2.10.4 Availability

This review illustrated that the availability of mental health services affected their use by older people with FMI. Factors influencing the availability of services related to where people lived and models of care for older people with FMI. Two studies highlighted the availability of community support was dependent on where an individual lived (Preville et al. 2009; Karlin & Norris 2006).

People living in metropolitan areas were far less likely to seek mental health support from services in comparison to those who lived in less urban or rural areas, as those living in metropolitan areas had more social support (Karlin & Norris 2006). Furthermore, older people with FMI who lived with a spouse were far less likely to access support than those who lived alone (Preville et al. 2009). The study, however, offered no explanation for its findings.

A study by Simning et al. (2010) of older people (*n*= 378) explored the use of a dedicated depression care management team in primary care. The study revealed that people who were distressed by their FMI symptoms were far more likely to see a mental healthcare professional. Another model of mental healthcare explored was assertive outreach (where a community mental health team will provide intensive support to a person who is acutely unwell in the community). This model was found to be less favourable to carers who lived with the person with FMI, who experienced more carer burden with this model of care (Fulford & Farhill 2001).

This review highlighted different models of hospital care exist, and some mental health services are ageless in contrast to others that are age-defined (where a person is automatically transferred to an older person's service at 65) (Abdul-Hamid et al. 2016). Abdul- Hamid et al. (2016), undertook a UK cross-sectional survey of 74 older people with FMI. The study aimed to compare the unmet need of older adults with FMI who were cared for in age-defined and ageless services. They concluded that older people with FMI who were cared for in ageless services were found to have a significant unmet need in relation to medication management, domestic life, and transport issues.

Abdul- Hamid et al.'s (2016) findings are supported by Palinkas et al.'s 2017 study and a study by Morrow-Howell et al. (2000), who focused on the needs of (*n*=169) older people with depression post-acute care, across psychosocial, medical, functional and psychiatric needs. That study revealed healthcare professionals working in an ageless service lacked the knowledge and skills to assess older people with FMI with regard to physical comorbidities.

By contrast, two UK studies concluded ageless services were better equipped to meet the needs of older people with FMI. A survey by Bawn et al. (2007), of mental healthcare professionals (*n*=55) revealed age-defined mental health services have fewer multidisciplinary provisions than ageless services. Another UK quantitative study of older people with FMI (*n*= 58) conducted by McNulty et al. (2003), aimed to measure the care needs of people aged over 65 with schizophrenia using a standardised tool. Their study reports that when older adults were transferred to age-defined services, there was an increase in their unmet clinical and social needs (psychotic symptoms, financial needs, and social life).

Older adults with FMI who live in care homes also experienced challenges relating to their mental health needs (McNulty et al. 2003). Clancy and Baldwin's (2008) UK comparative study of older people with FMI (n=23) adds weight to McNulty et al.'s (2003) contentions that older adults with schizophrenia in care homes have more concomitants and higher needs in relation to their activities of daily living in comparison to those living in their own homes. These needs were thought to be related to negative symptoms (apathy, social withdrawal, lack of emotion) of the illness and the high prevalence of physical comorbidity.

However, Clancy and Baldwin (2008), do not elaborate on which physical comorbidities participants in this study actually had. In this case, the needs of older adults with FMI were overshadowed by the needs of their counterparts who had dementia, and care home staff were better trained to care for the latter (McNulty et al. 2003; Anderson et al. 2000).

This review illustrated there are a number of variations in the availability of healthcare services influencing the use of services by older people with FMI. In countries where health services are not free, cost was identified as a significant determinant of their use.

However, the evidence suggests service delivery models have an impact on the unmet needs of older people with FMI, with two studies concluding that ageless services reduce unmet needs. Some of the barriers to accessing mental health support were related to the referral process to specialist mental health services, variations in community support, and service delivery models. In care homes, healthcare professionals were found to have more knowledge surrounding dementia, which resulted in symptoms of FMI in older people being overlooked.

This review has identified a gap in current research exploring the experiences of older people with FMI regarding support and whether the services available meet the needs of this population. Furthermore, little is known as to what influences healthcare professionals' decisions to provide support for older people with FMI. Finally, this review revealed that few studies have explored the experiences of family members who care for older people with FMI.

2.11 Discussion

The aim of this integrative review was to synthesise the findings of all available studies which explored the perceived experiences of older adults with FMI, their family carers and healthcare professionals in mental health service delivery. The review yielded 28 studies that have been summarised into one overarching theme, 'determinants influencing the use of services by older adults with FMI', and two main themes: 'The inevitable consequences of ageing' (which included stigma and ageism) and 'Variations in availability of healthcare services for older people with FMI'. The relevance of these findings is significant and has implications for policy, education, and future research.

2.12 Policy Implications

Findings from this review highlight that older people with FMI are less likely to access mental health services than younger people (Byers et al. 2012; Mackenzie et al. 2010; Robb et al. 2003). It also illustrated there may be a hidden population of older people with FMI who are invisible to mental health service providers (Holvast et al. 2012; Mackenzie 2008). Thus, government and health surveillance agencies need to collect accurate data on the prevalence of this population group as it correlates with the use of mental health services. These data must be dissected, analysed and interpreted nationally by policymakers and service providers to ensure equitable mental healthcare provision for this population group in the UK (Anderson 2011).

This review also illustrated that whilst different models of service delivery exist for older people with FMI, these models do not always embrace a holistic approach to care. Internationally, there is inconsistency in service delivery models for people with mental illness (WHO 2018), with an assortment of ageless and age-defined services. For older adults with FMI within the European Union, only six countries (UK (at time of publication), Switzerland, Romania, Slovakia, Ireland and Czech Republic) recognise Older Adult Mental Health services as a subspecialty of psychiatry. Across continental Europe, care and treatment are predominantly delivered in ageless services for people with mental illness across hospital and community settings by healthcare professionals with generalist mental health knowledge.

Different views prevail as to whether ageless mental health services should exist (Union of European Medical Specialties 2013), or whether age-defined services should be offered to all by staff equipped to deal with physical complexities such as pain and physical frailty, alongside FMI (Abdul-Hamid et al. 2016). There is consensus that community services are the desired model of delivery for mental health services (Union of European Medical Specialties 2013).

Warner and Jenkinson (2013), defend the need for specialist older adult mental health services and surveyed 76 OAMH services in the UK; 52% of respondents viewed the erosion of specialist older adult mental health services as detrimental to older people with FMI, due to the social, psychological, and physiological complexities which accompany old age. In contrast, Bawn et al. (2007), suggest that older people with FMI are disadvantaged by specialist OAMH services due to a lack of investment in such services. Anderson (2011), suggests that providing older people with the same level of mental health services as younger people, based on need, would cost approximately £2 billion a year, which then was one-seventh of the NHS budget. With an ageing population, this level of spending is not achievable. Therefore, new models of mental health service delivery for older people with FMI need to be urgently explored by service commissioners and providers to ensure models of care meet the needs of the population in an equitable, achievable way.

2.13 Education Implications

This integrative review has highlighted that changes are needed in the education of healthcare professionals in order to develop a holistic approach to treating older people with FMI (Abdul-Hamid et al. 2016; Palinkas et al. 2017; Morrow-Howell 2000). Support is needed therefore from educational institutes and healthcare systems to help healthcare professionals understand and deliver a more holistic model of care that focuses on both the physical and mental health needs of older people (Abdul-Hamid et al. 2016; Palinkas et al. 2017; Morrow-Howell 2000).

This integrative review demonstrated also that some general physicians lack a holistic approach when treating older people as there is only a 50% recognition rate of depression in this population group (Holvast et al. 2012). The impact is that older people with FMI often have unmet physical and mental health needs (Cummings 2009). Inadequate detection and treatment of FMI in older people represents a serious threat to this population’s quality of life and functioning (Crabb & Hunsley 2006). Amongst healthcare professionals and general practitioners, improved knowledge of screening and assessment for FMI in older people would improve the diagnosis of FMI and in turn facilitate support (Arean et al. 2007; Muir et al. 2014).

2.14 Research Implications

Most studies in this integrative review used a quantitative approach (*n*=23). Few authors have explored the experiences of older people with FMI, their carers’ and healthcare professionals in the in-depth way qualitative research fosters. Therefore, regarding mental health services, there is a gap in current research exploring the views and perspectives of older people with FMI, their carers’ and healthcare professionals.

It is argued that in healthcare, it is important to understand diverse perspectives in order to shape service delivery in a way that is optimal for recipients (Brookes 2007). Further research using a case study approach is needed to gain an in-depth understanding of what determinants influence the use of mental health services by older people with FMI. In addition, there is a need to identify best practices in relation to models of care for older people with FMI.

2.15 Strengths and Limitations of the Review

The strengths of this integrative review are that it has yielded relevant international studies which reflect the experiences of older adults with FMI as well as lay and professional carers’ in mental health service delivery. This review used a robust, transparent approach and involved at least two reviewers at all stages.

One limitation of this review is that the topic range is quite broad, therefore, synthesis of the literature was challenging as the findings were general. Also, the review did not consider health beliefs related to the ageing process or explore how the onset or duration of mental illness affected perceptions of and access to mental health services.

Furthermore, many of the quantitative study designs of the included studies used surveys with only one randomised controlled trial. Finally, studies published in foreign languages were excluded, hence, vital information may have been missed.

2.16 Conclusion

Several determinants influence the use of mental health services by older adults with FMI. Older people themselves consider FMI to be an inevitable consequence of ageing. This perception is mirrored by their carers' and healthcare professionals. This assumption, in turn, influences the decision to seek support. Likewise, it influences healthcare professionals' decision making in offering mental health support.

In countries where services are not free, cost affected decisions about whether to access support. Other determinants of the use of mental health services by older people with FMI were stigma and ageism. Older people with FMI reported that they experienced ageism from healthcare professionals, and they themselves stigmatised mental health problems. In the UK, a paradox exists in mental health service delivery models with the introduction of the Equality Act, which led to some mental health services adopting ageless services and others maintaining specialists in services for those over age 65. The introduction of this act has addressed issues of direct discrimination against older people but may inadvertently also be causing indirect discrimination (Warner and Jenkinson 2013).

This integrative review has highlighted there is limited evidence exploring the experiences of older people with FMI with regard to support and whether the mental health services available meet their needs. Furthermore, little is known about what influences healthcare professionals’ decisions to provide support for older people with FMI. Finally, this review revealed few studies exploring the experiences of family carers of older people with FMI. It is essential these gaps in evidence be addressed to allow commissioners and health services to address the needs of this population group.

2.17 Relevance to Clinical Practice

This integrative review adds to the current body of knowledge by illustrating there are a number of determinants influencing the use of mental health support by older people who are not currently accessing the mental health services they require.

However, there is a lack of current research informed by the perspectives of older people with FMI, their family carers and healthcare professionals. Therefore, further research is required and should use a qualitative approach to gain an in-depth understanding of what determinants influence the use of mental health services by older people with FMI.

In addition, there is a need to identify best practices through further research in relation to models of care for older people with FMI. Finally, a holistic perspective should be used by healthcare professionals who assess older people to ensure their mental and physical health needs are fully considered.

End of Published Article

2.18 Updated Literature since Publication

The rerun of the literature review was for the timeframe of 31st of October 2017 to 31st of October 2022. In total 637 articles were screened, and 432 articles were duplicates and deleted. 245 articles were identified as potentially relevant, (Embase 219, AMED 17, Medline 190, PsycINFO 30, Cochrane 15, CINAHL 206). After further screening of the abstract, ten articles were deemed appropriate after reading. An additional two were deemed appropriate to the review question. Both these studies were qualitative and undertaken in the UK.

A qualitative study by Frost et al. (2020), which was conducted in the UK, explored older frail peoples' experiences of depression and anxiety and how their needs are met. This study had (*n*=28) older people participants. This study adds to the notion that older people with FMI have low perceived need (Chapter 2; section 2.5.2). They contend that older people had low expectations of the support they would get for their mental health as they considered low mood to be a normal part of the ageing process. This perceived need influenced older people's decision making when seeking support for their FMI.

Adding to the findings of the published review, stigma was also identified by Berry et al. (2020), who undertook a qualitative study in the UK which explored the views and experiences of older people with Serious Mental Illness (SMI) and their carers' in relation to accessing Psychological Therapies. This study had (*n*=53) participants of these (*n*=22 people with SMI) and (*n*=11) carers of older people with SMI. The study identified stigma as a barrier to older people with FMI accessing support for their mental health due to perceptions about mental health when they were growing up which were negative and open to ridicule.

A further determinant for older people with FMI in accessing psychological therapies is identified by Frost et al. (2020), who identified the desire to be independent influenced treatment choices, and older people with FMI therefore preferred ‘talking therapies’ as opposed to medication, which they associated with dependency.

Berry et al. (2020) also explored the barriers for older people with severe mental illness (SMI) accessing psychological therapies. They interviewed 53 participants (older people with SMI *n*=22, family carer *n*=11, healthcare professionals *n*=20) and concluded older people experienced ageist attitudes as it was perceived by some HCPs that it was too late to support older people with therapy due to their age. The study conducted by Berry et al. (2020), illuminates that older people often fell through service gaps. This was seen particularly around service boundaries of primary and secondary care if people did not meet the criteria for secondary care, and adult mental health and older adult mental health services.

These two studies were appraised using the CASP quality appraisal tool (CASP 2018). Berry et al. (2020) study rated a CASP score of 9 out of 10, with no documentation that the researcher relationship with participants was adequately considered. Frost et al. (2020) rated a CASP score of 8 out of 10. Again, the researcher participant relationship is not considered, and ethical considerations are not discussed. The next section provides a summary of this chapter.

2.19 Chapter Summary

A robust integrative review was undertaken at two time points –1st January 2000 to 31st of October 2017 and 31st of October 2017 to 31st October 2022 using six international databases. For the time frame of 1st January 2000 - 31st October 2017, in total, 2556 articles were yielded.

After screening and inclusion and exclusion criteria being applied, a total of these were entered into RefWorks software. In total, 741 of these articles were duplicates, which were deleted. Titles were then screened; Medline 500 articles, Embase 344, CINHAL 209, AMED 146, PsycINFO 616.

Titles and abstracts from the Cochrane Library (1129) were reviewed separately, manually and screened for relevance. After screening all titles and abstracts, in total 342 articles were identified as potentially relevant to the review questions and 28 articles were included within this published review.

The published review included 23 quantitative studies and 5 qualitative studies. 13 of these studies were conducted in the USA (*n*=13), with the rest of the studies being conducted in; UK (*n*=5), Canada *(n*=3), Australia (*n*=2) Holland (*n*=2), Ireland (*n*=1), Norway (*n=1*) and New Zealand *(n*=1)*.*

Regarding the rerun of the literature review for the time timeframe of 31st of October 2017 to 31st of October 2022: in total, 637 articles were screened of which 432 articles were duplicates and deleted. 245 articles were identified as potentially relevant, Embase 219, AMED 17, Medline 190, PsycINFO 30, Cochrane 15, CINAHL 206. After further screening of the abstract 10 articles were deemed appropriate. After reading all 10 articles, 2 additional articles were deemed appropriate to the review question. Both these studies were qualitative and undertaken in the UK.

In summary, this integrative review highlighted several determinants influence the use of mental health services by older adults with FMI. Reasons for this included that older people with FMI had the perception *that FMI is an inevitable consequence of ageing*. This perception was mirrored by their healthcare professionals and family carers. *Variations of availability of healthcare services for older adults with FMI also influenced the use of mental health services by older people with FMI*.

This integrative review illustrated there is limited evidence exploring the experiences of older people with FMI regarding support or whether mental services available, meet the support needs they require. Furthermore, little is known about what influences healthcare professionals' decisions to provide support for older people with FMI. Finally, this review revealed there were few studies exploring the experiences of family carers of older people with FMI. This identified gap in current knowledge has informed the research aims and questions in this study. These aims and questions are presented in Chapter 3 (sections 3.1.2 and 3.1.3). In the following chapter, I discuss the philosophical paradigms, the rationale for the research design, the theoretical framework underpinning the study, data collection methods and analysis in exploring what determinants influence the use of mental health services by older people with FMI.

Chapter 3: Methodology and Methods

3.1 Introduction

In this chapter, I justify my research design which was a qualitative approach. Initially a case study design was adopted but due to the COVID-19 pandemic, the research design was adapted to an interpretive descriptive design which was undertaken over two phases. An overview of the study setting, research paradigms, philosophical assumptions and the theoretical framework underpinning this study are explored.

I discuss the limitations of my study in relation to my own positioning to this study, exploring any bias and trustworthiness issues. I then consider the methodology and my justifications for its use. Following which I discuss in more detail the aim of this study, data collections methods, the recruitment process, steps in analysis and ethical considerations.

3.1.1 Setting the Scene.

This study was conducted in a health board which covers an area of 25659 square kilometres. The geographical area of this health board has within it one of the most remote and sparsely populated areas in Scotland. The population is equally populated between remote and rural, and urban areas.

In this location, HCP participants could spend up to eight hours travelling to and from visiting older people with FMI to provide support in certain geographical locations. Likewise, an older person with FMI may be required to undertake similar travel to receive assessment or support. Due to the geography, in some cases a minority of people may live in areas which requires ferry access. Since the COVID-19 pandemic, access for those in remote and rural areas has been made easier with the rapid change to online consultations and support.

Within this health board - consistent with the UK model - referrals for secondary mental health services are made by the General Practitioner (GP). Older people with mild to moderate symptoms of FMI are generally managed within primary care. Those older people with FMI who have moderate to severe symptoms will be managed by secondary mental health services. Referrals to secondary mental health services are usually made to the Community Mental Health Team (CMHT) by the GP; the exception to this being if an older person with FMI was admitted directly to the mental health hospital or referred by the general hospital if a patient there.

At times, people with an acute mental health need will be brought to the attention of the Police, who will bring people with an acute mental health need to the psychiatric hospital as a place of safety. This will also trigger a mental health assessment and admission to hospital or referral onto the CMHT where appropriate. Those older people with FMI who are presenting in crisis will be seen either by the GP or CMHT in the absence of any older adult crisis intervention team in this health board.

Within this health board there is one main mental health hospital and two Older Adult Mental Hospital (OAMH) CMHTs; one in the remote and rural area, the other in the urban (city) area. This is further divided into Adult Mental Health CMHTs and OAMH CMHTs. The mental health hospital is in the city. The CMHT consisted of a Consultant Psychiatrist, a Psychologist, Community Mental Health Nurses, Occupational Therapists and Social Workers. Participants informed me this health board has a mixed approach to delivering secondary mental health services, with some areas offering age-defined services and others providing ageless services.

Some CMHT's had age defined services where, as soon as a person turned sixty-five, they are transferred to OAMH services. Other CMHTs appeared to take a more needs-based approach and if there was no evidence of cognitive impairment, they would not transfer the person to OAMH services. Age defined services appeared to be mirrored in the community and third sector setting, although there appears not to be a specific document stating the service design.

The next section of this study describes the research paradigm used and the philosophical theory underpinning this study.

3.2.1 Overall Aim and Research Questions of the Study

The overall aim of this research study was to explore the determinants influencing the use and provision of services for older people with FMI. This aim was informed (as discussed in Chapter 2), by an integrative review which highlighted some older people with FMI do not seek mental health support because they believe FMI is an inevitable consequence of ageing; a view mirrored at times by healthcare professionals and carers (Wells et al. 2020).

In addition to this finding, different views prevail regarding the impact ageless and age-defined mental health service delivery models have on the needs of older people with FMI. Further research was required to understand these findings. Therefore, the following research questions were developed.

3.2.2 Research Questions

The study set out to explore the following research questions;

- What influences older people with FMI to seek support from healthcare services?
- What influences healthcare professionals’ decision making to provide support to older people with FMI?

- How accessible are services to older people with a diagnosed FMI and their family carers?
- How do services available to older people with FMI and their family carers, meet their support needs?

3.3.1 Research Paradigm and Philosophical Theories

Following a robust review of the literature, a judgement was made that this study should be positioned in the qualitative research paradigm using an interpretivist epistemology. This judgement was based on the need to gather an in-depth understanding of the phenomena of older people with FMI, their family carers and healthcare professionals, within the complex context of their natural setting (the boundaries between organisations in relation to mental health support). Furthermore, it was important to understand the lived experiences of older people with FMI, their family carers and healthcare professionals, which was not evident from previous research studies identified in the integrative review (Morse 2015; Denzin, and Lincoln 2017; Silverman 2013; Wells et al. 2020).

As a novice qualitative researcher, it was important for me to acknowledge that I was bringing to this study my own views on what constitutes truth and knowledge in this context. My views in relation to this study are captured in detail within the Axiology section (Chapter 3; section 3.2.2) of this thesis, along with acknowledgement of how my truth and knowledge may have impacted upon my study findings. Views and perceptions guide researchers thinking, beliefs and assumptions and frame their view of the world around them. Social scientists refer to this as a paradigm (Kuhn 1970; Denzin & Lincoln 2017).

Knowledge refers to the awareness, familiarity and skills with various objects, ideas, or ways of doing things (Henriques 2013; Parahoo 2014; Creswell &

Creswell 2018). The acquisition of knowledge is commonly understood through two means: by experience (empirical) and reasoning (logic).

Knowledge is often thought to be congruent with truth (Nakeeran 2010). Theory of knowledge is complex and is discussed in greater detail in this section. It is, however, important to acknowledge beliefs may not represent truth or reality (Denzin & Lincoln 2017; Creswell & Creswell 2018; Braun & Clarke 2014). Furthermore, truth, belief systems and how individuals perceive and interpret reality may be different amongst individuals (Denzin & Lincoln 2017; Parahoo 2014; Braun & Clarke 2014; Thorne 2016).

As an experienced nurse, working in Older Adult Mental Health, I consider myself to have substantial knowledge about OAMH services. I equated my knowledge with truth in the context of this study and did not consider other individuals may have their own knowledge and truth. It is important to acknowledge that although I have vast experience of working in OAMH, my experience of working out with that speciality are limited and may also influence a bias in my knowledge.

As a novice researcher, I had to challenge myself around the assumptions I bought to this study, of what I believed was best for older people with FMI. For me, this was a strong assumption people should not be transferred to an OAMH service at the arbitrary age of 65. This was challenging to begin with, because I had heard first-hand, peoples' views at the point of transfer whom I had previously cared for.

However, other individuals may have different views on this. For example, those working in adult services, and it is important to acknowledge their truth and reality. At this point I began to look at the literature to gain a better understanding. The different worldwide views individuals may hold is an important consideration in research. When considering knowledge and reality, two paradigms address this: the positivist paradigm and the post-positivist paradigm (Denzin & Lincoln 2017; Parahoo 2014).

This study aligns with the post-positivist paradigm. The paradigm of positivism believes that truth is scientifically proven (Parahoo 2014; Braun & Clarke 2014). Positivists believe in the unity of science and refer to experience that is tested and systematised rather than undisciplined speculation (Kaplan et al. 1994). Within the integrative review which informed this study, only 7 of the 30 studies were qualitative in nature. Consequently, there are limited previous studies exploring peoples' perspectives. Quantitative research aligns with the positivist paradigm and is used to quantify findings from data that can be transformed into statistics (Parahoo 2014; Creswell 2017).

I discounted a positivist paradigm for this study. This was justified as the integrative review informing this study revealed mainly quantitative studies (*n*=27 out of *n*=30). Thus, having a previous strong statistical knowledge but a lack of knowledge and understanding of the experiences of older people with FMI, their family carers and healthcare professionals existed in relation to what determinants influence them seeking support for FMI.

This study aligns with a post positive paradigm which enables the researcher to gather an in-depth understanding from participants whilst acknowledging that knowledge gathered can be objective without the absolute certainty provided by a positivist approach (Denzin & Lincoln 2017; Frey 2018). The post–positivist paradigm - also referred to as qualitative research - views knowledge to be socially constructed and that reality is understood in words which is a fluid process and cannot be understood by precise measurement (Corbetta 2003; Bryman 2012).

It was vital for me in my research journey to understand in-depth what the determinants were for older people with FMI, their family carers and healthcare professionals in accessing health services. This needed to be understood by words reflecting participant's perspectives (their truth). Qualitative researchers emphasise that reality is socially constructed. They believe the intimate relationship between researcher and what is studied and situational constraints, shape inquiry (Denzin & Lincoln 2017).

In simplified terms, a social construct is something which exists because humans agree it does. It is not an objective reality, but an entity existing because of human interaction. Situational constraints are factors which place limits on how beliefs and attitudes affect individuals' behaviours.

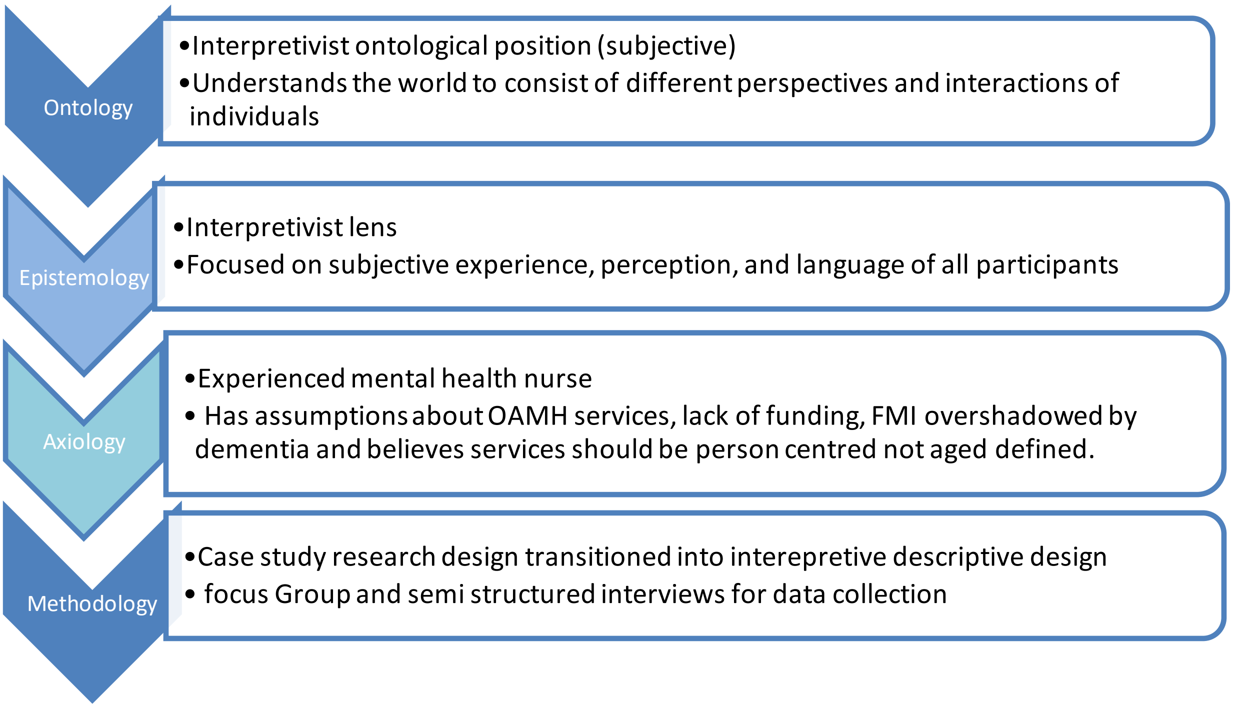
This was extremely important to my study because all participants, including the researcher, will have different perspectives but may also have similar perspectives (Thorne 2016). The role of the researcher is to analyse and synthesise these perspectives. In quantitative research, the researcher needs to acknowledge also how their worldwide view may impact upon findings and report using a reflexive approach so that the reader can see how their view may have influenced findings (Austin & Sutton 2014; Braun & Clarke 2014; Parahoo 2014).

As researcher, my view was older people are disadvantaged when they turn 65, as resources available for this population group are different. In my opinion, there are more services accessible and available for older people with dementia than for older people with FMI. I was aware of this bias, and discussion with my supervisory team provided a robust check that my research aims were not leading under this lens. I also kept a reflective diary which served as an audit trail for my decision making around my analysis. In addition, further objectivity and scrutiny was provided at my supervision meetings.

Initially I wanted to focus my research aims around age-defined services. However, the gap in knowledge identified from the integrative review was what informed the research aim which was far wider than just age defined services.

Philosophy informs how a researcher formulates their research problem and research questions and how they seek information to answer the questions (Creswell 2014). Creswell (2014), suggests there are four philosophical assumptions made by researchers when they undertake a qualitative study, being: ontology, epistemology, axiology, and methodology (Figure 2).

Figure 2: Philosophical Assumptions in Qualitative Research



Ontology
- Interpretivist ontological position (subjective)
- Understands the world to consist of different perspectives and interactions of individuals

Epistemology
- Interpretivist lens
- Focused on subjective experience, perception, and language of all participants

Axiology
- Experienced mental health nurse
- Has assumptions about OAMH services, lack of funding, FMI overshadowed by dementia and believes services should be person centred not aged defined.

Methodology
- Case study research design transitioned into interepretive descriptive design
- focus Group and semi structured interviews for data collection

Creswell (2014), suggests that philosophical assumptions or paradigms can be described as a framework which influences the nature of the phenomena being studied, the way the study will be conducted, and the methods chosen to answer the research questions. The next sections in this thesis will identify how the philosophy impacted upon this study.

3.3.2 Ontological Position

Defining the ontological position is the first stage in formulating research design (Creswell 2014). My ontological position in this study was a subjective one, aligned to interpretivism. The decision-making process will be discussed in detail in this section but, firstly, ontology is described.

Ontology, in basic terms, means the study of being or reality (Guba 1990; Braun & Clarke 2013). In simple terms ontology means either an objective or subjective view of the world (Creswell 2014). An objective perspective would indicate the individual believes that reality is made up of solid objects which can be measured. In contrast, a subjective perspective views reality as being constructed by the perceptions and interactions of living subjects (Crotty 1998; Braun & Clarke 2013).

My ontological position in this study meant I understand the world to consist of different perspectives and interactions of individuals. I further understand reality to be made up of multiple realities (individuals have a different perspective on what reality is), dependent upon individual perspectives. Finally, it is important for me as a researcher with an interpretivist ontological perspective, to explore the motives, reasons and meanings, and other subjective experiences which are time and context bound as experiences of people cannot be free from time and location (Thorne 2016).

Within this study my primary role is that of researcher. However, I am also a registered nurse, which has influenced my own position in this study. This was discussed in greater detail in the axiology section (Chapter 3; Section 3.3.4). In brief, I brought assumptions to this study about age defined services and believed OAMH services are under-resourced compared to mental health services serving the working age population group.

I considered an interpretivist ontological position to be justified in this study as the research aim was to explore what determinants influence older people with FMI's use of services. This approach enabled me, as a novice researcher, to use a philosophical lens which considered all perspectives when analysing the data that emerged from interviews, i.e. considering what participants views of the world was, whilst acknowledging my worldwide view as the researcher.

3.3.3 Epistemological Position

An interpretivist epistemology was justified in its use in this study as a philosophical lens which seeks to understand different viewpoints, values and recognises these are dependent on context (Alharahsheh et al. 2020; Parahoo 2014). Applying this lens to the research aims and questions of this study, I sought to explore and understand what motivates and influences decisions in older people with FMI and their family carers to use services and what motivates and influences decisions in healthcare professionals to offer support. Hence, participant's perspectives were essential to inform the research questions.

Being a novice researcher, it was challenging in the early stages of my study to grasp the theories of knowledge and the different philosophical lens', with an abundance of literature and so many different approaches. However, I understood epistemology refers to the way in which valid knowledge is obtained (Crotty 1998; Couper 2020) and within social and health sciences, the most common epistemological positions are positivist and interpretivist (Creswell 2014, Crotty 1998, Bryman 2011). A positivist approach typically aligns with an objective ontology. This approach undertakes research by positioning and explaining principles and focusing on facts.

In contrast, interpretivists align with a subjective ontology and seek to explore relationships, focus on meanings, and try to understand what is happening (Parahoo 2017, Bryman 2008, Crotty 1998, Childs 2020). It became clear that a positivist approach would not meet my research aims, as I was seeking to explore experiences rather than fact. I realised that an interpretivist lens would allow me to meet my research aims by enabling me to focus on subjective experience, perception, and language of all participants. This enabled me to explore and understand their motivation for seeking support for their FMI (Tenny et al. 2022).

By using an interpretivist approach to study perceptions and behaviours of participants, I understood I could not participate in this study as a detached observer. My role of researcher was to access the thoughts and feelings of participants (Austin & Sutton 2014). Therefore, I used methods (focus group and semi structured interviews) which were interactive and flexible - as human beings are not predictable in their actions and interactions in relation to outcome and process.

3.3.4 Axiological Position

Consideration of my own personal values, beliefs and assumptions were essential to identify, as there is potential for these to influence the research initiative (Creswell 2014). Austin and Sutton (2014) suggest the qualitative researcher should define their worldwide view at the outset of their research study. This worldwide view has potential to influence how the research aim and questions are designed, analysed, and reported (Austin & Sutton 2014). Therefore, reflexivity is essential in documenting how findings have been reached, providing rigour and trustworthiness to the process (Berger 2015).

At the outset of this study, I held the position of Nurse Consultant and Clinical Director for Older Adult Mental Health Services in a health board in Scotland. In 2020, I moved position to Service Manager for Mental Health and Learning Disabilities in a Local Authority Area and this role covered also the Older Adult Mental Health Team. I have worked within Older Adult Mental Health Services for over twenty years and believe the experience I have of working in this speciality enhances my knowledge and sensitivity of issues raised in this study.

For example, when I worked as a CMHN, I observed how an older person felt turning age 65 and being transferred to the older adult service. Some people felt insulted being transferred to an older person's service, others felt abandoned by a team they received support from for years. Older people also would highlight after transfer that they would get far more intensive support from the adult mental health service which the OAMH was not resourced to deliver, meaning less visits from the CMHT. However, on balance, it may be viewed that if older people with FMI do not need mental health support until later in life, they may not know the difference between OAMH and AMH services.

I know through experience that much attention is given to dementia services with little focus on FMI in older people. This is compounded further as much more attention is given to younger adults with the same conditions. Evidence has shown people with long term mental illness are less likely to seek the support they need when they become unwell, as their illness affects their insight (Corrigan et al. 2014). Furthermore, many in this population group have limited social and family networks (Green et al. 2018). In addition, people with severe mental illness suffer poorer mental health and are likely to suffer a physical health comorbidity (Nash et al. 2015). It is also important to highlight that people are living longer and many people in the UK are working past their normal retirement age, but old age services being defined at the age of 65 appears to be an arbitrary historical decision.

My previous experience of working in this field had potential to influence how I undertook this research study as I had very strong views and perceptions from having worked in this area. This could have affected my lens when constructing my research questions, interviewing participants, and analysing the data. My supervisory team were a very helpful sounding board in pointing out to me during the early stages of this research apprenticeship when I had, in fact, blurred the approach with my own views and perceptions and prompted me to reflect.

The biggest assumption I brought to this study was services should be provided according to need and not age defined. To explain these further, different models of care exist for older people with FMI, some mental health services are ageless in contrast to others that are age-defined (where a person is automatically transferred to an older person's service at age 65) (Abdul-Hamid et al. 2016).

My view is that services should be needs led, as I believe some people of 65 are still physically active and in my experience being labelled as an older adult has been detrimental to them psychologically as they do not identify as being old. Warner (2015), suggests older adult services are under-resourced in comparison to working age adult services and therefore believes older adults are disadvantaged by arbitrary transfer at 65 to a less resourced service.

Invariably there are countering views, and it is important to reflect these too. Many believe that age defined services are better for older people as they are a specialist service requiring a specialist skill set in the professionals who work there which generic working age services do not perhaps possess (Saad 2016; Warner 2018; Cheung 2015; Abdul -Hamid et al. 2016).

These specialist skills would relate to the comorbidity of physical ill health and mental ill health in an older person and the potential to develop dementia.

Personally, I do not support this perspective as I believe a holistic approach of meeting the comorbid needs of patients should be adopted across the lifespan of individuals.

Considering my strong view, I made strenuous efforts to ensure trustworthiness by acknowledging my assumptions throughout this study and was explicit of my stance in the reporting of findings. Furthermore, a reflective journal was kept. Regular discussions took place at my supervisory sessions which provided an objective stance from three other people about assumptions of my own I may not have recognised. An example of this is detailed below.

During my earlier interviews, where asking about referrals to the CMHT and how these were processed. I did not ask any probing questions. I was asked at supervision why I hadn't expanded and asked more. I said because I know what the process is. It hadn't dawned on me that I was interviewing as a researcher not interviewing participants as a nurse, who had preconceived ideas. It was my job as a researcher to find out why. This discussion was one of many enlightening moments I had during my research apprenticeship.

I was motivated to do this study as, during the many years I have worked in Older Adult Mental Health Services, as national and international policy in health care services has focused on dementia (since the genesis of the Scottish National Dementia strategy 2011). From my perspective, older people with FMI have been overlooked strategically and financially in terms of resource provision despite their complex needs. I also wondered how older people feel to be labelled an older person upon transition to older adult mental health services or indeed, arguably, labelled by their diagnosis.

3.3.5 Methodology

As stated previously, during the data collection phase of this study COVID-19 hit the UK in March 2020, impacting on my ability to recruit participants, causing some challenging decisions. This methodology section discusses the rationale to research design, the choices that I made and describes the methods of data collection.

3.3.6 Rationale for Research Designs in this Study

This study adopted initially a case study approach which evolved to an interpretive descriptive approach, to meet the research context during the pandemic. Lockdown due to the pandemic meant recruitment of older people with FMI was challenging, HCPs likewise, due to their increased workload. Those recruited to phase two were all interviewed by phone due to pandemic constraints.

In qualitative research several research designs exist, and it is important to identify why other approaches were discounted. The justification for using a case study approach was to capture the multiplicity of perspectives that are often context dependent. I considered case study design to be the most appropriate research strategy to use in this study- preferred to other designs, such as Ethnography and Grounded Theory. Justification for moving to an interpretive descriptive approach is discussed later in this section. It is helpful, however, to provide an overview of some other qualitative research designs in Table 4 which will allow further justification to the research designs that have been chosen in this study.

Table 4: Examples of Qualitative Research Designs

Ethnography	**Grounded Theory**	**Phenomenology**
Involves researchers observing participants in their natural settings over time. In ethnography, the natural setting is un-adapted for the researcher. The environment or natural setting is as important as the participants in a study using ethnography as an approach. This includes acknowledging that the environmental constraints and context influence behaviours and outcomes.	Is a framework that suggests theory must derive from data. It is an approach that suggests data should be used to test a theory. This approach is particularly helpful when little or nothing is known about something.	Attempts to understand problems, ideas, and situations from the perspective of a common understanding and experiences rather than differences.

Austin and Sutton (2014)

Reviewing the different approaches in research design, I discounted Ethnography as it is a quite lengthy process and, in undertaking a PhD, I was working to a defined timeline. Furthermore, it involves observing participants and given my study was being conducted in another health board it would have been challenging to spend so much time there as a part-time student. I discounted Grounded Theory, as the purpose of this design is to test a theory. Finally, I discounted Phenomenology as it seeks to understand a situation from common experiences, thus important data could be missed from those with differing experiences.

This study was conducted in two phases. Phase one formulated the exploratory phase of this study and was designed to provide local context to inform phase two. Phase two, at the outset of this study, was initially designed to provide an explanatory facet. However, this study design evolved (as discussed next) and this phase then aimed to explore thematic patterns and commonalities believed to characterise the phenomenon and the individual variations in accounts informing this (Thorne et al, 2016).

The pandemic impacted significantly on my ability to recruit cases to the study in terms of the numbers of participants and their connections as a 'case'. I therefore made the decision, after discussion with my supervisory team, to change my research design to an interpretive descriptive approach (Thorne 2016). This decision was made as I did not have enough data collected through completed cases to fully undertake a case study approach, in particular, cross case analysis as originally intended.

However, it was judged that an interpretive descriptive research design met the research aims of this study. This is because an interpretive descriptive design is still a qualitative approach and seeks to get an in-depth understanding of a phenomenon. In contrast to a case study approach, an interpretive descriptive approach is an approach that allows flexibility with low participant numbers, acknowledging that richness of findings does not necessarily come from numbers of participants. This design suggests a qualitative study could even be undertaken with one participant (Thorne 2016). The decisions surrounding the change in research methodology will be discussed in greater detail throughout this chapter.

3.3.7 Case Study Design

In the planning stages of this study, case study research was considered the most appropriate design for this study. This was justified as I wanted to gather an in-depth understanding of the phenomenon within its real-life context.

Yin (2018, Pg.13), describes case study research as *"an empirical inquiry that investigates a contemporary phenomenon within its real-life context, when the boundaries between phenomenon and the context are not clearly evident; and in which multiple sources of evidence are used".*

It would have been challenging to gather a true understanding of the influences and decisions of older people with FMI, their carers' and healthcare professionals to seek and offer support, without considering the context which influences the use of mental health services. Furthermore, consideration of the phenomenon - from the perspective of the participant - requires exploration to inform this study. Within, the natural setting is defined as the boundaries between organisations in relation to mental health support for older people with FMI and their family carers.

Context refers to the determinants which influence the use of services. It also relates to the decision making of healthcare professionals, older people with FMI and their family carers. To explain further, older people with FMI and their family carers living in the community can meet different healthcare organisations, ranging from primary care, specialist services, care homes and voluntary services.

A case study design is considered a beneficial approach where the boundaries are not clear between the phenomenon and the context (Yin 2018); which in this study is the phenomenon of FMI in the context of support from various health care organisations. Case study is also the preferred method compared to others when the main research questions are 'how', 'what' or 'why' (Yin 2018). These reflect the research objectives in this study and offer further justification for the use of case study research design.

As identified and as will be discussed, my research design was fluid to address the challenges of the pandemic. However, a case study was what I set out to do and aspects of this continued to inform my study even once the research design had evolved. It therefore remains important to acknowledge criticism and limitations of the case study approach.

Historically, quantitative researchers contend that case study research lacks validity and reliability and the results from these studies are unscientific and anecdotal (Cronin 2014); although case study research can be used in quantitative research. In addition to this, the vast amount of data produced is noted to be difficult to organise, with a temptation to veer away from the focus of the study. Therefore, this needs to be considered carefully in the design of the study (Heale et al. 2017).

It is important to highlight the five components of case study research as described by Yin (2018), to inform the decision-making process I was required to make in relation to the methodology for this study. These five stages are:

1. A case study's questions
2. Its propositions
3. Its unit(s) of analysis
4. The logic linking the data to the propositions
5. The criteria for interpreting the findings (which will be discussed in Section 3.10)

As intimated, the COVID-19 pandemic posed a real challenge to me as a novice researcher conducting my data collection in a different health board. As I reached phase two data collection, the country was placed in lockdown in spring

2020. I had not had the opportunity to raise my researcher profile in the health board and only really managed to form a connection with one potential key informant. Despite many efforts my recruitment of participants was not the numbers I had hoped for. I was given the opportunity to take time out of the study but decided against this as I felt valuable insights of conducting research in a pandemic would be lost.

Nevertheless, it was becoming apparent that the data I had could not generate sufficient case studies in terms of the defined unit of analysis (an older person with FMI, and up to two family carers and two HCP). Added to this, I would have been unable to undertake cross case/unit analysis, an essential proponent to case study methodology.

This was exceptionally disappointing to me and somewhat daunting having to consider changing my methodology mid-study. I made the decision to adapt and change to an interpretive descriptive design (following discussion with my supervisory team), which is discussed in greater detail in the following section. Some of the work captured during the cases study design remained pertinent to my study and findings.

Yin (2018) suggests that 'theoretical propositions' should be used as a blueprint for the study. The following theoretical propositions for this study emerged from the background information literature informing this study and my own professional experiences. These theoretical propositions remained pertinent to the study despite the change of methodology as they had informed emergent concepts from the integrative review and were used to validate findings from data collected (Yin 2018).

Table 5: Theoretical Propositions

Theoretical Proposition	**Source**
Decision making by older people with FMI to seek mental health support is influenced negatively because they believe FMI is an inevitable consequence of aging. This belief is often mirrored by family carers and impacts on their decision making to seek support too.	Crabb and Hunslet (2006), Holvast et al. (2012), Mackenzie et al. (2008), Muir et al. (2014), Mackenzie et al. (2010).
Decision making by generalist healthcare professionals, is influenced by their perception that FMI is an inevitable consequence of ageing. This affects the support that is offered to older people with FMI.	Holvast et al. (2012), Palinkas et al. (2007), Arean et al. (2007), Muir et al. (2014).
Ageism and stigma are evident in the natural setting and context of mental health services and support for older people with FMI. These factors are key in influencing the decisions of older people to seek support and healthcare professionals to offer support. Older people with FMI are more forthcoming to seek support for their mental health, if they have a physical co-morbidity. I propose this is because older people believe a physical illness to be more worthy of support and have less associated stigma than a mental illness.	Crabb and Hunslet (2006), Mackenzie et al. (2006), Preville et al. (2009). Byers et al. (2016), Muir et al. (2014), Palinkas et al. (2007), McCormack and Skatvedt (2017). • Professional experience
It is essential that the complex needs that older people with FMI have are fully understood. This knowledge is essential, as healthcare professional's knowledge of these complex needs influence how these needs are	• Professional experience Abdul-Hamid et al. (2016), Palinkas et al. (2017), Morrow-Howell (2000).

met in both the context and natural setting of mental health services.	

3.3.8 Interpretive Descriptive Research.

As stated at the outset of phase two, the research design in this study evolved to reflect the changing research context and the challenges posed by the COVID-19 pandemic. I had not managed to recruit enough participants to enable me to meet the defined unit of analysis in case study and would not have had sufficient data to undertake an essential proponent of case study research; cross case analyses and I lacked completeness of cases (Yin 2018). Therefore, I made the decision to change my methodology to interpretive descriptive research. The adaption in research design was justified, as an interpretive descriptive approach enabled me to get the best from a smaller than expected sample size. It provided a framework not reliant on quantity or cross case analysis.

However, there are some clear similarities between case study research and interpretive descriptive research which fostered this transition and justification as to an appropriate choice of methodology. For example, Yin (2018), speaks of “how”, “what” and “why” questions. In interpretive descriptive research, Thorne (2016), a seminal author in interpretive descriptive research, suggests the grammatical form of the question is important and how this frames concepts. For interrogative questioning, she suggests the researcher may use “what”, “how” and “when which enables an in-depth understanding of the phenomenon.

The following table demonstrates how I used the “who”,“ how”, “what” and “when” approach.

Table 6: “Who”, “how” ”what” and “when” approach.

Who	**How**	**What**	**When**
Older people with FMI	How they access mental health services	What their experience of mental health services are	They access mental health services
Carers	How they access support	What their experiences are of accessing support	They access support
HCP	How they offer support to older people with FMI	What their experience is of offering support to older people with FMI	They offer support to older people with FMI

A characteristic which differentiates interpretive descriptive research to case study research is that interpretive descriptive research can be undertaken on almost any sample size. This was a fundamental point in choosing this research design given my relatively small sample number (*n*=12) (Thorne 2016).

Interpretive descriptive research can be understood as a method which provides methodological direction to researchers in applied sciences including nursing as it provides a flexible, un-rigid approach that contributes to the production of knowledge (Teodoro et al. 2018). It is a relatively new methodology and is described as an inductive, qualitative approach designed to create ways of understanding clinical phenomena that yield applications and implications (Thorne 2016; Thompson-Burdine et al. 2021).

An interpretive descriptive approach is justified as a research design in this study, as it is an approach which intends to create a rich and detailed description of some phenomenon, discovering associations, relations and patterns that help the reader understand deeper and richer aspects, to enable them to have a better understanding of the phenomenon, triggering a vision and an action related to practice (Thorne 2016).

This was a very strong justification for using this approach in my study as I was aiming to gain an in-depth understanding of the phenomenon in this study. In addition, much of this study was related to the practice area of mental health. Furthermore, interpretive descriptive research, Thorne (2016) suggests, can be conducted on samples of almost any size, although likely to be relatively small (between five and thirty participants).

The deep involvement with a small number of individuals willing to share their experiences with the researcher makes it possible to produce something worth documenting (Teodoro et al. 2018). This further adds justification to my choice of this approach, although in some paradigms my relatively small data collection may be considered a limitation. This approach identifies the value of really understanding in an in-depth way experiences of people who have been willing to share their story. Thorne (2016), also suggests that several data sources can be used in interpretive descriptive research, including focus groups and semi-structured interviews, which were used in this study and is commensurate in approach as per Yin (2018), in terms of data sources.

Transitioning to an interpretive descriptive approach did not affect the research design in relation to the recruitment of participants and as mentioned by Thorne (2016), does not specify any sample size. In fact, she contends qualitative research can be conducted on very small sample sizes. However, Thorne (2016), suggests the researcher needs to generate a defensible claim about their participant size to validate that the findings of the research are worthwhile. Accordingly, my claim around this studies sample size is the following:

> *This study has recruited in total 11 participants. Older people with FMI (n=4), family carer (n=1), HCP (n=6) - one HCP participant participated in interviews in both phase one and phase two.*
>
> *This sample size has enabled an in-depth understanding of the determinants that influence older people with FMI to access support for their FMI. This in-depth understanding has been achieved as varying perspectives and experiences have been sourced from older people with FMI who have a range of different illnesses and experiences of how they have received support.*
>
> *Furthermore, a wide range of HCPs were interviewed which again provided an in-depth understanding of why different disciplines offer support. Unfortunately, only one family carer was recruited, a limitation in this study but nevertheless did provide the perspective from a family carer around accessing support for FMI.*

With a slight difference to a case study approach, Thorne (2016) highlights the importance of building credibility indicators into the research design. These should be used to ensure the integrity of the findings. I received as a minimum, monthly research supervision with three academic supervisors. Each of these supervisors challenged the entire process of this study- from the integrative literature review, coding and theming data to findings which have emerged from the data. My supervisors challenged my assumptions to ensure that insofar as is practicable, the findings of this study are trustworthy and credible. In addition to this I have kept a reflexive diary as an audit trail of my decision making.

Interpretive descriptive studies features and application to this study are highlighted in Table 7.

Table 7: Interpretive descriptive research design and application to this study

Interpretive descriptive research design and application to this study	
Features of Interpretive descriptive research design	**Application to this study**
- Are conducted in as naturalistic a context as possible in a manner that is respectful of the comfort and ethical rights of all participants	- Study was undertaken either in the work environment of the patients or over the phone in the CMHT setting. All participants consented. There was a balance to be achieved in respecting the rights of participants, one became quite anxious - therefore I respected this and did not ask so many enquiring questions, but this did impact upon the quality of data gleaned in this interview.
- Explicitly attend to the value of subjective and experiential knowledge as one of the fundamental sources of applied practice insight	- Semi- structured interviews which were analysed, whilst considering my own axiological viewpoint - documented in a diary.

	Findings were also discussed at supervision to ensure I was capturing the subjective experiences of participants and not projecting my own views.
• Capitalise on human commonalities as well as individual as well as individual expressions of variance within a shared focus of interest	• Wrote a narrative summary after each interview and compared each summary and transcript searching for commonalities whilst capturing individual perceptions. Commonalities in perceptions for example were that older people with FMI in rural areas were more stoic. Contrasting views existed around ageless and age defined services.
• Reflect issues that are not bounded by time and context, but attend carefully to the time and context within which human expressions are enacted	• The pandemic being a key feature which led to the methodology change. In addition to this coding and analysis reflected the perspectives of participants in relation to time and context on example being the geographical area influenced healthcare

	practitioners where offering support.
- Acknowledge a socially "constructed" element to human experience that cannot be meaning fully be separated from its essential nature.	- One example of this in relation to the application of this study is peoples' perceptions about mental illness. Society in older people has constructed a belief that it is a weakness to have a mental illness.
- Recognise that, in the world of human experience, "reality" involves multiple constructed realities that may well at times be contradictory	- An interpretivist lens (used in this study) recognises the multiple realties (older people with FMI, family carer, HCPs) that construct experience and truth. This study has different stakeholder that will have multiple realities, these are older people with FMI, Family Carer and HCPs. - This was created through multiple written drafts of findings with detailed feedback and discussion with the supervisory team.
- Acknowledge an inseparable interaction between the knower and the known, such that the inquirer and the "object" of that inquiry influence one another in the production of the research outcomes (Thorne 2016).	- I recognised my own assumptions and views and kept a diary in how I reached the decisions that I have in this study. A further layer of objectivity is bought to this study by

	discussing findings regularly at supervision.

Thorne (2016) suggests there are two ways to present study findings. The first is to organise findings and present an overall conceptual claim. The second approach to presenting findings as described by Thorne (2016) is to present a sequenced framework that allows the story of the study to be told. The second approach has been chosen for this study as it fits better with an interpretive approach. Furthermore, this study uses an interpretivist epistemological lens and is more interpretive than descriptive as it has attempted to explore the meanings and understand peoples' lived experiences rather than simply describe them. It is helpful to highlight that for Thorne (2016), concepts capture the essence of findings and are different to concepts which inform a conceptual framework.

Therefore, findings in this study are referred to as concepts. Thorne (2016) also suggests concepts need to be presented in a sequenced framework. This is presenting concepts in a logical order such as the order of this thesis. The next section of this thesis explains and offers justification for the data collection methods used in this study.

3.3.9 Justification for the Choice of Data Collection Methods

The data collection methods used in this study was one focus group of (*n*=3) HCP's and semi-structured interviews with all stakeholders (*n*=12). These were chosen to illuminate the lived experiences of older people with FMI, their family carers, and HCPs in relation to the determinants influencing older people with FMI's use of services.

To understand this further, the determinants related to decision making around both why mental health services were or were not accessed by older people and their family carers, and what influenced HCPs decisions to offer support sentence structure. I considered these data collection methods were an effective method for all participant groups to share their experiences.

The advantage of a focus group was to share richness of experiences from multiple perspectives, in one interview (Nyumba et al. 2018). The disadvantages are that one or two participants may dominate the conversation and some participants may feel uncomfortable speaking in a group setting. It is the researcher's job to try and manage the latter points (Gill and Bailie 2018).

3.3.10 Justification for Focus Group with Healthcare Professionals

I considered the use of a focus group necessary in this study to gain insight as to what influences health care professionals' decision making to provide support to older people with FMI. In addition, I wished to understand how organisations operate and provide services within the natural setting (hence only HCP included). I considered that findings in phase one (the focus group) were essential to inform the topic guide of phase two in case insights regarding decision making had been omitted from the topic guide.

Focus groups are described as being beneficial when gathering perceptions, feelings, and peoples' thoughts about a subject, identifying issues, gathering insight from others and developing strategies for service provision (Krueger and Casey 2015; Braun and Clarke 2013). Ocheing et al. 2018, suggests that focus groups are a useful tool in qualitative research and are uniquely suited to helping specific groups of people articulate their beliefs, values, desires, and concerns. Gill and Bailie (2018) suggest the focus group is more beneficial than surveys where trying to answer investigating questions particularly in the health care field. The focus group in this study was informed by a topic guide (Appendix 5).

3.3.11 Justification for semi-structured Interviews with Older persons with FMI, their Family Carer and HCP

In this section, I offer justification for the use of semi-structured interviews in this study. In qualitative research, interviews are the most common form of data collection (Jamshed 2014). I chose to use semi-structured interviews in this study; defendable as a data collection method which attempts to understand themes of the lived world from the perspective of participants' perspectives. As an approach, it should not be too dissimilar to a conversation but at the same time has a purpose (Wholey et al. 2015). The semi-structured interview is constructed to have predetermined questions with the fluidity to explore important issues raised by the participant during the interview (McGrath 2018).

The predetermined questions in the semi-structured interview topic guide were informed by the themes highlighted within the integrative review and findings from the focus group in phase one. The following is an example of a question asked at the focus group (in phase one - which informed the phase two topic guide), which was developed from the integrative review with the aim of understanding HCPs' experiences of working with older people with FMI and their family carers;

> *"Can you describe your experiences as a healthcare professional working with older people with FMI and their family carers?* "

This topic guide can be viewed in Appendix 5.

3.3.12 Sampling

This section offers an explanation and justification for the sample population, sample size and sampling strategy. Purposive sampling was initially intended to be used in this study to recruit participants. Purposive sampling is a widely used approach in qualitative research for the identification of information rich cases (Palinkas et al. 2015).

However, given that my research was being conducted in a neighbouring health board, recruiting participants was fruitless using purposive sampling, despite several attempts. Therefore, following discussion with my supervisory team, I changed my sampling strategy to convenience sampling, which proved more effective. Convenience sampling is a strategy that is non-probability. It is a strategy often used in areas where it is hard to recruit and selects participants who are willing and ready to engage (Hassan 2022). I considered this approach to be justified as I wanted to gain an in-depth understanding of a particular group of participants, older people with FMI, their family carers and HCP's and was having challenges recruiting using a purposive strategy.

3.3.13 Eligibility Criteria

The eligibility criteria for older people with FMI to participate in interviews was:

- A diagnosed FMI
- Be over the age of 65.
- Be in receipt of a mental health service.

Family carer:

- A family member with a caring role for an older person with FMI (either biologically or non-biologically related person to the older person with FMI).

HCP's to participate in interviews and focus group:

- A Healthcare professional (GP, Psychiatrist, Nurse, Psychologist, Allied Health Professional) who supports an older person with FMI.

Third sector professionals who support older people with FMI. Third sector in this study is an umbrella term for non-profit organisations, including charity and voluntary work (Oxford Scholastica 2023).

In this study, the sample collection for older people with FMI was based on a criterion of, having a diagnosed FMI, be the age of 65 or over and be in receipt of a mental health service. The sample collection of family carers was based on a criterion of being a family member with a carer for somebody who has a diagnosed FMI. The sample collection of HCPs was based on a criterion that they were linked to the older person with FMI by being an HCP involved in their mental health care and treatment.

Participants were excluded if they could not consent to participate or had any signs of cognitive impairment. This was screened by the key informant who used a mini mental state examination (Folstein et al. 1975) score to inform of above 25. Participants who did not speak English were excluded as there is no budget for translators and family members translating may add their own perspective.

3.3.14 Sample Size

What defines an adequate sample size in qualitative research is ambiguous with sample sizes often chosen arbitrarily (Cleary et al. 2014). However, it is widely acknowledged that the sample sizes in qualitative research are often much smaller that quantitative research. This is because qualitative research is concerned more with gathering an in-depth understanding and less concerned with making generalisations across wider population groups (Malterud et al. 2015).

Some qualitative researchers offer general guidance on sample size; Creswell (2007), recommends at least 20-30 interviewees. His view is also shared by Morse et al. (2002). Yin (2018), suggests at least six sources of evidence and Creswell (2007), suggests no more than four of five cases, with three to five interviewees per case. Thorne (2016), suggests participant sizes could be as little as one, her focus is more on capturing in depth data. For focus groups Krueger and Casey (2015), recommend between 5-8 participants who are diverse yet homogenous. Minimum participants for the focus group need to be considered, otherwise the richness of shared conversation will not be optimum (Cleary et al. 2014).

The sample size for the focus group in this study (phase one) was in total (*n*=3). In addition to this, there were three separate semi structured interviews of HCPs in phase one. My aim was to recruit to phase two five participants per case with an aim of recruiting five cases. This was not achieved, in main due to the pandemic as already discussed. This reflects Yin's recommendation, but also as the researcher I felt this sample size was a realistic, manageable number for data analysis to achieve an in-depth understanding.

As part of ethical permission, it was agreed participants would be excluded if they could not consent to participate and had any signs of cognitive impairment. In addition, any participant who did not speak English was excluded as there is no budget for translators and family members translating may add their own perspective. I did not encounter any participants who did not meet the criteria to participate.

3.3.15 Recruitment

Recruitment to phase one (focus group), was undertaken by me by letter of invitation (see Appendix 6) to healthcare professionals and third sector representatives (Senior Charge Nurse, members of the Community Mental Health Team, GP, Voluntary Services Aberdeen, Penumbra and Advocacy services). The focus group was held face to face (pre – COVID-19) in the mental health hospital as it is a central location, with good parking facilities and known to many of the invited participants who utilise the hospital facilities or work there.

Recruitment to phase two was undertaken by key informants (a Community Mental Health Professional and Psychologist). The key informant approach is a qualitative research method. The key informant is an expert source of knowledge, whose role should expose them to the information being sought by the researcher, hence justified in this study (Pannucci et al. 2010).

The key informants in this study were healthcare professionals who work with older people with FMI. They were provided with eligibility criteria and were then were able to determine the eligibility of potential participants (older person with FMI). Once potential participants were identified, the key informants gave them a letter of invitation to participate (Appendix 6) and informed me.

I then phoned the participants (older people with FMI and the family carer) and explained the study. If the older people with FMI identified were agreeable, I phoned approximately a week afterwards to establish they still wished to participate and to answer any questions they may have. This gave participants time to consider participating, allowing them time to discuss with family members or friends. When I interviewed participants for the first time, I sought their consent to involve their family carer and healthcare professionals in the study and sent them an information leaflet and letter (Appendix 7, 8 & 9) to give to them with my contact details on, if they were agreeable to participate in the study, I then contacted the older person with FMI one week later and asked if their family carer/ healthcare professional might consent to participate in the study. I then made telephone contact - if the older person with FMI had their contact number. For healthcare professionals, seeking their consent to participate in the study was initiated via email contact in order to arrange a mutually convenient time to speak.

3.4 Ethical Approval and Permission Process

Ethical approval for this study was obtained from Robert Gordon University School of Nursing, Midwifery and Paramedic Practice Ethical Review Panel (SERP). Approval from them was granted on 17th April 2019 (Appendix 10). The purpose of the SERP panel is to safeguard participant's welfare, dignity, rights, and safety. The following amendments to the proposal were made following SERP feedback, prior to final approval.

- Patient information sheet and invitation letters. Minor changes made to reflect Health Research Authority (2018) guidance.
- Minor change to consent form.
- Introduction added to topic guide.
- Storage of hard copies of data to be uploaded to university "R" drive

Ethical approval for this study was also granted by NHS Research and Development via an IRAS application approved on 13th September 2019, reference number 259385 (Appendix 11).

Initially the study was to be undertaken in the area I work. Feedback from ethical review suggested this may have potential to create bias and, therefore, they did not support me undertaking research in the health board where I work. This was quite a setback for me as a novice researcher. My principal supervisor suggested I appeal this decision. However, I was eager to get the study underway so approached a neighbouring health board to see if I could undertake my research there. On reflection, I think this decision made recruitment extremely challenging because I did not have any contacts to approach and when lockdown happened, it was impossible to visit the health board and raise my study profile.

However, the positive aspect of going to a neighbouring health board was my anonymity and the confidence that provided me with that my research was trustworthy insomuch that I knew participants were saying what was important to them and not what they may say to a manager.

An application was made to conduct this study in a Scottish remote and rural health board and permission given by the Research and Development Team; study number (Health Board) 1564, approved 9th October 2019, and by the health board management team (Appendix 12). This health board had some similarities to my area of work given the remote and rural location. Some teams in secondary services within this health board appeared to have a person-centred approach to transfer to older adult services upon turning age 65, whilst others had age restrictions. This was mirrored by peer support and support groups.

Informed consent

In terms of managing ethical considerations during this study, participants were recruited to this study by key informants. This was to ensure that there was no coercion or influence from the researcher over participants. Once participants were identified the key informant (HCP) alerted the researcher who posted or emailed an information sheet about the study to the participant (Appendix 7, 8, 9) potential participants were encouraged to discuss participation in the study with their family carers before they agreed to take part. If participants were agreeable to participate, I contacted them by phone seven days later to answer any questions they may have and organise a time to interview them and within this time frame they could withdraw from the study, participants were made aware that withdrawal from the study would not have any impact on their ongoing care and support. They were able to do withdraw by writing to me or phoning me. Participants were asked to sign a consent form (Appendix 13, 14, 15) before they participated in the interviews, which was posted or emailed to them.

Data management and confidentiality

This study was conducted within the NMC (2018) Professional Code of Conduct, in relation to confidentiality. Data was collected and stored safely, in line with the General Data Protection Regulation Act (2018), on the RGU R drive. The computer was password protected. Data will be stored for five years on completion and submission of this thesis in concordance with Caldicott (1997) principles. Only the four members of the research team had access to the data. Hard copies of data were to be scanned and uploaded to the RGU 'R' drive, however, there were no paper transcripts as all data was collected virtually by phone and recorded and then transcribed directly to electronic format. Every effort to maintain the anonymity of participants was made by using pseudonyms in written text; this was achieved by assigning a pseudonym to each interview transcript.

I considered potential negative consequences to participants from this study. Therefore, when participants became upset or distressed at any time during this study, I halted the conversation, I planned if that was not sufficient to signpost the participant to appropriate support such as counselling or GP, however, I did not encounter this in this study so did not have to do this.

It is possible that during interviews disclosures could be made about poor practice or professional misconduct. The limits to confidentiality were made explicit to the participant, verbally at the outset of the study. However, this was not something I encountered. There was also limited potential of risk to participants from partaking in this study should the interviews evoke powerful emotions around previous experiences. If participants become upset during an interview I would have ceased the interview. If a participant has required additional support to manage their emotions, I would have signposted them to a source of support ie, counselling, GP, CMHT. However, I did not encounter this during any interactions with participants.

The next section of this chapter illustrates the conceptual framework.

3.5 Conceptual Framework

Through engaging with the literature and reflecting on my own position and stance, I was able to develop a conceptual framework to help guide my reflexivity during data collection and analysis. I judged setting out the key and emerging concepts would allow me to focus on what the participants were telling me, and help me keep track of my developing understanding and thinking. In addition, it keeps the researcher focused on the study and allows the researcher to maintain order and offered clear explanation of their study (Green 2014).

The terminology of theoretical and conceptual frameworks in contemporary qualitative research are debated by Green (2014), who suggests there is no clear definition and limited literature regarding the differences between a theoretical and conceptual framework. Parahoo (2017), suggests a theoretical framework should be used in research where theory is informing the study; in contrast he suggests the conceptual framework draws on concepts from various theories and findings which guide the research.

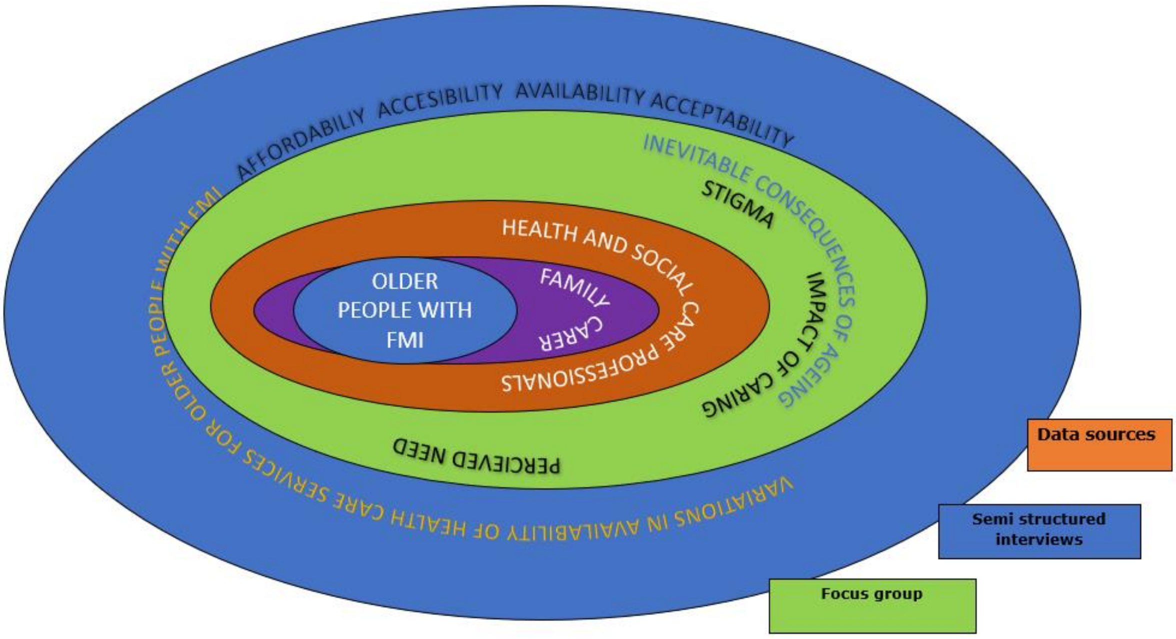
Thorne (2016), suggests concepts need to be set up in an organising framework. I have used the conceptual framework as an anchor and guide to maintain my focus on my study and the findings from the integrative review that have informed this study.

The conceptual framework is described by Miles, Huberman, and Saldana (2013), as either a graphic or narrative that explains the key things to be studied - including key factors, variables, constructs, and the presumed interrelationships between them. They describe that the researcher can then place this information into "intellectual bins".

The conceptual framework forces the researcher to identify, which relationships are most meaningful and consequently which data should be collected and analysed. It further allows analysis of the phenomenon which would have allowed eventual cross case analysis (in case study research). In more simple terms it is a map of what the study will investigate, and should be an emergent process throughout the research study. I have refined this conceptual framework on many occasions as the analysis of data has been refined.

The following conceptual framework is a map of my research study. This framework highlights the overarching themes which influence the determinants influencing why older people with FMI seek support, likewise, their family carers and what influences HCPs to offer support. The data sources informing the study are at the side of the framework.

Figure 3: Conceptual Framework



The next section of this thesis describes the data collection in phase one of this study.

3.7.1 Data Collection Phase One

The aim of phase one was to understand the context of the health board where this research was being conducted. This was used to inform the topic guide in phase two. In this section, I describe how I recruited participants to the focus group in phase one and collected data by conducting individual semi-structured interviews is this phase.

The Lead Nurse for the health board was my research point of contact, given by the research department in the health board. She was able to give me contact details for the service manager for the older adult mental health services. The health board chosen for this study has a large geographical area with a relatively low population of people. This health board is divided into two health and social care partnerships. Following discussion with the service manager, we agreed I should conduct the study in the health and social care partnership which is least remote. However, I then encountered my first challenge as a researcher unfamiliar with the healthcare system in this health board. I discovered there was not a team meeting (due to vast geographical restraints) for me to meet the older adult mental health team (OAMHT) to discuss and inform them about my study. The service manager therefore introduced me to the team by email and I forwarded an electronic invitation and information sheet to members of the OAMHT, in addition to writing to them.

Phase one of the study took place from September 2019 to January 2020. Table 8 highlights that I approached forty-four healthcare professionals, of which three participated in a focus group interview and three participated in individual interviews over the telephone. Individual letters, along with an information sheet (Appendix 3) were sent by me, to those forty-four healthcare professionals, who were chosen from Primary Care, Third Sector and Secondary Specialist Mental Health Services.

This was with the hope of recruiting healthcare professionals from a breadth of settings to bring a range of views and perceptions to the study. I received two emails (GP practice and Third Sector) stating they could not engage at this time and no other contact, from my initial letters. I found this really disheartening.

I waited a month and then discussed this with my supervisory team. We acknowledged the rurality and geographical spread of the area was perhaps causing a barrier to participation. My supervisory team suggested that a telephone call or individual conversation may be more appealing to potential participants. I therefore sent a slightly amended letter to all forty-four health professionals again, offering a telephone or individual interview. On this occasion I had ten responses; in total six people participated who were given information sheets and consent forms to complete (Appendices 13, 14, 15).

Table 8: Phase one-recruitment of healthcare professionals

	Approached	Agreed	Focus Group	Individual Interview	Withdrew	Did not participate
Consultant Psychiatrist	3	1	_	1	_	2
General Practitioners	9	0	_	_	_	9
Community Mental Health Nurse	11	5	2	_	_	9
District Nurse	1	0	_	_	_	1
Staff Nurse	3	0	_	_	_	3
Senior Nurse Practitioner	2	2	_	2	_	_
Clinical Nurse Manager	1	0	_	_	_	1
Occupational Therapist (mental health)	6	2	1	_	_	5
Third Sector	5	0	_	_	_	5
Healthcare Support Worker	2	0	_	_	_	2
Care Home	1	0	_	_	_	1
Total	**44**	**10**	**3**	**3**	**0**	**38**

3.7.2 Data Gathering Process

In this section, I explain how I conducted individual interviews and a focus group interview in phase one of this study. My reflections of this process are included.

Table 9 details the data sets for phase one of this study.

Table 9: Data gathering phases

Data set	**Methods**	**Participants**	**Data obtained**
Phase One			
Data set 1	Focus group (*n* =3)	• Community Mental Health Nurse (*n*=2) • Occupational Therapist (*n*=1)	1 transcript
	Individual interview (*n*=3)	• Consultant Psychiatrist (*n*=1) • Senior Nurse Practitioner (*n*=2)	3 transcripts

3.7.3 Focus Group with Healthcare Professionals

One focus group took place on the 11th of December 2019. This was held at the request of participants at the psychiatric hospital in this health board. Five participants were expected to join the focus group, but two had to cancel on the day, leaving three participants. These participants were healthcare professionals from the Multi-Disciplinary Team (see Table 8).

As the focus group was limited in numbers, it was decided in discussion with my supervisory team I, alone, would attend as researcher, without a co-facilitator or minute-taker. We felt that the balance of the focus group and flow of discussion may have been interrupted if there were too many people from the research team, hence the decision to attend alone.

I arrived at the hospital early and set the chairs around a small table. The group arrived together. I welcomed them, introduced myself and then asked if anyone had any questions from the participant information sheet and consent forms were then signed.

I initiated the conversation using the topic guide (Appendix 5). The topic guide allowed a flexible discussion between participants. One participant was much more talkative than the other two, but I ensured to ask other participants their views and they appeared comfortable with one participant taking the lead. The discussion lasted exactly one hour, and I feel that I facilitated the discussion in an inquisitive way. The interview was recorded onto a Dictaphone.

3.7.4 Interviews with Healthcare Professionals

Three individual interviews were undertaken with healthcare professionals who could not attend the focus group. The interviews were conducted over the telephone and varied in duration from thirty minutes to one hour. They were conducted on the 18th of November 2019, 25th of November 2019 and 29th of November 2019. The participants were two Senior Nurse Practitioners and a Consultant Psychiatrist.

Participants consented verbally to participate over the phone and then sent me a completed consent form (Appendix 6). The interview was conducted in a conversational way and the topic guide for the focus group (Appendix 5) was used to inform the discussion. The use of a conversational style interview allowed fluidity in the interview for participants to share other issues that were important to them. All three interviews were recorded, which participants consented to.

The first interview I agreed at the outset would last no longer than thirty minutes. This time limit was agreed to encourage the participant to engage due to their busy workload. This agreement undoubtedly affected the flow of the conversation. I found myself rushing and closing responses, to meet the timeframe instead of exploring and delving deeper into some of the answers. This transcript was shared with my supervisory team, who also highlighted that the interview felt rushed. I, therefore, reflected on this and for the next interview felt thirty minutes was not long enough.

The following two interviews I stated at the outset would take approximately one hour. This did allow more time for me to delve deeper. I was, however, aware that on occasions I asked closed questions and tried very hard to rectify this throughout the third interview.

I was also challenged in phase one data collection regarding the assumptions I bought to the study. My supervisory team explored with me why I had not questioned further around service delivery process. This made me think and reflect. As an experienced practitioner I understood what was being explained and why, but from a research perspective I did not know this and made lots of assumptions. I took this learning with me to improve my interview technique in phase two.

My final reflection on the phase one interviews was that data collected was richer than data collected in phase two (which will be discussed), I believe this was because all participants in phase one were HCP’s and, possibly, I was more familiar with the language. Data collection in phase two of this study is discussed in the following section of this study.

3.7.5 Data Collection Phase Two

The aim of phase two was to gather a deeper understanding of the use and provision of services to older people with FMI. In this section, I describe how I recruited participants to phase two and collected data by conducting individual semi-structured interviews. As previously outlined, I reached phase two of this study as the COVID-19 pandemic had just reached the UK and a nationwide lockdown was put in place on the 23rd of March 2020. I sought permission from the research and development team in this health board to continue with my research, which was granted on the provision I did not see participants face to face. All interviews in phase two, therefore, were undertaken by phone. The impact of COVID-19 on my research study was significant as during my stage of recruitment to phase two, the UK was in lockdown.

I contacted a couple of key informants I had been able to meet in phase one, but only one returned my emails. As it was lockdown, there was no opportunity to visit the area and raise the profile of my study and, furthermore, clinical teams were under immense pressure. The positive of continuing my study was that valuable insights were elicited of the impact of the pandemic on all participant groups. Data collection for phase two of this study was conducted between 2nd April 2000 to 19th May 2000.Table 10 highlights participants approached in phase two;

Table 10: Phase two-recruitment of older people with FMI, their family carers and healthcare professionals

	Approached	**Agreed**	**Individual Interview**	**Withdrew**	**Did not participate**
Older person with FMI	6	4	4	_	2
Family carers	3	1	1	_	2
Community Mental Health Nurse	1	1	1	_	1

Psychologist	1	1	1	_	-
Consultants	1	0	-	-	1
Total	**12**	**7**	**7**	**0**	**6**

3.7.6 Interviews with Older People with FMI

In total, I interviewed four older people with FMI in phase two. Recruitment for this stage being undertaken by a key informant. In the main, recruitment was challenging due to COVID-19. Two further participants identified, were then unable to participate.

Given the pandemic restrictions on travel and lockdown, it was hard to contact identified key informants - likewise, for key informants to approach potential participants. However, of the four participants that took part, once the key informant had contacted them and informed me they were potentially interested, I phoned one week later to check that this remained the case, and to arrange a mutually convenient time to undertake the interview by phone.

All participants recruited were receiving support from the community mental health team (CMHT). They were each given a patient information sheet and verbal consent to participate was gained over the phone. Participants were asked to complete a signed consent form, but I did not receive any back. Participants stated they were unable to leave their homes as they were all in the shielding category at that stage of the pandemic. Interviews were all recorded, and this also captured participant giving informed consent.

At the outset of each interview, to build rapport with the participant, I explained my research study. Semi-structured interviews were used because they offer a framework to cover the relevant information, whilst having the freedom for further information which may be of relevance to be explored (Parahoo 2014).

A topic guide (Appendix 16) was also used allowing me to lead the conversation which had been developed from key findings within the integrative review and related to the research questions of this study. The topic guide was refined via discussion with my supervisors, and the focus of the topic guide was their experiences of accessing availability of services and how they met their needs.

I found it quite challenging at times to interview the participants who had FMI For example, one participant, I could hear, was exceptionally anxious and I had to weigh up asking probing questions about the participant’s mental health for the benefit of my research against the anxiety I could hear it causing him. This was further challenged by not being in the same room as him, where I could have gauged facial expressions and been more empathetic and reassuring with nonverbal cues.

On reflection, I am also aware my interview technique improved the more interviews I did. This was because at the outset with my first interview I said to the participant the interview would last 30 minutes. This interview was rushed as I felt obliged to meet that timeframe. Therefore, future interviews I allocated an hour. I also became aware at supervision that in the early interviews I assumed the answer about service delivery. Therefore, I became self-aware that I did not know the answers and began to ask more probing and exploratory questions. Furthermore, although undertaking interviews over the phone had the benefit of not having to travel, it definitely made building rapport with the participants more of a challenge - as not being face-to-face at times made the situation a little difficult to read.

3.7.7 Interviews with Family Carers

Recruiting to this phase was exceptionally challenging. In total I was only able to recruit one family carer, which is a limitation within this study. One participant’s family were estranged. Another’s family lived in England and he did not wish to ask them to partake. A further participant approached her brother and he declined.

A topic guide (Appendix 17) was also used allowing me to lead the conversation which had been developed from key findings within the integrative review and related to the research questions of this study. The topic guide was refined via discussion with my supervisors, and the focus of the topic guide was their experiences of accessing services, availability of services and how they met their family member’s needs and their own needs as a Carer.

Again, due to COVID-19, the interview took place over the phone. The participant’s family member with FMI remained in the room with her. Consent was obtained verbally and recorded. The interview lasted approximately 20 minutes. Again, this was shorter in length as her husband (older person with FMI) was becoming quite anxious by my call. This highlighted that mental illness could impact significantly on family members. However, the family members were very supportive of their loved ones and keen to support them anyway they could.

3.7.8 Interviews with Healthcare Professionals

In total, two healthcare professionals were interviewed in phase two. This was during the period of COVID-19; therefore, interviews took place over the phone. Recruitment to this phase was really challenging, potentially because people were busier due to COVID-19, but also in relationship building and making contact face-to-face with people who potentially could have supported recruitment for me. For example, I could not visit and introduce myself to teams and then see if there were potential participants.

One participant in this phase was a CMHN and had been interviewed in phase one, the other, a psychologist. This was positive as, except for Social Work, I had manged to interview all key professionals within the multi-disciplinary team which provided a depth of perspectives.

Table 11: Data gathering phases

Data set	**Methods**	**Participants**	**Data obtained**
Phase Two			
Data set 2	Semi structured interviews	• Older person with FMI (*n*=4) • Family carer (*n*=1). • Healthcare Professionals (*n*=2)	7 transcripts

My final reflection on phase two data collection was that much of the semi-structured interviews contained less richness. This, I believe, was partly because five participants had lived experience and were less focused on the questions asked than HCP's. The next section of this thesis presents the approach taken to data analysis.

3.8 Transcribing

I, myself, undertook all transcribing verbatim. In total there were four transcripts collected for phase one and seven for phase two. All transcripts were typed on word documents, then uploaded into a spreadsheet as described. All typed transcripts were cross referenced to the original audio recording to ensure factual accuracy. To ensure confidentially, transcripts were allocated a code number and professionals' groups were also assigned a number. Pseudonyms were given to participants (older people with FMI) and their family carers.

3.9 Data Analysis Framework Justification

The data analysis framework was Braun and Clarke's (2019) Reflexive Thematic Analysis. This framework has developed from Braun and Clarke's (2006) Thematic Analysis framework. Braun and Clarke's work has evolved since their Thematic Analysis work of 2006 and their new model of Reflexive Thematic Analysis is theoretically flexible and can be used within different frameworks to answer quite different types of research questions.

It also suits questions gauged towards peoples' experiences and related to understanding (Braun and Clarke 2019). Braun and Clarkes (2019) Reflexive Thematic Analysis is justified where using an Interpretive Descriptive research design. Thorne (2016), suggests that to build findings in Interpretive Descriptive research, is not to simply look at the first set of patterns, rather, consider what the pieces may mean in relation to one another and what structures, processes or schemes may illuminate in relationships.

Braun and Clarke (2019), suggest Reflexive Thematic Analysis can be used to identify patterns of meaning across a data set that answer the research questions being asked. The framework provides a method which identifies patterns through a rigorous process of data familiarisation, data coding, theme development and revision. This framework supports the research design well, as it seeks to understand thoughts and behaviours across a data set (Braun and Clarke 2019).

Braun and Clarke (2006), suggest thematic analysis offers a more accessible form of analysis for those in the early stage of their research career. Nowell et al. (2017), contend thematic analysis is a useful method for examining the perspectives of different participants, highlighting differences, and generating unanticipated insights. Cassell and Simon (2004), add that thematic analysis is useful for summarising large data sets as it forces the researcher to approach analysis within a structured way.

3.10 Data Analysis

There are several ways qualitative research can be analysed.

Initially, I used coloured pens to identify codes and identify potential themes. However, I found this method a bit clunky and disorganised. I had undertaken a training session on NVivo during my research study days at university so chose to use NVivo 11 software (Lumivero 2019) to manage and store my data and used the software to code and theme data.

NVivo 11 (Lumivero 2019) refers to codes as nodes. The software does not have the ability to thematically analyse the data and therefore I undertook this myself. NVivo 11 also has the added benefit that data collected can be stored in the node. I used parent nodes to identify the overarching themes, with child nodes under each parent node to identify the data collected that contributed to that theme.

However, given NVivo (Lumivero 2019) did not have the ability to capture analysis, I abandoned this approach, deciding to code the data manually myself, by having a table, with one column for the data, one for the initial code, one for a descriptive code and a final column for any comments. This method I found easier as I could compare transcripts, edit where needed after a period of reflection and the descriptive column really helped me as a novice researcher analyse what was being said by the participant.

3.10.1 Data Analysis using Braun and Clarke's (2019) Reflexive Thematic Framework

This section presents my approach to data analysis in phase one. Phase one consisted of three individual interviews and a focus group (*n*=3). All participants in phase one were healthcare professionals. I used Braun and Clarke's (2019) Reflexive Thematic Framework to analyse the data in phase one.

Table 12: Phases in Reflexive Thematic Analysis (Braun and Clarke 2019)

Phases in the process	**Description of the process**
1. Familiarisation with the data	This involves reading and re-reading the data, to become immersed and intimately familiar with its content.
2. Generating codes	This involves generating succinct labels (codes) which identify important features of the data that might be relevant to answering the research question. It involves coding the entire dataset, and after that, collating all the codes and all relevant data extracts together, for later stages of analysis. To compliment this phase I also composed a narrative summary of each transcript.
3. Generating initial themes	This involves examining the codes and collated data to identify significant broader patterns of meaning (potential themes). It then involves collating data relevant to each candidate theme, so that you can work with the data and review the viability of each candidate theme.
4. Reviewing the themes	This involves checking the participant themes against the dataset to determine that they tell a convincing story of the data- and one which answers the research

	question. In this phase, themes are typically refined, which sometimes involves them being split, combined, or discarded. Using this approach, themes are defined as a pattern of shared meaning underpinned by a central concept or idea.
5. Defining and naming themes	This involves developing a detailed analysis of each theme, working out the scope and focus of each theme, determining the 'story' of each. It also involves deciding on an informative name for each theme.
6. Writing up	This final phase involves weaving together the analytic narrative and data extracts and contextualising the analysis in relation to existing literature.

3.10.2 Phase One and Phase Two Analysis

In this section, I describe the analysis of the data gathered from the phase one and phase two interviews and focus group interview.

Phase One: Familiarisation with the data

According to Braun and Clarkes (2019) Reflexive Thematic Analysis, phase one is familiarisation with the data. As a novice researcher I found this first phase quite challenging. My approach initially to this was to listen to each of the digital recordings of the interviews in full a couple of times. Then to emerge myself fully in the data by transcribing the interviews myself.

Phase Two: Generating Codes

This phase involved reviewing the data and examining what the data was saying, followed by coding the data accordingly to descriptive codes and then codes. Saldana (2021), suggests a code in qualitative inquiry is often a word or small phrase that symbolically assigns a summative, salient, essence capturing a portion of language based on visual data.

My supervisory team suggested that I may find it helpful to use descriptive coding. This really helped me analyse the data and cross reference the data with the codes I was generating. I coded the data systematically by coding participant one's transcript first. As I moved through the transcripts, it allowed me to consider the codes and findings from the previous data sets.

My supervisory team also suggested I write a narrative summary for each transcript. This enabled me to cross reference findings from each interview and look for similarities and differences in the data. As I was coding the data, I kept the research question and aim of phase one to hand, allowing me to keep my coding decisions focused. Codes were generated by considering each line or phrase in the transcript to summarise what story the data was telling.

The following examples provide an overview of how I labelled the data with a code.

Table 13: Example of Coding

Data	**Descriptive code**	**Codes**
"I would bring in the various therapeutic models and theories and create an individualised formulation for that person"	Use of various therapeutic models to create an individualised formulation for the person	Therapeutic Person centred Formulation

Phase Three: Generating Initial Themes

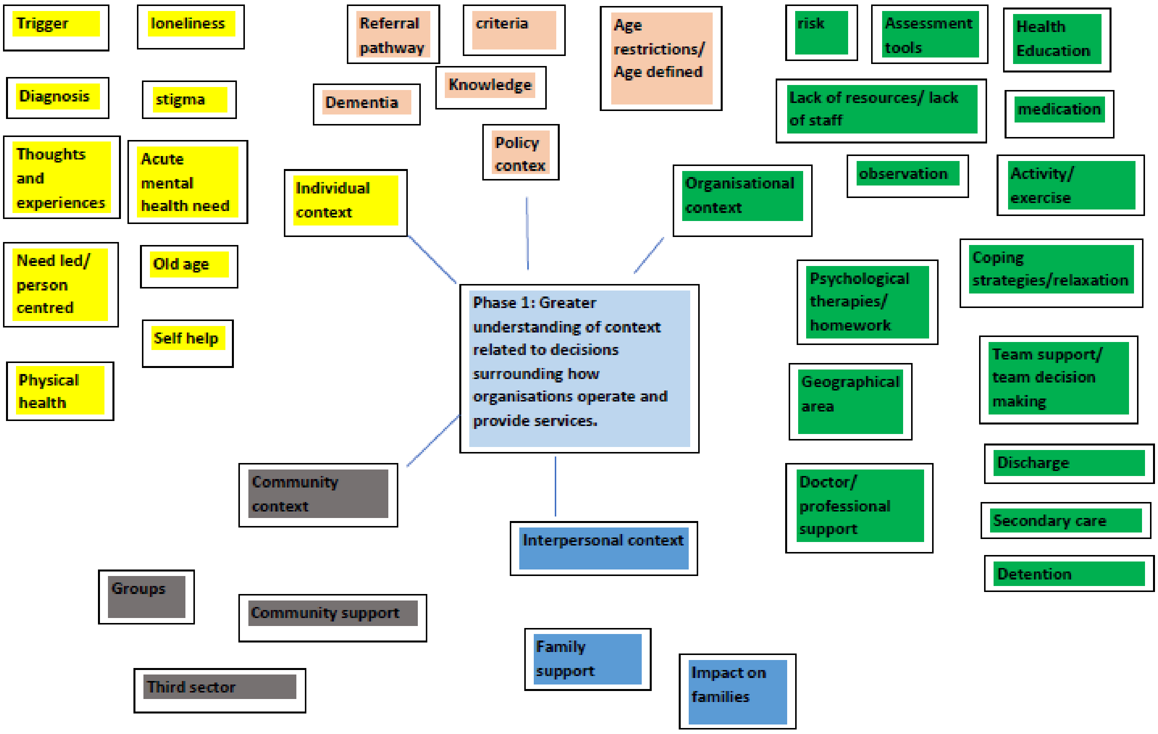
This phase involves examining the codes and collated data to identify significant broader patterns of meaning (potential themes).

Braun and Clarke (2019), re-named this phase from their 2006 work where they called it ‘searching for themes’. They did this to allow the phase to capture the way in which generating themes is an active and interpretive process, recognising themes do not just emerge from data fully formed.

Nowell et al. (2017), suggest this phase takes place once a list of codes across the whole data set has been developed. Codes that were not related to the research aims were discarded (Thorne 2016), for example, “fear” and “alcohol”. Themes generated from data by bringing together ideas, thoughts and components which individually are meaningless (Nowell et al 2017), and have meaning in relation to the research question (Braun and Clarke 2019).

To explore the data and search for components that met the research question, I wrote codes on post-it notes and made a mind map (Figure 4). Post-it notes allowed the flexibility to move codes around into similar clusters which met the research question of phase one. For example, the green cluster has all the relevant codes that are related to an organisational context.

Figure 4: Mind Map – the coding process

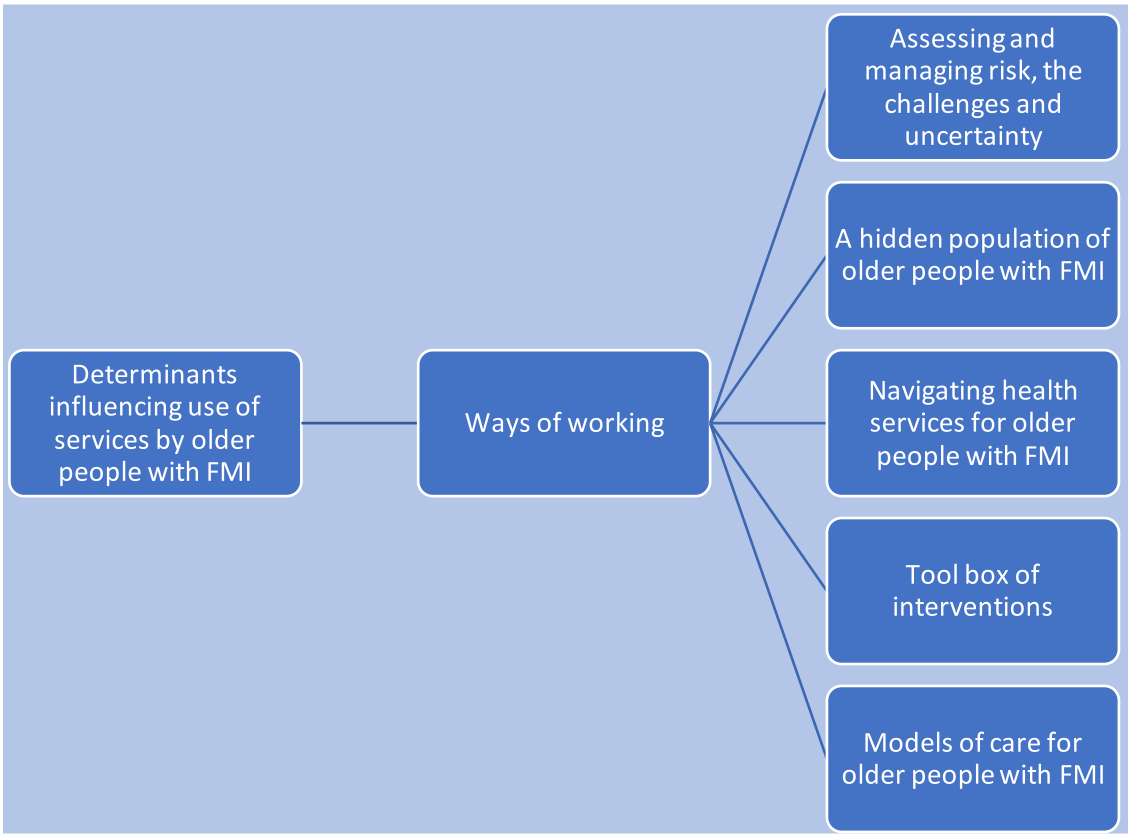


Within qualitative research, the researcher becomes the instrument for analysis. This includes making judgements about coding, theming, contextualising and decontextualising the data. To provide rigor and assurance and credibility around the analysis, it is the researcher's responsibility to detail and document their decision making process (Nowell et al. 2017).

I choose to document the insights and assumptions that informed my thinking in the coding and theming process in a research diary. Table 14 below provides an example of how the descriptive code was synthesised to a subtheme and theme.

Table 14: Example of coding and theming process taken from participant interview			
Data	**Descriptive code**	**Code**	**Sub theme/ theme**
"…again, it's the restriction on services if that's not available then we just can't do that"	Lack of resources, means services cannot be delivered	Lack of resources	Available resources / determinants influencing health care professionals to offer support to older people with FMI

Figure 5: Thematic Map



In addition to the thematic map (Figure 5), I chose to use a thematic matrix (Chapter 3; Table 15). Miles, Hubermann and Saldana (2013), suggest a matrix can facilitate the coding and theming process, by understanding different relationships and how concepts are connected or what causes are linked with what effects. This is demonstrated in the thematic matrix example on page 108. As an example, the following shows how one theme was refined; *"Navigating and circumnavigating FMI services"* was refined to *Pathways of care; navigation and adaptability to meet the needs of older people with FMI*.

Phase Four: Reviewing the Themes

According to Braun and Clarke (2019), this phase involves checking the participant themes against the dataset. This is to determine that the data tell a convincing story and answer the research questions. In this phase, themes are typically refined, which sometimes involves them being split, combined, or discarded as seen in Figure 5. For example, in phase two, two subthemes were refined and collapsed into one; these were accessing support for FMI and accessing hospital admission for FMI. This was refined to be accessing support and treatment for an older person with FMI.

Phase 5: Defining and Naming Themes

According to Braun and Clarke (2019), this phase involves developing a detailed analysis of each theme, working out the scope and focus of each theme and determining the 'story' of each. It also involves deciding upon an informative name for each theme. An overarching theme for phase one "*Ways of working with older people with FMI*" was generated from the data captured and for phase two the overarching theme was *"Accessing support and treatment for older people with FMI",* which will be described in chapters four and five.

The following table (15), shows how codes were refined to make an overarching theme in relation to the research aims.

Table 15: Thematic matrix v1	
Decision making **Support**	
Accessibility **Older people with FMI/ family carers**	
Older people with fMI **Services meet needs?**	
Themes- phase one	**Codes**
• Ways of working with older people with FMI	• Detention under Mental Health Act • Physical health • Stigma • Risk • Acute mental health need • Geographical area • Referral pathway • Lack of resources/ lack of staff • Team decision making • Referral criteria
Themes-phase two	**Codes**
• Accessing services for older people with FMI	• Detention under Mental Health Act • Physical health • Stigma • Risk • Acute mental health need • Geographical area • Referral pathway • Lack of resources/ lack of staff • Team decision making • Referral criteria • Family • Talking • Psychological therapies • Interventions • Person centred • Day service • In patient

Phase 6 Writing Up

This final phase involves weaving together the analytic narrative and data extracts and contextualising the analysis in relation to existing literature. This will be undertaken in Chapters four and five.

3.11 Theoretical Framework

The AAAQ (UNICEF 2019) Framework was used in this study, following on from thematic analysis of the data, to provide a lens to interpret the findings of this study in the context of the research aim and questions. The framework was not predetermined at the outset of the study but was adopted during the later stages of the thematic analysis process as a lens to help understand what the findings mean.

The following frameworks were also considered for use in the data analysis stage, to support the development of findings in this study; The Public Health Outcomes Framework, UK Government (2021). This was because there were two high level outcomes which related to the framework which were related to life expectancy rather than accessibility and availability to health services. The Petals of Recovery Framework (Higgins 2007), was also considered and discounted. Although this model provided a framework around mental health recovery, it did not provide a framework to understand new findings in relation to the determinants that influence older people with FMI to access services. Likewise, the Senses Framework (Nolan et al. 2006), was discounted. Although this framework is used from an HCP service and family carer perspective, it does not focus on what determinants influence people to access services. Therefore, these frameworks were all discounted.

The AAAQ Framework (UNICEF 2019) was justified in its use, as it is a framework developed for assessing healthcare services. It is used to identify barriers to accessibility to healthcare systems which may not be immediately apparent, such as stigma, affordability, and physical constraints. Given the research aim of this study was to explore the determinants influencing the use and provision of services for older people with FMI the components of this framework fitted. Furthermore, this framework is relevant to interpretive descriptive research which seeks to generate knowledge from and for practice.

The four components of the framework are defined below.

- **Availability** refers to the existence of healthcare services and if they are sufficient in quantity and type.
- **Accessibility** is multidimensional and refers to physical accessibility (are services nearby, on reasonable travel routes), financially accessible (how are the services funded), bureaucratic accessibility (paperwork and forms to access), socially accessible (language barriers, non-discriminatory) and have accessible information (advertised freely so users are aware of services available).
- **Acceptability** understands if services are socially inclusive and respectful of different cultures and communities. Are services sensitive to age, gender, race, and sexuality.
- **Quality** are people treated to the required standards, do staff have the required skills and training, are there plenty resources.

The AAAQ (UNICEF 2019) Framework also fits with the study findings due to a focus on mental health as a human rights-based framework. Physical, financial, social, information and bureaucratic and administrative accessibility are identified in the AAAQ framework as linked to the availability, acceptability and quality of services. Barriers arise when these accessibility issues are not facilitated, the social determinants of housing, education, employment, income, and childhood experiences and are known to impact upon people’s access to health services so the notion of social acceptability has relevance to this study of older people with FMI (Scottish Human Rights Commission 2021).

Further justification for using the AAAQ (UNICEF 2019) Framework, are positioned by its use is other studies. A study by Exworthy et al. (2012), adds weight to the use of this framework in mental health services. A further study by Axelsson et al. (2020), used the AAAQ (UNICEF 2019) Framework to understand the lived experiences of access to a mental health care service in Europe. Their study had (*n*=50) participants with various mental health issues. A key finding identified by the Axelsson et al study (2020) was mental health care could be more accessible through mobile teams and tele-health.

The next section of this study details the summary of this chapter.

3.12 Chapter Summary

This chapter has outlined the theoretical, philosophical, and methodological approaches that have underpinned this study. It has also highlighted the challenge of undertaking research during the COVID-19 pandemic and some of the difficult research design decisions that consequently had to be made.

In addition to this, the challenges to gain ethical approval have also been discussed. The justification for case study research and the change to interpretive descriptive research have been discussed as has the process of data analysis and the use of a theoretical framework to provide a lens to interpret the findings has been described. The following chapter will examine the data collected in phase one and how this illuminates the local context to inform phase two

Chapter 4: Phase One Findings

4.1 Introduction

The thematic analysis as described in the previous chapter, (Chapter 3; section 3.9.4), for phase one contained one overarching theme, "*Ways of working with older people with FMI*" and five subthemes, which were constructed from the data: 1) *Pathways of care, navigation and adaptability to meet the needs of older people with FMI* ; 2) *A hidden population of older people with FMI;* 3) *Assessing and managing risk, the challenges and uncertainty; 4) Tool box of interventions; and* 5) *Models of care for older people with FMI*. These themes and subthemes are illustrated in Table 16.

Table 16: Phase One Overarching Theme and Subthemes.

Overarching Theme	**Subthemes**
4.2 Ways of working with older people with FMI	4.2.1 Pathways of care; navigation and adaptability to meet the needs of older people with FMI
	4.2.2 A hidden population of older people with FMI
	4.2.3 Assessing and managing risk, the challenges and uncertainty
	4.2.4 Toolbox of interventions
	4.2.5 Models of care for older people with FMI

The participants in phase one are described in the following table (Table 17)

Table 17: Phase One Participants

Phase One Participants			
Dataset1	Semi structured interviews	- Participant One - Advanced Nurse	**Jane** (p1) Works in rural area of health board and has been in post for five years.
	Semi structured interviews	- Participant Two - Advanced Nurse	**Carole** (p1) Works in rural area of health board and has been in post for seven years.
	Semi structured interviews	- Participant Three - Consultant Psychiatrist	**Dr Brown** (p1) Works in rural area of health board and has been in post for eight years.
	Focus group	- Participant Four- CMHN	**Fiona** (p1 and p2) Works in the City area of health board and has been six months in post having moved from central belt, very experienced CMHN.
	Focus group	- Participant Five-CMHN	**Vicky** (p1)Works in the City area of the health board and has been in post for three months, worked previously as a CMHN
	Focus group	- Participant Six- OT	**Shona** (p1) Works in the City area of health board, and has been in post a few weeks. New graduate.

4.2 Ways of Working with Older People with FMI

The overarching theme "Ways of working with older people with FMI" illuminates several factors which influenced how specific services were delivered to older people with FMI. Data collected illuminated that HCPs were required to navigate a care pathway and be adaptable to meet the needs of older people with FMI.

HCPs reported that in order to be referred to secondary mental health services, the older person with FMI would normally be referred by the GP. The vast rural and remote geographical area of this health board meant that HCPs reported being adaptable and strategic when delivering services. This included allocating cases by geographical area to HCPs and substituting some face-to-face contact with a telephone review.

It also emerged there was potentially a hidden population of older people with FMI as rural community mental health teams in the study site had low numbers on their caseload. Some participants believed this was because GPs were managing and treating this population group without referring to mental health services. Other participants, with contrasting views, believed GPs were failing to identify (or not recognising) FMI symptoms such as anxiety and depression. There was a further view by participants that older people with FMI living in rural areas, were stoic and exercised choice and did not seek support for their FMI.

Data further illuminated that risk of self-harm or harm to others due to FMI was a significant factor in the decision making of HCPs when offering support. The higher the risk, the more intense and urgent the level of support provided. It also emerged HCPs had specific interventions they use to support older people with FMI.

In addition to this, there were different models of care in relation to service delivery for older people with FMI. Some services (day services and CMHTs) would not accept people aged over 65. This appeared to be an arbitrary decision, the basis for which was unclear.

4.2.1 Pathways of Care; Navigation and Adaptability to Meet the Needs of Older People with FMI

This subtheme illuminates that HCPs often navigate a pathway to arrange support for older people with FMI from secondary mental health services (services that are specialist, and which usually require referral from primary care). In addition to providing support for older people with FMI, some HCPs were also adaptable where delivering services. For example, the use of digital technology and telehealth, allocating older people with FMI to HCPs by geographical area, communicating treatment plans by email which was needed due to the vast geographical area of this health board. Telehealth is defined as the use of electronic information and equipment to support long distance clinical healthcare (Health Resources and Service Administration 2023). The pathway of care for older people with FMI to secondary mental health services (CMHT and in-patient setting) is normally via GP referral. This can be at the point of first referral or upon re-referral. One participant described the referral process;

> "...*for functional (mental illness) … almost always exclusively it will be the GP" (who refers to CMHT)* (Participant 3; Dr Brown Consultant Psychiatrist)

Another participant added:

> *"…so, referrals come in from the GP, we have a referral meeting, and we allocate that particular person"* (Participant 4; Fiona CMHN)

The above quotes demonstrate referrals usually come into secondary services via the GPs. Therefore, if an older people with FMI is to receive support from secondary services, they need to actively navigate a referral pathway and seek support from their GP. However, this referral pathway places an onus on GPs to recognise the signs and symptoms in older people with FMI to make the onward referral to secondary services. If these symptoms, low mood, apathy, irritability are not recognised by the GP the consequences potentially are the older person with FMI may not receive the appropriate support they require from mental health services.

The following quote highlights there is a referral criterion for OAMH services.

> *"If they don't fulfil the criteria to come into the CMHT service….. we deal with moderate to severe mental illness, so if it is a mild to moderate err… case of functional mental illness then we wouldn't offer support at that time but we would signpost them to something like our guided self-help worker or to some of the other erm online services".* (Participant 1; Jane Advanced Nurse Practitioner)

Once GP referrals reach secondary mental health services, they are then assigned to the appropriate CMHT team member for follow up. However, this quote illuminates there is a referral criterion for secondary mental health services which is moderate to severe symptomology. However, the CMHT will sign post referrals onto services which can provide support if a referral does not meet their criteria.

Participants described that the vast remote and rural area of this health board required older people with FMI to navigate a large geographical area to receive support:

> *"We don't have easy access to other (mental health) services. You know for example, our guided self-help worker is based in Village X if somebody is you know, or we have got Psychology based in Town X, that's 30 miles from here. Its 45 miles from Village Y. It's probably about the same from Village Z. So that's a 90-mile round trip. That you know an elderly person has to go"* (Participant 1, Jane Advanced Nurse Practitioner)

The excerpt above suggests the extensive distances healthcare professionals may need to go to visit an older person with FMI. Likewise, if an older person with FMI requires support, they may be expected to travel vast distances to receive this, which, for an elderly person may be challenging and influence negatively their decision making to seek support. The following reflection by a Consultant Psychiatrist highlights the impact that rurality has on their decision making where offering support:

> *"it's cruel but it's probably true to say that if they're very remote it can be harder to get erm... I think if they needed it, I will still refer them but they might not get the same level of care"* (Participant 3; Dr Brown Consultant Psychiatrist)

The above quote suggests that in planning their visit and navigating the delivery of support, this HCP tailors how they deliver services considering the context of where the older person with FMI lives. This participant suggests older people with FMI who live in very remote areas might not get the same level of care or specialist input from the CMHT in comparison to those who live in destinations easier to reach. The following quote adds to the notion that HCPs were required to navigate and be adaptable in the delivery of mental health services, as they identified the need to be strategic in planning their visits:

> *"We (CMHN's) also try to cover certain areas so that we're not, erm obviously we are out in the community, so we don't want to be up in Timbuktu one minute then down in Portsmouth the next, so we try and cover locality" (Participant 4; Fiona CMHN)*

CMHN's are allocated to certain geographical areas to undertake visits in one area, this is done to cut down travel time. For those living in very remote areas, some HCPs were adaptable and considered alternative ways to offer support and provide access to healthcare:

> *"...a couple of patients who live away out in err it's not even in xxxx it's even more rural than that away in the X peninsula. So, for me to go, if they can't make it to the clinic in town A takes erm a good three and a half hours for me to drive. Seven hours driving in a day. I might have to space out erm visits with phone calls so they are maybe not getting the support that they might have".* (Participant 3; Dr Brown Consultant Psychiatrist)

This extract adds to the idea that clinical staff, navigate the delivery of support by adapting to the rurality of the health board. They offer several modalities of support; this includes an approach balanced between face-to-face visits and phone calls. The practicalities of older people living in very remote areas being able to attend clinic appointments meant some healthcare practitioners considered alternative ways to support older people with FMI. This included phone call support with less frequent face-to-face visits (*this data collection predates COVID-19*).

Data in this study illustrated that technology was an adaptive mechanism for navigating support for older people with FMI in a vast geographical area. Nearly all participants discussed the use of digital technology, which was used by some to assess older people with FMI's needs, and offer ongoing assessment and monitoring of FMI symptoms. This varied with some HCPs using the phone, email, and/or video conferencing to support people who were geographically remote, for assessing their mental state, devising treatment plans and ongoing monitoring. However, there may be some older people who are not technically agile and using technology to support them may be a barrier to availability of online services.

In contrast, other participants had not embraced technology. Practical reasons as detailed below were reported:

> *"...we are quite isolated here and our system that we have at the moment I think the thing is we could try doing that (video conferencing) but then it's getting, you know you couldn't do that in somebody's home. It would*

> *need to go into one of the GP practices and then it is down to accommodation" (*Participant 1; Jane Advanced Nurse)

There appeared to be reluctance to explore digital solutions by this participant who felt there were potential barriers including arrangement for accommodation. The participant seems also to assume that older people with FMI would not have access to technology that would enable video conferencing in their home. This decision making may potentially impact on the HCPs workload with more travel time and consequentially less patient facing time. The impact on the person with FMI may be that they are required to travel a long distance to receive support, or due to rurality the patient may simply receive less support.

It is important to highlight that participant one was interviewed prior to the COVID-19 pandemic - which may have changed working practices to be more virtual, and it is recognised that since the pandemic working practices have changed, with nearly all support during lockdown delivered virtually by phone or video conferencing. Another participant describes an alternative perspective, explaining where an older person with FMI has engaged well with technology:

> *"...he will go to the err GP practice so we can do reviews by VC video conferencing and that I think he is just so relieved that he's not had to drive or be driven an hour and hour and a half away for him, I think he is so relieved not to do that but he's quite happy to speak to me on the video link"* (Participant 3; Dr Brown Consultant Psychiatrist)

Strategies were adopted by this participant to be adaptable in the face of limited resources, which at the same time suited this older person, given the remote area that he lives. Even though the older person did not have technology to enable virtual support in his home, HCPs found solutions by using technology in the local GP practice. This quote highlights that the clinician thought the older person was satisfied with virtual support, preferring this option to a long journey to see the doctor. This participant further adds:

> *"I prefer it if I've met the patient face-to-face before; this one in particular I haven't yet, I will catch up with him eventually face-to-face but I think if I've met them before and done the initial assessment then I find doing it by VC is almost as good as seeing them face-to-face"* (Participant 3; Dr Brown, Consultant Psychiatrist)

This decision does, however, have consequences. The doctor has been assessing this patient virtually, without having undertaken a face-to-face assessment, which is their preferred choice for their first contact and initial assessment. Thereafter, VC is reported to be almost as effective as face-to-face support by HCPs. With a contrasting experience, participant two highlights the challenges they have found using VC;

> *"…even though I work in this office our computers are not geared up to link in with the ones in the City. Erm so we are quite isolated here and our system that we have at the moment"* (Participant 1; Jane Advanced Nurse).

This extract illuminates that in some more rural areas, some offices do not have the IT infrastructure required to support the CMHT to adapt to strategies such as VC which could make offering support to older people with FMI more efficient and effective. This experience appears to contrast with the experience of the Consultant Psychiatrist who works collaboratively with GPs:

> *"...if I wanted to physically examine the patient, I can't do that from the VC but I can always ask; the rural GP's are brilliant and if there was something physical I was worried about its maybe something that GP should be seeing anyway" (*Participant 3; Dr Brown Consultant Psychiatrist)

This participant found VC as an effective way to navigate the care pathway to support someone's mental health. However, if a physical examination was required the GP would assist with this. This example demonstrates the GP and Psychiatrist were adaptable by working in partnership to support the physical and mental health needs of older people living in remote areas. Planning care and treatment by email and team working was also perceived to be effective in supporting older people with FMI in rural locations as described:

> *"...we are struggling with the geography of where he lives because he lives in a very rural area so there's a limit to the resources that are available locally and it's hard for me to get to him, but he's got a good, between myself, the GP, the CPN and the social worker we've actually managed to between us come up with despite the limitations quite a good plan because one of the things, he has had illness on and off for years and he has been on all sorts of medication and the problem is now he's getting older he's getting a lot of side effects so, we were able mainly through email kind of to get in touch and then I got in touch with the erm pharmacist is I came up with basically three options of what to do to manage his low mood his depression…. I was able to share that with the GP and .... the err nurse"* (Participant 3; Dr Brown Consultant Psychiatrist)

The quote above highlights that for this older person living in an extremely remote area, it poses a challenge for healthcare professionals to visit and provide face-to face support, and highlights a lack of resources, such as community groups, crisis services, intense input from the CMHT. The participant describes how they successfully navigated the geographical area offering treatment and assessment by leading the implementation of a treatment plan for an older person with complex needs (frailty, medication side effects, episodes of treatment resistance), virtually. They achieved this by working collaboratively with the multi-disciplinary team (MDT), GP, and pharmacist.

In devising this treatment plan, three options were made available which allowed clinicians involved to draw on a few options if any implemented were not effective, without having to go back to the Consultant. This extract demonstrates that this clinician was adaptable and navigated the Health Care pathway by working collaboratively with key partners illustrating that virtual assessment, treatment and support can be achieved successfully even with older people with FMI who have complex needs.

The following quote describes a different multi-agency example where navigating support with communality that all stakeholders partaking are from statutory services:

> *"… it's ongoing so the police, social workers and errr in fact it's a Huntington's, so there is quite a lot of err people involved and it's about group care and support actually from everybody (multi-agency)"* (Participant 5; Vicky CMHN)

This participant highlights a multi-agency approach referred to as 'group care', for this case, enabling a collective method to identify and agree the support required whilst sharing responsibility for risk. The participant highlights that this health board has a daily multi-agency huddle:

> *"…huddle every morning as well, so that ....erm everybody from the hospital ...erm to police also air ambulance, erm... the liaison team, mental health officer…. (to discuss) that's just what's happening overnight really"* (Participant 5; Vicky CMHN)

This extract adds to the contention that a multi-agency approach was beneficial where managing people who are at risk of harm or harm to others due to mental illness. The membership of the huddle also included emergency services which allowed a co-ordinated and planned response to any patients identified out-of-hours. This huddle appears to be a collaborative approach fostering strong communication amongst many agencies.

Reduction in bed numbers and recruitment challenges also meant HCPs had to be adaptable in their practice across the pathway of care. A participant explains:

> *"...we have got some real pressures on beds at the moment, which I know is not unique to us, so my practice about admitting has changed and our pressures are generally in our teams, well our teams have never been very well developed…… I have got a bit firmer about what we do and try to*

> *just do the really difficult bits" (*Participant 3; Dr Brown Consultant Psychiatrist)

This participant highlighted there is a demand for admission beds at this point in time which has led to some healthcare professionals adapting their practice and raising their admission threshold. Furthermore, services are being developed to address the gap in resource provision. Shortages in staffing also meant HCPs needed to be adaptable where delivering support:

> *"we are so limited in numbers now with the CPN's we're sort of covering all areas and ......erm.....but again it is err, we look for the needs of the person and what is necessary, sometimes our OT's will go out first and ....because that looks where the issue is arising, I mean if they go out and find that actually that's not what's on paper that actually isn't the issue but it will come back to the team and then we will look at erm... divvying it up again"* (Participant 4; Fiona CMHN)

The reported shortage of CMHN's meant the Occupational Therapists (OT) sometimes bridged staffing gaps by undertaking initial assessments to identify what the needs are and what support is required. It could be argued that OT's do not have the same skill set as CMHN's around the initial mental health assessment. The shortages of staff also affected the support and treatment of older people with FMI in crisis. A participant describes:

> *"we struggle a lot with crisis reviews ...... in that we've only got a sort of you know kind of sparsely resourced teams .... erm, which is essentially CPN a little bit of an OT if we're lucky and .... err you know doctors that are spread around a bit so if somebody's in crisis that can be difficult to get them seen quickly" (*Participant 3; Dr Brown Consultant Psychiatrist)

The quote reveals that staffing shortages and resource of teams means it can be challenging to respond and support an older person with FMI in an urgent way. This also impacted upon the teams' view of their work and how effectively they were managing to support people.

In summary, this first subtheme suggests that HCPs navigate services to support older people with FMI. The GP was identified as a pivotal determinant in what support older people with FMI received. Geography was also a determinant in the way in which older people with FMI received support as those in remote and rural areas were supported more by the GP by active input as opposed to secondary services. Furthermore, where secondary services were involved, support was often delivered by telehealth.

4.2.2 A Hidden Population of Older People with FMI

This subtheme revealed that secondary service HCPs in rural areas had very low numbers of older people (10-15% of their case load) with FMI known to them - based on prevalence per population, which is 15% according to the WHO (2017). Some participants reported only one or two older people open to their service with FMI, suggesting there may be a hidden population of older people with FMI without support. In contrast secondary service HCPs in urban areas had a caseload of people with both organic mental illness and FMI.

The following participant gives an overview of their caseload.

> *"……my caseload and two of the other CPN's who are no longer working just now…….erm and we were all 50/50, fifty organic (with cognitive impairment cases), fifty functional (with functional and mental health illness cases)"* (City team) (Participant 4; Fiona)

The above extract reveals within the city area of this health board, several HCPs had an even split of older people with FMI. However, in contrast, in the rural part of this health board a participant observed a low number of people with FMI were referred to them:

> *"I've got very few functional patients and I don't know why, like very few, ... like maybe 10% of my whole case load erm, now that might be because I don't cover the city so I've got a rural area ...... erm but even taking that into consideration it is very low, and I don't think it's because*

> *the GP's are just dealing, no disrespect to them, I think they're fine but I don't think they are doing a whole heap of work that would normally be done by psychiatry, I think for some reason there is just less of it, ... err the lower end of the spectrum"* (Participant 3; Dr Brown, Consultant Psychiatrist)

This extract illuminates further that in this rural area there appear to be very few people with FMI referred to the CMHT, and peoples' mental health needs appear to align more with tier one and tier two mental health needs (normally managed by primary care, not requiring specialist input). It was suggested there was a possibility that GPs might be managing people with FMI in Primary Care. However, their assessment may not be less comprehensive than a psychiatrist may perform. This participant explains further:

> *"I think sometimes people I think if they are of a certain generation, and they are old maybe just don't recognise depression and anxiety as an illness .... erm so they maybe don't come ...., they don't think to go to their GP and get seen but even taking that into consideration there's .... you'd think if they weren't I would be getting patients who are very sick and I've not given anybody ECT for about eight years yeah and it's not that, cause I'm not for ECT in the right circumstances obviously, I'm totally sold on the fact that it's appropriate in certain cases I just haven't had those cases crop up .... and I don't .... that can't be just patients .... not coming, not, not, not seeking help because you think there would be a percentage of patients who would come to the point where they would need to be detained and brought in you know even if they didn't want to seek help and I think because they were so ill, so .... there is something that's going on this area, and I don't know what it is"* (Participant 3; Dr Brown, Consultant Psychiatrist)

There is a suggestion by this participant that older people may not be aware their experience of depression and anxiety can be illness related and, therefore, may not seek help. The participant was uncertain why the numbers of people with FMI seeking help are low in rural areas, thus suggesting there may be a hidden population. It was thought that HCPs were not overlooking older people with FMI, as there was no evidence of people who had missed support presenting in severe crisis. However, there was a concern if older people with FMI were not seeking support they could then present in a more distressed state. This participant highlights a further anomaly in this health board with very few older people requiring Electroconvulsive Therapy (ECT) treatment for severe depression; around 370 people per year in Scotland receive ECT, with people aged over 50 being most likely to receive the treatment (Scottish Electroconvulsive Therapy Accreditation Network 2021) suggesting there is an absence of severe FMI in the rural areas of this health board. Another participant discusses their lack of older people with FMI presenting to their service:

> *"We don't have a lot of people with functional illness elderly patients, and I think, there is still a lot around that age group where you just get on and you manage"* (Participant 1; Jane Advanced Nurse Practitioner)

This quote leads to a further explanation for the low numbers of people with FMI seeking support which could be attributed to the fact older people are resigned to coping with their situation. It was thought older people accept that FMI accompanies old age, adding strength to the notion there is a hidden population of older people with FMI. However, an alternative view is that older people with FMI are recovering without intervention. The participant explains further:

> *"...there is still a lot around that age group where you just get on and you manage, so it's not a case of asking for help, so we don't have that many functional illness older adults down here and I think it is mainly down to the fact that they are really very stoic, and they don't want to have that sort of involvement from the GP practice"* (Participant 1; Jane Advanced Nurse Practitioner)

Stoicism was a further possible influencing factor for the low number of people with FMI seeking support. HCP participants thought some older people may choose to manage symptoms of FMI themselves to maintain a level of privacy from healthcare professionals, while others like to stay independent choosing to keep themselves hidden from services. Another participant adds:

> *"I think a lot of undiagnosed depression and anxiety in older people, and I think it doesn't come to light until, folk tend to be fairly significantly affected by it."* (Participant 2; Carole Advanced Nurse Practitioner)

This is a contrasting view to that of the Consultant (Participant 3) who felt people were not presenting with advanced symptoms. Participants had varying and contrasting views as to why there was low numbers of FMI:

> *"...they've been to GP's but there have been quite a few occasions where they have expressed concern you know about their mood, mobility and it's not been picked up, again I think this is because of the understandability factor (of GP) ……. we see that quite a few times"* (Participant 2; Carole Advanced Nurse Practitioner)

This account reveals this participant has a different view, believing some older people may have tried to seek support for their mental and physical health problems, and a possibility GPs might have overlooked them, thus leaving a population hidden without support. It was perceived that some GPs may not be aware or associate depression and anxiety with FMI. Another participant explains:

> *"…because they have got to a certain age it's just "och" it's down to old age and you know this is to be expected, when you get older. Difficult sometimes because people are then labelled its just older age, you know, it's one of these things. It's not and it's trying to get folk to you know, an older person can get depression an older person can develop anxiety for whatever reason, and we need to be taking that seriously. It's just as serious for them as it is for somebody aged under 65. But it tends to be, I'm not going to say dismissed as that's not the right word, it's just not, I don't think taken seriously when they go and see a GP" (*Participant 1, Jane Advanced Nurse Practitioner)

This extract illuminates perceptions that old age is an influencing factor in what support of people with FMI receive. It was considered by participant one that some older people's needs were not considered as seriously as people aged under 65, with a dismissive attitude to older people.

In addition, they perceived that some GPs undervalue the symptoms of FMI (depression and anxiety) in older people and put it down to old age or simply view these symptoms as inevitable in old age. This participant's perception appeared to be quite judgemental and slightly negative towards the support Primary Care offer to older people with FMI. If symptoms of FMI in older people are considered as an inevitable consequence of ageing, then this would account for a possible hidden population of older people with FMI that participants are describing in this health board. Participant two adds:

> *"...very overworked and there's very few resources around but I think they (Healthcare Professionals') quite often don't recognise I'd be very surprised if they recognise a significant depression, they might recognise a significant anxiety, err I think they tend to misinterpret symptoms"* (Participant 2; Carole Advanced Nurse Practitioner)

Similarly, this participant perceived other healthcare professionals such as nurses working in Primary Care were often unable to identify depression or mistook depression for anxiety. Their view may be because services are stretched and overworked. Again, this appeared to be a quite critical perspective about health care professionals' knowledge base in Primary Care.

However, this notion does offer a further rationale as to why there appears to be a hidden population of older people with FMI in this area. Another perspective was offered:

> *"I know that depression is under-diagnosed in the elderly .... but still and he (the GP) was like well we give them an antidepressant and they get better, or we refer them on to some sort of talking therapy and they are getting better."* (Participant 3; Dr Brown, Consultant Psychiatrist)

This quote suggests GPs might be managing their patient's depression in Primary Care by prescribing medication and using talking therapies, thus preventing some older people with FMI receiving onward referral to secondary mental health services. This offers an alternative reason why there may be few older people with FMI presenting to rural secondary mental health services as GPs are managing these symptoms, questioning if there is indeed a hidden population at all.

Data captured in this study illuminated participants beliefs that some older people with FMI choose not seek support as a participant describes:

> *"There is still stigma attached, and I think particularly for older people that stigma is very much there. I think that the younger generation, if we are looking at you know the sort of just on the cusp of 65 because they are more au fait with the system and more comfortable with it, they may be more open to going and seeking advice and help from the GP practices, but I think it is just a generational thing more than anything"* (Participant 1, Jane Advanced Nurse Practitioner)

This quote suggests the participant perceived that stigma was an influencing factor in some older people's reluctance or hesitance to seek support for their mental health from their GP. Another factor was the assumption that generational influences may hinder older people's desire to seek support.

It is thought by participant one that older people aged in their mid-sixties were more familiar and comfortable with the health care system for seeking support, compared to those older who may be less comfortable in seeking support. This may account for the perceived lack of older people with FMI presenting to secondary mental health services. A further possible reason is the link to stigma of mental illness. Another participant explains:

> *"I don't know if it's a kind of rural thing, where you just they feel you should just toughen up and get on with it"* (Participant 3; Dr Brown Consultant Psychiatrist)

Rurality emerged as another influencing factor thought to reduce support sought by older people and linked to the societal image perceived by people who live in the country that they should be strong and stoic. The following quote adds weight to this contention:

> *"...he is struggling and he has seen his GP and one thing he just kept saying was to me and I have had a few men that do this, they keep telling me about all the things they have done in the past, like I was in the Navy, I worked in the lifeboat, I'm not weak and then, it's like obviously that they feel mental illness is weakness and have a lot of guilt… the men erm you know they have been the kind of tough ones, especially if they've been doing a job that they think is quite .... a hardy job."* (Participant 3; Dr Brown Consultant Psychiatrist)

There is a suggestion some men may consider FMI a sign of weakness. When seeking support or highlighting they have symptoms of FMI, they appear to feel a need to validate their strength in describing the work they did in their youth. This perception may be due to how they regard the construction of masculinity. This participant's perspective was that older men who may view themselves as masculine and worked in challenging roles in their youth find it difficult to experience symptoms of FMI, thus adding to the belief there may be a hidden population of older people with FMI.

In summary, this subtheme reveals there is a perception amongst some HCPs of a hidden population of older people with FMI living in rural areas. Rural CMHTs received what they considered to be low referrals for support for people with FMI. There was a sense this may be because older people living in rural areas were more stoic and just "got on" with things. Another view was that HCPs believed some older people still associate mental health with stigma, thus making them reluctant to seek support or acknowledge they have mental health needs.

Some HCPs perceived that older people accept symptoms of depression and anxiety and do not recognise these as symptoms of mental illness. Other views were that GPs were in fact managing and treating older people with FMI and therefore did not refer them onto secondary mental health services. A contrasting assumption was that there was a lot of undiagnosed FMI as GPs were not picking up on the symptoms or were simply dismissive of FMI in older people.

The findings indicate, potentially, there is a hidden population of older people with FMI living in rural areas in this health board. Consequently, they may not be receiving the support or specialist input they require for their FMI and possibly this could impact upon the quality of life of the older person with FMI, if their symptoms are not being treated or managed. Furthermore, this could impact upon family carers who may be filling the void of professional support.

In contrast, there did not appear to be evidence that older people with FMI living in urban areas were not receiving support, as participants did not discuss this. The next subtheme describes how assessing and managing risk influences the decision making of the HCP.

4.2.3 Assessing and Managing Risk, the Challenges and Uncertainty

This subtheme highlights that risk of self-harm, harm to others, neglect, risk of physical ill health due to FMI, is a key determinant for HCPs when identifying and anticipating their approach to delivering appropriate care and services to older people with FMI. Family concerns are also an important guide in planning appropriate support.

> *"…I think the impact (of symptoms) upon quality of life and their ability to cope with life, if it's having a marked influence on that then they would fit*

> *criteria for our intervention, erm risk, risk to themselves, risk to others, risk to their physical health, self-neglect erm, I, I suppose to a certain extent the concern of the people who know them best, in terms of families whether they feel that the person is at significant risk, then that would influence the assistance that we would be able to provide."* (Participant 2; Carole, Advanced Nurse Practitioner)

Data captured revealed that risk related to mental health is multi-faceted and includes the older person being at risk of harm to themselves (by self-harm) or others (by physical harm). It also includes risk that mental health may have on their physical health and potential for self-neglect, thus adding further dimensions of challenge and uncertainty when assessing risk.

Although healthcare professionals discussed their referral criteria (severe and enduring mental illness, complex needs, risk of self-harm or harm to others) for secondary mental health services, they also considered families concerns in establishing appropriate and required frequency of support interactions.

HCPs used the following assessments with older persons with FMI's mood and risk of self-harm:

> *"we did some Geriatric depression scale erm assessment, anxiety management erm, STORM if need be ….., sometimes it's a case of helping them with the introduction of medication err looking at symptoms, looking at how best to manage symptoms, erm and some reassurance that they won't always be like this and they will get better".* (Participant 2; Carole, Advanced Nurse Practitioner)

The above extract illuminates some of the assessment tools used by HCPs with older people with FMI. The Geriatric Depression Scale is a scale that assesses for depression in older people (Sheik and Yesavage 1986). The Skills Training on Risk Management (STORM) (2008), tool is a risk management tool that assesses for suicidal risk and provides subsequent risk management tools for the HCP to complete with the older person with FMI.

Using ratified, recognised assessment tools provides an objective measurement for risk assessment and depressive symptoms and reduces uncertainty when assessing risk. The STORM risk assessment tool (2008), will be used by HCP's in secondary care if someone is identified as being at risk of self-harm. This focuses on suicidal intent, if the older person has considered methods, or has a plan of how they could harm themself; any factors they may be informing a crisis (e.g. relationship breakdown, loss of job); any contributing factors that make suicide less or more likely and coping mechanisms which may help. Another participant describes an example of uncertainty where managing risk:

> *"…they (patient) have err a whole sort of wellness recovery plan ......and so they know when they are becoming unwell, they know what to do at that point, this person is ready to be discharged but then when you bring to the team for discharge it's, ahh but they can rapidly go downhill (and then not want to discharge)"* (Participant 4;Fiona CMHN)

The wellness and recovery plan (WRAP) (Copeland 2022), is a tool which should be developed jointly with the older person with FMI and their CMHN. The aim is to equip the older person with the skills to recognise when they are becoming unwell and provide the support they need to access and manage this. This extract highlights the challenges and uncertainty where managing risk.

Participant four, appeared to have a different threshold to others in the team around risk and decision making in relation to when it was safe to discharge an older person with FMI from secondary mental health services. This led to some uncertainty in the MDT team around decision making particularly around risk assessment and discharge from the service. The reason for reluctance in taking steps towards positive risk taking was that this health board has a particularly high suicide rate. It is uncertain why. This participant further explains:

> *"I understand that ....but at the same time you know you're developing a crutch for them ....erm and then you know if you do for some reason then discharge ....they are going to feel completely*

> *abandoned and it's not going to be ....as positive as it should be…"* (Participant 4;Fiona, CMHN)

The above extract further highlights there is uncertainty when assessing and managing risk. This caused a reluctance in this MDT to discharge people in case they went on to harm them self. Arguably, uncertainty in risk management potentially could have a detrimental impact on the older person with FMI by fostering independence. As described above, a potential cause for the uncertainty in risk assessment in this health board is described:

> *"I think erm ....up here .... there is a high percentage of ....suicide and there is a fear" (Participant 4;Fiona, CMHN)*

The perceived high suicide rate appeared to impact upon some team members' decision making in relation to discharging older people with FMI from the CMHT and caused uncertainty across the MDT when assessing and managing risk of self-harm. Potentially, this is due to an element of fear of repercussions on the practitioner should there be a completed suicide but, also, a fear for the older person should they come to harm. The perception that there is a reluctance to discharge people due to uncertainty around risk management is further evidenced by the following participant:

> *"… what I've found is that there have been people who I inherited, who do not need.......our continuing service, they could have been discharged erm and managed self-management a bit better.......err but they've been held onto" (Participant 4; Fiona, CMHN)*

This participant's perception is that uncertainty across the MDT team in risk management further highlights that older people with FMI were not discharged as quickly as they could have been- potentially creating a dependency on services. Participant 4 believes these older people could have been supported to manage their own symptoms, empowering these older people in contrast to the extremely paternalistic approach which appears to be occurring in this health board due to the challenges the team are facing where assessing risk.

The data also illuminated that risk assessment was challenging as 'risk of self-harm' was viewed differently between adults aged 18 to 65 with mental illness, and older adults with FMI. The following quote describes:

> *"…I think young people just attract more attention because maybe they are going out … buying a car that they can't afford, or sleeping with people putting themselves at risk that way, where, as I think sometimes the risk in older adults can be overlooked because we forget that the behaviour might not be as dramatic but because they are frailer they may be at greater risk (of physical ill health)"* (Participant 3; Dr Brown, Consultant Psychiatrist)

The above quote suggests risk in older people with FMI may be overlooked because younger people may behave in more dramatic ways when mentally unwell. This meant that risk was more visible in younger people as their behaviours may be more extreme. In contrast, it may be more challenging to assess risk of harm older people with FMI as the symptoms may be more subtle or present in different ways. For example, risk of self-neglect or poor dietary intake. This participant further adds they believe the risk assessment across the age spans are different:

> *"I think the risk assessment is different because I think there is a different set of risks erm so things like not eating, not drinking or not taking your medication err is probably a greater risk if you are physically frailer or have other co-morbidities than it might be if you're younger"* (Participant 3; Dr Brown Consultant Psychiatrist)

Therefore, risk is aligned to specific conditions.

This data suggests that older people with FMI may present with different risks than younger people with FMI as older people may also have risks related to complex physical needs and frailty. Therefore, a challenge in the risk assessment of older people with FMI is that consideration of risks which may affect physical health may not be so pertinent in working age adults.

In summary, this second subtheme highlights that risk assessment is complex and uncertain. Risk assessment undertaken by HCPs was a determinant in what support or services the older person with FMI would receive. Furthermore, data captured illuminated that HCPs had different levels of tolerance in their risk assessment which again influenced the support older people with FMI received. Therefore, there could be variances on the support older people received depending on the level of risk perceived by their HCP.

4.2.4 Toolbox of Interventions

This subtheme reveals that several psychosocial interventions are used in this health board to support older people with FMI. Psychosocial interventions include strategies such as managing stress, coping skills, relapse prevention and psychoeducation. In addition to this, it includes psychological therapies such as CBT (Cognitive Behavioural Therapy) (Mullen 2009). The following quote reveals:

> "…*we would look at trying to tie in the thoughts and feelings, a wee bit of, tentative CBT work"* (Participant 2; Carole Advanced Nurse Practitioner)

This account highlights that CBT therapy explores the thoughts and feelings of older people, (which is the theoretical framework of the therapy and described interventions per session) to support the older person. CBT is generally used with people who have depressive symptoms or anxiety. This practitioner describes an indefinite approach to CBT, which suggest she does not adhere strictly to the rigidity of the approach. She uses some aspects of CBT as part of a toolbox of interventions to support older people with FMI. Another participant describes further approaches available where supporting people with anxiety and depression:

> *"…so we've got all The Decider Tools erm....in previously I have done the CBT training"* (Participant 4; Fiona CMHN)

Decider skills (2023) is an intervention that uses a CBT approach to teach people to recognise their own thoughts and feelings, to be able to manage FMI in everyday life. It is a much quicker intervention than CBT and in contrast to diploma plus training for CBT, the Decider skills is a two-day course. Arguably Decider skills is an adapted, shortened version of CBT and therefore another approach to be added to the HCP's toolbox of interventions. This participant also describes a mindfulness approach:

> "…*lot of the mindfulness we can actually apply for them to go on the .....course, Our Health board offers that, the course for that so, ...you can get on that quite quick"* (Participant 4; Fiona CMHN)

Mindfulness is an intervention that encourages the older person to focus on the present moment. It can be used in conjunction with other therapies such as CBT (Miller 2019). Mindfulness is an intervention used to reduce depressive symptoms and lower stress and is a tool to help people manage FMI in everyday life (NHS 2023). It was considered an easily accessible course for older people with FMI as the health board offers courses. As previously highlighted, CBT is a lengthy course, currently offered only in Central Scotland. The following extract reveals that some practitioners use an approach where they adapt therapies to meet the needs of the older person with FMI:

> *"…probably pinch little bits from your toolbox to suit the client, pick what you need, ... so erm, some of them can't just manage the CBT and the homework, sort of following a structured guide so .... you just tweak what it is that you need for the individual" (*Participant 4; Fiona CMHN)

This quote suggests that this CMHN assesses the patient's ability to engage in therapy and are then adaptable where delivering interventions to meet the needs of the older person with FMI. In this case the older person was not able to engage in the very structured approach of CBT, therefore, the clinician adapted the support to be more flexible in which interventions were delivered in each session and accepted if the person was not able to complete all aspects of the homework set.

Homework is usually agreed tasks and goal setting; for example, I will clean my dining room on Tuesday, my bathroom on Wednesday. This adds weight to the notion that HCPs adapt therapies and use a toolbox approach to meet the needs of their patients. Another participant explains:

> *"I would like to refer to Psychology more often as I would like to treat people with depression and anxiety with psychological therapy rather than medication. .... most of my patients .... don't want that to be honest, they would rather just come and see me and take a tablet rather than go and see a psychologist. .... I think that might be a generational thing"*
> (Participant 3: Dr Brown Consultant Psychiatrist)

It emerged this HCP understood that psychological therapies was the preferred first route of treatment for older people who have depression and anxiety. However, most older people that she had reviewed did not wish to engage in therapy, perhaps not seeing the value in talking therapies, preferring to take a tablet. This was thought to be a generational issue believing that the doctor and a tablet will make them better, rather than more contemporary models of treatment such as CBT, or other forms of therapy. Although HCPs may understand the value and promote talking therapies, it is still the patient's choice if they wish to engage in recommended treatments.

In summary, this subtheme illuminates that HCP's in this health board delivered several interventions to older people with FMI. This included CBT, Decider Skills, and Mindfulness, which is tailored more for people with anxiety and depression. There was a perception amongst HCPs that some older people with FMI could not manage the structured approach of some therapies such as the homework aspect of CBT. Therefore, therapies were used interchangeably and flexibly, which is at odds to how they are prescribed to be used. Psychological therapies are normally delivered very closely to the manual to ensure little or no deviation of the intended therapy. In this health board, HCP’s used therapies almost as a toolbox of interventions to meet the needs of the people they were supporting.

The next subtheme illustrates different models of care exist for older people with FMI.

4.2.5 Models of Care for Older People with FMI

This subtheme highlighted there were variations in models of care in this health board. A model of care broadly outlines the way health services are delivered. It emerged there were differences for older people with FMI, in comparison to mental health services delivered to those aged 18 to 65. Some services had a restriction based on age and would not see people aged over 65.

In contrast, some services adopt a more individualised approach and would keep people aged over 65, based on their needs. The data illuminated that often mental health services arbitrarily restricted access to mental health services for people upon turning age 65 and this was often just accepted by HCP’s. A participant discusses:

> *“…our generic team our adult team don’t automatically transfer people when they become 65 they will keep them unless their needs outweigh the staffs generic ability to look after them and then in which case they would be transferred but if people have had a stable care and are known to the service then they stay in that service unless things change.”* (Participant 2 Carole; Advanced Nurse Practitioner)

This quote suggests that some generic teams will keep older people with FMI once they attain age 65, whilst in other teams and locations they would transfer the person to the older adult service. Participant 2 adds weight to the idea that the older adult mental health team have specialist skills that the generic team do not have, around frailty, physical co-morbidity and cognitive impairment. This participant explains further:

> *"…and I think that the staff are happy to keep these patients and until such time that they feel that they are not meeting their needs. I think it works well because I think erm 65 as an older adult is not really accurate in today's society and I have had a couple of new people that I have seen, who have actually been really quite insulted coming into old age psychiatry at 65 /66"* (Participant 2; Carole Advanced Nurse Practitioner)

The above participant has a different perspective and claims that age defined services and older adult services being defined as 65 and over are not reflective of contemporary societal views. She suggests that many people aged over 65 now work and would not self-identify as an older person. She suggests that the generic service will keep people once they turn 65 rather than referring them to the older adult mental health team. This is arguably a more person-centred approach. Another participant felt that the needs of people did not change once reaching the age of 65:

> *"I think their needs are much the same as people under the age of 65, their needs don't change just because they suddenly become 65. So they do need the same level of support its just you know, if there were groups going in X City it is still difficult for somebody under the age of 65 to go to X City for these support groups but it's even more problematic for somebody over the age of 65 just because of the logistics, you know they may not be able to drive anymore. They may have to get buses, there is all that involved in it."* (Participant 1; Jane Advance Nurse Practitioner)

This participant adds to the suggestion that age defined services are not meeting the needs of people with FMI. This quote draws attention to the belief that when a person reaches 65 their needs do not suddenly change, and they require the same level of support they did at age 64, but in some cases, people will be transferred to an older adult service. It is unclear why this is. However, there may be issues in accessing services as people age, if they become less confident driving. The following participant has a contrasting view and believes the needs of people do change once reaching 65:

> *"I personally think that they do change in the sense that we, you know always that they've got a support group and things for people with depression or bipolar tend to be for under 65 and that's just because you know it's the way the service is run. But there is nothing geared up for the over 65 it's as if, as soon as they reach 65 you don't need these services and that's completely not the case. They still need the services, they probably need you know but it needs to be with like minded age group not in amongst all these young people. So yes there is a bit of disparity I think."* (Participant 1; Jane Advanced Nurse Practitioner)

The above quote suggests that there is inequality in services available for people with FMI, with a view that services are available for those under 65 and for some the arbitrary removal of services for those age 65 and above. It was also suggested by participant 1 that people no longer require groups or services once they reach 65. However, this participant feels the crux of the issue is not that services be defined by age, but important they are defined by commonality of people attending. Another participant highlights that services may be withdrawn upon turning 65:

> *"…when you get to old age, they drop off, erm.......so....... going back to schizophrenia erm, and I am just picking up another one today ....when they get to the age of 65 the adult service drops away from them ....so the support mechanism .... and there's nothing really.........suitable for them erm........and some of them have managed to ....stay a little bit longer ....post 65 but then eventually it does sort of......they get found out and err that's that door closed to them."* (Participant 4; Fiona CMHN)

This quote reveals the arbitrary decision that services are withdrawn upon attaining age 65 appears to be merely accepted by HCPs, who acknowledge the gap in service provision. Another participant describes that ageless services appear to exist in their area:

> *"… (ageless group) it seems to work fine, err I think no matter what the age they are, I've referred quite a few people and I think at the moment there's a err 80 year old, attending one of the groups, and it seems to work ok, I think a lot of it is down to the group leaders"* (Participant 2; Carole Advanced Nurse Practitioner)

It could therefore be argued there is a postcode lottery in relation to whether older people with FMI continue to receive mental health support upon turning 65. It would appear the underpinning factor in this service delivery decision is down to individual leadership in the services. This participant's experience was that mixed age groups worked well. Another participant also explained that at times the mental health ward is also of mixed age range; they explain further:

> *"…(mixed age ward) …well you know it seems to actually work quite well, for both groups, the young ones will tend to want to take care of them most of the time cause they see the vulnerability erm and the old ones seem to thrive on the company of and I suppose the conversation of the younger ones. It does seem to actually work out quite well for both"* (Participant 5; Vicky, CMHN)

The mixed age range in the in-patient mental health ward appears to offer a mutually beneficial relationship between both age groups with younger people supporting older people, whilst enjoying the company of the older person, therefore the rationale for not mixing age groups out with the hospital setting is unclear.

Data collected also illuminated that third sector and community support were another model of care within the health care system that supported older people with FMI. HCPs supported older people with FMI by signposting to these services:

> *"….a day centre.....so you pay for each day, so we took a patient along with us, just so they could see what's on offer and there is so much on offer, like they get their lunches, activities in the morning and afternoon"* (Participant 6; Shona OT)

The above highlights community resources that are available for older people with FMI are provided by the third sector. The Occupational Therapist identifies the rehabilitation activities on offer by a day centre and signposts older people to these resources where needed and will accompany and support the older people with FMI initially to attend. Participants identified that day centres are a beneficial resource providing social interaction and activities, and with the additional bonus of a meal provided could be beneficial if the person is not cooking much at home or is reliant on family carers to support with meals. Peer support groups also appeared to offer support to older people with FMI. They further explain:

> *"…like the group on a Wednesday is a peer support group so we all help out at that and that's every Wednesday, so we assist people to that and try and get them back out and get support and get them back into the community". (*Participant 6; Shona OT)

The extract above highlights that a model of care developed in this health board was that peer support groups are available for older people with FMI. The OT as part of an enablement approach will support older people with FMI to attend this group with the aim of integrating them back into the community. Another participant describes the model of peer support group as a source of support beyond discharge from health services:

> *"…our peer group, so ....although these people are being discharged, who are keeping themselves well and who are supporting each other"* (Participant 4; Fiona CMHN)

The peer support group was led by older people with FMI who were in the process of being discharged from secondary services. This was a potential source of mutual support for those with shared experiences and a means of building self-resilience and staying well.

There were many support groups run in the community of this health board as part of their model of care. The participant below shares her experience of referrals.

> *"…they (Professionals in Primary Care) make poor decisions in as much as they think groups are for everyone, and if they are not going to go to groups, well, I've done what I can, I've offered this and they haven't taken it"* (Participant 2; Carole Advanced Nurse Practitioner)

Arguably, this participant assumes that HCPs in Primary Care almost see referring older people onto groups as a way of abstaining from their responsibilities and she argues further that a 'one size fits all' approach for older people was not meeting their FMI needs, further suggesting that not all older people enjoyed groups. There was a further assumption from this participant that if the older person with FMI did not engage in the group work offered, then practitioners were dismissive, with limited identification and signposting to other resources.

In summary, this subtheme reveals variations in the availability of services within this health board. Some services had what appeared to be an arbitrary restriction based on age and would not see people aged over 65 In contrast, some services adopt a more individualised approach and will keep people aged over 65, based on their needs. This was for both mental health services and some mental health support groups, the latter was felt to be linked to the values of the leader and their perceived purpose of the service.

The mental health in-patient unit was ageless and this was felt to work well due to the mutual support different age ranges provided to each other. However, with contrasting experiences, some services would transfer or restrict access to services upon the person reaching the arbitrary age of 65. Some people were perceived to be offended at being transferred to an older person's service at 65, with a view this did not reflect old age in contemporary societal views. There were noted to be gaps in older adult services in comparison to younger people services and disparity across what was available to older people, thus highlighting inequalities in provision to people upon turning 65.

4.3 Chapter Summary

In conclusion, this chapter reveals the perspectives of healthcare professionals and provides insight into the overarching theme "Ways of Working with Older People with FMI" where several factors determine how and which services are delivered to older people with FMI. This included the referral pathway, the geographical area, and the model of care within the health board.

There were also five sub themes.

The subtheme, Pathways of Care: Navigation and Adaptability to Meet the Needs of Older People with FMI, revealed that older people with FMI were required to navigate a pathway to receive support from secondary services for FMI. This was because the GP was in a gatekeeping role and nearly all referrals to secondary mental health services come via the GP. Consequentially, there is a reliance on the GP to recognise the signs and symptoms of FMI to ensure the older person with FMI receives specialist support.

Furthermore, this theme illuminated disparity in available services and highlighted the lack of a crisis intervention team for older people with FMI. Data illustrated that rural GPs bridged the service gap and often were the support mechanism for those in crisis. The notion of team-working was not only apparent by the support offered by rural GPs but, furthermore, a multi-agency approach was found to be beneficial where discussing those presenting out of hours and sharing patient risk collectively.

In the subtheme Assessing and Managing Risk, the challenges and uncertainty illuminated there were variations within the MDT when managing and assessing risk. Participants felt this was due to the high suicide rate in this health board, which led to different approaches in the team.

The subtheme theme "A Hidden Population of Older People with FMI" revealed some participants (HCP's) presumed that older people particularly those in rural areas, were perceived at times to make a conscious decision that they did not want support for FMI- or they may not recognise that depression and anxiety is a mental health condition. Some participants in this study thought GPs in rural areas were managing the symptoms of FMI effectively, thus reducing the need for onward referral to secondary services.

The subtheme "A Toolbox of Interventions" illuminated that HCPs in this health board delivered several interventions to older people with FMI. This included CBT, Decider Skills, and Mindfulness.

The final subtheme from phase one data was "Models of Care for Older People with FMI". This showed variations in the availability of services. Some services had a restriction based on age and would not see people aged over age 65. In contrast, some services adopt a more individualised approach and will keep people aged over 65, based on their needs. This was both mental health services and some mental health support groups, with the latter felt to be linked to the values of the leader and their perceived purpose of the service.

Phase one of this study was exploratory and has illuminated the pathway of care to secondary mental health services, and variations in models of care in the local context in this health board. Thus, including the adaptations and strategic decisions HCPs make- in main due to the remote and rural geographical area of this health board they provide services to meet the needs of older people with FMI.

The key findings of phase one informs phase two by shaping the topic guides to reflect these findings and asking probing questions of participants around these. Phase two of this study and its findings are now presented in the following chapter. This phase considers findings from older people with FMI, one family carer and healthcare professionals.

Chapter 5: Phase Two findings

5.1 Introduction

This chapter presents the findings from phase two and builds upon the findings from phase one which illuminated one overarching theme "*Ways of working with older people with FMI*" and five subthemes. The findings from phase two provide an analysis of the lived experience of older people with FMI (*n*=4), one family carer (*n*=1) and the experiences of their HCP's (*n*=2), in relation to services and support they receive and the issues impacting upon this.

Data collected in phase two illuminated there are several determinants influencing the support older people with FMI received. These include accessibility to services, decision making and role of the GP, risk of self-harm influencing HCP decision making where offering support and the COVID-19 pandemic. Furthermore, data revealed that older people with FMI took an active role in self-care. Relationship building between HCP and older people with FMI was pivotal in the older person with FMI's journey to recovery.

It is helpful to recap, that phase one included HCP participants (*n*=6).
Participants in phase two are described in the following table.

Table 18: Phase two participants

Phase Two Participants			
Dataset 2	Semi - structured interviews	• Older person with FMI (*n*=4) • Family carer (*n*=1). • Healthcare Professionals (*n*=2)	**Joyce** (p2), - is a female **older person with FMI**, she has symptoms of low mood and previous episodes of self-harm. Lives alone in an urban location. Supported by a CMHN. **Bert** (p2), - is a male **older person with FMI**, previous episodes of self-harm and severe symptoms of anxiety. Lives with his wife in an urban location. No physical health co-morbidities. Supported by CMHN,

			Psychiatrist, and attends peer support groups. **Penny** (p2), - Bert’s wife and **family carer.** She lives with her husband in an urban location and no longer works. **Fiona** (p1 &p2), - **CMHN** (HCP) (also interviewed phase one) **Jeff** (p2), - male **older person with FMI** - psychotic illness. Lives alone. Supported by CMHN, Psychiatrist, and attends peer support groups. Lives in an urban location **Dr Smith** (p2) **Psychologist** (HCP) **Mary** (p2), - female **older person with FMI** - psychotic illness. Lives alone. Supported by Psychologist and Advanced Nurse. Lives remote and rural. • All participants are coded and more detail available within personal information within coding, not shared within this thesis as people could be potentially identified. • (p1) =phase one • (p2) = phase two

The thematic analysis as described in Chapter 3 (section 3.10.1), for phase two, illuminated one overarching theme: *Accessing support and treatment for older people with FMI* which reflects the lived experiences of participants in this study which are characterised by what influences older people with FMI to seek support and what influences HCPs to offer support. In addition, this theme highlights that older people realise the importance of relationships with their HCP's. This overarching theme builds upon findings in phase one, which illuminates these services are accessed and treatment is received due to several different influencing factors.

A key factor across both phases of this study is the GP's role around treatment as decision maker and referrer to secondary mental health services and the importance of risk of self-harm or risk to others in the older person with FMI. Further key factors are; how risk influences HCP decision making where offering support and the impact which the COVID-19 pandemic had upon access to treatment influencing older peoples' decision making not to access services.

This overarching theme is supported by three subthemes;

1) *Referral pathways and transitions across services for older people with FMI*

2) *Strategies for promoting self-care in older people with FMI*

3) *Relationship building between HCP and the older person with FMI*

which are described in Table 19 and in further detail thereafter.

Table 19: Phase two themes

Overarching theme	**Subthemes**
	5.2.1 Referral pathways and transitions across services for older people with FMI
	5.2.2 Strategies for promoting self-care in older people with FMI

5.2 Accessing support and treatment for older people with FMI	5.2.3 Relationship building between HCP and the older person with FMI

In rural areas it was evidenced that the GP was more actively involved in supporting the older person with FMI. However, two participants, one in an urban and one in a rural area, reported encountering barriers from the GP when trying to access secondary mental health services. In addition, experiences from wave one of the COVID-19 pandemic changed how support was offered from in-person to non, face-to-face (ie. Phone and videoconferencing), and the lived experiences of older people with FMI and the HCP's during lockdown are captured in these findings.

Data gathered further highlighted the impact of lockdown due to COVID-19 on older people with FMI by exacerbating their symptoms as they could not exercise or access peer support groups or face-to-face support from HCPs. These factors impacted on the daily routine of older people with FMI. Loneliness was a key factor caused by lockdown, which affected their mental wellbeing.

The subtheme *'Strategies for promoting self-care in older people with FMI"* illuminated that the Wellness and Recovery Tool (WRAP), was identified as a tool beneficial for older people with FMI to recognise the symptoms and signs of when their FMI was worsening. These data further identified that the HCP adopted a coaching approach by using goal setting and self-help these approaches emerged as being very beneficial to the participants interviewed, as tasks were broken down into manageable steps by the HCP to support the older person with FMI in their recovery journey.

The subtheme '*Relationship building between HCP and the older person with FMI'* illustrates the impact of relationship building between the HCP and older person with FMI, and the impact the relationship has on recovery, with both positive and negative issues emerging. Older people with FMI highlighted they found the relationship between HCP and themselves beneficial in the support they received to recover. One participant describe that HCP services lacked any approach towards building relationships with the older person with FMI. Evidence in this study illuminated that COVID-19 did impact upon the ability to build and maintain relationship-centred care, as part of the relationship was lost when face-to-face contact between the HCP and an older person with FMI was removed due to lockdown.

The following section of this study presents the overarching theme *"Accessing support and treatment for older people with FMI".*

5.2 Accessing Support and Treatment for People with FMI

This theme illuminates that all participants in phase two perceived and experienced several factors influencing how services and treatment were accessed by and for older people with FMI. Data collected, highlighted that the lived experience of some older people with FMI (*n*=4) and the family carer (*n*=1) was positive where accessing support, one participant described a negative experience, and another had a mixed experience.

This theme illuminates from findings in phase one that the GP is pivotal in either supporting older people with FMI themselves or referring on to secondary mental health services. These data evidenced that older people with FMI in remote and rural areas were supported heavily by the GP. In addition to the role of the GP, risk of self-harm and risk of harm to others was a significant determinant in the decision making of HCPs in the support and access to mental health services that older people with FMI were offered. Furthermore, COVID-19 was a significant factor in how older people with FMI accessed support. These findings are from the perspective of older people with FMI, a family carer and health professionals.

As already discussed, this overarching theme has three subthemes. The next section of this thesis will describe the first subtheme *referral pathways and transitions across services for older people with FMI.*

5.2.1 Referral Pathways and Transitions Across Services for Older People with FMI

This subtheme reveals the experiences of the four older people with FMI, one family carer and two HCPs in relation to their lived experience around referral pathways and transitioning across services for older people with FMI. This subtheme built upon findings from phase one in that the GP had a key role referring on for support for older people with FMI and their family carers. It is important to acknowledge I was unable to recruit any GPs, so their perspective is not captured in this study. A participant named Joyce explains:

> *"I had depression about 8 year ago and err my own doctor dealt with it……(R- was that your GP?) yeah my GP…..I went back to him err…..ahhh and ended up at The Psychiatric Hospital"* (Participant 7, Joyce, older person FMI)

This quote illuminates that at times, older people with FMI will be treated by their GP, but there may be times when their symptoms worsen and referral to the CMHT or hospital admission is required, and the older person with FMI will therefore transition across services. The quote highlights as in phase one, that GPs are treating depression, highlighting that the GP will treat people with mild to moderate symptoms of FMI.

These data illustrate that the GP is pivotal in their role in deciding where best the older person with FMI should be supported, ie, primary or secondary care, demonstrating the strong decision-making role of the GP across the referral pathway. In this case, the GP is pivotal in ensuring the older person with FMI receives the right care at the right time at the right place.

Another perspective is offered explaining how risk of self-harm influenced the GP’s decision making where referring to secondary mental health services:

> *“My daughter came with me to the doctor (GP) ……and he said are you depressed and I said yes and he said are you suicidal and I said yes……and erm all he did was organised for a team (crisis intervention service-this was in England), for three of them to visit me in the flat once ……and erm that was …….erm, I just felt worse and worse every day and then I decided to take my life.”* (Participant 7, Joyce, older person FMI)

The above quote highlights the role of the GP as key decision maker for the referral and access to secondary mental health services. It further illuminates that the GP made onward referral to a crisis intervention service, which had support from three clinicians. Despite this intensity of support, the older person with FMI’s mood worsened and suicidal intent continued to increase.

This example indicates risk management is uncertain, not precise, and difficult to measure. Consequently, this means HCPs can never truly negate risk of harm to self or others. A further explanation is now offered around the referral pathway to secondary mental health services:

> *“You can’t contact them (the CMHT) direct unless you already have contact with the mental health team ……you know you can’t make a first appointment with them (CMHT).”* (Participant 12, Mary, older person FMI)

Mary expressed that older people with FMI, or their family carer were unable to directly access or refer themselves onto the CMHT. She felt frustrated by this as she was having trouble accessing secondary mental health services via the GP. There may be several reasons why Mary was not referred onto secondary services but the current referral pathway as designed means that the GP’s decision is the sole determining factor in whether a person is referred to secondary services.

The referral pathway was a challenge for Mary as she could not access secondary services and as later quotes from Mary will highlight, eventually she obtained support via the police. This participant recognises the limitations of what GPs can do within current service delivery models:

> *"…..yes I think the…..demand on primary care GP's it is and the short time they spend with the client…. I think it makes it (difficult) for them to unpick some of the causes…it is horrible to say that…you know and when you need to do a full assessment … you are spending an hour to two hours and in that conversation and time period you can actually unpick some of that and you've got a clearer vision of what's going on….. and a 5 minute….10 minute appointment with the GP that just isn't possible so it is maybe just….I wouldn't say if they had the same luxury of having that time they would probably absolutely see (all) the right indicators and red flags ….due to the demand on the service they don't have that luxury."*
> (Participant 4, Fiona; CMHN)

The above participant believes the GPs responsibility as referrer to secondary services may pose some challenges when determining if referral to secondary services is required. GPs have limited time to spend with older people as their consultation time normally around 5-10 minutes. In contrast a full mental health assessment may take a professional from the CMHT up to two hours highlighting that the GP has limited time to undertake an assessment of mental state to inform their decision making if referral to secondary mental health services is required.

The extract below illuminates an approach made by a family member to secure a GP consultation due to their concerns about his brother or sister's condition:

> *"He (brother) just made a nuisance of himself laugh ….he phoned up the day that we went back after we agreed and the receptionist was being really stroppy and more or less saying that no we couldn't speak to the doctor because erm he was in doing surgery erm and they don't take calls when they are doing surgery and brother was like I just want to speak to your manager then…..and that's what he did and she got us an appointment"* (Participant 12, Mary, older person FMI)

This participant perceived there are barriers when accessing the GP and as a result, secondary mental health services. The participant viewed the GP in their referring role to secondary services as a barrier, due to the receptionist at the GP practice in their triaging role not providing immediate access.

Arguably these roles are needed due to the diverse nature of the GP role across all spectrums of illness and increased need placed on health care systems. However, in this case for the older person with FMI and their family carer, these possible barriers were seen as hindering timely help and input from services.

Another participant Joyce, shares a similar experience:

> *"I tried to get my own doctor and….. couldn't get past the receptionist….. it made me feel not very good ……(R-yeah) cause my GP said that ehhh just ask for him if he was there and he could, fit me in…you know ……but it just seemed to be the receptionist ….she just didn't seem to be very keen on it"* (Participant 7, Joyce, older person FMI)

Joyce's experience adds to the concept that as part of the referral pathway, the receptionist in some areas acts as the facilitator, triaging referrals, and decision maker in terms of whether an older person with FMI will get to see their GP. It is unclear from the data what the receptionist's knowledge and skills are about FMI in older people, or whether they have an algorithm in place to follow. In this case the GP had offered reassurance to this participant that they could phone, if they needed to. Not being able to speak with the GP had a negative impact on how this older person with FMI was feeling.

This participant's wife offers her perspective:

> *"…just one particular one (receptionist) and err when we seen the doctor ……..we actually happened to mention it you know, because it wasn't helping Bert very much that he maybe had to wait, so we have now got that we make an appointment with the doctor so we don't have to go through the receptionist."* (Participant 9, Penny, family carer)

Penny thought waiting to see the GP was having a detrimental impact on her husband's FMI. It appears the GP recognised accessing the receptionist was distressing for this participant. Therefore, the GP now makes the next appointment with Bert when he sees him. This a person-centred solution for this participant who now has scheduled appointments made. However, unscheduled appointments remain an issue to arrange for Bert and his wife.

Risk assessment in older people with FMI is an ongoing process, as risk is fluctuating, depending on a person's mental state. Data collected highlighted that an acute mental health need compounded by risk was usually the trigger in decision making for an admission to a mental health hospital. At times, the Mental Health Act (2003), was required to treat and care for people.

A participant named Jeff recalls:

> *"…. there I went with some hippies……and then I was sectioned and I was homeless for a short time….. well, I didn't like it (being sectioned) at the time but I'm very glad because although I used to live in the country, I always fancied the City …….and then I had to leave the city in the end laugh…."* (Participant 10, Jeff, older person with FMI)

Hospital was another identified part of the pathway where older people received support. This participant articulates he was admitted to hospital by use of legislation and detention order under the Mental Health Act, whereby his decision regarding not wishing to be admitted to hospital was discounted on legal terms. At the time of being detained the participant was not happy about the decision to detain him and admit to hospital. However, once his mental state improved, he was glad this decision was taken, thus suggesting that in some cases acute FMI clouds judgement which the person can later reflect upon and resonate with once well again.

Another perspective of seeking support for FMI is now described:

> *"I just couldn't seem to think logically about this it was you know I was frightened to go out err and in actual fact it was the police ….that said to me that I should seek help….although the doctor had been on about it the doctor had told me that I was imagining it all err and I just didn't believe him err…..and it wasn't until the police said it after being called out so many times erm err and that's when I went back to the doctors"* (Participant 12, Mary, older person FMI)

This data illuminates Mary's perspective when seeking support from her GP and the experience of transitioning across services to get support. She believes the GP was initially dismissive, and navigated different parts of the system including the police to get support and reassurance. This may be because it is not always clear where to get support for mental health.

However, as a counter argument, it is possible the GP did not consider there to be a risk. Therefore, her quote adds to the notion of uncertainty in risk assessment which may be perceived differently between HCPs and older people with FMI and their family carers.

The following quote highlights how older people with FMI move between services to receive support:

> *"I actually cut myself and….errr.errr…err I was in hospital…..the mental health hospital errr they put me up to (the Psychiatric Hospital) Dr Y. So when I came out I got the nurses from there, CMHN A… well first of all it was another nurse but they came to the house and she retired and the CMHN A came back in"* (Participant 8, Bert, older person FMI)

It emerged in this scenario that the decision to admit to hospital was triggered again by risk following a suicide attempt. To support discharge and maintain ongoing assessment of this participant's risk, he was supported by the CMHN. The quote shows that older people with FMI need to transition between services to meet their needs, rather than support being delivered to the person in one place. Risk is a deciding factor around when a person should be admitted to a psychiatric hospital or treated by the CMHT.

This family carer describes her husband's (Bert) experience:

> *"when he cut himself …..so yep that was errr…..another big shock but erm and then he went up to XXXX hospital and got help there. It made a big difference"* (Participant 9, Penny; family carer)

This quote highlights the lived experience of Penny, the family carer, who was also impacted by her husband's episode of self-harm. He was admitted to an in-patient setting due to the risk of self-harm which could not be managed at home safely. Penny further explains:

> *"…it (admission to psychiatric hospital) was difficult at first …….erm because he just looked lost if you know what I mean erm …..he was wanting out but we knew that inside was the best place for him. He knew that himself"* (Participant 9, Penny; family carer)

The above quote shows that admission to hospital was challenging for both the older person with FMI and also his family. Psychiatric hospital admission is the final resort in support across the care pathway. There is a sense from this participant that she feels helpless in supporting their husband whilst in hospital, but equally recognised he needed the specialist support to recover. This family carer also stated that her husband also acknowledged that he needed time in hospital himself.

Data captured in this study highlighted isolation, due to COVID-19, was found to be a determinant in the support an older person with FMI required. In this case it exacerbated the person's distress and subsequently had a detrimental impact upon their mental health and support was required. A CMHN describes how they managed this:

> *"I actually now have her in a place of safety because of that …..erm so….perhaps that's very difficult….its very harm erm and its about how to manage that erm so……it is a decision that the lady its erm erm….anxiety and depression and suicidal intent erm so she is actually residing in a nursing home for 3 months during Covid because I couldn't keep her safe at home"* (Participant 4, Fiona, CMHN)

COVID-19 was an extreme contextual factor that impacted upon how much access and support to secondary services older people with FMI had during lockdown. In this case the CMHN was unable to maintain this older person's safety due to COVID-19 because face-to-face support from the CMHT could not continue and the patient was not able to receive intense support at home for her mental health.

It is helpful to provide context that dependent on risk, an older person with FMI may be supported at home by their CMHN anything from daily to once every 6-8 weeks. This quote illuminates that the older person with FMI did not require hospital admission, however, loneliness was impacting upon her mental wellbeing. The CMHN did, though, find another part of the pathway (social care) which could support this lady by providing company, which had been removed from communities by lockdown.

This subtheme develops the findings of phase one of this study, illuminating that risk assessment and management- usually relating to self-harm - was a factor in the support older people with FMI received across the pathways of care. It emerged from these data that risk management was uncertain and risk could never truly be eliminated. The judgement of risk level could differ between HCP and the older person with FMI and family carer. Consequently, there were differing expectations on the level of support offered.

Furthermore, it was viewed by HCPs that there was inadequate resource when managing acute risk in the absence of a crisis intervention team. This was viewed by this participant as age discrimination, given that adult services had a crisis intervention team.

Findings in relation to the role of the GP had commonality with phase one, highlighting that the GP is pivotal in ensuring older people with FMI get the support they require. The GP role for some participants posed a challenge as two participants experienced barriers when trying to access their GP, impacting on timely onwards referral to secondary mental health services. Participants highlighted occasions where the GP had referred them for specialist support, but also where the GP had treated depression themselves without the need to refer onwards.

Data illuminated that COVID-19 was an extreme contextual factor that required an adaptable response in providing mental health support to older people with FMI. This was a shift away from face-to-face support (as dictated by lockdown) to support being provided virtually or by phone. The following section of this thesis highlights the findings of the subtheme *strategies for promoting self-care in older people with FMI.*

5.2.2 Strategies for Promoting Self-Care in Older People with FMI

This subtheme illuminates strategies that were promoted by HCPs for older people with FMI to achieve self-care, which is defined as the practice of taking action to preserve one's own health (Oxford Dictionary 2022). These self-care strategies were promoted to enable wellness and recovery in the older person with FMI.

Key emerging concepts were trade-offs older people with FMI were willing to make when taking psychotropic medication versus side effects, goal setting and the use of the Wellness and Recovery Plan (WRAP). WRAP is a strategy used by HCPs to promote self-care in older people with FMI. It is a tool which is completed by the patient and HCP towards identifying triggers for becoming unwell mentally, as now explained:

> *"…..tool (wellness and recovery plan) that erm quotes the information in regards to any triggers that causes your mental health to deteriorate erm what the signs are of you becoming unwell …….. what does that look like for you so its its putting down on paper what happens when you become unwell and how do you know that you have become unwell, what happens what does that look like and you know who have you got to support you who else would see that and what people have you got around you because sometimes as an individual you might not be the one sees these things happen so…..it gives you a list of people who are around you who support you you know when you are becoming unwell"* (Participant 4, Fiona, CMHN)

The Wellness and Recovery Plan (WRAP) documents triggers and indicators for when a person is becoming unwell. It becomes a resource for identifying people who can help the older person with FMI and resources they can tap into. It also documents the person's symptoms and behaviours for HCP's should they become unwell and what support and which treatment is most effective. Arguably, this tool is an anticipatory care plan adapted for mental health.

This is described further by Fiona a CMHN:

> *"you can get your last recovery plan out and it's got all your tools there so if you haven't utilised some it is a trigger to maybe use some of the other ones you haven't thought of but you've not to be using it on a daily basis because that's not how it works ……which he I believe….he has only taken out three times…. in the time he has had it"* (Participant 4, Fiona, CMHN)

Data illuminated, that to maintain self-care, wellness, and recovery, the WRAP can also be used as a tool for the older person with FMI to keep strategy details which are beneficial for their mental illness. In addition to the WRAP, some clinicians used assessment tools to support wellness and recovery in older people with FMI:

> *"we do use the HAD's err for anxiety and depression erm and really that's about it errr for assessment tools erm I do use err the WRAP wellness recovery action plan erm and sometimes that's good……erm with Joyce (p2) (we've) done it together"* (Participant 4, Fiona, CMHN)

Thus, suggesting the WRAP is a tool used to promote self-care in the patient. Where possible the WRAP would be done jointly with the older person with FMI, to empower the older person with FMI to self-manage their symptoms, recognise triggers and to seek support when needed. And, when done jointly, provides more meaning to the patient as they have been key to developing the plan This means the older person with FMI has a plan to maintain their wellbeing in preparation for discharge and beyond. In addition to the WRAP, guided self-help was also a method used by HCPs to maintain wellness in older people with FMI.

This participant explains:

> *"she (psychologist) sent me information booklets on anxiety and stress ….erm and I worked my way through them and found them really helpful…erm and err… I worked my way through them and from the ideas that came from these books I made a kind of plan of the things that I needed to put into practice for the one thing that came out of it was that I'm not really looking after myself very well at the moment"* (Participant 12, Mary, older person FMI)

It emerged from the data that guided self-help has benefits for older people with FMI, towards achieving wellness and recovery. This gave the older person some structure to identify what she needed to change in order to feel better. The outcome for this lady was that she learnt she needed to take better personal care as she had been neglecting herself due to her FMI. Guided self-help was also a tool that empowered the older person with FMI to maintain their own wellness and recovery by involving others.

A different perspective is offered from the Psychologist:

> *"given them homework…..recording their mood is their mood improving the more they go out and see people….. hopefully they would say yes…..just encouraging them to do that a bit more….if I can do that in a guided discovery way I would…if I can't I might be more directive and say this is part of the treatment"* (Participant 11, Dr Smith, Psychologist)

These data highlight that by keeping a mood diary the HCP is encouraging the older person with FMI to learn and discover more about themselves, and issues that make them feel better and issues which are contributing to low mood. The diary is a means of empowering the older person with FMI and a means to encourage them to socialise and meet people. The Psychologist encourages the older person to do slightly more- by using guided discovery-which is an approach encouraging the individual to reflect on the way they process information (Overholser 2018).

She further explains:

> "*something like CBT I would give them an activity diary to complete just that they have to record what they are doing in the morning and rate their mood what they were doing in the afternoon rate their mood their mood was you know 2/10 when they were lying in their bed but then when they phoned their granddaughter actually their mood was 8/10 so you know it helps so sort of track the link between activities and mood or it might be to keep a diary of their thoughts so if they have a panic attack keep a diary of that …….write down what were you thinking at the time what were you feeling what was the trigger ……"* (Participant 11, Dr Smith, Psychologist)

Dr Smith explains that to help people manage their condition, asks older people to keep a diary to rate their mood which can be linked both to what makes them feel better and to what may be a trigger to them feeling less positive. This is a means of empowering the person to engage in activities which make them feel positive, and to recognise activities that may trigger low mood.

Mindfulness and distraction techniques were identified by a participant as beneficial:

> *"he uses mindfulness …..or he goes out for a walk to distract himself err occupies his mind with something else he has err an app on his phone which is a game…so he engages in the game and preoccupies his mind with a game on the phone erm….if it's really bad he may text it to me and send it to me so it's gone or he may write it on a piece of paper and then screw it up and put it in the bin erm…..dispose of it that way and then once its disposed or sent to me it's gone"* (Participant 4, Fiona, CMHN)

Mindfulness and distraction techniques were identified by this participant as beneficial to distract himself from negative thoughts or feelings to manage his condition. His CMHN was a support mechanism and agreeable to the participant texting her his thoughts. He was also supported to have some self-resilience, and he managed his anxieties by writing the thoughts down and throwing them in the bin, which is a form of distraction. By doing this task he was alleviating himself from negativity and maintaining his wellness.

Another participant describes:

> *"I feel at the moment as if erm it's a brick wall that's facing me and I can't move past it at the moment although (the) psychologist gives me four tasks to do …… I can choose the tasks erm and anything that's going to make me feel better and I did the four tasks two which I didn't do particularly as well as I would have liked but that's just my character again and err that gave me quite a sense of achievement"* (Participant 12, Mary, older person FMI)

Here, Mary describes several strategies set for her by her psychologist to achieve self-care; these were breaking larger tasks into smaller more manageable ones supporting the older person with FMI to achieve their goals of helping themselves. The HCP adopts a coaching approach with the older person with FMI by suggesting several strategies that may help them. The older person with FMI finds great benefit from this approach and on completion of tasks feels a sense of achievement. Mental health assessment tools were also another way that HCPs monitored the wellness of older people with FMI and their progress.

A psychologist explains:

> *"personally I should just be much better at using them because I think it would give you a more objective it would give you something more objective to use….so if say the score wasn't improving and you did a measure every single week every single session it would give me more back up to say…look is this actually helping you or not I should use it a lot more….I don't know why I don't because I used to work as a Psychologist in adult services and they did use them"* (Participant 11, Dr Smith, Psychologist)

Dr Smith suggested assessment tools are not used as frequently as they are in adult mental health services. It's uncertain why, and when asked she was unsure. The benefit of using assessment tools as described from the perspective of this participant, is that they give an objective assessment and provide a baseline measure to monitor progress, recovery, and wellness. This participant used a formulaic mental state assessment approach instead, which is a series of questions practitioners ask about an older person's mental state, ranging from sleep pattern, dietary intake, enjoyment levels, thoughts of self-harm etc.

COVID-19 also affected how older people with FMI maintained self-care, as now described:

> *"I suppose the isolation….was covid related erm and that increased the distress and….erm yes that erm being on her own not being able to get out erm…..self- isolating was just too much yeah…..it was very bleak….very bleak"* (Participant 4, Fiona, CMHN)

The lockdown rules impacted upon older people’s ability to have social contact and ability to go out. Loneliness exacerbated symptoms of FMI in the older person.

The pandemic also affected another participant:

> *“I’m not terribly anxious but a little bit anxious with this Covid (R- that’s understandable) pandemic ……erm I tend to eat too much yeah, yeah but it’s something to do isn’t it”* (Participant 7, Joyce, older person with FMI)

Joyce further illuminated that the pandemic impacted upon her already present symptoms of FMI as she experienced mild anxiety due to COVID-19 and lockdown, and subsequent boredom causing her to overeat.

Another participant explains:

> *“…exercise is good for it, but since this coronavirus has come in I’ve not been err ……Dr .Z and Dr Y told me to do two walks a day…….and if anyone complains about it that err….put it to them……”* (Participant 8, Bert, older person with FMI)

Exercise was thought to be beneficial for their mental health and self-care, but lockdown restrictions meant exercise was limited to 30 minutes once a day as per Scottish Government guidelines. Bert suggests the doctor could see what the impact of not getting out to exercise was having upon his symptoms of FMI, and encouraged him to do more exercise than strictly allowed under lockdown. This is explained further:

> *“I go out with my wife, I was getting 4 walks in……but….I haven’t been able to do walks on my own ………since this (covid) came in….. it’s a pain not being able to go out for walks”.* (Participant 8, Bert, older person with FMI)

This data suggests that prior to lockdown, this participant’s daily exercise has halved. Walking is very much part of his routine in maintaining his self-care. However, Bert’s confidence due to his FMI and inability to do walks which keep him well has reduced since COVID-19 and now requires the support of his wife to go with him. It would appear the lack of freedom in being able to go for a walk was affecting him and his wife.

His wife explains:

> *“I try to encourage him to maybe just go around the block himself….he has done that in the past erm but coronavirus has erm erm he hasn’t been able to do that……it’s really just being there for him and listen to him and you know just encourage him”* (Participant 9, Penny, family carer)

It is suggested that the restrictions of the pandemic had affected her husband’s confidence and wellness. She emphasised the importance of her role in supporting and encouraging him and simply being there for him when he needs her. However, the impact of the pandemic on Bert’s FMI has caused changes for her too, where she now must accompany him on his walk as his confidence has been affected.

Furthermore, there was an impact felt by participants where community services were closed:

> *“…..one (group) in City X, and erm then its stopped due to the lock down”* (Participant 7, Joyce, older person with FMI)

This quote illuminates that groups were ceased due to lockdown. This had a negative effect on older people with FMI’s wellness as they were isolated and not receiving their usual support. In turn, this meant where possible, family members had to step up and bridge the void of support or as highlighted earlier, alternative mechanisms of support were found, such as care homes.

Jeff also had a similar experience as expanded on by the following quote:

> *"….art and writing and walking and that kind of thing but I feel very, very engaged but with this virus its not open at the moment"* (Participant 8, Bert, older person with FMI)

Thus, suggesting that groups providing structure, hobbies, and occupation for older people with FMI were closed during lockdown, highlighting the pandemic further affected older people with FMI, as their routine was impacted and they encountered loneliness.

A further insight from data collected relates to the strategies and support offered to family carers where supporting an older person with FMI to self-care.

Penny explains;

> *"well, I had to give up work…. Erm…… you know because when he came out of hospital…..he couldn't well when he cut himself and put into hospital, I ehh …… took sick leave because I was going up there every day you know to visit him and then when he came home ……he couldn't be left on his own so eventually after some sick time I had to …..give up work. It was a strain to be honest errr at the start but he's here and making progress"* (Penny participant 9; family carer)

> *"and was there…there any support that you had in the time when you were at work or was there anything available to you?"* (researcher)

> *"No , no…..I mean they came up with……I'd, we'd booked holiday for a week and then I let that ….And just as I was about to authorise it all….P8 phoned to say he had cut himself errr so I haven't been back to work since that's been two years last month, I haven't been at work so …..I just decided to retire"* (Penny participant 9; family carer)

This illuminates that from the perspective of this family carer, there were no available supports that could adequately keep her husband safe. Consequently, she had no choice but to stop working to care for him.

This subtheme has illuminated that one participant found the WRAP was a helpful tool for older people with FMI, their family carers and HCP's in identifying triggers and symptoms and strategies to stay well. The WRAP was completed in partnership by the HCP with the older person with FMI. These data further illuminated that very few other assessment tools were used to support decision making in assessing the older person with FMI's mental state and developing a formulation. Goal setting and self-help emerged as being very beneficial to the participants interviewed because tasks were broken down into manageable steps by the HCP who adopted a coaching style in supporting the older person with FMI to achieve everyday tasks. The older person with FMI felt great achievement at completing tasks.

COVID- 19 was a significant contextual factor found to impact upon the experiences of some older people with FMI. Some, with this condition and their HCPs, reported that COVID-19 exacerbated symptoms of FMI as lockdown restrictions impacted upon their ability to exercise freely, attend groups and community services, all of which were ways they could achieve self-care.

In addition, lockdown impacted upon a loss of routine, with increased loneliness potentially worsening symptoms of FMI. Furthermore, face-to-face support from HCPs was not delivered during lockdown- with support offered by phone or virtually. Older people with FMI accepted this way of working and understood the rationale why.

Finally, from the perspective of the family carer, there appeared to be limited support available for family carers to enable them to sustain work whilst in a caring role. The following subtheme explores the concept of relationship building between the HCP and older person with FMI.

5.2.3 Relationship Building Between HCP and the Older Person with FMI

This subtheme illuminates the perceptions of participants in phase two who really valued the relationship between HCP and the older person with FMI.

Participants (older people with FMI *n*=3) struggled to articulate what therapeutic support they were being offered but often recognised there was real benefit in talking, and the role that talking had in forming a relationship with the HCP and talking and the relationship with the HCP helped them stay well or recover. With contrasting views one participant (older person with FMI) described a lack of counselling, therapy or relationship forming between HCP's and herself. HCPs in this study understood the importance of the relationship with the patient and their use of therapeutic use of self, within the patient and professional relationship.

The following participant explains:

> *"I always talk about the therapeutic relationship and what they believe you know my role as a CPN is to support them….so I always have that conversation when I introduce myself to new clients…I have that discussion errr what is…..what are their expectations erm and what do they want to know about me as a person erm….so I often share who I am and erm share a bit of my family life and bit of my history of where I have come from and what my knowledge is and they share with me…so we get to know each other as individuals rather than them talking just about mental health"* (Participant 4, Fiona, CMHN)

This quote suggests the HCP understands that to support the person with FMI and their family, they need to build a relationship with them. They build the relationship around being personable, by sharing personal information about themselves and having a reciprocal conversational approach to their interaction.

They describe that knowing each other is an important component in helping support someone get better and allows trust to be built.

The relationship reassures the older person with FMI that they are important and what they are experiencing matters. At the outset of their interaction, they introduce themselves and define the anticipations of the support that will be offered, and boundaries are gently set. Another participant offers clarity around the relationship between HCP and the older person with FMI:

> *"therapeutic in a general sense to me would mean that it was……mean helpful for somebody and I suppose it would just mainly mean helpful perhaps more in a way….maybe through a relationship…..that's helpful….so I would talk a lot and I think just in general most of the benefits that my patients will get or any patient in psychological therapy will be through the therapeutic relationship. I think that's one of the main factors that's helpful"* (Participant 11, Dr Smith, Psychologist)

This participant illuminates the multifactorial concept of the relationship between HCP and patient. The relationship is developed through talking and consultation. This HCP highlights the biggest concept for them is being helpful to the patient. Another participant explains the reciprocal nature of the patient and HCP relationship:

> *"We look at how we could support each other ……we can work together to …….maintain good mental health and what that means and how they would like the support in doing that…. what their needs are and what support they would like and how that looks ……they ….there are some people who don't always know what that is until you work through things together and as you say you know a lot of it is trial and error erm….and being open and honest"* (Participant 4, Fiona, CMHN)

Fiona highlights that relationship building is important to achieve a model of shared decision making between HCP and older person with FMI. During this collaborative working, the HCP is working to identifying the support needs of the older person, getting clarity of what their needs are and their priorities around goal setting. She highlights that the older person with FMI may not realise what support they need and that working together with the HCP can help find clarity. However, reaching clarity may take several attempts to work through what the actual need of the patient is. Building the HCP/patient relationship is also a balancing act, ensuring the conversation is paced for the patient whilst gleaning the information required as part of the assessment process:

> *"…if you're constantly bombarding them with questions then they become more distressed and you can't continue the appointment so…..it's about making sure that they remain calm and relaxed…it's not an issue if you don't know doesn't matter…err and just making sure that they are at ease the whole time so….its guided very much by their body language …their facial expressions …..erm…and erm obviously their verbal communication"* (Participant 4, Fiona, CMHN)

Thus, suggesting that building and maintaining a relationship is a skill that requires the practitioner to ask questions in a conversational style to make the older person with FMI feel at ease, at a pace comfortable for them, alongside gathering information required to inform their assessment around risk of self-harm or harm to others. The practitioner does this not only by using a conversational style approach but reading the non-verbal communication of their patient too. This participant adds:

> *"…sometimes I think if you have too much knowledge when you go and see them erm about the clinical notes and you go in with……preconceived idea of what it is they need so that is why but obviously I need some kind of background before I go in to keep myself safe and them safe but….it's about not going in with that perception that you know what it is that you are going to offer"* (Participant 4, Fiona; CMHN)

This quote reveals Fiona feels it is important to visit the older person with FMI with few prepossessed ideas about them. This is to avoid making assumptions about the patient which they may do if they have knowledge of the full history before meeting with them. The HCP believes it is vital to consider the need the person has, at the time of assessment, particularly around risk of self-harm and risk to others, which is pivotal in the ongoing assessment of the older person with FMI. They glean the notes before a visit to ensure there are no significant risk factors, but other than that, they visit with an open mind. This participant explains further:

> *"…about knowing the person and or getting to build that therapeutic relationship to be able to know how you present the support ……and how they envision that that so you know…..again it's about keeping and maintaining someone's independence erm….some of the ladies the older ladies they meet they don't want somebody to come in and clean their house because they're very proud people and it is distressing them that they can't do it but the thought of allowing somebody else to come in and do it for them is just too much…..and often my way of getting around it is….this you know…your independence now is in delegation"* (Participant 4, Fiona; CMHN)

Again, this quote highlights the importance of knowing the older person, a key component in relationship building. This includes time invested getting to know the older person with FMI and building a therapeutic relationship, which then allows the healthcare professional to identify and explain to the person what support may be beneficial for them. Once that relationship is formed it is easier for the healthcare professional to encourage the older person to accept the support they need.

In this case it has been achieved by using a phrase such as "your independence is now in delegation" which is more palatable to the older person with FMI and enables them to maintain a level of control. This data highlights that HCPs may have some stock phrases they use to encourage older people with FMI to accept support when they are resistant to that idea.

Another participant explains:

> *"I used to sit and talk to her …..about things and err….she would…..err give me suggestions in how to deal with things and I used to go and see Dr. Y at X hospital and err he just used to sit there and talk to and he's very easy to get on with and Dr X …..she's the same like….just sit and talk to her ….it helped"* (Participant 8, Bert, older person FMI)

This quote illuminates that this participant can't quite articulate the input they receive from the healthcare professional to be therapeutic, but they do value the concept of talking and the relationship that has been built between them and the HCP. They acknowledge strategies suggested by HCPs to manage their symptoms as being beneficial. They explain further:

> *"…..she talks about what's bothering you, and how to deal with it…. I think that they err all of them (HCP's) do the same sort of thing …… you just talk to them"* (Participant 8, Bert, older person FMI)

Again, this quote highlights that this participant recognises that the skill of the healthcare professional, in health services is conversation and building rapport. This includes talking about any troubling problems and how to manage them. This quote further illuminates the concept of the older person with FMI just speaking to HCPs, with recognition that just speaking is beneficial to the older person with FMI.

Another participant comments on the benefit of talking:

> *"What works with me is the ability to talk through how I'm feeling and what I need to sort out….and what I can do about it. ……erm and mainly that is as I say just allowing me to talk and to come up with my own solutions erm…..but that to me is erm is what I what I find very beneficial"* (Participant 7, Joyce, older person FMI)

This participant adds to the concept that the relationship between HCP and patient and having a space to talk is hugely beneficial to her. This aspect of the relationship provided a safe space to talk and empower the patient by guiding and influencing them to find solutions to their own problems, Mary found this found particularly helpful.

Another perspective is now described:

> *"I would use erm techniques such as open questions …..summarising err…..giving space that sort of thing and basically I would want the patient to come up with the answers to their own things rather than telling them err you know you will feel better when you go out and see your friends it would be about……I wonder what erm impact that has…..what do you think and basically just questioning in a way that they come up with the answer themself which generally is more effective if somebody has discovered an insight in a way that has come from themself rather than being told"* (Participant 11, Dr Smith, Psychologist)

This data reveals techniques used by the HCP, where developing and managing the relationship. It highlights the importance of influence from the therapist to enable the older person with FMI to reach solutions themselves. This participant felt empowered to reach their own solutions rather than a professional telling them what to do.

The therapist achieves this by using psychological therapies to guide and influence the older person with FMI to find their own solution by using open-ended questions and reflecting the conversation in a summary to the patient:

> *"I think that the great thing is actually having CMHN coming to the house and chatting to her….and going up to the Psychiatric Hospital to see the psychologist and it's really just talking to people that helps you the most I think and they've been very positive as well you know…..if you've got any worries you can talk it over with them you know and they give you…tips on how to deal with anything that's……maybe …..bothering him I think it's just talking that's helping a lot"* (Participant 9, Penny; family carer)

The concept of talking is also viewed as an informal process by this participant who also acknowledges that whilst discussing any concerns the older person with FMI has, with the HCP there is an opportunity for coping strategies to be explored. The concept of talking and the benefit described by just talking adds to the notion that relationship centred care, is a beneficial approach in supporting older people with FMI. The intervention of talking was found to be beneficial to her husband's mental state. Another participant describes the benefits of talking:

> *"….the benefit that I get from practitioner is that I just talk over how things are going and how I'm feeling and it allows me to erm just talk through what I am feeling rationalising it a bit erm and I find that really helpful if I do it myself I just get myself in a knot sometimes."* (Participant 12, Mary; older person FMI)

This participant appears to value talking with the HCP about how they are feeling. She finds it extremely helpful to talk with another person about how she is feeling as opposed to trying to rationalise her feelings herself. This participant further describes:

> *"for me it is yeah….I think I'd be err….I think I need to talk over these solutions to make sure we I'm still on the right track erm…..it really is a confidence builder erm…..because that's one thing that got knocked bad…. my confidence erm but I I find that being able to come up with my own resolutions and then having them acknowledged as the way forward erm works for me"* (Participant 7, Joyce; older person FMI)

This suggests talking over problems and finding a solution with the healthcare professional is beneficial as it assures her that these solutions are on the correct trajectory, and instils confidence. This participant really highlights the worth of being guided and influenced by the HCP to reach a way forward themselves.

Another participant explains about their relationship with their HCP:

> *"…. They (HCP's) used to err talk to you if you had….you had any problems you could go and ask to speak to them and somebody would come and speak to you and the Dr. Y came ehh……one of the nurses used to come in with him"* (Participant 8, Bert; older person FMI)

This data refers to when the participant was in hospital and illuminates that HCP's also built relationships with older people with FMI in the in-patient services. He was able to talk through any concerns they have with staff.

Another participant adds:

> *"Just allowing me to talk through it and asking questions maybe turning back to me what I've said erm or ……err asking me to explain it a bit more or whatever erm but I've I find it really, I find doing that being able to talk to her about it is very helpful"* (Participant 7, Joyce, older person FMI)

This data illuminates that "just" talking to the HCP is very beneficial for the older person with FMI. The HCP during the conversation will ask questions and then reflect the answer back to the participant or they will delve a bit further by asking the person to describe their answers further.

Another participant states:

> *"I just…..let…..everything out"* (Participant 8, Bert, older person FMI)

Thus, suggesting that talking to a practitioner gave the older person with FMI a safe space to speak and then a sense of freedom once they had unburdened themselves of any worries they had, by talking with a professional.

A different perspective in discussing concerns is described by a CMHN:

> *"…and sometimes by walking somebody through their timeline can take……you know you have to give them the time to walk through that and it sometimes that can be….depending on their timeline and their life history that can be quite distressing and so sometimes you have to stop and go back…..erm and you just have to bring them back to a nicer place and then go back for the rest of the information"* (Participant 4, Fiona; CMHN)

This quote suggests that to support the patient the clinician will guide the person through their past history to a point in time that may now be contributing to their poor mental health - potentially helping them gain insight into the contributing problem so they can work to resolve the issue.

Some people can get upset by this process with old memories being revisited. The therapist will read this situation and help the person back to happier memories and revisit the issue later when the person is able to tolerate this.

Another perspective describes where talking is considered helpful:

> *"the two things that I found helpful were things like talking about worry time…… so that you are not spending your day worrying it's really about different things you park it and then you go back to it later on which I actually find really helpful because when I go back to it later on its so small that I've forgotten about it"* (Participant 7, Joyce; older person FMI)

This extract illuminates that talking about concerns is helpful, but also highlights the importance and healing properties of time and this participant has learnt that by pausing and then revisiting a worry a little later its significance has often diminished. The participant further explains:

> *"for me it is yeah….I think I'd be err….I think I need to talk over these solutions to make sure we I'm still on the right track erm…..it really is a confidence builder erm…..because that's one thing that got knocked bad…. my confidence erm but I I find that being able to come up with my own resolutions and then having them acknowledged as the way forward erm works for me"* (Participant 7, Joyce, older person FMI)

This data reveals that an aspect of the relationship-centred care with the HCP is the older person having the freedom and safe space to talk over their worries and finding their own solutions with the reassurance of the practitioner highlighting their solutions are appropriate. This approach of finding their own solutions has grown the older person with FMI's confidence levels.

The following quote highlights when the relationship is working well:

> *"I definitely get a sense of when it works really well and somebody's engaging and they're making use of what you say and making insights themselves and then there's the times when they just either talking at you and just not using anything that we are discussing"* (Participant 11, Dr Smith; Psychologist)

It emerged that the HCP could tell when the relationship is working, thus suggesting that non-verbal cues provide that insight to the practitioner. The practitioner can also tell when a person is putting into practice the support mechanisms they have discussed. An important aspect of relationship-centred care is that it is a reciprocal relationship, and unlikely to have as much benefit if both parties are not contributing effectively to the relationship.

In contrast, the practitioner can tell when a patient is not psychologically minded as it is not such a two-way conversation and strategies are not adopted. This participant describes further what psychologically minded means:

> **"** *I find this really difficult to define (Psychologically minded)……I know it's fine because it's actually one of the most important things is that somebody is psychologically minded it's just quite hard to……err describe that and pin point that and it's hard to assess that really but I think if somebodies able to reflect on their own experiences ….if they are able to verbalise their own experiences and articulate their thoughts and their feelings that would be…that would make it more psychologically minded if they were able to you know use a talking therapy and use that verbal aspect of it and if they were…..able to have some kind of insight and reflections into making links ….oh this has happened to me and that's why I feel this now…..and changing X Y Z might be you know understand you know what's caused their problems are they being maintained and changing something would effect a change and they've got some agency over that."* (Participant 11, Dr Smith; Psychologist)

An older person with FMI needs to have cognitive ability to engage in therapy or a therapeutic relationship. This means they need to be able reflect and discuss their feelings and any thoughts. Talking in therapy is the tool that can help people to understand cause and effect of different things that may have happened in their life and the impact this has upon their mental health.

Not all participants had a positive experience around relationship-centred care as participant seven describes:

> *"so I took an overdose (R- OK)……and erm landed ……in (general) hospital ……and err, it opened my eyes, all the family were around me….. looking very sombre erm…. And eventually I was discharged to …..err what's it called? (Psychiatric hospital) hospital and…. I was there for twenty-one months….and do you know….only once, once! did I have any counselling and it was one of the senior nurses ………they did absolutely nothing for me at all (R-ok) the only time I was seen, was once a week on a Tuesday …….and erm the… doctor and I was asked to go in and sit in front of them all and I was asked how I was doing, so I would tell them……and that was it…….actually….no ….treatment"* (Participant 7, Joyce; older person FMI)

This participant's perceived experience in the psychiatric ward was that they had very little therapeutic support, thus affecting their recovery. They believe themselves to only have received a talking therapy once during their (recent) twenty-one month admission. Their perception is that they received only one counselling session during this time, with only a weekly review from their consultant psychiatrist.

It is possible the subtleness of the therapeutic relationship was not identified by this participant. However, it is also possible there is a lack of understanding in some practitioners around the importance of relationship building and the benefits it has on the patient's recovery. The consequences of a lack of meaningful engagement to Joyce is that she feels she spent twenty-one months in hospital for no apparent reason as she cannot identify within herself what was done to aid her recovery. Joyce further describes:

> *"I went to them, in the same ward and I had to go, once a week ……..it was probably less than ten minutes and they would say how are you? Are you anxious or are….you depressed ……the questions you would imagine them to ask (R-yeah) but….absolutely….nothing! ……and my friend is a*

> *senior nurse….was absolutely horrified……..and I needn't have been in there, for they weren't doing any help for me".* (Participant 7, Joyce, older person FMI)

This quote highlights that this participant perceives that they received weekly reviews of very limited time duration. At the review Joyce feels the questions were formulaic with little personable value so, potentially, staff have not phrased the questions in a meaningful way to her. In her understanding, the friend also backed up her view around the lack of support she was receiving as an in-patient. This participant also adds:

> *"I would do everything in my power not to go in…… it was endless days of reading……and looking out of the window, which you couldn't open ……which was hell for me because I love fresh air erm…..and it was like being a prisoner ……it was awful…….it really was awful."* (Participant 7, Joyce, older person FMI)

This suggests that there was a lack of structure and therapy in the ward for this participant, who describes a feeling of loss of liberty and not being able to go outside. She further describes that she would try avoiding going into a psychiatric ward.

A contrasting experience is now described by Bert:

> *"I just couldn't get used to it (psychiatric hospital). …….I was wanting out but I knew that I needed to be in there the nurses in there were very good."* (Participant 8, Bert; older person FMI)

This participant highlights that he struggled to settle into hospital and wanted to leave but was able to rationalise he needed to be there. Bert also valued the therapeutic input from the nursing staff. He explains further;

> *"they used to err talk to you (in the psychiatric hospital)) if you had….you had any problems you could go and ask to speak to them and somebody would come and speak to you and the Dr. Y came ehh……one of the nurses used to come in with him….. yeah it was something like once a week or once a fortnight"* (Participant 8, Bert; older person FMI)

This participant suggests that the intervention received was talking. If he needed support from the healthcare professionals, this would be asked for and a member of staff would come and speak. The subtleness of the relationship appears to be understood by this participant who identifies the value of talking to the professional. The consultant psychiatrist would assess him fortnightly accompanied by a nurse.

Participant eights wife adds:

> *"(whilst in the psychiatric hospital) he knew that the nurses and that he could speak to the nurses and eh they were over a lot, giving a lot of encouragement as well"* (Participant 9, Penny; family carer)

This quote suggests that this older person with FMI was aware that he could speak to nurses when he needed to. In addition to this the nursing staff spent a lot of time with him without prompting. The value of speaking to a professional is, again, being highlighted, demonstrating the value of the relationship and the social contact that this relationship also provides.

Psychological therapies are also a treatment offered to older people with FMI as described:

> *"It would be ones that have an evidence base so it would be usually short term psychotherapies such as CBT (Cognitive Behavioural Therapy) erm other therapies might be IPT that's interpersonal psychotherapy or ACT which is acceptance and commitment therapy or I would use a mixture of erm ….a lot of the time it would be probably treating things like trauma as well so maybe using things like EMDR or prolonged exposure….the way that I would determine what would be suitable I suppose is just depending*

> *on the presenting problem ……so I would look for things like how psychologically minded somebody is……I would look for what ….what is the pressing problem for them"* (Participant 11, Dr Smith, Psychologist)

This reveals that only evidence based psychological therapies are being delivered by this psychologist. However, like phase one they use a toolbox approach of mixing different parts of therapeutic approaches together to meet the older person's needs of the older person with FMI. The choice of therapy is decided by the presenting problem and how able the older person is to engage in a therapeutic approach. This participant explains further:

> *"….specifically you sort of pick an area to focus on in this particular therapy so erm we were focusing on her interpersonal disputes that she was having with her partner so it was very structured and focused on looking at the relationship looking at her background what's what's caused her to have difficulties in relationships……. what buttons are being pushed for her and some sort of skills training in terms of different ways of responding …..different ways of interacting ….different ways of getting her needs met within the relationship and really in a general sense it's about you know when somebodies depressed they start to withdraw and avoid social interactions and if they're not getting that social support that they need so it's really very much about encouraging the socialising aspect …..to improve your mood."* (Participant 11, Dr Smith, Psychologist)

In the above scenario, the HCP for this specific approach identifies an area to target - in this case her interpersonal relationship with her partner. To deliver the therapy, the therapist explores the persons personal history and what from their history may be contributing to the present problem, then looks to upskill the person with skills to manage this. Thus, in turn, they are then equipped for future difficult conversations for which, hopefully, they will have the skill set after therapy to manage rather than having to retreat from the situation. This participant adds:

> *"…just like you know some of the medications won't work you know psychological therapy won't always work it's just kind of quite hard to admit that…..not for me to admit it…..it's just quite hard to say that to the*

> *patient because it feels a bit hopeless."* (Participant 11, Dr Smith, Psychologist)

It emerged that sometimes therapy doesn't work. When therapy doesn't work it can have a significant impact on the HCP who feels a sense of failure and an inability to offer anything further to support the older person with FMI. Relationship-centred care not only related to the older person with FMI but encompassed the family carer too:

> *"Sometimes the person with the mental illness is managing and coping ok ….. however that impacts on the family that is supporting them ….erm and they're not managing and coping as well as the client….so you….you for them for your client to remain erm healthy and well then you need you do have to support the family member as well because erm….if they're distressed and not managing then it's going to impact on the client with mental health so……sometimes you end up working with …more than just the client to maintain their mental health because they have to care for the people around them who are supporting them erm and sometimes that's just reassurance ….. sometimes that's done in texting, phoning, emailing erm….so that they maintain the strength and hope and provide the support that's needed it is about looking after them and saying you know….its ok to feel frustrated…..its ok to have these feelings…you're not alone"* (Participant 4, Fiona, CMHN)

This extract highlights the participants perspective around relationship-centred care, which includes supporting the family carer. The CMHN is aware that for the older person with FMI to be well, their family carer needs to be well and be supported in their caring role. Part of this support is offering reassurance and validation around how they are feeling. This CMHN supports the family carer by several modalities including virtual support.

A participant explains the impact of COVID-19:

> *"…she always comes in (CMHN)….well she's not at the moment as I say but if things were back to normal she would be coming in"* (Participant 12, Mary, older person with FMI)

COVID-19 impacted on how support was delivered to older people with FMI. This this participant had always been visited at home by the CMHN but due to the pandemic lockdown, home visits were withdrawn.

Another participant explains:

> *"(CMHN) used to well until the coronavirus…..come loads…..erm she was very good like. I used to sit and talk to her …..about things and err….she would…..err give me suggestions in how to deal with things and I used to go and see Dr. Y at the hospital and err he just used to sit there and talk to and he's very easy to get on with and Dr X …..she's the same like….. just sit and talk to her ….it helped but since this coronavirus came in its just obviously (stopped)"* (Participant 8, Bert, older person with FMI)

This quote illuminates that the pandemic impacted on the contact that older people with FMI would have received from Community Mental Health Nurses.

Prior to the pandemic, in this case, there appeared to be an ease of access to different members of the CMHT for support, which offered routine and familiarity, which was either withdrawn completely at the time of the pandemic or reduced. No alternative method of support was offered thus the patient missed the contact. However, this participant highlights how important the contact was, prior to the pandemic, with their CMHN who would visit and offer support in a very subtle way- thereby highlighting a relationship-centred approach.

The relationship is described by a family carer:

> *"I mean the support that he's getting erm…..it couldn't be any better it seems to be working…..it's just now you know the corona… err it's maybe just 10-15 minutes when (CMHN) used to come to the house she'd stay and he used to go up and see Dr X it was you know a longer discussion and err he says it's not the same over the phone but we realise that it's one of these things that can't be helped you know…..it will get better you know when everything gets back to some sort of normality"* (Participant 9, Penny, family carer of Bert)

Prior to the pandemic, the support from the CMHT was found to be beneficial for the participant. However, the pandemic had significantly impacted on the support offered, which was reduced in time and delivered by phone. This participant didn't feel the phone support was as beneficial and had a sense that the face-to-face contact of the house visit was missed, suggesting that relationship-centred care is not as obvious when delivered over the phone. There was also a real desire to return to normal routine and structure.

A patient explains:

> *"….well not at the moment with the virus ……but before the virus she (CMHN) used to stop off for a cup of coffee….and chat…cause I did some watercolours and write some poems and listen to the radio as well and she asks me if I'm feeling all right and observes me to see if I'm looking all right"* (Participant 8, Bert, older person with FMI)

This quote illuminates the skill of the HCP in relationship building by adding a social, relaxed element to visits by having a coffee and chat, whilst at the same time monitoring this patient's mental state. This relates back to the concept of personhood and its importance in relationship-centred care.

Therefore, it is implied that at this point in the pandemic his mental state wasn't being monitored and no feedback was being giving about his mental state. Such a reassurance appears important to this participant. In addition to this the CMHN visits also provided this participant with some social interaction.

With a contrasting experience this participant explains:

> *"I talked to my Psychologist on the phone err well I don't see my practitioner now either it's all on the telephone and err but between them…..I've found it really helpful"* (Participant 12, Mary, older person with FMI)

This quote illuminates that support during the pandemic has been over the phone by their Psychologist and Advanced Nurse Practitioner which they have found beneficial, they further describe:

> " *(phone contact) that doesn't bother me at all it really doesn't concern me one way or the other….. it's always better to see somebody in front of you so you can read their expression err but it doesn't err really put me up nor down being on the telephone about it"* (Participant 12, Mary, older person with FMI)

Here, Mary suggests that although it is more beneficial to receive support on a face-to-face basis to build rapport and see body language, she was willing to compromise and accept an alternative method of support, ie, phone support rather than no support.

However, this quote again highlights that perhaps an element of relationship-centred care is lost when people are not supported face-to-face. The following extract from a psychologist explains how they delivered services during the pandemic:

> *"we are not seeing anyone face-to-face, so……I'm doing……well…..it's a bit of a reduced service but I've been offering people telephone appointments and 'near me appointments' (a web-based platform for video consultations)"* (Participant 11, Dr Smith, Psychologist)

It emerged that face-to-face contact was ceased at the outset of the pandemic, with HCP's offering a reduction in service and support either virtually or by phone.

In summary, this subtheme illuminates older people with FMI appreciated and valued their relationship with the HCP as part of their journey to wellness and recovery, and valued the concept of talking to the HCPs albeit - as described by older people with FMI, one participant highlighted that she felt she was not counselled enough.

Talking they felt, allowed them to find solutions to their concerns, enabled them to find coping strategies and was a way of freeing themselves of burden and "letting it all out". Older people with FMI acknowledged they benefitted from talking to the professional but didn't really identify it to be any more than talking. In contrast, the HCP described this as using themselves as a therapeutic tool - which could be described as therapeutic use of self. By using themselves as a median to therapy, older people felt the benefits just described.

In addition to this, the practitioner illuminated that to form relationship-centred care, they needed to share a little bit about themselves with the patient, in keeping with the concept of personhood. They also visited them ensuring they had no preconceived ideas from reading case histories. To be able to form relationship-centred care the older person with FMI also had to be psychologically minded and have the ability of self-reflection and be able to look at links between cause and effect and change the cause to impact upon the effect.

For some, the experience of being in a psychiatric hospital was negative with a perception of a lack of support or therapeutic input. In addition to this, some felt a loss of purpose and even liberty whilst being in hospital. Another on the other hand didn't like being in hospital but felt they received good support from nursing staff. Another perspective was that hospitals are less regimented in their approach to care now, which, in fact, made it less relaxing.

COVID-19 impacted on the therapeutic relationship and lockdown prevented face-to-face visits. Therapeutic interventions were delivered by HCPs over the phone, although all participants acknowledged this was not the same as a face-to-face visit. They all reported it provided an adequate level of intervention, ongoing assessment, and monitoring during the constraints of the pandemic. However, it emerged that the concept of relationship care was diluted when there was no face-to- face interaction between the HCP and older person with FMI.

5.3 Chapter Summary

In conclusion, this chapter reveals the perspectives of older people with FMI, a family carer and healthcare professionals and provides insight into the overarching theme *"Accessing support and treatment for older people with FMI"* and subsequent three subthemes. COVID-19 was a significant contextual factor that impacted upon the support the older person with FMI received, particularly from CMHN's who saw this support at the home cease.

In some cases, not all this was substituted by phone support. Furthermore, COVID-19 impacted on older people with FMI's mental state. Also, community resources and groups ceased due to lockdown and restrictions due to the pandemic.

In commonality with phase one data collected, phase two identified that risk, usually from self-harm, is a significant determinant for the HCP when considering whether the older person with FMI be admitted to hospital. For some, the experience of being in a psychiatric hospital was negative with a perception of a lack of support or therapeutic input. In addition, some felt a loss of purpose and even liberty whilst being in hospital. Another, whilst not liking being in hospital, felt support from nursing staff.

Building on phase one in phase two, the GP was identified as pivotal to ensuring older people with FMI receive the support they require. The GP assumes the role of referrer to secondary mental health services and emerges as the key decision maker in the initial pathway as to where and what treatment an older person with FMI should receive. Participants highlighted where the GP had referred them on for specialist support, and also where they themselves had treated depression without the need for onward referral.

An HCP participant highlighted the lack of a crisis intervention service for older people with FMI. They described this as discriminatory given that working adults did have a crisis service to assess and manage people who present with acute risk.

Goal setting and self-help was identified as being very beneficial to the participants interviewed. This was because tasks were broken down into manageable steps and the person felt a sense of achievement at completing tasks. Data collected within this study illuminated that WRAP was a helpful tool in identifying triggers and symptoms but very few other assessment tools were used to support decision making in developing a formulation.

This study illuminated that the older person with FMI really valued the concept of talking to the HCP and the HCP saw the need to share information about themselves to build a relationship with their patient. However, adaptions to working in COVID-19 due to lockdown restrictions illuminated that phone support, could not replicate face-to-face support in the usual relationship way of working, that had been built.

Data also illuminated that the older person with FMI had to be psychologically minded, have the ability of self-reflection. Also, be able to look at links between cause and effect and change the cause in order to impact upon the effect to be able to experience benefit from talking therapies.

The following chapter (six), presents four key concepts and the story that has emerged from the data captured, and highlights the theoretical lenses used in the discussion chapter (seven) where discussing the findings from this study, and chapter (eight) highlights this studies specific contribution to new knowledge.

Chapter 6: Summary of Phase One and Phase Two findings

In this chapter, I present a summary of data generated from this study and the three key findings that have developed from phase one and phase two data. Thorne (2016), suggests there are two ways to present interpretive descriptive findings and suggests the presentation of findings is balanced by whether the findings are more descriptive or interpretive (Chapter 3; section 3.3.6). This study uses an interpretivist epistemological lens and is more interpretive than descriptive as it has attempted to explore meanings and understand peoples' lived experiences rather than simply describe them and how these have been influenced by context.

The first way is to organise findings and present an overall conceptual claim (Thorne 2016). The second approach to presenting findings as described by Thorne (2016), is to present a sequenced framework which allows the story of the study to be told. For this study a sequenced framework refers to a logical order to presenting this study- in this case the thesis. This latter approach has been chosen for this study as it fits better with an interpretive approach given this study does not have any conceptual claim there is a justified truth in participants stories. This approach allows the story of this study to be told. For the purpose of this chapter, the concepts that capture the essence of findings are presented.

6.1.1 Impact of 'Place' on Experiences of FMI

The finding - impact of "place" on experiences of FMI - illuminated that the geographical area of this health board, covering remote and rural, and urban locations, impacted upon older people with FMI's and the family carers experiences of how they received and accessed services for their mental health.

It also captured experiences for HCPs delivering care and where care was delivered. Furthermore, place determined how services were designed and delivered in this health board - the impact of the geographical area on delivering and receiving support for FMI. This meant some differences emerged for those with FMI linked to geographical location.

As identified earlier (Chapter 3; Section 3.1.1), this study was undertaken in a health board covering an area of 25,659 square kilometres comprising remote and rural, and urban areas. The population is distributed more or less equally between remote and rural and urban areas. This means that the health board has to manage its resources to meet the needs of these diverse locations and that key stakeholders are influenced by where they live.

HCP participants reported spending up to eight hours travelling to and from a patient visit to provide support in certain geographical locations. This impacts on the overall available resources to meet the needs of the population. Likewise, the older person with FMI may be required to make the same journey to receive psychological therapies (Chapter 4; Section 4.2.1).

HCP participants reported different ways to support (mental state assessment and ongoing monitoring) older people with FMI, which were adaptable, practical, and strategic when assessing and treating older people with FMI (Chapter 4; Section 4.2.1). In remote and rural areas, HCPs adapted their mental health assessments and ongoing monitoring of the mental state of their patients. This involved using digital technology (such as video conferencing) as an alternative to in-person consultations as the technology was used to deliver support, including ongoing assessment and monitoring, discussing coping strategies and treatment (pre pandemic) such as medication changes. Treatment plans were developed which could be implemented as and when required through online interventions (Chapter 4; Section 4.2.1), to ensure treatment was delivered in a timely way and not delayed by wider members of the MDT trying to locate the consultant to discuss treatment options. This means that, pre-pandemic, those living with FMI in remote and rural areas were more likely to receive online support than those living in urban areas.

Pre-pandemic, older people with FMI living in urban areas in this study, in secondary mental health services, were not supported by technology to any extent. Face-to-face interactions with HCPs were the norm. Therefore, there were differences in the support older people with FMI received, dependent on their "*place*" of residence. Participants (HCPs) reported a hybrid approach for those living in remote and rural areas. This involved a face-to-face first assessment followed, mainly, by virtual support.

The pandemic altered the delivery modes almost overnight with all mental health assessments, ongoing monitoring and interventions delivered virtually across the health board area. Older people with FMI had been used to face-to-face support, accepted the need for virtual support but did miss HCPs visiting them in their home or "*place*" of residence.

The meaning of place, and how some older people with FMI could be supported at home, was impacted by the pandemic and the need to provide online support. Moving an older person with FMI, who at the height of lockdown began to experience suicidal thoughts due to loneliness (Chapter 5; Section 5.2.2) to a care home on a temporary basis, as a place of safety, was an example of HCPs responding to an impact of the pandemic on the suitability of the person with FMI remaining in 'place' during that time.

Views differed amongst HCPs about the utility of technology to support older people with FMI with some HCPs questioning the availability of a satisfactory IT infrastructure to deliver support virtually. However, those HCPs covering remote and rural areas described supporting people virtually to be a very positive experience for them and the older person with FMI, as it reduced travel, was more efficient in terms of time management and resource and could result in more frequent support than would have been possible face-to-face.

HCPs who covered the urban area of this health board, maximised their resource through agreeing to cover specific geographical areas to reduce travel time. This indicates services could be delivered based on where the person lived, rather than the specialised expertise and interests of HCPs. Overall, this was judged by participants in this study to enhance their knowledge and experience of dealing with a range of mental health.

"*Place*" impacted upon the role of the GP and how the wider team worked. This health board had no crisis intervention service for older people with FMI (Chapter 4; Section 4.2.2). Therefore, the GP, as part of the multidisciplinary team, was pivotal in supporting people experiencing a crisis in their mental health. They managed mental health crisis by working with other primary care disciplines to support and treat older people with FMI in the community, often without onward referral to mental health services. (Chapter 4; Section 4.2.2).

Perceptions of how GPs managed mental health crisis in older people varied amongst participants. Across HCPs, views ranged from being positive about the role of the GP to some concerns they may lack the appropriate knowledge and time to devote to the healthcare needs of people in crisis. The Consultant Psychiatrist was of the view that GPs had adequate knowledge to support older people with FMI. In contrast, both Advanced Nurse Practitioners reported they believed GPs lacked the specialist knowledge around FMI.

Some Older people reported difficulties in getting support which resulted in them seeking support from the Police or from family members. Others reported challenges around being able to speak to the GP to discuss their situation (Chapter 5; Section 5.2.1) meant older peoples experiences of support for crisis varied.

Data collected in this study illuminated, that “*place*” may influence how many older people with FMI presented to secondary mental health services. All HCP participants perceived there to be very low numbers of older people with FMI, presenting in remote and rural areas to secondary mental health services, suggesting there, that are older people with FMI are being managed in primary care (Chapter 4; Section 4.2.2). Whereas, in urban areas, HCPs considered their service received consistent and expected referral rates (per population) for older people with FMI (Chapter 4; Section 4.2.2).

Therefore, it is possible that the remote and rural GP is supporting older people with FMI who then do not need referral onto secondary services. With a contrasting perception, participant Mary reported that she had found it exceptionally challenging, initially, to receive care for her mental health from her GP (Chapter 5; Section 5.2.2).

Other potential reasons that “*place”* influenced low numbers in older people with FMI in remote and rural areas, was attributed by HCPs to several factors. Older people living in rural areas are found to be potentially more stoic than those living in urban areas.

Furthermore, some older people believe that FMI is an inevitable consequence of ageing, and the role of the GP in remote and rural areas - who are very active in supporting older people with FMI in remote and rural areas (Chapter 4; Section 4.2.2). In addition to this, some HCPs perceived that stigma was still an influencing factor as to why some older people with FMI did not seek support for their mental health (Chapter 4; Section 4.2.2)

Given the perceptions of HCPs that older people with FMI may not be known to secondary mental health services, this was thought to be due to people managing themselves or being supported by the GP without onward referral. No older people or family carer participants reported challenges in knowing how to access services. It appeared, therefore, from the perspective of HCPs, that “place” influenced older people with FMI living in remote and rural areas, who may not actively seek support from secondary care as they had less expectations on the services they would receive. HCP participants perceived ‘they just got on with it’, with the support of their GP whom they will likely have known for a long period of time.

It is noteworthy there were no GP voices included in this study, although they were invited to participate. Older people with FMI in this study did not report avoiding using secondary mental health services. Therefore, place appeared to be an influencing factor on whether older people with FMI accessed support from secondary mental health services. This study illuminated that those older people with FMI, living in remote and rural areas. were less likely to seek support in contrast to those living in urban areas.

“*Place*” impacted experiences of FMI due to the configuration of services in this health board. It had a model of care where some CMHTs kept people with FMI open to their service once reaching age 65 - unless a person developed cognitive impairment (Chapter 4; Section 4.2.5). Other CMHTs did not. They transferred at an arbitrary age of 65 to OAMH services, there did not appear to be any evidence base informing this and looked to be a model based on service and leadership of historical preference (Chapter 4; Section 4.2.5).

Some HCPs suggested that transferring a patient to older people services was detrimental to their mental health and no longer consistent with modern society, with many people over age 65 still employed. In addition, some people experienced a negative experience when upon turning 65 as they could no longer access some services which were age defined.

Therefore, this data further illuminated how service design and the delivery model of ageless and age-defined services influenced experiences of older people with FMI in mixed ways. Some being no longer able to access services. Overall, HCPs in the community mental health team felt the age delineation was negative for older people.

Community support services (3rd sector, peer support) for mental health also seemed to have the same age 65 cut off, for mental health services. Hence, the configuration of the CMHT in this health board was a factor in how '*place*' impacted on the experiences of FMI in older people. HCPs described a sense that as soon as a person is 65, community support groups were less available (Chapter 4; Section 4.2.5).

In-patient services in the mental health hospital were age defined in this health board area - a further example of how service design influenced how '*place'* impacted upon the experiences of FMI. However, if there was a shortage of beds, under age 60 could be admitted to the older adult ward and vice versa (Chapter 4; Section 4.2.5). HCPs thought this model worked well as younger people would look after older people and enjoyed hearing the stories older people would share. However, this was not a view shared by one participant who reported feeling unsafe in the ward with younger people who he referred to as 'druggies'.

In summary, these data revealed that '*place'* impacted upon the experiences of FMI, in several ways. The geographical area of place in terms of remote and rural areas of this health board appeared to influence how online and face-to-face support was delivered to older people with FMI. Technology was used more frequently and accepted by HCPs and older people where delivering healthcare to older people with FMI, in remote and rural areas.

In contrast, older people with FMI living in urban areas received and preferred more face-to-face support. Place also impacted on how older people with FMI accessed support for their mental health as it appears there were low numbers of older people with FMI living in remote and rural areas presenting to secondary mental health services. This may have been because older people with FMI in rural areas accepted FMI as an inevitable consequence of ageing, accepted that services were less available due to geography, were stoic, and associated stigma with mental health. It also appears that the GP working in remote and rural areas was pivotal in maintaining recovery and managing the healthcare needs in older people with FMI. This support from the GP was evident as older people were not often presenting with acute mental health needs to secondary care.

In contrast GPs working in urban areas worked in a different way, as there was an assumption from HCP participants that referral rates to secondary services were much higher than remote and rural areas. *Place* also impacted upon the role of the GP in both urban and remote and rural areas given the lack of crisis intervention teams. HCPs in this study suggested the GP filled the void of this service by supporting people in crisis.

Place impacted upon experiences of all participant groups due to the model of service delivery in this health board, which was inconsistent. Some CMHTs would continue to support people after age, other CMHTs had an arbitrary transfer to older peoples' services once turning 65.

This model was mirrored in community support groups. At times older adult in-patient services would admit people aged under 65 if there were no adult mental health beds. Some HCPs interviewed, thought this model worked well. One older person did not like the model of mixed age group wards and felt intimidated by some younger people.

The next section of this chapter illuminates the concept of *building relationships* to support FMI in the context of this study.

6.1.2 Relationship Building to Support FMI

The HCP, older person, and family carer participants acknowledged "*relationship building*" was important in maintaining the health, wellbeing, and recovery of the older person with FMI. The relationship between the older person with FMI and the HCP was pivotal in the assessment, support, and treatment of that older person, as once elements of trust were embedded in a relationship it was more likely the older person with FMI would disclose personal and sensitive information (Chapter 5; Section 5.2.3).

Likewise, this helped the HCP ask sensitive questions such as any thoughts about ending their life. The key purpose of HCPs developing a therapeutic relationship with older people with FMI was to facilitate communication which enabled them to assess that older persons' mental state, undertake a risk assessment and then offer ongoing support (Chapter 4; Section 4.2.3). HCP participants- particularly nurses in the community setting - spoke about the need to '*build a relationship*'.

One strategy they used was to share personal information about themselves. This included sharing "nuggets" about themselves such as whether they have children, were married and their hobbies. The purpose of sharing this information was to encourage the older person with FMI to begin to share information about their life and experiences which was pivotal to their initial assessment (Chapter 5; Section 5.2.3).

Given that relationships are a constantly evolving process, the HCP would continue to chat and build the relationship at each interaction with the older person with FMI. Therefore, the importance of HCPs '*relationships building'* with older people with FMI and their family carer is to have a basis to undertake a risk assessment, assess mental state and then provide ongoing monitoring of mental state.

Relationships can be complex, transactional, and fluid, meaning they are never truly static. There is also a recognition that developing a relationship with people with severe mental illness is challenging as their symptoms may trouble them and cause them to push their HCPs away (Shroeder 2013).

However, data collected illuminated that despite these complexities once the basis of a relationship was established there appeared to be potentially mutual trust and where there wasn't, the HCP would continue to try and build the relationship through trial and error and being open and honest (Chapter 5; Section 5.2.3). Once trust was established the patient would then share information about their symptoms which allowed the HCP to undertake a thorough assessment of needs and formulate a plan for the support required. The WRAP was completed jointly by HCP and the older person with FMI and where appropriate their family carer, to plan how to manage symptoms and where to seek help if needed (Chapter 5; Section 5.2.3).

At the initial assessment the HCP would spend time getting to know the person in the initial stage of the relationship, whilst undertaking an assessment of risk and mental state. The HCP formed the relationship by having a conversation, which allowed the HCP to pace the assessment to the needs of the older person with FMI (Chapter 5; Section 5.2.3). Once a relationship was established (although relationships are fluid) CMHN's / Advanced Nurse Practitioners in this study would continue to visit older people with FMI, who viewed this input as a chat with perhaps, tea or coffee.

HCP participants viewed this interaction as complex and included observing the older person with FMI's wellbeing and assessing their mental state. The HCPs reported observing for any signs of risk in relation to harm to others or self-harm. Relationships were also important in empowering the older person with FMI through suggesting coping strategies. For example, writing down intrusive thoughts and then throwing them in the bin, maintaining a healthy lifestyle by going for walks and signposting to peer support which helped them to manage their illness, were reported by HCP participants.

This study highlighted that older people with FMI recognised benefits in talking with their HCP and the role talking had in helping form a relationship with the HCP (Chapter 5; Section 5.2.3). They acknowledged the relationship with their HCP was key in helping them to stay well or to recover. All older people with FMI participants valued talking or the need to talk with their HCP's but struggled to articulate that it was anything more than chatting. Older people with FMI did not recognise that HCPs were undertaking a risk assessment or assessment of their mental state whilst chatting or delivering any therapeutic intervention whilst chatting.

Therefore, the therapeutic relationship is developed by HCPs in mental health services to enable them to undertake an assessment of mental state and offer support but is undertaken in a subtle, skilful way. However, the therapeutic relationship is transactional and fluid and will be different for every participant-to-participant interaction which has implications for how HCPs gain experience, given the range of scenarios and situations which may exist.

The in-patient setting appears to have a less structured focus on '*relationship building'* and a lack of therapeutic activity or interaction from the lived experience of three older people with FMI. I was unable to recruit any HCP participants who worked in the in-patient setting. However, three older people commented on their experience in in-patient settings which they described as formulaic, infrequent, and rushed with the MDT and did not identify these as 'counselling' or 'treatment' in the ward.

The move to online rather than face-to-face during the pandemic altered support for those with FMI - especially those living in urban areas who were accustomed to face-to-face contact. People with FMI living in urban areas perceived virtual support as adequate, given the circumstances, but did highlight that it was a miss not seeing their HCP. HCPs recognised the potential to miss nuances of the conversation as they could not see the body language and facial expressions of older persons with FMIs of the older person with FMI - important factors in building and maintaining a relationship. This highlights further the complexity of mental health assessments, and all which that informs the assessment.

In summary, these data illuminate that '*relationship building*' was important to both older people with FMI and HCPs in this study. It emerged that HCPs in the community mental health setting understood the importance of '*relationship building'* with the older person with FMI. The relationship enabled them to undertake risk assessments, mental state assessment and offer therapeutic support to older people with FMI.

Older people with FMI and their family carer recognised that a '*relationship was being developed'* and that talking to their HCP was helpful in their recovery. However, older people with FMI and their family carer did not articulate the intervention as anything more than talking; whereas the HCP would describe that they were carrying out risk assessments, medication monitoring, assessment of mental state and suggesting coping strategies during these interactions.

In the in-patient setting, older people described that there was little '*relationship building'* from the HCPs and for one participant, a noticeable lack of interventions.

Although technology was used in some cases pre-pandemic, the pandemic during lockdown changed how support was delivered, which meant that in most cases support was offered by technology (VC or phone). Older people with FMI accepted the reasons for this and it did not appear to affect their relationship with their HCP. However, HCPs did highlight that technology did not allow for little gestures or body language to be noticed as would be when in a room with someone. The next section of this chapter explores the concept of *managing everyday life in FMI.*

6.1.3 Managing Everyday Life in FMI

It is helpful at this point to recap the complexity of FMI and the range of illnesses covered by this umbrella term such as anxiety, depression, schizophrenia, and bipolar disorder. These illnesses can manifest with mild, moderate, and severe symptoms. Mild to moderate symptoms will be managed in primary care, with moderate and severe symptoms managed in secondary care. *Managing everyday life in FMI* illustrates some of the strategies and approaches used by older people with FMI.

HCPs reported the WRAP was a helpful tool for symptoms where distraction techniques improved the older person with FMIs mental health (Chapter 5; Section 5.2.3). The WRAP was completed in partnership with the HCP and older person with FMI and documented triggers for becoming unwell, signposts and symptoms of becoming unwell and where to access support (Chapter 5; Section 5.2.3). One participant (who has obsessive compulsive disorder, anxiety, and depression) discussed how he would experience intrusive thoughts. An HCP was teaching this participant how to manage these thoughts, which she documented in the WRAP. The HCP coached the participant that when he experienced intrusive thoughts to take deep breaths and count to five and back again, which the older person with FMI found beneficial.

In addition to the WRAP, HCPs promoted the use of a diary with people who were psychologically minded (the cognitive ability to engage in therapy) and experiencing anxiety and / or depressive symptoms (Chapter 5; Section 5.2.3), to document when older people with FMI felt either well or unwell. The diary included the events that had caused a good outcome or a poor outcome on their mental health. In addition to using a diary, HCPs would encourage older people with FMI to use workbooks looking at specific illness. For example, an HCP asked an older person with FMI to work through health education booklets on anxiety and stress.

Guided self-help, ‘homework’ and goals were set for older people with FMI by the HCP. This is part of the Cognitive Behavioural Therapy (CBT) process and included breaking down tasks such as housework into smaller manageable tasks Mary (Chapter 5; Section 5.2.2) had described as facing a ‘brick wall’. The HCP used a coaching approach to set goals around household tasks with the older person with FMI. They spoke of a great sense of achievement on being able to complete these tasks.

Other goals which were achieved included were daily walks which helped alleviate symptoms of anxiety and built confidence. In addition to daily walking, peer support groups were identified as a way older people with FMI managed everyday life. Mindfulness and distraction techniques were also identified by both HCPs and older people with FMI as helpful in ‘*managing everyday life in FMI’.* HCPs also promoted coping strategies, such as putting intrusive thoughts on paper and throwing them in the bin (Chapter 5; Section 5.2.3).

Peer support groups were also identified as a beneficial way of ‘*managing everyday life in FMI’* - by some, but not all older people with FMI, the family carer and HCPs. One CMHT supported people discharged from the CMHT, to set up a peer support group. Walking football was helpful for some but there were variations in the types of activities participants found helpful.

The use of medication was also a way that older people with FMI managed everyday life. Medication helped control symptoms in older people with FMI. HCPs, as part of their assessment and support, would monitor the efficacy of medication, they were particularly vigilant in depressed people in the first few weeks of starting antidepressants as there is increased risk of suicidality. Older people themselves made a trade off in '*managing everyday life in FMI'* by taking medication that could give them horrible side effects but kept them well.

In summary, older people with FMI used several strategies to manage FMI in everyday life which involved goal setting, guided self-help, gentle exercise and peer support through a range of activities which seemed to help relieve anxiety and build confidence. The WRAP was perceived to be a useful means of identifying triggers, a relapse of symptoms, and when to seek help, should the person feel unwell again. Older people with FMI used the WRAP to identify symptoms and use distraction techniques to manage certain symptoms such as intrusive thoughts experienced by people who have OCD. Medication emerged as a way of maintaining wellness in people who had psychotic symptoms, with older people accepting there was a trade-off between enduring medication symptoms being balanced against maintaining wellness and the ability to manage elements of everyday life.

6.2 Theoretical Propositions

This section explores if the theoretical propositions that were developed in Chapter 3; Section (3.3.5), when a case study approach was being used are reflected in the study findings. Although this study design was adaptable to the needs of conducting research during a pandemic and changed to an interpretive descriptive approach, it is still helpful to use the theoretical propositions to sense check findings against the findings of the integrative review which informed this study. These theoretical propositions have been mapped to the AAAQ Framework (UNICEF 2019) (Chapter 3; section 3.6).

Table 20: Theoretical Propositions in the Context of this Study, mapped to AAAQ framework (2016).

Theoretical Proposition	Availability, Access, and Use of Services	Support Offered and Acceptability
Decision making by older people with FMI to seek mental health support is influenced negatively because they believe FMI is an inevitable consequence of ageing. This belief is often mirrored by family carers and impacts on their decision making to seek support too. Crabb and Hunslet (2006), Holvast et al. (2012), Mackenzie et al. (2008), Muir et al. (2014), Mackenzie et al. (2010).	Decision making by older people with FMI is influenced by "place". Older people with FMI in this study who lived in remote and rural areas were perceived by HCPs to be less likely to seek support for their mental health from secondary mental health services because of the distance, stoicism, and the support the remote and rural GP provided. (Chapter 4; Section 4.1.2) Older people with FMI in urban areas were judged by HCPs as more likely to access support,	Ageless and age-defined services impacted upon the support older people with FMI received, with services appearing to become less available once turning age 65.
Decision making by generalist healthcare professionals is influenced by their perception that FMI is an inevitable consequence of ageing. This affects the support that is offered to older people with FMI. Holvast et al. (2012), Palinkas et al. (2007), Arean	All HCPs interviewed older people with FMI and the family carer referred to the fact that the GP was the referring agent to secondary care. Some older people had experienced barriers in accessing secondary care from the GP. Some HCPs thought this was due to a lack of skills and knowledge	

et al. (2007), Muir et al. (2014).	around mental illness. Other HCPs thought it was because GPs were in fact managing older people with FMI in Primary Care. (Chapter 4; Section 4.1.1)	
Ageism and stigma are evident in the natural setting and context of mental health services and support for older people with FMI. These factors are key in influencing the decisions of older people to seek support and health care professionals to offer support. Older people with FMI are more forthcoming to seek support for their mental health, if they have a physical co-morbidity. I propose this is because older people believe a physical illness to be more worthy of support and have less associated stigma than a mental illness. Crabb and Hunslet (2006), Mackenzie et al. (2006), Preville et al. (2009). Byers et al. (2016), Muir et al. (2014), Palinkas et al. (2007), McCormack and Skatvedt (2017). • Professional experience		HCPs interviewed in this study identified that older people with FMI living in remote and rural areas still associated mental health with stigma (Chapter 4; Section 4.1.2). This study identified that risk of self-harm or harm to others was a pivotal factor in what influenced the decision making of the HCP in what support the older person with FMI received. However, one HCP felt that there were differing views in the MDT around risk management with some HCPs being extremely risk averse and paternalistic in their approach (Chapter 4; Section 4.1.3). Data collected in this study did not reveal that older people were more comfortable to seek support for their mental health if they have a physical illness.
• It is essential that the complex needs older people with FMI have are fully understood. This knowledge is	This study illuminated that different models of care for older people with FMI exist. There is an arbitrary service delivery model that once	

essential, as health care professionals' knowledge of these complex needs influence how these needs are met in both the context and natural setting of mental health services (community services, inpatient services and third sector service). These needs are understood by a GP assessment, mental health assessment or self-identification and are met by the above services identified. • Professional experience of older adults mental health Abdul-Hamid et al. (2016), Palinkas et al. (2017), Morrow-Howell (2000).	people turn 65 years of age, they are discharged to OAMH services. Likewise, peer support groups fall away for this generation due to age-defined services. This does not necessarily meet the complex needs of this population group. Furthermore, there is a lack of crisis intervention services for this population group, which could in turn lead to an unneeded hospital or care home admission (Chapter 5; Section 5.2.2).	

6.3 Chapter Summary

To summarise, the three findings emerging from the synthesis of data collected in this are:

1) *Impact of 'place' on experiences of FMI.,*

2) *Relationship building to support FMI.,*

3) *Managing everyday life in FMI.*

The following chapter presents a discussion of the findings in this study in relation to building on the findings of the literature review presented in Chapter two and other contemporary literature and considers further what these findings mean in relation to the AAAQ (UNICEF 2019) Framework.

Chapter 7: Discussion

7.1 Introduction

This chapter provides a discussion of the findings and concepts which were generated from the thematic analysis and synthesis of collected data as outlined in Chapter 6. The AAAQ Framework (UNICEF 2019) is used as described in chapter three (section 3.11). This chapter is structured around the research questions, of which each is a subsection. Within each research subsection, there are sub headings which address the research question. The first section of this chapter is what influences older people with FMI to access support from health care services. The next section discusses what influences HCPs decision making to provide support to older people with FMI, the section there after discusses how accessible are services to older people with a diagnosed FMI and their family carers and finally this chapter discusses how do services available to older people with FMI and their family carers, meet their support needs. The next section of this thesis discusses what influences older people with FMI to access support from health care services.

7.1.1 What Influences Older People with FMI to Access Support from Healthcare Services?

This study addresses the research aim and questions and illuminates several determinants which influence the access and use of health care services by older people with FMI. These determinants relate to the geographical location of the study site/health board area and the impact '*place*' had on how and why older people with FMI accessed services, the impact of the COVID-19 pandemic, and the acceptability of FMI. The next section of this thesis discusses how "*place*" influences older people with FMI to access support from healthcare services.

Place

This study illuminated that *place* was an influencing factor in the support older people with FMI accessed from healthcare services. Place in the context of this study included the distance involved for older people with FMI to access support. This was particularly so in remote and rural areas where the distances involved could be significant. Participants in this study reported this influenced their choices when seeking healthcare services. Consequently, some older people with FMI reported accessing less face-to-face support in both their local community and from secondary mental health services than those perceived to be accessed by those in urban areas (Chapter 4; Section 4.1.1). This reflects the findings of a study by Knight & Winterbotham (2020), that older people in remote and rural areas have more difficulty accessing mental health services, due to a lack of availability than older people in urban areas. For some older people in the current study, their home location impacted on the accessibility of services to support them, furthermore it identified those living in remote areas were more sufficient which was also identified in the integrative review conducted as part of this study (Wells et al. 2020). This study identified that services were not always accessible and there were accessibility challenges accessing HCPs.

Place also impacted upon how accessible HCPs were for older people with FMI and differences emerged for older people living in remote and rural areas, and those living in urban areas, with more accessibility to HCPs in urban areas. HCPs in this study also had to travel to remote and rural areas which led them making pragmatic decisions as to how they delivered support, with some using virtual means to make support accessible to older people. There was a perception amongst others that older people with FMI considered online support acceptable and accessible as it saved them travelling long distances (Chapter 4; Section 4.1.1). Other HCPs participants felt older people were not technically minded (pre-pandemic) and they did not attempt to use or ask older people if they had any preference about using technology to support their needs and recovery, thus older people received less support. Arguably HCPs by making assumptions and not assessing digital capability fully could prevent the availability and access to digital means of support for some older people with FMI. This finding reflects those of a scoping review by Silva et al. (2020) who identifies from twenty reviews a gap in practice of assessing older people for digital capability and, likewise, a lack of a standardised framework to undertake this assessment.

Access to mental health services for older people living remote and rural areas has been addressed in New South Wales, Australia in their workforce policy (Jackson et al. 2019). The policy focused specifically on service enhancement for older people's mental health in remote and rural areas and developed 23 new teams, which saw a 440% increase in older people in remote and rural areas accessing mental health services (Jackson et al. 2019). This suggests the availability of services in remote and rural areas is the predictor and determinant is use of mental health services by older people with FMI living in remote and rural areas.

Although no GPs were interviewed in this study the role of the GP emerged in relation to the concept of *place.* HCPs and older people with FMI recognised and spoke about how the remote and rural GP supported the needs of older people with FMI through providing more intensive support than their urban counterparts through increased contact. In doing so this was perceived to cause different referral practices to secondary mental health services. The intervention of the remote and rural GP is treating older people with FMI was judged to help avoid onward referral to secondary services thereby avoiding people being separated by distance from their home, family and community. Couch et al. (2019), contend there are marked differences between urban and rural healthcare access which in turn leads to different learning needs for HCPs in rural areas to bridge the gap in knowledge and ensure older people with FMI are receiving quality mental health support (Pohonstch et al. 2018, Walters et al. 2021) (Chapter 4; Section 4.1.1). In relation to urban GPs, participants thought they were more likely to take on the role of medical provider (Pohonstch et al. 2018, Walters et al. 2021) (Chapter 4; Section 4.1.1). Remote and rural GPs were perceived to be more personable, holistic in their approach and see themselves as the family doctor from "cradle to grave" thereby building strong relationships with their patients over the life cycle (Pohonstch et al. 2018).

The approach of the rural GP was thought by participants in this study to reduce the requirement for specialist referral and aligns with the acceptability and accessibility of services in *place*. Conversely, the GP as an expert generalist in healthcare (General Medical Service 2018) caused some HCPs to raise concerns around the quality of care some older people with FMI may receive in that GPs may not recognise symptoms of severe anxiety and depression and hence patients may not get appropriate specialist support (Chapter 4; Section 4.3.2). However, Konkin et al. (2021), suggest that remote and rural GPs are clinically courageous, as they push themselves to the edge of their scope of competency to meet the medical needs of the community, including mental health needs. Walters et al. (2021), claim that remote and rural GPs have a strong sense of belonging to their community. Consequently, they are willing to support the needs of their community and seek to prepare themselves to be competent, to meet the needs of their community.

However, data collected in this study illuminated the experiences of one older person with FMI who lived in an urban area and their family carer, who reported difficulty accessing support for an acute mental health need. Another older person and their family carer reported they could not access their GP for their mental health due to the receptionist acting as gatekeeper. A study by Turley et al. (2018), of fifteen older people identified barriers to accessing their GP. Barriers included the receptionist, engaged phone lines and unavailability of appointments. These experiences highlight a more negative issue around quality of accessing services, where places impacts upon peoples experiences.

Data collected in this study illuminate that *place* impacts on support networks such as day services accessed by older people with FMI (Chapter 4; 4.2.5), given these may be more available and accessible in urban areas and less so in remote and rural areas (Karlin & Norris 2006; Preville et al. 2009; Brenes et al. 2015). Therefore, arguably, HCPs in remote and rural areas need to be aware that older people may be more inclined to accept the impact of FMI. Consequently, HCPs in remote and rural areas need to have an awareness of FMI and support older people with FMI to accessible support systems such as virtual support.

In summary *place* impacts on the internal decisions that older people living in remote and rural areas make where seeking access to healthcare services. Older people with FMI living in remote and rural areas were less likely to access mental health services due to lack of availability. Access to mental health HCPs was also less frequently available due to distance, but the gap was bridged virtually where possible or older people with FMI were supported by their GP. Finally, support networks such as day services were less available and accessible in remote and rural areas, again technology is a potential solution to increase accessibility for those older people with FMI living in remote and rural areas. The next section of this thesis discusses how the COVID-19 pandemic impacted upon why older people with FMI accessed healthcare services.

COVID-19 Pandemic

Data collected in this study illuminated that the COVID-19 pandemic was a significant determinant in how older people with FMI accessed services. Data for this study were collected during the COVID-19 pandemic and, considering the restrictions on patient and HCP face to face interactions, it is appropriate to review availability of support for older people with FMI during this time. Older people with FMI could not access many of their normal peer and community supports due to lockdown which impacted upon loneliness (Chapter 5; Section 5.2.3). One HCP was required to find a place of safety for an older person with FMI on their caseload who was experiencing suicidal thoughts due to loneliness, caused by the fact their usual supports were not available. They found a place in a care home for three months (Chapter 5; Section 5.2.2). COVID-19 postdates the integrative review by Wells et al. (2020). However, a study by Dahlberg (2021), describes the impact of loneliness on older people with FMI during the pandemic, which exacerbated symptoms of FMI, some of whom had limited ability to use the internet. Those who are IT literate did not find virtual support to be a substitute for physical contact although for some, it was perceived to be better than no contact. A further study in Holland by Van Tilburg et al. (2021), reported that loneliness in older people increased due to the pandemic.

This study revealed accessibility to HCPs was markedly reduced during the pandemic as visits were discouraged, due to older people's vulnerability to the virus (Chapter 5; section 5.2). Group activities were prohibited so a number of community mental health services were not available. The pandemic caused older people to experience increased anxiety and depressive symptoms and more challenges managing their FMI in everyday life. This was exacerbated by a lack of support from both professionals and families and friends (Aslan & Kant 2022). Therefore, in summary it is evident the pandemic impacted significantly upon the availability and accessibility of mental health services for older people with FMI. The lack of available support impacted on older people experiencing loneliness which exacerbated symptoms of FMI. Furthermore, there was a general perception around that time that the NHS was focussing on COVID and therefore it was not advisable to seek support for other needs and conditions. The next section of this thesis discusses how acceptability can influence how older people with FMI decide to access healthcare services.

Acceptability

Data collected within this study illuminated that acceptability of FMI in older people was a significant determinant in their decision making to seek support. Within this study, all HCP participants in this study spoke of lower-than-expected referral rates of older people with FMI living in remote and rural areas to secondary care (Chapter 4; Section 4.1.2), but perceived referrals in urban areas to be as they expected. This finding concurs with the work of Knight & Winterbotham (2020), who contend that older people living in remote and rural areas are less likely to notice symptoms of anxiety or depression, as they are self-sufficient and accepted the symptoms of FMI and were therefore less likely to access support. Arguably, stoicism aligns with the data collected in this study that older people with FMI living in remote and rural areas are self-sufficient, stoic and independent (Chapter 4; Section 4.1.2).

Data collected illustrated an influencing factor in why some older people with FMI are reticent to seek support as some with FMI still stigmatise mental health services (Chapter 4; Section 4.1.2) and prefer to accept the symptoms due to the stigma than access support. One HCP participant believed people in their seventies were more likely to stigmatise mental health services than those in their sixties (Chapter 4: Section 4.1.2). A study by Schynder et al. (2018) illuminates that personal stigma is the most likely deterrent in people seeking support for their mental health. Data collected in this study revealed similar findings as the underpinning integrative review, which is older people find it easier to accept support for their mental health if they have a co-morbid physical health condition (Crabb & Hunsley 2006; Butterworth et al. 2014). However, Overend et al. (2020), contend that seeking mental health and physical health support simultaneously may have a negative outcome on mental health outcomes and recovery, as both GPs and the older person may prioritise physical health needs, causing the mental health needs to be overlooked. This concurs with data collected in this study (Chapter 4; section 4.2.2) where the GP was perceived by a HCP to overlook mental health needs in favour of the co-morbid physical health need. Thus, postulating that it is maybe more acceptable to have a physical health need than a mental health need where being treated by a generalist practitioner.

On a global scale, steps are being taken to address stigma and the acceptability of mental health as highlighted in a review by Wainberg et al. (2017), which explores how low to middle income countries are addressing stigma around the use of mental health services. They highlight the following areas require development to address the issue of stigma; diminish the mental health treatment gap, diminishing pervasive stigma building research capacity around mental health and stigma, implementing prevention programmes, and building capacity within public health to support mental illness.

On a more mental health focused level, Whitley et al. (2014), suggest that the recovery movement has made positive steps in reducing stigma in individuals due to the positive movement to empowerment and acceptability of mental illness. This current study highlighted from the perspective of HCPs that stigma continues to be a determinant stopping older people with FMI seeking support for their mental health. Therefore, it is important that older people are considered where policymakers are looking to reduce stigma and acceptability of FMI.

A further influencing factor as to why older people with FMI may not use mental health services emerging from this study from an HCP perspective, was stoicism. Older people with FMI may decide not to access support for their mental health due to stoicism, or a need to be independent (Chapter 4; Section 4.3.2) and simply accepted their symptoms of FMI rather than access support. Several studies within the integrative review underpinning this study, have identified that older people want to feel self-sufficient, resilient, and independent which affected their decision making whether to seek support or not (Byers et al. 2012; Crabb & Hunsley 2006; Muir et al. 2014; Frost et al. 2020). Perkins et al. (2013), has coined the phrase "rural stoicism" and they highlight there are cultural and attitudinal issues in rural communities which contribute to lower engagement with mental health services. Rural stoicism was a finding of this study, with a perception from HCPs that older people living in remote and rural areas believe you need to 'toughen up' and just 'get on with it' and accept their symptoms of FMI (Chapter 4; Section 4.1.2).

Older people in this study reported not contacting the general practitioner as they accepted the symptoms of FMI as an inevitable consequence of ageing. This view was mirrored by HCPs who perceived there to be unmet needs in this population. This finding concurs with findings in the integrative review (Holvast et al. 2012; Arean et al. 2007; Palinkas et al. 2007; Muir et al. 2014; Cummings 2009), and further studies by Kok et al. (2012), and Pocklington (2017). In addition to these studies, Chang et al. (2020), found that ageism is a significant contributing factor to the support older people with FMI receive and consequently treatments have not been given. This is possibly because older people accept

FMI as an inevitable consequence of ageing and therefore do not seek support. Alternatively, due to the assumptions HCPs make about older people and their needs, people are being disadvantaged and not receiving access to necessary quality mental health services.

Within this study it emerged from data gathered that three participants (two older people and a family carer) had experienced challenges when trying to access mental health support from their GP. They reported feeling dismissed and unsupported. A study by Sturman et al. (2022) mirrors this finding in their qualitative study of (*n*=16) interviews of people with severe mental illness. Some participants, spoke of GPs being dismissive, hurried care and dubiety and lack of confidence in the GPs training around mental health, which also highlights an issue of older people with FMI not receiving quality mental health support.

This study found the referral pathway to secondary mental health services to be a key determinant in whether older people with FMI accessed and used support from secondary mental health services. The service model in the United Kingdom is that the GP acts as the referring agent to secondary mental health services (Chapter 4; Section 4.1.1). However, this study illuminated two participants (older people with FMI) had perceived challenges obtaining the support required from the GP in facilitating secondary mental health referrals. Both felt their request for mental health support were not addressed by the GP service (Chapter 5; Section 5.2.1). This finding concurs with the work of Muir et al. (2014), Mackenzie et al. (2010), and Frost et al. (2020) -studies underpinning integrative review - who found there was a barrier to accessing mental health support where older people had to see their GP for referral to mental health services. Frost et al. (2020), adds to this contention by suggesting that physical frailty took priority over depressive symptoms within GP assessments. The integrative review identified from the perspective of HCPs that older people with FMI, due to stigma, may prefer to speak to their GP about mental health issues (Preville et al. 2009; Holvast et al. 2009; Crabb & Hunsley 2006; Mackenzie et al. 2010; Butterworth et al. 2014). This could be a further explanation why, in this study, there were perceptions of low referral rates to secondary mental health services in remote and rural areas as people with FMI were comfortable discussing their symptoms with their GPs, due to their established relationships (Chapter 4; Section 4.3.2).

In summary, several factors influence older people with FMI to access and use of mental health services. A mixed picture exists where the context (urban or rural) in which FMI is experienced impacts on the experiences of those affected or the support offered. Place was pivotal as to why and how older people with FMI accessed support, with the role of the GP a key influencing factor. In urban areas, the GP was perceived to be more likely to refer older people onto secondary services. In remote and rural areas, it was perceived the GP would treat and support older people with their mental health recovery without onward referral providing accessible mental health support. The COVID-19 pandemic was also a determinant with loneliness and altered or restricted access to support availability making managing FMI in everyday life a challenge. Finally, acceptability of FMI was a significant determinant influencing if older people with FMI accessed services, with many older people accepting the symptoms due to stigmatisation of mental health. Other older people just simply accepted the symptoms as a means to maintain their independence. The next section of this chapter discusses what influences HCPs decision making to provide support to older people with FMI.

7.1.2 What influences Healthcare Professionals’ decision making to provide Support to Older People with FMI?

This study illuminated several determinants which influence HCPs decision making to provide support to older people with FMI. These include how the COVID-19 pandemic influenced how HCPs delivered support, using technology where face to face contact was not possible. Further more risk of harm to self and others was a significant determinant for HCPs in what support they offered older people with FMI. The next section discusses how technology was pivotal in enabling HCPs to support older people in remote and rural areas.

Technology

Data collected in this study illuminated that HCPs working in remote and rural areas spoke positively about the use of technology to support older people particularly in the context of the pandemic. Others made assumptions older people may be less able to use technology - the latter being HCPs working in urban areas (Chapter 4; Section 4.1.1). Speyer et al. (2018), adds weight to the use of telehealth as the communication between HCP and patient by using technology such as phone, VC, and internet, despite the potential challenges age may present where using technology. They suggest this is a useful tool to enable accessibility to services for those living in remote and rural areas who may not be able to, or may not want to, travel.

However, a contrasting view from Spanakis et al. (2022), found in their survey of 249 adults with severe mental illness, 42.2% had no digital foundation skills. Spankanis et al. (2022), highlight that digital enablement has supported some people with FMI to engage in online ordering and social contact, others have reported they find it overwhelming which has prevented their engagement in learning how to become comfortable in IT use. From the perspectives of HCPs captured in this study it was reported that telehealth was beneficial to older people with FMI to save them travelling long distances. Two older people with FMI reported telehealth was adequate but not as good as face-to-face support (Chapter 4; Section 4.1.1).

The use of technology was delivered at an accelerated pace due to the restrictions of the pandemic and was needed, not only, to meet the needs of people with mental health issues, but also used much wider than just mental health services due to the lockdown restrictions (Torous et al. 2020). A study by Mann et al. (2020), provides some context to the rapid way in which telecare was used in American urgent care. At the onset of the Covid-19 pandemic between March 2nd 2020 and April 14th 2020, use of digital technology increased by 683% in urgent care by HCPs in response to working within the restrictions imposed by the COVID-19 pandemic. As found in this current study, older people with FMI adapted quickly to virtual support during the pandemic and reported being satisfied. This finding concurs with studies by Kirby et al. (2021), Isautier et al. (2020), and Garfan et al. 2021. Garfan et al. (2021), undertook a systematic review and identified that accessibility to telehealth during the pandemic was particularly helpful in keeping people with serious mental illness engaged in talking therapy such as CBT.

Professional and regulatory bodies within the UK such as The Healthcare Professionals Council (HCPC 2023), were supportive of new ways of working during the onset of the COVID-19 pandemic and welcomed the benefits virtual support provided. They offered guidance on using VC and stated the HCP must ensure service users and carers receive information in a way they understand and which meets their communication needs. This is important guidance as some HCP participants had preconceived ideas before the pandemic and assumed that older people were not IT literate (Chapter 4; Section 4.1.1). The changes made in service delivery challenges that assumption as all older people with FMI interviewed in this study had to engage with their HCP virtually, due to the pandemic and were satisfied with this method of support. The next section of this thesis discusses how risk influenced HCPs decision making to offer support.

Risk

Risk assessment was a key determinant in the decision making of the HCP participants in the support and treatment they offered to older people with FMI. Risk influenced the frequency of support offered to them which was more frequent the higher the risk of self-harm or harm to others (Chapter 4; Section 4.1.3). To assess risk, the HCP worked to build a relationship with the older person with FMI. This was particularly important in suicide risk assessment which Harrison et al. (2018), argue is undertaken by forming a collaborative working partnership between people and HCP which relies on honesty from the older person with FMI around any suicidal thought. Petrik et al. (2015), further found that HCPs need quality time to build rapport with patients and once rapport was established patients were more likely to be honest about suicidal ideation. They further highlight the importance of using a conversational approach when asking questions around risk, whilst maintaining rapport.

This study illuminated that risk assessment was complex and multifaceted, including risk to self, risk to others, risk of physical health and frailty (Chapter 4; Section 4.1.3). Lemon et al. (2016), suggest there is a need for relationship building between HCPs and patients to monitor risk. Some HCP participants in this study reported being risk averse, due to previous experiences of patients who completed suicide and the emotional impact on them as an HCP. Finally, Lemon et al. (2016), speak about the importance of trust, which is multifaceted in risk assessment and relates to the trust the practitioner has in them self, trust in the assessment tools used and trust in the patient, which all enables a quality risk assessment.

In contrast, another HCP spoke about having high tolerance for risk management (Chapter 4; Section 4.1.3) and some HCPs were perceived by colleagues as being very risk averse and paternalistic in their approach. The risk averse approach was believed to be because they were apprehensive of the consequences for them should an older person in their care come to harm (Chapter 4; Section 4.1.3). Therefore, there were different tolerance levels towards managing risk, with some HCPs recognising that being risk averse may impact upon the resilience of the older person with FMI and disempower them. Risk management in the team was subjective and uncertain. These findings concur with the work of Regehr et al. (2022), who illuminate a relational dynamic that arose during risk assessment of self-harm, by talking with patients. Arguably, some variables surrounding risk cannot be captured by risk assessment tools and therefore professional judgement is an important factor (Chapter 4; Section 4.3.3). Downes et al. (2016), suggest mental health nurses, (who are HCPs), specifically understand that risk assessment is an integral part of the nurse role. It emerged from the data that for HCPs in this study, they appreciated the uncertain and tenuous nature of risk and understood it was not possible to eradicate risk completely (Hawton et al. 2013).

To assess risk, different approaches emerged in this study. This included using a ‘conversational approach’, guided by key questions from a standard mental state examination assessment tool (Martin 1990). This provided the HCP with structure for undertaking the assessment (Chapter 4; Section 4.3.3). Four HCPs used the quality evidence based STORM approach, which was found useful by HCPs, as it provided a standardised approach to risk assessment which is undertaken with the patient.

Downes et al. (2016), suggest most nurses feel that risk assessment tools support professional judgment around risk. This view is compounded by Wood (2012), who adds that structured professional decision making reduces risk. With opposing views, Graney et al. (2020), argue that HCPs describe that the use of risk assessment tools is an aid for communication and helps with relationship building, thereby suggesting these components are mutually exclusive.

Woods (2012), suggests that a combination of a conversational approach supported by professional expertise and validated risk assessment tools, may provide a more structured and robust approach to risk assessment. Part of building a relationship was creating a sense of security for the older person with FMI so they had someone to communicate with about their FMI and support their recovery. Data collected in this study mirrors Woods (2012) contention by illuminating that risk assessment is complex and requires an approach of relationship building and conversational skills to compliment the process of risk assessment.

In summary, several determinants influence HCPs decision making in practice. Technology was found a helpful medium to deliver accessible support to older people with FMI living in remote and rural areas, the pandemic also accelerated the use of technology, which was used where face to face support was not advised due to the restrictions of the pandemic. Furthermore, risk was a determinant with the HCPs decision to be practical and risk aware in delivering support to those living in remote and rural areas. This meant creating accessibility by spacing out face-to-face visits with virtual support and allocating caseloads by geographical area. The next section of this chapter discusses how accessible services are to older people with FMI.

7.1.3 How accessible are Services to Older People with a diagnosed FMI and their Family Carers?

This study illuminated different views from HCPs, older people with FMI and a family carer interviewed around how accessible services were to older people with FMI. Place was a determining factor for how accessible service were to older people with FMI, family carers reported perceived challenges where accessing support, anticipatory care was one method HCPs used to make services more accessible to older people and family carers, and finally models of care had the potential to be a barrier for older people and family carers where accessing support. The next section discusses the impact of place on how accessible services are for older people with FMI and their family carers.

Place

When considering the findings of this study in relation to *place,* distance and geographical location were determinants influencing why older people with FMI seek support. Wong and Regan (2009), speak of a concept called the "distance decay" effect. This is where there is a lowering use of services as distance from them increases. They suggest this is mediated by the role of the family and communities. Wong and Regan's (2009) study was undertaken in Canada and focused on people living in remote and rural areas. They suggest people make 'trade-offs' with the cost of travel versus getting their healthcare needs met.

The notion of "distance decay" may suggest people living in remote and rural areas have less expectation from services, fewer services available and may rely on personal resourcefulness and self-determination. In addition, their personal choices to live remotely may come with the acceptance all services may not be local. Accessing services at a distance may be challenging if an older person can no longer drive or public transport is not readily available (Nicholson 2008; Perkins et al. 2013). This finding concurs with the integrative review by Wells et al. (2020), where affordability impacted on older people with FMI and their family carer's ability to access healthcare. (Karlin & Norris 2016; Palinkas et al. 2007; Robb et al. 2003) and resonates with travel costs that are implicated within this study as challenges with travel (Chapter 4; Section 4.1.1), where some older people with FMI may need to undertake a 90-mile round trip to receive secondary mental health support.

The next section of this chapter discusses how accessible services are for family carers of older people with FMI.

Family carers

This study highlighted further that the family carer perceived challenges accessing support for her husband, to the extent she had to take early retirement (Chapter 5; Section 5.2.3). This was because services were perceived by her as not being available. Again, concurring with findings from the integrative review by Broady & Stone (2015), which demonstrated only one in four family carers received support in their caring role. Further research conducted by Ong et al. (2018), highlights family carers perceived that levels of support and services available compared to actual levels of support and available services may depend on the caregiver's levels of resilience. This is a different finding to the integrative review where family carers often do not access services for themselves as they did not have time due to their caring duties (Broady & Stone 2015). Furthermore, a study by Schulz et al. (2020), explored the family caregiver's role to older adults with all health care needs, highlighted caregiving can be positive overall but given the demands on time and associated stress it may be a negative experience overall. The next section of this chapter discusses how anticipatory care plans affect accessibility to services for older people with FMI.

Anticipatory care

A finding from this study identified that telehealth was used to make accessibility to treatment easier for a patient living in a remote and rural area by developing an Anticipatory Care Plan (ACP) who had complex needs. Brazil et al. (2022), describes Anticipatory Care Plans (ACPs) as a method to record the patient's wishes for future care, it an approach which looks at ways of the person staying well, with treatment options developed in conjunction with the person and family members. This was a successful approach for this person whilst providing accessible, available, quality evidence based treatment efficiently and effectively without delays of HCPs trying to contact the Consultant to see what the treatment options should be.

The ACP, translated into mental health terms, is very similar to the anticipatory care plan the WRAP provides. The ACP or WRAP was used for ease as the Consultant was not local and recognised the time involved in HCPs, who were local to the older person with FMI, trying to track her down to discuss treatment options. She listed three medication treatment choices that could be used should the need arise following discussion with the patient and offered him the choice to choose his preferred option. This treatment plan was shared with the MDT including the GP and led to more responsive, timely support and treatment for the older person with FMI. The next section discusses how models of care affect the accessibility of services for older people with FMI and their family carers.

Models of care

Evidence gathered in this study illustrated that some services became less available when people turned age 65 (Chapter 4; Section 4.1.5). This was because, for many, community support services were age-defined, and this also applied to secondary mental health services. A study within the integrative review by Abdul-Hamid et al. (2016), highlights that specialist mental health services are better equipped to meet the needs of older people due to specialist skills and knowledge. However, specialist services appear to be at the trade off, of less availability of services.

It emerged from this study that in some community mental health services in this health board there was a cut-off age of under 65 for people to attend adult mental health services (Chapter 4; Section 4.1.5). This arbitrary age-defined model was perceived by HCP participants to be decided by leaders working in these services. It is unclear why services were configured like this, possibly due to historical custom and practice. One participant was enabled to attend a mental health day service for a short while once he turned 65 but he then found he had little in common with others who were attending as there was a lack of similar interests, which was a determinant that influenced his decision to no longer attend (Chapter 4; Section 4.1.5). It could be argued the lack of available services for older people is due to ageist approaches to commissioning services (Anderson 2011). Burns et al. (2019), undertook a systematic review on ageism against older adults and concluded that ageism needs to be included in international policy to improve perceptions about the ageing process. They also recommend strongly that further research on ageism is urgently required.

Lack of services available for older people with FMI has been identified as a common problem and reported by HCPs (Muir et al. 2014; Anderson 2011). One reason for this may be that more investment has gone into funding services for physical health problems for older people rather than towards mental health, with an assumption older people have more physical health needs than mental health needs (Bawn et al. 2007; Hilton 2016). Anderson (2018), postulates the current the UK service delivery model is discriminative towards older people with underfunding in the region of £2billion in comparison to working age adult mental health services. He contends that services should be person-centred and needs led. The new Scottish Mental Health and Wellbeing Strategy Consultation (2022) is currently out for consultation. There is a focus on addressing inequalities in the strategy, but more from a lens of equality in social circumstances. Furthermore, little appears to feature in the consultation in redressing the balance of fiscal arrangements for older adults' services, with children and adolescent services being the focus of the strategy, and mental health expenditure, under the premise of early intervention and prevention (Scottish Government 2022).

HCP participants in this study perceived there was an identified gap for people in crisis (Chapter 4; Section 4.1.1). HCP participants expressed there were inequalities in the provision of service for older people with FMI in contrast to working age adults with mental illness, where there appeared to be more services available. This was understood by an HCP to be a funding issue (Chapter 4; Section 4.3.2). However, those with FMI made no reference to age-defined services. This may be because they were unaware of their existence, or accepted the care that was available and accessible.

Toot et al. (2011), highlights that older people services were excluded from the development of crisis intervention/home treatment teams in the development of the National Service Framework for Older People (Department of Health 2001). However, there is growing evidence to suggest there is a need for crisis services for older people with mental health problems to avoid admission to hospital or care home (Moye et al. 2019). Lloyd-Evans et al. (2018), undertook a national survey in England in the use of crisis resolution teams. They discovered few crisis services adhered fully to national guidelines; implementation of these services is inconsistent with use of crisis services in older mental health uncommon. Therefore, there appears to be an availability and accessibility issue for older people in acute mental health crisis, inequitable with adult mental health support.

Nizum et al. (2020), contend that crisis situations can overwhelm an individual’s ability to cope and can have long lasting harmful effects on the individual if the appropriate support is not provided. Within this health board, the void of crisis intervention services was perceived to be filled by the GP, who supported people in crisis. HCPs felt GPs managed crisis well. In contrast, one participant described that she could only gain support for her mental health whilst in crisis by calling the police (Chapter 4; Section 4.1.1).

In summary, participants identified that some services were difficult to access due to arbitrary age limits upon services, which excluded people over age 65, potentially impacting upon the quality of services received. However, there were some older people with FMI who continued with their normal care but found that some peer support activities were not what they expected or needed. In addition, there was an identified gap in availability in the service provision for older people who were in crisis. This was perceived by HCPs to be a funding/commissioning issue. Also, there was very limited available support identified for family carers. Finally, in the pandemic during lockdown, face-face services were unavailable to older people with FMI.

The next section of this chapter discusses how services available meet the needs of older people with FMI.

7.1.4 How do Services available to Older People with FMI and their Family Carers, meet their support needs?

This section discusses the findings of this study in relation to how services available to older people with FMI meet their needs and the needs of their family carers. The findings indicate that relationship building was essential to how older people and family carers needs are met, how older people with FMI and their family carers could manage FMI in everyday life, with interventions available to them and finally transitions across pathways impacts upon the availability of services to for older people with FMI. The next section highlights how relationship building was perceived by older people with FMI to contribute towards meeting their needs.

Relationship building

One finding of this study illuminated that participants spoke about their experiences of relationship building in the community, which they viewed as very positive in meeting their needs. All participants perceived their support from the community mental health team was helpful in supporting them to manage everyday life in FMI (Chapter 5; Section 5.2.4). Relationship building with older people with FMI was key in keeping them well in the community setting. This was because relationship building enabled a quality, robust mental state and risk assessment. This was achieved by the HCP establishing trust from the older person with FMI.

Community nursing staff interviewed in this study also spoke about the importance of relationship building with older people with FMI. One participant spoke particularly about the importance of personhood and sharing reciprocal personal information with patients to build a quality relationship (Chapter 5; Section 5.2.4). Communication skills of the HCP are essential where building a relationship by getting to know the patient and connecting with them (Mckenna et al. 2018). Dewar et al. (2013), suggest the following strategies develop positive relationships; sharing personal information, using banter and humour, and establishing a shared understanding. Hartley et al. (2020), suggest that within the community mental health setting, mental health nurses deliver short term or longer-term therapies which require the nurse to build a quality relationship with the patient. They add that where there are challenges around relationship building, the nurse will work to build mutuality, and reciprocity.

This study illuminated that building the relationship with the patient was a subtle skill which included normal social tasks. HCPs in this study described the subtle approach they took to assessing and supporting the patient, by using a conversational approach (Chapter 5; Section 5.2.4). Burnard (2003), describes the skill the nurse has in using phatic conversation (small talk) to put the patient at ease, but also at the same time gleaning important information about the person’s mental state by engaging in conversation. Coombs et al. (2012), highlight the importance of the HCP undertaking simple tasks such as making a cup of tea, as this is seen as a social act and normalises the process of the support from the HCP and puts the patient as ease. One participant recognised the importance of the HCP visiting him and having a cup of coffee with him. All older people with FMI participants highlighted the value of talking with their HCP but did not articulate this as being any type of formalised assessment or model of support (Chapter 5; Section 5.2.4). In this study, the aim of relationship building was to initiate interpersonal communication, to allow the HCP to understand patients' and family carers perceptions and needs. This, in turn, helped them to understand and find a solution to their problem (Moreno-Potayo 2021). Moreno-Potayo (2021), contend that experienced nurses found it easier to build a relationship with their patient. This is evident in the current study as older people with FMI described they have strong relationships with community-based HCPs, who generally are more experienced practitioners.

In contrast older people with FMI in this study described negative experiences around the quality of relationship building in the in-patient setting. One participant perceived they received no therapeutic input whilst in hospital. Two older people with FMI stated they had to actively seek support in the in-patient setting if they needed it (Chapter 5; Section 5.2.4). There is a body of evidence suggesting there is a lack of quality therapeutic relationships between HCPs and people with FMI in the in-patient setting which is driven by power and lack of choice (Newman et al. 2015; McAndrew et al. 2014; Cleary et al. 2012).

Further findings in this study also revealed one older person felt her liberty had been taken from her, as she was admitted to hospital under the Mental Health Act. Murphy (2017), suggests that involuntary admissions can make patients feel disengaged but when staff approached patients and spoke in a respectful way this was viewed by them as person-centred. The experiences of some patients in this study suggest they had to approach staff in the in-patient setting themselves for attention (Chapter 5; Section 5.3.3). However, one participant in this study did recognise once they were well, they did need to be in hospital. Some of these described challenges of relationship building with people with FMI are described by Clement et al. (2015), who state there is some mistrust in mental health services. Some people have had poor experiences with mental HCPs, experiencing coercion in their treatment, poor quality treatment, and discrimination from HCPs, hindering their recovery journey.

Hartley et al. (2020), suggest it is challenging to deliver relationship-centred care in the in-patient setting, with the additional strains of the environment and staffing shortages. Furthermore, Staniszewska et al. (2019), highlight mental health in-patients have concerns about coercion due to the power balance between patients and HCPs, limited quality recovery focused support and a lack of therapeutic activities (group work, one-to one-time activities etc). Literature suggests that relationship building, and therapeutic activity does not appear to be a priority in the mental health in-patient setting, with patients reporting they have few opportunities to speak with staff and report a tense atmosphere in which they felt insecure (Moreno-Potayo et al. 2016; Pazargadi et al. 2015). With a contrasting view Cutler et al. (2020), suggest that mental health nurses are aware that safety in an in-patient mental health setting is vital and nurses being available to patients is important to patient safety.

A literature review undertaken by Wyder et al. (2017), describes the challenges nursing staff in particular face in the in-patient setting when considering patient safety, whilst meeting therapeutic needs. Wyder et al. (2017) highlighted that the mental health nursing role is complex, as they must balance relationship building with older people whilst at times having to enforce the legislative requirements of the Mental Health Act for people who are in hospital on an involuntary basis. In addition, further inhibiting factors for relationship building is the business of the ward environment. Nurses at times are reporting that they need to use opportune moments to build relationships with their patients such as walking past them in the corridor and engaging briefly (McKenna et al. 2018). Newman et al. (2015), argue that building relationships is fundamental in meeting the needs of patients and obtaining engagement in their care. The therapeutic relationship is key in providing quality mental health nursing (Moreno-Poyato et al. 2021). The mental health nursing relationship is described as “a significant therapeutic interpersonal process (that) functions cooperatively with other human processes that make health possible for individuals and communities” (Peplau, 1988, pg.16).

The next section of this chapter discusses how FMI is managed in everyday life.

Managing FMI in Everyday Life

HCP participants used several approaches to signpost older people to *manage everyday life in FMI* and aim to provide evidence based quality care. One approach identified by HCPs was 'guided discovery' (Chapter 5; Section 5.2.4). Guided discovery uses a therapeutic approach to assist clients to find solutions to their problems using a Socratic approach which involves visual explanations of important concepts (Overholser 2013). Guided discovery is a key concept in cognitive behavioural therapy (CBT), an approach that focuses on patients' assumptions and ability to discover alternative solutions for themselves (Fenn et al. 2013).

Roscoe et al. (2022), highlight that guided discovery is a style of questioning focused on achieving change management in the patient and addressing issues out with their current awareness. Roscoe et al. (2022), suggest that guided discovery is integral to formulation and treatment in therapy, but there is little research informing peoples' experiences of guided discovery.

CBT was also identified in this study as a way that supported older people with FMI to manage FMI in everyday life. This was achieved by goal setting (Chapter 5; Section 5.2.4). CBT is defined as an intervention where self-stigmatising beliefs are regarded as irrational beliefs, and which are held by the person. These irrational beliefs lead to depression and a reduced sense of hope (Young et al. 2019). CBT focuses on goal setting. These goals should be mutually agreeable using the SMART (specific, measurable, achievable, realistic and time specific) framework. For example, homework assignments may be set to achieve these goals (Fenn et al. 2013).

The Psychological Therapies Matrix (2014), - which is the best practice framework- states there is a strong evidence base that psychological approaches are effective in the treatment of depression and anxiety in older people, and secondary care CBT would be the advocated choice of therapy.

A HCP in this study used the guided discovery approach, goal setting with an older person with FMI who found it a useful experience which made her feel empowered and gave her a sense of achievement (Chapter 5; Section 5.2.3). However, this participant highlighted a lack of referrals for older people with FMI for psychological therapies such as CBT. Petit et al. (2017), state that older adults with FMI are known to be under-referred for psychological therapies with greater access for younger people. This is particularly noted in people aged over 80, even when they request referral (Frost et al. 2020). This concurs with findings in this study identifying accessibility to psychological therapies is limited for this population.

As part of the CBT approach, HCPs used a goal setting approach and asked patients to undertake homework. This approach was used by HCPs in this study to enable older people to build personal resilience. Mary found this approach beneficial to her recovery (Chapter 5; Section 5.2.3). Homework is defined as activities that are set, to be undertaken out with, and between, the therapy sessions with the aim of achieving therapeutic goals (Beckwith et al. 2014). Homework setting is a key component of CBT and aimed at equipping patients with available skills to manage everyday life once therapy has ceased (Haller et al. 2021).

However, a psychologist expressed that many older people with FMI did not want to be referred for psychological therapies. Instead, the psychologist’s perception was that older people wanted medication to get better rather than therapy, basing this perception on what some patients had told her (Chapter 4; Section 4.1.4). Therefore, either older people with FMI do not understand the positive effects of psychological therapies, or they believe medication to be more effective, or psychological therapies do not meet the needs for older people with FMI from their perspective.

In contrast, Frost et al. (2020), identified patients' desire to accept symptoms and be independent influenced treatment choices, and older people with FMI may prefer talking therapies as opposed to medication, which they associated with dependency. Kok and Reynolds (2017), contend that older people with depression will often need the same doses of medication as younger adults, but this carries more risk for older people due to medical co-morbidities and polypharmacy.

This study illuminated perceptions by HCPs that older people are more likely to be prescribed antidepressants and less likely to be referred for psychological therapies compared to younger people. This becomes even less frequent once someone reaches aged 80 (Frost et al. 2020). However, NICE Guidelines (2022) [NG222], suggests that treatment choices for depression and anxiety should be driven by the patient's choice, with consideration to any treatments that have worked before.

Another tool which emerged from the data collected in this study, as a self-care method was the Wellness and Recovery Action Plan WRAP (Copeland 2022). The WRAP was developed by the HCP and older person with FMI and / or their family carer. HCPs identified this as a tool to support older people with FMI with their mental health (Chapter 5; Section 5.2.3). O'Keeffe et al. (2015), defines the WRAP as a tool that is cross diagnostic, person-centred, and uses a self-care intervention for mental illness. The WRAP is a quality validated tool in recovery-focused practice to promote self-help (Higgins et al. 2012; Scott et al. 2011). This tool was first developed by a person with lived experience who was frustrated by the lack of support she received from HCPs to manage her illness (Scott et al. 2011). The WRAP is a tool used to empower people to take control of their wellness and is underpinned by factors such as personal responsibility, education, hope, and future planning (Higgins et al. 2012). The WRAP is used in several countries including Canada, USA, Ireland, New Zealand, and the UK (Canacott et al. 2019). Canacott et al. (2019), illuminate that the WRAP is superior in promoting self-perceived recovery outcomes, but not effective in reducing clinical symptomology.

In this study the tool was used to look for triggers for exacerbation of symptoms, how to manage these symptoms and signposting support, which HCPs reported as beneficial. The WRAP is a staged self-management tool if used successfully. The older person with FMI, will spend 10-15 minutes per day reviewing their WRAP, considering potential triggers, symptoms, and behaviour which encourages self-awareness and surveillance of their mental state (Scott et al. 2011). A study conducted by Mak et al. (2022), reported the use of the WRAP resulted in significant improvements in depression, anxiety, hope, and empowerment.

With contrasting findings, Canacott et al. (2019), undertook a meta-analysis of six papers and concluded the WRAP resulted in no significant improvement in symptoms of depression and anxiety but had significant improvement in peoples' feeling of hope. A further finding by O'Keeffe et al. (2015), shows that the WRAP did not have significant impact on personal recovery, quality of life or psychiatric symptoms, but did improve self-identity and self-esteem. However, one HCP in the current study found the WRAP a helpful tool, to empower older people with FMI to manage everyday life. There was no feedback from older people with FMI or their family carers on how helpful they found the WRAP.

Techniques such as *Mindfulness* were used by HCP participants as a quality intervention for supporting older people to manage depressive and anxiety symptoms. Mindfulness, therefore, was a tool that can help older people manage everyday with FMI as reported by HCPs (Chapter 5; Section 5.2.3). It is a practice that can decrease the psychological distress of a person by them being aware of the present moment, and what that moment is, and being aware of how they react to it (Robins et al. 2013).

A meta-analysis undertaken by Fumero et al. (2020), reviewed twelve papers on the effectiveness of mindfulness on anxiety disorders. They surmised mindfulness is quality intervention that reduces symptoms and enables individuals to use a strategy for self-regulation, self-awareness, and improved wellbeing. A further study by Hatch et al. (2022), found mindfulness interventions appear to be effective in reducing the symptoms of anxiety in older people. Another study by Yan Lam et al. (2022), revealed that using mindfulness in schizophrenia also has the potential to improve global functioning, emotional regulation, and prevention of a relapse of symptoms. HCPs in this study perceived mindfulness to be one evidence based quality intervention that could be used to help older people manage FMI in everyday life.

Peer support groups were identified by all HCP participants, two older people and the family carer as being helpful in managing FMI in everyday life (Chapter 4; Section 4.1.5). Naslund et al. (2016), define peer support as a social group which enables shared experiences and connectedness. Shalaby et al. (2019), adds peer support as a simple process people with lived experience can give back to one another. Sweet et al. (2018), highlight that peer support groups enable the older person to experience a sense of connectedness which is essential to achieving recovery.

Gillard (2019), suggests peer support is distinct, insomuch that there are shared values from lived experience. Gillard (2019,) also highlights that the UK government are exploring peer support services and peer support worker roles. Van Orden et al. (2021), go as far as suggesting that given the ageing population, peer support has the potential to mitigate workforce challenges. They add that peer support provides the benefits of carer respite, self-management, and navigation of services. Gum et al. (2018), further suggest that peer support for older people with FMI is essential support in avoiding hospital readmission. This study illuminated that peer support groups helped older people with FMI build relationships with peers who have lived experience and manage FMI in everyday life (Beales & Wilson 2015).

No findings were identified within this study around acceptability of FMI from the perspectives of family carers in this study. This is potentially because there was one family carer who participated in this study which is a limitation. The next section of this chapter discusses how transitions across pathways affect accessibility of healthcare services to older people with FMI and their family carers.

Transitions across pathways

As highlighted previously, this health board had a service delivery model where older people were predominantly transferred to OAMH services when turning 65. Varied views of HCPs in this study prevailed as to whether age-defined, or ageless services met the needs of older people (Chapter 4; Section 4.1.5). This service delivery model did not appear to be influenced by '*place'* with the same model in both urban and remote and rural areas. One team retained people upon turning age 65 as they were known to the team and adopted a person-centred approach. They would only transfer patients to OAMH services if there were signs of cognitive impairment. HCP participants perceived that transferring people to OAMH services was not reflective of a modern society as people now often work into their seventies. They believed further that peoples' needs were not being met with any quality by being transferred to an OAMH service upon turning age 65 (Chapter 4; Section 4.1.5).

Jolly et al. (2004), refers to older people with severe and enduring mental illness who are referred from adult mental health services to OAMH services as graduates. Khrypunov et al. (2018), suggest that the transition of 'graduates' to OAMH services can be challenging and can lead to a loss of relationships with HCPs, disengagement with services and deterioration in their mental health and recovery.

There were mixed perceptions by HCPs around ageless and age-defined services. Some HCPs felt a mixed age group was particularly helpful in the in-patient setting as younger people helped older people around the ward. Abdul-Hamid et al. (2016), strongly contends that older people with FMI needs are not met in ageless services. This view is backed further by a belief that HCPs in ageless services have limited knowledge of physical health morbidity in this population group which would affect the quality of care and treatment (Saad et al. 2016; Warner 2014).

With a contrasting view, Bawn et al. (2007), argue that ageless services better meet the needs of older people with FMI compared to age-defined as they have better funding and more accessibility to equitable services available. Saad et al. (2016), argue that ageless services would support acceptability with less discrimination towards older people and would be financially effective. However, they argue there would be unintended consequences of adopting ageless services such as safety and wellbeing issues of mixed ward environments of frail elderly people with acutely mentally unwell younger people. Warner (2014), adds weight to Saad et al's (2016), view by arguing that in ageless service older peoples' needs would be eclipsed by younger adults who often present in a more dramatic way. He further adds that older people often have physical health needs that HCPs and psychiatrists are familiar in treating.

However, the current study shows contrasting perceptions when there was a mix of older and younger people in the ward setting. Some perceived these two age groups complimented each other by supporting each other. Younger people were found to enjoy older peoples' life experiences and younger people would support older people with physical needs (Chapter 4; Section 4.5). In contrast one older person felt uncomfortable in the mixed age ward (Chapter 4; Section 4.1.5).

In summary, there are different perspectives from older people with FMI in community care and in-patient care, in relation to the quality of relationship building. The quality of relationship building was perceived to be improved in the community setting in comparison to the inpatient setting, and was used effectively to assist in risk assessment and delivering quality interventions. Managing everyday life illuminates that quality evidenced based interventions are used to signposted by HCPs to older people with FMI as easily accessible ways to meet the needs of their symptoms. Finally, transitions across pathways highlights that arbitrary service model decision cans impact upon how older people and their family carers needs are met, due to the quality of service delivery model.

The next section of this chapter highlights how the AAAQ (UNICEF 2019) framework has underpinned new knowledge and insights in relation to; *the context needed for the journey of recovery.* This concept has been chosen to explain the findings of this study as this is a qualitive research design which is understood by context and recovery in mental health to be an ongoing journey (Higgins & McBennett 2007). Recovery is justified to map the findings of this study against, as it is the underpinning model of care in mental health services (Higgins & McBennett 2007).

7.2.1 The Context needed for the journey of recovery.

The findings of this study illuminate the context needed for recovery are now demonstrated in the following table mapped against the AAAQ framework (UNICEF 2019) (chapter 3: section 3.6).

Table 21: The Context Needed for the Journey of Recovery

The Context Needed for the Journey of Recovery	
Availability	• The remote and rural GP was perceived by some HCPs to be an enabler in providing treatment for older people with FMI in remote and rural areas avoiding onward referral to secondary services. • There appeared to be more referrals in urban areas compared to remote and rural areas suggesting GPs

	referred older people to secondary care if there was a specialist mental health need in urban areas- potentially enabling specialist mental health support. Data collected within this study revealed there was less availability of mental health services in remote and rural areas within this health board, which was a barrier to accessing services for older people with FMI in remote and rural areas. • Mental health services were configured differently for the over 65's with a perception by HCPs that there is less available for this population group in this geographical area. Again, this was a barrier to accessing support and services. • There was a perception from HCPs that there was no availability of crisis services for older people with FMI, this was believed to be a resource issue. • HCPs working in OAMH services who described under-resourced services for example, no crisis intervention service for this age group which was a further identified barrier to accessing support and services. • HCPs supported older people with FMI and their family carers in *managing FMI in everyday life,* by upskilling them with tools such as the WRAP, CBT approaches, distraction techniques and peer support groups, which supported the older persons personal journey with recovery. These were all enablers to older people with FMI and their family carers receiving support.
Accessibility	• Physical accessibility was one barrier identified from the data of this study. For some older people with FMI, they may have been required to make a 90-mile journey to access face to face support from specialist secondary mental health services. This was a barrier to accessing services. • HCPs were strategic and adaptive and would space their appointments out between face-to-face and telehealth meetings to support other interactions. HCPs would try to make the initial appointment face-to-face to build the initial rapport. This was an enabler to older people with FMI receiving support and services. • Given the distances involved in travel to remote and rural areas, there was a cost financially for older people to travel the distances outlined, but also a cost to service for a HCP to spend one day travelling to see one person, not being an efficient use of their time. This was a barrier. • There was a perception that community services become less accessible to older people with what could be viewed as a discriminatory approach to social accessibility, with many community resources being age-defined. Where there were ageless services

	however, some participants reported they had little in common with the younger people attending. Again, this was a barrier for older people with FMI accessing support and services.
Acceptability	• Some HCPs perceived that older people with FMI experienced negative self-worth due to the arbitrary age restrictions on services in this health board. This was a barrier to older people with FMI accessing support and services. • The use of telehealth was also identified as an acceptable intervention in the journey of recovery. Telehealth was used in remote and rural areas pre-pandemic to support people, and then across urban areas too, at the onset of the pandemic. This study illuminated, where possible, the initial assessment undertaken face-to-face allowed relationship building to take place for future virtual sessions and helped to build a sense of continuity. This was also perceived to be an enabler to older people with FMI accessing mental health support. • The referral pathway was highlighted by older people and the family carer (who lived in urban areas) as challenging in seeking to receive acute mental health care, as the GP was the facilitator (as first point of access for the referral process) to support these participants. This was a perceived barrier to accessing services.
Acceptability	• HCPs believed there is a hidden population in remote and rural areas but it was unclear if people are managing self-recovery. The counter argument without support from HCPs is they do not have relationships and given how important relationship building has been identified to be in this study, it is unknown if they are achieving self-recovery. • Stigma was also highlighted as a key feature which prevented older people with FMI accessing support, particularly in remote and rural areas. Stigma was a perceived barrier to older people with FMI seeking support. • Stoicism and a need for independence was also a determining factor preventing older people with FMI seeking support for their mental health. Again, stoicism was a perceived barrier to older people with FMI accessing support and services.
Quality	• *Relationship building* emerged as a concept in this study which underpinned accessing services which contributed to perceived quality of care and support. Older people with FMI in the community spoke about the importance of ‘talking’ to their HCP. Older people with FMI recognised talking made them better but did not articulate as being more than talking. In contrast,

	older people who experienced in patient care did not recognise relationship building in this setting, which they perceived to hinder their recovery. Therefore, relationship building was an enabler in the community but the lack of this was perceived barrier in the in-patient setting. • HCPs articulated the complexity of talking and how this was done in a therapeutic way, whilst at the same time assessing a multitude of components such as risk of self-harm or harm to others, and mental state. This was an enabler, from their perspectives, to older people receiving the care and treatment they required. • HCPs perceived that OAMH services were under resourced with a lack of crisis support, which was bridged by the GP or at times the Police. Under funding was also a perceived barrier to older people with FMI accessing support and services. • HCPs used interventions such as guided discovery, mindfulness, decider skills and the WRAP to enable older people with FMI and their family carers to manage FMI in everyday life.

This section has demonstrated how the AAAQ framework (UNICEF 2019) has enabled explanation of this study’s findings.

To summarise, table 21 has summarised key components linked to the context needed for healthcare recovery by using the AAAQ framework (UNICEF 2019). Mapping the findings from this study to the AAAQ framework (UNICEF 2019) has addressed the research questions by identifying components which relate to availability, accessibility, acceptability and quality of services and how each of these impact on the internal decisions of older people with FMI and their family carers where accessing mental health services and likewise the internal decisions HCPs make where planning interventions and delivery of services.

7.3 Chapter Summary

This discussion chapter has used the AAAQ framework (UNICEF 2019) to understand the findings of this study and literature and evidence related in the field. *Place* illuminates that access to services is determined by the geographical area, which in turn impacts further upon affordability due to travel and accessibility and acceptability which are influenced by perceived views around stigma and stoicism which is found to prevent older people with FMI from accessing services. These findings are all mirrored in the integrative review by Wells et al. (2020).

However, one unexpected finding in this study relating to place is the perceived role of the remote and rural GP who appeared to support people in remote and rural areas avoiding onward referral to secondary services. This study illuminated that the role of relationship building affects perceptions about the quality of services. Where a good relationship was established then the experiences of people with FMI were judged to be better. If the relational aspects were missing, as in the inpatient setting as reported by participants in this study, then quality was compromised. Finally, *managing FMI in everyday life* was not a key finding of the integrative review, but pivotal in preventing older people from accessing services by staying well, and as available resources for them.

The next chapter of this thesis addresses the concepts that have emerged from this study in relation to the AAAQ framework (UNICEF 2019) and describes the specific contribution to knowledge this study provides and recommendations for policy and practice. It further explores the strengths and limitations of the study and my final reflections on my research journey.

Chapter 8: Conclusion, and Recommendations

8.1 Introduction

The overarching aim of this study was to explore the determinants influencing the use and provision of services for older people with FMI. I was motivated as a researcher to undertake this study as my background as a nurse predominantly involved working within the Older Adult Mental Health (OAMH) setting. In my experience, OAMH services are overshadowed by Adult Mental Health (AMH) or Dementia services in terms of funding and national and international policy. There is limited research exploring the experiences of older people with FMI and I wanted to understand the lived experience of key stakeholders including Healthcare professionals.

In terms of reflexivity, I brought several assumptions to this study. I was strongly of the opinion that age defined services did not meet the needs of older people given they were based on an arbitrary age of 65 when people were judged to be 'old'. I believed services should be needs based.

I further realised as I progressed onto phase one of my interviews, that I assumed services were delivered from a basis of my own experience. Therefore, I did not always ask probing, exploratory questions. I overcame my early assumptions in future interviews by assuming I knew nothing about OAMH services and asking probing questions. Furthermore, I used a reflexive diary to challenge myself to ensure I was not bringing personal bias to the study. My interview style was also critiqued heavily by my supervisory team, who highlighted I had not been probing enough at interview.

This chapter presents an evaluation of this study in terms of the research design and explores if the research question has been adequately addressed. The research design used was an interpretive descriptive study design, but, given that, initially, a case study approach was adopted, this chapter further revisits the theoretical propositions (Yin 2018) set out at the outset which emerged from the integrative review which informed this study, and explores if these theoretical propositions are represented in my findings. Strengths and limitations of this study will be examined, then a critique of this study will be presented and the contribution it has made to knowledge and recommendations for practice and areas for future research will be discussed.

8.2 The Research Questions

This study was informed by an integrative review and an updated search of the literature prior to submission of this thesis (Wells et al. 2020 and Chapter Two). This integrative review highlighted that some older people with FMI do not seek mental health support as they believe FMI is an inevitable consequence of ageing.

This view was mirrored at times by healthcare professionals and their carers'. In addition to this finding in the literature, different views prevail regarding the impact that ageless, and age-defined service delivery models have on the needs of older people with FMI. Some perceived that age-defined services are required as OAMH is a specialist service with specialist skills and knowledge (Saad 2016; Warner; Abdul-Hamid et al. 2016). In contrasting views, others believed that services should be designed and delivered due to need (Katona et al. 2009; Bawn et al. 2007).

The integrative review identified a lack of qualitative data. Accordingly, this study intended to understand the experiences of older people with FMI, their family carers, and HCPs. The following research questions were developed and underpin this study.

- What influences older people with FMI to seek support from health care services?

- What influences healthcare professionals' decision making to provide support to older people with FMI?
- How accessible are services to older people with a diagnosed FMI and their family carers?
- How do services available to older people with FMI and their family carers, meet their support needs?

The next section critiques the suitability of the research design to address these questions.

8.3 Review of Research Design

This research design was chosen purposefully to address the research aims of this study. The study intended to provide an in-depth understanding of the determinants influencing why older people with FMI and family carers seek support, and what influences HCPs to offer support.

Drawing on the literature it was apparent that an in-depth understanding was likely to emerge from the multiplicity of perspectives; older people with FMI, HCPs, and their family carers. Given the potential impact of context in which people experience and manage FMI, the initial justification for a case study approach was to allow the in-depth exploration of FMI where the contextual factors around one case could be explored from different perspectives. However, as discussed (in Chapter 3), the COVID-19 pandemic required me to reconsider my approach to data collection and the study. The chosen study design still enabled me as the researcher to gather a multiplicity of perspectives from older people with FMI, HCPs and a family carer as originally intended and provide an in-depth account of key stakeholders' experiences although these could not be linked, compared and contrasted across cases.

An interpretive descriptive approach facilitated the exploration of the impact of the context on participant's experiences, thus meeting the original intentions of the study. The impact of the context included key issues linked to place, relationships and managing everyday life as influenced by risk assessment, management of FMI and availability of services and distance.

Using convenience sampling, phase one interviews with HCPs, a focus group (*n*=3), and semi-structured 1:1 interviews (*n*=3) with those who could not attend the focus group but wished to contribute, were conducted. Data were analysed using thematic analysis (Braun & Clarke 2019), and provided an in-depth understanding of the research questions. Given the sample size was smaller than expected, an-in depth analysis of the data was undertaken by transcribing the data myself, then placing data into descriptive codes which were refined to codes. Following this, codes were refined into themes, which were discussed and refined further at supervision.

The analysis was then synthesised, and the AAAQ (UNICEF 2019) theoretical framework -was used to understand and explain what the findings of this study meant. The literature gathered from the integrative review alongside literature relevant to the findings was also considered. This illuminated that *place, building relationships and managing FMI in everyday life* all impacted upon the recovery of older people with FMI.

The strengths and limitations of this study are now discussed.

8.4 Strengths and Limitations of this Study

One strength of this thesis lies in the qualitative interpretive approach which has enabled the presentation of multiple perspectives in relation to the research aim and questions. The research aim and questions were developed from a robust and published review of the literature (Chapter 2), which arguably provides a strong underpinning to the components of this thesis. Acknowledging the overall sample size is small due to the impact of the COVID-19 pandemic, the included participants were key stakeholders who could relate their experiences of FMI. Efforts were made to maximise recruitment in the circumstances. This included recruitment in another health board where I was not known, and contacting a key person who could help with recruitment, which meant those who participated were not influenced by me.

The recruitment of HCPs across the disciplines from the Multi-Disciplinary Team (except for Social Work and General Practitioners) adds to the trustworthiness of these findings. Data collection using focus group and semi-structured interviews added to the strength of this study as they are useful methods for achieving multiple perspectives and a rich understanding of the phenomenon (Kruger & Casey 2015).

It is important to recognise that the voice of Carers is limited, as only one could be recruited, and Social Workers and GPs are missing. Much was identified by other stakeholders in this study about the role of the GP whose voices are not included. Furthermore, I was unable to recruit any HCPs working in the in-patient setting and third sector.

Acknowledging the small sample size, there was no intention at the outset of this study to make findings generalizable. Instead, I focused more in gathering an in-depth understanding. Thorne (2016), suggests an in-depth understanding of a phenomenon is not achieved by quantity of data collection, more the quality of data collection, analysis and interpretation. One HCP participant took part in both phases of this study - this is a strength as it provides some continuity in the data gathered. Likewise, however, it could be considered a limitation as their perspective is stronger than other HCPs in the study.

Some limitations, alongside strengths, of conducting interviews by phone are noteworthy. These allowed me to continue the study during the pandemic, but, when one participant being interviewed became anxious it was difficult to offer reassurance, thus affecting my decision in balancing how much as a researcher I should ask as I could not observe over the phone how anxious he was. I asked several times if he was OK to continue. Consequently, the interview was cut short following minimal probing questions.

A combined strength and limitation in this study is my own professional background and experience. Although during this study I have changed my role, I have 23 years' experience working in OAMH services, latterly as Nurse Consultant and Clinical Director. This experience did provide me with knowledge and understanding of the phenomenon and the context. I have only worked in one health board, and acknowledge other health boards may be configured differently to meet the needs of the population. However, my experience also meant I brought assumptions to the study and how I addressed these to ensure trustworthiness was discussed in Chapter 3; Section 3.2.2. I highlight that my findings were discussed regularly with my supervisory team to ensure they were credible, trustworthy and representative of the stakeholders' perspectives (Stenfors et al. 2020).

Documenting my thoughts and experiences throughout this research apprenticeship journey in a reflexive journal afforded me an opportunity to consider how I might have approached this study differently. As highlighted in Chapter 3; Section 3.2.2, I recruited one family carer, due mainly to the impact of the Covid-19 pandemic, which limits understanding their perspectives.

Furthermore, in my study design I stipulated that the older person with FMI would approach their family carer. Two older people did not wish to approach family members to participate, another family member declined, thus only one family carer participated in this study.

To understand the lived experience from the perspective of family carer, it may have been beneficial to have widened the selection process, for key informants to identify potential participants, or to have tried to recruit a focus group from 3rd sector organisations. Also, it may have been beneficial in terms of recruitment to have recruited from more than one health board. However, had I done so, I would needed to have considered the differences in context of different health boards within the analysis of the data.

Given I could not recruit GPs and Social Workers I could have approached Practice Managers or the SW department directly. In phase one, prior to the pandemic, I could have attended team meetings to introduce myself and highlight my study. Likewise, I could have written to Social Workers to try and identify how to make participation easier. On reflection these things did not happen due to constraints of the study time frame and the challenges the pandemic presented.

I further note I omitted to ask older people with FMI their age. The age inclusion criteria was simply age 65. This information about participants' ages may have been a limitation in this study where considering ageless and age-defined services. This would have provided greater depth to the analysis of data. However, older people in this study did not highlight this concept in any way.

Furthermore, I could have included more details around participants' demographics. For example; how long the older person had received services, and the age they transitioned to age-defined services (if applicable). This detail would have provided more depth to my analysis.

Finally, I have reflected on my interview technique and as a novice researcher in the first phase of this study. I very much had a nursing hat on (without realising it). When HCPs spoke about referral pathways, organisational process, or service delivery I did not probe these points enough, as I thought I knew the system, given my previous experience. In addition, as I was undertaking the study in a health board I was unfamiliar with, I could have explored the design of the service in more depth. This is a limitation of the findings in phase one and an important feature in my growth in this research journey.

In the second phase of this study, I consider that my interview technique had improved significantly. I asked more probing and exploratory questions. I allowed and scheduled with participants an hour per interview. I also reminded myself constantly that my role was a researcher.

Throughout this study, I considered my leadership skills developed due to improved knowledge about research. Throughout the duration of this study, my workplace was considering going for Magnet accreditation.

Having the knowledge and understanding of how to undertake qualitative nursing research enabled me to understand and contribute to the discussion in relation to the research element of Magnet and the requirements to achieve Magnet designation. Furthermore, undertaking a PhD has equipped me with skills to underpin practice with evidence as I now know how to undertake a literature review, critique and evaluate the findings. Importantly, given that I am in a senior nursing role, understanding research gives me credibility and given my position, the gift to encourage our future and existing workforce to undertake research to underpin practice.

8.5 Contribution to International Literature of the Study Findings to Understanding the Determinants Influencing Older Peoples Experience of FMI

The research aim of this study was to explore what determinants influence older people with FMI's use of services. Therefore, four research questions were formulated to guide data collection. In the next section, I provide a summary of the specific contributions this study makes to the field of older adult mental health practice.

It emerged those who lived in remote and rural areas may decide not to seek support and this was linked to both the place in which they lived and individual choices they made linked to personal beliefs and being independent. Place, was a determinant in the care and treatment older people with FMI received, in remote and rural areas. HCPs perceived GPs were treating older people with FMI to avoid onward referral to secondary care.

Place, also impacted upon the decision making of HCPs in undertaking face-to-face assessments. In remote and rural areas, HCPs spaced out face-to-face assessments with telehealth. HCPs perceived an initial assessment was best undertaken in person to allow relationship building, which Higgins (2007), suggests is an important component in the recovery of self. HCPs perceived once the initial face-to-face assessment had taken place then telehealth could be used.

This study further suggests that some older people with FMI, living in remote and rural areas specifically, may choose not to seek support for their mental health, as this generation were perceived by some HCPs to stigmatise mental health- thereby reflecting the internal choices people make about their health.

The referral pathway emerged as a determinant for what support older people with FMI received. This was in the context of the GP being facilitator to secondary mental health services. There was a sense by some HCPs that some GPs were dismissive and thought FMI was an inevitable consequence of ageing, thus influencing their decision not to make onward referral to secondary services.

It emerged that service delivery models were a determinant in the support older people with FMI and their family carers received. This was in the context of age-defined and ageless services. There were mixed views from HCPs and an older adult with FMI participant in this study about age-defined services, which appeared to be historical custom and practice. HCPs described how some of the older people with FMI expressed a sense of loss when being transferred to OAMH services. HCPs also were unable to access some services in the community once the person reached age 65.

In contrast, some HCPs felt there was benefit to a mixed-age model for in-patient care and described mutual support across the age groups from their experience. This view was not shared by one older adult participant who felt uncomfortable in the presence of younger people who may have comorbid substance misuse issues. It is unclear from this study - given the mixed views - if ageless or age-defined services are the best model to provide an enriched care environment for older people with FMI.

Relationship building emerged as a key determinant in how older people with FMI received support. Older people who received support from the CMHT realised they were equipped with interventions from HCPs to aid their recovery in the context of talking and conversation with their HCP. To HCPs this was far more complex and relationship building influenced their risk assessment and then how often they supported the person, and which interventions they undertook to aid their recovery.

Finally, it emerged that *managing everyday life in FMI* was a way that older people with FMI achieved self-recovery. HCPs furnished older people with FMI and their family carers with a number of interventions which enabled them to manage FMI in everyday life. Older people with FMI chose to use distraction techniques to stay well. They chose to use goal setting and CBT techniques to achieve recovery and HCPs found the WRAP a useful tool to achieve recovery.

Contribution to knowledge

Contribution of the findings of this study to understanding FMI and older people illuminate three significant considerations which help to illuminate experiences of older people with FMI. The connections between the *place* where people experience FMI and those who offer support, are linked to what is available in a local urban or rural context. This is also influenced by local and cultural norms such as stoicism and perceptions of risk and how acceptable older people view what is available to them. *Relationship building* emerged as important to the management and recovery of FMI. Taking time to build relationships was viewed as essential to HCPs who saw these as critical to interventions which would help them support older people with FMI. Although older people did not explicitly identify relationships per se, these findings illustrate where these are not established, such as in the inpatient setting, this impacted on recovery and perceptions around quality of care. Relationship building was also impacted by place and the use of telehealth and online resources. *Managing FMI in everyday life,* was a key outcome for older people, carers and HCPs. How people manage and live with FMI are components affecting how each older person experiences their recovery journey. HCPs in this study used a range of strategies and interventions to assist in this endeavour.

Combined these three concepts impact on decisions older people with FMI and their family carers, make about accessing mental health services. Likewise, these concepts influence HCPs decision making when planning interventions and delivering services. Therefore these key concepts help to provide an in-depth understanding of perceptions and experiences of FMI in older people within the context of this study. This alerts HCPs and service planners to the contextual importance of availability, acceptability, accessibility and quality issues in services for those experiencing and supporting FMI in older people.

Influences on the Decisions of Older People with FMI and Carers to seek Mental Health Support

In summary, the findings that have emerged from this study in relation to the influences on the decisions of older people with FMI and carers to seek mental health support are;

- Older people with FMI living in remote and rural areas may choose not to seek support for their mental health due to the distance they need to travel, stigma, stoicism, and independence. Furthermore, there may be acceptance that access to services in remote and rural areas is different to urban areas. This speaks to the individualised nature of the recovery journey.

- The remote and rural GP was considered to work differently than urban GPs. This was perceived by HCPs to be because of the established relationships GPs had with older people in their area. The GP input was perceived to prevent onward referral to secondary care.
- The referral pathway of GP as facilitator to secondary services (national model) influenced the support older people and family carers received for their mental health. Two older people reported challenges in receiving support from their GP (urban areas) for their mental health.
- HCPs perceived that age defined and ageless services were an influencing factor as services appeared to be less available for people over the age of 65.

Influences on the Decisions of Healthcare Professionals providing Support for Older People with FMI

- Place was an influencing factor for the method and frequency of support offered to older people with FMI. Face-to-face visits were spaced out with virtual support.
- Relationship building was a further influencing factor in the support HCPs offered to older people with FMI. Relationship building was pivotal in enabling HCPs to undertake a robust risk assessment of risk of harm and then determined the frequency of support required.
- Managing FMI in everyday life was a factor in how older people with FMI achieved self-recovery. HCPs furnished older people with FMI and their family carers with a number of interventions which enabled this.

8.6 Recommendations for Policy and Practice

This study highlights several recommendations to influence future policy and practice.

- Educators should highlight the benefits of relationship building to a person's recovery, and the importance of preparing healthcare professionals to undertake complex risk assessments.
- Commissioners and service designers should consider the impact place has on practice for older people with FMIs living in remote and rural areas compared to urban areas when designing services- in the context that services are designed for people based on need (Chapter 4; Section 4.3.2).
- HCPs should recognise that face-to-face first assessments contribute to relationship building with older people with FMI and their family carers, before virtual follow up by telehealth (Chapter 4; Section 4.3.1).
- Policymakers and service commissioners need to consider and establish pathways to support the needs of older people with FMI who are in crisis (Chapter 4; Section 4.3.1).
- HCPs to act as educators to older people with FMI and their family carers by highlighting the interventions they use to aid recovery such as; distraction techniques, goal setting and advanced preparation in the use of WRAP being beneficial in practice where managing FMI in everyday life (Chapter 4; Section 4.3.4).
- HCPs and service planners to consider the contextual importance of availability, acceptability, accessibility and quality issues in services for those experiencing and supporting FMI in older people.

8.7 Recommendations for Further Research

- Further research is required to understand the role of the remote and rural GP in managing FMI and the urban GP in managing FMI and what impact relationship building has on this.
- Further research is required in the context of managing FMI in everyday to understand the barriers (eg. some older people preferring medication rather than therapy) in older people with FMI engaging in psychological therapies.
- Further research is required to understand place in the context of how accessible services are, for older people with FMI living in remote and rural areas and how effective telehealth is in supporting their needs.

- Further research is required to understand place in the context of the learning from COVID-19 and the use of telehealth for support in contrast with face-to-face support with older people with FMI.
- Further research is required to understand age-defined and ageless services and how these services impact upon patient need, and person-centred care.
- Further research is required to understand any barriers to implementing relationship-centred care in the in-patient setting.

8.8 Dissemination of Findings

The findings of this study will be shared through journal articles, poster displays and presentations (an abstract has been submitted to the Magnet American Nursing Association conference) and a submission will be made to the UK Mental Health Research conference. These will be made accessible to older people with FMI, family carers and HCPs. Findings will also be disseminated to the Scottish Mental Health Lead Nurse group, and NHS Grampian's mental health strategic huddle and NES, in the absence of any national groups for older peoples' mental health.

8.9 Final Reflections

There is no doubt that undertaking a PhD whilst working full time has been challenging, then added to the mix, which no one could have predicted was the COVID-19 pandemic. Throughout these six years there have been frustrations, tears, and laughter. However, undertaking this study has taken me through such a journey of personal development that no other learning opportunity could have provided. I had a Masters before undertaking this study but was no way near equipped in an educational sense to undertake this level of study. However, with supervision, reading and dogged determination I have now produced a thesis.

This research apprenticeship has taught me how to undertake a robust review of and appraise literature. I have learnt about research methodologies and how to choose an appropriate research design. I have further learnt how to obtain ethical approval, how to sample participants and recruit. I have learnt how to code and theme data, then how to synthesise these data into meaningful concepts which have informed findings and developed knowledge. Importantly I learned I carry strong assumptions, and the importance of stepping back and reflecting on these assumptions. I would like to take this opportunity to again thank my supervisory team Prof C Kennedy, Dr H Bain, and Dr S Lee, for all that they have taught me, and for their patience.

At the outset of this study, I was convinced that age-defined services were damaging for older people. I now understand this was my perception and my assumption. For some this may be accurate, for others it may not be, and certainly was not raised by any older people within this study as an issue. What I have learned though is that there is always more to learn and the importance of recognising personal bias in the process of developing new knowledge.

This study has been thought provoking and I will change my clinical practice and influence my sphere of influence and leadership around the importance of relationship building. The lack of relationship building identified in the in-patient setting has made me reflect on my own experiences of working in a ward setting and, sadly, I can see this finding resonates with personal experience. This challenges the concept of what the specific contribution that in-patient mental health nursing makes in professional practice.

Finally, this study has gone some way to addressing the gap in research around older adults' mental health. Hopefully this work will inspire others to undertake research in this field which will develop practice, influence policy, and contribute to new knowledge.

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Appendices

Appendix 1: publication; integrative review

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REVIEW

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The experiences of older adults with a diagnosed functional mental illness, their carers and healthcare professionals in relation to mental health service delivery: An integrative review

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Abstract

Aims and objectives: To analyse the experiences of older people with a diagnosed functional mental illness and their carers in relation to mental health service delivery and analyse the experiences of health and social care professionals who care for and treat older people who have a diagnosed functional mental illness.

Background: The prevalence of functional mental illness in older adults is notable but to date has received less research attention than dementia. Older adults with functional mental illness have life expectancy of up to 20 years less than the rest of the population. Therefore, the experiences of older adults with functional mental illness, their carers and healthcare professionals, in relation to mental health services, need further exploration.

Design: Integrative literature review.

Methods: A five-stage process was informed by Whittemore and Knafl. MeSH was used. Keyword searches of MEDLINE, CINAHL, Cochrane Library, PsycINFO, EMBASE and AMED were conducted between January 2000–October 2017. Titles were screened, and data were extracted manually and analysed using narrative synthesis. The PRISMA checklist was used.

Results: A total of 342 articles were deemed potentially relevant to this review. Once inclusion and exclusion criteria were applied, 28 articles were included. The literature presented an overarching theme "determinants influencing older people with functional mental illness use of services." The overarching theme is supported by two main themes: inevitable consequences of ageing and variations of the availability of healthcare services for older people with functional mental illness.

Conclusion: Several determinants influence use of services by older people with functional mental illness. Older people with functional mental illness often perceived they did not have a mental health need. Within the literature, there was little

acknowledgement of the experiences of older people with functional mental illness regarding their support needs.

Relevance to clinical practice: This integrative review has highlighted that some older people with functional mental illness do not seek mental health support because they believe that functional mental illness is an inevitable consequence of ageing; this is mirrored at times by healthcare professionals and carers. In addition to this finding, different views prevail regarding the impact that ageless and age-defined mental health service delivery models have on the needs of older people with functional mental illness. Further research is required to understand these findings.

KEYWORDS

carers/families, functional mental illness, healthcare professionals, mental health services, mental illness, older adults, severe mental illness

1 | INTRODUCTION

In many healthcare systems around the world, mental illness in older adult mental health services is classified into two main groups: organic or functional mental illness (FMI; Collier, 2008). Organic mental illness is defined as a mental illness caused by a physical change in brain tissue; these changes are often degenerative in nature, as in dementia (Logsdon, 2018). In contrast, FMI is not degenerative in nature and encompasses illnesses such as depression, bipolar disorder, schizophrenia and anxiety disorders (Collier, 2008).

Worldwide, care and support for older people with FMI is primarily provided by informal carers such as spouses, family and friends (Broady & Stone, 2015). However, caregiving can have a negative impact on carers' own psychological and physical health (Mccann & Bamberg, 2016). This negative impact, termed "carer burden," can be exacerbated by needing to be available to the older person with FMI to provide support, monitor symptoms and navigate professional support when required, often at the cost of the carer's own health (Broady & Stone, 2015). Carers of people with FMI are reported to have a higher prevalence of depression (including feelings of guilt and sadness) in comparison with those who do not provide care for people with FMI (Mccann & Bamberg, 2016). Additionally, carers can experience feelings of loss and grief when caring for a person who was once independent in their role as the carer's spouse or parent (Mccann & Bamberg, 2016). Meeting the needs of older people with FMI is therefore important and significant.

Broady and Stone (2015) study in New Zealand illustrated that the caring role can also be a positive intervention, with carers describing experiences of love, support, fulfilment and a sense of achievement (Broady & Stone, 2015). Others describe how caring for a family member can provide a sense of purpose and fulfilment. Furthermore, providing care as a family member—as opposed to hiring a stranger—may be comforting, as highlighted by Mccann and Bamberg (2016) in their Australian study. A number of factors contribute to informal carers being the biggest source of care provision; these include an ageing population, increasing costs of care and limited availability of services.

What does this paper contribute to the wider global clinical community?

- Different views prevail regarding the impact that ageless or age-defined mental health delivery models for older adults with functional mental illness, and therefore, their impact upon need in this population group is ambiguous.
- This review illuminated that there are gaps in service delivery models and health and social care professionals' knowledge to support a holistic approach to health in older adults with functional mental illness.
- Older adults with functional mental illness may not perceive that they require support with their mental health, thus impacting on what support they access.

Worldwide, the ageing population is growing; in 2017, the global population of people aged over 60 was 582 million, and this figure is projected to almost double by 2050 (World Data Bank, 2016). This ageing population presents a major challenge to health and social care services, now and in the coming decades (Anderson, 2011). The growth of the ageing population seems to suggest that the incidence of FMI in older people will also increase, and for some illnesses, such as depression and anxiety, it certainly will. However, a dichotomy currently exists, as some older people with FMI (those with severe and enduring mental illness such as schizophrenia and bipolar disorder) have an expected life expectancy of up to 20 years shorter than the general population (WHO, 2018).

Worldwide, the number of people living with FMI in the general population is significant, and while this number is lower among older adults than younger ones, it is still notable and projected to increase in incidence (Anderson, 2011). Currently, FMI is estimated to affect one in four people in the general adult population and 15% of people aged over sixty worldwide (WHO, 2018). Globally, it is predicted that depression will be the leading cause of illness burden in older people by 2020 and will affect one in five people over 60, with severe depression expected to increase by 49% by 2026 (Royal College of Psychiatrists, 2018). Schizophrenia is estimated to affect 0.5% of the world's population aged over sixty (Loebach-Wetherell & Jeste, 2017), and anxiety disorders are reported to affect one in twenty older people (Royal College of Psychiatrists, 2018). As people with FMI become older, they are also more likely to develop a physical illness (Government UK, 2018).

Older people with FMI have complex needs. In addition to coping with specific symptoms relating to their FMI (including delusions, hallucinations and agitation), they are also likely to develop a physical comorbidity (Government UK, 2018). Reasons for this might be that some older adults with FMI are more likely to have experienced years of economic deprivation, poor diet, significant alcohol intake and heavy smoking (Government UK, 2018), all of which are contributory factors to their poor life expectancy and place this population at increased risk of diabetes, stroke, cardiac problems and vascular illness (Government UK, 2018).

In older adults with FMI, physical and mental health needs impact one another and rarely appear singularly (WHO, 2018). Generally, the physical health needs of an older adult present as general functional decline, accompanied by pain, physical frailty, sensory impairment and multiple medication use (WHO, 2018). These complex needs may inhibit the ability of an older person to seek appropriate support. Furthermore, the complexity of both physical and mental health needs poses a potential challenge to healthcare professionals who may work in silos, focusing on either physical or mental health (Hilton, 2010). This siloing may contribute to a potential lack of the skills and knowledge needed to holistically meet the needs of this population.

TABLE 1 Inclusion and exclusion criteria

Types of study
▪ Empirical research, including quantitative, qualitative and mixed-methods studies, was included in this review. ▪ Editorial, commentary, discussion, opinion papers and systematic reviews were excluded. ▪ Papers on dementia, substance misuse, eating disorders and alcohol use were excluded. Papers with a primary focus on physical health were also excluded.
Types of population/participant
▪ People aged over 65, with a diagnosed FMI, were included in this review. ▪ Carers/families aged 18 and above. Carers or family members are defined in this review as a person who provides unpaid care to another person (Broady & Stone, 2015). ▪ Healthcare professionals (including nurses, support workers, social workers, medical staff, allied health professionals and those working in third sector organizations) working in mental health service, for those aged over 65 who have a diagnosed FMI.

Care and treatment of older people with FMI can be offered across a spectrum of services, depending on the severity of the person's symptoms. While many older adults with mild symptoms of FMI will be managed by their physician, those with more severe and enduring symptoms, mainly psychosis or severe depression, are likely to need specialist mental health input in both hospital and community settings (Warner & Jenkinson, 2016). Given the ageing population, increasing costs and limited services, care for older people with FMI worldwide is primarily provided by family members and other informal carers (Broady & Stone, 2015).

Globally, little attention is paid to older adults with FMI and their carers, leading to a large research gap (McCormack & Skatvedt, 2017). In contrast, dementia has been a key priority in health and social care policy and in research internationally (Saad & Bangash, 2016). In 2014, The Glasgow Declaration called for a European dementia strategy that led to many European countries producing their own strategies. In contrast, there are no specific clinical guidelines relating to older adults with FMI. Therefore, the emergence of different service delivery models for older people with FMI has evolved with minimal supporting evidence. Therefore, this review fills an important gap: exploring the experiences of older people with FMI, their carers and healthcare professionals in relation to mental health services.

2 | AIMS

The aims of this integrative review were to (a) analyse the experiences of older people with a diagnosed FMI and their carers in relation to mental health service delivery and (b) analyse the experiences of health and social care professionals who care for and treat older people who have a diagnosed FMI.

Therefore, the following review questions were developed.

- What are the experiences of older people with FMI, their carers and healthcare professionals providing mental health services?
- How are the physical and mental health needs of older people with FMI, their carers and healthcare professionals identified and met?

3 | METHODS

A review protocol was registered with the International Prospective Register for Systematic Reviews (PROSPERO) 2017 CRD42017080576 (https://www.crd.york.ac.uk/prospero/export_record_pdf.php).

3.1 | Design

An integrative literature review was chosen because this approach encompasses diverse research designs, ensuring no research findings were excluded (Whittemore & Knafl, 2005). An integrative review can provide a holistic understanding of how older adults with

TABLE 2 MEDLINE search

MEDLINE Search: January 2000–October 2017		
Search	MeSH/Keywords	Hits
1.	(MH "Mental Disorders")	14,129
2.	(MH "Anxiety Disorders")	29,918
3.	(MH "Depressive Disorders")	67,442
4.	"serious mental illness"	2,881
5.	"psychotic illness"	1,274
6.	(MH "Personality Disorders")	19,145
7.	(MH "Schizophrenia")	92,954
8.	"functional mental illness"	17
9.	"mental illness"	25,627
10.	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9	340,268
11.	(MH "Patients")	19,099
12.	"clients"	31,478
13.	"carers"	10,048
14.	"clients"	31,478
15.	"service users"	3,578
16.	"older adult mental health"	40
17.	"older people"	17,202
18.	"family carers"	4,200
19.	"families"	211,899
20.	"family caregivers"	7,500
21.	" family carers"	66,700
22.	"healthcare professionals"	14,665
23.	11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22	322,697
24.	"old age psychiatry"	1,252
25.	"psychiatric services"	3,857
26.	(MH "Mental Health Services")	29,798
27.	"older adult mental health services"	12
28.	(MH "Community Mental Health Services")	17,720
29.	24 or 25 or 26 or 27 or 28	50,554
30.	10 and 23 and 29	2,667
31.	29 and (limit year 1 January 2000–30 October 2017; English Language)	420

FMI, their carers and healthcare professionals experience mental health services. The methodological approach includes five stages described by Whittemore and Knafl (2005): (a) problem identification, (b) literature search, (c) data evaluation, (d) data analysis and (e) presentation.

3.1.1 | Literature search

Search strategy

For the purpose of this integrative review, the focus was on FMI in older people (older than 65). Inclusion and exclusion criteria were applied (See Table 1). Six international electronic databases were searched: MEDLINE, CINAHL, Cochrane Library, PsycINFO, EMBASE, AMED and grey literature. Reference lists of included studies were scanned to identify articles that might be eligible for the review. MeSH and search terms were used (Table 2). The search was piloted in MEDLINE and adapted to other databases (Table 2).

The early part of the millennium saw key legislative reviews and the introduction of new legislative acts that impacted this population group; therefore, the search was limited to the years 2000–2017. The articles included were published in English and were from Europe, New Zealand, Australasia and North America. All articles were exported to RefWorks, allowing duplicates to be documented and then deleted. The Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) guided the audit trail (PRISMA checklist: See Supplementary File 1) (Moher, Liberati, & Tetzlaff, 2009).

Study selection

Two reviewers (JW and SHL) screened the titles and abstracts independently. The reviewers used Rayyan QCRI software (2018), which allows the process of screening titles and abstracts to be "blinded" to reviewers. Potential full texts were retrieved and assessed, and any doubts were discussed between the two reviewers. If agreement was not reached, then a third reviewer made the final decision (CK).

3.1.2 | Data evaluation and quality appraisal

Data were extracted using a predetermined format. Key information was extracted: the author, year, country of study, type of study design, aims of the study, characteristics of participants, methods of data collection, key stakeholders' experiences in relation to mental health service delivery and accessibility of mental health services for older people with FMI. Key findings were also documented. Data extraction forms were used to produce summary Table 3.

Quality appraisal of included studies

Qualitative and quantitative articles were appraised for quality using the recognized Critical Appraisal Skills Programme tools (CASP, 2017), and cross-sectional studies were appraised using the NHLBI (National Heart Lung Blood Institute) appraisal tool (2018). No mixed-method studies were yielded in this review. Appraisal of literature in this review was not intended to exclude articles on the basis of quality but rather to draw on all available evidence.

3.1.3 | Data analysis

Whittemore and Knafl (2005) suggest that data analysis be ordered, coded, categorised and summarised to allow the drawing of conclusions regarding the research problem. Therefore, the narrative synthesis framework by Popay et al. (2006) was used to theme data in this review; this approach was chosen because it can synthesize multiple studies by focusing on words and text (Popay et al., 2006). Using the framework of narrative synthesis, key findings were tabulated from a summary table (Table 3). Next, key findings were coded and grouped

TABLE 3 Evidence summary of included studies

Author, year and Country	Study design, data collection and method	Aim of the study	Participant characteristics/sample size/setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key findings	Quality Appraisal
Abdul-Hamid et al. (2016) UK	Quantitative (Cross-sectional survey) Assessment using Elderly Psychiatric Needs Schedule (EPNS)	To compare OAMH services with general psychiatric wards in relation to unmet need in over 65-year-olds	Older patients with functional psychiatric disorders (n = 74) Community Setting	Authors found unmet need higher in those patients in ageless services across all domains of the EPNS	Not discussed	Authors consider their findings to support models of ageless services	NIHBL Yes to all questions
Anderson and Lewis (2000) USA	Quantitative Completion of Quality of Life (QoL) psychometric properties	To examine the QoL in association with resident's characteristics who lived in an Intermediate Care Facility	People aged over 60 with Schizophrenia or Affective disorder (n = 100) Intermediate Care Facility	Poorer contact with family members and lower QoL than those living in a state hospital. Patients dissatisfied with their finances	Not discussed	People within an intermediate Care facility had lower QoL in all domains than those living in state hospital. Patients had financial dissatisfaction	CASP 10
Arean et al. (2007) USA	Quantitative Randomised Control Trial	To explore the use of mental health care by low income older adults	Patients aged 60 and over with a diagnosis of depression (n = 1,801) Multisites Primary care	An integrated model in primary care, including mental health practitioners improved the outcome for lower income people with depression. This was because of a lack of routine screening for depression in primary care	Not discussed	Integration of depression treatment into primary care improves use of service by low-income elders. Mental health practitioners screen for depression in a primary care service which would ordinarily be missed. Limitations Participants were not stratified and were volunteers perhaps with some biased opinion	CASP 9/10
Bawn et al. (2007) UK	Quantitative Survey	To investigate how CR110 (Royal College of Psychiatry Report) has influenced policies relating to the transfer of people with long-standing mental illness to older adult services	Health care professionals (n = 55) Community Setting	Adult services are better funded and have more MDT input. Services should be needs led and not age led. A noted lack of joint up working	Not discussed	Protocols regarding age transition were found to be beneficial. Services should be needs led not age led. Limitations: Patients/carers not asked about their experiences. Mangers consulted who with minimal patient contact	CASP 6/10

(Continues)

TABLE 3 (Continued)

Author, year and Country	Study design, data collection and method	Aim of the study	Participant characteristics/sample size/setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key findings	Quality Appraisal
Broady and Stone (2015) New Zealand	Quantitative Survey	To investigate carers experience of health and well-being of those who care for someone with a mental illness compared to those who care for someone who does not	Carers (n = 1,916) Community setting	Mental health carers paid less attention to their own health compared to other carers. Being a carer for someone with mental health likely to affect individuals own health and emotional burden	One in four carers was unable to access the support they needed, due to time constraints of caring role and cost implications. Carers were likely to experience barriers accessing services	Carers of people with mental health more likely to need support but less likely to access due to time and financial constraints. Carers experienced poor physical and mental health themselves. **Limitations:** Findings may be skewed by carers who are more willing to participate and may not be representative of general population. Age group of patients not provided	CASP 10/10
Byers et al. (2012) UK	Quantitative Survey	Survey of prevalence and key factors of non-use of mental health services in older adults	Adults aged 55 and over with a mood disorder (n = 348) Community setting	Many patients had chronic pain but perceived low need around mental health, leading to the belief that pain was psychosomatic	Vast majority of respondents with low mood or anxiety did not access services due to low perceived need, lack of motivation and moderate resources. People of ethnic origin were more likely not to seek support	Older people embarrassed to seek support for mental health. Perceived low need affected decision-making to seek support and people of ethnic origin less likely to seek support. **Limitations:** Depressive symptoms may be secondary and therefore not a true representation	CASP 9/10
Clancy and Baldwin (2008) UK	Quantitative Comparative study	Comparative study of older people living in their own home and care homes	Older adults with Schizophrenia (n = 23) Community	Individuals living in care homes have higher levels of symptomology such as medical comorbidity and negative symptoms of Schizophrenia and are far less likely to be independent with activities of daily living	Not discussed	Those living in care homes had more positive and negative symptoms o Schizophrenia. Those living in care homes were less independent with activities of daily living	CASP 8/10

(Continues)

TABLE 3 (Continued)

Author, year and Country	Study design, data collection and method	Aim of the study	Participant characteristics/sample size/setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key findings	Quality Appraisal
Crabb and Hunsley (2006) USA	Quantitative Survey	Comparison of mental health service use by middle-aged adults and older adults	People aged 45–64 (n = 35,958) Aged 65–74 (n = 12,788) 75 years and older (n = 10,578) Community setting	Perceived self resilience, inner strength and resilience	Older people with physical comorbidity were more likely to seek help from mental health services The older the person, the less likely they are to seek mental health support from specialist services	Adults aged 65 and over are less likely to seek support for depression than those aged 45–64 In all age groups people more likely to approach a physician about depression than a psychiatrist. **Limitations:** Wide sample group of where people live	CASP 8/10
Cummings (2009) USA	Quantitative Descriptive and experimental design Assessments on depression and life satisfaction	To explore the need and unmet need in older adults with severe mental illness	People with severe mental illness aged 65 and over (n = 75) Community setting	70% of participants did not receive the support they needed. Those with physical needs relied heavily on families to support them People received more support for their mental health than physical needs	Not discussed	Patients were far less likely to experience assistance with both physical and mental health needs. Limited assistance with financial matters. **Limitations:** The findings cannot be generalised as the study focused on CMHT only	CASP 8/10
Fulford and Farhall (2001) Australia	Quantitative Questionnaire	To explore the experiences of carers in relation to care during acute psychosis	Carer of a person with SMI (n = 77) Community and hospital setting	The majority of participants preferred hospital care compared to assertive outreach. Carers felt less burden from managing the illness and felt there was less chance of relapse	Not discussed	Proportion of caregivers who prefer assertive outreach to hospital admission is less than thought. **Limitations:** Low response rate and patient views not explored	CASP 7/10
Holvast et al. (2012) Holland	Quantitative cohort study	The study identifies and analyses factors that determine whether older people with depression receive treatment or not	Older people aged 65 and over (n = 167) Primary care	Not discussed	70% of people with depression saw their physician almost exclusively compared to specialist services. Most people sought help for their mental health from their physician	Older people and their physicians think depression is a normal part of ageing. **Limitations:** Urbanised areas over-represented	CASP 10/10

(Continues)

TABLE 3 (Continued)

Author, year and Country	Study design, data collection and method	Aim of the study	Participant characteristics/sample size/setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key findings	Quality Appraisal
Houtjes et al. (2011) Holland	Quantitative Cross-sectional survey	To gain insight into the unmet needs of outpatients with late-life depression	Patients (n = 99) Carers (n = 96) Healthcare professionals (n = 85)	Patients had a higher perception of unmet need that their healthcare professionals did. Carers and patients had different perceptions on unmet need. Patient staff contact was felt to be insufficient	Not discussed	Patient's depression severity correlated with their unmet need. Patients, carers and healthcare professionals all had different perceptions around unmet need. Limitations: Patients with severe depressive disorder underrepresented	NIHLB Yes all questions
Karlin and Norris (2006) USA	Quantitative Data collected from CARE system	To investigate the extent to which older (60+) versus younger (18–59) adults begin treatment in the public mental health sector in relation to psychotherapy	People aged 18 and over (n = 12,810) Community setting	Urban consumers less distressed than those in rural areas	Older adults were more likely to access services when they were cost-free	Only 5% of the population using mental health services were aged over 65. Older adults more likely to use services when they are free. Limitations: Data were collected retrospectively Ethnic groups over-represented	CASP 8/10
Mackenzie et al. (2006) Canada	Quantitative Questionnaire	To explore age and gender attitudes towards seeking professional and psychological help and to examine whether attitudes negatively influence intentions to seek help among older adults	Men (n = 105) Women (n = 95) Community	Not discussed	People preferred to speak to a friend and then their physician rather than specialist services. Older people found it easier to speak to their physician about their mental health compared to younger people	Men viewed mental health as weakness which affected their decisions to seek support. Older peoples find it easier to access mental health services than perhaps other studies suggest. Limitations: Data collection took place at a train station, perhaps missing the population of people with mental illness	CASP 8/10

(Continues)

TABLE 3 (Continued)

Author, year and Country	Study design, data collection and method	Aim of the study	Participant characteristics/sample size/setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key findings	Quality Appraisal
Mackenzie et al. (2010) USA	Quantitative Survey	To examine sociodemographic and mental health correlates of whether older adults sought professionals help, perceived the need for help without seeking it and sought help from mental health professionals	People aged 55 and over (n = 3,017) Community	Not discussed	Perception of need was a significant barrier in accessing mental health services. Majority of people want to sort the problem themself and only 16% of older people sought specialist help, preferring to see their physician	Older people did not perceive they had a mental health need and wanted to be self-sufficient. Limitations: Questionnaire does not include help-seeking perceptions, therefore findings cannot be generalised	CASP 8/10
Mackenzie et al. (2008) USA	Quantitative National comorbidity survey	To compare older adults' attitudes and beliefs to younger adults' and to examine the influence of age on these variables after controlling for other demographic variables, prior help-seeking and mental disorders	Community dwelling people (n = 5,692 Adults aged 65 and over (n = 1,341) Community	Age was a significant factor in people's willingness to seek professional help as it was in relation to concern if a friend found out that they needed help. Younger adults also had more positive beliefs about the effectiveness of mental health services. There was no difference in younger people compared to older people in terms of beliefs about treatment effectiveness	80% had a positive help-seeking experience in terms of attitudes. However, the person's age had a significant bearing on professional help seeking with those over 65 less likely to seek help	Older Americans do not have negative help-seeking attitudes or negative beliefs about the efficacy of treatment for mental health problems. 80% of adults aged 55 and older had positive attitudes, and more than 70% had positive treatment beliefs. Results also show that older adults' attitudes are positive relative to younger adults'. Limitations: The study only focused on community living people, and therefore, those in hospital's views were not sought	CASP 8/10
Mccann and Bamberg (2016) Australia	Qualitative Semistructured interviews	To explore caregivers' experience of the way public mental health nurses and other mental health clinicians responded to them as carers of older adults with mental illness	Carers of people with mental illness aged 65 and over (n = 30) Community	Generally, clinicians were viewed as supportive. However, carers felt their contribution was undervalued by clinicians and they felt left out of decision-making. Failure to provide culturally appropriate meals	Carers expressed not getting enough help, lack of information	Carers felt uninvolved in decision-making about their relatives care. They generally felt undervalued, not involved and that poor care was delivered. Limitations: Recruitment from carers who are well engaged with a service may not reflect the views of people not so well engaged	CASP 9/10

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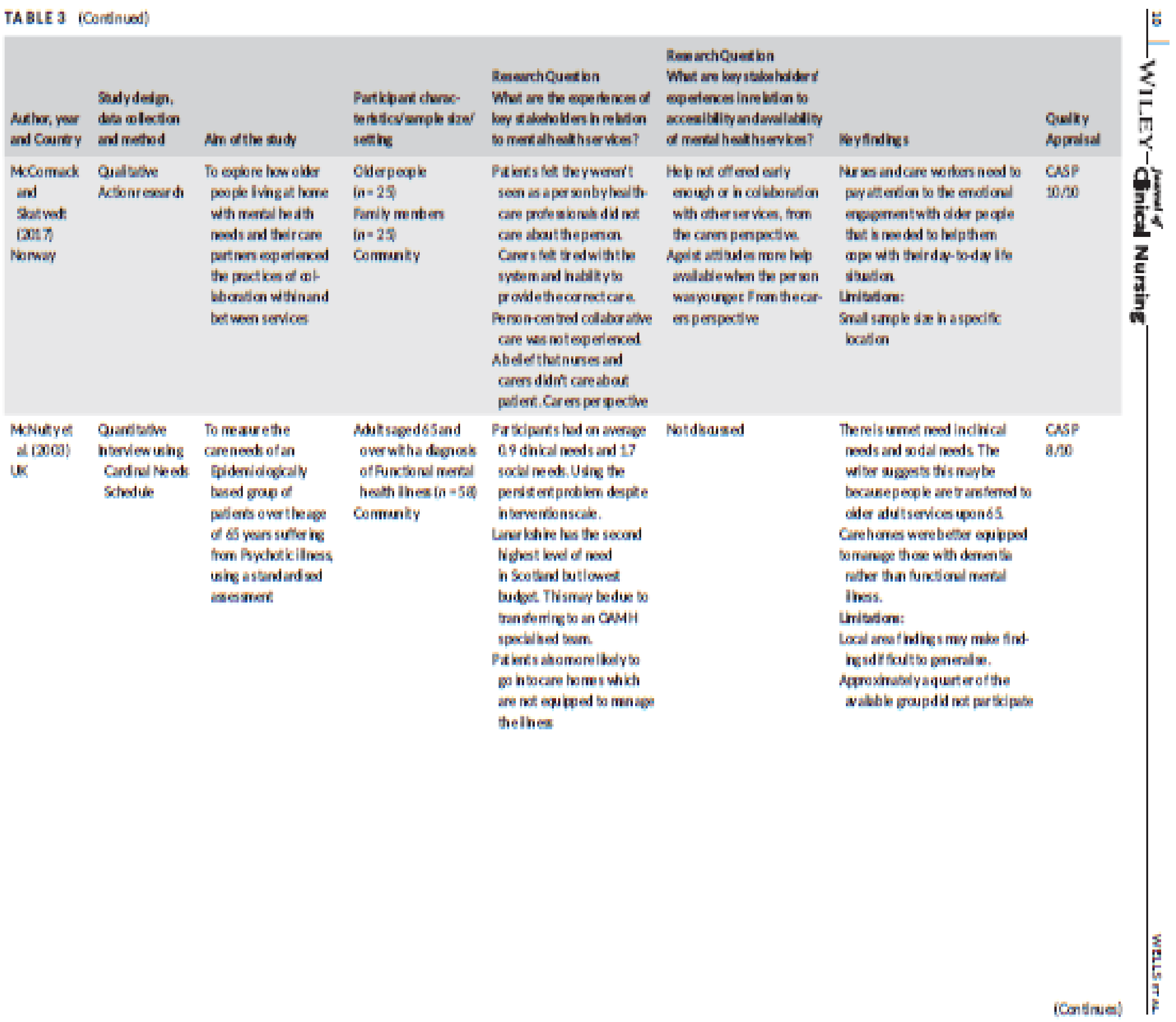

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McCormack and Skatvedt (2017) Norway	Qualitative Action research	To explore how older people living at home with mental health needs and their care partners experienced the practices of collaboration within and between services	Older people (n = 25) Family members (n = 25) Community	Patients felt they weren't seen as a person by health-care professionals did not care about the person. Carers felt tired with the system and inability to provide the correct care. Person-centred collaborative care was not experienced. A belief that nurses and carers didn't care about patient. Carers perspective	Help not offered early enough or in collaboration with other services, from the carers perspective. Ageist attitudes more help available when the person was younger. From the carers perspective	Nurses and care workers need to pay attention to the emotional engagement with older people that is needed to help them cope with their day-to-day life situation. Limitations: Small sample size in a specific location	CASP 10/10
McNulty et al. (2003) UK	Quantitative Interview using Cardinal Needs Schedule	To measure the care needs of an Epidemiologically based group of patients over the age of 65 years suffering from Psychotic illness, using a standardised assessment	Adults aged 65 and over with a diagnosis of Functional mental health illness (n = 58) Community	Participants had on average 0.9 clinical needs and 1.7 social needs. Using the persistent problem despite intervention scale. Lanarkshire has the second highest level of need in Scotland but lowest budget. This may be due to transferring to an OAMH specialised team. Patients also more likely to go into care homes which are not equipped to manage the illness	Not discussed	There is unmet need in clinical needs and social needs. The writer suggests this may be because people are transferred to older adult services upon 65. Care homes were better equipped to manage those with dementia rather than functional mental illness. Limitations: Local area findings may make finding difficult to generalise. Approximately a quarter of the available group did not participate	CASP 8/10

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TABLE 3 (Continued)

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Molyneux et al. (2008) Ireland	Quantitative Cross-sectional study	This study assessed the prevalence of depression, the level of carer burden/strain, and the problems experienced by the carers of patients referred to Psychiatry of Old Age Service	Carers of people referred to an OAMH service (n = 100) Community	Spouses had less identified need and burden, hypothesis for this is it is expected of their role to care for their spouse	Not discussed	Patient's diagnosis did not affect carer strain; carers who cared for people with depression experienced the same amount carer burden. Many carers caring for a person are also depressed. Limitations: The use of the Geriatric Depression Scale may not reveal the severity of depressive symptoms. Low sample group in each illness domain	NIHLB Yes to all questions
Morrow-Howell et al. (2000) USA	Quantitative Data from medical records collected	This study explores need to reflect a biopsychosocial approach to mental illness including mental, psychosocial and functional need	Older people hospitalised with depression (n = 169) Post acute care	Unmet physical and psychosocial need affect the mental health outcome of carers	Not discussed	Older adults admitted to hospital for depression have extraordinary levels of need across the domains of a biopsychosocial model. This illustrates the complexities of older adults in terms of experiencing physical illness at the same time as mental illness	CASP 8/10
Muir-Cochrane et al. (2014) Australia	Qualitative Semistructured interviews	This study explored the views of health and social care providers of the barriers to effective mental health care for older people in a rural region	Older people aged 65 and over (n = 19) Community	Older people showed reluctance in recognising they had a need for help. Carers focused on the needs of the person and neglected themselves	Participants felt services were not available and had difficulties getting appointments with their physician and mental health services. There was a feeling mental health services were stretched, and therefore, there was no capacity when people needed them. Transport posed a difficulty to frailer people. Having to go via a physician to access referral to specialist service was seen as a barrier	Older people are not accessing services for reason's including ageism, lack of appropriate service, fear of loss of independence and Financial constraints. There is a perception from professionals that Depression is a natural part of ageing. Limitations: Recruitment area very specific in geographical area. Illness types not defined	CASP 9/10

(Continues)

TABLE 3 (Continued)

Author, year and Country	Study design, data collection and method	Aim of the study	Participant characteristics/sample size/setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key findings	Quality Appraisal
Nelson and Park (2006) Canada	Quantitative Survey	This study was to shed light on the magnitude and underlying reasons for perceived unmet mental health needs and their relation to gender and age	People using mental health services across all age spans (n = 13,814). People aged 65 and over (n = 2,752) Community Health Services	Younger age groups reported more unmet need than older people. Because older people were more accepting of their need. Younger adults were more likely to report barriers to accessing services, including cost and lack of transport	Not discussed	People over 65 are eight times less likely to have unmet need compared to 15- to 24-year-olds. However, the study did not explore if older people had a perceived need. Limitations: Perceived need was not explored which may skew findings	CASP 8/10
Palinkas et al. (2007) USA	Qualitative Semistructured interviews	To explore unmet need in older adults with mental illness in San Diego	Phase 1: Care providers (n = 23) Older people (n = 16) Care givers (n = 19) Phase 2 Care providers (n = 18) Older people (n = 50) Caregivers (n = 39)	Many older people will not access services for fear of stigma of losing their independence. A lack of understanding of older people's needs was felt along with an ageist attitude. Depression is viewed as a natural part of ageing. There is a lack of resource for caregivers of older adults	A lack of accessibility of age appropriate services, older people don't fit into general services. Lack of information on follow-up. Financial constraints if people do not have insurance. Lack of affordable transportation	Older people are not accessing services for reason's including ageism, lack of appropriate service, fear of loss of independence and Financial constraints There is a perception from professionals that Depression is a natural part of ageing. Limitations: Recruitment area very specific in geographical area. Illness types not defined	CASP 8/10
Préville et al. (2010) Canada	Quantitative (Cross-sectional study) Survey	To document the use of mental health services by older people in Quebec and any unmet need	Older people (n = 2,784) Community setting	Not discussed	Those living in urban or rural area more likely to seek help than people from the inner city. Most sought help via a physician who referred onto specialist service. Unmarried people more likely to seek services. 57% of people who would have met a Diagnostic Statistical Manual V diagnosis did not seek help from services	57% of older people who meet diagnostic criteria for mental illness are not seeking the help they need and therefore there is significant unmet need in this population. Limitations: Findings were self-reported and therefore may be biased regarding the patients attitude at the time of the study	CASP 10/10

(Continues)

TABLE 3 (Continued)

Author, year and Country	Study design, data collection and method	Aim of the study	Participant characteristics/sample size/setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key findings	Quality Appraisal
Robb et al. (2003) USA	Quantitative Survey	To explore older people's perception of mental health care in comparison with younger people	Adults aged 65 and over (n = 474) Adults aged <65 (n = 1,001) Community setting	No difference in satisfaction scores between younger and older adults in relation to mental health services. Older people were less knowledgeable about the services available. Younger people were more open to the idea that they need to do things to improve their own mental health	Younger people almost twice as likely to have seen a mental health practitioner. Younger people stated they had better access compared to older people. Lack of insurance and cost both seen as barriers to accessing services in both age groups	Older adults less likely to use services than younger people. Older adults less confident in their knowledge about services available. Older adults less likely to have insurance coverage. Limitations: The older population was affluent and well educated which may not be true of a more generalised population	CASP 10/10
Sarkin et al. (2015) USA	Quantitative Survey	The study explores how age, gender and ethnicity and mental health diagnosis contribute to stigma for those using mental health services	People with FMI (n = 1,237) Community	As age increased people felt less discriminated against. This was only a marginal finding with younger people perceiving they experienced more discrimination	Not discussed	Older people experienced marginally less stigma. Limitations: Age breakdown findings are only discussed generally	NIHLB Yes all questions
Simning et al. (2010) USA	Quantitative Interviews to collect data on Goldberg Anxiety Scale, The Patient Health Questionnaire, and Service utilisation	To explore mental distress of and help-seeking utilisation of older people in a community setting	People aged 60 and over (n = 378) Community	Individuals who were distressed used more than one service. Likelihood of a distressed individual seeing a mental health professional was significantly higher than a nondistressed individual	Not discussed	People who were distressed had more contact with services, and therefore may be effective at reducing admission. Limitations: Participants were from a single area and the findings cannot be generalise	CASP 10/10

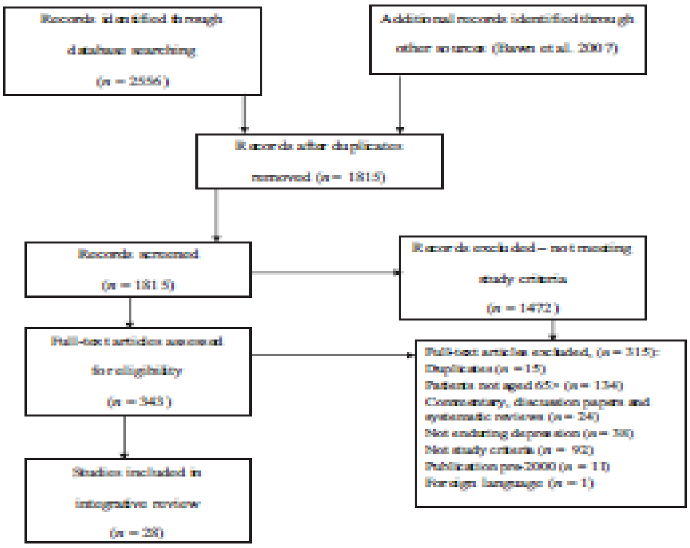

FIGURE 1 PRISMA checklist

into similar concepts by the PhD student. These concepts were then checked and refined via reflective discussion at supervision, thus ensuring the validity and reliability of results by minimizing any potential bias of the reviewers. This process ultimately led to the development of one overarching theme and two main themes.

4 | RESULTS

4.1 | Search results

The search yielded a total of 2,556 articles. In total, 741 of these articles were duplicates, resulting in 1,815 titles and abstracts being screened. A total of 342 articles (PRISMA flow chart: Figure 1) were identified as potentially relevant to the literature review question. The inclusion and exclusion criteria were then applied to the 342 articles remaining; this revealed 27 articles that were considered relevant for this review. One additional appropriate paper (Bawn, Benbow, Jolley, Kingston, & Taylor, 2007) was revealed by screening the reference lists of included articles. No articles were included from the grey literature. Therefore, 28 studies were included in this review.

4.2 | Study characteristics

There were 23 quantitative studies and five qualitative studies. Thirteen studies were conducted in the USA (n = 13), with the rest conducted in the UK (n = 5), Canada (n = 3), Australia (n = 2), Holland (n = 2), Ireland (n = 1), Norway (n = 1) and New Zealand (n = 1).

4.3 | Study quality

The overall quality of the included studies appeared to be moderate. Of the five qualitative studies, four did not discuss the relationship between the researcher and participants, and in two studies, ethical considerations were not documented. Of the five cross-sectional studies, all aspects of the appraisal tool were met.

4.4 | Themes

Thematic analysis of the literature illuminated an overarching theme: "determinants influencing the use of services among older people with FMI." This overarching theme illustrates a number of factors that influence this population's decisions whether to use mental health services. The theme "inevitable consequence of ageing" highlights that older adults with FMI often do not access mental health services because they perceived their FMI needs as related to the ageing process. This perspective was shared by family carers and healthcare professionals. Other factors, including stigma and ageism, were also found to influence the use of services by older adults with FMI.

The second theme, "variations in availability of healthcare services for older people with FMI," highlights that the cost and availability of services may influence older people to seek support for their mental health needs. This theme also highlighted that service delivery models may influence a healthcare professional's decision-making when offering support.

4.4.1 | Inevitable consequences of ageing

Seventeen studies (eleven quantitative and six qualitative) supported the theme "inevitable consequences of ageing." These studies were from the USA (*n* = 8), Australia (*n* = 2), Holland (*n* = 2), the United Kingdom (*n* = 1), Ireland (*n* = 1), New Zealand (*n* = 1), Canada (*n* = 1) and Norway (*n* = 1).

4.4.2 | Perceived need

The literature yielded in this review illustrated that perceived need was a factor influencing what support and mental health services older people with FMI received. Nine studies from two countries (USA *n* = 7; Holland *n* = 2) illustrated that older people with FMI and their healthcare professionals share the perception that mental health needs decline as people age. Mackenzie, Pagura, and Sareen (2010), in their quantitative study, demonstrated that 47.1% of older people (*n* = 5,017) were less likely to perceive that they had a mental health need compared to younger people. Crabb and Hunsley (2006) demonstrated that low perceived need in older people correlated with lower use of mental health services, with those aged over 65 (*N* = 28,864) found to be half as likely to seek mental health support compared to those aged 45–64 (*N* = 55,958).

Cummings (2009), in a study of (*n* = 75) older people, found that 70% felt they did not receive the support they required for their mental health and therefore had unmet needs in relation to chronic illness, functional disability (with impairment in four or more activities of daily living) and decreased social support, including home care. Houtjes, Meijel, Deeg, and Beekman (2011) suggest this situation occurs because mental health needs are not always discussed by healthcare professionals during assessments in specialist services. This finding was corroborated by Muir-Cochrane, O'Kane, Barkway, Oster, and Fuller (2014), who revealed that older people and their carers shared the perception that healthcare professionals believed older people's mental illnesses were due to dementia and therefore overlooked.

Several studies revealed that physicians can see depression as an inevitable consequence of the ageing process (Arean, Gum, Tang, & Unutzer, 2007; Holvast et al., 2012; Muir-Cochrane et al., 2014; Palinkas et al., 2007). Arean et al. (2007) conducted a randomised controlled trial of older people (*n* = 1,801), examining older adults' use of mental healthcare. Within this study, collaborative care for depression was compared with the usual care for depression in primary care. This study illustrated that physicians generally did not routinely screen for depression in older adults, which resulted in under-treatment of depressive symptoms. Muir-Cochrane et al. (2014) demonstrated that healthcare professionals focused more on the physical needs of older people rather than their mental health needs.

Another factor in the reluctance of older people to seek attention for FMI was that healthcare professionals did not always recognize that older people with FMI required mental health support, even when the healthcare professional was a specialist mental healthcare professional (psychiatrist, community mental health nurse or psychologist; Houtjes et al., 2011).

Two studies revealed that older people with FMI often do not recognize that they have a mental health need (Mackenzie et al., 2010; Muir-Cochrane et al., 2014). Muir-Cochrane et al. (2014) explored health and social care barriers for older people with mental health issues in rural Australia. These studies do not specify why older people with FMI often fail to recognize that they need support. However, Crabb and Hunsley (2006) propose that older people with FMI often felt that younger people were more in need of services than they were.

Several studies have identified that the use of mental health services decreases as people age (Crabb & Hunsley, 2006; Mackenzie, Scott, Mather, & Sareen, 2008). Holvast et al. (2012) found that people aged over 65 were less likely to seek mental health services than younger people because they used their social support networks instead. Mackenzie's et al. (2008) study revealed similar findings; they examined the variables between older people and younger people who sought mental health services and found that people aged over 75 were four times less likely to seek mental health services than those aged between 65–74.

In contrast, two studies found that older people were more likely to use mental health services than their younger counterparts. Mackenzie et al. (2008) surveyed adults in community living (*N* = 5,692) on the attitudes of younger people compared to older people (*N* = 1,541) and their use of mental health services. They found that 80% of older adults were more likely than younger people to access mental health services. Another study by Nelson and Park (2006) found that older people had fewer unmet mental health needs and experienced fewer barriers when accessing services compared to younger people. This study demonstrated that most people who experienced unmet needs did so because they preferred to manage their needs themselves.

4.4.3 | Stigma

The literature included in this review highlighted that stigma influenced the decision-making of older people with FMIs when they considered seeking mental health support or services. Three American studies (Byers, Arean, & Yaffe, 2012; Crabb & Hunsley, 2006; Mackenzie, Gekoski, & Knox, 2006) illustrated that older people with FMI were more forthcoming in seeking support for their FMI if they had a comorbid physical illness. Crabb and Hunsley (2006) revealed that the tangible aspects of physical ill health were often easier for older people with FMI to recognize (examples include diabetes, chronic cardiovascular disorders and chronic pain). However, the study failed to address whether it was a physical or mental health condition that propelled them to seek support from a physician or whether the mental health issue was secondary to their physical illness.

Four studies from a range of countries (Canada *n* = 1; Holland *n* = 1; USA; *n* = 2) found that older people with FMI preferred to see their physician rather than specialist services about their mental health, particularly about psychological distress (Préville et al., 2010; Holvast et al. 2012; Crabb & Hunsley, 2006; Mackenzie et al., 2010). Older people with FMI found it easier to confide in their physician about their mental health needs compared to a mental healthcare professional; this decision largely stemmed from the stigma that older people projected onto mental health services (Mackenzie et al., 2010).

Byers et al.'s (2012) study found that physical health conditions correlated with higher use of mental health services in older people. Crabb and Hunsley (2006) found that 95% of older people seeking support from mental health services were found to have co-existing medical comorbidity. People who experienced cardiovascular illness, chronic pain or any medical condition were far more likely to seek mental health support because they had the tangible reason of physical ill-health accompanying their less-tangible mental health needs (Byers et al., 2012; Crabb & Hunsley, 2006).

Several studies highlighted that stigma and ageism were determinants of the usage of mental health support in older people with FMI (Byers et al., 2012; McCormack & Skatvedt, 2017; Muir-Cochrane et al., 2014; Palinkas et al., 2007). Byers et al.'s (2012) study revealed that some older people with FMI reported being embarrassed to discuss their mental health needs and therefore did not access mental health services. Furthermore, some older people with FMI did not access mental health services out of concern that their friends might find out (Muir-Cochrane et al., 2014). Muir-Cochrane et al. (2014) found that access to mental health services can be associated with stigma; this was sometimes perceived as a generational issue, with an apparent lack of understanding regarding mental health in the older age group.

A number of studies found that older people with FMI want to remain self-sufficient, independent and self-reliant as well as be seen as resilient (Byers et al., 2012; Crabb & Hunsley, 2006; Muir-Cochrane et al., 2014). In addition, older people took pride in their ability to manage and wanted to be perceived by others as stoic (Muir-Cochrane et al., 2014). However, this sense of pride had a negative impact; Byers et al.'s (2012) study found that 70% of older people were embarrassed to acknowledge that they needed help. Older men in particular viewed seeking mental health support as a sign of weakness (Muir-Cochrane et al., 2014).

Another barrier to seeking support could be that people of some ethnic origins are less likely to seek help for their mental health needs (Byers et al., 2012); one explanation is that they might be uncomfortable discussing mental health needs, which they view as personal problems, with healthcare professionals. In contrast, Sarkin et al. (2015) found that older people (*n* = 1,257) felt less stigmatised than younger people and were therefore more likely to access mental health services. That study focused on people living in San Diego, which may offer some explanation for these diametric findings. However, it was the only paper to use a validated tool (the stigma scale) when assessing stigma.

4.4.4 | Ageism

This review illustrated that ageist attitudes, or perceived ageist attitudes, from health and social care professionals influenced the decisions of older people with FMIs regarding accessing mental health services or mental health support. Some older people with FMI perceived ageist attitudes among healthcare professionals and reported that they had experienced ageism (McCormack & Skatvedt, 2017; Palinkas et al., 2007). Ageism is defined by Palinkas et al. (2007) as negative attitudes towards older people from service providers, and it has influenced older people's desire to seek mental health support (Palinkas et al., 2007). Healthcare professionals also reported a lack of available mental health services appropriate for older people (Bawn et al., 2007; Muir-Cochrane et al., 2014; Palinkas et al., 2007). Muir-Cochrane et al. (2014) suggest that services for older people are set up to meet physical needs and do not focus on mental health. Bawn et al. (2007), in a UK survey, reported that there is less financial investment in older adult services compared to ageless services, meaning there are fewer services available to older people with FMI.

A study by McCormack and Skatvedt (2017) explored the experiences of older people with FMI who received mental health services and had carers living at home. This study highlighted that some family carers perceived that their loved ones did not always receive the standard of mental healthcare that they expected from mental health nurses. In a qualitative study, Mccann and Bamberg (2016) aimed to understand the lived experiences of carers of older people with FMI (aged over 60 (*n* = 50)); it was reported that older people and their carers expected mutual respect with their healthcare professionals, which they did not always perceive.

4.4.5 | Impact of caring

The literature gathered in this review highlighted that older people with FMI rely heavily upon family carers for mental health support and that family carers play an important role. However, playing that role heavily impacted the health of family carers. Cummings (2009) found that 75% of older people with FMI had to rely heavily on their family members for support with their physical needs and highlighted that family carers are often a main and essential source of care for older people with FMI. One study illustrated that family members were expected by society to support their older relatives with their mental health needs (Broady & Stone, 2015). This expectation was heightened if the carer was a spouse, as support was considered to be part of the marital role (Molyneux, McCarthty, McEniff, & Cryan, 2008). Some family carers expressed that healthcare professionals were unaware of the impact that their caring role had on their own health (Muir-Cochrane et al., 2014). Other family carers reported that their caring role impacted their own mental and physical health; some had depressive symptoms that increased the need for prescribed medication as a means to cope with their caring role (Broady & Stone, 2015). Healthcare professionals often focused on the needs of the older person with FMI and did not consider the carer's needs and how the caring role affected their health (Muir-Cochrane et al., 2014).

Evidence gathered under this theme identified several factors considered to be inevitable consequences of ageing that impacted the use of services by older people with FMI. For example, older people with FMI often did not perceive that they had a mental health need and strove to remain independent in their daily living, and men in particular viewed support for mental health as a sign of weakness. Stigma and ageist attitudes were a deterrent to seeking support among older people with FMI. Older people found it easier to confide in their physicians about their mental health, using the guise of a physical health need. However, support from physicians was not always available, as many viewed FMI as an inevitable consequence of ageing. Finally, there was an identified societal expectation that older people would receive support for mental health from their family, particularly a spouse. The caring role often impacted the health of the caregiver, who might receive little support when performing their caring role.

4.4.6 | Variations in the availability of healthcare services for older people with FMI

Eighteen papers relating to this theme were identified: fifteen were quantitative and three qualitative. The studies were conducted in the USA (*n* = 10), UK (*n* = 3), Canada (*n* = 2), New Zealand (*n* = 1), Australia (*n* = 1) and Norway (*n* = 1).

4.4.7 | Affordability

This review found that the affordability of mental health services influenced the decision to seek support not only by older people with FMIs but also by their family carers. Four studies from two countries reported that the cost of mental health services was an influencing factor in service usage by older people with FMI (USA *n* = 3; New Zealand *n* = 1). Two studies found that older people were often unable to afford medical insurance, which in turn affected the mental health services they could access (Broady & Stone, 2015; Karlin & Norris, 2006).

An American survey conducted by Karlin and Norris (2006) of people aged over 18 (*n* = 12,810) revealed that only 5% of older adults accessed mental health services. The authors attributed this finding to older people often being financially restricted, lacking healthcare insurance and being unable to fund the services they required. This finding is corroborated by Pallinkas et al. (2007) and (*n* = 16) and Robb's , Haley, Becker, Polivka, and Chwa (2003) studies of older people (*n* = 474), which also found that older people are less likely than younger people to have healthcare insurance.

Broady and Stone (2015) discovered that financial restrictions affected not only older people with FMI but also their carers. That study demonstrated that only one in four carers accessed the support they need to effectively deliver their caring role. Carers' decisions to access services were affected by the cost implications, with many not having medical insurance due to reduced income from being retired. Furthermore, the caring role itself was time-consuming, and carers often simply did not have time to access services because their time was occupied with caring for their family member (Broady & Stone, 2015).

4.4.8 | Accessibility

The literature analysed in this review highlighted that a number of issues affected the accessibility of mental health services and their use by older people with FMI. One such issue was poor knowledge regarding available services and referrals to mental health services by a physician. Two studies from the USA found that accessing mental health services was more challenging for older adults with FMI compared to younger people, who are more adept at identifying their needs (Byers et al., 2012; Mackenzie et al., 2010), as, according to Byers et al. (2012), older people received insufficient information about mental health services. This finding was also highlighted by Robb et al. (2003), who discovered that older adults were found to be less confident in their knowledge about the services available to them in comparison with their younger counterparts, and this was a barrier to accessing support.

Older people with FMI also faced challenges in accessing mental health services, as they often found they had to be referred by their physicians to specialist mental health services, which they perceived as a barrier to accessing specialist support (Muir-Cochrane et al., 2014). However, in primary care services that had an integrated mental healthcare professional (such as a Community Mental Health Nurse or Psychologist), the experience for the older person was reported to be more positive because these healthcare professionals would assess for FMI and make referrals to the appropriate specialist services (Arean et al., 2007). Another barrier to accessing specialist mental health services, identified in Australia, was that older people with FMI felt that some local mental health services were unable to meet their mental health needs because they were already stretched and at full capacity (Muir-Cochrane et al., 2014). With contrasting findings, a study by Nelson and Park (2006) examined unmet need in Ontario in people aged 65+ (*n* = 2,752) and in people aged 15–64 (*n* = 10,482); they report that older people have fewer unmet needs than younger people: older people accessed support, whereas younger people reported challenges around the availability of services (professionals unavailable in area, professionals unavailable when required and waiting times being too long).

4.4.9 | Availability

This review illustrated that the availability of mental health services affected their use by older people with FMI. Factors influencing the availability of services related to where people lived and models of care for older people with FMI. Two studies highlighted that the availability of community support was dependent on where an individual lived (Karlin & Norris, 2006; Préville et al., 2010); people who lived in metropolitan areas were far less likely to seek mental health support from services in comparison with those who lived in metropolitan urban/rural areas, as those living in metropolitan areas had more social support (Karlin & Norris, 2006). Furthermore, older people with FMI who lived with a spouse were far less likely to access support than older people who lived alone (Préville et al., 2010); however, the study offered no explanation for its findings.

A study by Simning et al. (2010) of older people (n = 578) explored the use of a dedicated depression care management team in primary care. The study revealed that people who were distressed by their FMI symptoms were far more likely to see a mental healthcare professional. Another model of mental healthcare explored was assertive outreach (where a community mental health team will provide intensive support to a person who is acutely unwell in the community). This model was found to be less favourable to carers who lived with the person with FMI, who experienced more carer burden with this model of care (Fulford & Farhall, 2001).

This review highlighted that different models of hospital care exist, and some mental health services are ageless in contrast to others that are age-defined (where a person is automatically transferred to an older person's service at 65; Abdul-Hamid, Lewis-Cole, Holloway, & Silverman, 2016). Abdul-Hamid et al. (2016) undertook a UK cross-sectional survey of 74 older people with FMI. The study aimed to compare the unmet need of older adults with FMI who were cared for in age-defined and ageless services. They concluded that older people with FMI who were cared for in ageless services were found to have a significant unmet need in relation to medication management, domestic life and transport issues. Abdul-Hamid et al.'s (2016) findings are supported by Palinkas et al.'s (2007) study and a study by Morrow-Howell, Proctor, Rubin, Li, and Thompson (2000), who focused on the needs of (n = 169) older people with depression postacute care, across psychosocial, medical, functional and psychiatric needs. That study revealed that healthcare professionals working in an ageless service lacked the knowledge and skills to assess older people with FMI with regard to physical comorbidities.

By contrast, two UK studies concluded that ageless services were better equipped to meet the needs of older people with FMI. A survey by Bawn et al. (2007) of mental healthcare professionals (n = 55) revealed that age-defined mental health services have fewer multidisciplinary provisions than ageless services. Another UK quantitative study of older people with FMI (n = 58) conducted by McNulty, Duncan, Semple, Jackson, and Pelosi (2003) aimed to measure the care needs of people aged over 65 with schizophrenia using a standardised tool. That study reports that when older adults were transferred to age-defined services, there was an increase in their unmet clinical and social needs (psychotic symptoms, financial needs and social life).

Older adults with FMI who live in care homes also experienced challenges relating to their mental health needs (McNulty et al., 2003). Clancy and Baldwin's (2006) UK, comparative study of older people with FMI (n = 28) adds weight to McNulty et al.'s (2003) contentions that older adults with schizophrenia in care homes have more concomitants and higher needs in relation to their activities of daily living in comparison with those living in their own homes. These needs were thought to be related to the negative symptoms (apathy, social withdrawal, lack of emotion) of the illness and the high prevalence of physical comorbidity. However, Clancy and Baldwin (2006) do not elaborate on which physical comorbidities participants in this study actually had. In this case, the needs of older adults with FMI were overshadowed by the needs of their counterparts who had dementia, and care-home staff were better trained to care for the latter (Anderson et al., 2010; McNulty et al., 2003).

This review has illustrated that there are a number of variations in the availability of healthcare services, influencing the use of services by older people with FMI. In countries where health services are not free, cost was identified as a significant determinant of the use of services. However, the evidence suggests that service delivery models have an impact on the unmet needs of older people with FMI, with two studies concluding that ageless services reduce unmet needs. Some of the barriers to accessing mental health support were related to the referral process to specialist mental health services, variations in community support and service delivery models. In care homes, healthcare professionals were found to have more knowledge surrounding dementia, which resulted in symptoms of FMI in older people being overlooked. This review has identified a gap in current research exploring the experiences of older people with FMI regarding support and whether the services available meet the needs of this population. Furthermore, little is known about what influences health and social care professionals' decisions to provide support for older people with FMI. Finally, this review revealed that few studies have explored the experiences of family members who care for older people with FMI.

5 | DISCUSSION

The aim of this integrative review was to synthesise the findings of all available studies that explored the perceived experiences of older adults with FMI, their family carers and healthcare professionals in mental health service delivery. The review yielded 28 studies that have been summarised into one overarching theme, "determinants influencing the use of services by older adults with FMI," and two main themes: "The inevitable consequences of ageing" (which included stigma and ageism) and "Variations in availability of healthcare services for older people with FMI." The relevance of these findings is significant and has implications for policy, education and future research.

5.1 | Policy implications

Findings from this review highlighted that older people with FMI are less likely to access mental health services than younger people

(Byers et al., 2012; Mackenzie et al., 2010; Robb et al., 2003). This review also illustrated that there may be a hidden population of older people with FMI who are invisible to mental health service providers (Holvast et al., 2012; Mackenzie et al., 2008). Thus, government and health surveillance agencies need to collect accurate data on the prevalence of this population group as it correlates with the use of mental health services. These data must be dissected, analysed and interpreted nationally by policymakers and service providers to ensure equitable mental healthcare provision for this population group in the UK (Anderson, 2011).

This review also illustrated that while different models of service delivery exist for older people with FMI, these models do not always embrace a holistic approach to care. Internationally, there is inconsistency in service delivery models for people with mental illness (WHO, 2018), with an assortment of ageless and age-defined services. For older adults with FMI within the European Union, only six countries (UK, Switzerland, Romania, Slovakia, Ireland and Czech Republic) recognise older adult mental health services as a subspeciality of psychiatry. Across continental Europe, care and treatment are predominantly delivered in ageless services for people with mental illness across hospital and community settings by healthcare professionals with generalist mental health knowledge.

Different views prevail as to whether ageless mental health services should exist (European Union of Medical Specialities, 2018) or whether age-defined services should be offered to all by staff who are equipped to deal with physical complexities, such as pain and physical frailty, alongside FMI (Abdul-Hamid et al., 2016). There is consensus that community services are the desired model of delivery for mental health services (European Union of Medical Specialities 2018).

Warner and Jenkison (2015) defend the need for specialist older adult mental health services and surveyed 76 OAMH services in the UK; 52% of respondents viewed the erosion of specialist older adult mental health services as detrimental to older people with FMI due to the social, psychological and physiological complexities that accompany old age. In contrast, Bawn et al. (2007) suggest that older people with FMI are disadvantaged by specialist OAMH services due to a lack of investment in such services. Anderson (2011) suggests that providing older people with the same level of mental health services as younger people, based on need, would cost approximately £2 billion a year, which is one-seventh of the NHS budget. With an ageing population, this level of spending is not achievable. Therefore, new models of mental health service delivery for older people with FMI need to be urgently explored by service commissioners and providers to ensure that models of care meet the needs of the population in an equitable, achievable way.

5.2 | Education implications

This integrative review has highlighted that changes are needed in the education of health and social care professionals in order to develop a holistic approach to treating older people with FMI (Abdul-Hamid et al., 2016; Morrow-Howell et al., 2000; Palinkas et al., 2007). Support is therefore needed from educational institutes and healthcare systems to help health and social care professionals understand and deliver a more holistic model of care that focuses on both the physical and mental health needs of older people (Abdul-Hamid et al., 2016; Morrow-Howell et al., 2000; Palinkas et al., 2007). This integrative review demonstrated that some general physicians lack a holistic approach when treating older people, as there is only a 50% recognition rate of depression in this population group (Holvast et al., 2012). The impact is that older people with FMI often have unmet physical and mental health needs (Cummings, 2009). Inadequate detection and treatment of FMI in older people represents a serious threat to this population's quality of life and functioning (Crabb & Hunsley, 2006). Among health and social care professionals and general practitioners, improved knowledge of screening and assessment for FMI in older people would improve the diagnosis of FMI and in turn facilitate support (Arean et al., 2007; Muir-Cochrane et al., 2014).

5.3 | Research implications

Most studies in this integrative review used a quantitative approach (*n* = 28). Few authors have explored the experiences of older people with FMI, their carers and healthcare professionals in the in-depth way that qualitative research fosters. Therefore, regarding mental health services, there is a gap in current research exploring the views and perspectives of older people with FMI, their carers and healthcare professionals. It is argued that in healthcare, it is important to understand diverse perspectives to shape service delivery in a way that is optimal for recipients (Brookes, 2007). Further research using a case study approach is needed to gain an in-depth understanding of what determinants influence the use of mental health services by older people with FMI. In addition, there is a need to identify best practices in relation to models of care for older people with FMI.

6 | LIMITATIONS AND STRENGTHS OF THE REVIEW

The strengths of this integrative review are that it has yielded relevant international studies that reflect the experiences of older adults with FMI as well as their lay and professional carers in mental health service delivery. This review used a robust, transparent approach and involved at least two reviewers at all stages.

One limitation of this review is that the topic range is quite broad; therefore, synthesis of the literature was challenging, as the findings were general. In addition, the review did not consider health beliefs related to the ageing process or explore how the onset or duration of mental illness affected perceptions of and access to mental health services. Furthermore, many of the quantitative study designs of the included studies used surveys, with only one randomised controlled trial. Finally, studies published in foreign languages were excluded; therefore, vital information may have been missed.

7 | CONCLUSION

Several determinants influence the use of mental health services by older adults with FMI. Older people themselves consider FMI to be an inevitable consequence of ageing; this perception is mirrored by their carers and healthcare professionals. This assumption, in turn, influences the decision to seek support; likewise, it influences healthcare professionals' decision-making in offering mental health support.

In countries where services are not free, cost affected decisions about whether to access support. Other determinants of the use of services by older people with FMI were stigma and ageism. Older people with FMI reported that they experienced ageism from healthcare professionals, and they themselves stigmatised mental health problems. In the UK, a paradox exists in mental health service delivery models with the introduction of the Equality Act, which led to some mental health services adopting ageless services and others maintaining specialists in services for those over 65. The introduction of this act has addressed issues of direct discrimination against older people but may inadvertently also be causing indirect discrimination (Warner & Jenkinson, 2013).

This integrative review has highlighted that there is limited evidence exploring the experiences of older people with FMI with regard to support and whether the mental health services available meet their needs. Furthermore, little is known about what influences health and social care professionals' decisions to provide support for older people with FMI. Finally, this review revealed few studies exploring the experiences of family carers of older people with FMI. It is essential that these gaps in evidence be addressed to allow commissioners and health services to address the needs of this population group.

8 | RELEVANCE TO CLINICAL PRACTICE

This integrative review adds to the current body of knowledge by illustrating that there are a number of determinants influencing the use of mental health support by older people, who are not currently accessing the mental health services they require. However, there is a lack of current research informed by the perspectives of older people with FMI, their family carers and health and social care professionals. Therefore, further research is required and should use a qualitative approach to gain an in-depth understanding of what determinants influence the use of mental health services by older people with FMI. In addition, there is a need to identify best practices through further research in relation to models of care for older people with FMI. Finally, a holistic perspective should be used by health and social care professionals who assess older people to ensure that their mental and physical health needs are fully considered.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

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Appendix 2: Medline Search Strategy

MEDLINE Search: January 2000–October 2017		
No.	**Search MeSH/Keywords Hits**	**Number of hits**
1.	(MH “Mental Disorders”)	14,129
2.	(MH “Anxiety Disorders”)	29,918
3.	(MH “Depressive Disorders”)	67,442
4.	“Serious Mental Illness”	2,831
5.	“Psychotic Illness”	1,274
6.	(MH “Personality Disorders”)	19,145
7.	(MH “Schizophrenia”)	92,954
8.	“Functional Mental Illness”	17
9.	“Mental Illness”	25,627
10.	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9	340,263
11.	(MH “Patients”)	19,099
12.	“Clients”	31,478
13.	“Carers”	10,048
14.	“Service Users”	3,578
15.	“Older Adult Mental Health”	40
16.	“Older People”	17,202
17.	“Family Carers”	4,200
18.	“Families”	211,899
19.	“Family Caregivers”	7,500
20.	“Healthcare Professionals”	14,665
21.	11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20	322,697

22.	“Old Age Psychiatry”	1,252
23.	“Psychiatric Services”	3,857
24.	(MH “Mental Health Services”)	29,798
25.	“Older Adult Mental Health Services”	12
26.	(MH “Community Mental Health Services”)	17,720
27.	22 or 23 or 24 or 25	50,554
28.	10 and 21 and 27	2,667
29.	October 2017; English Language)	420

Appendix 3: Summary of Studies- The Experiences of Older Adults with a Diagnosed Functional Mental Illness, their Family Carers and Healthcare Professionals in Relation to Mental illness

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
Abdul-Hamid et al. (2016). UK.	Quantitative (Cross-sectional survey). Assessment using Elderly Psychiatric Needs Schedule (EPNS).	To compare OAMH services with general psychiatric wards in relation to unmet need in over 65 year olds.	Elderly patients with functional psychiatric disorders (*n*=74). Community Setting.	Authors found unmet need higher in those patients in ageless services across all domains of the EPNS.	Not discussed.	Authors consider their findings to support models of ageless services.	NIHBL Yes to all questions.

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
Anderson and Lewis (2000). USA.	Quantitative. Completion of Quality of Life (QoL) psychometric properties.	To examine the QoL in association with residents characteristics who lived in an Intermediate Care Facility.	People aged over 60 with Schizophrenia or Affective disorder (*n*=100). Intermediate Care Facility.	Poorer contact with family members and lower QoL than those living in a state hospital. Patients dissatisfied with their finances.	Not discussed.	People within an Intermediate Care facility had lower Qol in all domains than those living in state hospital. Patients had financial dissatisfaction.	CASP 10
Arean et al. (2007). USA.	Quantitative. Randomised Control Trial.	To explore the use of mental health care by low-income older adults.	Patients aged 60 and over with a diagnosis of depression (*n*=1801). Muti-sites Primary care.	An integrated model in primary care, including mental health practitioners improved the outcome for lower income people with depression. This was because of a lack of routine screening for depression in primary care.	Not discussed.	Integration of depression treatment into primary care improves use of service by low-income elders. Mental health practitioners screen for depression in a primary care service which would ordinarily be missed.	CASP 9/10

Author, Year & Country	**Study Design, Data Collection and Method**	**Aim of the Study**	**Participant Characteristics / Sample Size / Setting**	**Research Question** **What are the experiences of key stakeholders in relation to mental health services?**	**Research Question** **What are key stakeholders' experiences in relation to accessibility and availability of mental health services?**	**Key Findings**	**Quality Appraisal**
						Limitation Participants were not stratified and were volunteers perhaps with some biased opinion.	
Bawn et al. (2007). UK.	Quantitative. Survey.	To investigate how CR110 (Royal College of Psychiatry Report) has influenced policies relating to the transfer of people with long standing mental illness to older adult services.	Healthcare professionals (*n*=55). Community Setting	Adult services are better funded and have more MDT input. Services should be needs led and not age led. A noted lack of joinedup working.	Not discussed.	Protocols regarding age transition were found to be beneficial. Services should be needs led not age led. **Limitations** Patients/carers not asked about their experiences. Mangers consulted who with minimal patient contact.	CASP 6/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
Berry et al. (2020). UK.	Semi structured interviews.	The aim of this study is to explore specific barriers encountered by older people with SMI where accessing psychological therapies.	Healthcare professionals (*n*=20), older people with SMI (*n*=22) and family carers (*n*=11). Primary, secondary and tertiary settings.	Younger peoples' needs appeared to be prioritised over older people. Fears amongst older people with SMI that therapy may open old wounds. Older people associated stigma with mental health services.	Older people with SMI fall in-between the gaps of primary and secondary care. Medication was seen as a quick fix as opposed to psychological therapies. Therapies were more likely to be accessed if a professional known to the patient explained it.	Older people with SMI face considerable challenges where trying to access Psychological therapies. This in part was due to the stigma that older people have about mental health. **Limitations:** Limited range over service user diagnosis and ethnic diversity. Large population size large for a qualitative study.	CASP 7/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
Broady and Stone (2015). New Zealand.	Quantitative. Survey.	To investigate carers experience of health and wellbeing of those who care for someone with a mental illness compared to those who care for someone who does not.	Carers (*n*=1916). Community setting.	Mental health carers paid less attention to their own health compared to other carers. Being a carer for someone with mental health likely to affect individuals own health and emotional burden.	One in four carers were unable to access the support they needed, due to time constraints of caring role and cost implications. Carers were likely to experience barriers accessing services.	Carers of people with mental health more likely to need support but less likely to access due to time and financial constraints. Carers experienced poor physical and mental health themselves. **Limitations** Findings may be skewed by carers who are more willing to participate and may not be representative of general population. Age group of patients not provided.	CASP 10/10
Byers et al. (2008).	Quantitative. Survey.	Survey of prevalence and key factors of non use	Adults aged 55 and over with a	Many patients had chronic pain but perceived low need	Vast majority of respondents with low mood or anxiety did	Older people embarrassed to seek support for mental health. Perceived low need	CASP 9/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
UK.		of mental health services in older adults.	mood disorder (*n*=348). Community setting.	around mental health, leading to the belief that pain was psychosomatic.	not access services due to low perceived need, lack of motivation and moderate resources. People of ethnic origin were more likely not to seek support.	affected decision making to seek support and people of ethnic origin less likely to seek support. **Limitations** Depressive symptoms may be secondary and therefore not a true representation.	
Clancy and Baldwin (2008). UK.	Quantitative. Comparative study.	Comparative study of older people living in their own home and care homes.	Older adults with Schizophrenia (*n*=23). Community.	Individuals living in care homes have higher levels of symptomology such as medical co-morbidity and negative symptoms of Schizophrenia and are far less likely to be independent with activities of daily living.	Not discussed.	Those living in care homes had more positive and negative symptoms of Schizophrenia. Those living in care homes were less independent with activities of daily living.	CASP 8/10

Author, Year & Country	**Study Design, Data Collection and Method**	**Aim of the Study**	**Participant Characteristics / Sample Size / Setting**	**Research Question** **What are the experiences of key stakeholders in relation to mental health services?**	**Research Question** **What are key stakeholders' experiences in relation to accessibility and availability of mental health services?**	**Key Findings**	**Quality Appraisal**
Crabb and Hunsley (2006). USA.	Quantitative. Survey.	Comparison of mental health service use by middle aged adults and older adults.	People aged 45 - 64 (*n*=35,958). Aged 65-74 (*n*=12,788). 75 years and older (*n*=10,576). Community setting.	Perceived self - resilience, inner strength and resilience.	Older people with physical co-morbidity were more likely to seek help from mental health services. The older the person, the less likely they are to seek mental health support from specialist services.	Adults aged 65 and over are less likely to seek support for depression than those aged 45-64. In all age groups people more likely to approach a physician about depression than a psychiatrist. **Limitations** Wide sample group of where people live.	CASP 8/10
Cummings (2009). USA.	Quantitative. Descriptive and experimental design. Assessments on depression	To explore the need and unmet need in older adults with severe mental illness.	People with severe mental illness aged 65 and over (*n*=75). Community setting.	70% of participants did not receive the support they needed. Those with physical needs relied heavily on families to support them.	Not discussed.	Patients were far less likely to experience assistance with both physical and mental health needs. Limited assistance with financial matters.	CASP 8/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
	and life satisfaction.			People received more support for their mental health than physical needs.		**Limitations** The findings can't be generalised as the study focused on CMHT only.	
Fulford and Farhall (2001). Australia.	Quantitative. Questionnaire.	To explore the experiences of carers in relation to care during acute psychosis.	Carer of a person with SMI (*n*=77). Community and hospital setting.	The majority of participants preferred hospital care compared to assertive outreach. Carers felt less burden from managing the illness and felt there was less chance of relapse.	Not discussed.	Proportion of care givers who prefer assertive outreach to hospital admission is less than thought. **Limitations** Low response rate and patient views not explored.	CASP 7/10
Frost et al. (2020). UK.	Semi structured interviews.	To explore frail older peoples' needs and their experiences of anxiety and depression and how services	Older people (*n*=28). Community setting.	Social factors contributed to low mood, causing feelings of hopelessness about treatment.	Older people considered low mood was normal and therefore had low expectations about	Psychology referral rates for older people are lower than expected.	7/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
		adapted to meet their needs.			what support they should get. Formal mental health care was only considered for people with severe symptoms. Independence was key for older people and influenced their decision to seek support negatively. Some support was only delivered virtually which some	Frail older people tend to only seek support when mental health symptoms are severe. **Limitations:** No specific data on therapies, low response rate from people in care homes.	

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
					older people could not access.		
Holvast et al. (2012). Holland.	Quantitative. Cohort study	The study identifies and analyses factors that determine whether elderly people with depression receive treatment or not.	Older people aged 65 and over (*n*=167). Primary care.	Not discussed.	70% of people with depression saw their physician almost exclusively compared to specialist services. Most people sought help for their mental health from their physician	Elderly people and their physicians think depression is a normal part of ageing. **Limitations** Urbanised areas over represented.	CASP 10/10
Houtjes et al. (2011). Holland.	Quantitative Cross sectional survey.	To gain insight into the unmet needs of outpatients with late life depression.	Patients (*n*=99) Carers (*n*=96) Healthcare professionals (*n*=85)	Patients had a higher perception of unmet need than their healthcare professionals did. Carers and patients had different perceptions on unmet need.	Not discussed.	Patients depression severity correlated with their unmet need. Patients, carers and healthcare professionals all had different perceptions around unmet need.	NIHLB Yes all questions

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
				Patient to staff contact was felt to be insufficient.		**Limitations** Patients with severe depressive disorder under represented.	
Karlin and Norris (2006). USA.	Quantitative. Data collected from CARE system.	To investigate the extent to which older (60+) versus younger (18-59) adults begin treatment in the public mental health sector in relation to psychotherapy.	People aged 18 and over (*n*=12,810). Community setting.	Urban consumers less distressed than those in rural areas.	Older adults were more likely to access services when they were cost-free.	Only 5% of the population using mental health services were aged over 65. Older adults more likely to use services when they are free. **Limitations** Data was collected retrospectively. Ethnic groups overrepresented.	CASP 8/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question **What are the experiences of key stakeholders in relation to mental health services?**	Research Question **What are key stakeholders' experiences in relation to accessibility and availability of mental health services?**	Key Findings	Quality Appraisal
Mackenzie et al. (2006). Canada.	Quantitative. Questionnaire.	To explore age and gender attitudes towards seeking professional and psychological help and to examine whether attitudes negatively influence intentions to seek help amongst older adults.	Men (*n*=105). Women (*n*=95). Community.	Not discussed.	People preferred to speak to a friend and then their physician rather than specialist services. Older people found it easier to speak to their physician about their mental health compared to younger people.	Men viewed mental health as weakness which affected their decisions to seek support. Older people find it easier to access mental health services than perhaps other studies suggest. **Limitations** Data collection took place at a train station, perhaps missing the population of people with mental illness.	CASP 8/10
Mackenzie et al. (2010). USA	Quantitative. Survey.	To examine sociodemographic and mental health correlation of whether older adults sought professionals help,	People aged 55 and over. (*n*=3017). Community.	Not discussed.	Perception of need was a significant barrier in accessing mental health services. Majority of people want to sort the problem them self	Older people did not perceive they had a mental health need and wanted to be self-sufficient. **Limitations**	CASP 8/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
		perceived the need for help without seeking it and sought help from mental health professionals.			and only 16% of older people sought specialist help, preferring to see their physician.	Questionnaire does not include help-seeking perceptions, therefore, findings cannot be generalised.	
Mackenzie et al. (2008). USA.	Quantitative. National co-morbidity survey.	To compare older adults' attitudes and beliefs to younger adults' and to examine the influence of age on these variables after controlling for other demographic variables, prior help-seeking, and mental disorders.	Community dwelling people. (*n*= 5692). Adults aged 65 and over (*n*=1341). Community.	Age was a significant factor in peoples willingness to seek professional help, as it was in relation to concern if a friend found out that they needed help. Younger adults also had more positive beliefs about the effectiveness of mental health services.	80% had a positive help-seeking experience in terms of attitudes. However, the person's age had a significant bearing on professional help-seeking with those over 65 less likely to seek help.	Older Americans do not have negative help-seeking attitudes or negative beliefs about the efficacy of treatment for mental health problems. 80% of adults aged 55 and older had positive attitudes, and more than 70% had positive treatment beliefs. Results also show that older adults' attitudes are positive relative to younger adults. **Limitations**	CASP 8/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
				There was no difference in younger people compared to older people in terms of beliefs about treatment effectiveness.		The study only focussed on community living people, and therefore those in hospitals views were not sought.	
McCann et al. (2016). Australia.	Qualitative. Semi structured interviews.	To explore caregivers' experience of the way public mental health nurses and other mental health clinicians responded to them as carers of older adults with mental illness.	Carers of people with mental illness aged 65 and over (*n*=30). Community.	Generally, clinicians were viewed as supportive. However, carers felt their contribution was undervalued by clinicians and they felt left out of decision making. Failure to provide culturally appropriate meals.	Carers expressed not getting enough help, lack of information.	Carers felt uninvolved in decision making about their relative's care. They generally felt undervalued, not involved and that poor care was delivered. **Limitations:** Recruitment from carers who are well engaged with a service may not reflect the views of people not so well engaged.	CASP 9/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
McCormack and Skatvedt (2017). Norway.	Qualitative. Action research.	To explore how older people living at home with mental health needs and their care partners experienced the practices of collaboration within and between services.	Older people. (*n*= 25). Family members. (*n*= 25). Community.	Patients felt they weren't seen as a person by healthcare professionals who did not care about the person. Carers felt tired with the system and inability to provide the correct care. Person-centred collaborative care was not experienced. Family perspective: A belief that nurses and carers didn't care about patient.	Help not offered early enough or in collaboration with other services, from the carers perspective. Ageist attitudes more help available when the person was younger- from the carers perspective.	Nurses and care workers need to pay attention to the emotional engagement with older people needed to help them cope with their day-to-day life situation. **Limitations:** Small sample size in a specific location.	CASP 10/10
McNulty et al. (2003).	Quantitative.	To measure the care needs of an Epidemiologically based group of	Adults aged 65 and over with a diagnosis of functional	Participants had, on average, 0.9 clinical needs and 1.7 social needs. Using the persistent problem	Not discussed.	There are unmet clinical needs and social needs. The writer suggests this may be because people are	CASP 8/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
UK.	Interview using Cardinal Needs Schedule.	patients over the age of 65 years suffering from Psychotic illness, using a standardised assessment.	mental health illness (*n*=58). Community.	despite intervention scale. Lanarkshire has the second highest level of need in Scotland but lowest budget. This may be due to transferring to an OAMH specialised team. Patients also more likely to go into care homes which are not equipped to manage the illness.		transferred to older adult services upon 65. Care homes were better equipped to manage those with dementia rather than functional mental illness. **Limitations:** Local area findings may make findings difficult to generalise. Approximately one quarter of the available group did not participate.	
Molyneux et al. (2008).	Quantitative.	This study assessed the prevalence of depression, the level of carer	Carers of people referred to an OAMH	Spouses had less identified need and burden Hypothesis for this is, it is expected of	Not discussed.	Patient diagnosis did not affect carer strain; carers who cared for people with depression experienced the	NIHLB Yes to all questions.

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
Ireland.	Cross sectional study.	burden / strain, and the problems experienced by the carers of patients referred to Psychiatry of Old Age Service.	service (*n*=100). Community.	their role to care for their spouse.		same amount of carer burden. Many carers caring for a person are also depressed. **Limitations:** The use of the Geriatric Depression Scale may not reveal the severity of depressive symptoms. Low sample group in each illness domain.	
Morrow - Howell et al. (2000). USA.	Quantitative. Data from medical records collected.	This study explores need to reflect a bio -psychosocial approach to mental illness including mental,	Older people hospitalised with depression (*n*=169)., Post-acute care.	Unmet physical and psychosocial need affects the mental health outcome of carers.	Not discussed.	Older adults admitted to hospital for depression have extraordinary levels of need across the domains of a bio-psychosocial model.	CASP 8/10

Author, Year & Country	**Study Design, Data Collection and Method**	**Aim of the Study**	**Participant Characteristics / Sample Size / Setting**	**Research Question** **What are the experiences of key stakeholders in relation to mental health services?**	**Research Question** **What are key stakeholders' experiences in relation to accessibility and availability of mental health services?**	**Key Findings**	**Quality Appraisal**
		psychosocial and functional need.				This illustrates the complexities of older adults in terms of experiencing physical illness at the same time as mental illness.	
Muir et al. (2014). Australia.	Qualitative. Semi structured interviews.	This study explored the views of health and social care providers of the barriers to effective mental health care for older people in a rural region.	Older people aged 65 and over. (*n*=19). Community.	Older people showed reluctance in recognising they had a need for help. Carers focused on the needs of the person and neglected themselves.	Participants felt services were not available and had difficulties getting appointments with their physician and mental health services. There was a feeling mental health services were stretched and therefore there was no capacity when people needed them.	Older people are not accessing services for reason's including: ageism, lack of appropriate service, fear of loss of independence and financial constraints. There is a perception from professionals that depression is a natural part of ageing.	CASP 9/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
					Transport posed a difficulty to frail people. Having to go via a physician to access referral to specialist service was seen as a barrier.	**Limitations:** Recruitment area very specific in geographical area. Illness types not defined.	
Nelson and Park (2006). Canada.	Quantitative. Survey.	This study was to shed light on the magnitude and underlying reasons for perceived unmet mental health needs and their relation to gender and age.	People using mental health services across all age spans (*n*=13,814). . People aged 65 and over. (*n*= 2752).	Younger age groups reported more unmet need than older people. Older people were more accepting of their need. Younger adults were more likely to report barriers to accessing services, including cost and lack of transport.	Not discussed.	People over age 65 are eight times less likely to have unmet need compared to 15–24-year-olds. However, the study did not explore if older people had a perceived need. **Limitations:** Perceived need was not explored which may skew findings.	CASP 8/10

Author, Year & Country	**Study Design, Data Collection and Method**	**Aim of the Study**	**Participant Characteristics / Sample Size / Setting**	**Research Question** **What are the experiences of key stakeholders in relation to mental health services?**	**Research Question** **What are key stakeholders' experiences in relation to accessibility and availability of mental health services?**	**Key Findings**	**Quality Appraisal**
			Community Health Services.				
Palinkas et al. (2007). USA.	Qualitative. Semi-structured interviews.	To explore unmet need in older adults with mental illness in San Diego.	<u>Phase 1:</u> Care providers. (*n*=23). Older people. (*n*=16). Care givers. (*n*=19). <u>Phase 2:</u> Care providers. (*n*=18). Older people. (*n*=50).	Many older people will not access services for fear of stigma of losing their independence. A lack of understanding of older peoples needs was felt along with an ageist attitude. Depression is viewed as a natural part of ageing. There is a lack of resource for care givers of older adults.	A lack of accessibility of age appropriate services, older people don't fit into general services. Lack of information on follow up. Financial constraints if people do not have insurance. Lack of affordable transportation.	Older people are not accessing services for reasons including: ageism, lack of appropriate service, fear of loss of independence and financial constraints. There is a perception from professionals that Depression is a natural part of ageing. **<u>Limitations:</u>**	CASP 8/10

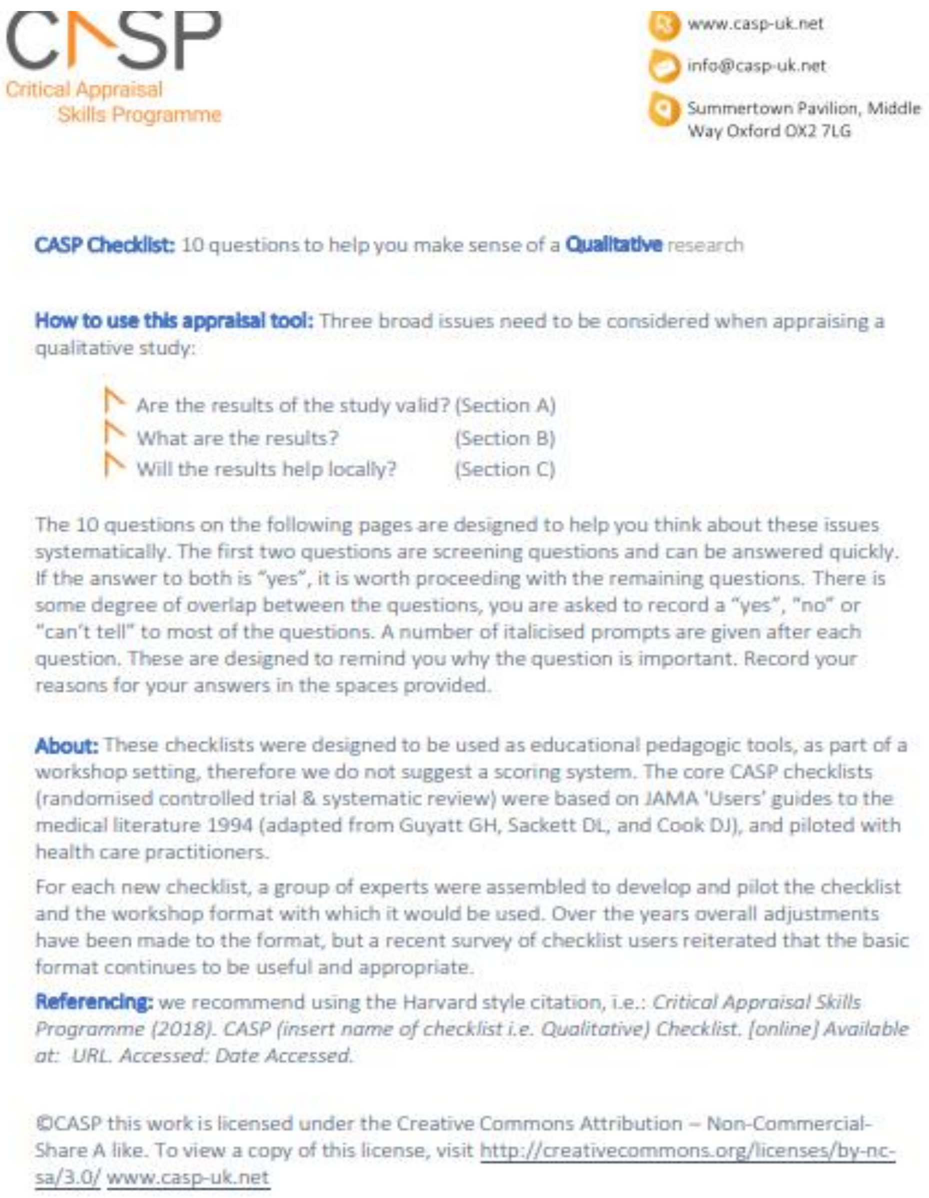
Author, Year & Country	**Study Design, Data Collection and Method**	**Aim of the Study**	**Participant Characteristics / Sample Size / Setting**	**Research Question** **What are the experiences of key stakeholders in relation to mental health services?**	**Research Question** **What are key stakeholders' experiences in relation to accessibility and availability of mental health services?**	**Key Findings**	**Quality Appraisal**
			Care givers. (*n*=39).			Recruitment area very specific in geographical area. Illness types not defined.	
Preville et al. (2009). Canada.	Quantitative. (Cross sectional study). Survey.	To document the use of mental health services by older people in Quebec and any unmet need.	Older people (*n*=2784) Community setting.	Not discussed	Those living in urban or rural area more likely to seek help than people from the inner city. Most sought help via a physician who referred on to specialist service. Unmarried people more likely to seek services. 57% of people who would have met a Diagnostic Statistical	57% of older people who meet diagnostic criteria for mental illness are not seeking the help they need and therefore there is significant unmet need in this population. **<u>Limitations:</u>** Findings were self - reported and therefore may be biased regarding the patients attitude at the time of the study.	CASP 10/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
					Manual V diagnosis did not seek help from services.		
Robb et al. (2003). USA	Quantitative. Survey.	To explore older peoples' perceptions of mental health care in comparison to younger people.	Adults aged 65 and over. (*n*= 474). Adults aged < 65 (*n*=1001). Community setting.	No difference in satisfaction scores between younger and older adults in relation to mental health services. Older people were less knowledgeable about the services available. Younger people were more open to the idea that they need to do things to improve their own mental health.	Younger people almost twice as likely to have seen a mental health practitioner. Younger people stated they had better access compared to older people. Lack of insurance and cost -.both seen as barriers to accessing services in both age groups.	Older adults less likely to use services than younger people. Older adults less confident in their knowledge about services available. Older adults less likely to have insurance coverage. **Limitations** The older population were affluent and well educated which may not be true of a more generalised population.	CASP 10/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
Sarkin et al. (2015). USA.	Quantitative. Survey.	The study explores how age, gender, ethnicity and mental health diagnosis contribute to stigma for those using mental health services.	People with FMI. (*n*=1237). Community.	As age increased people felt less discriminated against. This was only a marginal finding with younger people perceiving they experienced more discrimination.	Not discussed.	Older people experienced marginally less stigma. **<u>Limitations:</u>** Age breakdown findings are only discussed generally.	NIHLB Yes all questions.
Simning et al. (2010). USA.	Quantitative. Interviews to collect data on Goldberg Anxiety Scale, The Patient Health Questionnaire,	To explore mental distress of and help seeking utilisation of older people in a community setting.	People aged 60 and over. (*n*=378). Community.	Individuals who were distressed used more than one service. Likelihood of a distressed individual seeing a mental health professional was significantly higher than a non-distressed individual.	Not discussed.	People who were distressed had more contact with services, and therefore may be effective at reducing admission. **<u>Limitations:</u>** Participants were from a single area and the findings cannot be generalised.	CASP 10/10

Author, Year & Country	Study Design, Data Collection and Method	Aim of the Study	Participant Characteristics / Sample Size / Setting	Research Question What are the experiences of key stakeholders in relation to mental health services?	Research Question What are key stakeholders' experiences in relation to accessibility and availability of mental health services?	Key Findings	Quality Appraisal
	and service utilisation.						

Appendix 4: Level of Evidence (CASP)



CASP
Critical Appraisal
Skills Programme

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CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

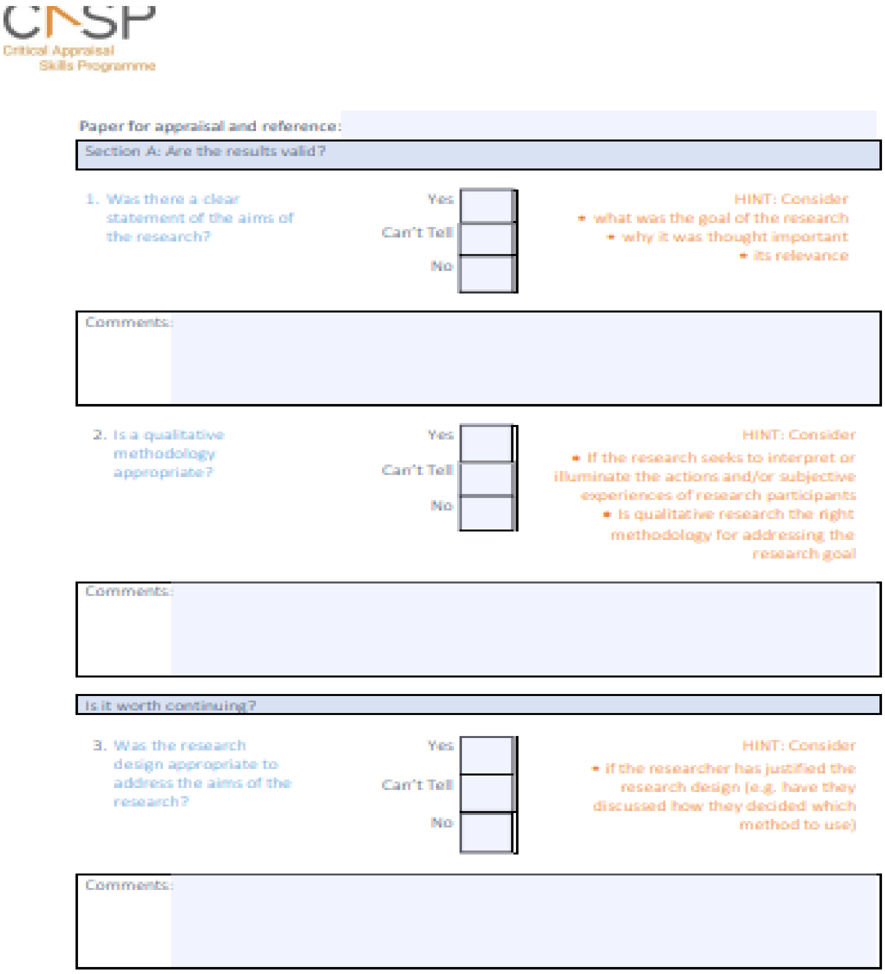
Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:



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Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • what was the goal of the research • why it was thought important • its relevance

Comments:

2. Is a qualitative methodology appropriate?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

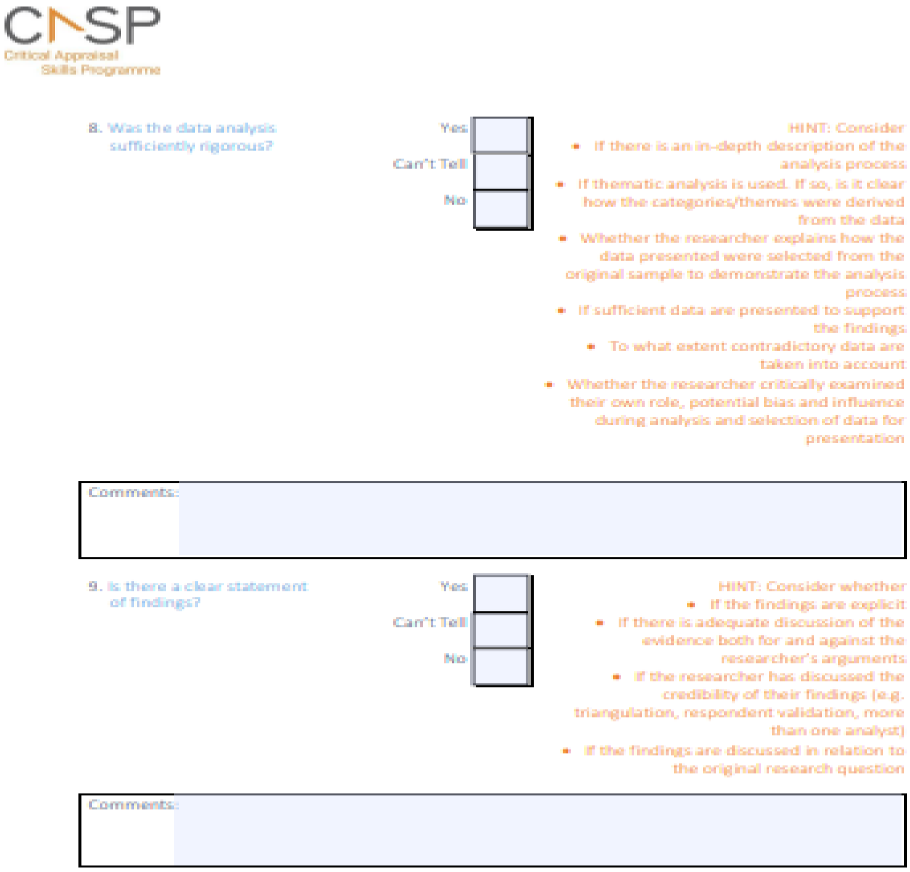
7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:



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8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

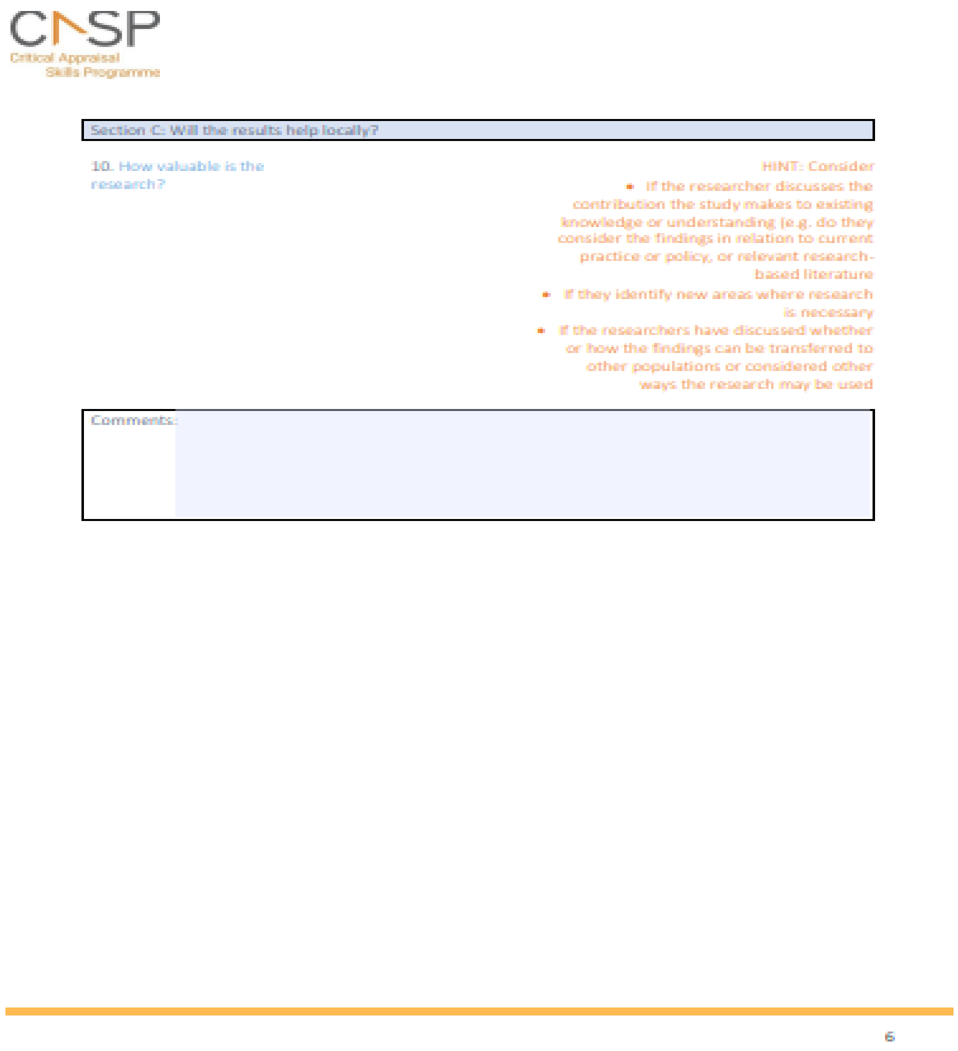
Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:



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Section C: Will the results help locally?	

10. How valuable is the research?

HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:	

6

Appendix 5: Topic Guide Focus Group

Introduction:

- Go over information sheet
- Consent
- Freedom to withdraw from study at any point
- Confidentiality
- Inform that interview will be recorded
- Purpose of interview
- Discussion around support and defining participants understanding of it
- Check if participants have any questions

Questions

1. **Can you describe an example when you offered support to someone?**

2. **Can you describe an example of when you didn't offer support?**

   Prompt:

   - In your experience what influences you to offer support?

   - What influences you to refer on to another service?

   - What is your experience of older people with FMI and their carers seeking support?

   - Do you use a patient pathway?

   - What assessment tools, if any, do you use and why?

   - Do you have any good examples of support offered?

   - Do you have any examples where support offered could be improved?

Questions

3. **Can you describe your experiences as a health and social care professional working with older people with FMI and their family carers?**

   Prompt:

   - What have been your experiences of sourcing support for older people with FMI?

- In your experience, how do services meet the needs of older people with FMI and their carers?

- In your experience do this population group have specific needs?

- What are your experiences of health and social care professionals in relation to skills and knowledge surrounding this population group?

- How frequently do you see older people with FMI? What determines the frequency?

4. **Anything else that you wish to add in relation to your experiences of available services for persons with FMI?**

Draw interview to an end and thank participants for their time.

Appendix 6: Invitation to Focus Group

Letter to health and social care professionals, third sector employees (focus group)

This research study aims to explore the determinants influencing the use of services by older people with functional mental illness (FMI).

(Invitation letter)

Dear.......

I am writing to you by way of introduction. My name is Julia Wells. I am a PhD student studying at The School of Nursing and Midwifery, Robert Gordon University. My study aims to explore the determinants influencing the use of mental health services by older people with functional mental illness (FMI) (Schizophrenia, Depression, Anxiety, and Mood Disorder). In addition to this we are keen to learn what influences health and social care professionals to offer support.

To date little research has been undertaken to explore the experiences of older people who have FMI or their carers and healthcare professionals, in relation to mental health service delivery. The outcome and analysis of this study will help us inform local practice.

I write to invite you to participate in a group interview. This is known as a focus group that will explore the experiences of health and social care professionals, working with older people who have FMI. This meeting will take place on the **XXXXXX**. This meeting will take no longer than sixty minutes. The findings from the focus group will inform the second phase of this study, which will involve interviewing up to five older people with FMI, their carers and health and social care professionals (these will be known as cases).

If you wish to take part in this study, please read the attached information sheet. Once you have read the information sheet and wish to take part, please contact me on telephone number 01224 557017 or email j.wells1@rgu.ac.uk.

Participation in this study is completely voluntary.

Thank you for taking the time to read this letter.

Yours sincerely,

Julia Wells (Research Student)
School of Nursing and Midwifery
Robert Gordon University
Garthdee Road
Aberdeen
Email: j.wells1@rgu.ac.uk
Telephone: 01224 557017

Appendix 7: Patient Information Sheet

This research study aims to explore the determinants influencing the use of services by older people with functional mental illness (FMI).

You are invited to take part in this research study exploring what influences older people with mental illness to use mental health services. Before you decide to take part, it is important that you understand why this research study is being undertaken and what it will involve. Therefore, please take time to read this leaflet and consider the information provided, perhaps having some discussion with family and friends.

What is the purpose of this study?

The purpose of this study is to understand your experiences of mental health services including what influences your use of mental health services. This will help to improve care in the future.

Why have I been invited?

Sharing your experiences about the care that you receive and why you use services can help us work together to improve mental health services that people receive.

Do I have to take part?

It is up to you to decide whether or not you wish to take part and there is no requirement for you to do so. Please take time to consider whether or not you wish to participate. If you do wish to participate you will be asked to sign a consent form. You are free to withdraw from this study at any time without giving any reason.

What will happen to me if I take part?

Taking part in this study will involve talking to me (Julia) about your experiences of mental health services. Your first interview will be held at a mutually convenient time, either in the GP practice you attend, the ward you are in, or the care home you live in. The interview will take no longer than sixty minutes and will be recorded on a tape to allow the researcher to fully listen to what you have said, after the interview. The tape will be transcribed into text. The interview will be confidential and all information collected will be anonymous. Any information obtained will be kept in a locked place that only I and the three other members of this research team will have access to. The data will be stored no longer than is required for this study. You are welcome to bring somebody along to your interview with you including your family carer.

What are the possible risks of taking part?

The interview will involve sharing your experiences about your care and experience of using mental health services. It aims to be a useful experience, but there is the possibility you may feel upset sharing these experiences. We will ensure that you receive support and attention should this happen, if you wish this.

What will happen to the results of the study?

With your permission these findings will be shared with the research supervisory team. These findings may be submitted to journals for consideration for publication and presented at conferences.

Where can I ask for more information?

I am very happy to be contacted. My details are Julia Wells (research student) my telephone number is 01224 557017.

If you wish to speak to an independent person, who knows about this study, but is not involved, you are invited to contact:

Dr Flora Douglas

School of Nursing and Midwifery

Robert Gordon University

Telephone number: 01224 263198

What if there is a problem?

If you have a concern about any aspect of this study, please contact, the Principal Supervisor, Professor Catriona Kennedy, on 01224 262000 or email c.m.kennedy1@rgu.ac.uk . If you remain unhappy and wish to complain formally you can do this through The Robert Gordon University complaints procedure available at https://www3.rgu.ac.uk/footer/complaints/complaints.

Privacy Statement

As a [university / NHS organisation] we use personally-identifiable information to conduct research to improve health, care and services. As a publicly-funded organisation, we have to ensure that it is in the public interest when we use personally-identifiable information from people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use your data in the ways needed to conduct and analyse the research study. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

If you have read this information sheet and you would like to participate in this study. Please inform the Senior Charge Nurse in the ward you are being cared for. If you are a patient in a care home or living at home, or a member of staff working in the community or care home, please contact the community mental health team leader.

Thank you for taking the time to read this information sheet and I look forward to hearing from you, should you wish to participate.

Julia Wells

Research Student

School of Nursing and Midwifery

The Robert Gordon University

Garthdee Road

Aberdeen

AB10 7QG

Tel: 01224 557017

Or email j.wells1@rgu.ac.uk

Appendix 8: Information Sheet: Family Carer

Letter to family carer (recruitment)

This research study aims to explore the determinants influencing the use of services by older people with functional mental illness (FMI).

Dear Sir/ Madam,

I am writing to you by way of introduction. My name is Julia Wells. I am a PhD student studying at The School of Nursing and Midwifery, Robert Gordon University. My study aims to explore what influences older people with Functional Mental Illness (Schizophrenia, Depression, Anxiety, and Mood Disorder) to access mental services. I would also like to explore family carers experiences of accessing services. Your relative has agreed to take part in this study and has agreed that I can approach you to participate, should you wish to. I would, therefore, like to invite you to participate in this study as a family carer of an older person with functional mental illness to participate in this study. The outcome of this research will help us inform local practice.

Interviews will be undertaken to inform this study, which will take no longer than sixty minutes and will take place either in the hospital ward, care home or GP practice you attend, your home, or by telephone at a time that is convenient to you. If you wish to take part in this study, please read the attached information sheet. Once you have read the information sheet and wish to take part, please contact me on telephone number 01224 557017 or email j.wells1@rgu.ac.uk and I will then contact you to arrange to discuss this study with you further. If you do not wish me to contact you, please tell your relative or email me on the above email address.

Thank you for taking the time to read this letter.

Yours sincerely,

Julia Wells (Research Student)

School of Nursing and Midwifery

Robert Gordon University

Garthdee Road

Aberdeen

Email: j.wells1@rgu.ac.uk

Telephone: 01224 557017

Appendix 9: Information Sheet: Healthcare Professionals

This research study aims to explore the determinants influencing the use of services by older people with functional mental illness (FMI).

(Invitation letter: healthcare professional, third sector employee)

Dear Sir/ Madam,

I am writing to you by way of introduction. My name is Julia Wells. I am a PhD student studying at The School of Nursing and Midwifery, Robert Gordon University. My study aims to explore the determinants influencing the use of mental health services by older people with Functional Mental Illness (FMI). Your patient / service user has consented to participate in this study and for me to contact you to ask if you would wish to participate.

To date little research has been undertaken to explore what influences the use of services by older people with FMI. I wish to invite you to participate in this study, to explore what influences you, as a healthcare professional, to offer support and what your experiences are of working in services which support older people with FMI.

Interviews will be undertaken to inform this study, which will take no longer than sixty minutes and will take place either in the hospital ward, care home or hospital setting where you work, at a time that is convenient to you. If you wish to take part in this study, please read the attached information sheet. Once you have read the information sheet and wish to take part, please contact me on telephone number 01224 557017 or email j.wells1@rgu.ac.uk and I will then contact you to arrange to discuss this study with you further. I will also contact you by phone to find out if you wish to participate. If you do not wish for me to do this, please email me.

Thank you for taking the time to read this letter.

Yours sincerely,

Julia Wells (Research Student)

School of Nursing and Midwifery

Robert Gordon University

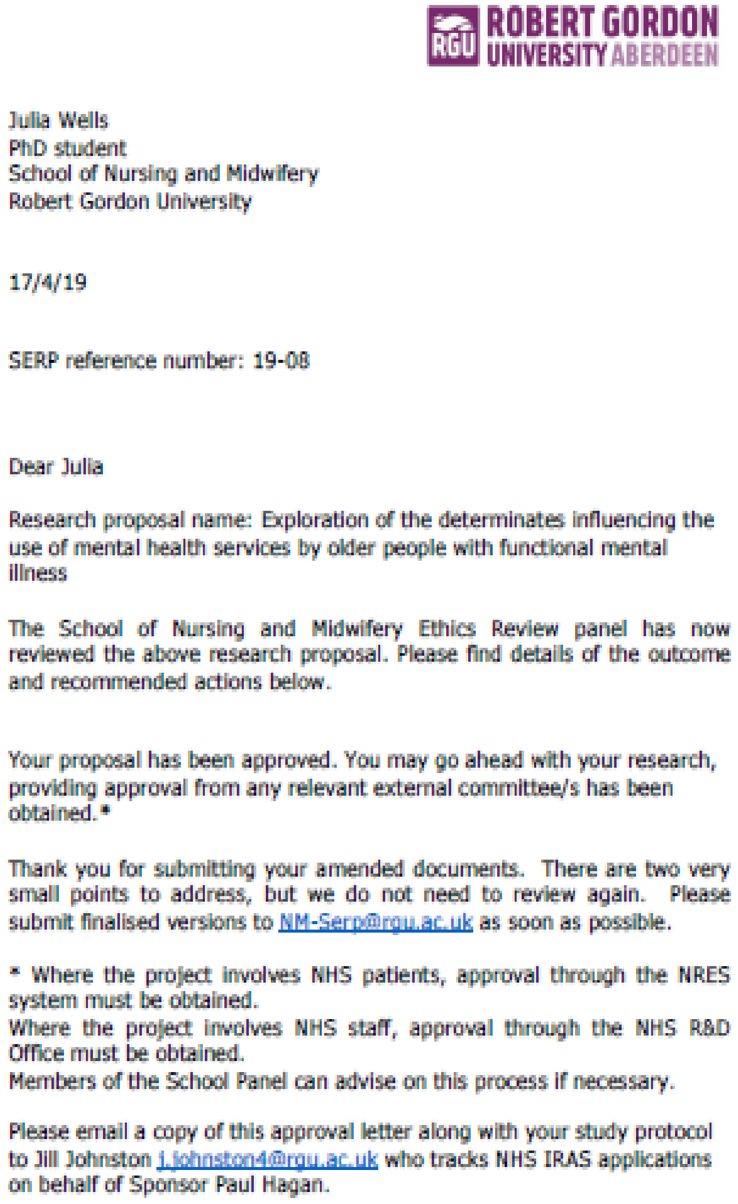
Garthdee Road

Aberdeen

Email: j.wells1@rgu.ac.uk

Telephone: 01224 557017

Appendix 10: The Robert Gordon University Ethics Approval



ROBERT GORDON
UNIVERSITY ABERDEEN

Julia Wells
PhD student
School of Nursing and Midwifery
Robert Gordon University

17/4/19

SERP reference number: 19-08

Dear Julia

Research proposal name: Exploration of the determinates influencing the use of mental health services by older people with functional mental illness

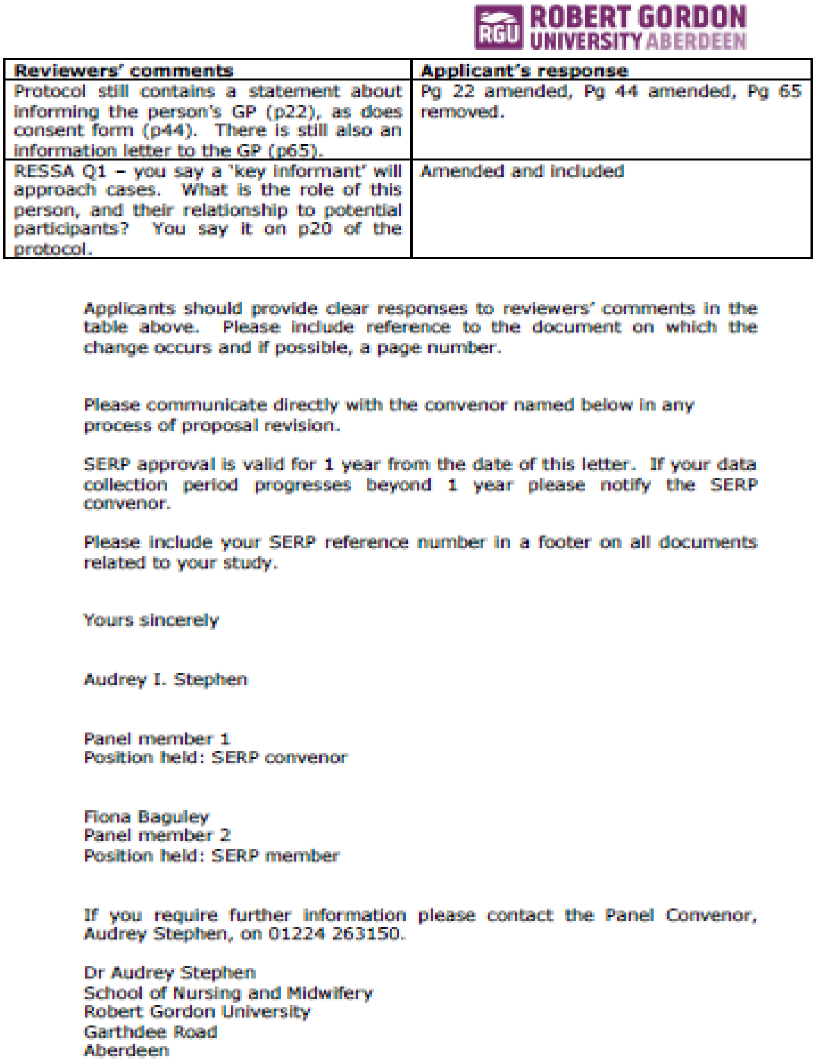
The School of Nursing and Midwifery Ethics Review panel has now reviewed the above research proposal. Please find details of the outcome and recommended actions below.

Your proposal has been approved. You may go ahead with your research, providing approval from any relevant external committee/s has been obtained.*

Thank you for submitting your amended documents. There are two very small points to address, but we do not need to review again. Please submit finalised versions to NM-Serp@rgu.ac.uk as soon as possible.

* Where the project involves NHS patients, approval through the NRES system must be obtained.
Where the project involves NHS staff, approval through the NHS R&D Office must be obtained.
Members of the School Panel can advise on this process if necessary.

Please email a copy of this approval letter along with your study protocol to Jill Johnston j.johnston4@rgu.ac.uk who tracks NHS IRAS applications on behalf of Sponsor Paul Hagan.



ROBERT GORDON UNIVERSITY ABERDEEN

Reviewers' comments	Applicant's response
Protocol still contains a statement about informing the person's GP (p22), as does consent form (p44). There is still also an information letter to the GP (p65).	Pg 22 amended, Pg 44 amended, Pg 65 removed.
RESSA Q1 – you say a 'key informant' will approach cases. What is the role of this person, and their relationship to potential participants? You say it on p20 of the protocol.	Amended and included

Applicants should provide clear responses to reviewers' comments in the table above. Please include reference to the document on which the change occurs and if possible, a page number.

Please communicate directly with the convenor named below in any process of proposal revision.

SERP approval is valid for 1 year from the date of this letter. If your data collection period progresses beyond 1 year please notify the SERP convenor.

Please include your SERP reference number in a footer on all documents related to your study.

Yours sincerely

Audrey I. Stephen

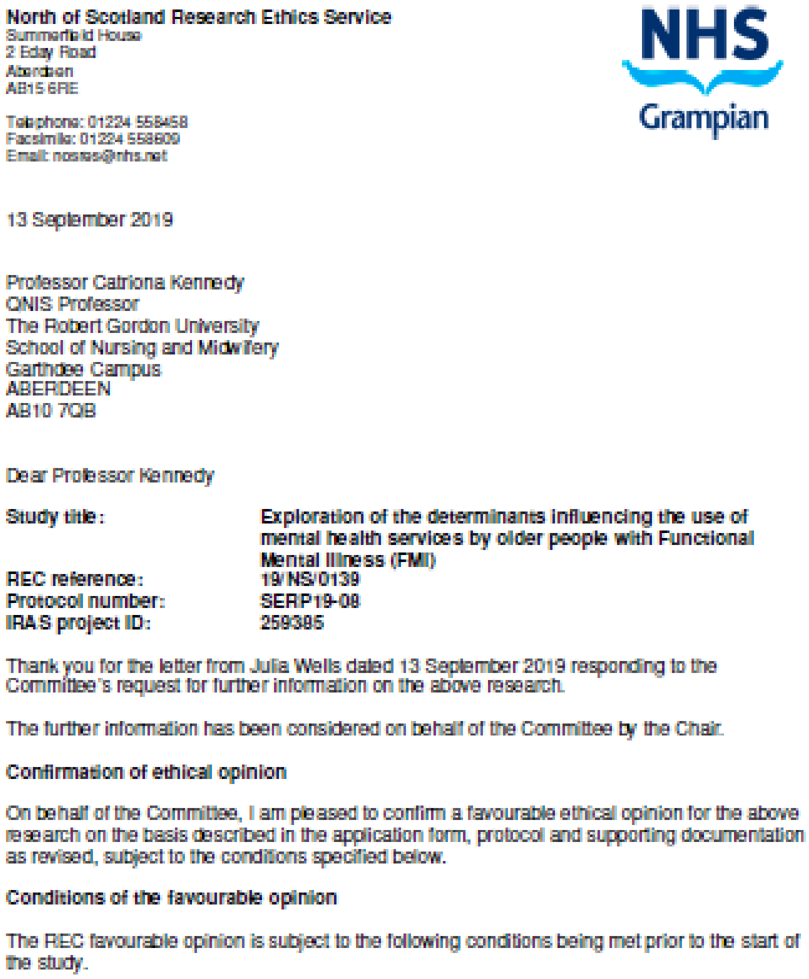
Panel member 1
Position held: SERP convenor

Fiona Baguley
Panel member 2
Position held: SERP member

If you require further information please contact the Panel Convenor, Audrey Stephen, on 01224 263150.

Dr Audrey Stephen
School of Nursing and Midwifery
Robert Gordon University
Garthdee Road
Aberdeen

Appendix 11: NHSG Ethics Approval



North of Scotland Research Ethics Service
Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

Telephone: 01224 558458
Facsimile: 01224 558609
Email: nosres@nhs.net

13 September 2019

Professor Catriona Kennedy
QNIS Professor
The Robert Gordon University
School of Nursing and Midwifery
Garthdee Campus
ABERDEEN
AB10 7QB

Dear Professor Kennedy

Study title:	**Exploration of the determinants influencing the use of mental health services by older people with Functional Mental Illness (FMI)**
REC reference:	**19/NS/0139**
Protocol number:	**SERP19-08**
IRAS project ID:	**259395**

Thank you for the letter from Julia Wells dated 13 September 2019 responding to the Committee's request for further information on the above research.

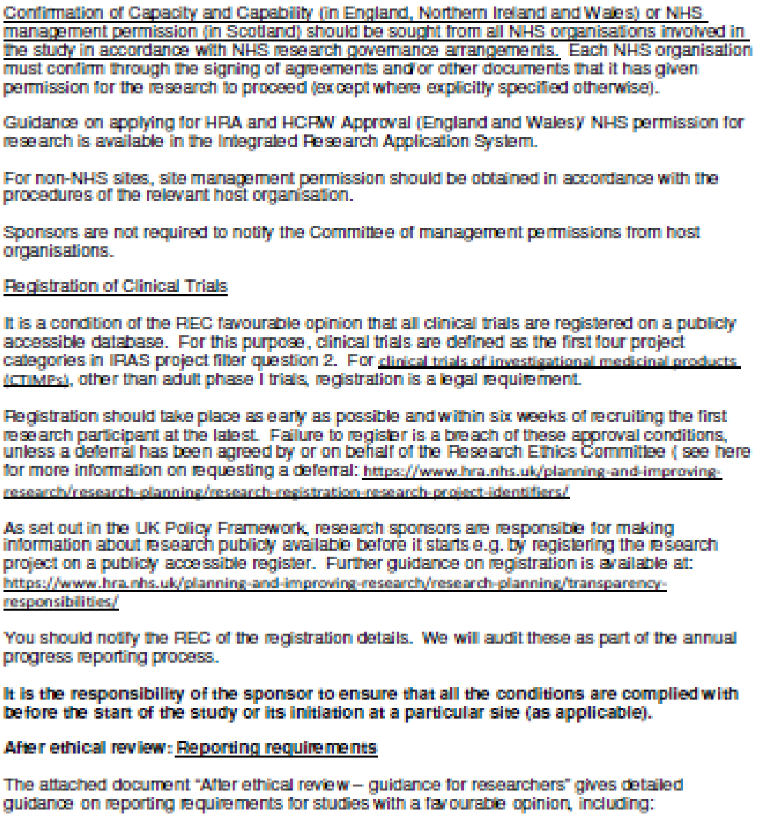
The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.



Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

It is a condition of the REC favourable opinion that all clinical trials are registered on a publicly accessible database. For this purpose, clinical trials are defined as the first four project categories in IRAS project filter question 2. For clinical trials of investigational medicinal products (CTIMPs), other than adult phase I trials, registration is a legal requirement.

Registration should take place as early as possible and within six weeks of recruiting the first research participant at the latest. Failure to register is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/

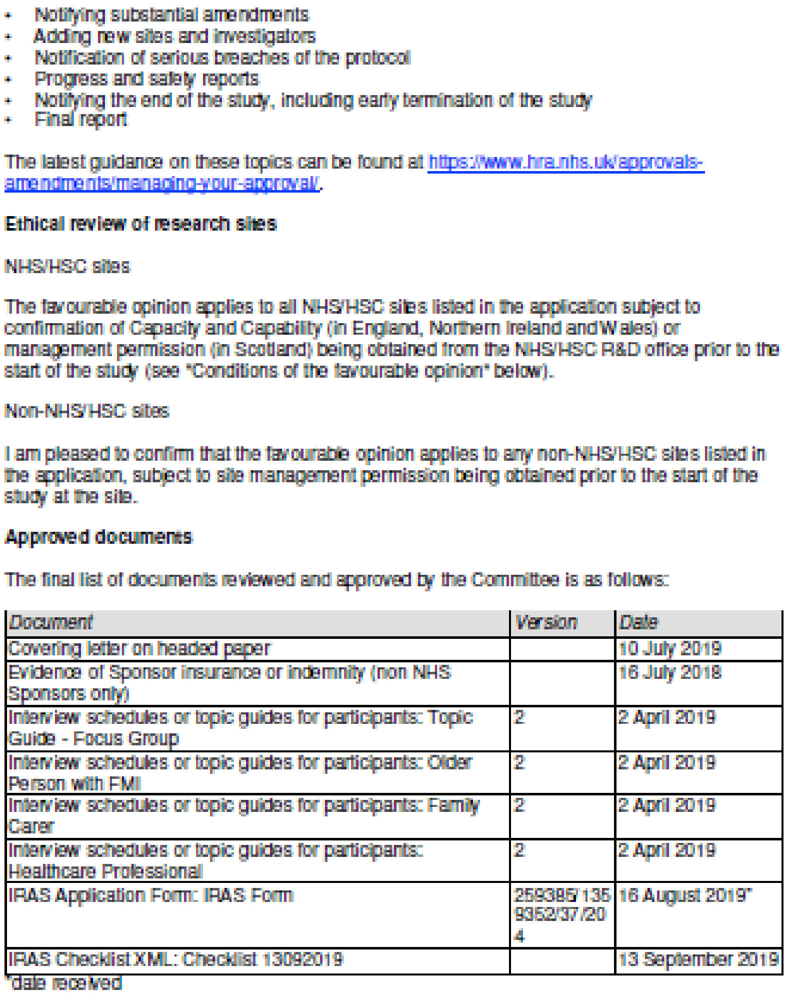
As set out in the UK Policy Framework, research sponsors are responsible for making information about research publicly available before it starts e.g. by registering the research project on a publicly accessible register. Further guidance on registration is available at: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/

You should notify the REC of the registration details. We will audit these as part of the annual progress reporting process.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:



- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites listed in the application subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

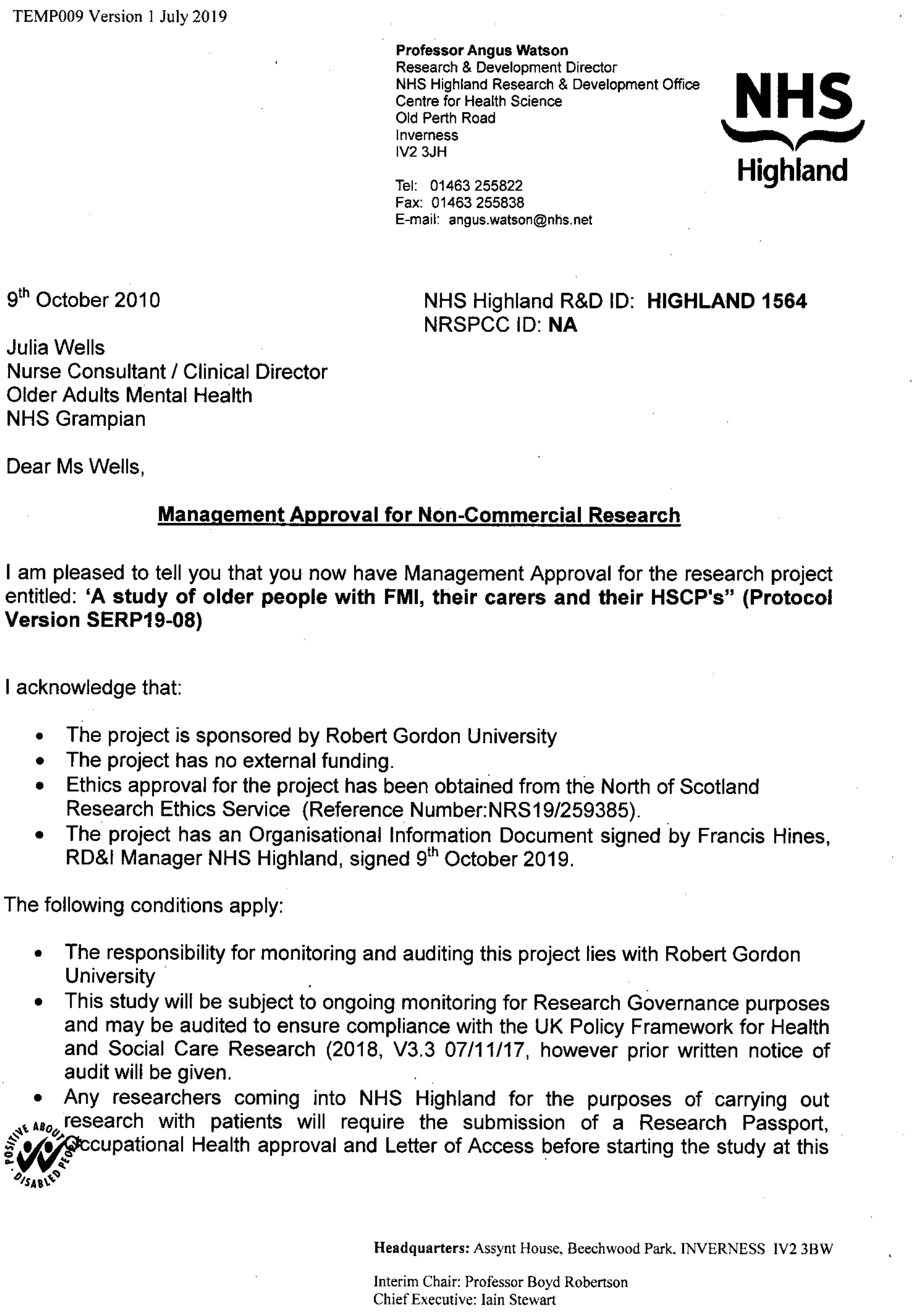
Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering letter on headed paper		10 July 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		16 July 2018
Interview schedules or topic guides for participants: Topic Guide - Focus Group	2	2 April 2019
Interview schedules or topic guides for participants: Older Person with FMI	2	2 April 2019
Interview schedules or topic guides for participants: Family Carer	2	2 April 2019
Interview schedules or topic guides for participants: Healthcare Professional	2	2 April 2019
IRAS Application Form: IRAS Form	259386/1359352/37/204	16 August 2019*
IRAS Checklist XML: Checklist 13092019		13 September 2019

*date received

Appendix 12: NHS Highland Approval



TEMP009 Version 1 July 2019

Professor Angus Watson
Research & Development Director
NHS Highland Research & Development Office
Centre for Health Science
Old Perth Road
Inverness
IV2 3JH

Tel: 01463 255822
Fax: 01463 255838
E-mail: angus.watson@nhs.net

NHS
Highland

9th October 2010

NHS Highland R&D ID: **HIGHLAND 1564**
NRSPCC ID: **NA**

Julia Wells
Nurse Consultant / Clinical Director
Older Adults Mental Health
NHS Grampian

Dear Ms Wells,

Management Approval for Non-Commercial Research

I am pleased to tell you that you now have Management Approval for the research project entitled: **'A study of older people with FMI, their carers and their HSCP's" (Protocol Version SERP19-08)**

I acknowledge that:

- The project is sponsored by Robert Gordon University
- The project has no external funding.
- Ethics approval for the project has been obtained from the North of Scotland Research Ethics Service (Reference Number:NRS19/259385).
- The project has an Organisational Information Document signed by Francis Hines, RD&I Manager NHS Highland, signed 9th October 2019.

The following conditions apply:

- The responsibility for monitoring and auditing this project lies with Robert Gordon University
- This study will be subject to ongoing monitoring for Research Governance purposes and may be audited to ensure compliance with the UK Policy Framework for Health and Social Care Research (2018, V3.3 07/11/17, however prior written notice of audit will be given.
- Any researchers coming into NHS Highland for the purposes of carrying out research with patients will require the submission of a Research Passport, Occupational Health approval and Letter of Access before starting the study at this

site. Please contact a member of the RD&I Governance team at high-uhb.nhshighlandresearchpassports@nhs.net for further assistance, if this is required.

- The paperwork concerning all incidents, adverse events and serious adverse events, thought to be attributable to participant's involvement in this project should be notified to the NHS Highland R&D Governance team. Please email documents to RD&I Facilitator at High-UHB.RandD@nhs.net.
- You are reminded that all amendments (minor or substantial) to the protocol and associated study documents or to the REC application should be copied to the NHS Highland Research and Development Office to obtain a R&D amendment approval letter. Guidance can be found at https://www.nhsresearchscotland.org.uk/services/permissions-co-ordinating-centre/permissions
- If applicable, monthly recruitment rates should be notified to the NHS Highland Research and Development Office, detailing date of recruitment and the participant trial ID number. This should be done by e-mail on the first week of the following month, to Debbie McDonald, Data Manager (debbie.mcdonald@nhs.net). Please quote your RD&I Highland reference number (Highland 1564).
- Please report any other changes in resources used, or staff involved in the project, to the NHS Highland Research and Development Manager, Frances Hines (01463 255822, frances.hines@nhs.net).

Please quote your RD&I Highland reference number (Highland 1564) on all correspondence.

Yours sincerely,

Frances Hines

Frances Hines
R&D Manager

Cc: c.m.kennedy1@rgu.ac.uk

Appendix 13: Consent Form Healthcare Professional

IRAS ID: 259385

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Exploration of the determinants influencing the use of mental health services by older people with Functional Mental Illness

Name of Researcher: Julia Wells

Please
initial box

I confirm that I have read the information sheet dated.................... (version.1...) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐

I agree to interviews that I participate in being recorded. ☐

I agree to take part in the above study. ☐

______________________ ______________________ ______________________

Name of Participant	Date	Signature
______________________	______________________	______________________
Name of Person taking consent	Date	Signature

Appendix 14: Consent Form Family Carer

IRAS ID: 259385

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Exploration of the determinants influencing the use of mental health services by older people with Functional Mental Illness

Name of Researcher: Julia Wells

	Please initial box
I confirm that I have read the information sheet dated.................... (version.1...) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers.	☐
I agree to interviews I participate in being recorded.	☐
I agree to take part in the above study.	☐

______________________	______________________	______________________
Name of Participant	Date	Signature

Name of Person taking consent	Date	Signature

Appendix 15: Consent Forms

Consent Form: Older Person with FMI

IRAS ID: 259385

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Exploration of the determinants influencing the use of mental health services by older people with Functional Mental Illness

Name of Researcher: Julia Wells

Please initial box

I confirm that I have read the information sheet dated................... (version.1...) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐

I agree to my family carer being involved in the study. ☐

I agree to interviews I participate in being recorded ☐

I agree to take part in the above study.

______________________	______________________	______________________
Name of Participant	Date	Signature
______________________	______________________	______________________
Name of Person taking consent	Date	Signature

Appendix 16: Topic Guide - Patient

Semi-Structured Interview Older Person with FMI

- Introductions
- Go over information sheet
- Consent
- Ensure participant happy to proceed with interview
- Freedom to withdraw from study at any point
- Confidentiality
- Inform that interview will be recorded
- Purpose of interview
- Discussion around support and how participants understand it
- Define that interview will last no longer than sixty minutes
- Encourage participant to speak freely and to be open
- Check if participant has any questions

Questions

1. **Tell me a bit about the conditions you have?**
2. **Can you describe how these conditions make you feel?**

Prompts:

- What is your understanding of your illness?
- What support do you receive for your mental illness?

Questions

1. **Can you give me an example of where you accessed services?**
2. **Can you describe a time when you accessed support?**
3. **Can you give an example of when you didn't access services**
4. **Can you describe a time your family carer accessed services as a carer?**
5. **Anything else that you wish to add in relation to your experiences of accessing?**

<u>Prompts:</u>

- What were you experiencing that influenced you to access services for your mental health?

- Can you describe occasions where you wouldn't access services for your mental health and any particular reasons why?

- Who do you seek support from for your mental health and why?

- What have been your experiences when you have accessed support?

- Has there been any occasion when you have been referred to a service? What were the circumstances and what was your experience?

- When you have accessed support or services, how were your needs met?

- If your family carer has sought support, what were the circumstances and your experience?

- What do you think works well and what could be improved?

Draw interview to an end and thank participants for their time.

Appendix 17: Semi-Structured Interview: Family Carer of Older person with FMI

Introduction:

- Introductions
- Go over information sheet
- Consent
- Ensure participant happy to proceed with interview
- Freedom to withdraw from study at any point
- Confidentiality
- Inform that interview will be recorded
- Purpose of interview
- Discussion around support and how participants understand it
- Define that interview will last no longer than sixty minutes
- Encourage participant to speak freely and to be open
- Check if participant has any questions

Questions

1. **Can you tell me about the condition your relative has?**

   Prompts:
   - How were they diagnosed?
   - What symptoms do they have?
   - What support do you provide?

2. **Can you describe your role to me as their family carer?**

   Prompts:
   - How does the caring role impact on you?

3. **Can you give an example when your relative accessed services?**

4. **Can you describe a time when your relative didn't access services?**

   Prompts:

Can you describe a time when you have accessed services as a carer?

Can you describe a time when you didn't access services as a carer?
Can you tell me about a time where you accessed support as a carer that went well?

Can you tell about a time where support for you as a carer could have been improved?

Can you describe a situation where support was provided well for your family member?

Can you describe a situation where your family member accessed support that could have gone better?

Draw interview to an end and thank participants for their time

Appendix 18: Semi-Structured Interview: Healthcare Professional of an Older Person with FMI

Introduction:

- Introductions
- Go over information sheet
- Consent
- Ensure participant happy to proceed with interview
- Freedom to withdraw from study at any point
- Confidentiality
- Inform that interview will be recorded
- Purpose of interview
- Discussion around support and how participants understand it
- Define that interview will last no longer than sixty minutes
- Encourage participant to speak freely and to be open
- Check if participant has any questions
- Go over information sheet

Questions

1. **Can you describe your role please?**
2. **Can you give me an example of a time you offered services/ support?**

3. Can you describe a time you didn’t offer a service or support to someone?

Prompts

- Which setting would you see an older person with FMI?
- What influences your decision to offer support?

- What influences your decision to refer to another service?
- Do you have or use a referral pathway?
-
- How do you receive your referrals?
- Do you use any assessment tools?
- What informs your assessment process?
- Would you be involved in offering family carer support?
- What would you do to offer family carer support?

4. Describe your experiences as a health and social care professional.

Prompt
- Which setting do you work?
- How frequently would you see older people with FMI?
- Can you describe a situation where you have really enjoyed your work?
- Can you describe a situation in your work that could be improved?

5. Anything else that you wish to add in relation to your experiences of accessing services?

Draw interview to an end and thank participant for participating.