Scottish Government
Riaghaltas na h-Alba

Older adults' mental health before and during the COVID-19 pandemic: Evidence paper

HEALTH AND SOCIAL CARE

social research

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Executive summary

Background

Scotland has an ageing population. The proportion of 'older adults' (65 years old and over) in the population has increased from 16% in 2000 to 19% in 2020. This is expected to continue increasing over the next decade, putting more pressure on public services. Regarding mental health and wellbeing, older adults are viewed as being neglected across the spectrum of promotion, prevention and treatment services in the UK.

The need for improvement in the provision of and access to mental health services for people aged 65+ was emphasised within the Scottish Government report, A Fairer Scotland for Older People, published in 2019. The Scottish Government's COVID-19: Mental Health – Transition and Recovery Plan, published in 2020, further emphasised the need to ensure equitable access to mental health support and services for older adults. The plan includes: supporting the development of peer support approaches to maintain good mental health; developing actions to support people experiencing loneliness; and improving the understanding of how COVID-19 has affected older people's mental health.

Aims

This evidence paper has been prepared by analysts from the Health and Social Care Analysis Division. It aims to establish a better understanding of Scotland's older adults' mental health and the access to and delivery of older adults' mental health services. It aims to address the following three research questions:

1. How does older adults' mental health and the access and delivery of older adults' mental health services compare with other age groups?
2. How has the COVID-19 pandemic affected older adults' mental health and the access to and delivery of older adults' mental health services?
3. How do individual characteristics (e.g., ethnicity) affect older adults' mental health and the access to and delivery of older adults' mental health services?

Methods

The findings presented in this report were generated by identifying and reviewing existing quantitative and qualitative evidence and analysing data from the four annual Scottish Health Surveys (SHeS) conducted between 2016 and 2019. This provided insights into the differences between older adults based on age and other demographic characteristics (e.g. sex, Scottish Index of Multiple deprivation). The review focused on six mental health outcomes from SHeS 2016-2019: mental wellbeing; a possible psychiatric disorder; depression symptoms; anxiety symptoms; a suicide attempt in the last 12 months; and an incidence of self-harm in the last 12 months. These were assessed using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), the General Health Questionnaire (GHQ-12) and the Revised Clinical Interview Schedule.

Key findings

1. Need for more evidence

There is currently a lack of evidence relating to older adults' mental health, particularly relating to LGBTI identities, ethnic and religious backgrounds, caring responsibilities and finances and deprivation. There is also little evidence specifically concerning non-statutory mental health services. Inconsistency in the methods used to generate evidence and small sample sizes in many studies make it challenging to draw strong conclusions.

2. Older adults compared to other age groups

Older adults appear to report better mental health outcomes than younger adults; however, this might reflect that they are less likely to report poor mental health, particularly due to more stigmatising views of mental health amongst older people and reliance on self-reported data. Findings also indicate that age-related stigma affects older adults in various ways, such as how they are treated in mental health services and how they engage with these services (e.g., not accessing services due to not wanting to be a burden).

3. Avoid viewing older adults as a homogenous group

Findings from the research indicate differences between older adults of different ages (e.g., 65-69 and 75+). However, older adults were commonly grouped into one broad category in survey data, which prevents an understanding of how mental health experiences and needs from services change over the course of older adulthood. Findings from available data indicated differences between older adults (e.g., older men/women, living alone/with others). Consequently, the diversity of older adults as a group should be considered and reflected in evidence, policy and services. Older adults with a physical health condition (compared with those without), and who live alone (compared to living with other) indicated poorer mental health for some specific outcomes, (e.g., mental wellbeing, loneliness).

4. Distinguish between dementia and mental health

A clear distinction should be made between dementia and mental health, particularly in older adulthood. Evidence indicates that an older adults' mental health issues might be neglected if they are diagnosed with dementia. Mixed wards (i.e., patients with dementia, mental health issues or both) are viewed as detrimental for older adults with mental health issues. Without making a clear distinction between these, a clearer understanding of each is impeded.

5. Challenges for older adults' mental health services

Several challenges for older adults' mental health services were identified, including the varied approach to older adults transitioning from adult to older adult services and the low availability and quality of services.

6. Impact of COVID-19

The COVID-19 pandemic appeared to have a detrimental effect on older adults' mental health, particularly loneliness. However, in terms of psychological therapy referrals, waiting lists and new patients, older adults' mental health services show signs of recovering following a decrease in these rates during the COVID-19 pandemic.

Introduction

Scotland has an ageing population. The proportion of 'older adults' (65 years old and over) making up the population has increased from 16% in 2000 to 19% in 2020, which reflects 256,600 more older adults in 2020 than in 2000[1]. The proportion of older adults in Scotland's population is expected to continue increasing over the next decade, which will likely put greater pressure on public services[2]. As such, an increased focus on the health of older adults is crucial[3]. However, regarding mental health and wellbeing, older adults are viewed as being 'neglected across the spectrum of promotion, prevention and treatment services' in the UK[4].

Recognising the wider marginalisation of older adults, the Scottish Government published A Fairer Scotland for Older People[5] in 2019. To tackle this inequality, this report outlined planned actions relating to communities, accessing services, and financial security. Within these actions, emphasis was placed on addressing mental health issues in older age, specifically by improving the provision of and access to mental health services (e.g., psychological therapy) for people aged 65+.

Ensuring equitable access to mental health support and services for older adults – taking into account the extent to which they can access digital resources – is also stated in the Scottish Government's COVID-19: Mental Health – Transition and Recovery Plan[6], published in 2020. Further proposed actions in this plan concerning older adults' mental health included: supporting the development of peer support approaches to maintain good mental health; developing actions to support people experiencing loneliness; and improving the understanding of how COVID-19 has affected older people's mental health.

Aims

This report presents the findings from an evidence review and analysis with the overall aim of better understanding Scottish older adults' mental health and the access to and delivery of older adults' mental health services. More specifically, the review aimed to address the following three research questions:

- How does older adults' mental health and the access and delivery of older adults' mental health services compare with other age groups?
- How has the COVID-19 pandemic affected older adults' mental health and the access to and delivery of older adults' mental health services?
- How do individual characteristics (e.g., ethnicity) affect older adults' mental health and the access to and delivery of older adults' mental health services?

In this report, 'older adults' are defined as 65 years old and over. Regarding the term 'mental health', a broad definition is adopted that is inclusive of general mental wellbeing as well as more specific issues and symptoms (e.g., anxiety, depression, loneliness). Similarly, the term 'older adult mental health services' is defined broadly and is inclusive of any services (i.e., statutory, third sector) that aim to improve older adults' mental health. As dementia often takes attention away from

older adults' mental health[7], the definitions of 'mental health' and 'mental health services' are not inclusive of dementia symptoms and dementia services, respectively.

Structure of report

The next section outlines the methods used to conduct the evidence review. Focusing on older adults' mental health, access to, and delivery of older adults' mental health services separately, the subsequent sections present the findings of the evidence for each of these areas in turn. The final section presents conclusions based on the report findings.

Methods

Review of existing evidence

Search strategy

Three main strategies were used to identify relevant evidence. First, several databases[8] were searched to identify relevant literature using various combinations of search terms (e.g., “older”, “elderly”, “geriatric”, “pensioner”, “later life”, “Scotland”, “Scottish”, “mental”, “lonely”). Further relevant sources were identified by manually searching reference and citation lists of previously identified reports, and by consulting and requesting evidence from stakeholders (e.g., third-sector organisations)[9]. The evidence searching process was completed in November 2021.

Inclusion criteria

The review includes qualitative and quantitative evidence. The following criteria were applied to guide the inclusion of evidence in the review:

- A report of research, not including review articles
- Includes findings specific to Scotland’s population and older adults[10]
- Includes assessment of mental health outcomes and/or access and delivery of older adult mental health services
- Regarding quantitative research into older adults’ mental health, evidence was included that involved one of the following three comparisons:
    - Compares older adults to other age groups
    - Compares older adults before and after the first COVID-19 lockdown (23rd March 2020)
    - Compares older adults with different characteristics
- Evidence reported in the last five years (since 2016)
- Written in English

In the identified reports, it was not typically clear whether statistical significance had been calculated for the quantitative findings. As such, differences reported in the text might not be at a statistically significant threshold, and should be interpreted with caution, but nevertheless may have useful learning to be applied/tested in the Scottish context.

Analysis of Scottish Health Survey data

The Scottish Health Survey (SHeS) is an annual survey of a representative sample of people living in private households in Scotland, and includes questions about mental health[11]. Data from the four SHeS surveys conducted between 2016 and 2019 (SHeS 2016-2019) were analysed to provide more insights into the differences between older adults on the basis of age (e.g., those aged between 65 and 69 compared with those between 70 and 74) and other demographic characteristics (e.g., sex, Scottish Index of Multiple Deprivation quintile). The data from the 2016, 2017, 2018 and 2019 surveys were pooled for the dataset used for

these analyses to increase the sample size to 4510 over-65 year olds and, in turn, to allow more robust statistical analyses to be conducted.

SHeS 2016-2019 mental health outcomes

For the purposes of this report, six mental health outcomes from SHeS 2016-2019 were focused on: mental wellbeing; a possible psychiatric disorder; depression symptoms; anxiety symptoms; a suicide attempt in the last 12 months; and an incidence of self-harm in the last 12 months. These were based on a key assessment measures included in SHeS.

Mental wellbeing was assessed with the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)[12]. WEMWBS comprises 14 statements (e.g., 'I've been feeling relaxed') that respondents rate to indicate how often over the last two weeks they have felt that way, ranging from 'None of the time' (scored as 1) to 'All of the time' (scored as 5). The scores for all the items are then summed to give each participant a total score from 14 (lowest mental wellbeing) to 70 (highest mental wellbeing).

The General Health Questionnaire (GHQ-12)[13] was used to assess whether a participant indicated a possible psychiatric disorder. The GHQ-12 comprises 12 questions relating to the respondents' experiences over the previous two weeks in relation to issues such as sleep, stress, self-esteem and despair. If a respondent indicates that they have experienced four or more issues 'more than usual' or 'much more than usual' over the previous two weeks, their score is interpreted as indicating a possible psychiatric disorder.

Depression and anxiety symptoms were assessed with the Revised Clinical Interview Schedule (CIS-R)[14]. In CIS-R sections relating to depression and anxiety, respondents are asked to indicate the presence of related symptoms. CIS-R scores are presented in this report separately for depression and anxiety symptoms; indicated by two or more of the respective symptoms.

Respondents were also asked separate questions about whether they had made an attempt to take their own life in the last 12 months or had had an incidence of self-harm without the intention of taking their own life. However, due to the small proportion of participants indicating these actions, these findings are not broken down by demographic characteristics.

All findings for the SHeS 2016-2019 mental health outcomes are presented as percentages of the samples that meet the specific thresholds. The exception for this is for findings relating to mental wellbeing (WEMWBS), which are reported as a mean score for the samples. All differences reported in the text that relate to the SHeS 2016-2019 analyses are statistically significant[15].

Older adults' mental health

This section focuses on findings related to older adults' mental health. Evidence presented in this section has defined and grouped older adults differently. Figure 1 presents National Records of Scotland data[16] concerning the proportion of older adults in Scotland in 2020 in narrower age ranges. The proportion of older adults within each age range decreases as age increases. For example, there are a smaller proportion of older adults aged 90 years and over (1%) than 65 to 69 years (5%).

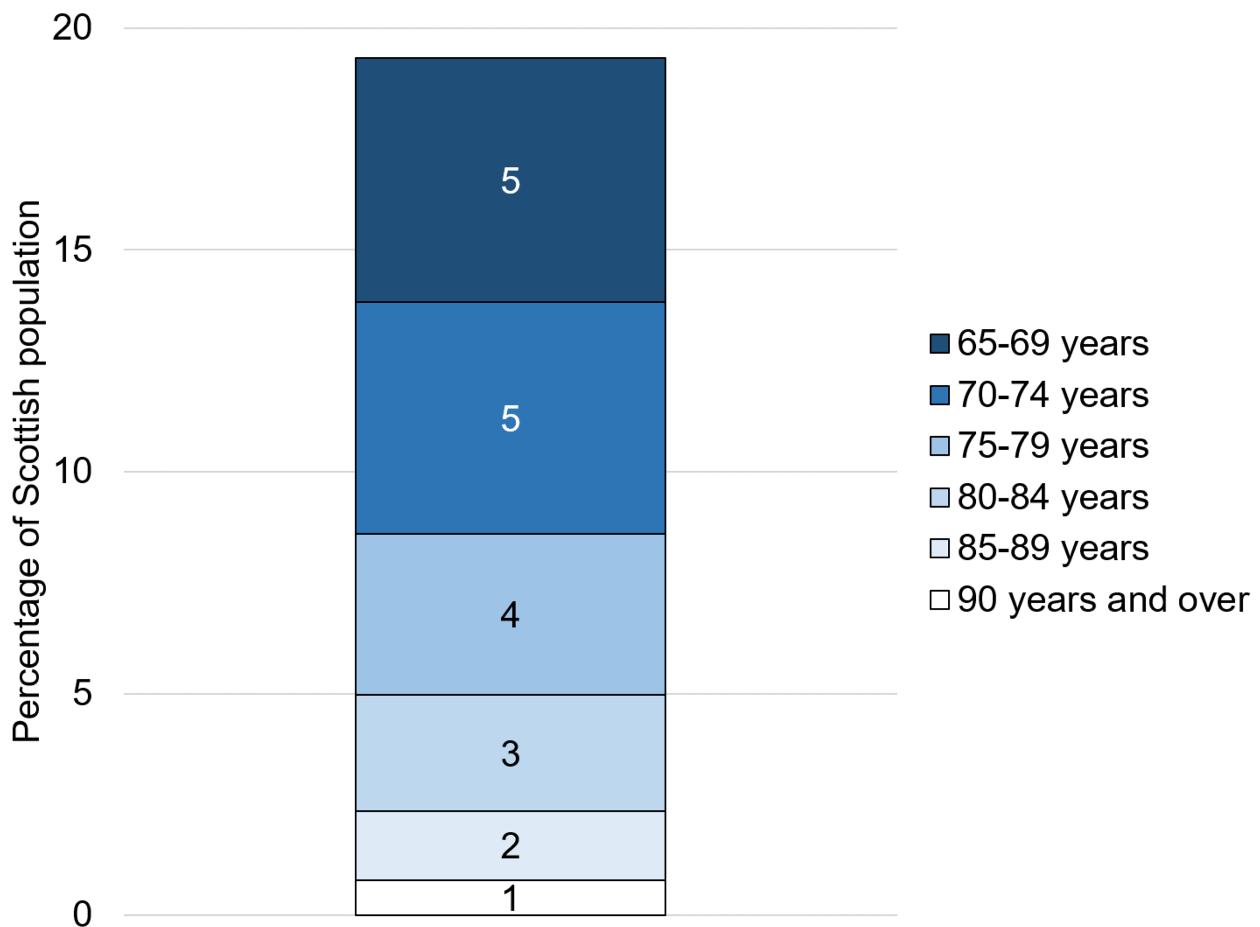


Figure 1. Age breakdown of older adults in Scotland in 2020 (National Records of Scotland)

Compared with other age groups

This section presents evidence that makes comparisons between older adults and other age groups (e.g., adults aged 18-64), and comparisons between older adults of different ages (e.g., 65-69, 70-74, 75+). These comparisons of mental health are presented in relation to the following: mental wellbeing and related aspects of mental health (e.g., life satisfaction, happiness, optimism); loneliness; mental ill-health, anxiety and depression; and suicidal thoughts and attempts, and incidences of self-harm. Evidence collected before and during the COVID-19 pandemic is presented in this section. However, as this section focuses on comparisons on the

basis of age, no evidence is presented regarding comparisons across time, which is the focus of the next section.

Mental wellbeing

Survey-based evidence appears to show that older adults consistently report better mental wellbeing (and related factors, such as life satisfaction and happiness) than younger adults:

- Analysis of SHeS 2016-2019 data indicated that older adults aged between 65 and 74 years old reported the highest mental wellbeing of all age groups (Figure 2).
- The SHeS telephone survey conducted between August and September 2020[17] reported similar findings – older adults aged between 65 and 74 years reported higher mental wellbeing compared with adults aged between 16 and 64.
- In each of the first four survey waves of the Scottish COVID-19 Mental Health Tracker study (conducted at several points during the pandemic) [18] older adults (defined as 60+) reported better mental wellbeing (assessed by the short version of WEMWBS) than adults aged between 18 and 59.
- A Scottish Government survey conducted at several points during the pandemic[19] found that a higher proportion of adults aged 55-69 and 70+ reported being 'completely happy' in Spring 2020 than younger adult age groups (e.g., 35-54). Similarly, in Spring 2021, adults aged 55+ reported higher levels of happiness than younger adults.
- A survey conducted for The Scottish Wellbeing Index report published in November 2021[20] found that, on average, adults aged 65+ reported a higher mental wellbeing than younger age groups (e.g., 55-64). The same pattern of results was also found for specific aspects of wellbeing: life satisfaction, feelings of worth, and happiness.
- Findings from a 2017 survey by researchers at the University of Dundee[21] found that higher life satisfaction was reported by adults aged 65+ compared with those aged 50 to 64.

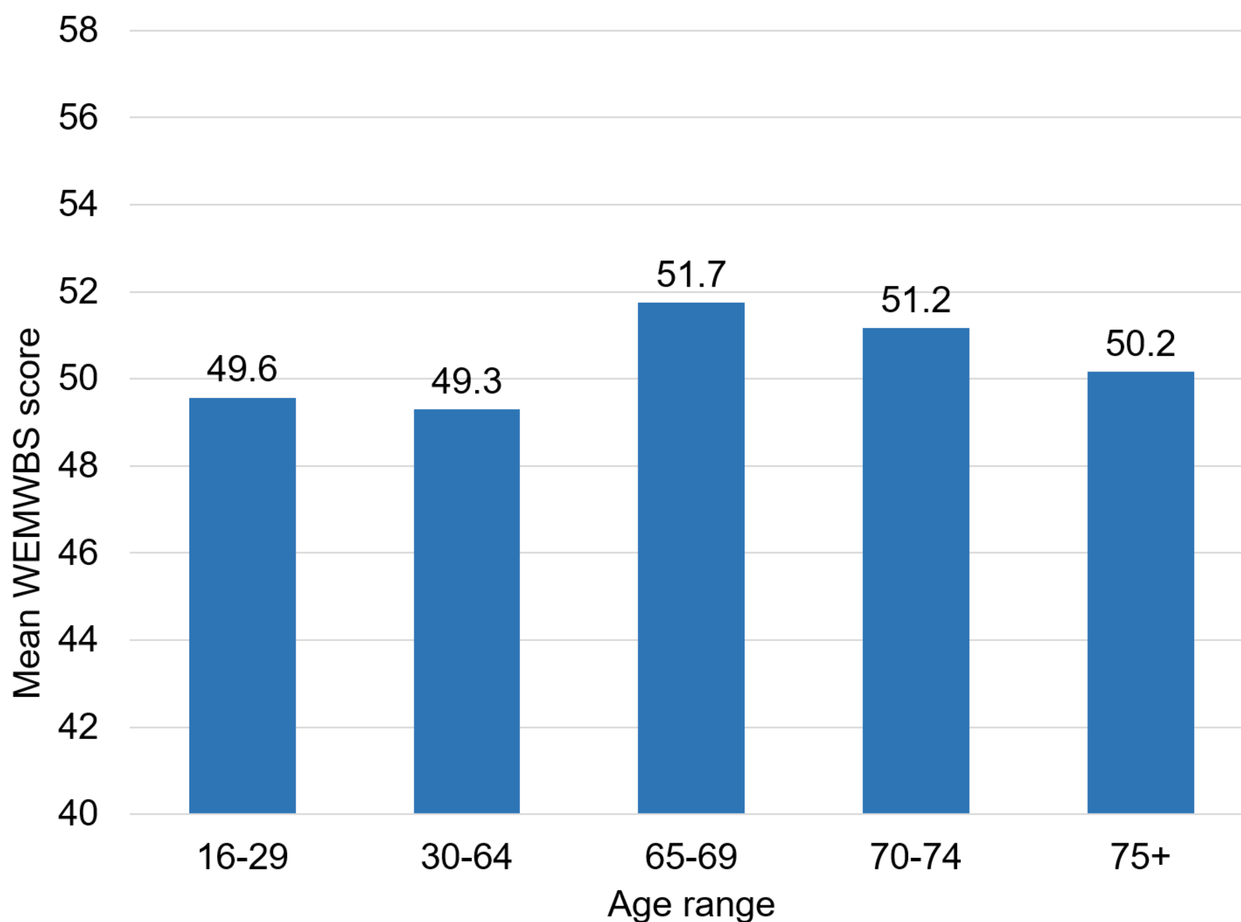


Figure 2. Average mental wellbeing scores by age (SHeS 2016-2017)

The previous findings concern fairly broad age ranges, such as older adults being defined as anyone 65+. However, these broader age ranges might conceal differences between, for example, older adults aged 65-69, and those aged 70-74.

Findings comparing mental wellbeing across narrower age ranges are less consistent than those based on broad age ranges:

- The following research suggests that older adults experience poorer mental wellbeing as their age increases:
    - The SHeS 2016-2019 analyses (Figure 2) found that older adults in the 75+ age range reported poorer mental wellbeing than the 65-69, and 70-74 year-olds. Compared with adults under 65, the 75+ older adults had similar mental wellbeing to the 16-29 adults, and higher mental wellbeing than the 30-64 adults. The SHeS telephone survey in 2020 reported a similar pattern of results – those aged 65-74 reported higher mental wellbeing than those aged 75+[22].
    - The Lothian Birth Cohort Study 1921, a longitudinal study of a sample followed since birth, found that participants reported poorer psychological quality of life at 90 years old than when they were 79 years old[23].
    - In Age Scotland's Big Survey in early 2021[24], the percentage of adults feeling optimistic about their future was found to decrease with age – 27% of those in their 50s, compared with 13% of those in their 90s.

- In contrast to the previous findings, the following studies suggested that older adults' mental wellbeing improves (or is similar) with increasing age:
  - In Spring 2020, a Scottish Government survey[25] found that older adults aged 70+ were more likely to report being 'completely happy' than those aged 55-69. However, there was no difference between these age groups in terms of their average happiness score.
  - Age Scotland's Big Survey[26] found that the percentage of respondents rating their mental health as 'good' or 'very good' increased with age – 50% of those in their 50s, compared with 74% of those in their 90s.
  - The Healthy Ageing in Scotland pilot survey[27] found that, compared with adults aged 50-59, adults aged 70-79 and 80+ reported higher life satisfaction, and those aged 70-79 also reported higher levels of happiness.

Loneliness

Compared with younger adults, older adults appeared to report better or similar outcomes in relation to loneliness[28]:

- Across the first four waves of the Scottish COVID Mental Health Tracker study[29], older adults (defined in the study as 60+) reported feeling less lonely than younger adults.
- Scottish Government survey-based research conducted during the pandemic[30] found that similar proportions of older adults (70+) reported experiencing at least some loneliness compared with adults aged 35 to 54, and 55 to 69.
- A 2017 survey by researchers at the University of Dundee[31] found no difference between adults aged 50-64, and 65+ in terms of their reported loneliness.

When comparing older adults in narrower age groupings (e.g., in their 60s, 70s, 80s), findings suggest a higher likelihood of experiencing loneliness with increasing age in older adulthood:

- The Scottish Household Survey 2018[32] found that a larger proportion of older adults aged 75+ reported experiencing at least some loneliness in the previous week compared with adults aged 60-74 (26% and 18%, respectively).
- At different points during the pandemic, two surveys of Generation Scotland participants[33] found that a higher proportion of participants aged 80+ experienced some loneliness in the previous week compared with participants in their 70s.

Mental ill-health, anxiety and depression

When compared with younger adults, research evidence tends to indicate that older adults are less likely to report poor mental health, or report better average mental health (e.g., possible psychiatric disorder, anxiety, depression):

- The SHeS 2016-2019 analyses data found that older adults were less likely than younger adults to meet the threshold for a possible psychiatric disorder (i.e., 4+ psychiatric symptoms; Figure 3). For anxiety, older adults aged 65-69 and 75+ were less likely to indicate two or more symptoms than younger

adults. However, older adults aged 70-74 were less likely to report two or more anxiety symptoms than those aged 16-29, but were similar to those aged 30-64. For depression, older and younger adults were similarly likely to report two or more symptoms.

- The same pattern of results for possible psychiatric disorder and anxiety were reported for analyses of the SHeS telephone survey conducted between August and September 2020[34]. However, no significant differences were reported in the rates of depression across the different age ranges.
- Similarly, in each of the first four waves of the Scottish COVID Mental Health Tracker study[35] a smaller proportion of older adults (defined as 60+ in the study) indicated a potential psychiatric disorder or moderate to severe anxiety or depression symptoms compared with younger adults.
- In the CovidLife survey of Generation Scotland participants,[36] those in their 60s, 70s and 80+ appeared less likely to report (mild to severe) depression than those in younger age groups.
- In Spring 2020, a survey conducted by researchers at Glasgow Caledonian University[37] found that older adults aged 65+ were the age group least likely to indicate anxiety, depression and post-traumatic stress disorder.
- Supporting information from an analysis of UK Household Longitudinal Study data[38] indicated that older adults reported better mental health on average than younger participants at six points between 2017 and 2020.
- A 2017 survey by researchers at the University of Dundee[39] found that older adults reported lower depression scores on average than adults aged 50-64, although no differences were found with regard to anxiety.
- Through a survey with a sample representative of the Scottish population, researchers at the University of Aberdeen found that older participants were less likely to indicate anxiety or depression from their survey responses than younger participants[40].
- In a 2018 report from Support in Mind Scotland[41], survey findings were presented indicating that 54% of respondents aged 65+ said they had a lived experience of mental ill health, compared with higher proportions of younger age groups (between 68% and 81%).

With regard to possible psychiatric disorder, anxiety and depression, the findings from comparisons of older adults in narrower age groupings (e.g., in their 60s, 70s, 80s) are inconsistent:

- The SHeS 2016-2019 analyses found that similar proportions of the three older adult age groups (65 to 69, 70 to 74, 75+) indicated a possible psychiatric disorder, or two or more anxiety or depression symptoms (Figure 3). Similarly, the SHeS telephone survey conducted in 2020[42] found that similar proportions of older adults aged 65-74 and 75+ met the threshold for a potential psychiatric disorder (13% and 15%, respectively).
- The longitudinal study of the Lothian Birth Cohort 1921[43] found that participants reported higher levels of depression, but lower levels of anxiety at 90 than they did at 79.
- The CovidLife survey[44] indicated that a larger proportion of older adults aged 80+ reported experiencing depression than those in their 70s. In contrast, fewer participants reported experiencing anxiety as age increased.

- Scottish Government survey-based research conducted during the pandemic[45] found that a higher proportion (20%) of older adults aged 70+ reported high levels of anxiety compared with those aged 55 to 69 (20% and 17%, respectively).

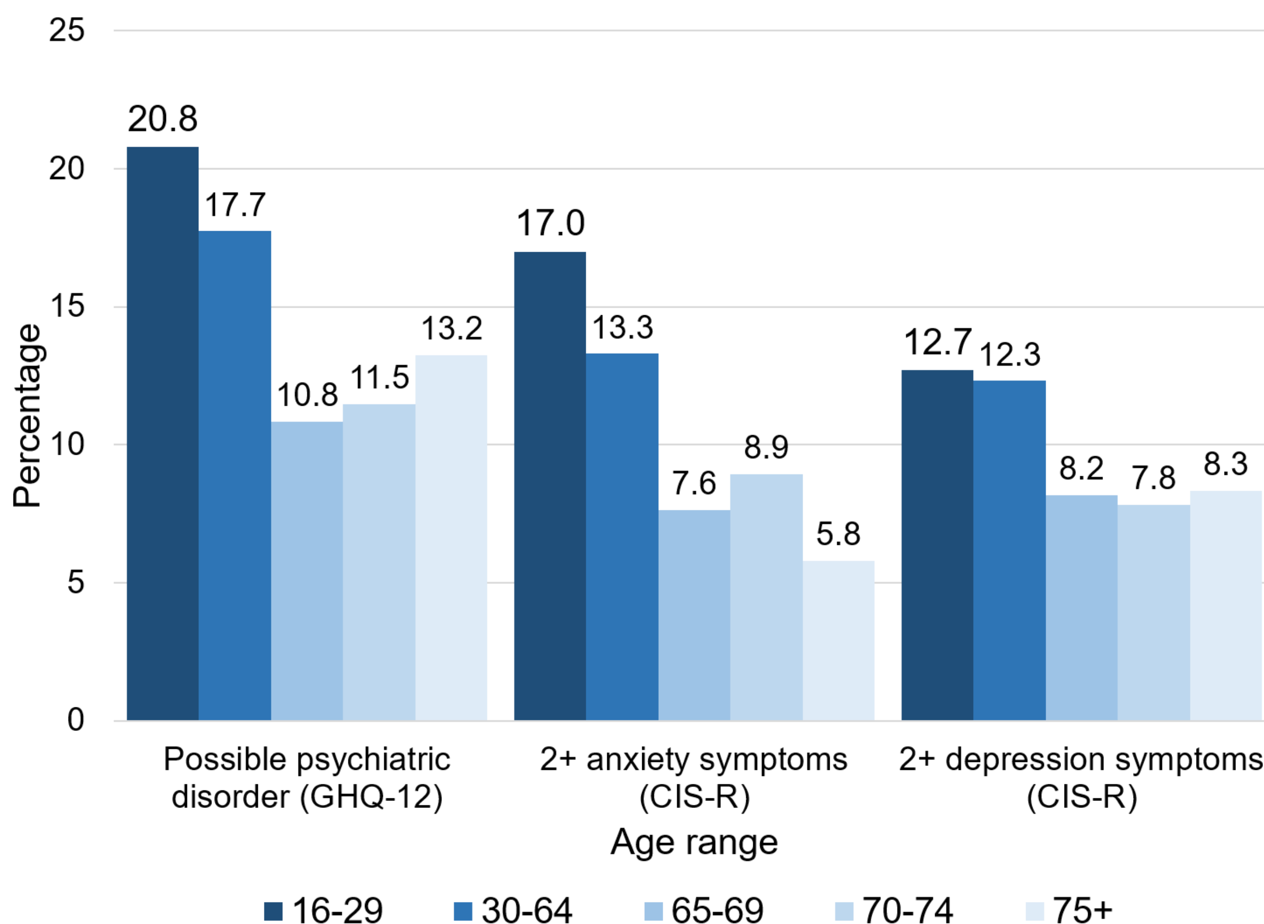


Figure 3. Percentage of sample indicating a possible psychiatric disorder, or two or more symptoms of anxiety or depression by age (SHeS 2016-2019)

Suicide and self-harm

Statistics published by the National Records of Scotland indicate that 12% (98) of probable suicides in Scotland in 2020 were completed by older adults (65+)[46]. As older adults comprised 19% of Scotland's population in 2020, this statistic suggests that they are less likely to be recorded as dying from suicide than younger age groups.

Survey-based findings indicate that older adults are less likely to report suicide attempts, incidences of self-harm and suicidal thoughts compared with younger adults. Specifically:

- The analyses of SHeS 2016-2019 data indicated that fewer than 5% of respondents in all age ranges reported a suicide attempt or incidence of self-harm in the year preceding the completion of the survey (Figure 4). No older adults aged 75+ reported a suicide attempt, and no older adults aged 70+ reported an incidence of self-harm. For the age ranges in which at least one person had indicated a suicide attempt (all except 75+), there was a similar

prevalence of suicide attempts across all age ranges. However, for the age ranges in which at least one person indicated an incidence of self-harm (16-29, 30-64, 65-69), younger adults aged 16-29 were more likely to report such an incidence than adults aged 65-69.

- Across the first four waves of The Scottish COVID Mental Health Tracker study[47],a smaller proportion (between 2.3% and 3.6%) of older adults (defined as 60+ in the study) reported having suicidal thoughts compared with younger adults.

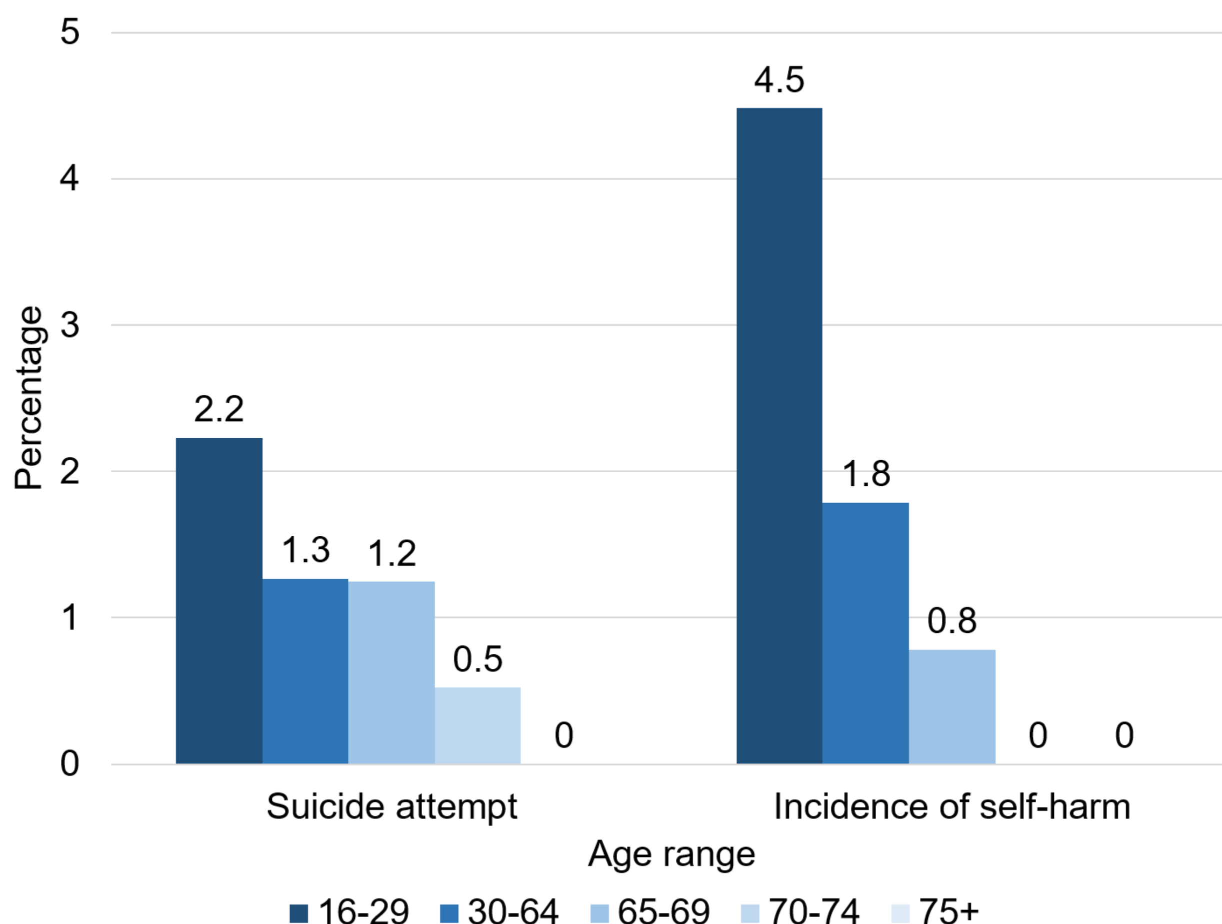


Figure 4. Percentage of sample reporting a suicide attempt or incident of self-harm in the preceding year (SHeS 2016-2019)

Before and during the COVID-19 pandemic

The COVID-19 pandemic impacted Scotland's population in a wide variety of ways[48]. Impacts on the population's mental health could be for a variety of reasons, such as people experiencing social isolation due to various restrictions, as well as concern about catching the virus. This section appraises the evidence relating to the impact of the COVID-19 pandemic on older adults' mental health.

Comparing before and during the pandemic

Overall, evidence tends to indicate that older adults report poorer mental health during the pandemic than before. This evidence comes from research that asked

older adults before and during the pandemic to report their mental health, and then compared these scores (i.e., longitudinal research), or asked older adults during the pandemic to report their mental health at the time and how they remember it being before the pandemic.

Two longitudinal studies – The Lothian Birth Cohort 1936 study[49] and the UK Household Longitudinal Survey[50] – have compared older adults' mental health before and during the pandemic. Findings from the UK Household Longitudinal Survey showed that older adults' mental health (assessed by GHQ-12) was worse during the pandemic compared with before. Similarly, the Lothian Birth Cohort 1936 study found that a smaller proportion of the sample reported 'excellent' or 'very good' emotional and mental health during the pandemic than before. In contrast, however, the Lothian Birth Cohort 1936 study also assessed changes in mental wellbeing (assessed by WEMWBS) and loneliness, and found no statistically significant differences before and during the pandemic.

In contrast to the findings from the longitudinal Lothian Birth Cohort 1936 study, findings from other studies conducted during the pandemic indicated a negative impact of the pandemic on older adults' loneliness. Specifically, two surveys – conducted separately by researchers at the University of Stirling[51] and Age Scotland[52] – reported that just over half (54% and 53%, respectively) of their mainly older adult samples reported feeling more lonely during the pandemic compared with before. Similarly, in the COVID Life survey[53], higher proportions of older adults (in their 60s, 70s and 80+) reported feeling lonely during the pandemic than before, with those aged 80+ appearing to indicate the largest proportional increase. In Wave 1 of the Scottish COVID-19 Mental Health Tracker study[54], older adults (60+) also reported an increase in their average level of loneliness during the pandemic (with this increase being larger than for younger adults). These survey findings align with a consultation undertaken by Health and Social Care Alliance[55] (with 29 older adults, and people who work with and support them), in which older adults' feelings of loneliness were said to have worsened during the pandemic.

Two of the studies conducted during the pandemic – those by the University of Stirling and Age Scotland – also presented findings about the impact of the pandemic on older adults' experience of anxiety and depression. However, no clear conclusions can be drawn from these findings. While the study by the University of Stirling reported that the majority (61%) of their sample experienced anxiety and depression similarly before and during the pandemic, Age Scotland found that just over half (51%) of their sample indicated that the lockdown in early 2021 made them feel more anxious about the future.

An important consideration regarding the research in this section is that asking people to remember how they felt at some point in the past is likely to be less accurate or more subjective than asking them to indicate how they feel at the time. The overall conclusions should therefore be considered critically but still has the potential for future exploration.

Experiences during the pandemic

Evidence concerning older adults' mental health during the pandemic (i.e., not making comparisons with before the pandemic) presents a mixed pattern of findings.

In line with an easing of restrictions, researchers at the University of Aberdeen[56] found that the proportions of older adults reporting loneliness and/or depression decreased from June to August 2020. Similarly, findings from the UK Household Longitudinal Survey[57] suggest that older adults' average level of mental health improved from April to July 2020. In contrast, over a wider period of time, older adults' (60+) average mental wellbeing was not found to differ over the first four waves – from May/June 2020 to February/March 2021 – of the Scottish COVID-19 Mental Health Tracker study[58].

It is important to note the previous findings are based on samples of older adults, and might conceal individual older adults' experiences. For example, a participant in the Health and Social Care Alliance's[59] consultation stated how the various lockdown cycles had had different impacts on their mental health.

Demographic differences

While older adults are often broadly grouped together (e.g., 65+), it is crucial to keep in mind that older adults are not a homogenous group and represent a diversity of experience equal to individuals of other ages. For example, the SHeS 2016-2019 analyses found that, within the broad 65+ grouping, older adults aged 75+ reported poorer mental wellbeing than those aged 65-69 and 70-74. As well as age, older adults' mental health is likely influenced by a wider range of characteristics (e.g., physical health conditions, ethnic background), which are likely to interconnect and influence each other. This section focuses on different characteristics in turn, and presents evidence on how they influence older adults' mental health.

Older men and women

The proportion of older adults who identify as female compared with male increases with age. While female and male older adults each comprise roughly half of those aged between 65 and 69 years, roughly two-thirds of those aged 90 years and over are female (Figure 5)[60].

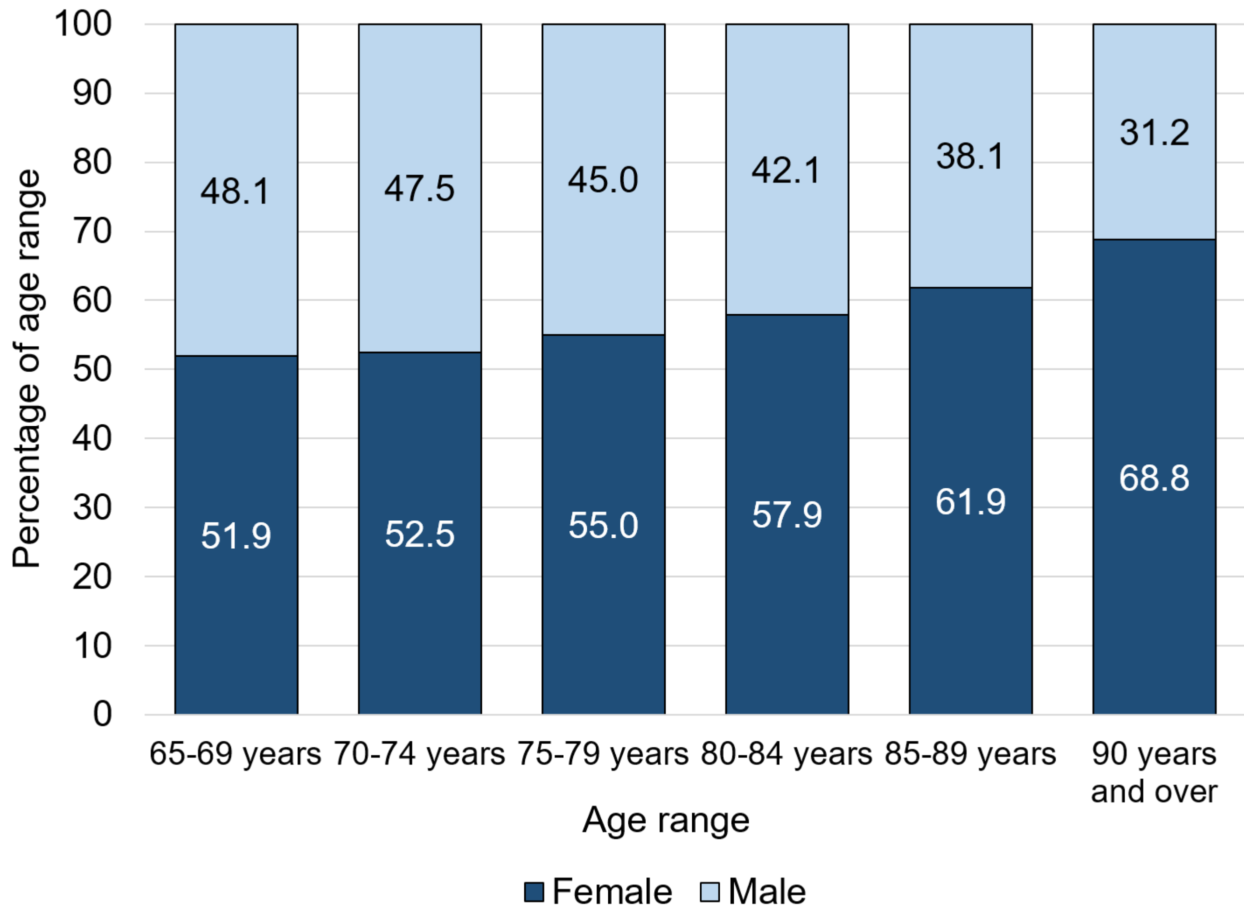


Figure 5. Proportion of female and male adults in older age ranges (National Records of Scotland)

Data from three nationally representative surveys provide evidence for differences between older men and women relating to mental wellbeing, anxiety and depression symptoms, having a possible psychiatric disorder and suicidal thoughts. Findings from the SHeS 2016-2019 analyses (graphs A to D, Appendix 1), the SHeS survey conducted between August and September 2020[61], and the first four waves of the Scottish COVID-19 Mental Health Tracker study[62], demonstrate that:

- Regarding mental wellbeing and depression symptoms, older men and women appear to be similar. Findings from the three surveys were consistent, with no differences between older men and women being found.
- Regarding anxiety, findings are inconsistent, but suggest older men might be more at risk. While the two SHeS analyses found no differences regarding anxiety, at waves 3 and 4 of the Mental Health Tracker study, older women were found to be less likely to report anxiety.
- Regarding possible psychiatric disorder, findings are inconsistent, but suggest older women might be more at risk: The SHeS 2016-2019 analyses indicated that a higher proportion of older women than men aged 65-69 indicated a possible psychiatric disorder, but there were no differences for the other age ranges. Similarly, older women (60+) were found to be more likely to indicate a possible psychiatric disorder at waves 3 and 4 of the Mental Health Tracker study. In contrast, no differences between older men

and women were identified through the analyses of the SHeS survey conducted between August and September 2020.
- Findings are limited regarding suicidal thoughts, but suggest that older men might be more at risk. In line with roughly two-thirds of people aged 65+ who died by probable suicide being male[63], the Mental Health Tracker study reported that older men (60+) were more likely to report suicidal thoughts than an older women. Neither of the SHeS analyses assessed suicidal thoughts.

Findings concerning loneliness are mixed and it is unclear whether older women and men differ in terms of the likelihood of experiencing loneliness. However, differences in the level of loneliness (e.g., mild, moderate) are slightly better supported by evidence and suggest that older women experience a higher level than older men. The specific evidence for these findings is presented below:
- The Scottish COVID-19 Mental Health Tracker study[64] did not find any differences between older men and women (60+) in terms of loneliness (at any of the four waves). In contrast, the following studies suggested differences in experiences of loneliness between older men and women:
- An NHS survey of older adults in the Highlands conducted before the pandemic found that a higher proportion of older men (70%) than older women (63%) reported feeling lonely, although more older women than men reported feeling 'intense' loneliness (9% and 7%, respectively)[65].
- In Age Scotland's Big Survey, conducted during the pandemic, 29% of older women reported never feeling lonely, compared with 41% of older men[66]. This survey also found that more older women (58%) than men (42%) felt that the pandemic and associated restrictions had made them feel lonelier, which was in line with similar insights provided by older women participating in a consultation conducted by the Scottish Women's Convention.
- Similarly, older women were found to report higher loneliness on average in a survey conducted by researchers from The University of Stirling during the pandemic[67].

A common insight in feedback from stakeholders for this review was that older women's mental health is not seen as a sufficiently serious issue[68]. Indeed, the limited evidence identified for inclusion in this section highlights the lack of focus on older women's (as well as older men's) mental health. While it is difficult to draw strong conclusions about differences between older men and women based on this evidence, tentative findings suggest that older women might be more at risk of some mental health outcomes (i.e., possible psychiatric disorder, loneliness), and less at risk of others (i.e., anxiety, suicidal thoughts and death by suicide). However, these findings should be viewed critically due to the limited evidence.

LGBTI+ People

A large evidence gap in this report concerns the mental health of older adults who identify as LGBTI+ as no evidence could be identified concerning these older adults throughout the pandemic. Related to this gap, due to insufficient sample sizes , no SHeS 2016-2019 analyses could be conducted on the basis of sexual orientation.

Insights provided through our consultations with stakeholders in the Mental Health Equalities and Human Rights Forum (EHRF)[69] highlight several specific experiences that older LGBTI adults are likely to have had throughout their life that might negatively impact on their previous and current mental health. Examples include lack of acceptance, marginalisation, and prejudice (e.g., from family and society), discrimination (e.g., in employment, health and social care, being historically banned from military service), criminalisation, pathologisation (e.g., sexual orientations and trans status being considered as a mental illness), living through the AIDS epidemic, and participation in unwanted therapies (e.g., psychiatric[70], conversion practices or so called ‘conversion therapy’) and subsequently minority stress.

Related to these examples, the stakeholders also stressed how isolation in older LGBTI adults was being a key issue. Reasons given for this included people possibly choosing to conceal their identities when forming new social connections, losing friends and family through coming out, feeling “ignored” by younger LGBTI people, and LGBTI spaces in which they could be open about their true identity closing during the pandemic. Bereavement also likely has specific complexities for older LGBTI adults, particularly for those who are not out and lose a primary partner, as they might experience less recognition from others of their loss, and a reduced connection with their LGBTI identity. Last, the COVID-19 pandemic might have raised a particular challenge for older LGBTI adults by triggering past traumas associated with the AIDS epidemic.

Ethnic and religious background

Another large evidence gap in this report concerns how older adults’ mental health varies across different ethnic and religious backgrounds. As with evidence for LGBTI older adults, SHeS 2016-2019 analyses could not be conducted on the due to insufficient sample sizes, and no evidence could be identified that investigated older adults’ mental health in relation to these characteristics.

Physical health conditions and sensory impairments

Physical health deteriorates over the lifespan, both in terms of self-assessed general health (Figure 6), and the prevalence of limiting and non-limiting long-term health conditions (Figure 7)[71]. Regarding COVID-19, older adults are also at greater risk of mortality from the virus[72], and, accordingly, perceived catching the virus to be more serious for themselves than for younger adults[73]. As such, the impact of physical health issues on mental health likely becomes increasingly important as age increases.

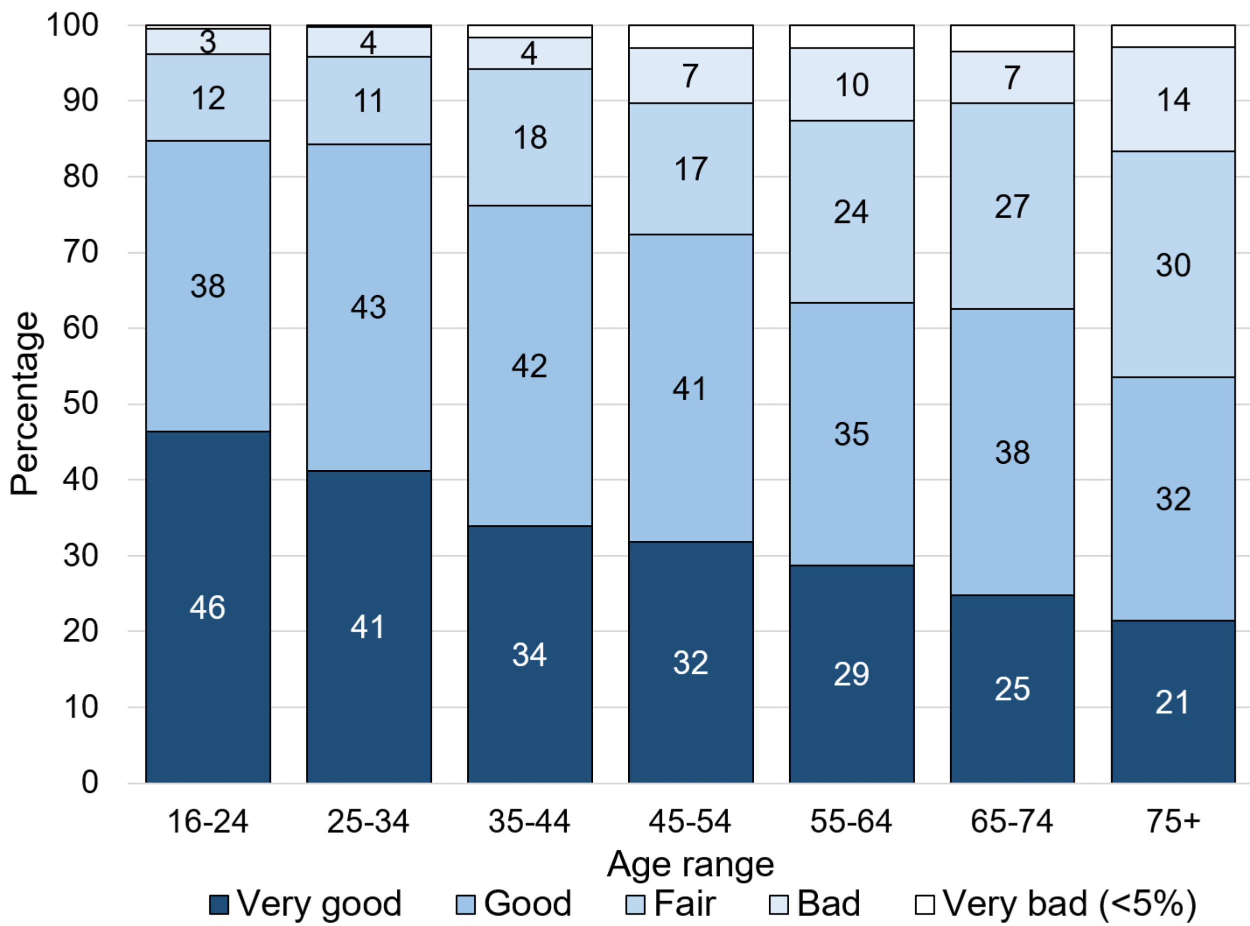


Figure 6. Self-assessed general health by age (SHeS 2019)

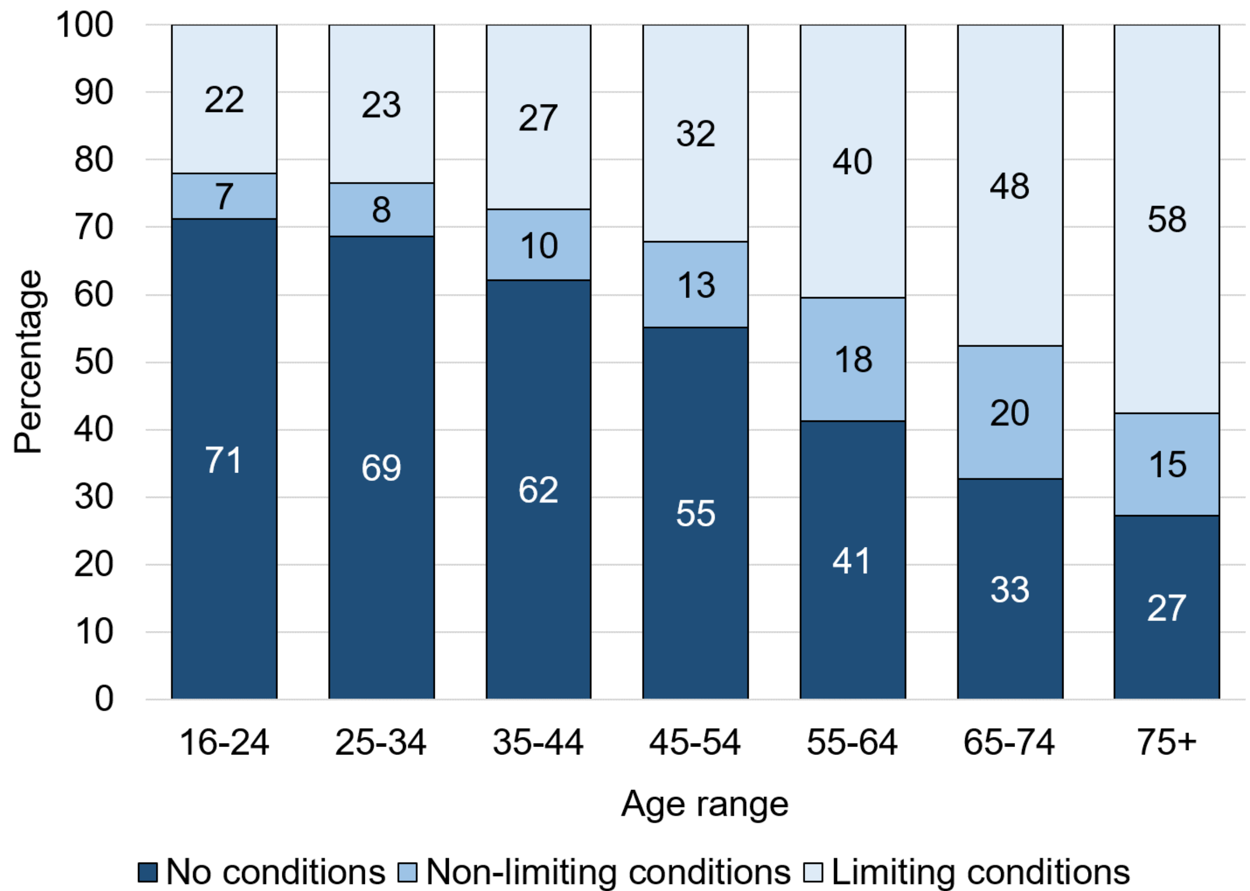


Figure 7. Limiting and non-limiting long-term health conditions by age (SHeS 2019)

Overall, older adults with a physical health condition, or who have poor general health, tend to have poorer mental health outcomes than those without such health issues. The evidence is consistent for some mental health outcomes (mental wellbeing, having a possible psychiatric disorder and loneliness), but less clear for other outcomes (anxiety and depression symptoms). Specifically:

- Regarding mental wellbeing:
  - The SHeS 2016-2019 analyses found that older adults (in each age range) who rated their general health as poor reported poorer mental wellbeing than those rating it as good[74] (Graph A, Appendix 2). Similarly, older adults (in each age range) reporting limiting long-term health conditions reported poorer mental wellbeing than those with non-limiting or no such conditions (Graph A, Appendix 3).
  - Supporting these findings, an analysis of data from the Lothian Birth Cohort 1936 Study[75] reported that, in the sample of older adults, having a history of cardiovascular disease was associated with a decrease in mental wellbeing during the pandemic. Another analysis of Lothian Birth Cohort longitudinal data[76] also found that poorer self-reported mental health during the pandemic was associated with more chronic diseases and poorer self-rated general health.
  - In addition to the perceived seriousness of catching COVID-19 likely impacting on older adults' mental health, consultations with older women[77] indicated that their mental health had also been impacted by difficulties in accessing the correct treatment for physical illnesses during the pandemic.
- Regarding having a possible psychiatric disorder:
  - The SHeS 2016-2019 analyses found that a higher proportion of older adults (across all age ranges) indicated a possible psychiatric disorder if they also reported poor (compared with good) general health, and/or had a limiting long-term health conditions (compared with having a non-limiting or no condition).
- Regarding anxiety symptoms:
  - No differences were found on the basis of self-assessed general health, and having limiting or non-limiting health conditions (Graph C, Appendix 2 and 3). The only exception was that older adults aged 70-74 were more likely to report two or more anxiety symptoms if they reported poor (compared with good) general health.
- Regarding depression symptoms:
  - Older adults (across all age ranges) were more likely to report two or more depression symptoms, if they also reported poor (compared with good) general health (Graph D, Appendix 2). However, the only difference having a limiting health condition was that a higher proportion of those aged 75+ who had such a condition reported two or more depression symptoms (Graph D, Appendix 3).
- Regarding loneliness:
  - A survey of older adults in the Highlands[78] found that a higher proportion of those with more than one health condition reported

    - feeling lonely (80%), compared with those with one such condition (66%) and those with no such condition (60%).
    - During the COVID-19 pandemic, findings from the Lothian Birth Cohort 1936 Study[79] data also found that feeling lonely during the lockdown was associated with the number of chronic diseases the older adults had, as well as reporting a higher level of disability, and poorer self-rated general health.
- In addition to physical health issues, sensory impairments also appear to be associated with poorer mental health outcomes for older adults. Specifically:
    - During the pandemic, a survey of older adults with varying degrees of hearing loss[80] found that worse hearing was associated with greater anxiety around going out due to speaking to people from a distance, or others wearing masks. Furthermore, worse hearing was associated with greater concern than usual regarding managing problems with hearing aids, although was also associated with greater relief about not being obliged to attend events where hearing would be an issue. In open-text responses, participants expressed experiencing stress during to video calls, which involved often asking people to repeat themselves.
    - Regarding visual impairments, a cross-sectional analysis of almost 300,000 older adult patient records[81] found that, compared with older adults without a visual impairment, those with an impairment were significantly more likely to have each of the mental health conditions captured in the records (e.g., depression, anxiety, eating disorders).
    - Comparing visual and hearing impairments, in the survey of older adults in the Highlands[82], conducted before the pandemic, a higher proportion of those with a visual impairment appeared to report feeling lonely compared with those with a hearing impairment.

Isolation

Evidence concerning different types of isolation was identified. Specifically, whether or not older adults have regular contact with others, live with other people, or live in rural or urban areas. Overall, evidence was mixed across these types of isolation, although more consistent findings included older adults living alone reporting poorer mental wellbeing and a higher likelihood of experiencing loneliness than those living with others).

Older adults are suggested to be at particular risk of experiencing social isolation and not having regular contact with others. Before the pandemic, such isolation was suggested to be prevalent for several reasons including: experiences of mental health stigma and discrimination in earlier adulthood increasing social isolation over time[83]; bereavement for family and friends, resulting in smaller social networks[84]; and a lack of access and/or ability to use digital communications[85].

Older adults' risk of isolation likely increased during the COVID-19 pandemic, with 68% of Age Scotland's Big Survey 2021[86] sample reporting difficulty accessing

friends and family – 24% did not see anyone else during a typical week and only 21% saw someone every day. Added to which, many older adults were advised to or chose to minimise in-person contact during the pandemic. Roughly 9% of Scotland's older adult population (91,463) was asked to shield in June 2020, and an estimated 45-50% of adults aged 60+ choose to shield despite not being asked to do so[87]. Furthermore, restrictions on visitations to care homes might have isolated some older adults living in residential care from family and friends[88], even if they were not on a shielding list or did not choose to shield. The increased reliance on digital communications also likely impacted older adults' contact with others.

In a survey conducted before the pandemic, the Mental Health Foundation found that 80% of older adults reported that spending time with family and friends in-person improves their mental health, in comparison with 50% who indicated that it improves with time alone[89]. This finding is in line with results from the COVID-19 Shielding Programme (Scotland) Impact and Experience Survey, which found that 64% of older adults who were asked to shield reported a negative impact of shielding on their mental health. Relatedly, a survey of older adults conducted during the pandemic by researchers at the University of Stirling found that less social contact was associated with feelings of loneliness[90]. An insight from a 76-year old participant in this survey reflects this finding, as they expressed feeling the loss of their spouse "more acutely as [they had] no overnight stays from grandchildren or visits from family and friends". However, the COVID-19 Shielding Programme (Scotland) Impact and Experience Survey found that older adults aged 75-79 and 80+ were less likely to report a negative impact of shielding on their mental health (56% and 60%, respectively) than those aged 65-69 and 70-74 (70% and 63%, respectively). Such a finding might indicate that 'older' older adults were more socially isolated before the pandemic, and so the restrictions might not have had as large an impact.

The evidence was more mixed in relation to older adults' mental health outcomes depending on whether or not they live alone. Specifically:

- Older adults who live alone indicated poorer mental wellbeing and a higher likelihood of experiencing loneliness:
    - The SHeS 2016-2019 analyses indicated that older adults aged 65-69 and 70-74 (but not 75+) living alone reported poorer mental wellbeing than those living with others (graph A, Appendix 5).
    - Before the pandemic, an NHS survey of older adults in the Highlands[91] reported that a higher proportion of those living alone experienced loneliness than those living with others (75% and 62%, respectively).
    - In Age Scotland's Big Survey[92], a higher proportion of older adults living alone reported that the pandemic had made them feel lonelier, compared with those living with one other person (65% and 44%, respectively).
    - Similarly, analyses of the Lothian Birth Cohort 1936 longitudinal data[93] indicated that those living alone were more likely to report an increase in loneliness during the pandemic compared with before.
- Evidence concerning mental ill health, anxiety and depression was more mixed:

- The SHeS 2016-2019 analyses found that similar proportions of older adults living alone or with others (across all age ranges) indicated a possible psychiatric disorder or two or more anxiety or depression symptoms (graphs B, C and D, Appendix 5).
- However, analyses of Lothian Birth Cohort Study data found that, during the pandemic, poorer self-reported mental health was correlated with currently living alone[94] and that those living alone were more likely to report an increase in anxiety during the pandemic compared with before[95].

Concerning living in rural or urban settings, roughly two thirds of older adults report living in urban areas, with this being similar for those aged 65 to 74, and 75+ (Figure 8)[96]. Over 10% of older adults live in remote locations. Additionally, 39% of households in remote rural areas are older adults (living alone or with another older adults) compared with 33% of accessible rural areas[97].

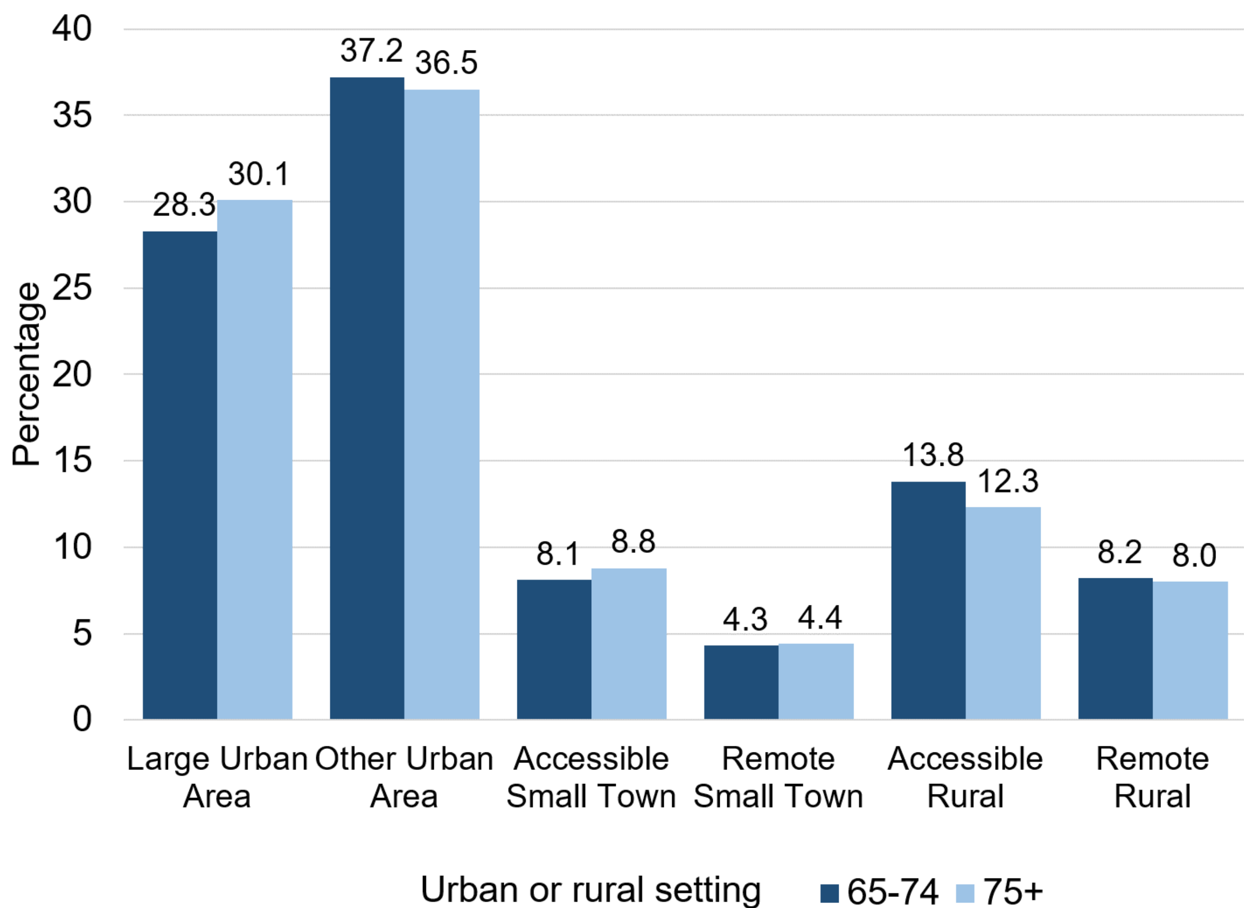


Figure 8. Percentage of older adults living in urban and rural settings by age range (Scottish Surveys Core Questions)

The evidence was also mixed in relation to older adults' mental health outcomes depending on whether they lived in rural or urban settings:

- The SHeS 2016-2019 analyses found that:

- Older adults living in rural settings reported better mental wellbeing, although this was primarily the case for those aged 70-74 (Graph A, Appendix 4).
    - For older adults aged 70-74, those living in rural settings were also less likely to report two or more symptoms of depression (Graph D, Appendix 4).
    - For older adults aged 65-69, those living in rural settings were less likely to indicate a possible psychiatric disorder.
    - The proportions of older adults living in rural and urban settings who reported two or more anxiety symptoms were similar.
- Before the pandemic, a survey of older adults in the Highlands[98] found that:
    - Older adults living in urban areas were the least likely to experience loneliness (60%), compared with those living in very remote rural and accessible small towns (72% and 71%, respectively).
    - However, for 'intense' loneliness, older adults living in very remote small towns and urban areas were more likely to experience this feeling (10% and 9%, respectively), compared with those living in accessible rural settings (5%).

Caring responsibilities

Combined data from several representative surveys indicates that roughly 17% of older adults aged 65-74 provide unpaid care, compared with 12% of those aged 75+[99]. However, little evidence was identified that compared the mental health of those with and without such responsibilities. The SHeS 2016-2019 analyses were able to investigate this, but those with and without such caring responsibilities were found to be similar in terms of mental wellbeing, having a possible psychiatric disorder, and experiencing anxiety or depression symptoms (graphs A to D, Appendix 6).

Regarding loneliness, a survey of older adults in the Highlands conducted before the pandemic[100] found that a larger proportion (79%) of older adults providing 20+ hours of care reported feeling lonely, compared with those providing fewer hours of care (between 58% and 65%). This finding is in line with the insight that loneliness results from older adults' caring responsibilities, which was found through a consultation with older adults[101], and open-response questions on a survey conducted by researchers at the University of Stirling[102]. Consultations also suggested that a lack of respite from caring responsibilities during the pandemic impacted older adults' mental health, and that caring responsibilities were seen as more likely to fall to women rather than men[103].

Finances and deprivation

Little evidence was identified that investigated how older adults' mental health varies in relation to finances and deprivation. In terms of mental wellbeing, the SHeS 2016-2019 analyses found that older adults with lower (compared with higher) incomes, and who experienced higher (compared with lower) deprivation reported poorer mental wellbeing (Graphs A, Appendices 7 and 8). However, no differences between older adults on the basis of income or deprivation were found regarding the likelihood of indicating a possible psychiatric disorder, except more

deprived older adults aged 65-69 being more likely to indicate a possible disorder. Regarding loneliness, similar levels of loneliness were reported by adults living across the SIMD quintiles in an NHS survey of older adults in the Highlands conducted before the pandemic[104].

Older adults’ mental health services

This section focuses on findings related to the access and delivery of older adults’ mental health services.Evidence is first presented about how the access and delivery of older adults’ mental health services compares with other age groups’ services. Research findings are discussed relating to how the access to and delivery of these services were impacted by the COVID-19 pandemic. Last, research is outlined that has compared older adults with different characteristics (e.g., older men compared with older women) in terms of the access and delivery of mental health services.

Compared with other age groups

Accessing mental health services

This review was unable to identify research that directly compared older adults to other age groups in terms of their access to mental health services. Feedback following consultations with third-sector organisations[105] gave insights into issues that are more likely to affect older adults..

Age-related self-stigma (i.e., when someone holds negative and unfair beliefs about themselves) was particularly emphasised as making it less likely that older adults will access mental health services. For example, seeking help for mental health might affect older adults’ self-esteem, as they might view it as embarrassing or self-indulgent, or as affecting how others view them (e.g., as having lost status or the ability to make decisions for themselves). Relatedly, it was suggested that older adults may feel too proud or stoic to seek help, find it difficult to be open about their mental health, want to avoid being a burden, or believe that other people require the services more.

Knowledge about mental health and support was also indicated in the consultations to affect older adults’ accessing of mental health services. Specifically, compared with younger adults, older adults were suggested to be less aware of signs of mental health issues, modern therapies or treatments for these issues, or how to access mental health support. In research concerning local authorities’ COVID-19 helplines[106], findings suggested that callers to these helplines were often older, and seemed distressed, anxious and isolated. This finding could therefore suggest that older adults do not have sufficient knowledge about mental health and associated services and, as a result, they reach out to less appropriate services.

Transition to and delivery of older adult mental health services

Evidence concerning the transition to and delivery of older adult mental health services highlighted three key issues. First, the transition from adult to older adult statutory mental health services varies greatly between local authorities, and is indicated to be problematic. Second, there is a lower availability and quality of older adult services compared with adults services. Third, older adults with mental health issues are suggested to be detrimentally impacted when admitted to wards that also see older adults with dementia, compared with wards that only see patients

with mental health issues. A key piece of evidence relating to both of these issues is a report from the Mental Welfare Commission for Scotland[107], which presents findings based on visits to 23 National Health Service wards for older adults with 'functional mental illness' (which excludes dementia).

Regarding the transition from adult to older adult mental health services, the variability of the transition was captured in the Mental Welfare Commission for Scotland's consultations with psychiatrists. Specifically, a third of the psychiatrists reported that a discussion with the patient about the transition occurs at 65, while a minority reported an automatic transfer at 65 (7%) or the patient remaining in general adult services (6%). Other processes for transitions were also outlined, including different cut-offs (e.g., 70) or being dependent on the patient developing further mental or physical health problems. The majority of psychiatrists consulted (24 out of 44) indicated that the patient was involved in the transition decision, and the commission's report indicated that there was 'a sense' that automatic transfers should not occur due to age limits being arbitrary (i.e., not reflecting retirement age). As a result of the transition between adult and older adult mental health services, patients moving between the services were indicated to commonly experience a disruption in their mental health support.

Regarding the availability and quality of older adult mental health support, the psychiatrists consulted for the Mental Welfare Commission for Scotland's report suggested that, there was a smaller range of social work services, as well as a lack of Crisis Assessment and Support Teams for those in crisis, longer waiting times for multidisciplinary team services, and fewer specialist services (e.g., eating disorders). Staff lacking experience of working with older adults was also highlighted in the Mental Welfare Commission for Scotland's report, such as nursing staff turnover being seen to result in less experience working with older adults. Research conducted for the Age in Mind project[108] also found that older adults using mental health services reported experiencing discrimination from health and social care staff, such as overhearing abusive comments, not being believed or listened to, and being made to feel worthless. The Health and Social Care Alliance Scotland consultation with older adults, and those who support and work with them, found that older adults reported that their services were less aspirational[109]. This was also supported with our consultation with Support in Mind Scotland, who expressed a cultural perception that deteriorating mental health is 'part and parcel' of older adulthood.

Concerning dementia and mental health issues, the Mental Welfare Commission for Scotland found that the majority of wards for older people with 'functional mental illness' (19 out of 23) reported being mixed wards – i.e., including older adults with dementia and mental health issues – or being mental health wards that regularly admitted dementia patients (e.g., due to bed shortages). Mixing older adults with dementia and/or mental health issues was viewed by staff contributing to the report as negatively affecting older adults with mental health issues. In roundtable discussions conducted as part of the 'Falling Off a Cliff at 65'[110] project, participants suggested that dementia takes attention away from mental health issues in older age. Furthermore, in focus groups detailed in the Fragile Foundations report[111],

care staff mentioned that if an older adult is diagnosed with dementia, any mental health issues they might experience are often neglected or attributed to their dementia.

Before and during the COVID-19 pandemic

Specific aspects of the pandemic likely affected older adults accessing services (e.g., fear of catching COVID-19, concern about putting pressure on the National Health Service, increase in remote or digital appointments)[112].

Public Health Scotland data concerning psychological therapies indicates that the number of adults being referred to and starting therapy and the percentage of older adult referrals seen within 18 weeks all decreased following the start of the pandemic[113]:

- Regarding referrals of older adults to psychological therapies:
    - The number of older adult referrals to psychological therapies decreased from 4,083 during January to March 2020 (mainly before pandemic related restrictions) to 2,599 during April to June 2020 (mainly coinciding with the first lockdown).
    - From these two periods in 2020, the number of older adult referrals for these services increased to 4,855 in April to June 2021.
- Regarding the number of older adults starting psychological therapies:
    - 537 older adults accessed psychological therapies during the period April to June 2020 (mainly coinciding with the first lockdown), which represented a 52.1% reduction (from 1,121 older adults) compared with the previous quarter (January to March 2020, mainly before the introduction of any restrictions).
    - The number of older adults starting psychological therapies in April to June 2020 represented a larger reduction (55.3%, from 1,201 older adults) when compared with the same period in 2019.
    - During April to June 2021, the number of older adults starting psychological therapy treatments (1,176) was similar to before the start of the pandemic.
- Regarding the proportion of older adults seen within 18 weeks of a referral to psychological therapies:
    - During April to June 2020, 84.4% of older adults had started psychological therapy within 18 weeks of being referred, which was a reduction from 87.2% in January and March 2020, and 87.3% in April to June 2019.
    - While the proportion being seen within 18 weeks during April to June increased in 2021 (86.3%), this was still lower compared with the same period before the pandemic in 2019 (87.3%).
    - Numbers of older adult mental health inpatients, and discharges from inpatient services also decreased during the pandemic[114].
- Concerning numbers of mental health inpatients, there were fewer older adults patients in the 2020/2021 financial year (3,010 in psychiatric specialities, and 8,020 in any specialities), compared with before the

pandemic in 2019/2020 (3,250 in psychiatric specialities, and 8,840 in any specialities)[115].
- Fewer older adult mental health inpatients were discharged during the 2020/2021 financial year (4,570 from psychiatric specialities, and 18,880 from any specialities), compared with 2019/2020 before the pandemic (4,980 from psychiatric specialities, and 19,520 in any specialities).
- A caveat of these data are that the numbers include inpatients with dementia, and, as such, these patterns might not be the same for older adult mental health inpatients excluding those with dementia.

With regards to dementia, in a roundtable conducted as part of the 'Falling Off a Cliff at 65'[116] project, the mixing of older adults with mental health conditions and dementia was suggested to have increased since the previously discussed Mental Welfare Commission for Scotland's report[117], which was published shortly before the pandemic. As these mixed wards tend to be viewed as detrimental to older adults with mental health conditions, the increased mixing might have made this situation worse. However, further evidence is needed to confirm the extent to which such wards have become more mixed.

In addition to health services, other services providing mental health support to older adults were likely impacted by the pandemic. Through consultations with older adults and people who work with them, the Health and Social Care Alliance[118] reported that other agencies and services were more difficult to access during the pandemic, such as social work, housing associations, and community groups (e.g., churches). As a result, some older adults in these consultations indicated that they felt as if they had been left to cope on their own during the pandemic.

Demographic differences

Older adults are not a homogenous group and different characteristics might influence some older adults' interactions with mental health services.

Experience of mental health services before turning 65

Through our stakeholder consultations as part of the mental health EHRF[119], older adults who had had experience of accessing mental health support and services before turning 65 were viewed to be at an advantage (e.g., better knowledge about services). As a result, concerns were expressed in these consultations that older adults accessing mental health services for the first time are likely at a disadvantage.

However, in the 'Falling Off a Cliff at 65' roundtables[120], older adults were said to potentially experience a loss of access to or continuity of mental health services when they turned 65 (e.g., community psychiatric nurse support, psychiatrists). As a result, older adults who have been engaged in mental health services in earlier adulthood might experience a reduction or loss in support networks that they have developed over time when they turn 65.

Relatedly, participants in the Age in Mind research project's focus groups[121], highlighted that some financial benefits (e.g., Disability Living Allowance) were only available to those who developed a mental health issue before 65. As such, older

adults who develop a mental health issue after 65 might experience financial issues as a result, which might have an impact on their mental wellbeing (as indicated in the SHeS 2016-2019 analyses).

Older men and women

Public Health Scotland's mental health inpatient activity data[122] provides information separately for older men and women. The data indicates that a higher number of older women were inpatients and discharged in the 2019/2020 financial year. The same pattern was observed in the 2020/2021 financial year with regard to inpatients and discharges from any specialities, although more older men were inpatients and discharged from psychiatric specialities. Despite these differences being observed, it is difficult to draw strong conclusions based on these data, as the figures include inpatients with dementia and the increasingly higher proportion of older women within the older adult population as age increases could explain the differences.

Concern was expressed in our stakeholder consultations that older women's mental health was not viewed as a sufficiently serious issue, and that even healthcare professionals minimised older women's experience of mental health issues[123]. This was specifically mentioned in relation to the greater consideration given to stressors that affect younger women, such as pregnancy and maternity. The Scottish Women's Convention also spoke with older women as part of a consultation on older women's mental health in 2021, where several participants stated that they felt insufficiently supported, and that there is an expectation in society that older women should be able to deal with their own mental health issues. However, a service provider participating in the consultation reported having unused capacity to support older women, but had experienced issues in identifying older women who would benefit from the service.

LGBTI+ People

Through our stakeholder consultations[124], older LGBTI adults were suggested to be concerned about experiencing a lack of understanding from services (including care homes), as well as experiencing discrimination or feeling 'invisible', and receiving poorer treatment. This is evidenced as an existing issue in research pre-pandemic. Older LGBTI adults were also suggested to conceal their true identity when engaging with services to avoid stigma and discrimination, as well as due to concerns about the services' confidentiality (e.g., informing the individual's family or friends).

Ethnic and religious background

Older adults from Black, Asian and Minority Ethnic (BAME) groups[125] appear to be overrepresented in mental health services. In the 'Racial Inequality and Mental Health in Scotland' report[126], the Mental Welfare Commission for Scotland present National Health Service data showed that 7% of admissions and detentions to older adult beds were people from BAME groups, compared with 1% of older adults in Scotland being from BAME groups.

In several stakeholder consultations[127], the lack of information, advice and support provided in languages other than English was raised as an obstacle for some older adults accessing mental health services. These services were also suggested to be insufficiently sensitive to minority ethnic and religious needs of older adults, instead taking a 'one size fits all' approach[128].

Physical health conditions and sensory impairments

Mental health support is suggested to be negatively impacted if older adults also have other health conditions. As outlined earlier in this section, dementia is suggested to have a large influence on older adults' mental health services. For example, the Fragile Foundations report[129] indicated that an older adults' mental health issues might be neglected if they are diagnosed with dementia. This appeared to extend to any physical issues experienced by older adults, as participants in the Health and Social Care Alliance's consultations[130] suggested that general practitioners typically focus on older adults' physical health issues to the detriment of their mental health needs.

Changes to services during the pandemic were also seen to pose specific challenges for older adults with hearing loss. Through a survey conducted during the pandemic of older adults with varying degrees of hearing loss[131], participants expressed experiencing stress due to the lack of transparent masks available for healthcare staff, as well as highlighting that remote communication was not always suitable due to hearing loss.

Isolation

For older adults who were geographically isolated, or who were digitally excluded, access to mental health services was highlighted to be problematic. In Support in Mind Scotland's 'Well Connected Communities' report[132], older adults living in rural communities stated that there were transport barriers to accessing in-person mental health support, particularly in the most rural areas, and in the evenings and at the weekends. Through consultations with older adults[133], older adults were suggested to be more likely to be digitally excluded, and, therefore, excluded from digital forms of mental health support and services, which became the main form of delivery during the pandemic. It should be noted that being geographically isolated and digitally excluded are not mutually exclusive, as older adults living in remote areas might not have access to reliable internet[134].

Receiving care

For older adults living in care homes or receiving care at home, accessing mental health support or services was considered challenging. The Fragile Foundations report[135] in particular highlighted this issue through focus groups with care staff working across the independent social care sector. The care staff stated that there was often a neglect of older adults' mental health in their care plans, and further emphasised that dementia can distract from the mental health needs of older adults receiving care. Supporting the mental health needs of older adults receiving care at home was viewed as particularly problematic, as care staff's contact with the individual was extremely limited. However, limited time to support older adults was

also cited for care home staff, as there were typically competing demands that the staff had to deal with.

Conclusions and next steps

Conclusions

This evidence review sought to answer the following 3 research questions:

1. How does older adults' mental health and the access and delivery of older adults' mental health services compare with other age groups?
2. How has the COVID-19 pandemic affected older adults' mental health and the access to and delivery of older adults' mental health services?
3. How do individual characteristics (e.g., ethnicity) affect older adults' mental health, and the access to and delivery of older adults' mental health services?

The key conclusions to be drawn from the review are:

While older adults (65+) appear to report better mental health outcomes than younger adults, this might alternatively reflect that they are less likely to report poor mental health. The grouping of all older adults into one age range (e.g., 65+) might also conceal differences across the life course, with tentative evidence suggesting that those in later older adulthood (e.g., 75+) might report poorer mental health outcomes than those in earlier older adulthood (e.g., 65-69).

The COVID-19 pandemic appeared to have a detrimental effect on older adults' mental health, particularly loneliness.

Older adults with a physical health condition (compared with those without), and who live alone (compared to living with other) indicated poorer mental health for some specific outcomes, (e.g., mental wellbeing, loneliness). Differences based on older adults' demographics could not be assessed for several characteristics (e.g., ethnic and religious background) as large gaps in evidence were identified.

Several challenges for older adults' mental health services were identified, including: the varied approach to older adults transitioning from adult to older adult services; low availability and quality of services; and dementia being seen to lead to a neglect of older adults' mental health.

In terms of psychological therapy referrals, waiting lists and new patients, older adults' mental health services show signs of recovering following a decrease in these rates during the COVID-19 pandemic.

Large evidence gaps were also identified in relation to demographic differences in older adults' mental health services.

Limitations of evidence

Lack of evidence

The largest limitation of the findings from this review concerns the lack of evidence to meet some of its aims. The scarcity of evidence concerning older adults' mental health was also emphasised by stakeholders and other researchers[136]. A lack of evidence concerning demographic differences meant that strong conclusions could not be drawn, particularly on the basis of LGBTI+ identities, ethnic and religious backgrounds, caring responsibilities and finances and deprivation. Regarding older adults' mental health services, there was little evidence concerning non-statutory services, with most available evidence regarding statutory services, such as National Health Service wards. There was also a general lack of evidence from during the pandemic, which could be a result of practical issues (e.g., restrictions on in person meetings), and the time taken from collecting evidence to publishing a report.

Inconsistency in methods used to generate evidence

The evidence presented in this review does not allow strong conclusions to be drawn, as there is inconsistency in how the evidence included in the review was generated. For example, the evidence varied in terms of: the mental health outcomes that were focused on (e.g., loneliness, anxiety, mental wellbeing); how a mental health outcome was assessed (e.g., a scale or one question); how older adults were defined (e.g., 55+, 70+); and the groups older adults were compared with (e.g., 18-29 year-olds, 30-59 year-olds). The different points at which data on mental health was collected during the pandemic is also important to consider, as evidence collected two months' apart might not be comparable due to different restrictions being in place.

Small and unrepresentative samples

Several studies had small or unrepresentative samples. Such samples make it difficult to conclude how meaningful a difference is, or whether the findings can be applied to others not represented in the sample. The SHeS 2016-2019 analyses was conducted to address these issues, as the SHeS 2016-2019 data allowed more robust conclusions to be drawn due to the larger and more representative samples involved. The representativeness of samples during the pandemic should be considered in particular, as many studies had to be conducted online due to restrictions. As older adults might be less likely to be able to get online[137], those participating in the studies might not be representative of the wider older adult population.

Reliance on self-reported data

When assessing mental health, there is a large reliance on self-reported data (e.g., survey questions). As a result, it is not possible to conclude whether differences between two groups (e.g., younger and older adults) reflect different experiences of mental health, or different willingness in reporting mental health issues. As older adults tend to have more stigmatising views of mental health[138], they could be expected to underreport their experiences of poor mental health, resulting in the

false impression that they experience better outcomes than younger age groups. As such, the findings from self-reported data should be considered with caution.

Lessons learned and next steps

Avoid viewing older adults as a homogenous group

Findings from this review indicated differences (e.g., in mental wellbeing) between older adults of different ages (e.g., 65-69 and 75+). However, older adults were commonly grouped into one broad category (e.g., 65+), which prevents an understanding of how mental health experiences and needs from services change over the course of older adulthood. Relatedly, where evidence was identified, findings indicated differences between older adults who differed in terms of other characteristics (e.g., older men/women, living alone/with others).

Distinguish between dementia and mental health

A clear distinction should be made between dementia and mental health, particularly in older adulthood. Evidence indicated that an older adult's mental health issues might be neglected if they are diagnosed with dementia. Relatedly, mixed wards (i.e., patients with dementia, mental health issues or both) were viewed as detrimental for older adults with mental health issues. Without making a clear distinction between these, a clearer understanding of each is impeded.

Age-related stigma

Findings from this review indicate that age-related stigma affects older adults in various ways, such as affecting how they are treated in services (e.g., mental health issues to be expected in older adulthood), as well as affecting how they engage with services (e.g., not accessing services due to not wanting to be a burden).

Evidence needs

There is an overall need for more and better evidence concerning older adults' mental health and mental health services. Specific evidence needs include:

- Greater consistency in the assessment of mental health outcomes (e.g., mental wellbeing, anxiety). For example, if mental wellbeing is consistently assessed with WEMWBS, comparisons across studies are more robust.
- Clearer reporting of older adult samples in terms of age (e.g., narrower older adult age ranges, average age and range in older adult sample) and demographic characteristics (e.g., proportion of men/women, from different ethnic backgrounds).
- More quantitative and qualitative data. Where appropriate, more data from large and representative samples are needed to enable robust analyses and comparisons to be conducted. However, qualitative evidence is also needed to capture the experiences of older adults – and the various people involved in their care – in more detail. Such qualitative data can also mitigate practical issues with quantitative data collection (e.g., insufficient numbers of older adults with specific characteristics being recruited).
- More service data. While more service data are needed in general, data concerning non-statutory services are also particularly needed, as most

evidence identified in this review concerned statutory services. Additionally, the ‘Falling Off a Cliff at 65’[139] project emphasised the need for data concerning the patient journey, such as how many times they are admitted, what issues they had, what treatment they received.
- Clearly distinguishing older adults with dementia and/or mental health issues.

How to access background or source data

The data collected for this social research publication:

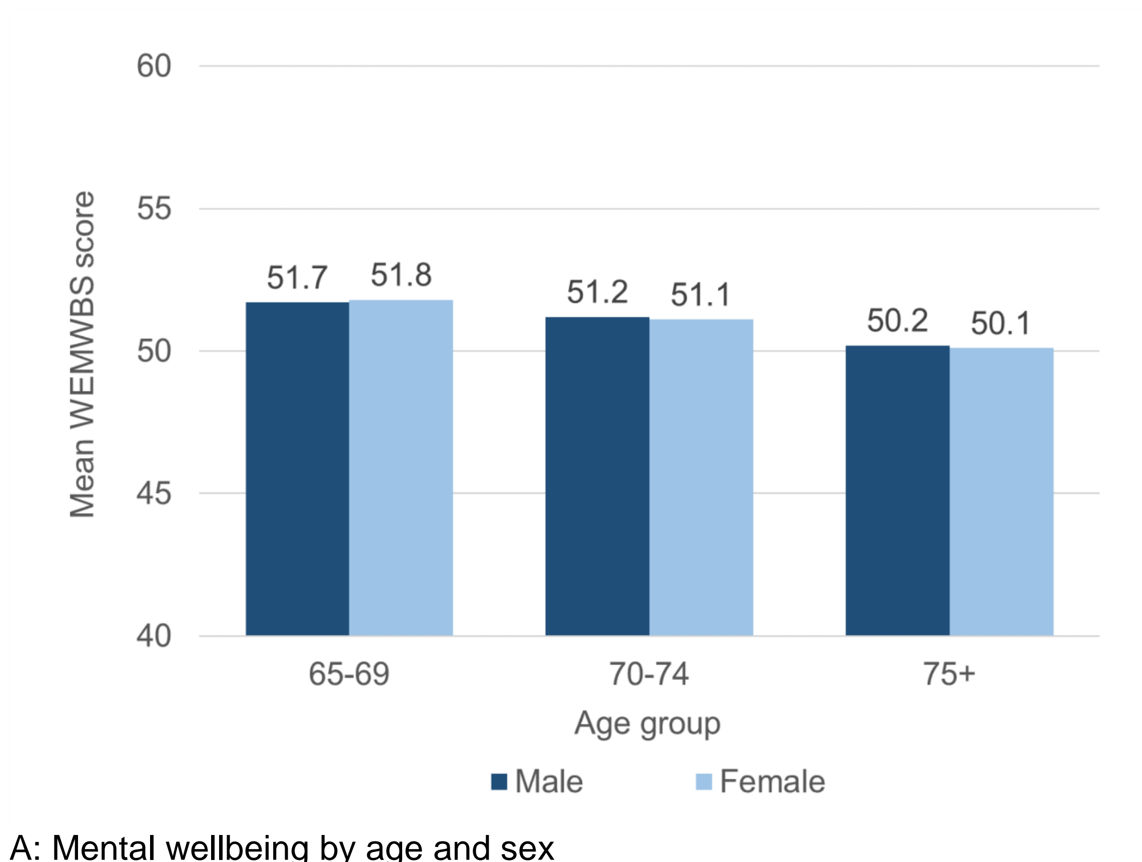
☐ are available in more detail through Scottish Neighbourhood Statistics

☐ are available via an alternative route

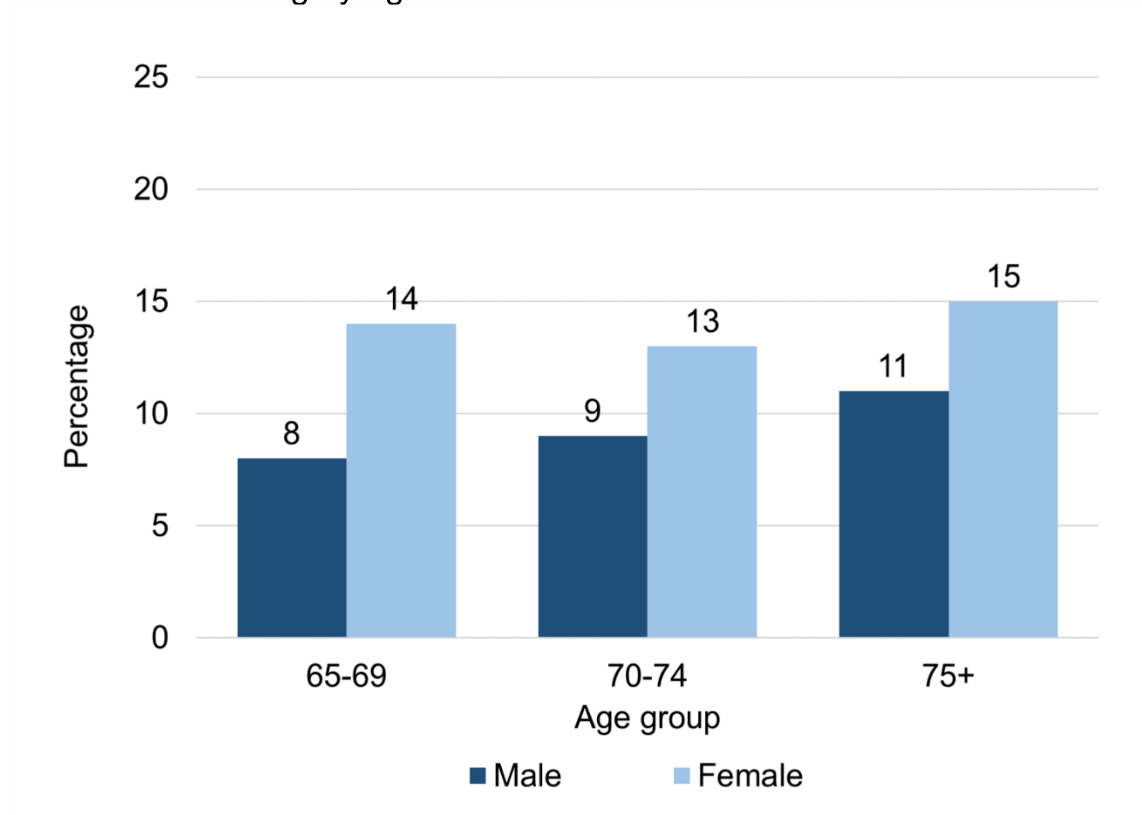
☒ may be made available on request, subject to consideration of legal and ethical factors. Please contact social_research@gov.scot for further information.

☐ cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.

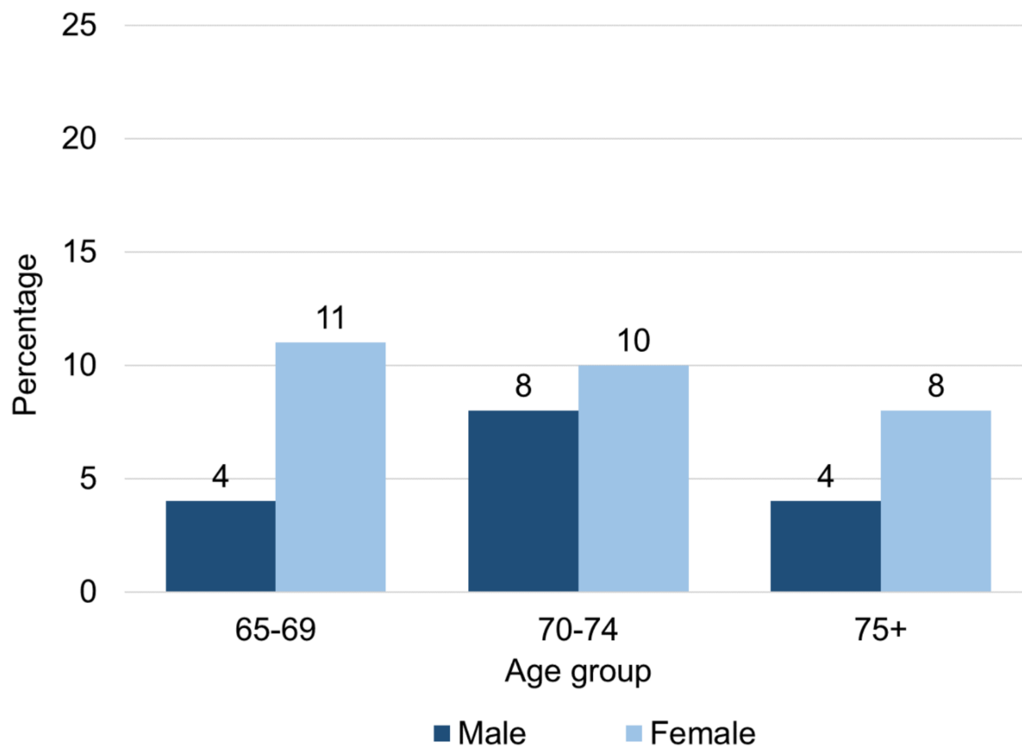
Appendix 1: SHeS 2016-2019 – Sex



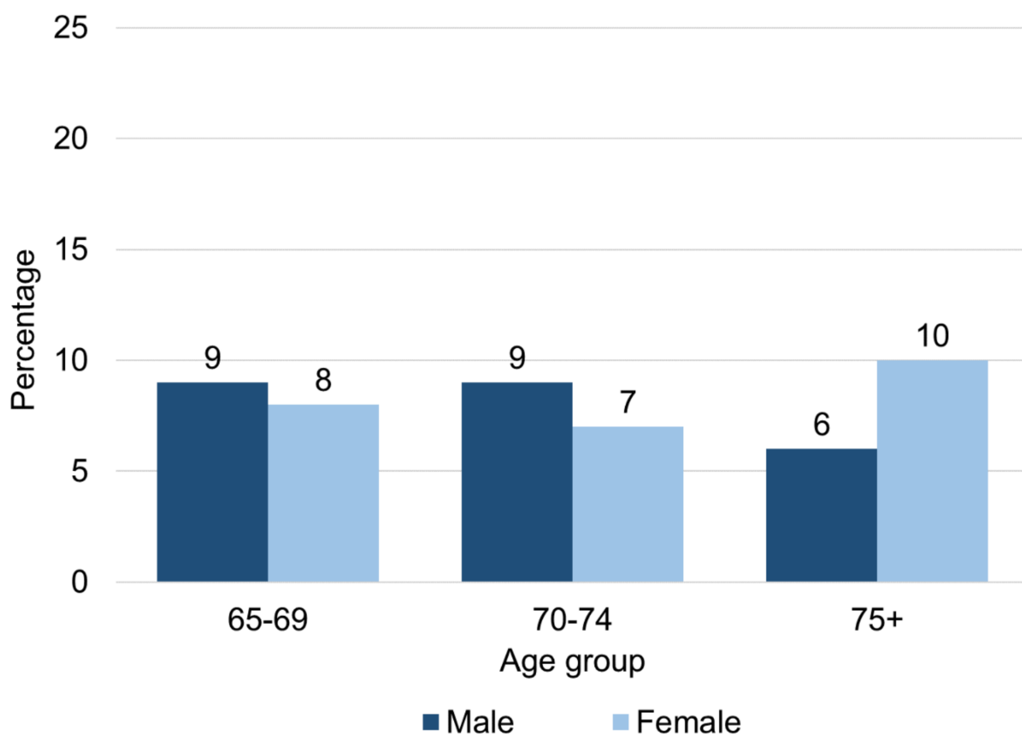
A: Mental wellbeing by age and sex



B: Possible psychiatric disorder by age and sex

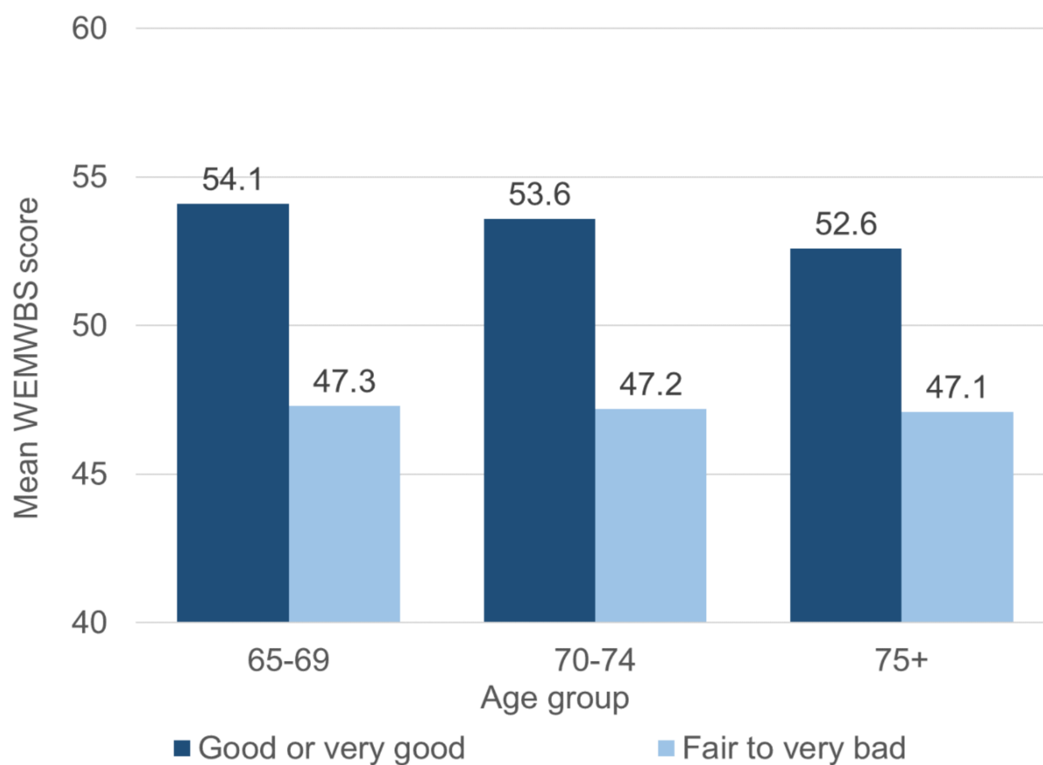


C: 2 or more anxiety symptoms by age and sex.

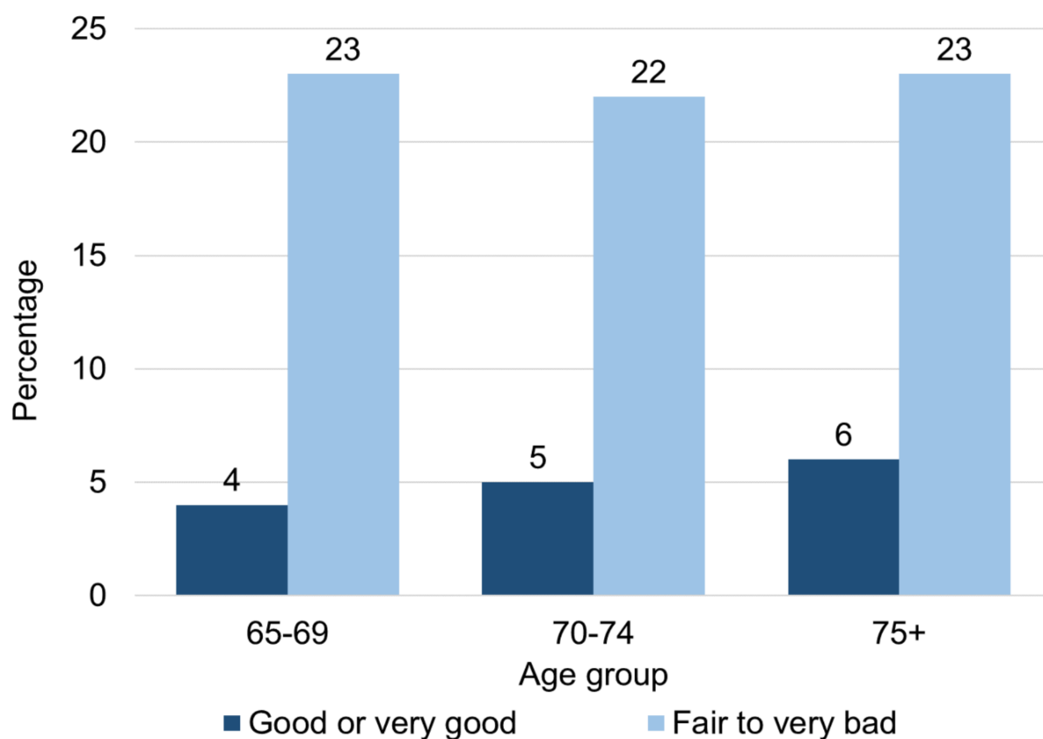


D: 2 or more depression symptoms by age and sex

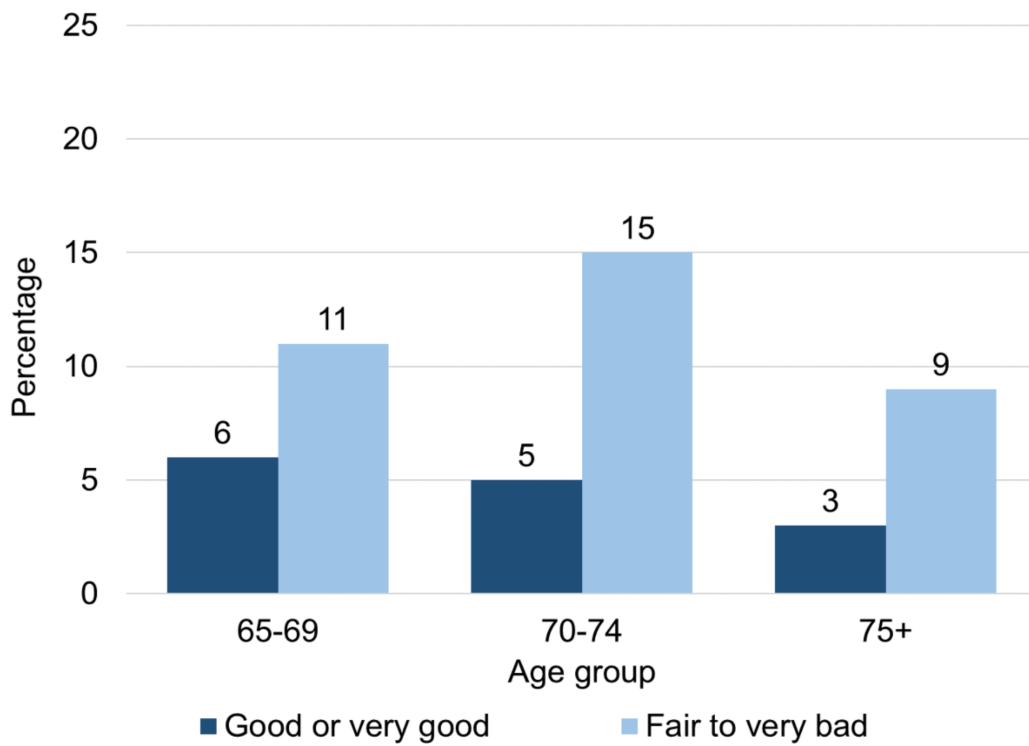
Appendix 2: SHeS 2016-2019 – Self-assessed general health



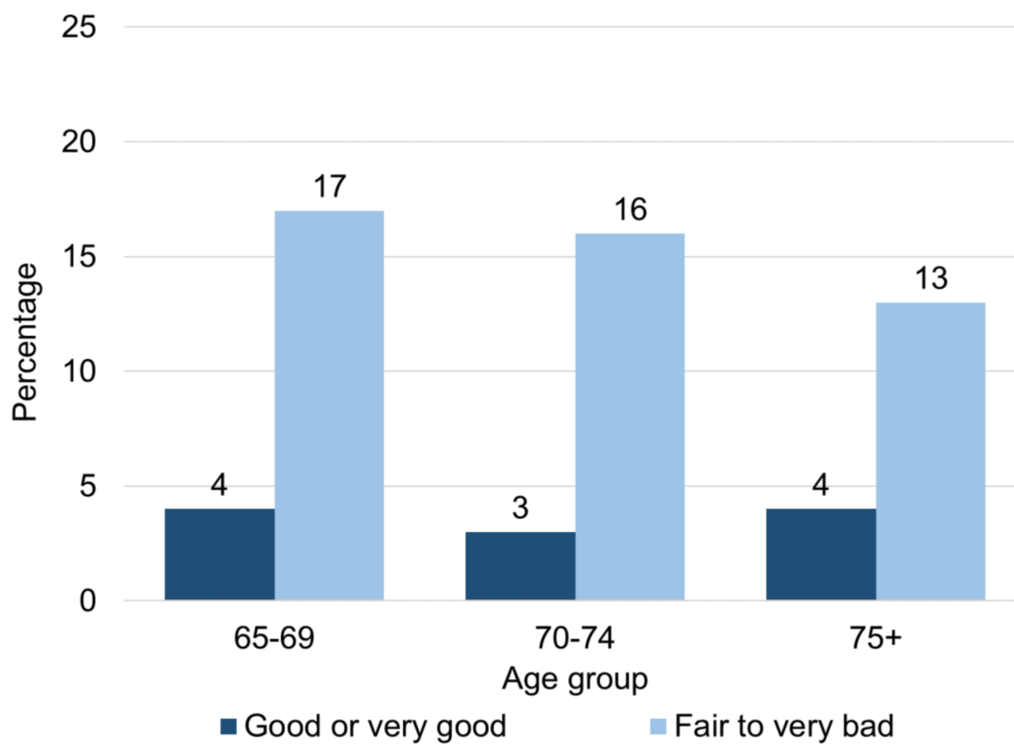
A: Mental wellbeing by age and self-assessed general health



B: Possible psychiatric disorder by age and self-assessed general health

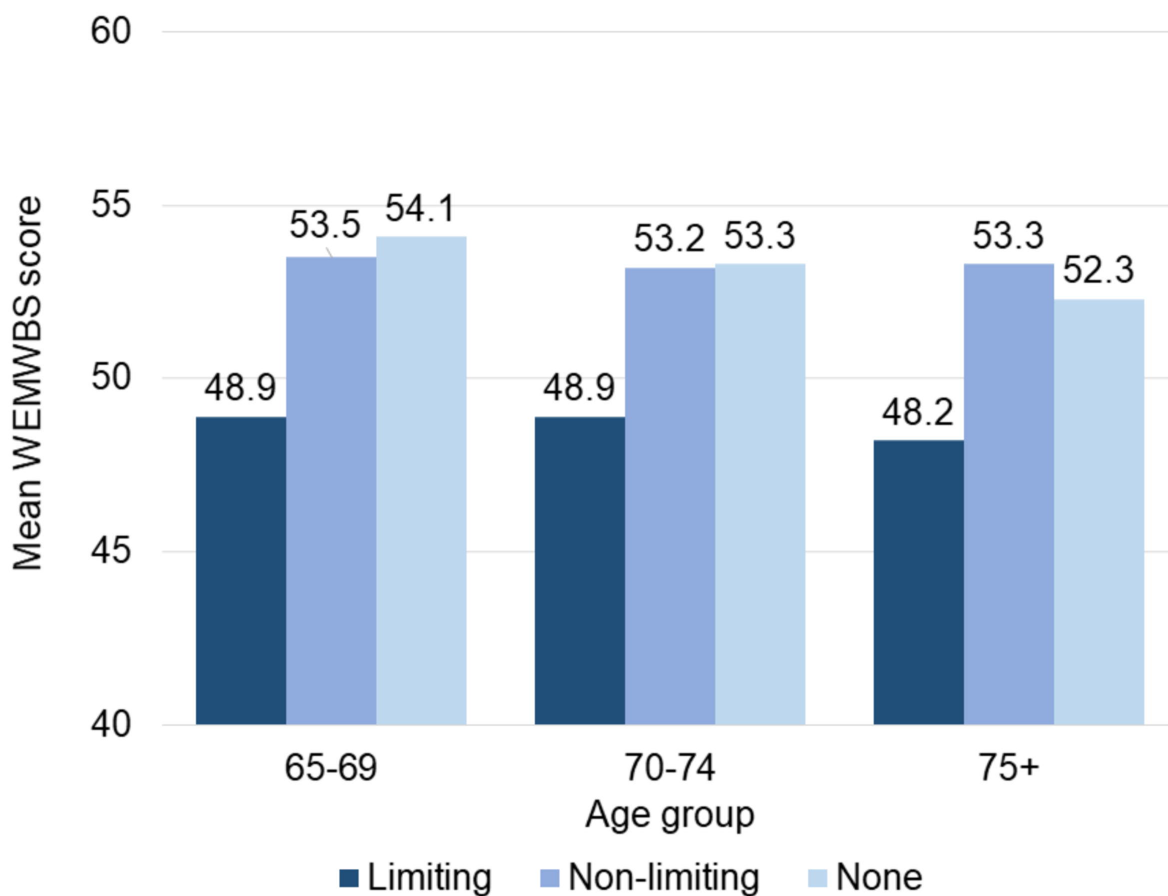


C: 2 or more anxiety symptoms by age and self-assessed general health

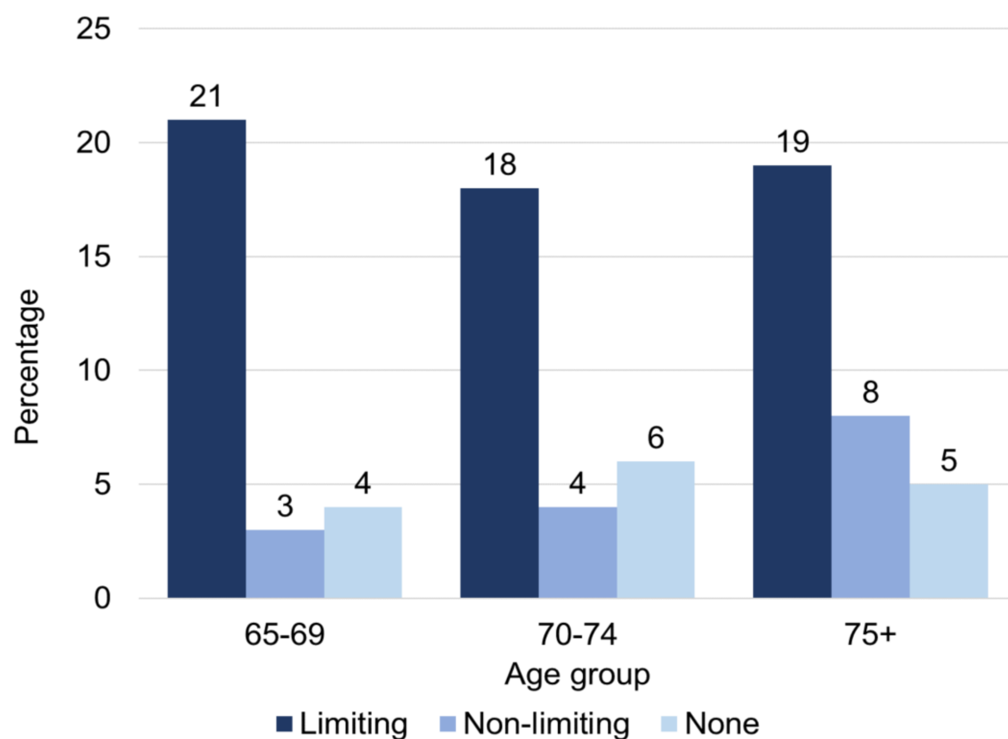


D: 2 or more depression symptoms by age and self-assessed general health

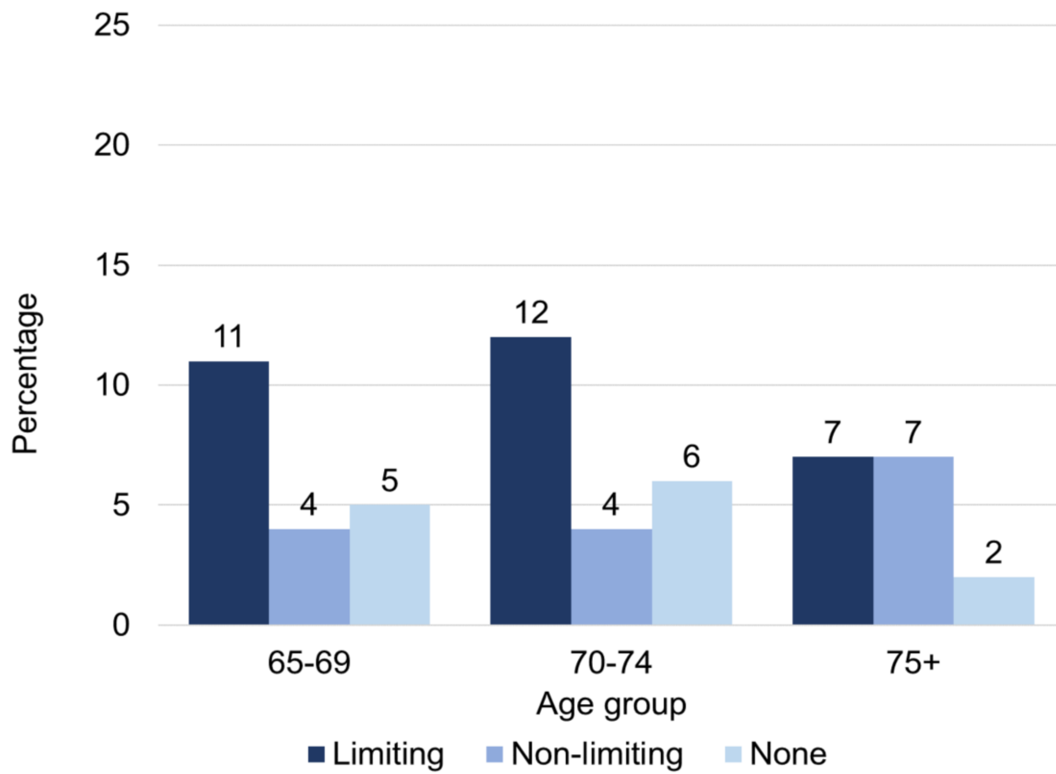
Appendix 3: SHeS 2016-2019 – Limiting long-term health conditions



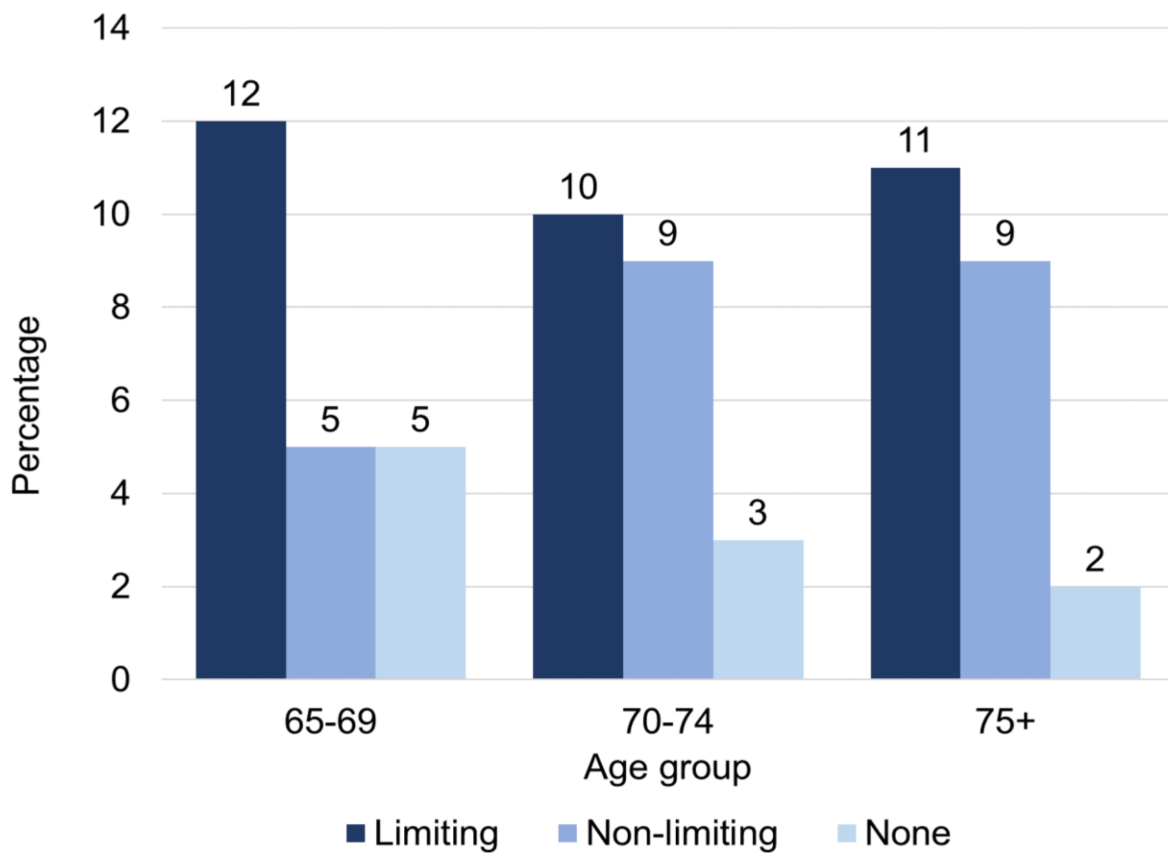
A: Mental wellbeing by age and limiting long-term health conditions



B: Possible psychiatric disorder by age and limiting long-term health conditions

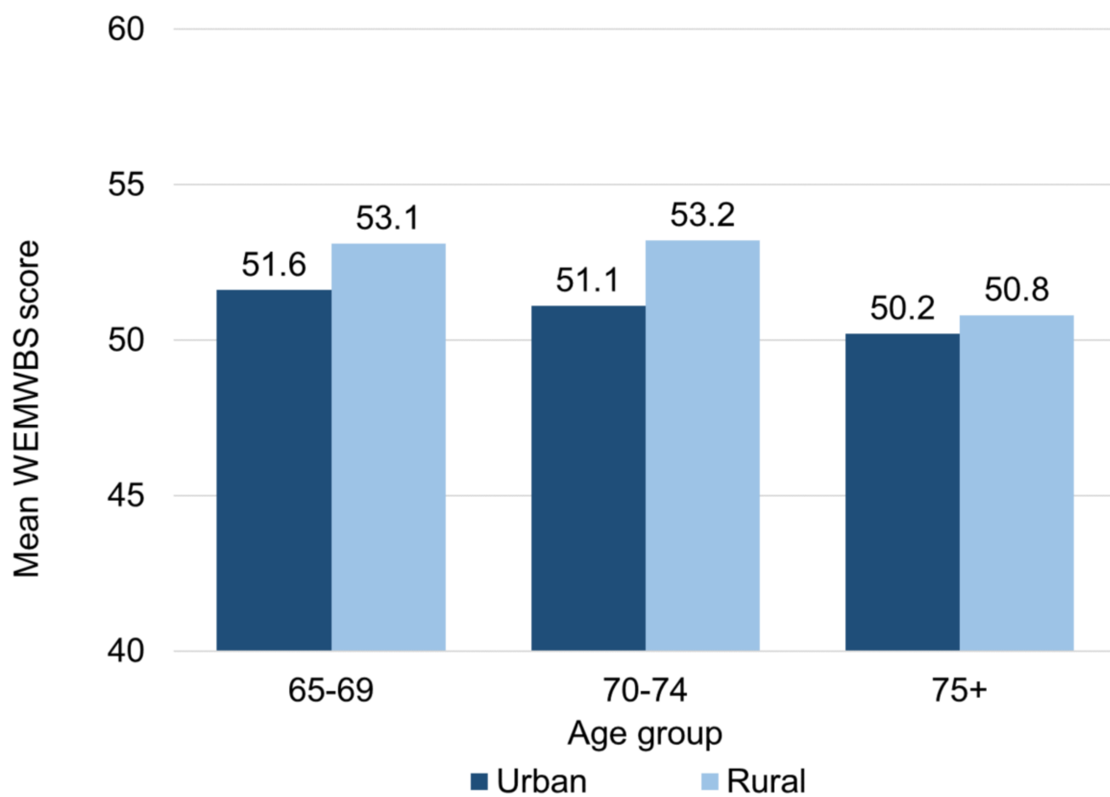


C: 2 or more anxiety symptoms by age and limiting long-term health conditions

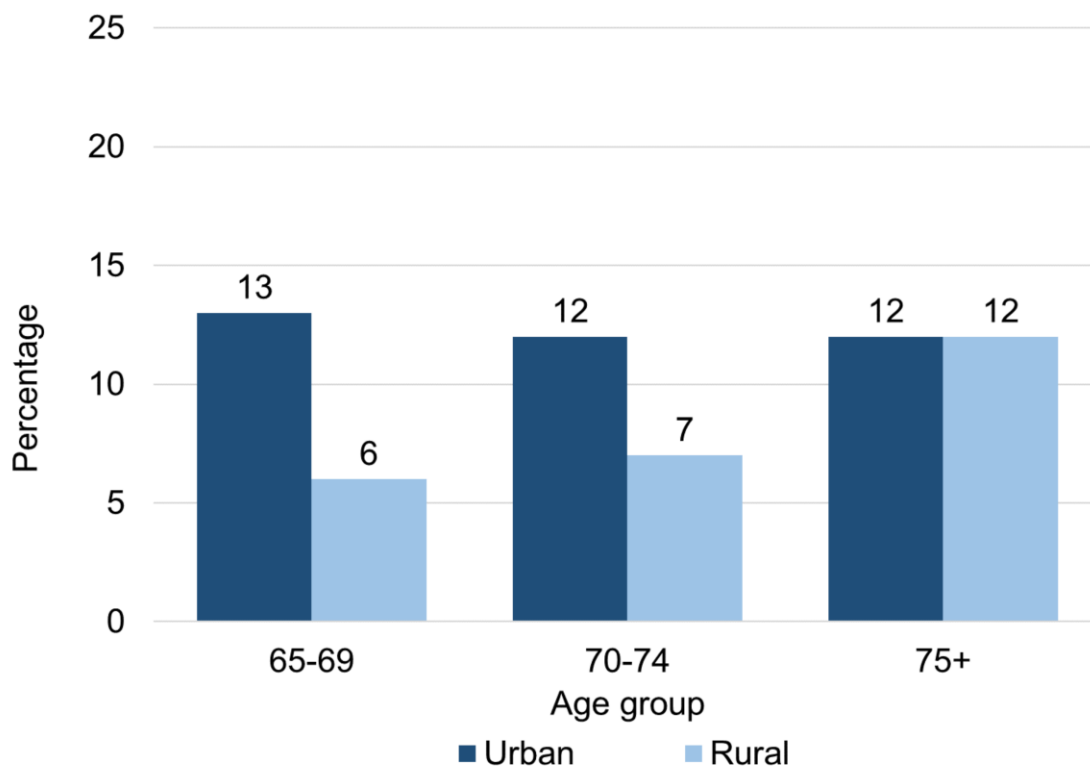


D: 2 or more depression symptoms by age and limiting long-term health conditions

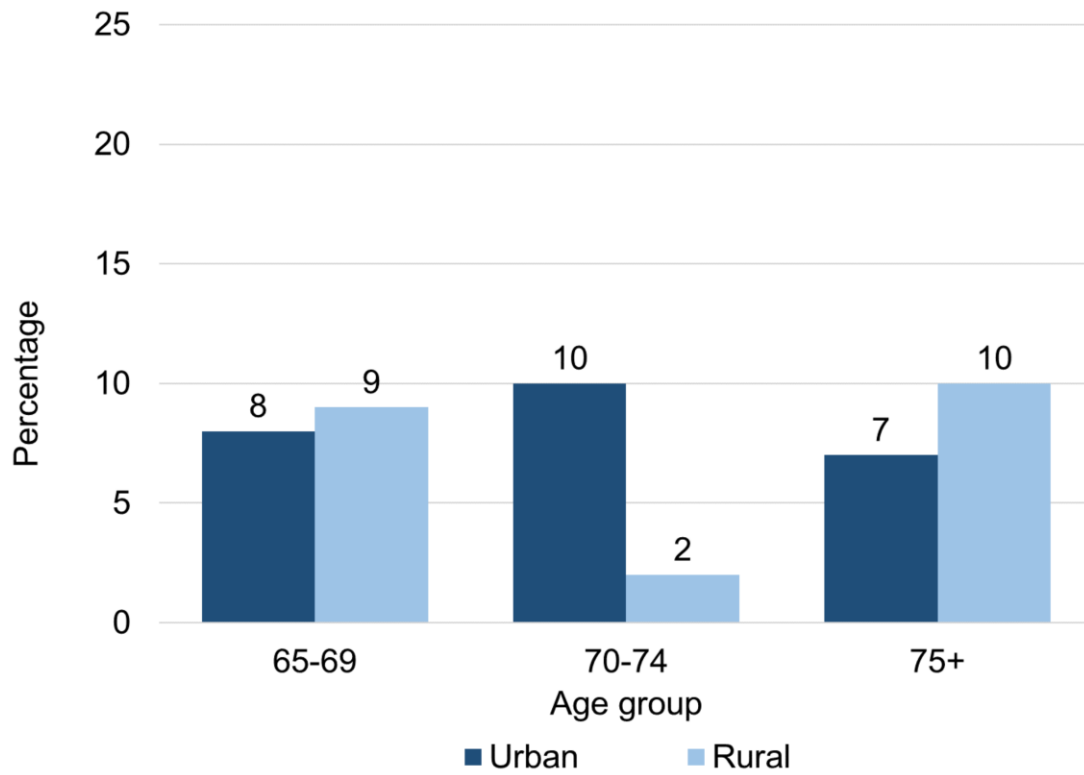
Appendix 4: SHeS 2016-2019 – Living in urban or rural settings



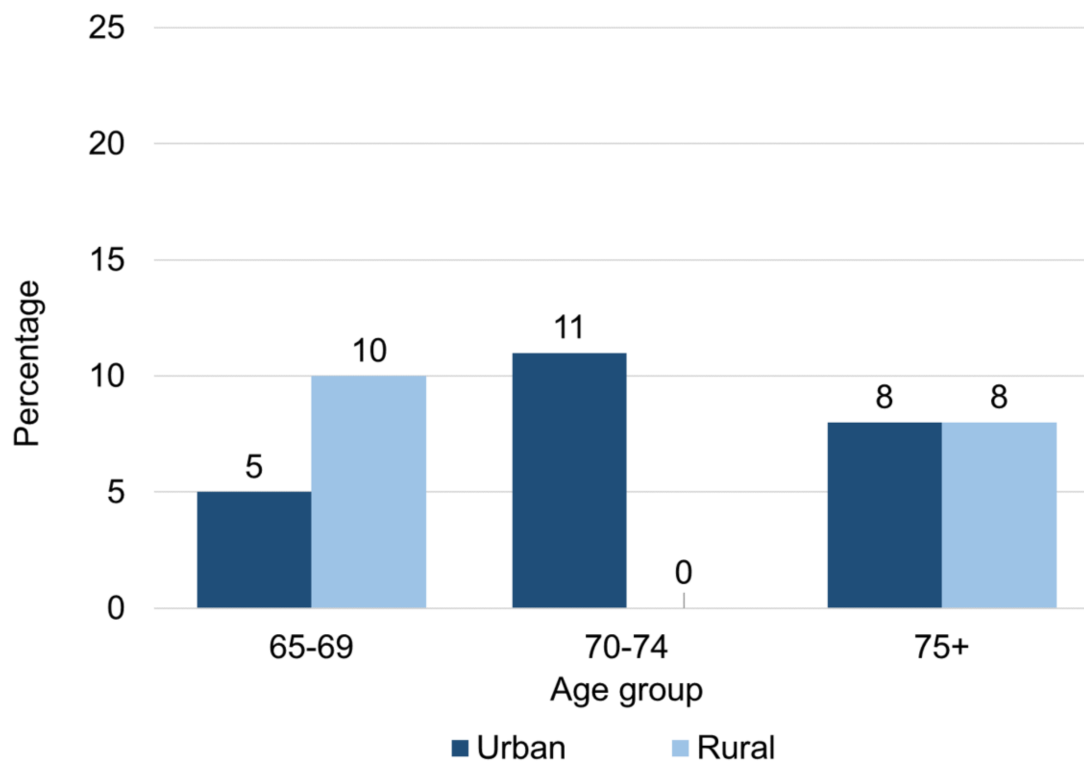
A: Mental wellbeing by age and urban or rural



B: Possible psychiatric disorder by age and urban or rural

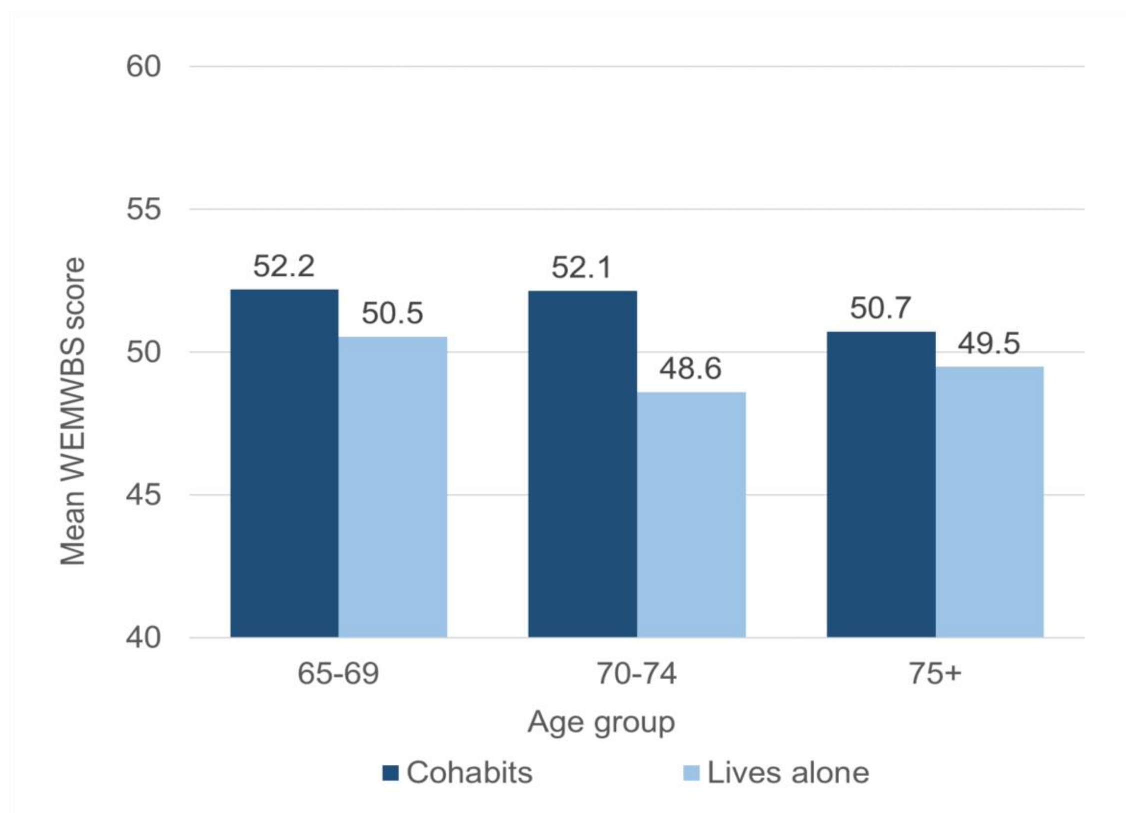


C: 2 or more anxiety symptoms by age and urban or rural

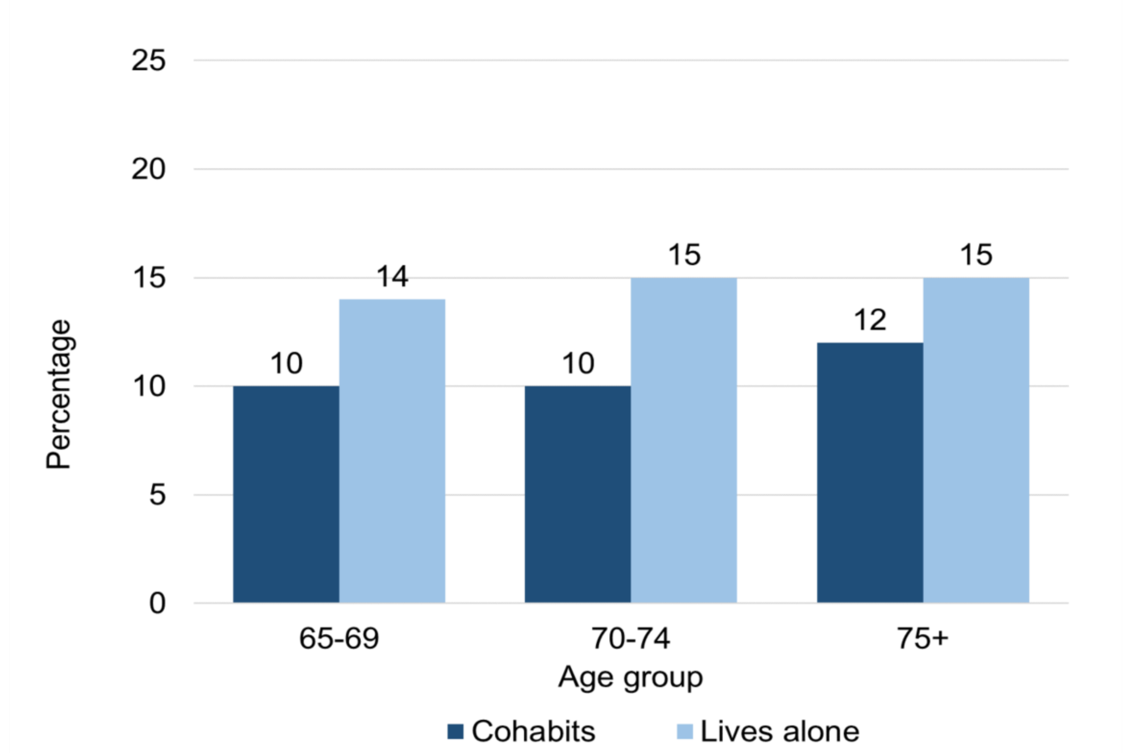


D: 2 or more depression symptoms by age and urban or rural

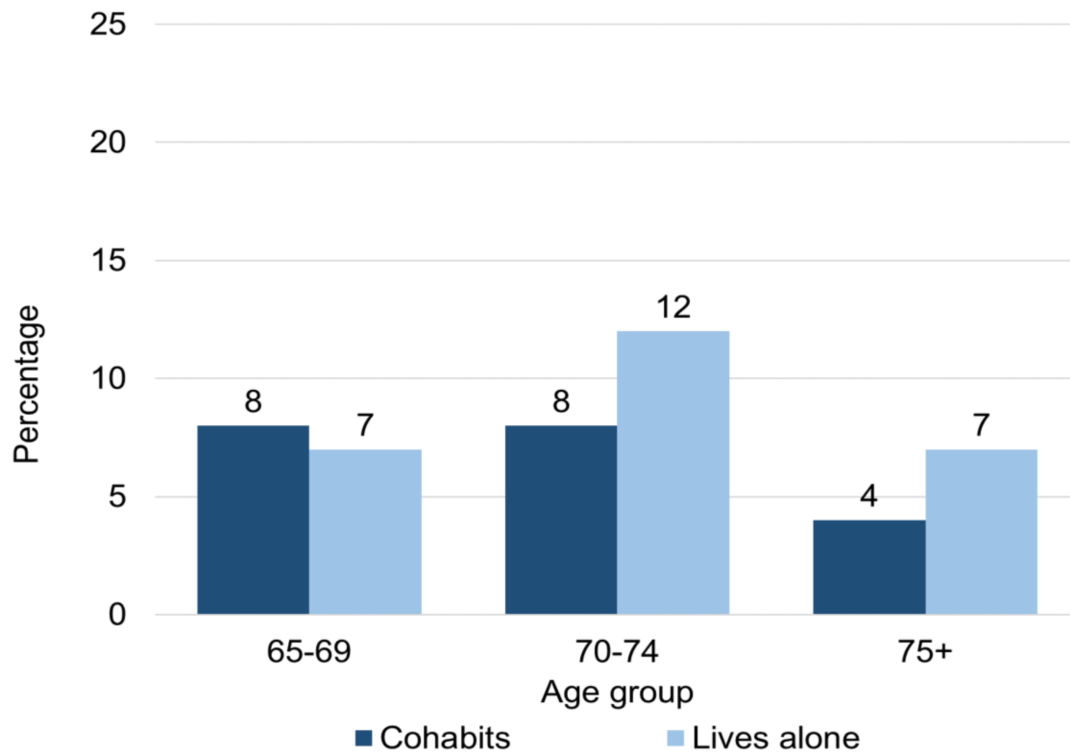
Appendix 5: SHeS 2016-2019 – Living alone or with others



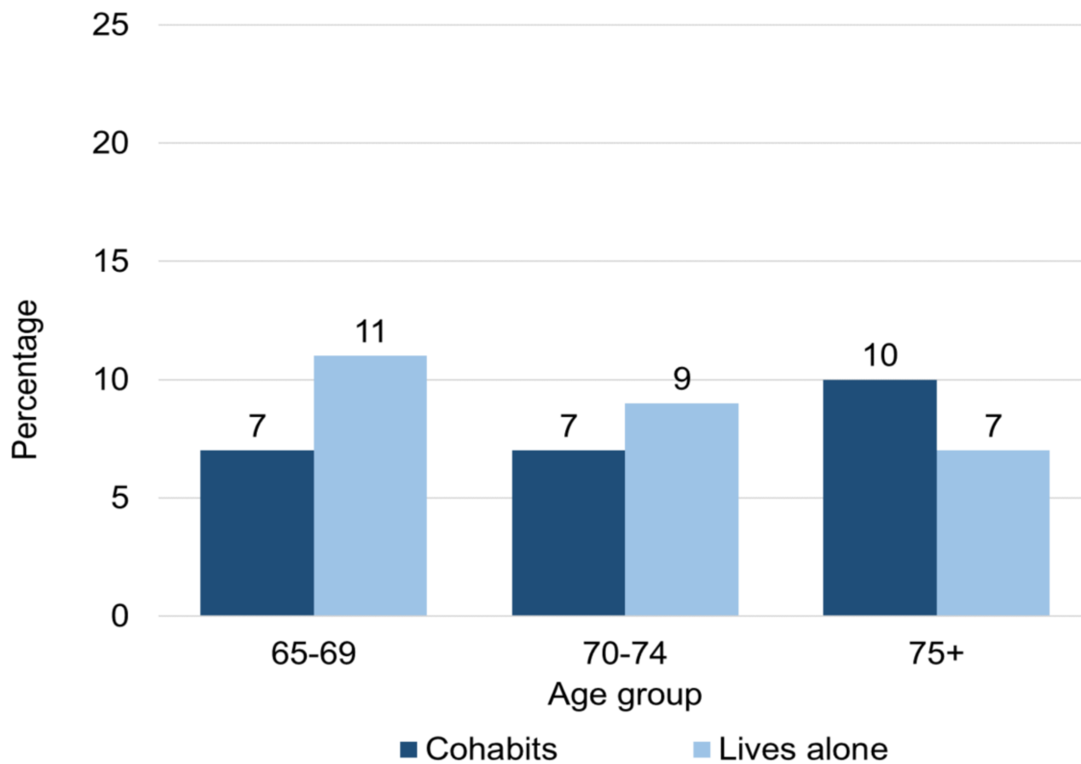
A: Mental wellbeing by age and living alone or with others



B: Possible psychiatric disorder by age and living alone or with others

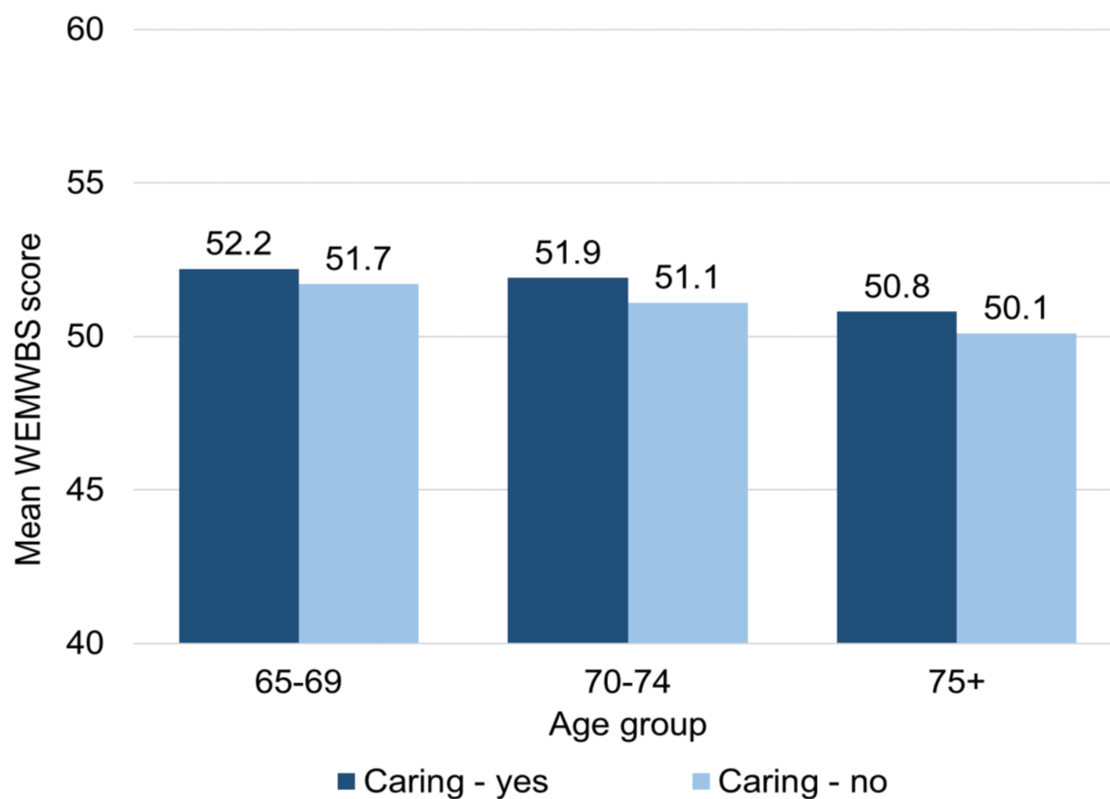


C: 2 or more anxiety symptoms by age and living alone or with others

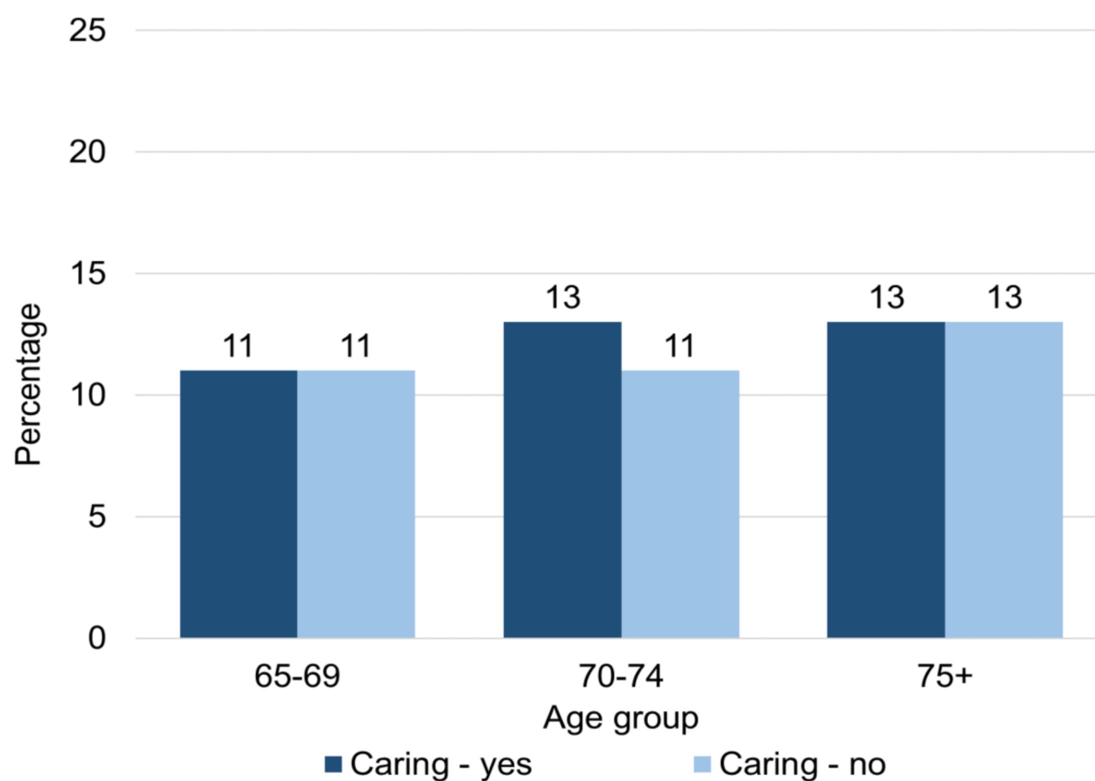


D: 2 or more depression symptoms by age and living alone or with others

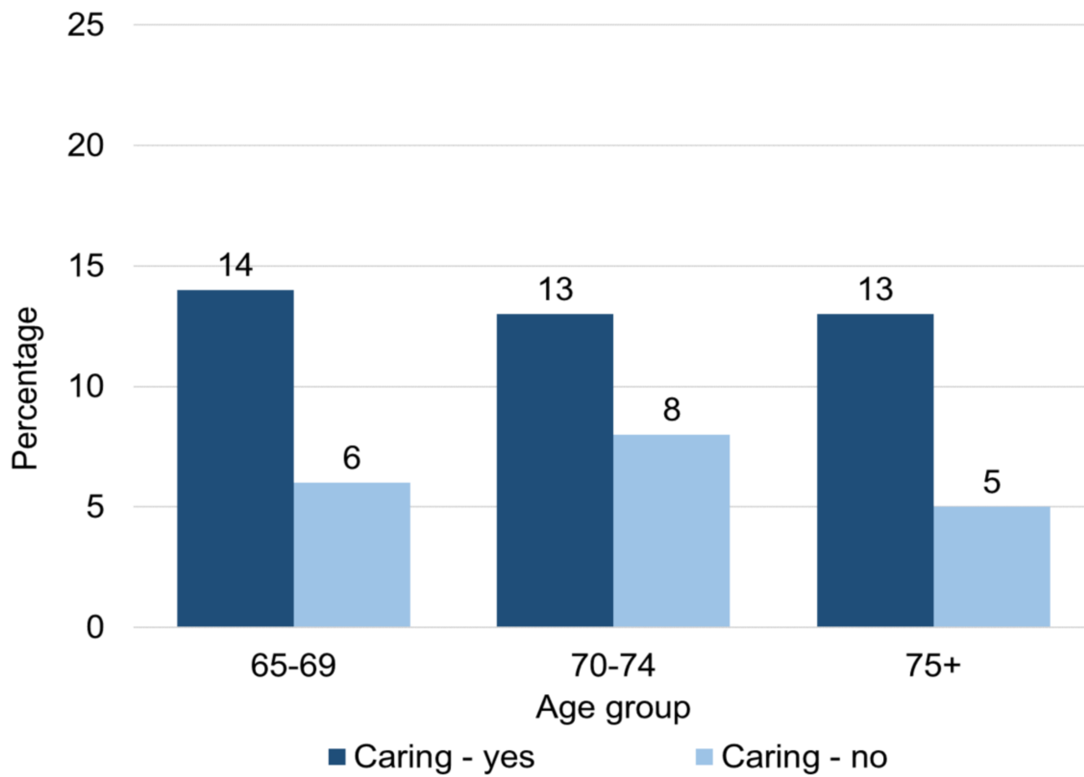
Appendix 6: SHeS 2016-2019 – Caring responsibilities



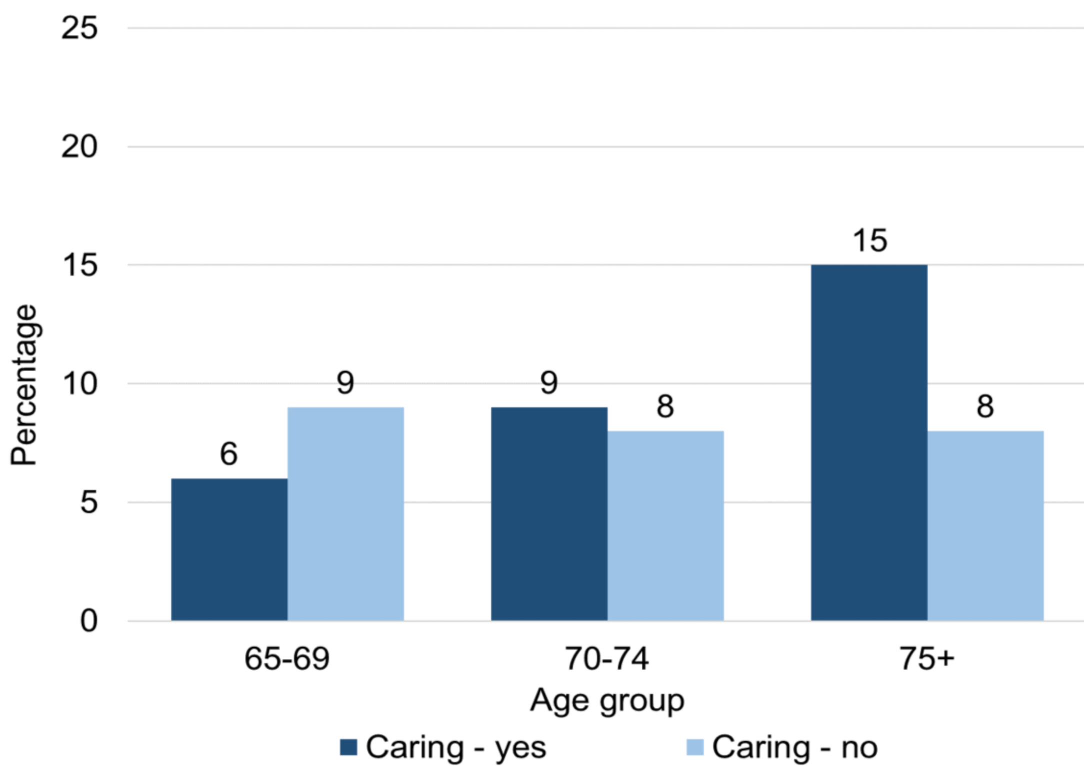
A: Mental wellbeing by age and caring responsibilities



B: Possible psychiatric disorder by age and caring responsibilities



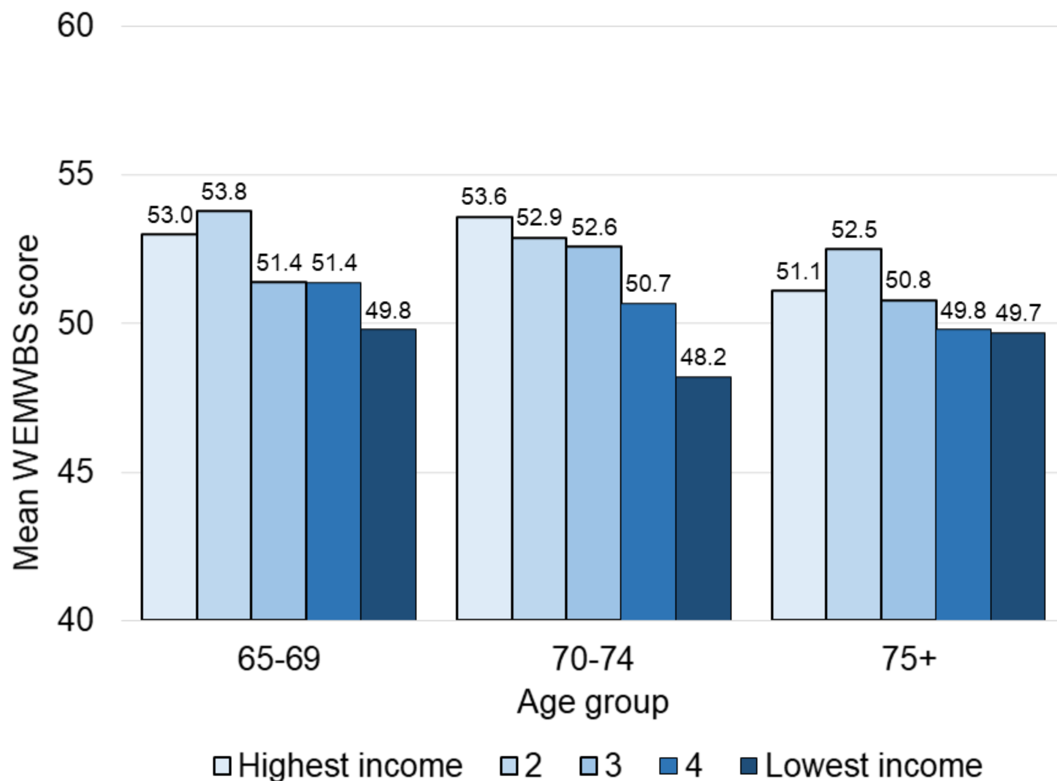
C: 2 or more anxiety symptoms by age and caring responsibilities



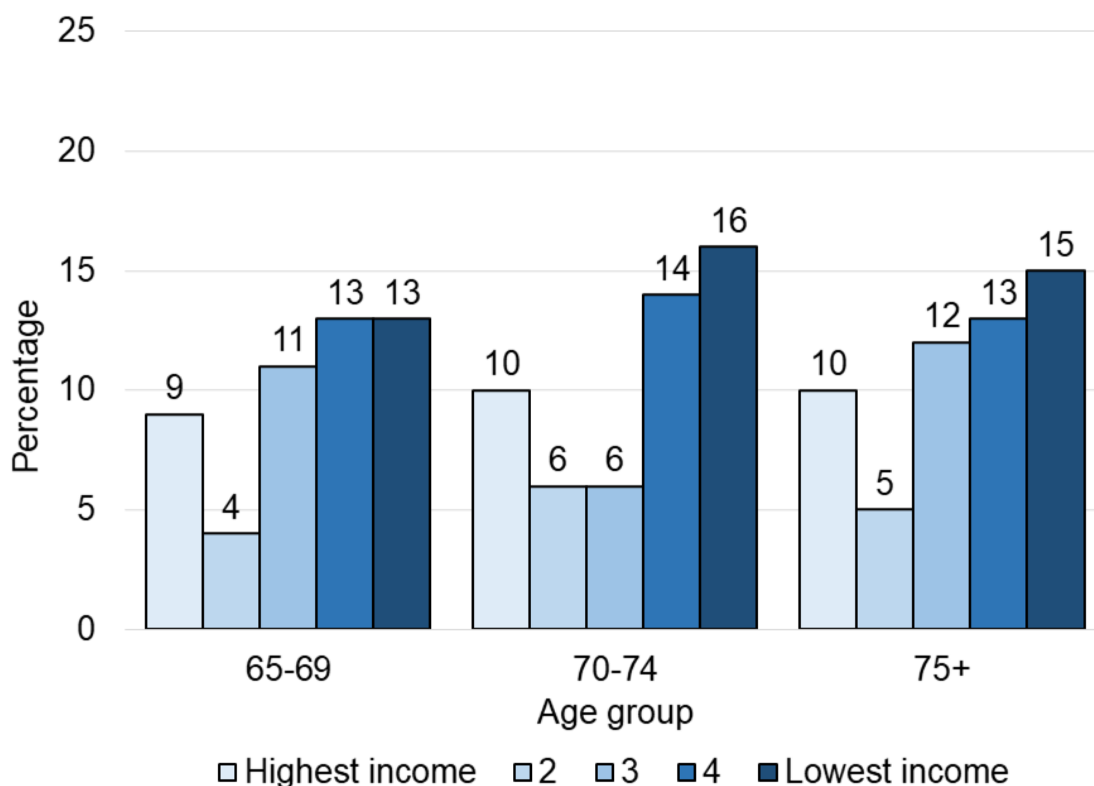
D: 2 or more depression symptoms by age and caring responsibilities

Appendix 7: SHeS 2016-2019 – Income

Income is presented in quintiles, with 1 representing the highest income, and 5 the lowest income.



A: Mental wellbeing by age and income

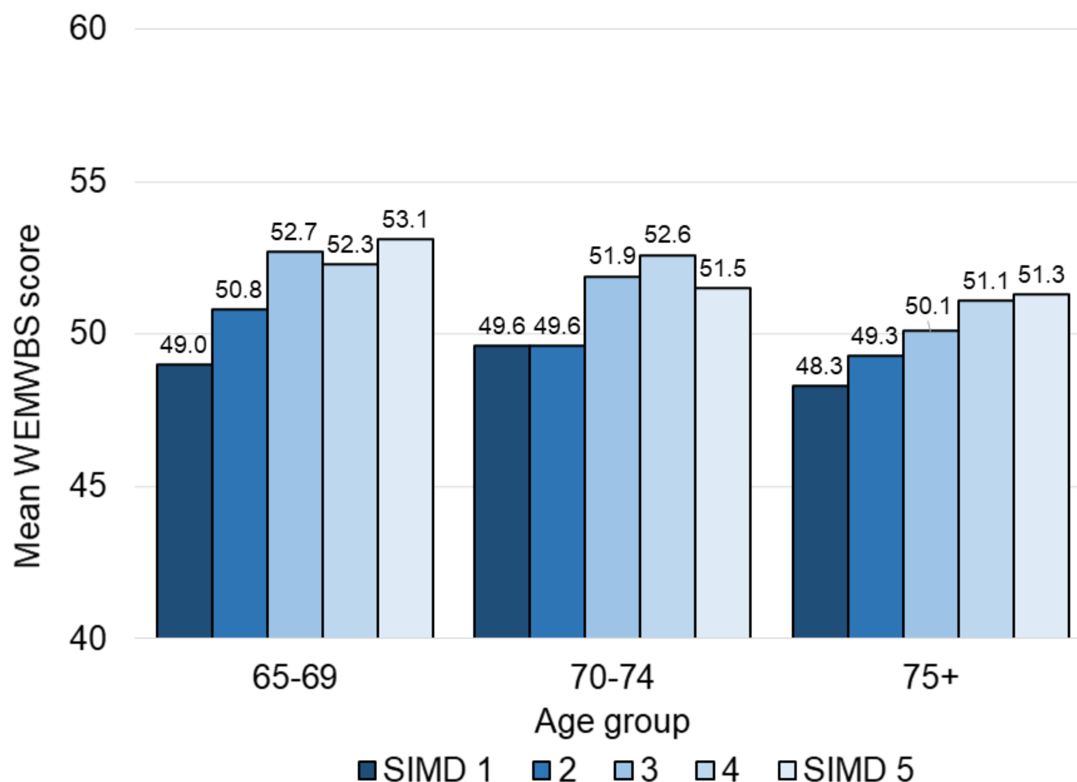


B: Possible psychiatric disorder by age and income

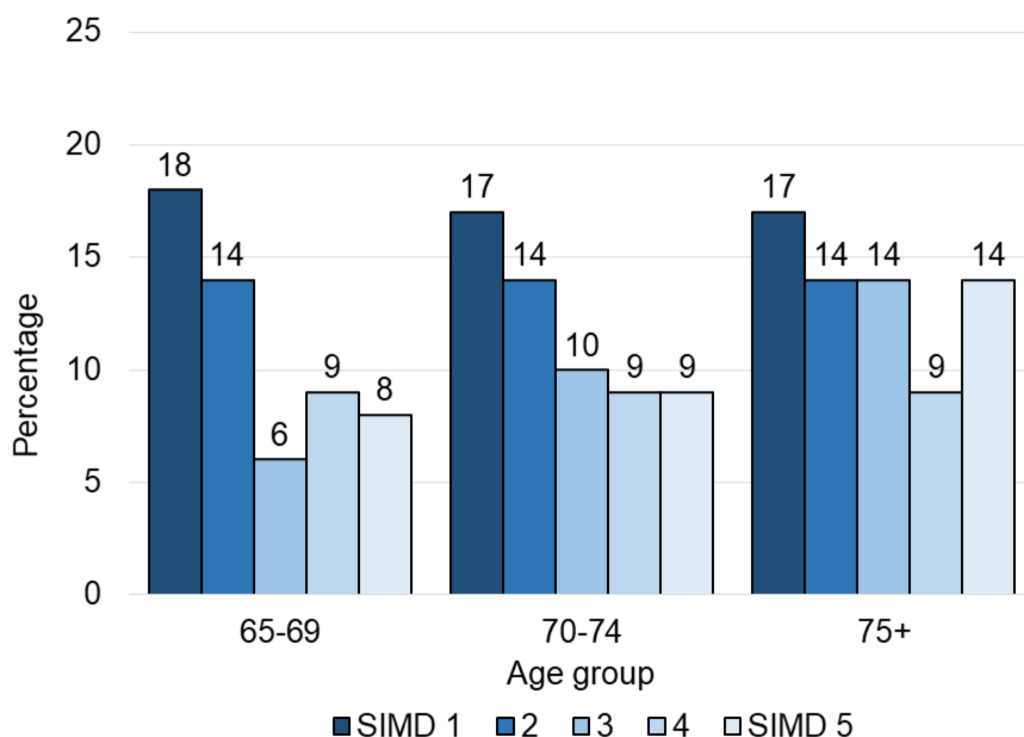
Results for anxiety and depression symptoms not presented due to small sample sizes.

Appendix 8: SHeS 2016-2019 – Scottish Index of Multiple Deprivation

Scottish Index of Multiple Deprivation (SIMD) is presented in quintiles, with 1 representing the highest deprivation, and 5 the lowest deprivation.



A: Mental Wellbing by age and SIMD



B Possible psychiatric disorder by age and SIMD

Results for anxiety and depression symptoms not presented due to small sample sizes.

[1] National Records of Scotland (2021) Mid-2020 Population Estimates Scotland
[2] Scottish Government, (2010) Demographic Change in Scotland
[3] UK Health Security Agency (2019) Ageing and health expenditure
[4] Mental Health Foundation Promoting Mental Health And Well-being In Later Life
[5] Scottish Government (2019) A Fairer Scotland for Older People: framework for action
[6] Scottish Government (2020) Coronavirus (COVID-19): mental health - transition and recovery plan
[7] Voluntary Health Scotland (2019) Falling Off a Cliff at 65: Key Learnings
[8] Specific databases searched were: KandE, a Scottish Government search engine covering several databases; PubMed and Google Scholar; PsyArXiv and medRxiv, which host research reports that have not been peer-reviewed (i.e., have not been reviewed by other experts as a form of quality assurance); and Public Health Scotland's Research Repository
[9] The evidence review's scope and research questions were presented to stakeholders at a virtual forum, after which they were asked to complete written feedback packs to provide or signpost to any relevant evidence. All feedback packs were reviewed to identify and assess evidence for inclusion in this report.
[10] While this report defined 'older adult' as 65+, this definition was flexible in terms of how other research defined them (e.g., having a younger minimum age, such as 55+ or 60+)
[11] Scottish Government (2022) Scottish Health Survey
[12] University of Warwick (2005) The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)
[13] Goldberg & Blackwell (1970) Psychiatric Illness in General Practice: A Detailed Study Using a New Method of Case Identification. British Medical Journal, 2(5707), 439–443
[14] Lewis, Pelosi, Araya & Dunn (1992) Measuring psychiatric disorder in the community: a standardized assessment for use by lay interviewers. Psychological medicine, 22(2), 465-486
[15] Differences between WEMWBS scores were assessed for statistical significance using analyses of variance. Differences between percentages were considered statistically significant if calculated confidence limits for different groups did not overlap.
[16] National Records of Scotland (2021) Mid-2020 Population Estimates Scotland
[17] Scottish Government (2021) Scottish Health Survey – telephone survey – August/September 2020: main report
[18] Scottish Government (2022) Scottish COVID-19 (SCOVID) Mental Health Tracker Study
[19] Scottish Government (2021) Coronavirus (COVID-19): wellbeing research
[20] Diffley Partnership (2021) Understanding Scotland Report - Wellbeing
[21] Hannaford, Moore & Macleod (2018) What a difference a year makes: comparing relationships between stressful life events, mood and life satisfaction among older adults, and their working-age counterparts. Aging & Mental Health, 22(12), 1658-1665
[22] Scottish Government (2021) Scottish Health Survey – telephone survey – August/September 2020: main report
[23] Brett, Dykiert, Starr & Deary (2019) Predicting change in quality of life from age 79 to 90 in the Lothian Birth Cohort 1921. Quality of Life Research, 28, 737-749
[24] Age Scotland (2021) Big Survey
[25] Scottish Government (2021) Coronavirus (COVID-19): wellbeing research
[26] Age Scotland (2021) Big Survey
[27] Healthy Ageing in Scotland (2019) HAGIS pilot study report
[28] Loneliness is considered to be a subjective feeling in contrast to social isolation, which is considered more objective and refers to an individual's contact with others.
[29] Scottish Government (2022) Scottish COVID-19 (SCOVID) Mental Health Tracker Study
[30] Scottish Government (2021) Coronavirus (COVID-19): impact on wellbeing research
[31] Hannaford, Moore & Macleod (2018) What a difference a year makes: comparing relationships between stressful life events, mood and life satisfaction among older adults, and their working-age counterparts. Aging & Mental Health, 22(12), 1658-1665
[32] Scottish Government (2019) Scottish household survey 2018: annual report
[33] Generation Scotland (2021) CovidLife and RuralCovidLife reports
[34] Scottish Government (2021) Scottish Health Survey – telephone survey – August/September 2020: main report
[35] Scottish Government (2022) Scottish COVID-19 (SCOVID) Mental Health Tracker Study
[36] Generation Scotland (2021) CovidLife and RuralCovidLife reports
[37] Glasgow Caledonian University (2021) COVID-19 psychological wellbeing study initial results - Scotland report

[38] Serrano-Alarcón, Kentikelenis, McKee & Stuckler (2021) Impact of COVID-19 lockdowns on mental health: Evidence from a quasi-natural experiment in England and Scotland. Health Economics, 31(2), 284-296
[39] Hannaford, Moore & Macleod (2018) What a difference a year makes: comparing relationships between stressful life events, mood and life satisfaction among older adults, and their working-age counterparts. Aging & Mental Health, 22(12), 1658-1665
[40] Hubbard, den Daas, Johnston & Dixen (2021) Sociodemographic and Psychological Risk Factors for Anxiety and Depression: Findings from the Covid-19 Health and Adherence Research in Scotland on Mental Health (CHARIS-MH) Cross-sectional Survey. International Journal of Behavioural Medicine, 28(6), 788-800
[41] Support in Mind Scotland (2018) Well connected communities report
[42] Scottish Government (2021) Scottish Health Survey – telephone survey – August/September 2020: main report
[43] Brett, Dykiert, Starr & Deary (2019) Predicting change in quality of life from age 79 to 90 in the Lothian Birth Cohort 1921. Quality of Life Research, 28, 737-749
[44] Generation Scotland (2021) CovidLife and RuralCovidLife reports
[45] Scottish Government (2021) Coronavirus (COVID-19) - impact on wellbeing: survey summary
[46] National Records of Scotland (2022) Probable Suicides: Deaths which are the Result of Intentional Self-harm or Events of Undetermined Intent
[47] Scottish Government (2022) Scottish COVID-19 (SCOVID) Mental Health Tracker Study
[48] Scottish Government (2022) COVID-19 in Scotland
[49] Taylor, Page, Okely, Corley, Welstead, Skarabela et al. (2021) Impact of COVID-19 lockdown on psychosocial factors, health, and lifestyle in Scottish octogenarians: The Lothian Birth Cohort 1936 study. PLoS ONE, 16(6) and Okely, Corley, Welstead, Taylor, Page, Skarabela et al. (2021) Change in Physical Activity, Sleep Quality, and Psychosocial Variables during COVID-19 Lockdown: Evidence from the Lothian Birth Cohort 1936. International Journal of Environmental Research and Public Health 18(1), 210; Studies comprise a cohort of participants born in 1936, who completed a survey before the pandemic (at a point between 2014 and 2019) and early during the pandemic (May to June 2020), when they were, on average, 84 years old. Please note that the results from this study were not intended to be representative of the Scottish population.
[50] Serrano-Alarcón, Kentikelenis, McKee & Stuckler (2021) Impact of COVID-19 lockdowns on mental health: Evidence from a quasi-natural experiment in England and Scotland. Health Economics, 31(2), 284-296; sample comprises 286 older adults in Scotland (scores weighted to be representative of the Scottish population), who completed questions at two points before the pandemic (once between 2017 and 2019, and once between 2018 and 2020) and at four points during the start of the pandemic (April, May, June and July 2020)
[51] Tomaz, Coffee, Ryde, Swales, Neely, Connelly et al. (2021) Loneliness, Wellbeing, and Social Activity in Scottish Older Adults Resulting from Social Distancing during the COVID-19 Pandemic. International Journal of Environmental Research and Public Health, 18(9), 4517 (May to July 2020, 84% of the sample were 60 years old or over)
[52] Age Scotland (2021) Big Survey (February to March 2021; 87% of the sample were 65+)
[53] Generation Scotland (2021) CovidLife and RuralCovidLife reports (April to May 2020)
[54] Scottish Government (2020) Coronavirus (COVID-19): mental health tracker study - wave 1 report (May to June 2020)
[55] Alliance (2021) Older people and mental health: Consultation event report
[56] Chief Scientist Office (2021) Looking after the elderly during the COVID-19 pandemic: a focus on addressing physical activity, loneliness, and help-seeking behaviour (sample were between 58 and 90 years old, mean age 72; rates of loneliness - June 30%, July 23%, August, 23%; rates of probable or possible depression – June 20%, July 20%, August 16%).
[57] Serrano-Alarcón, Kentikelenis, McKee & Stuckler (2021) Impact of COVID-19 lockdowns on mental health: Evidence from a quasi-natural experiment in England and Scotland
[58] Scottish Government (2021) Coronavirus (COVID-19): mental health tracker study - wave 1 report (May to June 2020, July to August 2020, October to November 2020, February to March 2021).
[59] Alliance (2021) Older people and mental health: Consultation event report
[60] National Records of Scotland (2021) Mid-2020 Population Estimates Scotland
[61] Scottish Government (2021) Scottish Health Survey – telephone survey – August/September 2020: main report
[62] Scottish Government (2022) Scottish COVID-19 (SCOVID) Mental Health Tracker Study
[63] National Records of Scotland (2022) Probable Suicides: Deaths which are the Result of Intentional Self-harm or Events of Undetermined Intent

[64] Scottish Government (2022) Scottish COVID-19 (SCOVID) Mental Health Tracker Study
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[66] Age Scotland (2021) Big Survey (February to March 2021; 87% of the sample were 65+)
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This document is also available from our website at www.gov.scot.
ISBN: 978-1-80525-083-8

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for
the Scottish Government
by APS Group Scotland
PPDAS1176022 (11/22)
Published by
the Scottish Government,
November 2022

Social Research series
ISSN 2045-6964
ISBN 978-1-80525-083-8

Web Publication
www.gov.scot/socialresearch

PPDAS1176022 (11/22)