Ageing with Agency: Multidisciplinary Support for Older People Living in Community

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Assoc Prof Caroline Johnson (00:00:00):

Welcome everyone who's joined us for tonight's live activity and to the viewers who are watching the recording. On behalf of MHPN, I'd like to acknowledge the traditional custodians of the Land, sea, and waterways across Australia, upon which our webinar presenters and the participants are located. Want to pay our respects to elders past and present and acknowledge the memories, traditions, culture, and hopes of Aboriginal and Torres Strait Islander people. So my name's Caroline Johnson. I'm a GP who's going to be moderating tonight's session and I'm based here on Woiwurung Land in Victoria. I'll briefly introduce the panel, but just to remind everyone you can read more detailed biography of this wonderful group on the website. So first of all, can we have a wave from Professor Sharon Lawn, executive director Lived Experience Australia? Thanks for being here. It's lovely to work with you again, Sharon. And now to my GP colleague from the ACT, Dr.

(00:00:59):

Paresh Dawda. Hi Paresh, thanks for being here and to our nursing colleague, Deb Booth, who's a registered nurse and has got a lot of experience in aged care management, also from the A CT. Good day Deb. And finally, Dr. David Lie is a geriatric psychiatrist. So we've got a bit of a Canberra heavy presence here tonight, but that's fine. I'm sure that will be good for us to role model multidisciplinary team-based care. So as you all know, if you've been to MHPN webinars before, the purpose of the organisation is to really promote and support multidisciplinary team-based care in the mental health space. And we really want this activity to showcase what multidisciplinary team-based care would look like. So there's going to be a bit of discussion about some of the hurdles, some of the enablers, and a real focus on good practise that we hope you can take away with you when you leave the webinar and go back into your clinical spaces afterwards.

(00:02:02):

And tonight's model is going to be very much a hypothetical. So the panel will be asked to think and talk on their feet. I hope there'll be a bit of negotiation between them and a bit of a conversation thinking a bit about some of the soft skills around how team-based care works as well as some of the clinical conundrums we're going to be presented. And at the same time we're going to talk about that, what that looks like just as role models. All these people have been selected for those disciplines that they represent, but I'm hoping they will also ask questions of each other as we go. Fantastic. I think we can get straight into the hypothetical. And for those of you who have joined online, I want to introduce Hilda. Again, if you've lost Hilda's case study, you can find her again in the supporting resources tab on the website. So please take out those cases and have a little look at Hilda who we're going to be discussing tonight. I'll just give you a moment to get that up and be ready to go. Panellists, have you all got Hilda firmly in your mind?

Deb Booth (00:03:12):

We have.

Assoc Prof Caroline Johnson (00:03:14):

Okay, let's launch in. I'd like to probably start with the GP because you and I as gps will probably recognise patients like Hilda. I guess I'd like you just to comment when you read this case vignette, how typical did you think the case was?

Dr Paresh Dawda (00:03:37):

Yeah, thanks Caroline. And hello everyone. Look, it's not uncommon is it patients like Hilda, although the context may be different in terms of their age of history, the comorbidities, we are seeing so many more people with comorbidities with mental health, comorbidities and physical comorbidities and this sort of presentation, I think Hilda presents with symptoms which aren't completely clear. It's a bit more chaotic, bit more confused, bit more defensive, very subtle symptoms to try and decipher what's going on and work out what's going on. It is not uncommon at all. So yeah, very realistic, very common type of presentation. I think the thing that speaks to me really is we are taught in medical school history, history, history and the issue I think in this sort of case sometimes is getting the history a reliable history can be challenging and difficult. And so as well as knowing the patient and their longitudinal history, which of course in general practise we often know if they've been with us for a while, getting that history from other people involved. Could be family, it could be carers, it could be community workers going in such as a community nurse in this case that collateral history is a really important part of trying to understand what's going on.

Assoc Prof Caroline Johnson (00:05:21):

Thanks Paresh. So because there'll be a lot of people in the audience who aren't gps themselves, so hello to the GPS in the audience, but I'd like you to talk through for those who aren't sitting in the GP seat, what's going through your mind when you read a case like this or when you meet someone like Hilda in your consulting room, what are some of the things you're thinking and give us a bit of a sense of how you prioritise them.

Dr Paresh Dawda (00:05:45):

Yeah, thanks Caroline. So I guess what I'm kind of thinking here is we've got a bit of a vague history, need to try and work out what's going on, need to try and work out the priority in terms of hilda's safety. So what's a sense of urgency around working things out. And I guess the first thing that's going through my mind as I kind of hear this history of, or the subtle presentation around confusion and being a bit chaotic, is this something acute or subacute coming on? Is it like a delirium beginning to set in? We know here with us on medications like lithium, when did she last have her levels? Is this lithium toxicity or renal impairment beginning to set in? So that's kind of the other thing that's going through my mind. And of course if that's the case, there's a greater sense of urgency around getting on top of things.

(00:06:47):

How safe is Hilda on her own? She's getting confused, she's getting chaotic, she's at risk of falls. So what's a safety risk here and who else can come in? So if things were to deteriorate more quickly, if we were to keep heal at home, who else is coming in so we could escalate if things were deteriorating? So

that's a clinical reasoning going on in my mind. And I guess I'm trying to work out okay, there's some immediate needs we need to look at and work out. There's some longer term planning issues as well for Hilda. And the immediate needs I'm kind of thinking about is what's going on? Is this delirium, is this a relapse of a bipolar disorder? Is this a new condition beginning to develop an emerging for the first time? So for example, we often find that the first diagnosis of dementia at a point when that there's a little trigger and that's when the first diagnosis occurs. So this could be that trigger, it could be that event which leads to dementia diagnosis as well. So that's where I'm at with my sort of clinical reasoning. And I guess what I really want to do is pick up the phone and speak to that community nurse and the carer and get that collateral history so I can start answering some of these questions in my mind.

Assoc Prof Caroline Johnson (00:08:18):

That sounds perfect. And aren't you lucky that you do work in a multidisciplinary team? So you do know the community nurse, you've worked with the nurse before and their name and their face and you know can just pick up the phone, which is a luxury that not all GPS in Australia have. But let's role model what that looks like because it is a definite bonus. So let's move over to Deb. And Deb. I guess I'm really interested in your views of you are the community nurse. If you were going out to visit Hilda and you saw this, what would the phone call to the gp? Talk us through some of the challenges of it. Can you just get on the phone to the GP and he answers the phone right away and if you do, no, go ahead.

Deb Booth (00:08:59):

That's the

Assoc Prof Caroline Johnson (00:09:00):

First challenge.

Deb Booth (00:09:01):

So for community nurses to what I read with great joy was that you had a stable gp. Often with these kind of cases it's quite chaotic and they might GP jump. So in order to have someone as wonderful as Prh to sit down and talk to through a case management process, but I would share those concerns, is your lithium toxic, what's a renal function? How long she'd been on lithium? Is this an acute condition that you're trying to treat The difficulty with C-P-O-C-O-P-D, is she oxygen deprived? So is it something I'm very sorry they were asleep. Stop it, go away. That's okay. Three dogs, I'm very sorry. So A-C-P-A-I would do some oxygen SATs on her. Is she febrile? Is she got a delirium, do a urinalysis just to take away those acute kind of causes? But she does have that history of bipolar but not to rest on that alone.

(00:10:08):

So certainly I would be advocating a strong case management approach and just sit down and discuss what's known about her. If I've been the committee nurse for her for a while, if she's been on lithium and whatever else, how long's the history known and certainly to the gp, what's usual, what's not the neighbour I would be talking knocking on the door of the neighbour and what are their concerns? They might be a much put upon person who is doing their very best to support this person in the absence of being that she's annoyed everybody else. So certainly for me management it would be that is she taking her medications, are they packed, is she having them with food or not with food depending on what

she's taking and has she got enough nutritional support behind that to actually be giving her, I just lost my notes. So to be giving her that level of support so that she's not not languishing from things that are preventable and reversible.

Assoc Prof Caroline Johnson (00:11:19):

I love it. So you're thinking you've actually really helped think about things not only about the immediate presentation but also about the reality is that it's highly likely that something will happen and she'll end up back in your care, whatever that something is. That's right, that's right. You're already thinking, well what can I do to prevent future episodes? What I also love about it is that ability for the nurse and the GP to bounce ideas off each other. Certainly much better when the nurse says, I've thought to check the oxygen, I've thought to check the temperature than that, the GP has to remember and say, please tell me all these things. It really improves the efficiency and speed we've been trained on. Is bar, I beg your pardon,

Deb Booth (00:12:00):

We've been trained on IS bar.

Assoc Prof Caroline Johnson (00:12:01):

I love it. So maybe talk through because there'll be people in the audience who aren't familiar with IS Bar and I think it is helpful for people in the audience to know it's an important acronym that helps clinicians in terms of clinical handover. And for some of ours who are working more in the mental health space, they might like to hear that. Deb and Press, do you feel comfortable talking about IS Bar and what it stands for?

Deb Booth (00:12:23):

I could remember what the acronym is. I know, I'll just

Dr Paresh Dawda (00:12:27):

Look it up. I can kick off. So look, Isma a structured communication tool, it's one of other similar tools as well, and the commission for Quality and Safety have got a whole guide on it called the Aussie Guide to Clinical Handover. And it's got some information in there. It's as Deb says, it's an acronym and the acronym stands for the I for identification. So we're talking about Hilda, the S is for the situation situation. What's the situation we're finding ourselves in that we're talking about this, the B is the background. So that's some more detailed background to the reason we were talking about Hilda. The A is assessment. So what do I think, what does Deb think is happening with Hilda and the R is a recommendation. What do we think should happen next? So think of it as a mental model around how to structure communication when you're handing over to colleagues.

Assoc Prof Caroline Johnson (00:13:34):

That's really helpful and I think it's also helpful for mental health professionals who might want to know how to, doctors and nurses think it might be a bit different, but certainly presenting information in that

way. I often hear psychologists complain about how hard it is to talk to GPS because they're so busy. But a structured report like that you've just described could be very helpful for getting the GPS attention.

Deb Booth (00:13:56):

It certainly helps Caroline from an aged care perspective where I've spent the last few years to get those nurses not to ring the doctor in the middle of the night to say so-and-so's unwell. So it really structures there because then Paresh can come back and say, okay, run me through the IS bar and then you go, okay, what's the identity? Those kinds of things. So it really focuses that conversation down so you're not wasting people's time with they're not Well

Assoc Prof Caroline Johnson (00:14:24):

Yeah, and that's certainly, I mean that's one of the reasons why I cut back my aged care. I got sick and tired of people ringing me saying someone's not well. I had patients in the waiting room, patient with me wanted to help, but I kind of need that information. Otherwise the conversation goes over

Deb Booth (00:14:38):

Really, really, really important.

Assoc Prof Caroline Johnson (00:14:39):

It'd be good for the people in the audience to reflect what does that is a model look like in your world? What are sort of the things if you were handing over care of someone to another professional, think about what the kind of headings you might want to cover are. They'll be different for all of us according to our discipline. But now I want to move on to what Deb raised is she does know that Hilda's got a local neighbour, she's lucky, she's got someone who lives close by and I really struggle with this as a GP because I meet a lot of lovely people like Hilda's neighbour who are helping out and they didn't necessarily sort of volunteer to help out. They just kind of naturally got absorbed into it because they're just a nice caring person and they observe things and they just want to help but maybe they don't want to help as much as as health professionals ask of them. And I always worry a little bit about that, asking them to do more than perhaps they're prepared to do and negotiating that. And this is where I'd really like Sharon's input. How do you decide as a volunteer care, if you like, how much time you could give, how's that communicated to you? How would you like health professionals to relate to you if you were Hilda's neighbour and being asked to keep an eye on Hilda?

Sharon Lawn (00:15:59):

Thanks Carolyn and thank you Deb and Paresh. I've been listening with interest obviously with this particular neighbour, we don't know much about her from the case, so we don't know if she's ever actually seen Hilda when she has been unwell with her bipolar for example. So this might be the first time that she's seeing Hilda in this way and given Hilda's normally quite switched on, charismatic, et cetera, all those things that are described in the case, this might be quite a new experience for the neighbour. The other thing I'd say is that she's a neighbour. She's not someone who might be used to having a dialogue with health professionals at all.

(00:16:51):

So she's not just a source of information and I know it's health professionals, it's very easy to slip into that mode. She has some sort of a relationship with Hilda and the language that she uses and the language that the health professionals are using might be two different things altogether. So she's certainly won't be used to perhaps talking to someone in the third person. And yeah, there's a whole range of questions that I have about the neighbour potentially. Is she someone who's working? How big is the group of units? Is she one of a number of people? How social is Hilda? She's only been in these block of units for two or three years. So is it a large community? Is it a small community that the neighbour is even connected with? There's a lot of questions.

Assoc Prof Caroline Johnson (00:18:02):

Yeah, thanks. I really agree. There are a lot of questions. So let's mess with the case a bit. Let's say hypothetically Deb, you do get to talk to this neighbour and the neighbour says, oh, I really love Hilda. She's so much fun. We've had some great times together and I've really enjoyed, we sometimes watch the footy together and we have a couple of glasses of wine and she's great fun, but I'm really worried about her and I actually think it's a risk for us. We are all in the block of units and I've been there a couple of times where she's left the stove on and I'm really worried that we should report her as being unsafe because I'm worried she'll burn the house down and I really think you and your team need to do something about it right away. We all feel unsafe. How would you respond to something like that, Deb?

Deb Booth (00:18:49):

Well, she's got the right to exist. This is her house. So what again, but not to derive the carer in any way or the neighbour because I've been in situations managing IOUs where this exact thing happens and fires have been set and people with adjoining units are very frightened. I know she may be a bit disassociated with her sons, but I would go to the sons, see who's got power of attorney over mum, whether a power attorney exists. If it doesn't, then do we explore guardianship with her that maybe some of the decisions she's making might not be safe for her? Is there a community team along with the community nurses because that's different but a community support package that could go in and support her? Is it possible for the suns to turn the power off to the stove if that's the problem and the only problem, so you just kind of look at each issue in its context, what can be done is the suns are completely not willing to, everyone's been burnt and there's no one, there may be that the public trustee might need to be consulted just to try and keep her safe, but her safety but her dignity is primary in the focus and that she needs to understand what it is and have some degree of consent in the processes that you are dealing with her so you don't go behind her back.

(00:20:27):

Yes, you recognise the danger that's there and you try and mitigate that risk as best you can.

Assoc Prof Caroline Johnson (00:20:33):

Well thanks Deb. Sharon, what would you say to that from a lived experience perspective?

Sharon Lawn (00:20:38):

Yeah, I guess all of those steps are a fair way down the track and the first thing that seems to have been missed is actually asking Hilda for me. And if it was me working in the Multid team, if I was her

community worker, I would as you say respectfully include a conversation with the neighbour and with Hilda. So she's not completely othered from day one?

Deb Booth (00:21:14):

No, that's, sorry. No, that's really my intent and that she has control over some of as much of the process as she can

Sharon Lawn (00:21:23):

Actually have a conversation. It may be that there are other stresses in her life or something that's happened recently that's really unsettled her and there could be, we need to understand I guess what's been happening for her rather than jumping to that. Yeah, it's possibly this. It's very easy in a multid team when you get heads together and people have seen a lot of scenarios that you can start to stereotype people as well. I know that from working in teams. So really and at each step with the neighbour and with Hilda really having a three-way actual meaningful conversation that really does try and be very inclusive and respectful of her. So that's the starting point. And it also supports the neighbour as well because they can feel that they're just a source of information otherwise, whereas they may have great care for their neighbour who seems to be someone who is very much engaged with other people and with her artwork and everything else. Yeah.

Assoc Prof Caroline Johnson (00:22:51):

Okay, thanks. So thanks Sharon. So I'm going to get to bring in the psychiatrist in a minute, but first I want to just flick this back to the gp. So this conversation's happened. Deb's had an attempt to have a conversation with Hilda and the neighbours involved and feels it goes fairly well that Hilda does acknowledge that her memory isn't quite as good as it was and she's a little bit worried about how she's coping and she's open to talking to some people about getting some more help. But then on Monday morning, Perez, you've got a fully booked place, no appointment spare, but reception says Hilda's at the front door of the clinic. She's demanding to be seen right away and you decide that you will see her because you think you're aware that things aren't going too well. It seems to be a bit more urgent.

(00:23:42):

And she says to you that she's very upset that people have been talking about her behind her back, that people have been making decisions without her, that she's spoken to a friend who's a lawyer who's suggested she talk to her sons and her sons have said that they want to get new paperwork saying that she's competent to make some decisions that they'd like her to fill in some paperwork that gives them medical power of attorney. They're not sure the paperwork's right and all she's here for is for you to get the nurse off her back and she wants the paperwork that says she's competent to make some decisions. Talk us through how you might handle that. Keeping in mind you haven't yet heard from Deb because she hasn't got to work yet. It's a Monday morning.

Dr Paresh Dawda (00:24:29):

Yeah, thanks Caroline. It's always a Monday morning. It, it's obviously a challenging situation and what we really looking at here is a capacity assessment. The problem with the capacity assessment is it's decision specific and sometimes time specific as well. So it is not as simple as signing a piece of paper. I think it's much more involved than that. And so I think then again needs to be, I think really emphasising

what Sharon was saying earlier around having Hilda feel part of the process. I think there needs to be at least an attempt at a good conversation with Hilda around understanding her, having empathy for her in the situation she's in and acknowledging that it's important for this paperwork to be completed, but also taking her through the process of completing that paperwork and what is needed there in terms of a capacity assessment, it needs to be a rigorous process because the principles around this are what I said earlier, the person has capacity until proven otherwise and that capacity is decision specific and time specific.

(00:26:02):

So it could be that Hilda doesn't have capacity at the moment for certain decisions but does for others given there may be a subacute presentation going on here. So I think it's really about having that respectful conversation with her. I have the luxury of having a social worker in the practise, so I would probably knock on the social worker's door and get her involved with Hilda, but that's not a luxury every general practise has. So I think what we are looking at here is a bit of a complex decision making process. It probably is also one that requires some specialist input. I'm glad David's around because it's going to be one that's not going to be able to be made like that. It's going to be one that requires my knowledge of Hilda over time and how she's changed because I've been her GP since 2017, the input from her neighbour Deb. But I think there's a degree of specialist input that's probably going to be needed here in terms of her capacity assessment, particularly if we thinking that she hasn't got capacity because it's going to need to potentially go to guardianship and there's going to need to be supporting documentation around that. So this is where again, part of the conversation would be with Hilda around the fact that I need support to help make the right decisions for her together with her and therefore we need to get David involved.

Assoc Prof Caroline Johnson (00:27:41):

Yeah, that's a fantastic segue and I agree absolutely that sharing those decisions is particularly important for the GP because it also becomes a situation where you don't want the patient to reject you outright. You want to stay in a therapeutic relationship. So bringing an extra person in an expert if you will, and this is where David definitely, if you can get access to someone who's got experience in geriatrics and psychiatry, they're like gold in this situation. I mean David, I want you to imagine, I don't want to get too much into the medical sort of jargon because not everyone is a doctor on this webinar, but let's imagine that Prh has done his job, he's done a mini mental state exam and her score has definitely dropped her blood show. Her kidneys aren't perfect, they're not terrible. She's got a slightly drop in her haemoglobin, but again it's not terrible. All the other bloods and she hasn't got a urine infection and he only did an MRI last year, so he wasn't sure whether he should do another one just yet. So he's kind of done the basics. What would be your approach if Paresh rang you on the Monday, Monday morning tea time to say help?

Dr David Lie (00:28:51):

Well, I think my guidance would be that just getting in touch and having a phone call, there's a few tips I've got here because there are actually, well first of all, most of Australia is covered by an older person's mental health team that will have access to a psychiatrist. That can be tricky. For example in the Northern Territory, I don't think they've got one of those teams at all the function's kind of a geriatric medical function. But one of the tips I've got is that the filter between you and that phone call first of all

can be in some districts that all the traffic to older person's mental health will be via some sort of triage line. And often the clinicians, whilst they might be good neighbours and good citizens, they may not get older adults and they're attuned to this concept of mental illness, but they never tell anybody what mental illness is.

(00:29:56):

But what they mean is they're after people who've got that they're going to prioritise access to services and opinions around the assessment and treatment of people with psychotic disorders and with mood disorders and people who have expressed suicidal thinking and they're often very, very resistant. If you start off a conversation with, I would like you to do a capacity assessment because many people are going to just say no. So I think my tip around this is that there would be a much more refined type of referral which says I've got a lady who may have, I'm trying to do a capacity assessment, I've got a lady who may have active mental illness and I'd like some input to try and work out to what extent that's at play. So I don't know if you've been in that situation, Carolyn, where you're just not getting anywhere trying to talk to mental health

Assoc Prof Caroline Johnson (00:30:55):

Many times and it's really many times.

Dr David Lie (00:30:57):

So first of all, be helpful to know, not

Assoc Prof Caroline Johnson (00:30:59):

To emphasise the thing that made you push the phone button, but rather to emphasise the clinical question that you have that you need help.

Dr David Lie (00:31:07):

And if the person has both dementia and a mood psychotic disorder, you don't start the sentence with I've got a person with intellectual disability or I've got a person with dementia because someone who's not in our world of being a bit more attuned to realising that everybody has a right to a sophisticated assessment depending on their needs and severity. You'd start that sentence with I've got a work person, I'm quite concerned that they might have the beginnings of a manic episode or a depressive episode or I'm quite concerned there might be a psychotic problem here. And then at the end of the sentence you might say, and they're living with dementia or they've got some intellectual disability. It can be as frustrating as that I think trying to talk to just to get the wrong person in the wrong service somewhere in Australia. The other thing I'd say is that more of the services actually potentially will allow you to talk to a psychiatrist without necessarily needing a referral because sometimes what we do is we get referrals that have been triaged and have just trickled through the system.

(00:32:15):

And I would say it's not quite, look, it sounds like they just want some advice about a medicine. So in this service, do they just call us because some services pride themselves on the idea that they think they've got allocated. So I've been in services now doing locums where they actually have this availability because when I was in general practise a long time ago and I was used to that if I had problem with

thyroid management or whatever, I expected they would be able to speak to a specialist and I won't go through the full history of mental health services, but there are specialists, psychiatrists around. But sometimes I think if your problem is, I just want to clarify something, I wonder if I can speak to a psychiatrist, there'd be some services that might actually allow you to not have to fill out 500 forms and actually have that phone call, but they usually don't make it easy for you. So that's a bit of a random, it might sound like I'm criticising my own services, but I think that the problem with criticising other people is when you actually look in and start working with them, some of them are quite nice and mental health is like that as well, but I think there's some tips just with just how to have that conversation at all.

Assoc Prof Caroline Johnson (00:33:35):

Yeah, thank you David. So that is really important to think about how you frame the conversation to get the help you need and certainly I'd be interested in impression and Deb to reflect on has that been your experience? What are some tips you'd have for people listening to this webinar of when you need that extra help that's a bit more complex? What are some strategies you've used to reach the team who are all good people but are also very busy and might be using exclusion rules to keep people out of their books?

Dr Paresh Dawda (00:34:03):

Yeah, one of the common barriers I come across Caroline is especially when speaking to mental health services, it says something physical going on. Is there a medical thing here? You need to exclude that before we'll see them. It's a very common barrier I come up against. So again, the tip and technique is very much to perhaps speak to a general physician first, perhaps a medical on-call team, send them out and if we've got the confirmation from them to say no, we don't think there's anything medical going on, the bloods are okay, you excluded a UTI, blah blah. Having that piece of information when you speak to the mental health service, it's really helpful ammunition because you can say no, look, we've ruled out medical causes and we're really worried about the mental health side of things here. So I found that pretty useful. Increasingly I think around the country there are hospital avoidance schemes beginning to emerge and these hospital avoidance schemes are very much about trying to get some rapid diagnostics and specialist input and preventing people from going into hospital. So in the A CT, there's a service called the radar service, which is a geriatrician led service and they would come out. So again, if those services exist, I think it's useful to know about them and getting them involved as well because it can be a catalyst for getting the other assessment and the other access points once you ruled out some of acute stuff.

Dr David Lie (00:35:54):

Carolyn, if I could just say that we've got a similar kind of thing in the back of our minds that sometimes a GP or a facility may have had trouble having a person like Hilda who comes with a mental health label to convince them that there might be something physical going on and the fact that they've actually had a psychiatric assessment to say, no, look, we don't think this looks like delirium to us even though you haven't been able to find a definitive cause, this is not a psychiatric admission. We support that, but in fact that flips around as well where per is saying sometimes you can get physical health folk to help mental health people open their eyes. In fact, sometimes we can be helpful in a situation where it is

unclear. I mean in this scenario Hilda's lucky her GP knows her in other situations sometimes to have just changed practises or things like that.

Assoc Prof Caroline Johnson (00:36:53):

Can I say then that's a really interesting thing that which comes first, the chicken or the egg and absolutely my experience is like parishes, if you haven't done the physical ruling out stuff, the mental health service won't talk to you. But on the same token, sometimes the perspective from a mental health service is really useful. I wonder if Deb, you can comment because I imagine working in the aged care sector, you've often felt like the meat in the sandwich for being sitting by Hilda's side trying to help her get some kind of care and different services are saying not a cup of tea. How do you deal with it?

Deb Booth (00:37:26):

It's really difficult, especially in the manic stage because that's really annoying to everybody around. The depressive stage is sad for the person, but managing the manic behaviour is really difficult and trying to appreciate David's point of view. But when you've really ruled out and you've looked and you've looked at the delirium situation and this is somebody's not slept for days and days and days and sung at 4:00 AM in the morning to the annoyance of everybody else, it's very difficult to manage. And sometimes it may be that the medication's just not effective or it's a cycle of it, but just having strategies, not necessarily medicate them, but strategies to cope. And I guess the advantage of some dementia services is that they can come with strategies. So is there something that we could do in order to, I don't know, put a programme on that they might enjoy in the quietness of somewhere and let people cope. But it is certainly difficult in a community setting and much easier to manage in the home on their own.

Assoc Prof Caroline Johnson (00:38:44):

Yeah. So let's bring Hilda back in here. Sharon, I'd like to hear your views on both what Hilda and the neighbour need to know after these professionals have all been shuffling Hilda's problems back and forth amongst themselves.

Sharon Lawn (00:38:55):

Yeah, I guess I'm identifying with the neighbour, but also Hilda. And as someone who's been in her mental health care for nearly 25 years, I can well imagine that Hilda is a bit fearful and worried because she's previously lost her home and moved into the unit. She's lost her licence, she understands what's happened in the past when she's been manic. So I can imagine that all of that is playing on her mind and the fact that she's banged on the GPS door, there's an element where she's aware and is help seeking for something via to the GP who she trusts. So the idea of something in the home early enough, if this is early enough, would seem to be really working with her to alleviate some of those stresses as well.

(00:40:00):

And the neighbour can really be part of that as well because obviously Hilda feels most comfortable in her home with her painting As anyone who's worked in aged care knows, when you take someone out of their familiar environment, things can get a whole lot more disorienting and worse, certainly much more stressful. So it may reveal more mania, but it can be incredibly stressful for her and then it can damage those relationships as well with the neighbour and others when the person returns. So there's a whole scenario of the life and the relationships that have to be managed here as well and the trust.

Assoc Prof Caroline Johnson (00:40:50):

Yeah. So talking about that, this idea of managing all these competing demands and different things. I mean, who's conducting this orchestra? What are your views about where does the buck stop? If Hilda says she doesn't want to do anything other than stay in her own home and everyone's trying to rally around and help her, where do you think this Hilda will get hand to next Presh? Maybe you would like to comment.

Dr Paresh Dawda (00:41:16):

Thanks Carolyn. I think the idea of who's doing the coordination and the coordination, the conducting of the orchestra is really, really important. And I often a GP or somebody from the general practise will take that responsibility on, but it doesn't always have to be the case. So I reflect on cases similar to hilden. There've been times when I've taken that coordination responsibility supported by other people from the practise, like the practise nurse or the social worker. And I can think of a number of active patients in very similar situations where we're doing that at the moment. But at other times in a multidisciplinary team it may be someone else. So sometimes a community nurse for example, if there's an ACA package and there's a manager in that ACA package, it may be that they take the coordination responsibility. As I've thought about multidisciplinary teams and I've been involved in MDTs for a long time and establishing and developing them, increasingly I've kind of been drawn to this idea of teaming, which is teamwork on the fly and recognising that someone needs to conduct the orchestra and whoever's involved in the team because that can be a dynamic being explicit and working out who's doing that.

(00:42:59):

So I think it's important the functions identified who fulfils that function can vary between the team. Often it will be the gp, but it doesn't have to be the gp. It's really who's best place to do that and it will vary from person to person and case to case.

Assoc Prof Caroline Johnson (00:43:18):

Thanks. Deb or David, would you like to comment on your experience around that? Sort of who takes responsibility for making sure things go ahead and head in the direction they should?

Dr David Lie (00:43:27):

Well, I can tell you that whether it's a fantasy or not that in mental health generally we've got this fantasy that the general practitioner is there with God knows what resourcing to somehow coordinate anything. But certainly I'm much drawn to this idea of teaming as something that is possible. So for example, I think where teaming sometimes occurs in situations of hoarding. So say for example there were concerns about Hilda and her art collection and she's refusing to get rid of these treasures and there are services trying to get in and there's concerns about their access and so forth.

(00:44:13):

You'll find a small number of mental health services have a hoarding intervention function in Australia, but most don't. And the same goes with problematic drinking at home who won't come to outpatients. So where there's been some successful things I've seen is one agency or person calls together an

impromptu case conference and you throw all your heads together and you see if you can come up with novel solutions and you share resources that perhaps other people didn't know of. So that's an example of parish's teaming where lots of people will say, well, I can't do that, I can't go to her and do that home visit or we don't do that or whatever. But they might be able to contribute some ideas where there's great complexity because sometimes part of the complexity is no one can get into actually work out who the lead agency should be if there is one. And for hoarding sometimes there is no lead agency. So that's a couple of thoughts there. I'm not sure whether that answers the question, Carolyn.

Assoc Prof Caroline Johnson (00:45:17):

Thanks David. It was very helpful to know that we probably do need to have more of a conversation about it. I tend to agree with you, people often assume that, that it might maybe should be the gp, but they also recognise that the GP isn't resourced to do it or is too busy or not available. So it is a complex thing and it will depend a lot on the region that you're working in. I'm sure it's different in rural, smaller rural communities than it is in big city communities. Would you say

Deb Booth (00:45:42):

To it, well case I would recommend a case conference in the first instance and that teaming approach and that ability to have the conversation because it may be that the community nurse could do some of it, GP could do some of it and the social work could do others. But to David's point on hoarding in the a CT, the fire brigade actually can take the lead. There's a hoarding team in the A CT and I've called them in many occasion to come and speak with a degree of authority that isn't medical, so it's not so threatening, but for the person's safety and the safety around them. And I've had quite, not that you're ever cure hoarding, but I've had good responses in like somebody in uniform seems to be that authority that can speak to people. So it really depends on the person and the situation. And I've taken case management roles and I've referred to gps and we've sat together and who can do what with the resident, not against the resident or the person, sorry, the patient and bear them in mind and again, come from dignity and respect.

Assoc Prof Caroline Johnson (00:47:03):

So on that note, can we talk, I was just Sharon, you put your hand up. I was going to segue to you, I'm interested in other members of the team and I'm particularly interested in the growing role of peer support in these kinds of situations. Could you comment?

Sharon Lawn (00:47:15):

Yeah, just before I mention peer support, I'd also wave the flag for the neighbour because there's often the health professionals will connect with each other, but then the communication loop back to the person and the neighbour is often a gap. So as a family carer who is a magic fairy navigator for communication in my house, it's me that's being that glue between my family member and the health professionals, reiterating what they've said, reiterating what the plan is, keeping them up to date with the next step, taking the calls from a health professional, correcting a health professional on information, repeating the story so the person doesn't have to repeat it over and over again to the various health professionals. So this neighbour may or may not be within some of those things, but

they'll certainly perhaps be keeping Hilda when the team are off doing whatever they're connecting with each other.

(00:48:31):

There's also that connect back. So the idea of peer support is a really interesting one. And there are two types of peer workers in particular in the mental health sector. So there's people who are identifying as a consumer peer worker and they're an individual who's had a personal life changing recovery oriented experience of mental health challenges or suicide or drug and alcohol use, service use and diagnosis. So they're working primarily with people accessing services with a focus on the personal autonomy of the person, and they're working around a very mutual reciprocal relationship with the person. So it's very nonclinical. The other type of worker who is very much more common in services for older people is a family carer, kin peer worker. These have different labels, but it's actually a person who has firsthand experience of witnessing or walking beside and supporting another person. And they are in an employed role as a family peer worker.

(00:49:48):

So they're primarily working in a relational way, in a family inclusive way as part of a whole family network around the person. So seeing them in their context, in their community more, if that makes sense. So as a formal role, it might be very useful for someone like Hilda, maybe in this process, maybe not, but once she's over this hurdle, it may be a very nice thing to compliment because otherwise she's caught up just in the whole being pulled along with all the clinical multi D process. And that can be quite disempowering for her too, I'd imagine.

Assoc Prof Caroline Johnson (00:50:39):

Yeah. So I'm interested to know from Deborah Paresh or David, have you had any experience of working with peer workers and how do you negotiate that and how do you consider their role within a multidisciplinary based team? Based on some of the things we've been talking about,

Deb Booth (00:50:56):

I haven't, but I'm fascinated by the concept. I'd really like to know more about it. What a great idea. David or

Assoc Prof Caroline Johnson (00:51:05):

Peresh?

Dr David Lie (00:51:06):

Yeah. Well, we've had a carer worker in our older adult community team in one of the teams I've worked in Queensland. It was difficult for, we had allocated time, potential time and access to lived experienced peer workers, but they were generally younger rather than older. And they were generally a bit more helpful if the person had been admitted to psychiatric ward. That's my experience. I was also aware that at one point Victorian DHS actually had a 90 page monograph on involving older people in their care, which is probably the most useful thing I've seen in terms of what's truly non tokenistic, finding the views of older adults. So just having someone over 60 at every meeting is not necessarily what you're after here.

Dr Paresh Dawda (00:52:13):

Carolyn, I haven't had any direct experience of peer workers in an older population, bit like David. I have seen it in a younger cohort of people, but I guess I wanted to just use it as a bit of a segue to talk a bit more about social prescribing because I think the whole kind of idea of supporting an older person like Hilda, we could sort of think about social prescribing and tapping into what other community assets are out there and utilising those. So for example, with Hilda, once we get over this acute episode, and let's say the outcome is she remains in her apartment, there is the increasing risk of loneliness, for example, she's not driving anymore, she's lost her licence, et cetera. And so there may be a whole range of services in the community that tap into that. So I think we should really be thinking about social prescribing more broadly in supporting older people. The other thing I'd like to just sort of use as a bit of a segue is coming back to the carer, we often overlook the carer burden in looking after people. And so again, identifying carers, the burden on them of looking after a person and supporting the carers by again, tapping them into services that may already exist in the community and community assets.

(00:53:51):

It's a more sustainable way of allowing the carer to do the caring in the longer term because otherwise the carer burns out and then the house of cards tumbles very quickly if that happens. So I think if we're thinking more longitudinally in Hilda's case, we should be thinking about supporting the carer involved, but also supporting Hilda through social prescribing initiatives as well.

Assoc Prof Caroline Johnson (00:54:16):

Thanks, Preston. And whose role is it then to help the carer? I mean the Hilda's gp, but you're not the carer's gp. Where does that come from and how does a community set up structures where that support for carers is more visible? Deborah might have a comment.

Deb Booth (00:54:31):

Yeah, look, in the A CT, it'd probably be carer's, a CT, but you would need to talk to the neighbour, how much support does she need or how much is she putting in or pulling back? Has she had enough? So you'd need to ascertain where the carer was up to. And again, to take Sharon's point of view, where's Hilda up to? Is Hilda running out of food? Is she tired? Is she exhausted? Is she sick of battling or does she want to keep going at home? How much does the neighbour want to put in? But those carer support groups where they can go and they can talk to other carers, find communal support, have activities that just take some of the burden off. And also for aged anyway, is that use of respite care or overnight carers offer respite care so that the carer gets a break.

(00:55:31):

So it may not be in the manic stage, but it may be in the depressive stage where you are worried more about them. You can hear them in the manic stage, but in the depressive stage where they've taken to their bed or sleeping 23 hours a day and you only see them and the letters have mounted up where you don't know what's happening for them. It's a really stressful kind of situation to be in and you just don't know what you are going to come across sometimes. So it's difficult for the carer, but certainly I could recommend the carers groups to help.

Sharon Lawn (00:56:07):

Yeah, it's tricky with this because this is a neighbour, we don't know the extent of the relationship that she has and how much she's willing to step into that carer role because she's also presumably friend as well of Hilda. So it may be not appropriate at all for her to go to care support groups where a lot of the people will be, they'll either be a family, a relative of the person in some form and very focused. So this person might not want to take on that carer identity as such. But the importance of having a team around the person when the person's supported, then the carer is supported and informal peer support from others in the same experience is always valuable, but it needs to sit in a context of actual meaningful, helpful support from the Multid team.

Assoc Prof Caroline Johnson (00:57:25):

Well, I'm going to throw one more thing in the hypothetical based on those comments before we sum up in about five minutes. Certainly I've seen a situation like we're talking about now, where my family members contacted me as the GP and said, I think this neighbor's causing trouble. I think the neighbor's contributing to the problems or interfering and we're worried that they've got an evil intent that they're trying to actually get some gain from my mother. I'm sure you've seen that too. How do you handle that? Or David, I'd be interested if that comes up in your services as well of as clinicians trying to work out where the truth lies in those kind of complex social issues that can sometimes arise when somebody's needing care from other people.

Dr Paresh Dawda (00:58:15):

Thanks car. And I think it again, really comes back to taking a principle space approach. So really the duty of care here is to Hilda. In order to exercise my duty of care to Hilda, it's really important I information gather and try and understand the context of what's going on and the reality of what's going on for Hilda, including those complex psychosocial dimensions, therefore hearing out what the other parties have to say. So it could be the relative of Hilda, the neighbour, and listening to those conversations and hearing out what they've got to say I think is part of that information gathering process. Ultimately, however, I think the duty of care is to Hilda, and so putting all that information together, synthesising it and making some sort of assessment becomes a care team responsibility. Sharing that love with the care team is important. So as the gp, I'm not doing it on my own because I think we implied earlier that multiple brains on the problem are better than a single brain. And so coming back and bringing that information to that teaming approach, to that case conferencing type of approach to get a care team assessment of that's probably the way to go.

(00:59:49):

I note that this comments in the chat about privacy and the way and sharing information with the neighbour and the carer, and of course if we haven't got that informed concern from Hilda, it makes it very hard to do that in the early period when we're information gathering the principal, I establishes it's okay for me to receive information but not necessarily to share information. There will come a later point in that care journey where one needs to make a deliberation, whether information shared back or not, and I think it comes back to the consenting principles we have. So do we have informed consent from Hilda? Is she able to give informed consent? And if she's not, it's a breach of her privacy acting in

her best interest still or not. So I think it's a very complex area to discuss in a matter of minutes, but I think there are some well established principles that can guide us in making those decisions.

Assoc Prof Caroline Johnson (01:00:57):

Thanks. That's a comprehensive answer. David, what would you say?

Dr David Lie (01:00:59):

Yeah. Okay. So I'm principal based helps you there as well. In terms of the use of the Mental health Act, every state and territory articulates the principles that should be used. I think the most difficult things are where people believe they've got a duty of care and they're usually in a true dilemma here. I think what's useful there is to work is to actually remember the risks that are involved to the person. If a person is forced into residential care against their will, if a poor person is forced into an acute hospital, because it's not as if you don't have risks of falling or over medication in hospitals and nursing homes and being away from your familiar environment, that doesn't help you solve everything. But I think when think people are concerned about negligence and so forth, but you're probably familiar with these discussions around medicolegal things, Carolyn, when things go wrong, it's useful to actually have articulated how you balanced up the risks before you did what you did. And I think what is forgotten sometimes is that dignity of risk because these are hard decisions and in the end it's clear you looked at the risks of hands off versus hands on.

Assoc Prof Caroline Johnson (01:02:18):

Yeah, I think very helpful advice and certainly that's something I've found talking to family members and other carers about those challenges without actually talking about the person's individual circumstances. You can talk about some principles without breaking confidentiality, get them to talk about what their concerns are and then turn that into, well, in principle, this is how we operate without revealing private matters. And sometimes that can help because I think we can't assume that people who aren't health literate in the health system the way a clinician is, we shouldn't assume that they understand what's going through our head. So that's really helpful advice. I'm mindful now of the time and I'd like to give you each just one or two minutes to sort of reflect on something you would like the audience to take away from this discussion we've had, which has been about a person who's got some quite complex health issues in an aged care community setting, but in an aged care environment. I might start with, well, I'll let you decide who wants to go first. So whoever's ready to speak up first, something you'd like the audience to really remember from this webinar,

Dr Paresh Dawda (01:03:30):

I'm happy to jump in Caroline. And that's with the message Stronger together. So it's about multidisciplinary team-based care. And I think when we've got the complexity we have with people like Hilda, and we're going to see more and more of this complexity with changing demographics, we can't do it alone. We have to do it together. And so we're working in a team-based way, working together, having that shared goal, shared purpose, developing those relationships and having trust in the professional relationships is really important. And I think a key point is the patient's a member of that multidisciplinary team.

Assoc Prof Caroline Johnson (01:04:10):

Yes, that's fantastic advice. Victoria, who wants to go next? Sharon, I think you put your hand up.

Sharon Lawn (01:04:18):

Peresh was thinking the same things like my message would be that Hilda and her neighbour are potentially equal members of this team. They're vital, so particularly Hilda and really keeping her in the communication the whole time at each step along the way, because it can be very quickly become a conversation between health professionals and you want to bring her along. And it's about modelling for everyone, including the neighbour who, although with the confidentiality and privacy issues, their awareness may need to grow so that they can be of benefit to their neighbour as well in this. So all modelling really inclusive behaviours and communication would be my message because it won't always be like this for Hilda. There'll be a time when hopefully she's got on top of this and yeah,

Assoc Prof Caroline Johnson (01:05:29):

Excellent advice. So stronger together and remembering bringing Hilda along on the journey really is forefront in our minds. David or Deb?

Dr David Lie (01:05:40):

Yeah, I'll go. So basically I think if you're, you find yourself navigating this, a communication has been theme tonight. One of them. And I think you're trying to communicate the behaviour that is of concern to you rather than trying to, if you're not used to using labels, if you're not sure what label to use, don't use a label. Indicate the behaviour that's of concern to you and the outcome that you fear will occur. And I think that will help all of us relate to each other and have leaner, more efficient conversations when we're in time poor situations. Thanks.

Deb Booth (01:06:15):

And I guess I'd just like to add that Hilda is the centre of our care and as much as we can give her the dignity and respect that she deserves and would respond to and not to take anything for granted, and we do as I think health professionals get caught up in our own world and forget about that person in the centre.

Assoc Prof Caroline Johnson (01:06:39):

Yeah, I think that is good advice. We talk about patient-centered or person-centered care. I think what we've also touched on tonight is that it's also relationship-centered care that all the parts of the puzzle, the patient, the carer and all the parts of the team have to communicate together. What we probably haven't had time to do tonight is really unpack enough of some of the challenges around that. And I know that certainly I know the GPS in the audience who are from my tribe will be saying, well it's all good to say this, but it's hard to fund it. And I guess we should be optimistic that the government has heard that we need to change some of the way we fund health systems away from such a strong reliance on fee for service and move a little bit more to towards a funding that acknowledge this, that if you want teams to work together, you have to fund that.

(01:07:31):

It's been very slow journey. I think Paresh will agree, but I do think that this webinar tonight is really role modelled what that can look like even though there are still some challenges ahead. Does anyone want to make any final comments before I begin the summing up? Anything we've missed? Any sort of issues? I mean we haven't talked, I guess a lot about technical aspects of communication. I'm getting the impression that most of you would just think you need to get on the phone, but I'm just interested to touch on that point. Do any of you have any other ways you use to communicate that you think have been effective other than just talking to people

Deb Booth (01:08:10):

Really, medicine's very useful, Caroline. So that can somehow lessen the distance. So for those without the privilege of living in the A CT, that might be a bit hit and miss, but you might be able to talk to someone in Sydney or someone elsewhere. And I think it's just one of the best inventions that have come along in the last five years I think.

Assoc Prof Caroline Johnson (01:08:34):

Yeah, I agree. It's one of the small good things we got from the pandemic, isn't it?

Deb Booth (01:08:39):

Absolutely. Yeah. Even though we all look terrible on various bits and pieces.

Assoc Prof Caroline Johnson (01:08:45):

And

Sharon Lawn (01:08:45):

Sharon, yeah, just a last plug given the context that we started on was talking about physical health and mental health and certainly as someone who lives in a house with someone, with both of those things going on, they are the one thing in a person's life, they become very interactive with each other and this particular case with Hilda is a very good example of all of those possibilities. So putting in a plug for equally well and that really fantastic role that GPS play in putting physical health and mental health together and the MULTID team around them that's also working to look at all of those things that are going on for the person, the social, the physical, the mental health, et cetera.

Assoc Prof Caroline Johnson (01:09:38):

Thank you. And for those in the audience who don't know much about equally well, I'm happy to say MHPN have run some webinars sponsored by the equally well aligned. I'm also a member of that and I think it's what Sharon's referring to, which is the morbidity and mortality gap experienced by people with serious mental illness. Their risk of death is not due to the things a lot of people assume like suicide, their risk of death is actually due to chronic illnesses that they experienced earlier and more severely than people who don't have serious mental illness. They also die younger of conditions like cancer because of lack of access to screening. So that's a whole other topic of conversation. But I think absolutely when we look at Hilda, those of us who are GP should be thinking, if I met Hilda when she

was a young woman, what are some other things I could have proactively done then to maybe help her not develop COPD and not develop osteoporosis and all those kinds of things. We call that in general practise looking left. So it is an important part of what we do. David, I think you were also off mute for a minute. Did you have something to add?

Dr David Lie (01:10:43):

Oh no, I just think people are sick of multiple assessments they get from all our different, one of the things about the country is there's less teams to actually have to refer to. Sometimes there's only just one or two people that can talk to themselves. So I think it'd be good to see what the potential of these personally owned health records are. Anything that helps the poor Punta have to just answer the same things over and over that's already been collected 15 times.

Assoc Prof Caroline Johnson (01:11:10):

Absolutely. That's good advice. So anything you can do as health professionals to reduce the need for consumers to tell their story multiple times is very appreciated. And that's a whole other topic about how we communicate both verbally but also in writing or in the health record. Well that's wonderful. It's been a wonderful evening talking to you all and we're now at 10 past eight, so I think it's a good time to sort of complete the webinar and sum up. I think we have talked about a really interesting case of an older person who's had mental health issues but is now experiencing cognitive decline and some of the clinical aspects around considering that, but also the social aspects. I hope that we have role modelled how good multidisciplinary care can work. I don't think we quite nailed a reassurance of how to actually decide who does what.

(01:12:01):

It clearly does take time and does take conversations, but I think that has been demonstrated by our panel tonight and I hope that you'll all reflect a little bit about in your own work that you don't need to do the mental health work you do on your own. The more you can bring other people in the team along including the person you're caring for and their carers or family members, you'll get more benefit for the person than if you just see it as an individual interaction between patient and clinician. I hope you've also benefited from some of the tips and strategies that our panel has shared. I think there are some beauties there and I'm very pleased to see the person who's seeking healthcare, being at the centre of that care, but everybody recognising that there's strength in numbers. I think that's really powerful and I really appreciate David's comment about focusing on the behaviour, not necessarily focusing on the label, because I think that is very empowering for people to actually get change rather than just saying that the diagnosis or the label is the goal.

(01:13:01):

So thank you for that advice as well. So now for those in the audience, this is your opportunity to complete the feedback survey. We obviously are really keen to know whether this hit the mark because it is a very difficult topic. You'll see a button below the video where you can give that feedback for MHPN and also statements of attendance will be available to you in your MHPN portal and you'll also be able to access a recording of the webinar and resources will be emailed to you within the week. So please make use of those resources, tell your colleagues, tell your friends about some of the stuff that we're covering here in MHPN and hopefully you can access some of the other content. There'll also be some links in the chat for you to see some of that content that we're promoting. So thanks very much

everyone for coming along to this activity. I want to, again, thank the panel. I want to thank the team at MHPN who makes all this technical stuff happen and I want to thank the audience for coming along and listening to what we had to say. I've really enjoyed the conversation and I hope you all did too. And that's good night from us.