Transitions: Navigating the Older Years

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Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series MHPNs aim is to promote and celebrate interdisciplinary collaborative mental health care.

Dr Monica Moore (00:17):

Welcome to the Ageing Well Podcast, a podcast that's being released by MHPN as a series focusing on the transitions as we age from birth until the very end. My name's Monica Moore and I'm a GP working in Sutherland and specialising in mental health at the moment with a wide experience in general practice. And with me is my colleague Julianne Whyte.

Ms Julianne Whyte (00:40):

Yes, I'm a mental health social worker and I've been in private practice for about 10 years. Prior to that I had about 30 years in nursing and my interest in mental health in this space has been around palliative care, grief, loss and trauma. And it's been a privilege to work with you, Monica, in our previous episodes.

Dr Monica Moore (00:58):

And so as Julianne was saying, this is the second as we focus in the older age group. If you haven't listened to our first podcast, please do so. And in this issue, Julianne and I are going to be discussing how we as clinicians work with our patients and clients in the older age group and how we actually can support each other in our work. And so this is good not just for people who are clinicians, but also people who are experiencing problems and would like to know how to approach and what benefits and what resources are out there. And I wanted to start off by saying when you're thinking about the GPs contribution and the mental health social workers' contribution, I'm thinking about how I work with someone and certainly my experience of someone because not often in general practice, you see people for short periods of time, but over a really long time.

(01:53):

And so you get to really know them, not just their physical complaints and their medication lists and all those sorts of things, but you get to know them as a person and especially their style. Do they use a physical sore toe to get a foot in the door and talk about more distressing, emotionally relevant topics and how much do you have to dig, how much silence you have to give them and all those sorts of things. And so we're going to talk a little bit about how to listen the most important item and the agenda. And that's one of the things you were talking about Julianne as well, about when you are talking to someone that things will be raised in your discussions that the GP doesn't even know.

Ms Julianne Whyte (02:38):

Isn't it a lovely privilege working with people? And we can't ever, ever forget the importance of that therapeutic relationship of developing relationships with people because as we all know in clinical practice, it's often that the relationship between the patient or the client and the person, the clinician, the doctor, is of vital importance to people feeling that they can trust them and work well with them. But you're so right and it's a blessing when we are working with people too, Monica, is to looking at that broader social constructs in people's life, not just focused on perhaps a diagnosis or a depression or an issue, but actually look more at the systemic, the social, the environmental, the family, the cultural things. And we are very, very privileged to actually have an hour to spend with people and really explore some of those issues that they come in with. So it is a lovely place to work and lovely to work with people in that older age group too because of the richness and the curiosity that we can have as we work with them

Dr Monica Moore (03:47):

And the sorts of things. You can still do counselling with someone who is at the early onset of dementia. You can still do counselling with someone who you might not be able to do as much as you would with someone else who's not cognitively impaired, but you can in fact do things that are really, really helpful. And we as GPs need to know that we can refer to someone with your skills that would be able to provide a really positive aspect of someone's treatment. Because we GPs, we focus on their physical. We know that the psychological and emotional and cultural and relationships, all of those things have an impact. One of the things that I think you were talking about was recognising when one of your patients wasn't getting better from their depression. And so you were able to refer back and say, look, their diet is really poor.

(04:48):

And I would know that someone with either an alcohol problem or vitamin B 12 deficiency or even pancreatic cancer depression might be their first presenting symptom. And so having that sort of lovely feedback from a clinician with your expertise would be a really good thing to be able to do to finalise and say, okay, well this is what's happening, and so we need to make sure that this person's getting the best of care. And so how could we work together? How can we collaborate together to make sure that we are getting the best treatment for people?

Ms Julianne Whyte (05:25):

Look, isn't that a really, really good point? And I think it's the important relationship we have with our patients and clients is critical, but also building up relationships with the people that refer the GPS and other specialists is just from my perspective, one of the most important things I've got to put some time and effort into and find out from the doctor or their practice, how do they best want to get information?

When I first started, I prided myself on writing two to three page letters with the whole mental health examination stuff and what I really deep and meaningful narratives and then realise that well actually in a busy practice, they probably weren't read, you'd go to the heading. You don't have to put that much in to be succinct, to be to the point to actually bring up some key items. I think we had in our notes there dot points say, this is what's happened, this is what's going.

(06:17):

Give some dot points if it's urgent, make sure you've got a relationship with the doctor or their practice. Build that work on that relationship just as much as we do with our clients I think, and patients is just as important. Look, it's a really busy space. Mental health, we've got psychiatrists, psychologists, clinical psychologists, social workers, mental health, social workers, social workers, sorry, and occupational therapists all providing mental health under Medicare, under the NDIS, under aged care, under a range of different program's. And look, I think it must be in a confusing space for people looking to think, I just want something fixed. I'm not sleeping well or I'll go to the GP. That's the best place to go. And then for the GP to think now who's the most appropriate person to work collaboratively in this person's care, then how do you then select for a particular client in this older ageing group that might have a lot of comorbidities, other things wrong with them, and lots of medications sometimes. And if you are looking at exploring beyond just the physical, how would you choose a clinician to work with you?

Dr Monica Moore (07:24):

When we were chatting together, I was sort of sharing a story of being with other GPs at a meeting, and it was one of those dinner things where a speaker comes and you learn something. And the conversation, this was years ago, but the conversation was around what's the difference between a psychologist and a mental health social worker and a mental health nurse and how do you choose, oh, it's just so much easier to just refer to a clinical psychologist and be done with it and we don't have to know the difference. And I think as a GP, one of the things that's really lovely is I'm a facilitator at the local mental health practitioners network. And so a lot of GPs get into contact with me and say, I have this patient, these are the presenting complaints, and who would be the most suitable person to work with them?

(08:15):

And I think each discipline brings its own training, its own perspective, and then you've got the personality of the person, you've got their life experience and the area that they're working in. And so that's one of the reasons why I think the local MHPN groups are so successful because they improve the referral pathways and stop people falling through the cracks or getting inappropriate referrals. And so I think word of mouth perhaps you even ask one of your patients, oh, so you worked with that person and what were they like? Oh, okay, I'll put their name down in my referral list. And that would be one of the ways of making sure that you actually get people sent to the right person and how you make that choice. But it can be really challenging. I mean, you can think that someone a really good fit and then the patient comes back and goes, no, it's not going to work. And so you have to, it's a trial and error. It's like trying on shoes. You go into a shop, you try on the shoes, no, this shop doesn't have the shoes that fit, you're going to go somewhere else. And really sharing that journey with the patient to say, it's okay, it's okay that the first pair of shoes didn't fit. Let me help you find someone who's a little bit better. So I think it can be really challenging at times.

Ms Julianne Whyte (09:22):

Absolutely. And I like your analogy of a good pair of shoes. I say to my patients and clients say, look, it's got to feel like a good pair of slippers. Counseling's got to be comfortable. That can't pinch and hurt. Sometimes it should pinch and hurt if we push a little bit. It's got to hurt a little, but it's got to be comfortable. And if it's the client, it's not about people. It's sometimes the wrong therapist or the wrong therapy could be for their issue or the problem that they've got. So it's really about helping people get informed choice, make choices, know who's out there, know what skills like mental health, social workers and social workers have just such a complimentary, but a vast range of skills that are perhaps not widely understood because most people see social workers in hospitals or Centrelink or community service organisations and not always in private practice that I see our work when I've worked with psychologists and clinical psych's to actually see it as really complimentary that we are not competing and it's just such a big space.

(10:19):

So many people need support and help. We shouldn't get too caught up is who's better or another that we all offer something different depending on our skill sets, our personality and the way we approach particular problems. I think that's very important. And it's a bit like the older age group people we are working with clinicians, mental health clinicians. We're not a homogenous group of people either. Not all the clinical psych's are the same. Not all social workers are the same. So it is, like you said Monica, it's about trying the shoes on and if it doesn't fit, that's fine. It's not your problem. It's not that you were bad or didn't do the homework or the therapy. It means that it just wasn't a good fit for that particular problem. It might be a better fit at another time. And I think that's an important point to help people understand.

(11:02):

And that's where the collaboration works well whereby say I felt that I was working with a client, and look, this has happened once where I actually felt that I wasn't the right clinician for this person. They really needed somebody with a lot more expertise around diagnostics and just skills that I didn't have that this person was presented with lots of very complex health issues, but also some preexisting mental health issues that I'm not saying all social workers can't do it, but my particular skillset isn't with a lot of mental health, preexisting issues and drug and alcohol issues, it's just not an area I've focused on. And I was able to just ring the GP, sit with that client and just ring the GP and say, look, I think is it okay with you if I refer this person onto a colleague of mine who's got these skills? And I think that's sometimes a good way to practice or an honest way to practice.

Dr Monica Moore (11:54):

It's funny, when I was thinking about the relevant person to refer to, and this is an example I use from a colleague, and she was sharing with me that she was working with an older woman who was in a residential aged care facility and she was very with depressed and withdrawn. And so the staff drew this GPs attention to this problem and suggested that she see a psychologist, but my friend is a really good listener. She does that thing of listening for 90 seconds in a really deep and focused way. And she actually was able to draw this person out and to actually say, okay, so from what you're saying this is happening, she validated her emotions and then she summarised and rather than adding another pathology to the list, you know what I mean, rather than saying right now you have depression, she was able to recognise that this woman was having.

(12:43):

And I think if anything else with patients, if we write the mental health treatment plan, this is for GPs out there, I think about putting adjustment disorder because most of it is adjustment disorder rather than adding another pathology, it's a life transition. And so it's a more appropriate thing. And this is what was happening for this lady because even though she had cancer, and that's what the staff thought she was depressed about, what she was depressed about was the urinary incontinence that she developed, which meant that she couldn't go out with her family and she was missing out on this social contact. And so the appropriate referral was actually to an incontinence nurse. It wasn't to a mental health clinician. And so that's one of the things we as GPs can really identify and sit with the person and say, without getting too, what would give you the biggest bang for your buck?

(13:34):

What would be the person that we could refer or the thing that we could do that would make the most difference to you? And recognising that when we are talking to people about their options and asking them what options they have, that sometimes we can be a bit sneaky, something for example, that's going to help their osteoarthritis. Well, they can't walk anymore. And so they've got to change transition to an activity that's low impact like aqua aerobics. Well sneakily that's going to help them with their social support because they might meet people that they have a really good time with having a coffee after the class when they get warm again. So all of these things we can do even before we have to refer, we can actually do that sort of identifying the problem and really recognising it. And then for the people who really have a major transition are having problems with adjusting, we can refer to the experts. And it's good to know that people like you are out there Julianne.

Ms Julianne Whyte (14:24):

I was just thinking as you were talking, it's those social referrals, isn't it? Knowing your community, knowing what's out there. I remember a couple of years ago, GPs were given a list of walking tracks, for example, in the local communities. So a referral could be written like a prescription for a walk a day. Sometimes people love that sense that it's been prescribed. I have treatment, so joining a group, doing something that can make an improvement. But I think also with the adjustment, sometimes it's so easy to say to someone, look, I think you should join a group. Or maybe there's that art group, or go and go to probus or some of those things. And for a lot of people that aren't extroverts that are more introverted and perhaps if they're in this older age group and their friends are dying or no longer able to travel as much and they're a bit more isolated, sometimes helping people then unpack that adjustment or that difficulty they've got or like the urinary incontinence, how can you get the help?

(15:22):

Most definitely. And then help them learn some of those adjustment skills. There's one thing I often do when I meet, especially an older person, is because they've lived with problems for a long time, they've had a lot of strategies, they've lived a life. Anyone that sort of gets to old age has actually done a lot, seen a lot coped with a lot, dealt with stuff. So they've got, maybe they haven't labelled their strategies or what they've done in the past that's helped them, but reconnect them back to a time when they felt more competent and they had a similar problem and how did they solve it previously? And do I think that solution's going to be useful this time for them? And the other thing I always, always ask is, what brought you today? Obviously this has been going on or maybe or not obviously, but maybe this problem's been going on for a while, but what made it bad enough for you now to get help?

(16:10):

What is it about the problem you've got or this story you've got today? And often then we get to the point straight away, we're not taking time doing assessments. Look, I just think too, Monica, if people make an effort to come for therapy, they want to talk about the thing that they're struggling with. So I know in my practice, I often put off the assessment until the second session if I'm lucky if they'd come back for the second session, and most of mine do, there's six or seven sessions. But I like to hear the story, what was it about the trigger that made them come? And that I think creates then a lovely story about the problem or the issues that are impacting on them and then worry about some assessments if needed later down the track, but rather listen to the story and validate them.

Dr Monica Moore (16:52):

And I think when you're talking about the story and that difference between introversion and extroversion, because people think of introversion as shyness, but really the definition of introversion is how do you recharge your batteries? Do you recharge your batteries by being on your own or do you recharge your batteries by being with other people? So the classic example is me on a Sunday morning, you'll see me reading a book, my neighbour two doors up, you'll see her entertaining 50 people with lunch. She cooked herself. That's how she recharges her batteries. It doesn't mean that I don't enjoy having fun with friends and family and going out, but to recharge my batteries, I will need to be on my own or just with one person. And so I do remember writing a script for someone because people say, I just want to stop the suffering. And a lot of goals are sort of, I want to stop something.

(17:40):

And when you really sit down with someone and use that framework of the smarter goal, it's specific, it's measurable, it's achievable, and you kind of go, well, what does that movie look like of what you want to achieve? And so I wrote a script for a lady to say that she no longer had to cook Sunday lunch and got her to put it on the fridge. She'd cooked Sunday lunch for years and years and years, and she was just over it. She was just over it. And so that was the script we identified. That was the behaviour. And so sometimes saying, no, that's right, letting go is not letting go of all the joys of your life, but letting go of all these burdens that you've been carrying, you thought you had to carry them. And so that's really important to reassure people. And I think that's one of the things as I've got older that I hear my friends, it's kind of like, yeah, no, it's just so much easier to say. No, no, no, I'm not going to, don't have to.

Host (18:37):

Our podcast series feature national and international experts sharing their perspectives, insights and experience in supporting, treating and or living with mental health issues.

Ms Julianne Whyte (18:49):

But Monica, your point there about the smart goals I think are really, really lovely because tapping into people's strengths, tapping into perhaps language that they're familiar with, not introducing a, as you said earlier, to not introducing yet another label or a diagnostic category that if we can actually help people look at what their view of the world, like you said, the vision of what they want to achieve. And I loved what you said in that first episode we did, which was on the, just remind me of the phrase you used again, that the realistic expectations.

Dr Monica Moore (19:22):

Yeah, radical acceptance.

Ms Julianne Whyte (19:24):

Giving someone a word for what they're trying to achieve sometimes gives them a bit of a sense of control back. So it sounds like to me that radical acceptance is maybe what you're trying to find. Would I be right, reflecting back to people rather than lecturing them? Because what I'm conscious of with this older age group is that these people have had life experiences. They've been professionals, they've had jobs, they've had life experiences. They haven't come to us with nothing. They're not a blank sheet. They're a rich lived life. And if I've got someone in front of me and I'm not getting to know what is behind this story, this person that's presented with maybe the relationship breakdown, the poor sleep, the failed business, the kids who won't talk to them but not understand the story of their life and what they have achieved and what meaning they put behind them and what goals that set themselves as to why this particular problem or this adjustment they've got is a problem, then I think we are failing people. We are not really getting to understand or helping people find words to express what this problem that they've got is. And you've got a beautiful analogy you use too, Monica, haven't you? That bathe technique. I love that.

Dr Monica Moore (20:36):

Oh, the bath technique, the bathes technique, which is actually something which two Canadian physicians thought up, which is when we actually listen to someone, it's a very quick time saving tip for GPs that you ask someone, how can I help you today? As in what's the bother? And then you validate their emotion, their affect, that's the A in bathe. And then T is what troubles you the most about this. And the example I had is that someone had, their husband had left and she broke into tears. And what troubled her the most is that it was for her best friend. And so she'd lost her friendship as well as her husband's relationship. And it was just so hard. And then the fourth question is, how are you handling it? And this is where you tap into their strengths because this lady said, I'm handling it really well.

(21:31):

I stopped all the bank accounts because I'm the one who does all the financial stuff in the family, and I'm going to handle this really well. I'm not going to take it lying down mind. She was lying down to have a pap smear. So that was very funny. So we both laughed, we both giggled, and I said, wow, the E is the empathic response. It sounds like it's really hard, and yet you are handling it really well. If I can help in any way, let me know. And this is the thing that surprises us if we are really curious and give patients that space to actually tell us what troubles them the most, validate their emotional response and how are they handling it, it's such a lovely sort of short cut way of keeping the consultation short, but at the same time creating that space where people feel heard and understood.

(22:21):

And I was thinking about that at radical acceptance as well, that one of the things that a physiotherapist actually helped me at one point was I was suspecting that a patient was having great difficulty accepting that the osteoarthritis in her knee was here to stay and that she would no longer be able to do things. And so the physiotherapist was able to tell me that while they were doing what they were doing with the patient, that the patient had disclosed that they were seeing lots of other clinicians and in fact getting lots of other medication prescribed and non-prescribed medications and things, which then I sort of thought, my goodness, what kind of cocktail is happening inside this person and what harm could

it be? So that's one of the things I think that mental health clinicians can do as well. Like you said, you've got the hour, you might be able to get back to me and go, Monica did you know, and that will be really, really helpful.

Ms Julianne Whyte (23:11):

A really, really good point. Communication, communication, communication. We can't stress it enough to say that if we think there's something, there's a red flag and you think, oh, we'll just check in on that, that we shouldn't just brush it off or try and be the expert in something that perhaps we don't have the skills in or don't have the knowledge to do, to just make contact back to the GP or the other, that psychologist or physio. I love that analogy too of a physio working in that space because I think we all have an opportunity to work with people around coping and resilience and mental health. It's not just the domain of the doctor or the social worker, psych's, the physios and OTs and even the support workers that we've got going into the homes of people doing incredible work right at the coalface of dealing with people's lives and the problems that they have.

(23:59):

Had a client on Saturday did a home visit and oh, so sad. And she's in the early older age group, but they'd been together with her partner over 30 years and they'd promised to get married in November this year, and she had an aneurysm and then a couple of strokes, and then now she's bedridden and she doesn't know if she'll be able to stand for her wedding. And I got such a richness of stories from the support workers that are going in and showering her and she hates being showered, and she hates the fact that she can't stand, and she hates the fact that her hair is always flat and looking awful, and she's depressed and hates the fact that she's now on an antidepressant and she is just sad. She's just sad, really, really missing the life that she had and her vision of what her future was.

(24:43):

And so I went around and visited her in her home and we just sat there for a while and said how very, very sad this was. And we sat there for a while. I said, let's just sit with this sadness for a little bit. I think it's nice to go, don't be positive and look on the bright side. Look, you're alive, aren't you? And she said, yeah, I wish I had died. I wish I had died. She said, who said that this was a right way to live? Who said that this would be okay? And she said, I'm sick of people telling me just to be on the bright side to be positive. She said, some days I just want to be sad, but I've just got to be conscious of always being happy for people, happy and grateful. She said, sometimes I'm so not.

(25:19):

And I thought, that's my job today, just to sit there and go, yeah, this is so sad. And then we had the cup of tea, and that's the privilege of sometimes being in someone's home is that you can one view the environment, check out what's else is going on, make sure that things are safe, and then sit with someone in their space. She definitely wants to meet again. She said, I really liked the opportunity to say out loud and not have someone to go into a suicide intervention for her to say, I wish I had died. And really, if I don't get better and I can't stand my wedding, I don't want to be here anymore.

Dr Monica Moore (25:52):

When you and I were sort of planning this podcasts, we also wanted to share our experience of what it's like the effect that this work has on us as clinicians, as human beings, because I teach registrars and I was talking about working with anxiety. That was the topic. And so we had sort of a section on anxiety in

the patients, but then the anxiety of the clinician, how do you manage your own anxiety in a consultation? And because they were GPs, some of them said, no, no, I don't feel anxious. I'm professional at all times. I don't have anxiety. And what I was trying to convey was that feeling anxious is a part of the normal human experience. Of course, our behaviour may still be professional. So how do we compassionately acknowledge our grief, our emotional responses, our own limitations? How do we look after really well? I mean, this is a space for another podcast, but I think it really needs to be acknowledged. And so what are the sorts of things you do to look after yourself? We're not preaching, okay, but what are three things that you do that you think this really helps me as a clinician?

Ms Julianne Whyte (26:59):

Glad you asked me that, Monica, that's great because it actually came up in, there's so many times people say, how do you do this work? And you do think, how do we do this work? One, we do it because we love it. I think it's always focusing in, I try to practice what I preach, and I constantly say to my clients about being congruent when my thoughts, values, and actions are aligned. So if I'm teaching people to be conscious of their breath, to lean into the discomfort, I'm often very, very, I wouldn't say anxious, but I feel very, very sad when I hear some very complex stories and people's lives where they've had quite a bit of trauma and distress and they're living with multiple comorbidities or multiple health issues, and they're sad about their life. It's not the life they'd wanted or they've disengaged from their children.

(27:42):

I often feel immense sadness and a blessing that perhaps my life is not there at that stage and this is not my life, this is their life. And that I've got to remind myself in that mindfulness place that I can be with this person in this space, but I can also step out. And it's been able to step out metaphorically and realistically into my space. So I drink lots of tea. I have licorice tea, I have peppermint tea, I have green tea, I have chai, I have three different types of coffee. And I walk down to the kitchen mostly after every session and think, what does that deserve? What tea I have now? And that just revitalises me. And a lot of my clients that have got to know me now will say, so what tea does this bring? And it's sometimes a really lovely ending of a session with a person.

(28:34):

And we both go, we've been to some big places today, and if the clients have got to know me a little bit, they'll go, so what tea will you drink after today's sessions? I say, oh, it needs a licorice and look, and I've got a beautiful, beautiful garden. A bit like you, Monica, a bit of an introvert. Even though I just absolutely love company and love to party, but I love my garden. I'll often sit in my garden and just watch things happen without me having to talk to them, do anything to them or create anything. It just happens. And I often sit in that mindful space and just watch things like weeds, watch them grow in my garden, and that revitalises me for the next one. And what about you?

Dr Monica Moore (29:16):

This thing about radical acceptance and the radical acceptance that just being there with a person is enough that just my choice to listen to their story and to just be with them that I am helping them. So that's one thing that I'm making a positive difference in the world. Another one is that I discovered that if I just have a very short amount of time every day at the end of the day where I focus on things I'm grateful for, what made me happy, kindness I observed, or kindness I did to myself, kindness I did to someone else, an achievement for the day that if I actually review the end of my day, I sleep better. And

that if I can identify my strengths and use them to help solve problems and help other people to identify their strengths and to identify the problem and what is the work around that, it's kind of like solving a puzzle or a jigsaw crossword that it gives me a lot of pleasure.

(30:18):

And so identifying what gives me pleasure and also the opportunities. I've been so enjoying telehealth, never thought I would thought it would be so difficult and so bad. And yet a lot of my patients are in fact getting really big improvements. And I'm thinking, wow, this is amazing. And it just provides such access to people who'd normally would not have access in timely interventions where people can just get their referral or a script that day or result for that test that day, rather than having to book in three weeks time for a non-urgent appointment. And so I feel very excited about the future if these things are going to continue to happen. So I think as we wrap this up, what are some things that you would like to say as a summary for these two podcasts that we've done on the later years?

Ms Julianne Whyte (31:06):

Look, it's made me really reflect on, as we said at the beginning, we are both in this cohort at the beginning of it anyway, the young old. And it made me really reflect on what I do bring as an individual and a person in my role. And it's made me reflect on my own age and my expectations and my own frailties. I think we've got to be honest, we perhaps think a bit slower. Like I'm studying, I'm doing my PhD at the moment, and just some of those complex terms that maybe 20 years ago I would've dealt with things like ontology and stuff like that. It's just really tripping me up some of this stuff at the moment. So I'm being a bit gentler with myself and thinking it's okay. So this has been a wonderful opportunity for me to reflect on what am I doing with my clients in this cohort as well as all clients, but specifically in this older age group. And also thinking about what would I want? What do I need? What would I want from a clinician who's working with me? How would I want those questions to be asked in a very respectful way, recognising my strengths, not just assuming I'm just a 62 year old woman who's still working and just waiting for retirement. So I think that's what this wonderful opportunity of working with you, Monica, and their MHP and has been around this really, really, really important topic.

Dr Monica Moore (32:29):

And I just wanted to add, if I may, one of the things that you said when we were workshopping this together, we die as we live, to have realistic expectations of the people that we work with. Some people have never really got on the right side of the bed or got on well with others. And so how can we create a space for them where we accept them as they are and not work harder than they do to change? Because although most people have developed great life skills, sometimes the skills that these people have developed is actually to be more dependent and more curmudgeonly. But that's okay. We are all different. We all bring something to life. And there are so many things that we are going to add some support for clinicians and support for patients on the podcast notes. But self-knowledge and knowing yourself and just understanding personalities is so important in our work.

Ms Julianne Whyte (33:30):

Look, that's really, really important. Understanding the personalities, isn't it? And just knowing that people will, and as you were saying, that people bring what they have to the picnic. But it took me a long time to realise too, that people die as they live. When I was working in palliative care and working with people as they're dying, they die as they live. They bring their skills, their strengths, their deficits, their

problems. It is their life. It's not ours. And we shouldn't be forcing people to do things that are perhaps outside of their scope or their relevance or what's within their expectations and their life story. And I think that's the blessing of being able to have that space to listen. So this has been a wonderful, wonderful opportunity, and I thank you, Monica. And I'm Julianne White. I'm a mental health social worker working across the rural region of the Riverina. And would like to just pull your attention to our next podcast, which I'm going to let Monica introduce.

Dr Monica Moore (34:22):

Well, we're very excited because we are putting together a two-parter again on the life stage where you transition from being an individual, perhaps part of a couple, to being a family. And I think that that's a space where so much changes and there is so much that we take on and so much that we let go. So I'm really looking forward to talking not just about the challenges, but how we as clinicians deal with it and some of the tips that we find very useful.

Ms Julianne Whyte (34:50):

Absolutely. Thanks for that, Monica, and thank you again. So, so much for today. And thank you to the MHPN for this opportunity.

Host (34:59):

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