



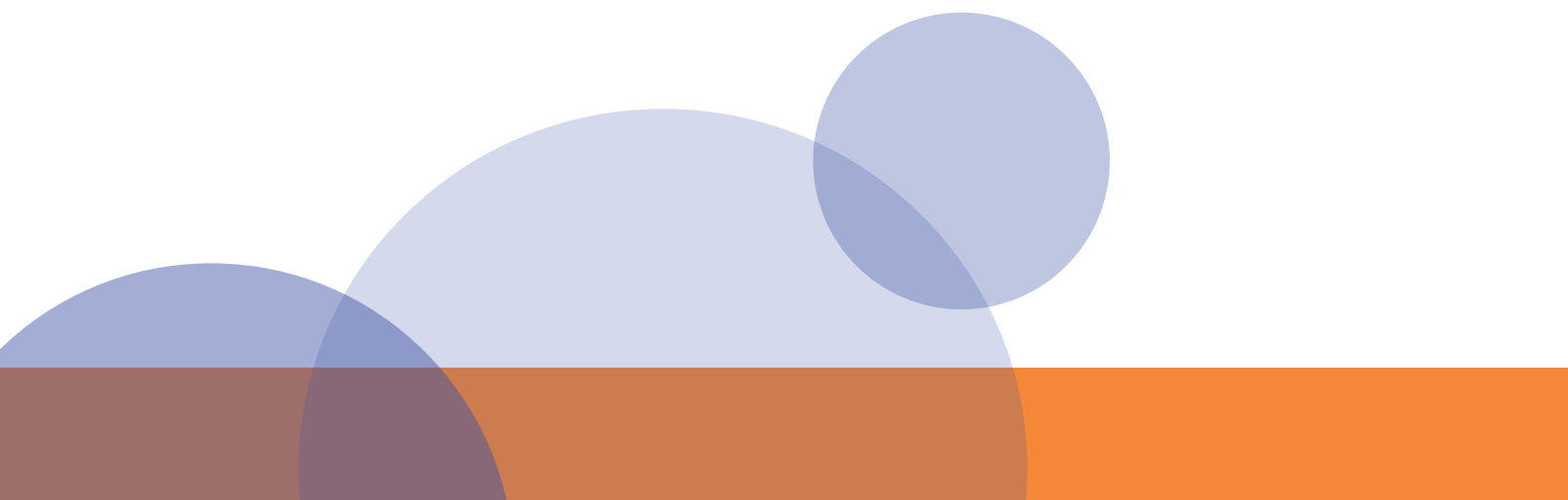
**Mental
Health
Commission**
of New South Wales



Participant discussions from
*Working with Older People to Make Recovery Real in
Later Life*

Hosted by
Health Education and Training Institute, and **NSW
Older People's Mental Health Policy Unit**

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This article includes the discussions and presentations of participants in this event but does not necessarily reflect the views or policies of the Mental Health Commission of NSW.

Working with older people to make recovery real in later life

By Gayle Bryant

The complexity involved in working with older people who have suffered a mental illness was very clearly spelt out in a two-day match organised as part of the IIMHL's 2017 Leadership Exchange. The match: *Working with older people to make recovery real in later life* highlighted just how complex and fast-moving the area is.

The types of mental health conditions experienced disproportionately by older people are many and varied, including depression, anxiety and behavioural and psychological symptoms associated with dementia. But as the match host Rod McKay, director of Psychiatry and Mental Health Programs at the Health Education and Training Institute (HETI) pointed out, "If you want things to change in this area then first you have to make people care about older people."

The match took place at the Health Education and Training Institute (HETI) North Parramatta campus within the grounds of Cumberland Hospital. While small in number, the quality of attendees meant this match was huge in experience. As well as Rod McKay, also presenting were Kate Jackson, manager of the NSW Older People's Mental Health Policy (OPMH) Unit and Andrew Webster, clinical psychologist, Specialist Mental Health Services for Older People at the Central Coast Local Health District.

Match attendees were Tracey McCown, manager of the Lived Experience Network with Sydney-based Suicide Prevention Australia; Khushboo Baheti, psychiatry register with Western Sydney and Nepean Blue Mountains Local Health District; Lynne Lane, former New Zealand Mental Health Commissioner and managing director of New Zealand-based Zygal International, and Robyn Shearer, CEO of Te Pou o Te Whakaaro Nui in New Zealand.

Discussions were lively and informative with views and initiatives between New Zealand and Australia shared and dissected. And they weren't all carried out sitting in a room, as a visit to the historical Glengarriff Museum within the grounds of Cumberland Hospital was included. On show here was equipment previously used on mental health patients – a reminder of the great and positive strides made over the past few decades in mental health. Match attendees also joined psychiatry students in one of their lectures, led by McKay.

Little attention for a big issue

But it was the match presentations where most of the key issues arose. Mental health in older people is a topic that receives little public attention but is a growing concern. The statistics are alarming. In the Australian state of New South Wales for example, there is a large and growing ageing population, with the number of older people – defined as 65 years and older – with diagnosable mental health problems projected to rise to more than 200,000 by 2021.

Mental health conditions evoke different feelings and can become barriers, McKay says. “Some people would generally prefer to identify with having experienced a trauma rather than a mental health issue because of how mental health is viewed.”

The OPMH Unit is making great headway in providing services to this sector. Kate Jackson, as manager of the unit, was instrumental in developing the [NSW Service Plan for SMHSOP](#) (Specialist Mental Health Services for Older People) 2005-2015.

“When our unit was first set up we saw the need for a state-wide long-term plan,” Jackson says. “There were many issues, including lack of policy, few specialists in rural areas, and even a lack of consistency over whether a separate unit for older people in mental health was needed. The bottom line is that something needed to happen.”

How the plan helped

Jackson says an evaluation of the service plan in 2011 showed significant progress within community care, although it was more limited with inpatient care. In the past 10 years, five new SMHSOP units have opened but there were noted gaps in the overall availability of services, especially in the context of new local health district structures.

“We had specialist leaders in each region involved in developing and then implementing the service plan,” Jackson says. “This helped with the engagement and the overall success. The service plan is referenced all the time with whatever we do.”

The outcome, she says, is that there is a broader working group for older people and a broader agenda for older people accessing the services. “The policy unit provides the framework for it all to work together by linking between internal and external people,” Jackson says. “This has been very important in developing models of care.”

New service plan on its way

A new service plan is now being developed, guided by upfront consultations with consumers and carers. Jackson says the plan will cover current policy and planning, a summary of SMHSOP service model elements, good practice approaches and directions in key areas, current challenges, new and emerging priorities and key directions for NSW SMHSOP over the next 10 years.

“The previous plan brought clinicians together but this time we are starting with what is it that consumers and carers want from key services,” Jackson says. “We are having the conversations with these groups before the plan is devised. It is currently in development.”

Pathways to Community Living

A critical element of the state’s mental health reform strategy, set out by the Mental Health Commission of NSW is assisting long-term patients to live in the community. This program is called: *Pathways to Community Living Initiative*. Data shows that at any one time there are 2000 patients in mental health inpatient facilities suffering a mental health condition. While most have a pathway home, there is a core of 380 who don’t.

“This initiative aims to create new contemporary recovery-oriented options for these 380,” Jackson says. “We aim to change the way we work with people with severe and enduring mental illness with complex needs to decrease long admissions.” This includes everyone, such as older people, who currently experience or are at risk of experiencing long stays – that is 12 months plus – in mental health facilities.

In other developments, in 2013, the OPMH unit conducted a survey to assess the current workforce landscape and to identify areas of training need and competency across the NSW SMHSOP workforce. This survey will be repeated in 2017.

The unit also conducted a [Recovery project](#) in 2014 to promote locally driven recovery-oriented practice improvement projects across the state.

Jackson’s presentation was followed by McKay’s discussion on the role of HETI Higher Education before the match attendees gave their presentations.

Helping NZ workforce needs

All attendees are given the opportunity to speak about what’s happening in their area. First up was Robyn Shearer, who gave a New Zealand perspective of older people’s mental health and addictions.

Shearer is the CEO of Te Pou o te Whakaaro Nui, which is a name gifted to the organisation by the indigenous people of Waikato within New Zealand. It loosely means “knowledge transfer” – something that is very apt for the work it does.

“At Te Pou, we work alongside other providers to help develop their workforce,” Shearer says. “We have a team of 40 people located in three bases across New Zealand and provide information, education and practical resources to inform service and workforce planning.”

Research conducted by Te Pou in 2014 found that 3.5 per cent of the mental health and addictions workforce of 9,500 work with older people. Shearer says figures from the NZ Ministry of Health show that of older people with mental health and addiction issues who are seen in services, 82% were only seen in specialist services such as DHB (District Health Boards); 7% by an NGO and 12% by both an NGO and DHB.

“Our challenge is the group of people seeing both types of services and to work out if that is the best use of our resources,” Shearer says. “Could we move people being seen by the secondary specialist sector to the NGOs, for example?”

A snapshot of the mental health workforce showed most people get their training while on the job. “Part of our role is to encourage qualifications and career pathways in the workforce. We have training grants to improve the level of qualifications and 31,000 people in the disability sector have furthered their career through this programme,” Shearer says. “The key issues continue to be pay rates, retention and some of the working conditions to encourage more flexibility in roles.”

One of Shearer’s hopes is for each person to have a respectful end of life that is supported by acute and restorative care, and with support for people with high and complex needs.

“We’re trying to get service providers to think much more about what their workforce will look like in 10 years’ time and using methods to help get them there,” she says.

Technology is key for improvements

Lynne Lane followed Shearer with a presentation that looked at translating strategy into what was happening on the ground in New Zealand. Lane says the challenges facing the health sector include escalating demand due to the ageing population and the increasing burden from mental health and addiction issues, of which there are limited resources available to provide treatment and support.

“About 15 years ago a report showed that if health services continued to be delivered as they were then, given the projected growth in demand, by 2020, there would be a 30% shortfall in the number

of professional staff available to deliver the services needed by the sector,” Lane says. “Fortunately things have changed and we have been responding to the projected need.”

Another challenge is that more older people are living at home with increasingly complex needs. “This is a major challenge for community based service providers,” Lane says.

Workforce issues remain a concern in this sector, especially as many mental health and aged care workers have low skill levels and are on minimum wages. “The level of staff turnover is high as once carers are offered jobs above the minimum wage many will leave,” Lane says.

“We also know we’re achieving poor health outcomes for people with high and complex mental health and addiction needs.”

Lane is a former Mental Health Commissioner and was instrumental in the development of the Commission’s second [Blueprint](#) document in 2012 that outlines a strategy for improving mental health and wellbeing for all New Zealanders.

“We realised if we intervened early we could change a person’s life course around mental health and wellbeing,” she says. “The strategy was also about making mental health everyone’s business and responsibility. Everyone knows what to do to keep your heart healthy and we need to achieve this for mental health.”

Following this point, McKay opened up the discussion by asking: “Do we know if promoting mental well-being actually decreases the rate of mental illness? What should be expected from promoting mental health well-being?” he asked, which certainly got the match participants thinking about the pros and cons of this approach.

The same year the second Blueprint came out, the Commission released: [Rising to the Challenge](#), a five-year action plan that set out priorities for implementing Blueprint. “We are now at the end of that period but we don’t yet have a new plan,” Lane says. “New Zealand needs to think about the next priorities. This includes understanding what skill sets are needed if the sector is going to work together to provide more integrated client centred services.”

Late last year the New Zealand health strategy was released and sets out the need to focus more on technology and smart systems. “A big area of opportunity is using IT to enable positive change,” Lane says. “IT can be a driver of efficiency and improvements and we need to fully embrace it. One issue is that many people working in health are older and therefore are not ‘digital natives’.”

The healthy ageing strategy also came out at the end of last year and initiatives are being developed in response.

“DHBs are co-developing action plans to fund integrated primary and secondary health services,” Lane says. “For example, they’re investing in dedicated psychiatrists who are available 24/7 on the phone for GPs needing advice. They’re also employing people to work in the community to improve mental health literacy in particularly vulnerable community groups.”

Another solution involves increasing service standards and “regularisation” of the workforce. Lane says providers now pay staff for their travel time when they see patients in their homes. “Previously they weren’t paid and that’s a lot of downtime when you’re on the minimum wage,” she says. “Now this time is taken into account. But providers now need a decision-support system to work out the best schedule for their workers so they use their time efficiently,” she says. “This requires a significant upgrade of management systems.”

She adds there is also work being carried out on equal pay. “Unions are suing providers and the government for different pay rates between men and women, and people in essentially similar roles. We now expect to see increases in workforce pay rates, levels of qualifications, and terms and conditions,” she says.

Lane finished by saying she believed the framework in place is “quite positive for being able to provide services for older people in the community, not just for mental health but for their social connection, and physical health and well-being. However, integration remains an issue: how to work together and how to work with non-sector agencies.”

A registrar’s view

While it is easy to talk about initiatives and what’s been implemented, it is the viewpoint of those at the coalface that carry the most weight. Psychiatry register Khushboo Baheti discussed several case scenarios she has been involved with. These highlighted the issues faced by particular patients from admission to discharge as well as some recommendations. Baheti stressed each case was her personal viewpoint.

The scenarios included working out why a woman who was able to leave hospital was refusing to, and why a husband kept bringing his diabetic wife lollies.

McKay says often you hear the answer to questions about why particular actions are being taken by listening rather than making assumptions because often when you ask, “you get told what the person thinks you want to hear”.

Baheti agreed and in one case explained how she made sure the team leaders scheduled a daily 10-minute call to a carer as a way of handling a particular situation. “Although while team leaders play a big role in patient care, if they don’t agree on the course of action, then it’s very hard to get collaboration,” Baheti says.

The case scenarios prompted interesting discussions about the role of carers and support for family members. Lane said in New Zealand they run dual programs for patients and families to help with modifying behaviours.

Suicide prevention and older people

Suicide among older people is an issue that needs to be spoken about more, Tracey McCown says. She opened her discussion with a moving recording of an older man who had attempted suicide after losing his senior management job following a diagnosis of depression.

McCown said the story showed how there is a need for a range of services to deal with this situation. “While he had a diagnosis of depression, he was also lonely and without family support so these situations need to address a number of issues,” she says. “The critical component is for when people who have attempted suicide are discharged; they need follow-up care. This is where peer-to-peer support fits in so people can have non-clinical conversations.”

McKay added that older people value peer support as much as younger people but that the “peer” must have life experience that they can relate to.

McCown mentioned a pilot program Beyond Blue is running in the NSW city of Newcastle where anyone in the area who is identified as likely to or has actually attempted to commit suicide are invited to participate.

“The uptake has been huge; 85 per cent of people contacted have taken it up,” she says. “There is another group for the family. The pilot looks at the social determinants affecting that person’s life and how Newcastle is supporting that individual as they move on through their life.”

McCown also discussed a number of other initiatives her organisation is involved with, stressing the need for networks that include people who have lived experience with suicide.

“We are also creating a better practice register that lists places and services to guide people to get the help they need,” she says.

Older Person’s Peer Worker Project

Andrew Webster gave an interesting talk on the Older Persons Peer Worker Project with the Central Coast Local Health District. There are seven peer workers employed and Webster says it’s clear that both the peer workers and the patients have benefitted from the scheme.

“From the perspective of the peer worker, new friendships and a support network have been formed with other peer workers,” Webster says. “It’s been positive for their own mental health recovery and they bring a wealth of knowledge, patience, understanding and good judgement to the role.”

However, there have been some challenges, notably from staff. Webster says some staff have resisted the program, although this resistance has been minimal.

“Other barriers include a lack of role clarity around what the peer workers do and how it is different to what the staff do,” Webster says. “Other concerns revolve around competency and trust issues, particularly if the peer worker causes damage to the consumer and staff are left to pick up the pieces.”

Overall, it has been found that older peer workers provide a valuable service and that older persons are well suited to this type of work. “Looking ahead we intend to recruit more older peer workers this year and will also be finalising our evaluation,” Webster says. “As far as I know, this program is the first to meet the specific recovery needs of older people who experience mental illness and has been welcomed by all involved.”

Plenty to think about

The two-day match left all attendees reinvigorated with new knowledge and ideas to take back to their organisations. It was reassuring to see how much is being done to address the concerns of older people with mental health conditions but the complexity of the area and the increasing number of people expected to be diagnosed means there’s no room for any complacency.