The Peregrine Centre Rural Mental Health Podcast

Episode 14. Getting the Most out of: Working with Older Persons

Speaker Key:

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NJ Neil Jeyasingham

IR Ian Rawson

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Intro Hello. I'm Dr Rebecca Sng, director of The Peregrine Centre. As we begin this episode of The Peregrine Rural Mental Health podcast, please join me in stopping to consider the land beneath your feet, wherever you might be listening from today. Let's take a moment together to acknowledge the traditional owners of that land. We pay our deepest respects to the elders of the past, those of the present, and the emerging elders of tomorrow. The Peregrine Rural Mental Health podcast is brought to you as part of our rural mental health partnership with New South Wales Health.

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CM Hello and welcome to this episode of The Peregrine Rural Mental Health Podcast. My name is Caitlin Miller, I'm a research associate and clinical psychologist working for the Rural Mental Health Partnership at The Peregrine Centre.

Today, we're talking about working with older people in mental health, which means working with people that are 65 years or older. I'm joined today by two guests, Doctor Neil Jeyasingham and Ian Rawson. Thanks so much to both of you for making time to be here today.

Neil, I might start with you. Would you be able to tell us a little bit about who you are, what your training background is, what sort of work you do and where you're coming to us from today?

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NJ My name is Neil, I'm an old-age psychiatrist by training and I completed my training as a Maudsley research scholar with Guy's and St. Thomas' Hospital in London and completing my research into personality disorder prevalence in older adults. I'm the former chair of the Faculty of Old Age of Psychiatry and for the last two years have been the fortunate clinical lead of the Far West Local Health District Mental Health, Drug and Alcohol Service, covering Broken Hill and surrounds, looking at the implementation of mental health intervention for rural and remote areas.

CM Wonderful. Thank you so much for giving us your time today, Neil. Ian, would you be able to introduce yourself, please?

IR Sure. I'm Ian Rawson. I'm currently the service manager for older people's mental health in the Hunter New England region. I'm a social worker by background.

The vast majority of my career, however, was spent in Western New South Wales as the coordinator of older people's mental health out there. And I grew up and spent most of my life out in Western New South Wales as well.

CM Fantastic. It sounds like we'll have a wealth of knowledge that will be really helpful for our rural and remote mental health practitioners from you both. So, let's dive in. My first question is I guess a little bit of a general question to introduce us to the topic. So, when thinking about older people who are living in regional, rural or remote areas what would you say are the main mental health challenges that they might experience and are there any challenges that they may face that might be different from younger populations?

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NJ So this is a really common question but it's incredibly difficult to answer because it comes straight to the definition of what we call an older person. Which no one actually has any idea about.

We tend to arbitrarily think of people over the age of 65 as older people and this is because 65 was defined as old age about 100 years ago when the average life expectancy was more in its 30s and 40s. So, we still have difficulty knowing what an older person is in that depending on where you grew up, which is what we call the cohort effect which is the background and experience of the people that you were with, you would have different expectations of what your older adult life would be.

I would say one of the biggest difficulties that older people have is that the current generation that is still those arbitrarily defined old ages of 65 on average are living beyond the age when their parents died. Meaning that they have literally no blueprint as to what they are supposed to be doing with that final stage in life.

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You add to that the challenges of rural and remote locations in terms of isolation, transportation access together with the global difficulties of maintaining a quality of life with reduced financial support and together with the fact that society doesn't seem to have a really good idea what the older person is for, it's not surprising that that can be such a problematic challenge for them.

These all lead towards the idea of identity. You'll notice that I haven't said anything about mental health yet and that's because one of the good news about being an older person is that most of the research with the exception of cognitive impairment suggests that the older you get the better your mental health actually seems to get. Rates of depression, anxiety, psychosis, everything seems to drop as you get older. Even personality disorder related behaviours also seem to improve.

So the challenges that they do face are questions of identity, questions of social role, questions of social integration. And the challenge of what it means to be an older person where you are when no one else seems to know and certainly not your colleagues or peers.

CM And when there is no blueprint on what other people have done before you.

NJ There was a lovely study which was done in 2013 by the Age and Disability Commissioner which had people ask what an older adult was. And they had focus groups and the approximately 35-year-old focus groups, they defined an older adult as anyone over 65. What was fascinating was the 55 to 75 focus group which generally said an older person is someone older than me and they couldn't really quantify that. It seemed to come towards some sort of arbitrary life stage which was generally about maybe going into a nursing home. So, that was what an older person was.

So, that arbitrary benchmark of being admitted to a nursing home would then be seen as now I'm an older person.

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Which when you add to the stigma of supported accommodation living that fits really well with what we understand about the challenges of identity clarification for the older person.

CM Wow. Thank you so much, Neil. That's a really interesting perspective that I hadn't considered before. But I think you're spot-on in that there is no blueprint on what to do next or who to be or how to act in this developmental stage. Ian, what would you like to add to that?

IR I think just to reiterate what Neil said, it is great to see that rates of life satisfaction in rural areas generally is higher than the city and the prevalence of mental health issues in older people is actually similar across both metropolitan and rural areas. However, we should note that the rates of suicide in rural older people is generally higher, especially men. And in some rural or remote areas in fact is significantly higher.

But specific to older people in rural areas, Neil mentioned isolation. And of course, we know about geographic and great distances in rural areas but also social isolation. And this is one big thing that we look at in mental health.

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And if you think about it, with families all grown up and moving to regional and metropolitan centres for work or older people who may have lost a partner or a number of their social network loneliness can be a big issue.

And in older people, grief and loss is something that we think a lot about as well. Loss of partners or friends, loss of their physical health, loss of a home. One other thing though that I think rural older people experience is significant stigma around mental health. And I think it's generally high in older people who did not grow up thinking about mental health like we do now, they didn't have a language around it perhaps or they weren't exposed to ideas such as R U OK? Day. They had to just get on with it or suffer in silence.

I think the mental health literacy in older people is probably less than younger people. And also for older people, things like depression can sometimes be harder to detect or the symptoms of depression might be passed off as just a

normal part of ageing or a reaction to chronic or physical illness.

And also, we should mention, there are also higher proportions of Aboriginal and Torres Strait Islander people in rural Australia and we know our First Nations people experience particular disadvantages around access to healthcare. Another thing to say, and I think Neil mentioned this, is that look, there are simply just fewer services in rural Australia, not just mental health services but poorer access to GPs or various physical health services. That in turn impacts on what we can do about mental health and that can be an issue.

CM So, I think Neil has already somewhat addressed part of my next question which is very helpful. So, Ian, I might start with you for this. Which is what are some of the common myths about mental health in older people?

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I have written down here, for instance, are older people really more depressed and lonely? Which I think Neil has started to address.

IR The common myths such as all older people at some point get dementia or older people can't learn new things. The big myth is older people get more depressed. And yes, Neil has talked a bit about that. But it's really important. Depression is not a normal part of ageing. In fact, as Neil said, most people feel satisfied with their lives as they get older despite having more illnesses and physical problems people tend to get happier and more content as they age.

I should say though that there are some groups where depression is higher such as older people living in aged care facilities or in hospitals. By the way, only about 5% of older people in fact live in residential aged care. But look, generally speaking, depression is reported more in younger people.

CM Do we have any sense of why it is that people's mental health tends to improve as they get older?

IR There's a few things. I think there's a lot of issues around the psychology of ageing about how people's thought processes change as we get older and we stop looking at expanding our horizons and we start looking at things that are more meaningful like relationships.

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But the other thing that we have to be careful about also is older people tend not to talk about their feelings or about mental health as readily as younger people.

Just recently we had the National Study of Mental Health and Wellbeing and they were looking at the prevalence of mental health disorders with younger populations and older populations and they found that in the 16 to 24 age group about 40% of people reported a mental health disorder. Whereas in the 65 to 75 only about 10% did. Or in fact in people over 75 only about 3 to 4%.

And also in addition to that, how many people see a health professional for their mental health? In younger people, it's much higher, about 25%. In older people, it's right down to about 7%. But as I said, Caitlin, I think there's a warning with those stats because older people tend not to talk about things like depression

or how they're feeling as we mentioned before. And so sometimes that can be a bit hard to find.

CM Yes, absolutely. Neil, do you have any common myths that you come across other than this idea that older people are more depressed?

NJ I'm very glad that Ian was commenting about the caveat that we had to raise. Because the jury is still actually out as to whether... The consistent research has always said that older people seem to have improving levels of mental health issues. There's always been this nasty question as to whether they are actually better or whether it is because they're just not presenting as readily to primary care services for mental health supports.

When people have tried more proactive means of going out and surveying and study that we have seen higher rates of depression than in terms of self-reporting. But my understanding of the last set of literature is that it still seemed to be better.

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One area which is a serious problem is the question of suicide and there is a very strange international figure that has turned up with suicide demographic data. And that is by far the highest risk category for suicide is males over the age of 85. And most of the literature and most of what you'll be seeing in the papers keeps talking about dramatic 25 to 35-year-old deaths and those sort of headline-grabbing things. But they are nothing compared to the suicide rates for 85-year-old males, which is easily half... Sorry, which is easily twice that of any other competing demographic.

And the strange thing about it is that it's an international thing. You actually see these rates turning up in Australia, in the UK, in China, in England, in America. Every part of the world, with one exception, Japan. Japan seems to be the only part in the world where we don't see that sudden rise in older male suicides. So, why that is? The only thing that I can think of because we're looking at the differences between Japanese society and Chinese society, that why would we be seeing that difference.

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And the only thing I can see that probably makes sense is that Japanese society has a very high emphasis on veneration of the older person. They see the older person as a source of wisdom and to be lauded in society. Which is quite unique to their societal framework that is very different to the rest of the world. So, whether that's the cause of why the suicidality is such a major issue...

I'd want to put in one other myth here and that is the idea of dementia. Because it's true, absolutely, that older people do not all get dementia, the actual rates are not high. But the more damaging myth is the idea that older adults always have a degree of memory impairment that is untreatable.

And yes, there is some memory changes as people get older and I'll summarise quite quickly here as I like to use the analogy of the forklift effect. If you have a reasonable sized warehouse and you have a bloke at the front who's fulfilling

orders. He heads back into the warehouse to get you what you need. The problem is that, so when you're a young person you don't really have that much of a warehouse. You don't have that many memories that you have to get through.

The problem is that when you get older the warehouse is massive and the bloke at the front has to work a lot harder in order to get it back. Which leads to impairment in what we call delayed recall, in that it's harder to get the memories out but it comes out. That's a simplified difference between a physiological change in memory as people get older or a pathological change in memory, where it comes back eventually but it's a bit delayed that's normal, that is usually nothing to worry about.

The dangerous myth is that any sort of memory issue is expected and cannot be treated in older people.

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And why that's damaging is because we know that there are a number of extremely effective memory agents on the market that if mild cognitive impairment can be picked up early enough, presented to your GP and started on treatments can substantially change the quality of life. We can't cure dementia, we can't reverse it but we can greatly reduce the symptomatology and keep people at an adequate level of independent functioning for very long periods of time as long as they see the GP about the issue.

So I think the common thread here between what Ian and myself are saying is the problem for older people is lack of access and lack of presentation to services. And I think it goes both ways. One of them is older people tend to be more stoic and less likely to present for help but also the help is harder to get as well because of the limited services, generally speaking.

CM Sure. So, let's explore this differentiation a little bit more between what is a normal part of ageing and what is something that we should be concerned about as mental health practitioners.

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So, let's say that I'm seeing an older person and they're thinking back on their life and they're speaking about a lot of regret about things that might have happened. Or maybe they're planning for the future and they're speaking a lot about the end of their life and death and organising things for the end of their life. How would I differentiate what is a normal process and what might actually be a sign of a mental health concern?

NJ I have a very simplified response to that.

CM Great.

NJ Which is kind of cheating. I use a geriatric depression scale. So, the Geriatric Depression Scale is a 15-item score which takes about a minute to learn how to use and it utilises theory from cognitive theory in terms of the cognitive changes that happen as a person gets depressed. And it was developed for older people

because one of the challenges for older people is that standard things with things like sleep and appetite and so on, they don't really work that well as depression markers but cognitive changes do.

And the Geriatric Depression Scale has performed ridiculously well in terms of identifying depression. There is one study that suggests that if you use a cut-off of eight out 15 it had 100% accuracy in detecting major depression. Which I still don't believe. But my problem is that I've been using it clinically for about ten years and it still hasn't failed me. It keeps on picking up things when I thought that there wasn't too much of a problem and been able to identify those.

So, being aware of the Geriatric Depression Scale and as a mental health professional knowing to use it, specifically the 15-item scale as that's been found to be the most effective that makes it very, very easy to determine whether or not there is depression driving the suicidality whether we are talking about rational end-of-life decision making.

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We want to believe that older people are satisfied with their lives but remember that an older person, provided that you've done your job right, an older person is kind of an older version of you with your mistakes, your experiences and everything else brought into it. So, it's actually not that unusual for people to be presenting with dissatisfaction.

The problem is what they think about the dissatisfaction and what they intend to do with that. I'm reminded of... So, most psychologists and medical students would be aware of the Eriksonian stages of personality development with the eight stages of how people go through life and the stage as an adolescent in terms of role identity and being able to forge romantic attachments and determining on your career. Those are standard things.

And the last stage he just put down as over age 65 of wisdom versus despair. And the idea is that after 65 you're supposed to look back on your life and if you're satisfied with how you how you've done, you achieved wisdom, if you're not then you achieve despair.

Not too many people know that Erikson and his wife, later on, happened to develop a ninth stage of ageing because they looked at their friends and noted that they were changing as well as they got older and determined a stage for 85 and older which was about responding to deterioration of ageing and more so a sophisticated capitulation of their past life.

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The problem I have with the ninth stage is that it makes for the most depressing piece of psychoanalytic literature I have ever read. And I've read a lot of depressing stuff, particularly in... I don't know, psychotherapists are very depressing people. And this had a... They thought that it was kind of inevitable for people to despair and deteriorate and they wrote it up as a personality development. As you basically go through all eight stages but in reverse, as you lose control of your bowels, as you lose control of your senses and everything through.

I take away from that the general perspective that they must have had some incredibly depressing friends. The other thing that I take from it is that people change in very, very different ways. People go through and approach that final stage in life in very different ways.

I think our role as mental health professionals is to assist them with that. Not to be put off by the idea that it's not all going to be sunshine and roses, that there are going to be hard times but that's what wisdom is. You get wisdom from having made mistakes, there's no other way.

CM Thank you so much. I think that's a really good framework to couch our work in. Ian, what about you? How would you help people to differentiate what is a normal process of ageing and what is a mental health concern?

IR So, Caitlin, earlier I heard you mention regret and Neil was certainly talking about that as well.

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And as we age we do tend to review our life and reflect and look back and regret might be a part of that, or pride in what we have done might be part of that as well. There has been research in older people about the types of regret they go through and it could be regret... And look, mental health workers might come across this, regret in not expressing their love to a family member or regret for not travelling enough, or regret in not resolving a lifelong family conflict say with an estranged adult child. Some people might regret not taking good enough care of our bodies or spending too much time worrying about things.

But I think the thing to say here though is the research does say that older people tend to resolve their regrets much more than younger people. And as I said before, that's kind of part of the thought process.

Look, one thing that does happen with depression, however, or anxiety in older people is that our thinking gets a bit clouded and distorted which might heighten someone's experience of regret. People might feel like they've become a burden and they feel they're better off dead. And it's important for the mental health worker to sit and talk through that and to understand that this reflective kind of looking back at our life negatively or positively is normal. But to keep in mind how thought processes really can be clouded by mental health issues.

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And then it's about assessing that using things like the Geriatric Depression Scale, as Neil said, and other clinical assessments and working through all those things.

CM Thank you so much, Ian. So, say that I am a rural mental health practitioner who doesn't have a lot of experience working with older people but I get a referral from a GP for treatment with an older person. Ian, what would be some general principles that would be helpful for me to keep in mind walking into the room for the first time with this older person?

IR So, for clinicians who are not used to working with older people the thing that I want to say to them is firstly, older people are people with the same needs and rights. The same need for dignity and worth. Older people want equal opportunity to participate actively in society. To work and to learn. And people want equal access to healthcare. These things might sound obvious but they're not always given to older people in the same way as younger people.

And I think if we're working with older people we really need to think about this and to play our part in trying to reverse that. But more specifically around the caring of older people, I think we need to be mindful of a few things. It's about showing proper respect. Look, older generations think more about respect for elders perhaps differently to what younger generations do. I think we need to be mindful of that. Building rapport is important.

We need to be mindful of things like failing hearing or eyesight when communicating, we need to be patient. I think we need to be mindful of physical discomfort or potential frailty. We need to be respectful of possible past traumas around war or Stolen Generation for Aboriginal people.

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And of course, grief and loss as we mentioned before is an important thing to be aware of. But I think we also need to be mindful of our own ageist stereotypes and prejudices that we ourselves might hold.

And not all older forgetful and older people can still feel young. Older people should and do express sexuality. But older people are often more ignored in popular culture compared to younger people and they might feel invisible because of that. And as we know, older people might be looked over for employment as well. So those are things that we really need to think through ourselves as we're working with older people.

CM Thank you. Neil, what would be your general principles to keep in mind?

NJ I absolutely endorse everything that Ian said. The only thing that I would probably add to that was there is a lovely study called the Harvard study of ageing which followed a cohort of initially about 680 people but now I think about 2000 individuals over a course of about 70 years. And they psychologically check in on them every six months and the general question is the thing about happiness, about what people did at different stages in life that was most associated with happiness.

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And what I found most interesting and relevant to our discussion was looking at those over the age of 75 and trying to identify what was most associated with satisfaction. And in earlier years we had elements of productivity tending to pre-service as particularly in 50 to 55-year-olds that tended to be a time of career consolidation. And certainly, of course, we have to remember that everyone ages differently. But the majority of people over the age of 75 they found that if they were involved in any activity that involved transmitting knowledge to the next generation that was associated with the highest degree of satisfaction.

So, it didn't matter what it was, they could be grandparenting, they could be mentoring, they could be teaching, they could be running apprenticeships, they could be volunteering at a local school, bible study, adult education, whatever it was. As long as they were passing knowledge down that was associated with a greater sense of satisfaction and personality development towards a positive identity resolution. So, ageism and discrimination is a global problem, it's a systemic problem.

The last review that I read on this suggested that it's probably a deteriorating problem. On a global basis, we tend to more alienate the older person and not respond to them with the respect and dignity that they afford.

But in terms of how we're supposed to respond to them, if they come to us for advice and what I do is that I tell them, look, the literature says that whatever you're doing that involves work with the next generation that seems to be most associated with benefits. So I point them towards the Australian volunteer society towards any of the non-government organisations that are looking for help, anything that can involve them being able to...

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So, peer-support networks are excellent for this as well, particularly who have had lived experience of mental illness to be able to support younger people who are just coming into mental health services, they're lost, they're confused, they would greatly benefit from an older person to guide them as to what they should be expecting and how to respond.

CM So it sounds like it's really important to keep in mind different ways that older people can engage in community and a sense of belonging and giving back. So let's talk about things like dementia. I know that you've mentioned that the actual prevalence isn't very high but obviously it's something that lots of mental health practitioners are concerned about. So, when we have someone in the room who does have a comorbid medical or neurological condition like dementia what should we be doing to modify treatment to help and to make sure that we can make the best of our time together?

NJ So, this is a challenging question but the first thing is something to do with capacity. We suffer in Australia from not having a capacity act. So, we actually don't have legislation that enshrines how it is that we're supposed to determine whether or not a person is able to give consent.

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But the basic principles of capacity are the same and they are consistent with the UK's Capacity Act as well as the EEC. It is, is the individual able to retain the information necessary to be able to make an informed decision, weigh up the pros and cons and convey both their decision as well as their rationale? That's the very short version of capacity, there are other caveats in terms of whether or not it's coercive, whether it's being impacted negatively or positively by mental illness in terms of... But that's basically the upshot of it.

If we are concerned about the person's capacity we need to think about things like the Guardianship Act, the issue of substitute capacity with our family

members and thinking about what is going to be acting in the patient's best interests. We cannot assume that the person doesn't have capacity just because they're older. The golden rule of capacity decision-making is that we presume that the person has capacity unless they fail a capacity test.

And if we are concerned about cognitive-related issues and if they're not being treated we should get them to a memory clinic, we should get them evaluated by a psycho-geriatrician or a neurologist or a geriatrician regarding the intervention for those.

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And we also need to look at, with that formal diagnosis, access to social supports through the My Aged Care network, occupational therapy, assessments, social work assessment, ensuring that they have the supports that they need.

It's really important to have those in place because when a person is inside the GPs room they have six minutes for someone to be looking at their tongue. But that six minutes can really change a person's life and it may be their only chance to actually get these severe life-changing conditions to be restored.

I still give a lot of training with Alzheimer's Australia to GPs regarding memory difficulties and dementia screening. And one of the common questions that GPs give to me is it's an incurable disease that we can't do anything about so why should we bother screening for it? And the answer that I generally give is if we do screen for it, if it's early on we can potentially modify the impact of the dementia, we can improve their quality of life, giving them at least about 18 months extra in terms of living at home, control for psychiatric comorbidities, reduce the risk of falls, improve the quality of what's happening with their family, as well as avoid unnecessary chemical restraint psychotropic medications for a very long period of time.

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And most importantly, it's what I would want someone to do for me if I was the older person in the room. People seem to forget about the golden rule of health which is we are supposed to treat everyone the way that we would want to be treated ourselves. If I'm inside that room and something is going to start eating away at my brain, for God's sake, do something about it.

CM Yes. Ian, what do you think about principles to keep in mind for modifying treatment if you're working with someone with a medical or neurological condition?

IR I think when I think of things like dementia and depression, and we know that depression can happen in concert with dementia. I think it's often important to realise that people with cognitive decline just may not be able to articulate how they're feeling and so it's really important that we talk to people who know the person well, like a family member or another health or support worker who might be involved in their care.

I do remember Neil mentioned the Geriatric Depression Scale earlier. There's also things like the Cornell Scale for Depression and Dementia and other tools

that kind of try to focus on depression within dementia. That's important. Just to be clear, however, some of those tools while they are fantastic adjuncts, they're not a substitute for a specialist clinical assessment. They form part of it and they're a great conversation starter.

The other thing with depression and dementia and I think Neil, you mentioned this reatments for depression can generally be used to treat depression in people with dementia as well, activities that raise someone's mood like a pleasant social or physical activity.

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With dementia though, it's got to be within the person's capability without it overstimulating what's going on. Various cognitive behaviour therapies to counteract those negative thinkings, that's for people with mild dementia though. And there's anti-depressant medication, things like electroconvulsive therapy as well.

It's important to just remember that depression can be treated in people with dementia as well, we shouldn't just accept it.

CM And it sounds like the general rule of modification is that we can still do the typical therapies that we might do with someone younger but we might just need to be aware of the limits and look at the person in front of us and make an individualised treatment plan around that.

IR Yes, absolutely.

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NJ There's one more thing that I that I just realised I can't believe that we've been spending this much time talking about the older person but we haven't mentioned yet which is the issue of exercise. I tell my patients that there's literally nothing that I can give them that is going to be more effective than exercise. And it's just strange, it just seems to work in everything. About 30 minutes of any kind of exercise, provided that it's done daily, reduces your rates of depression, falls, self-harm, suicide, cognitive impairment, progression to dementia, pretty much every single social functioning domain that you can name. It is ridiculously good for older people more so than I think for any other demographic.

One of the most bizarre studies that I read was one... You know these little $2 handgrips that you get from Asian grocery stores that are particularly popular in Korea that look like a little spring with a little hand grip?

CM Yes.

NJ And they gave two groups of people these hand grips and over a six-month period found a statistically significant reduction in people progressing to developing dementia amongst the people who happened to have a hand grip and were instructed to use it for five minutes each morning.

CM Wow.

NJ So five minutes of a hand grip stopped people from progressing on to dementia

which doesn't make any sense to me. But it's what actually works. So, most literature thinks maybe about 30 minutes of the aerobic exercise but we're getting a lot more for the anaerobic exercises as well. Anaerobic is defined by things like muscular exercises that don't require increase in oxygen input.

Generally, when we are working with the older people we had to include issues of what they are doing for exercise. And regardless of your level of physical incapacity there are always opportunities for exercise. It doesn't have to be treadmills and gym, it can be hand grips, it can be hand cycles, it can be hydrotherapy, it can be walking inside a pool, whatever it is.

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It doesn't seem to matter what it is, as long as it's done that slightly stresses the body for at least about half an hour a day, that makes a prodigious difference to mental health.

CM And that is such good practical advice that we can provide to our clients as well. Thank you so much. So, let's talk about supporting our clients with their family. What's the role of family in older age mental health and how does this change with age? And for people who live in rural areas what about if family live far away, how can you include them in treatment?

IR Look, so the role of families and caregivers is really important no matter how old you are really. I think who the carers are will probably change across the lifespan. In younger people, of course, parents are often the key family support but in older people, it could be a spouse, an elderly spouse, siblings, adult children, grandchildren might take on a caring role.

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The thing to think about though, spouses might be elderly with their own chronic health conditions or they may be deceased, adult children may be distant leading their own lives in a city somewhere, or for people who might have had a lifelong mental health issue there may be an estrangement with families and carers that have come and gone, that has produced quite a level of isolation for the person. Either way, families and carers really need to be seen as key partners in care. That's what we say, key partners in care for the older person.

I think another factor that we mentioned in the previous question, we do rely on family members a lot in older people's mental health to help us understand the health issues of their loved one, especially if the person has dementia and can't really articulate how they're feeling.

CM And so it sounds like family members are perhaps even more integral in the treatment of older people than they are for adults or younger populations.

So, we know that things like risk assessment are always important and you've mentioned that generally people in older age the research says that perhaps there's less depression, although there is a question mark around that. But Neil, you've mentioned that actually, the suicide rate for over 85s internationally is quite high.

So, in relation to risk assessment and specifically around suicide risk, I think often as practitioners we have our own way of assessing risk and we might not think to modify this if we are working with older people. Are there any differences that you would think are important when you are assessing safety or assessing risk for older people, particularly if you are in a rural area maybe with less support or less other allied health professionals to lean on?

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NJ Unfortunately, I can't be very comforting in this area, The basic rule with suicide risk assessment is that older people get it right. They are far more lethal and far more likely to carry out suicide attempts. For younger people, the general thrust of a suicide attempt tends to be around trying to seek support for the alleviation of serious mental distress. But for the older person, they often feel simply that they've got nothing to lose and they very quickly gravitate.

So, even minor things like self-harm and scratching which we would probably think of in a younger person and see fairly frequently in community settings or in emergency departments. That's a massive red flag as a new behaviour in an older person. I have an extremely low threshold of tolerating suicidal and parasuicidal behaviours in older people.

The basic rule with any sort of suicide attempt or suicide-related behaviour is to ask for motive in terms of why does the person want to harm themselves. And if you are unable to address the motive in the setting that you're in they need to be in a more secure location. And for the older person that motive is usually much harder to try to respond to.

We did talk about issues for how the older person can have regrets about their life experiences and everything else and certainly I have seen and I'm sure Ian has seen as well, people who present in that sort of framework.

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But why we have to have such a high bar is there is a question of resilience. Older people by virtue of the fact that they have more lived experience they are generally more resilient. So, when something is able to overwhelm their already well-honed, mature defences over literally decades of tolerating adverse events to the point that suicide is seen as a potential option whatever it is has to be pretty important as it is.

Essentially, my bar for suicide risk and I work with younger people and general adults as well as older people. The general rule for older people is that the suicide risk assessment has to be a much higher level of concern regarding the potential for progressing towards a completed suicide attempt.

CM Ian, what would you say is different around safety planning and suicide risk in older adults?

IR Well, I guess before I get into that I think one thing that is really sad about this is that suicide in younger populations seems to get more attention than it does in older populations. And society seems more tolerant of suicide behaviour in older people compared to younger people. And I think ageism plays a part there and

we talked about that before.

Look, Caitlin, I think the principles of caring for people who are suicidal are probably similar across the lifespan. And in older people's mental health we look at things like early intervention if we can, engaging the person, doing a mental health assessment, of course, looking at the past attempts of suicide.

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But looking at those things we mentioned before around social isolation, overwhelming hopelessness or despair, I think we need to assess substance use and that can be high in older people. We need to understand if there's a presence of a plan or access to means of suicide.

And as Neil said, sadly, the ratio of suicide attempts to actual death is significantly higher for older people than it is for younger people. But look, it's about building resilience in people and I think Neil, you mentioned that. Engaging in problem-solving, tapping into that person's personal strengths. And this all remains the same across the lifespans.

NJ It's about trying to understand what the purpose of the suicide attempt is. The question which I find is least asked after a suicide attempt is why did you do it. That really is the most important question to ask for any person, including an older person. Because that answers the question as to what the suicide attempt was attempting to address. And being able to look at that and answer why it is can help us in terms of working out how to resolve the problem.

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I'm reminded of a patient who presented with recurrent suicidal thoughts and she actually had psychotherapy in terms of trying to rationalise it. Because she spent about nine months in hospital with intractable suicidal ideation. What we eventually found was that her mother had treatment-resistant depression and killed herself after the patient got married and her husband stated her mother couldn't live with her.

Now, this patient's own suicide attempts started when her daughter got married and determined that she couldn't be living with them anymore. So, what was happening was that she was reliving the sense of trauma from letting down her mother being directed at herself. And this was quite a complex presentation but it was a new presentation. And we were able to address her suicidality, fortunately, with the patient having a good response to psychotherapy.

The rationale for the suicidality can be quite complex, it's certainly not anti-depressants all the time. Sometimes it's about the right social intervention or the right psychological intervention or even the right sort of biological intervention. Because I've had patients killing themselves because of chronic pain simply because they had pain managed by well-meaning general practitioners but had difficulties in access towards pain control specialists. And with that, the concern was addressed.

One of the reasons why suicidality is so different in older people is because it gets conflated with the euthanasia debate, with the idea that it's acceptable for

older people to die because it's a form of euthanasia. Now, we really need to separate these two debates. Euthanasia is about the resolution of an intractable physical comorbidity with deterioration and impact on quality of life. And we are usually not talking about that when we are thinking about suicide and mental health.

CM So it sounds like the most important thing and the most important piece of advice that you have is to understand the function of the suicidal behaviour or the ideation so that we can work with the patient?

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And perhaps even working with those Erickson models of where they are in personality development and marrying it to that might be something to consider?

NJ It's a difficult question. If we don't understand what the suicidal act or suicide-related behaviour is being motivated by we can't address it. I had a patient who repeatedly self-harmed and it was thought to be related to all sorts of things from their childhood. But what it turned out to be was an untreated psychosis in that she felt that she was trying to respond to a psychotic phenomenon. And as she was recommenced on anti-psychotics after 30 years the attitude towards the self-harm behaviour gradually changed.

Suicide is a horrible, dramatic act but in order to try to respond to it we need to understand it. And if we don't understand it we need to make sure that the right services involved that can understand it are appropriately involved.

CM So there are lots of changes that might happen in these later stages of life for people. How can mental health practitioners support someone who, for instance, might be transitioning to an aged care facility or even might be considering advanced care planning or end-of-life care?

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NJ So, the first thing I would say is to congratulate the individual, to say that they are making sensible and appropriate life choices. So, coming back to the issue that we want people to be doing things that are for the next generation, we remind them that the way that you are making these decisions now in your stage of life you are providing a template for your children if they are lucky enough to get to that stage.

There is often this feeling that when you go into a nursing home it's a failure, you've given up on life, you are now a person who is going to be relegated to God's waiting room and that inevitable deterioration.

And that's a horrible stigma that is still very, very prevalent. What we need people to see is that it's a sensible, logical choice when your nursing needs... And it is about nursing because it's a nursing home facility, it's in the name. It's because they need 24-hour nursing. So, if you are able to have 24-hour nursing at home that would be amazing but it is a sensible decision given what your actual care needs are.

And finding the facility that is able to provide you with what you are needing from a physical and mental perspective together with social supports, that is something which fortunately people have a lot more opportunities and much more options now. Certainly, in rural and remote areas we still have difficulties in terms of the shortage of potential available facilities. But it's really about trying to make it your own. With the advent of telehealth and video conferencing interventions, there's an incredible amount of stuff that can be now done regardless of where you are, that make any place a home, that can make any place an opportunity for learning and living.

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So, an extremely well-adjusted superior older person who is a template to me and to their children in terms of the best way to live their lives is a person who has worked out their advanced care directives, worked out their last will and testament, determined and chosen their aged care facilities and teed up what they're going to be doing in terms of their hobbies, their interests, their creative pursuits or how many girlfriends they're going to be chasing after.

But then after that, there are things like the University of the Third Age, the U3A, which provides online and in-person opportunities for older age living. There is the slightly more elitist but nonetheless impressive Probus organisation which also runs lecture circuits including nursing home interventions. I can't understand their lectures which is why I tend to call them elitist. There are a number of volunteer organisations that provide in-reach and outreach and charity organisations that also provide these within nursing home facilities.

The other important thing I would raise is that there are less options in rural remote areas but if there are options, by all means, look for them. My favourite aged care facility anywhere is a caravan park in Dural. Which started out as just a caravan park but gradually people kept on turning up with their caravans and then parking there. It is the only caravan park in the world with garden plots.

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And they applied for residential aged care facility status and got it because that was a community that they eventually built up.

And depending on what your interests are there are aged care facilities that have full-functioning farms, frogs, chickens, whatever. And one of the most amazing experiences I remember was seeing a patient with severe frontotemporal dementia, she was in an awful state. She was throwing faecal matter on the walls, extremely disordered, very frontal lobe disinhibited, not really responding to any medication and anything else.

But the facility that she was at noted that she had an interest in cross-stitch and was able to actually maintain remarkably greater gradients of colour out of these things. And this an individual that you thought could not be possibly capable of any sort of productive intervention.

But the facility supported her in this and staged her first and last exhibition of her works. And her family said that they had never seen her that proud ever in her life. And two weeks later she passed away. We are talking about end-of-life care,

we are talking about very weighty and very big decisions that happen and they are probably the most challenging things that any person can go through. But there can be incredible opportunities for hope and redevelopment. There can be incredible opportunities for connection.

If we pursue it and assume it with a mindset of failure and deterioration it will be an experience of failure and deterioration. But if we approach it as something where, all right, fair enough, your parents died, you don't know what you're supposed to be doing in life but then I don't know what I'm going to be doing if I manage to make it to your age either.

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If you could show me the pathway that's going to make it easier for me that's going to change the entire dialogue.

CM Thank you, I think that's really beautiful advice and a nice reframe for what is often considered a not-ideal circumstance. Ian, what would your advice be to mental health practitioners who are helping clients with that end of life care or transition to an aged care facility or similar situations?

IR I think people need to realise and understand that moving to an aged care facility can be really stressful and difficult. And the person may be ready to enter care or they may not. I think the key is to promote the person's choice as much as possible and control it's not always possible, by the way. And as Neil said, some people might see it as the beginning of the end and that's pretty confronting.

But I think my advice to mental health practitioners is to work together with the aged care facility staff and the families to assist that person to find their new place in the aged care facility.

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I think whatever we do we have to make sure the person has a voice. They're losing a level of control and independence and privacy going into an aged care facility, let's not let them lose their voice, let's listen to them.

And I think let's not shy away from those challenging questions about death and dying. I think older people do generally want to talk about death and dying, it's on their minds. I think they're not so much afraid of death, possibly more concerned about the dying process. For example, will there be pain, will it be slow and protracted, will there be dignity or will I have some level of control over what occurs leading up to my death and at the moment of death?

I think my advice is, to mental health practitioners, don't shy away from talking about that. If you can, create the space to allow that conversation to occur. Allow them to reminisce. And by the way, reminiscence, that's a profound part of being a mental health worker and it's quite a privilege to share in that type of conversation with the old person. It's quite a profound moment, I think.

CM Thank you so much, Ian. So, before we finish up if listeners were to take away one or two things about this episode, Ian, what would you want it to be?

IR Look, for me it's about working with older people, I've come to enjoy it more and

more. And think about it, older people have experienced more, they've seen more, they've learnt more, they, of course, have lots to contribute to their families, their communities and the whole of society. I think working with older people has prompted me to think about my own ageing or the ageing of my own family members and what it means to age well. And I know ageing can be a positive, fantastic experience despite all the deteriorating physical health that can occur with ageing.

I think the positive aspects of ageing is something that in older people's mental health we see it.

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CM Beautiful. Neil, what would be one thing that you would want listeners to take away from this episode?

NJ Simply because we've covered a lot of very important ground inside this and I have to go back towards the issue of exercise because it is just simply so powerful as an intervention, I would ask listeners to ensure that every older person they look after that they encourage them towards 30 minutes of any form of exercise that they are able to tolerate. It will greatly reduce the likelihood that they will need to have anything to do with someone like me. Which is always going to be a good thing.

CM Absolutely. I think that's a really good practical piece of advice to finish on. So, if listeners want to know more about this topic we will list out some resources for them on our learning platform page. That's all that we have time for on this episode. We have gotten through a lot of information. A big thanks to our wonderful guests, Ian and Neil. Thank you so much for spending your time today talking to us. I've been your host, Caitlin Miller and this has been another episode of The Peregrine Rural Mental Health Podcast. Thanks for listening.

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Outro I hope you found today's episode helpful. You'll find specially selected resources on this topic on our digital learning platform. To join the platform for free or to suggest questions or topics for further episodes, please visit our website theperegrinecentre.com.au.

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