



FRAGILE FOUNDATIONS: EXPLORING THE MENTAL HEALTH OF THE SOCIAL CARE WORKFORCE AND THE PEOPLE THEY SUPPORT



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PREFACE

“Do not judge me by what you see, I am hidden.”

These are the words of a care home resident after years of mental health struggle, of being limited by a diagnosis and by the assumptions of others that what they saw was all there was to see.

This report is about what is often the very hidden world of older peoples’ ‘mental health.’ Two words which still carry a sense of taboo and stigma. They mean so many different things to people. For some they have been the grammar of their daily living for decades, a constant presence in their relationships with themselves and with other people; for others they are words which weigh them down with fear, suffocating their energy, limiting them by anxiety and depression. For so many today living their life means a daily struggle to come to terms with the mental stress and emotional distress that lies at the very heart of who they are.

This report in part tells the stories of the hundreds of individuals who have become old having lived with mental health challenges for all their lives. It also tells the experiences of those who now in old age have for the first time come face to face with mental distress. In that telling the Report challenges us to do more as a society to recognise, support and care for those who are old and facing mental health issues. It is unapologetic about what appears to be at times a wilful disregard for the mental health needs of older citizens in Scotland.

But this report also seeks to describe the experiences of those who work in care at home and care home services and who every day are supporting individuals to live better lives and in some instances to overcome the mental stress and distress that crowds in on their living. It shares the voices of a workforce offering dedicated, person centred care but which is itself struggling to deal with the very real challenges which caring itself brings and which are heightened when supporting people in mental distress.

At times the voices heard in this report make for an uncomfortable read. They ask us to challenge the lack of recognition and resource we allocate to the mental health supports of individuals who are often hidden at the heart of our communities. They challenge us to acknowledge just how precarious the system of care and support is at this present time right across Scotland.

I hope you find an authenticity in the voices you read in this report and through their voices decide that simply hearing them is insufficient, but rather that urgent action is required.

Dr Donald Macaskill

Chief Executive
Scottish Care



1. INTRODUCTION

Between Summer and Autumn 2017, Scottish Care undertook a significant piece of research around mental health within the independent social care sector. Through this we sought to:

- Gain an understanding of the level and range of mental health support being delivered throughout the independent care sector, and any challenges associated with this delivery
- Identify the current skills, plus the training needs, of the front line care workforce in the independent sector
- Explore the mental health impact on front line staff of delivering care
- Identify any recommendations which would better support the promotion of positive mental health within an integrated workforce environment, both for older people and the care workforce
- Identify innovative and best practice around mental health support within the independent sector

By engaging directly with the front line care home, care

at home and housing support workforce we wanted to better understand their experiences of mental health, both personally and professionally, and the ways in which mental health and wellbeing issues impact upon them in their care roles and their ability to support individuals. It is the results of this engagement which form the basis of this report.

Scottish Care's commitment to front line engagement has been generously supported by the Office of the Chief Social Work Advisor (OCSWA) since 2014. Part of this commitment has involved creating a better understanding of the experiences of support workers working within the independent sector. Another aspect is to enable and support front line support workers to contribute to organisational, local and national policy discussions within an integrated health and social care landscape.

Scottish Care's organisational priorities have long been focused on protecting and promoting the human rights of older people. We are clear that health and social care supports should exist to improve and enable individuals to exercise their rights, and that the importance of these rights should not diminish based on age, care setting or any other factor.

Context

2016 figures for the UK indicate that:

- Of those aged over 65, depression affects approximately 22% of men and 28% of women but an estimated 85% of older people with depression receive no help at all from the NHS.
- The number of people living with dementia in Scotland is estimated to be almost 70,000.¹

What's more, Scotland's population projections indicate that the number of people aged 75 and over will increase by 79% in just a quarter of a century to 360,000 more than today². Inevitably, this will mean a higher proportion of those with mental health needs being over the age of 65 and also a higher proportion of these individuals requiring the support of older people's care services.

There are over 33,000 older people living in care homes in Scotland any night of the year, and nearly 1,000 other individuals living in care home services for adults with mental health issues³. Additionally, 61,500 individuals receive support through home care services, over 50,000 who are over the age of 65⁴. Given these figures, it is crucial that high quality mental health care and support is built into the provision of these services, which nearly 100,000 people across Scotland access.

In Scotland the **See Me**⁵ programme, funded by the Scottish Government, seeks to address mental health discrimination and stigma. Its mission includes to:

"Ensure that the human rights of people with mental health problems are respected and upheld."

Whilst a national programme, it has particular focus areas of young people and the workplace and therefore doesn't specifically address the mental health challenges facing older people. However, its workplace focus includes a number of resources to support employers and employees to create a positive mental health culture at work.

In March 2017, the Scottish Government published its *Mental Health Strategy 2017-2027*⁶. It sets out a vision:

"... of a Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma. Over the 10

years of the Strategy, we will work on achieving parity between mental and physical health."

Despite this laudable aim, the Strategy does not recognise the mental health needs of older people anywhere in its 39 page documentation, other than to briefly acknowledge the need for read across with the *National Dementia Strategy*⁷ and the *Strategic Framework for Action on Palliative and End of Life Care, 2016-21*⁸. However, as Scottish Care recognises and this report will explore, there is far more complexity and nuance to the mental health needs of older people than those more narrowly confined to dementia and palliative and end of life care, as important as these areas of support are. This serves to highlight how invisible the needs of older people can become compared to other individuals and groups, perhaps due to a lack of understanding as to the general and particular challenges that older people may face in relation to their mental health and wellbeing. It is important to support parity between mental and physical health, but also to support parity of recognition, access and quality of mental health support to different groups, including older people and those who access social care services.

Some work has been undertaken in an effort to start addressing the often forgotten issue of older people's mental health.

The Mental Health Foundation's guide, *How to look after your mental health in later life*⁹ highlighted that one in five older people in the community and two in five people in care homes experience poor mental health. It identifies practical steps against five issues which significantly impact on an older person's mental health and wellbeing:

- Discrimination
- Participation in meaningful activities
- Relationships
- Physical health
- Poverty

Building on these areas, Outside the Box have focused on raising awareness of older people's mental health and wellbeing through the *Creating Conversations* project¹⁰, which ran from June 2016 to July 2017. The latter stages of this project involved focus groups with older people

¹ <https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2016>

² <https://www.nrscotland.gov.uk/files/statistics/nrs-visual/prog-pop-16/pop-proj-2016-scot-nat-pop-pro-info.pdf>

³ <https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2016-10-25/2016-10-25-CHCensus-Report.pdf>

⁴ <http://www.gov.scot/Publications/2016/11/8311>

⁵ <https://www.seemescotland.org/>

⁶ <http://www.gov.scot/Publications/2017/03/1750> ⁷<http://www.gov.scot/Publications/2017/06/7735>

⁸ <http://www.gov.scot/Publications/2015/12/4053> ⁹<https://www.mentalhealth.org.uk/publications/how-to-in-later-life>

¹⁰ <http://otbds.org/projects/raising-awareness-of-older-peoples-mental-health-and-wellbeing/>



who access independent sector care services across care home, sheltered housing and care at home supports. As well as highlighting the coping strategies that older people often adopt to promote positive mental health and wellbeing, the findings of this work also indicated that:

"Nearly everyone we spoke with had been affected by loss, either a life partner or close friends or both. People found it hard to talk about it and talked about 'just getting on with things'... People can face other losses, once they have started using the care service, such as further bereavements of friends they met, living in the care home or sheltered home."

The report particularly stressed the importance of conversations as a mechanism to support more older people with their mental health and wellbeing, including conversations with care staff.

Loneliness has also been identified as a significant threat to the mental health of older people. Research undertaken by Age UK found that perceived loneliness increases with age, with 2.9 million over 65s feeling like they have no one to go to for support. What's more, 39% of the older people interviewed for the research identified themselves as being lonely and 20% said that they felt that they had been forgotten. This is not only troubling from a mental health perspective but it has also been proven that loneliness, social isolation and living alone increase the risk of premature death, all of which are most commonly associated with older people.

The clear evidence to date regarding the stressors on older people's mental health makes the omission of over 65s from the new Mental Health Strategy even more concerning, particularly in terms of the potential impact on future recognition, understanding and subsequent planning of supports.

However, significantly less research has been undertaken in to the mental health of the social care workforce.

In 2014, the Social Care Institute for Excellence published a research briefing¹¹ on mental health and wellbeing across the UK in the context of employment in social care. It highlights that at a general level, despite mental health challenges being common amongst employees, employers tend to be unaware of the support levels required and managers can struggle to support their staff.

In terms of the particularities of social care, the briefing explains that:

"Employees in social care may be more at a high risk of poor mental health because of the demands of their challenging roles and their increased tendency to empathy and self-selection into the job, as has been shown for health care professionals."

The paper also notes the ways in which employment in social care may contribute to positive mental health and wellbeing:

"Research in social care has found that the vast majority of staff enjoy spending time with clients and developing relationships with them, along with the sense of camaraderie of working in a team with friendly colleagues."

Yet the paper identifies that there is little specific research on mental health in social care which relates to its workforce, and the quality of existing work in this area is variable. Instead, it identifies that a number of research endeavours identify interventions which may be at least partly relevant and applicable to social care but that these haven't been undertaken or tested in social care settings thus far. It is therefore likely that some of the nuances, complexities and challenges associated with working in these settings are missed.

Beyond this particular body of work, it is extremely difficult to locate any relevant research or literature pertaining to the mental health and wellbeing of the social care workforce. What's more, there appears to be a distinct lack of work undertaken which examines the ongoing impact of working in social care on care staff's mental health, either positively or negatively.

Given current widespread awareness of the practical, physical and emotional challenges faced by those working in care, combined with the current recruitment and retention crises, it is even more surprising that there is a lack of work in this area. Scottish Care would suggest this points to a wider political and societal issue of, at best, a lack of prioritisation and at worst, disregard, for both older people's care and the value placed on the social care workforce.

¹¹ <https://www.scie.org.uk/publications/reports/report48/files/report48.pdf>

What prompted the research?

Research undertaken over the last two years by Scottish Care has focussed on discovering what it is like to work at the front line in social care services, across care home, care at home and housing support services. That research was published in *Voices from the Front Line*¹² (2016), *Voices from the Nursing Front Line*¹³ (2016) and *Trees that Bend in the Wind: Exploring the Experiences of Front Line Support Workers Delivering Palliative and End of Life Care*¹⁴ (2017). These reports have all served to highlight a range of particular challenges relating to the mental health and wellbeing of those older citizens being supported but also the mental health and wellbeing of the workforce, despite mental health not being the overt focus of previous research endeavours. All of these have indicated that mental health challenges in the social care sector may be greater than expected.

“We are now being expected to deal with people who have really serious mental health challenges and we don’t have the time and sometimes the skills to be able to dedicate to their needs.”

As the population ages and people access care and support services later due to the success of community and informal support, care staff reported that they are increasingly supporting individuals at advanced stages of life with more complex and wide-ranging needs. This increasingly includes those living with significant and varied mental health conditions. The capacity of care staff to effectively support people living with mental health conditions was raised on multiple occasions.

“I find the emotion hardest to work with, especially when there are issues of self-harm.”

Whilst dementia is an undoubtedly crucial element of mental health that requires specific planning, participants in previous focus groups and interviews highlighted that the spectrum of mental health conditions that an older person may be living with is much wider and these conditions may even be undiagnosed. By narrowing our lens to dementia support only, we risk failing to improve the availability, appropriateness and quality of support for older people living with other conditions, including but not limited to depression, anxiety, eating disorders, bipolar disorder and schizophrenia. The fact

that people are living longer does not diminish the range of conditions they may be living with nor the requirement for tailored, effective support to be available to those over 65.

“I know I make a difference because I do care and it hurts when you are short staffed because you can’t spend time with people one-to-one and that means people get lonely.”

There are particular factors relating to older people and social care which may prompt or exacerbate mental health conditions. For instance, older people are more likely to experience bereavement through the loss of friends, spouses and relations which can require mental health support. The negative mental health consequences of social isolation and loneliness are also more likely to be experienced by older people. Additionally individuals who go through transitions such as moving into a care home or another care setting may experience difficulties in adjusting to a loss of home or a perceived loss of identity, if adequate support is not present.

“It is really hard sometimes to do your work when someone you have known for a long time dies. But we have to roll up our sleeves and get on with it. I don’t think people realise how much hurt we feel.”

Care staff across care home, care at home and housing support services have highlighted to us the unique challenges of delivering palliative and end of life care and the impact this can have on their own mental health and wellbeing. With more people being supported to end of life in community settings rather than in hospital, it means independent sector services are delivering palliative and end of life care to individuals with whom relationships and bonds have been formed. This also means that staff are subsequently dealing with bereavement; that of relatives and their own.

“There’s no emotional support for us as carers. Sometimes you can get depressed.”

For those working in social care, the factors and circumstances which can negatively impact on a worker’s

¹² <http://www.scottishcare.org/wp-content/uploads/2016/06/Voices-from-the-Front-Line.pdf>

¹³ <http://www.scottishcare.org/wp-content/uploads/2016/11/SC-Voices-from-the-Nursing-Front-Line-.pdf>

¹⁴ <http://www.scottishcare.org/wp-content/uploads/2017/02/PEOLC-Report-final-.pdf>

mental health are wide-ranging and include the impact of dealing with challenging, stressful and emotionally charged situations on a daily basis, long hours and poor pay and lone working practices for those in homecare services. The feedback we regularly receive from front line care staff includes feelings of exhaustion and being close to 'breaking point'. From managers and owners of services, we are often told that the continued pressure to deliver more with less resource is continuing to restrict the quality, availability and regularity of training and support for staff, which is negatively impacting on their resilience and is compounding staff retention problems.

What's more, despite Scottish Government interventions and initiatives the challenges facing the care home, care at home and housing support sector have intensified, none less so than in terms of recruitment and retention. Scottish Care currently estimates there to be a 31% nurse

vacancy level in care homes and research with our members demonstrates that 77% of care homes and 90% of home care organisations are having difficulty filling vacant posts. This is putting providers and their workforce under intolerable pressure to continue to maintain and develop high quality, responsive and innovative care provision.

The multitude of ways in which mental health and wellbeing has been reflected through Scottish Care's engagement and research processes to date reinforced how important it was to undertake specific work on this issue. It has highlighted the need to identify and address the current gaps in support for older people with mental health conditions and to examine how we support and train staff in care services to deliver positive outcomes for individuals with mental health conditions, and to promote their own positive mental health.

Research objectives

This research therefore seeks to provide a starting point for much more extensive work in the area of mental health in social care, and an initial insight into the realities of both receiving and delivering social care in the context of individual mental health.

By gathering more intelligence from the front line workforce, including but not limited to support workers, we hope to understand more about the mental health of people living in care homes and accessing care at home

and housing support services. We also hope to be able to provide more in depth analysis of the mental health of the social care workforce.

It is hoped that this report can stimulate debate and discussion as to how all organisations with an interest and investment in the success of social care services can work collaboratively to improve mental health experiences in this sector.



2. METHODOLOGY

This report is based on focus group research with 43 members of care staff working across the independent social care sector.

Four focus groups were held across Scotland, in Edinburgh, East Kilbride (South Lanarkshire), Arrochar (Argyll & Bute) and Glenrothes (Fife). Each focus group lasted three hours and was based around a semi-structured group interview process exploring different elements of mental health. Each session was led and facilitated by two or three researchers, with additional scribes supporting the data collection. The research questions which formed the basis for each focus group can be found in the Appendices.

Adopting a narrative methodology meant that the focus of the data collection was on the ‘stories’ of participants, allowing the researchers to explore how care staff understood their own mental health experiences and those of others, whether families, colleagues or the people they support. This method presented the opportunity to hear and interpret people’s attitudes, feelings and experiences around their own mental health and that of others in a way that was both sensitive and flexible, ensuring that participants did not feel obliged to contribute more than they were comfortable to but also enabling the emerging issues and themes to be explored in some depth. It ensured that the researchers could maintain a level of consistency and structure whilst at the same time ensuring that discussions were participant-led.

This method and the size of the study mean the findings reflected in the report do not seek to present a fully representative picture of the mental health experiences of care staff. They can be even less representative of the mental health experiences of older people given that any instances relating to older people’s mental health were second hand accounts. However, we strongly believe that the voices of care staff contained in this report and the thoughts and experiences they reflected strongly highlight the importance of not only listening to but hearing the views and experiences of our workforce in relation to delivering care and support. It is the only way to really understand and therefore improve the picture, not only for staff but for the individuals receiving support.

In order to ensure a spread of participation in relation to service type, geography and local difference, the researchers selected four areas within which to host the

focus groups. Thereafter information about the research was communicated via email to independent sector services operating in those areas. Direct engagement with organisations was also led through Scottish Care’s network of Independent Sector Local Integration and Improvement Leads working in the relevant locations. In all communication, it was emphasised that participation in the focus groups should be entirely voluntary on the part of each worker.

43 members of care staff participated in the four focus groups, consisting of a mix of staff from across care home, care at home and housing support services. Of these, 21 people took part from care home services and 22 participated from home care. Only four participants were male. This gender split is largely reflective of the fact that 82% of the workforce in independent sector care home and home care services are female. A further breakdown of the focus group composition is as follows:

Edinburgh

- 9 participants - all female
- 3 care homes
- 6 care at home & housing support

East Kilbride

- 9 participants – 6 female, 3 male
- 6 care homes
- 3 care at home & housing support

Arrochar

- 11 participants – 10 female, 1 male
- 1 care home
- 10 care at home & housing support

Glenrothes

- 14 participants – all female
- 11 care homes
- 3 care at home

Each focus group contained varying degrees of experience and a range of job roles.

Whilst previous primary research exercises conducted by Scottish Care have been specifically targeted at those in front line support worker and nursing roles, the opportunity to take part in this research was intentionally extended to those in managerial and supervisory roles



as well as front line support workers and nurses. Around three quarters of the participants identified themselves as having management or leadership responsibilities recognising that in addition to managers and deputies, those employed in senior care, supervisory and nursing roles also have a number of leadership qualities and duties associated with their work. It immediately became clear that the pressures of delivering front line care extend to those with responsibility for coordinating and running it. The breakdown of participant job roles was as follows:

- Care assistant/ support worker – 8
- Nurse – 4
- Senior carer/ supervisor – 8
- Team leader – 3
- Manager/ deputy manager – 16
- Other – 4, comprising of coordinator, office manager & visit officers

The focus groups were supplemented by a secondary process, utilising a specific full day mental health event coordinated and hosted by Scottish Care in September 2017 to address some key research questions. The event, entitled 'Care in Mind', brought together 85 individuals with an interest in exploring the mental health and wellbeing of the front line social care workforce in Scotland. Delegates primarily consisted of employees from independent sector services, including a range of owners, managers and front line staff, plus representatives from partner organisations such as regulatory bodies and charities. Approximately one third of delegates occupied front line support worker roles. At the event, group discussions were captured and delegates were specifically invited to indicate their agreement or disagreement with a number of statements. They were additionally invited to comment or share their thoughts and experiences relating to these statements (see

Appendices for further information). This exercise was formulated to test the emerging themes from the focus groups with a wider group, and the data was collected and analysed for inclusion in this report.

Throughout the process of undertaking this research, it was stressed at every stage that the focus was on mental health in its entirety, rather than mental illness. The researchers felt that it was extremely important to distinguish between these two classifications for three reasons; firstly in order that some focus could be given to positive elements of mental health and what can bolster this, to contribute in a small way to the continuing campaign of ending mental health discrimination and stigma based on a lack of understanding or fear of talking about it, and finally to ensure that participants felt safe to disclose only what they felt comfortable sharing rather than feeling any pressure to impart details of diagnosed or undiagnosed mental health conditions that they or others faced. The researchers were clear that the focus groups could not and should not be misconstrued as a form of therapy or a place for people to come to terms with personal issues. To support this end and to protect contributors, it was stressed that people could leave the groups at any time and specific time was dedicated in each session to clearly signposting people to support organisations, should they choose to make use of them.

It is also necessary to reflect the fact that those who contributed to either part of the research process were self-selecting. It was extremely important, given that this was a small-scale research project and the skills and facilities required to fully support people with disclosure did not exist, that participants were willing contributors. Inevitably this included a range of different experiences and perceptions of mental health and their input was invaluable. However, it is equally important to recognise that there are thousands of care workers whose mental health experiences are not contained in this report and who are potentially struggling even more with acknowledging, expressing and being supported to address these challenges.

3. FRAGILE FOUNDATIONS

Two of the most pervasive themes emerging from this research were of the perception of strength and weakness in relation to mental health, and of the idea of support; whether supporting an older person, a colleague or one's own mental health and wellbeing. What was also reinforced through the research process was the sense of just how much expectation is placed upon care services and ultimately care staff in terms of the quality, flexibility and diversity of care provision.

Combined with the often articulated notion of doing more for and with less, this creates an analogy of care staff and the services they work for as operating similarly to the structure in a game of Jenga™ or a building.

As we continue to, rightly, expect more from care services and the attainment of certain standards associated with the quality of provision and the skills, professionalism and values of the workforce, we inevitably place more pressure upon both services and individuals to meet and exceed these expectations. With more people living longer, often with complex and multiple conditions, and with an increased desire to support people in community rather than acute settings, we amplify these pressures even more given the supply and demand burden. However, these top-down societal, political and system-based expectations can positively serve to raise a service up and drive improvement, like additional blocks placed on top of a Jenga™ tower.

Where this becomes problematic as opposed to a positive driver is where the foundations of that tower are unstable; in this case, the foundations of social care. In a time of austerity and uncertainty as to the future of social care, particularly as policy-driven culture and system change such as integration, partnership working and power shifts have yet to bed in and be made meaningful in many places, we end up in a situation whereby social care seeks to continually deliver better outcomes but faces more risks and challenges to doing so.

In the name of efficiencies and limited resource, we are faced with a situation where more and more elements are being removed or minimised from social care services and their workforce, from the time allocated to visiting clients to staffing levels to training budgets. Not only this, but Scottish Care's previous research has highlighted that many services' viability is under significant threat. It therefore feels, to many providers and care workers, that continuing to pile demands and expectations on services whilst simultaneously stripping out elements which stabilise a service and allow it to develop means that

many now feel like they are constantly trying to maintain a precarious balance.

Pull one more piece out, and the whole thing may collapse.

So how does this analogy relate to mental health? Because the same analogy can be applied to an individual employee in social care.

This report will examine the many factors which both comprise and impact upon care workers' mental health and wellbeing. If we consider the individual care worker as the building structure, we will then examine the many pressures and expectations that are placed on them in carrying out their roles, often acting as a link between many individuals and services. But again, there are a multitude of ways in which the elements that build resilience in a care worker are being compromised. From the foundations of their role, in terms of the value – financial or otherwise – placed upon their work and understanding of what their role consists of, through to the columns and beams of training and coping mechanisms which provide strength to the person in managing strains and finally, to the cement of support which holds the structure together. What we will see in the findings is that each element is being diminished. By continuing to remove and destabilise the elements which enable a person to continue to deliver high quality care, we will ultimately lead them – and their mental health – to the point of collapse and beyond. We must do all we can to protect the integrity of these invaluable structures. After all, they hold up the construction that is the care of older people in Scotland.

The difference is that unlike Jenga™, the findings of this report are not a game. The voices of care workers that are shared throughout, and the implications of continuing to put too small a price on the mental health of both older people and the care workforce, point to real consequences – for health and wellbeing, for the care sector and ultimately, for people's lives.



4. MENTAL HEALTH & OLDER PEOPLE

"Because they are older, they are put in a box."

It is important to examine how participants viewed mental health support to be handled in society and in social care, and then to extend that to consider the treatment of older people with mental health needs.

General perceptions of mental health

Firstly, participants generally agreed that mental health is much better recognised in society these days and that awareness raising campaigns had been largely effective in decreasing levels of stigma and encouraging people to feel able to talk about mental health more openly.

However, they expressed that this general societal recognition did not necessarily extend to the proper acknowledgement of mental health in older people's care.

"You can't see mental health. If someone isn't well, it's presumed it's physical health."

"People with mental health issues are still referred to as a patient rather than a person."

Therefore despite significant advances, most participants felt that there was still differentiation in the treatment of mental health conditions compared to more recognisable physical ailments or aspects of ageing. This ranged from discriminatory treatment in relation to diagnosing, assessing and planning care provision to a downright invisibility of mental health needs in care and support. In fact, many of the care staff involved in the research spoke frequently about having to 'fight the corners' of individuals and to provide additional input in their own time because of a system-wide lack of recognition of the relationship-based care often required to support mental health.

"Care plans are all about wash, tea and toast, shower, brush hair... nothing about 'how are you feeling'. Where do you fit in that bit?"

In examining why care staff felt there to be a different approach to mental health generally, the most commonly cited reasons centred on public awareness and degrees of exposure to the realities of different mental health needs.

"You don't hear positive stories about mental health, always on the news it's about negative harm by someone with a mental health issue."

This narrow reporting of mental health can act as a contributing factor to the perception that mental health is

about mental illness, risk and safety rather than the wider definition of mental health of a person's psychological and emotional wellbeing, both positive and negative.

Older people and dementia

Furthermore, participants acknowledged a shift in perception of some conditions which relate to mental health because of increased visibility and experience amongst the general public. This particularly related to the understanding and acceptance of dementia:

"The big words like schizophrenia and psychosis are scary and not socially acceptable to many in the community. Dementia & Alzheimers are now more socially acceptable because lots of families experience it. Someone that you love can get it but with other mental health, people think someone they know won't get it."

It is extremely positive that in recent times, dementia has received much higher recognition in society and steps have been taken to reduce stigma for older people living with it. This is reflected in initiatives such as dementia friendly communities and the Promoting Excellence Framework for health and social services staff¹⁵. However these steps are borne out of the less positive fact that between 2014 and 2020, there is likely to be a 17% increase of people diagnosed with dementia each year with the largest increase taking place amongst people aged 80-84¹⁶. We already know that in care homes alone in 2016, approximately 57% of residents had a diagnosis of dementia (a 59% increase in those medically diagnosed over the last ten years)¹⁷. It is likely that an even higher number of people are living in their own homes with dementia. It is therefore crucial that both professionals and the public have a better awareness of how to support individuals with dementia, and research participants believed this is taking place given that more people have or will have personal experience of dementia affecting a loved one.

However, the perhaps unintended consequence of the raised profile of dementia is two-fold for older people and seems to be linked to additional stigma and discrimination on the grounds of age. Firstly, it masks the fact that older people can be affected by a wide range of mental health challenges including but also far beyond dementia. Again in relation to care home residents, almost 10% were living with diagnosed mental health conditions in 2016 and it is more than probable that many more would have varying

¹⁵ <http://www.gov.scot/resource/doc/350174/0117211.pdf>

¹⁶ <http://www.gov.scot/Resource/0051/00511467.pdf>

¹⁷ https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2016_10_25/2016_10_25_CHCensus-Report.pdf



and fluctuating degrees of negative mental health in the same way that any other person would. Worryingly, these wider mental health needs regularly seem to be lost sight of purely because an individual is older and may also have dementia.

“Once dementia has been diagnosed, all other mental health needs wither away.”

“People with mental health needs get lumped in with people with dementia. Their care plans don’t reflect that their needs are very different. They can mostly look after themselves, tend to manage their own personal care, and so they often get less attention.”

This highlights the potential existence of a concerning practice whereby, because someone presents as physically able, they are either inappropriately assessed or inadequately supported. This applies to both those supported in their own homes, who are likely to receive smaller packages of care and less hours, and those in care homes whose needs may be deemed less intensive and therefore lower priority in relation to those of less physically able residents. However, what this fails to recognise is that someone’s mental health support needs may be different but no less crucial or intensive.

Secondly but in a linked way, participants frequently expressed concern that even where there are mental health needs which are clearly identifiable, these are being attributed to and dismissed as being a manifestation of an individual’s dementia, even by medical professionals.

“Doctors say it’s just dementia when it’s not.”

“People assume the behaviour is dementia, they don’t look for anything else. It would be different if they were younger.”

From a human rights perspective, this is unacceptable. Just because someone is over 65 and has a particular diagnosis, their right to health should not be jeopardised by discriminatory practices preventing them from accessing wider support or receiving proper care and attention. Additionally, participants shared the negative ways it impacted on them as care workers when they could identify that an individual was unable to access the type of care and support they desperately needed, therefore resulting in even more people experiencing poor mental health.

The types of discriminatory practices identified by care staff may point to a wider issue that still exists in relation to dementia awareness. Whilst, as previously detailed, significant progress has been made around promoting an understanding of dementia it would appear that unfortunately, this does not always translate into positive practice. In fact, participants identified a number of examples whereby the fact that an older person has dementia has led to a failure to treat them with dignity and respect. This ranged from the quality of information received by care staff about a person’s care needs, to the language used by colleagues in identifying and describing

both them as an individual and their behaviours.

“The information will say vascular dementia and that’s where it stops.”

“They are still people, not a label, not just dementia.”

“If someone is having a bad day, some colleagues think they’re ‘playing up’ and think I’m making excuses for them. Colleagues saying things like ‘what do they know? They have dementia’ or ‘they know what they’re doing’... that is shocking. I challenge it but it gets me down.”

It is therefore extremely important that we continue to raise awareness of dementia and challenge practice and language which is disrespectful or discriminatory in nature. However, it is perhaps time to extend this to a wider range of mental health needs affecting older people in order that we don’t continue to perpetuate stigmatisation or human rights abuses in relation to their care and support needs.

Supporting under 65s

Finally, whilst this particular research focuses on mental health within older people’s care services, participants also raised another extremely important issue in terms of the care and support they provide. This relates to those being supported in traditionally older people’s care settings who are living with mental health challenges but are under 65, and this is a particular issue for care home settings.

A number of participants reflected on the vast range of mental health conditions they are supporting people with, including but not limited to learning difficulties, Korsakoff syndrome, early onset dementia, drug and alcohol related illnesses and addiction problems. Given the number of people living with these conditions, they often require more intensive care support at an earlier stage and therefore some enter care home services whilst they are under 65.

“The demographics are changing. People are developing dementia much earlier, and their needs are so different.”

“I have people in my care who are younger than me.”

“The average age of our care home is 71. We have 5 people under the age of 65.”

This raises a number of issues about how to best support these individuals and their mental health needs. Firstly, their care requirements may be significantly different to those of their fellow residents given their particular mental health conditions and therefore the suitability of these settings for best meeting their needs should be explored. In fact, one participant expressed her concern that, ***“there’s no place for them”***, meaning that these individuals are often placed in care homes for older people because of a lack of alternative care options. What’s more, it highlights just how flexible and wide-

ranging care services are expected to be in terms of the provision they offer and the skills and qualities of the workforce, perhaps to an unreasonable extent. Should we be requiring care services to be both generalist and specialist at the same time, for whom, and what impact

does this have? These are issues which need further exploration in relation to mental health, older people's care and additionally the support of individuals under the age of 65.

5. SUPPORTING OLDER PEOPLE

“We’re not mental health experts, but people think we are.”

It is hoped that this report can start to address the question of impact in relation to supporting older people's mental health where, as already identified, it tends not to be an explicit part of provision. More specifically, it will look at the impact on the care workforce because what has emerged in the course of conducting this research is how intrinsically linked the mental health of care workers and that of the people they support really is.

Mental health support in practice

Whilst this research explores a range of nuances, intensities and experiences in relation to mental health, both positive and negative, it was extremely eye-opening to discover just how many care staff, across both care home and home care services, have had very difficult personal involvement in supporting people in their care through severe mental health issues which has resulted in a significant impact on their own mental health.

“I spent a whole night lone working on a mental health unit during which a man was very intimidating and my life was threatened. That experience really impacted on me. No support was offered afterwards.”

“I’ve physically had to stop someone taking their own life.”

“I was supporting a man who, because of his dementia, couldn’t communicate. Out of frustration, he stabbed the table with a knife right next to my leg. It wasn’t a direct act of violence, he planned to use it on himself. But I sat back afterwards with a ringing in my ears and thought, ‘Am I brave enough to go back in to that situation?’”

“I’ve had cups thrown at me and staff chucked out. It has a big impact on staff.”

“We had an experience of someone who is bipolar.”

They wrecked the house in front of a carer, but they had no training to deal with that.”

“We spent 13 hours supporting a man who was a real risk to himself. The man, other residents and staff were all affected. We felt like we had failed him.”

As is demonstrated through this vast, but by no means exhaustive, number of examples, the impact on staff of supporting people's mental health can be substantial and wide ranging. The ramifications extend to issues of training, support, feelings of personal responsibility, safety and resilience, all of which will be explored in more detail.

However what these illustrations also serve to highlight is that older people are living with often severe and diverse mental health challenges and each of these stories tells a tale of, at some level, a failure to support someone adequately given that each relates to a manifestation of a significant breakdown in someone's mental health.

So what leads up to the extremities of experience detailed here? There is no simple answer to this, particularly given the complexities of mental health, and it would be incorrect to suggest that the nature and quality of a care intervention is singularly responsible for deterioration in someone's mental wellbeing. However care workers shared a multitude of ways in which they believe older people are being let down in this area, but also the positive ways in which they and others are trying to make a difference.

Systems and relationships

Participants talked at length about the various ways in which they are both reliant on and relied upon by other professionals in their local areas to support an older person's mental health. However, some did express a general view that the way in which care is currently planned, procured and even delivered is not conducive



to the positive promotion of good mental health and wellbeing.

“Systems are detrimental to older people’s mental health.”

This related to the finance-driven culture where because of austerity and the lack of resource available, services are planned in terms of efficiencies and finding the lowest possible price. It can lead to older people being treated more like commodities than people, with various services looking to “get someone off the books” and on to the responsibility of another service. This was particularly expressed in terms of relationships with social work departments and information sharing was cited as the most problematic element of this.

“By not divulging proper information about the mental health of somebody being cared for, you are putting them and staff at risk.”

Participants shared a view that it was extremely difficult to effectively meet the mental health needs of an older person in situations where relevant, quality information was either missing, not imparted or delayed. Many believed there to be a rationale behind this of securing a care placement for someone first, recognising the demand on both social work departments and acute services, rather than prioritising the needs and outcomes of the individual, how these can best be met, and by whom.

Almost all participants mentioned their link with local Community Psychiatric Nurses (CPNs) as an important form of professional support. However, the quality of this relationship varied across areas and services, seeming to be entirely dependent on partnership approaches at locality level.

“Our CPN listens to us and works with us and that makes a real difference.”

“I have had to complain about the CPN service & the lack of a person-centred approach.”

The frequency of CPN support was also a critical yet contested and variable factor, with some detailing established routines for contact whilst others finding this to be sporadic. However, almost all participants who shared information about their service’s CPN links expressed a desire for more frequent contact.

“6 weeks, even 24 hours, is a huge amount of time when someone has mental health needs. Things can change overnight.”

Others expressed issues in terms of access to professionals, with some citing that links to CPNs were easier than establishing meaningful contact with psychology teams or GPs and others having the opposite experience. It would appear that these local links with mental health professionals and other support colleagues are sporadic and varied at best. Where good working relationships are established, participants were quick to share the benefits of this to both staff and the people being supported. These positive examples included access to shared training.

Care settings

One of the most prevalent themes emerging from the research is the extent to which the particularities of a care setting can impact on an individual’s mental health, regardless of the quality of the care delivered. This applies to both care at home and care home settings.

In terms of care at home services, the nature of time-limited, in-and-out provision proves to be problematic when supporting someone’s mental health needs.

“How can you support someone when you’re just popping in and they’re sitting there all day with everything that’s going on in their head?”

Many participants from a care at home background expressed a level of ‘guilt’ in having to leave someone on their own who is struggling to achieve or maintain positive mental health. The focus on task-oriented commissioning of home care led many care staff to express their constant battle to maintain a balance of getting tasks done and build relationships with the people they support, often compounded by strict time allocations. This is particularly exacerbated for older people, given they are most at risk of loneliness and social isolation and often do not have other forms of informal and community support.

“Loneliness is all day – they see someone for a few minutes each day and in between, it’s only the TV or radio.”

It is therefore easy to comprehend how an older person being supported in their own home can quite easily become at risk of developing poor mental health, even if this is not something they have experienced at other stages in their life.

For care home services, the issues are different but just as profound. They include the reality of undertaking the transition into a care home, which is often associated with times of crisis, a recent bereavement and the experience of losing one’s own home, all of which can put strain on

a person's mental wellbeing. What's more, there can be a significant change in terms of the support they have received, including the relationships which accompany that support.

“Once they come into a nursing home, they lose their social supports. She used to have something every day but she lost all of those, and this has had a huge impact on us – who can take her out?”

One participant expressed the issue of care home support being largely constrained to on-site care, particularly in light of funding and staffing pressures, which can make it extremely difficult to ensure that an individual maintains community links if other formal or informal supports are not available.

Additionally, a number of participants recounted the challenge of providing mental health support in a setting which consists of communal living arrangements.

“In care homes, there can be a ripple effect on different individuals with mental health issues.”

“One trigger can trigger everyone.”

Given the interconnectedness of support arrangements in care homes, it is easy to understand how managing that group dynamic and ensuring the wellbeing, outcomes and human rights of all residents are supported at all times can be challenging and are heightened even further when dealing with episodes of mental distress. It was clear to see that this issue significantly concerned a number of care home workers and led to them feeling like they are never able to do enough for every resident.

“Resident wellbeing is our biggest challenge. There's only so much you can do... it's not intentional, but if someone is screaming further down the corridor that's where you're going to go. You think the quieter ones are alright, but their needs are then missed and it impacts on their mental health. They can become withdrawn and start thinking, 'what's the point in asking?'”

It is really important to recognise the danger, whether in care homes, care at home services or in assessment and planning processes, of assuming that those who don't outwardly display signs of emotional and psychological distress do not have mental health support needs. It highlights the criticality of preventative and time flexible approaches to care, combined with ensuring sufficient staffing levels and skill mixes, to ensure that everyone who requires support receives it and is not having their mental health unintentionally but nevertheless negatively

impacted by their care and support.

Mental health advocates

Despite the challenges associated with delivering mental health care in these settings, it is possible to do this well and participants were embodiments of that high quality support in the way they spoke about supporting older people's mental health. However what this highlighted was the importance of having these dedicated staff, who remain committed to supporting the holistic needs of those in their care and acting as advocates for those less able to have their voice heard and their mental health needs met.

The relationships and knowledge developed by supporting an older person regularly means that care staff are often required to question decisions or protect a person's interests in relation to other professionals' interventions.

“The secret is not to be afraid to challenge sometimes – the professionals only come in at crisis point but as front line, we know that person. We see them every day.”

“If they'd spoken to us, we could have told them that something won't work”

This requires a level of courage and confidence, as well as demonstrating care staff's commitment to person-centred outcomes. It is important that this is recognised and valued by other professionals, not to undermine their competent decision making but to ensure that decisions made about a person are made in partnership with both the individual and those closest to them who know what they need and want: in many cases, this will be their care workers.

Yet given the pressures on the sector, the reality of advocating on behalf of others and ensuring their mental health is supported means care staff going above and beyond in the support they provide.

“I realised that if she didn't have consistency, nobody would have picked that up. It took hours of my time [to source additional community supports], but the benefits were clear.”

“We rely on kind hearted members of staff who come in on their day off, but this can impact on their mental health.”

What's more, it highlights how essential consistent support is for older people, given the fact that someone's mental health journey can be changeable and often subtle.



“I can spot a trigger and try to divert her from going down that road, but only because I know her. How do you know that without experience- to spot it and stop it?”

This raises a number of issues relating to the current recruitment and retention challenges being faced by the care sector. If there is a high turnover of staff or the calibre of new recruits is not sufficient, we risk a significant breakdown in the quality of these relationships and therefore in the quality of mental health care delivered day in day out. Furthermore, the current requirement of many care staff to spend their own time supporting people risks driving even the most dedicated staff towards a level of burnout whereby they feel unable to continue delivering this care. The ramifications of not addressing these issues are considerable and concerning for the support of older people.

Training

Throughout the course of conducting this research, training played a huge role in understanding how care staff are able to support others and to support themselves. Interestingly though, there was notable variation in both the prevalence of mental health training and the perceived benefits of different types of training and experience.

Around half of participants indicated that they had not received any formal training in mental health and that instead, the only relevant training they had had was related to dementia. They deemed this to be problematic given the increase in mental health support they were delivering.

“They are not trained in mental health, they are trained in dementia. But mental health is what it’s about, not the dementia.”

Interestingly though, whilst most indicated that they would like to have more training in mental health it was an area, unlike for instance palliative care, where more people felt that personal experience could teach you a great deal in terms of how to deal with challenges. The number of people who recounted personal experiences of mental health also demonstrates just how many people mental health challenges impact upon.

“Training is useful but personal experience of mental health challenges is invaluable – you are more comfortable talking about mental health.”

However, participants did express a need to be more informed about supporting a wider range of mental health

conditions and some cited particular courses they had undertaken which gave them more insight into challenges ranging from loneliness to anorexia. Very few people had undertaken training to this extent unless they came from a mental health background.

Others cited the fact that time and support to implement training, or even to be released to undertake it, were the most significant challenges.

“We need to do more... actually I mean do less, but ‘be’ more. Have time just to be with the person.”

In relation to skills and learning, participants felt most strongly about the personal skills, qualities and attributes that are required to promote positive mental health with people who access care and support.

“Sometimes the best training is hands on. While you need academic too, you need a holistic approach. For instance, I found out someone hadn’t eaten his dinner all day and I was to call the GP, but I asked the person what was wrong and they told me. By the time the GP arrived, they were eating their tea. They just needed to tell someone what was wrong.”

“I come from a psychiatric background and appreciate all the training I’ve had, but it’s unbalanced. There’s a worker comes in and his personality brings out more things in people we care for than the rest of us, and he’s probably had no mental health training at all. You can have all the training in the world but having an empathetic approach to people is more important.”

Many reflected on the importance of picking up on cues and small changes in behaviour, and of being able to just listen and be there for people who need it. For these sorts of skills, it was emphasised that these were innate qualities and more to do with the values and natural approach of the worker rather than something that could be taught. However, it continued to be reflected that training could enhance this and support it.

Training was also discussed in terms of an additional benefit it provides; that being the ability to cope with situations that test either the mental health of the person or of the worker. It seemed that training could be a tool to support the ability to rationalise experiences and to process them effectively, in order that the worker’s own mental health is not jeopardised in the support of others.

“Training is so important. It doesn’t matter if you’re young, middle aged or more experienced. Training does affect how you manage it.”

“Training has helped me and helped me to be able to

switch off when I go home and be with my family.”

It is therefore clear that more mental health training is required to support care staff with the mental health needs of both themselves and others. If it is used to

complement the existing skills, attributes and experiences of care staff, its benefit can be significant and can enable staff to positively address difficult situations rather than simply hoping they are resilient and competent enough to manage, as is often the case presently.

6. SUPPORTING OTHERS

“We are expected to be the scaffolding that holds everything together.”

It was abundantly clear through the discussions with care staff that their role in mental health support extends far beyond the clients or residents in their services.

Professionals

In order to deliver high quality mental health care, it is crucial that care staff can operate in a mutually supportive working environment and this extends beyond their immediate care setting to the multi-disciplinary care sector in any given locality. This includes social work departments, CPNs, district nurses, GPs, statutory services, the NHS and community organisations to name but a few.

However, care staff highlighted particular issues in terms of partnership working around mental health and more specifically a distinct lack of professional recognition and respect experienced by the vast majority of participants.

“They see us as just support workers.”

“They don’t understand our workload.”

“We are professional. Maybe not medically trained, but we are trained. It’s about recognition.”

This lack of professional value, usually but not exclusively discussed in relation to social workers and CPNs, was largely attributed to a lack of awareness and understanding of the complexity of the role of care workers and the skills they have, particularly in relation to how these can support joint decision making and easy information sharing around an older person’s mental health needs.

Care staff, regardless of their setting or particular role, expressed frustration at the perceived imbalance of expectation in regards to information and work practice with colleagues in other parts of the care sector. This led to many care staff feeling like they were treated as ‘second class citizens’ within a hierarchy of care professionalism.

“We’re expected to feed up the tree and communicate freely at all times, but there is no acknowledgement or return information. We don’t get the same respect back.”

“It feels like we’re expected to do their job for them. They expect clear and accurate information but give us a 15 minute meeting.”

“When they’re looking for something, we’ve got to jump but when we want support from them, it’s not a high priority.”

Given the fact that these social care workers are the professionals who see and support individuals on a daily basis and arguably know their needs and wishes best, it is disappointing to see that they are not given the recognition they deserve in this role. What’s more, it is troubling from the perspective of delivering the best possible mental health support to an individual if care staff are requesting information and support and are not receiving this in an effective and timely manner because of an issue of recognition and value.

For the highest quality care to be delivered, it is absolutely essential that a partnership approach based on mutual respect and equitable treatment is in place. One participant therefore suggested that job shadowing opportunities should be made available in order that professionals in different parts of the care sector could be better informed about each other’s roles and challenges.

“They should come and do our jobs for a week, once a year, to help them understand and keep in touch with reality.”

Beyond the frustration this issue causes and the unnecessary barriers to effective working subsequently created, this lack of value and professional support is also having a detrimental effect on care workers’ own mental health.



“Because I’ve not got letters after my name, I feel they don’t listen when I know the situation is a crisis. We know support is needed now but we have to wait for help, sometimes whilst watching things breaking down.”

“It sometimes feels like we’re screaming in the dark because no one is listening.”

“I felt resentful towards the authorities because I’d be flagging for days that his depression was worsening and I wasn’t listened to.”

The phrase ‘no one is listening’ was used a significant number of times when discussing partnership support and is leading to feelings of helplessness and isolation amongst the social care workforce. This is not good for workers’ own mental health and it certainly is not acceptable for the individual who requires that professional intervention.

Colleagues

Given the often emotional nature of delivering care and support, it is important that workers are well supported by colleagues and can also offer support to them when it is required. This is true at all levels of an organisation.

“Good team morale is the biggest thing, and realising we can all support each other. It’s not hierarchical. Mental health shouldn’t be seen as a weakness.”

Most participants stressed that this mutual care and attention was extremely important to them in supporting their own mental health in the workplace, even if that team is not immediately accessible such as in care at home services.

However in a similar way to reflecting on higher mental health needs of people they support, participants identified that they were aware of more mental health challenges affecting the people they work with.

“Mental illness isn’t just increasing for people coming into care homes, but it’s increasing with the staff we are recruiting.”

“There are more mental health problems with the staff than the people we care for, and the job is making it worse.”

The reasons for this are likely to be multi-faceted. It may partly be the result of an increased awareness and acceptance of mental health, which means more workers feel able to admit to personal challenges and also that employers are more willing to recruit people with

experience of poor mental health because of reduced stigma. Linked to this, previous research has highlighted that those with mental health needs are more likely to be drawn to roles which involve caring and showing empathy; a trend that participants recognised and agreed with. However more negatively, it also seems to be the case that for many staff, regardless of past experiences, the realities of the role including, for instance, the delivery of palliative and end of life care are impacting on their mental health.

“I’ve seen the best of staff reaching breaking point.”

“Some of our staff are young. We’re trying to source bereavement training, often they have never encountered death before.”

This poses challenges for those in management and leadership roles as to how to best support staff to acknowledge and address the mental health challenges they are facing. In fact, this research has highlighted particular and profound challenges for managers in relation to mental health.

Firstly it would appear that managers are struggling on a number of fronts in relation to supporting their staff, including their ability to identify appropriate assistance and their capacity to provide this in a pressured environment.

“Staff put themselves second to the clients, so you don’t always know how to support them.”

“I don’t have time to properly listen to staff.”

As the See Me¹⁸ campaign’s workforce information emphasises: ***“Everyone has a responsibility to look after themselves and others but the values and ethos must come from senior management - welcoming people with mental health problems and creating a culture that is inclusive and understanding of individual’s needs.”***

The fact that many managers feel unable to do this effectively is concerning, not least because of the implications this has for the whole workplace’s approach to mental health recognition but also considering the impact this may be having on individual workers who are in need of this support from their manager and are unable to access it.

Yet managers’ difficulty in supporting staff becomes easier to comprehend when considering the immense pressures they are experiencing in terms of their own mental health.

“Personally I get down... I’m a marriage counsellor one day, debt advisor the next. I need more training

in counselling. I sit at night and wonder, 'did I say the right thing?'"

"There's pressure... always asking staff to do extra shifts, pressure to make sure they can do runs. I don't have anybody to delegate to. I have to delegate to myself."

"You're fortunate to get to sign in before being stopped or asked something... I get stopped in the car park."

Whilst some participants, including managers, acknowledged positive practices they had in place to support themselves and others, the vast majority appeared to be constantly trying not to buckle under the enormity of support they need to provide to others and subsequently in ensuring they themselves remain mentally well. What is clear is that it can be extremely difficult to identify ways in which managers can access personal mental health support in the workplace, with a number of participants highlighting that managers are rarely afforded opportunities to network with other managers and access informal support that way because of the sheer demands of the job.

Employers

This raises the question of the role of employers in supporting all levels of staff within their organisation.

An astonishing level of honesty as to the challenging decisions employers face was imparted through the research, with a few employers acknowledging the difficulty in marrying employee support with the pressures of delivering care. This was particularly prominent in relation to recruitment processes.

"People don't want to say. Let's be honest, as an employer, if you could hire someone who has mental health problems or someone who hasn't – we just

don't have the time or finances to support them."

"If we're honest as employers, if it's between two candidates the one with mental health needs means thinking about covering more shifts, extra sickness, etc."

Whilst improvements undoubtedly must be made in terms of ensuring recruitment isn't discriminatory against candidates' mental health, this also highlights the level of challenge facing the care sector in relation to staffing shortages and the capacity they currently have to support staff. As a sector devoted to care and compassion, this is not the direction we want to be moving in with regards to employment practices.

For those already in employment in the sector, participants stressed how important it is for employers to fully understand the realities of delivering that care – whether that is the mental health needs of the people being supported or the pressures facing managers and care workers. Those who took part in the research had mixed experiences of the quality of links with senior management and employers.

Equally, participants highlighted their own responsibilities in relation to creating a workplace that is supportive of mental health and conducive to improving it.

"We as staff have to take responsibility to say to managers and colleagues, 'I'm not coping'."

It is apparent that, given the range of support needs that a social care worker both caters for and requires themselves, there must be a culture of shared responsibility and professional recognition as well as a workplace environment that lends itself to promoting compassionate, non-discriminatory practice around mental health whether that is in the immediate workplace or the wider care sector.

¹⁸ <https://www.seemescotland.org/workplace/>



7. SUPPORTING THE SELF

“We forget that we need to look after ourselves to look after somebody else.”

Care workers, regardless of role, tend to choose to do the job they do because of their caring, empathetic nature. Throughout every aspect of the research, care workers not only talked about but demonstrated their commitment to high quality care. They were genuinely affected by the people they care for, moved when they could support them well and distressed when sharing examples of when something had gone wrong or someone's needs could not be fulfilled to the utmost.

Impact

Yet all of this impacts on these individuals' own mental health in one way or another. For different people this looks very different, but almost everyone shared physical, psychological and emotional manifestations of the strains of their role.

“I’ve had my stomach churning on the way into work.”

“A lot of the time I drive out, park at the next bus stop and cry.”

It is important to note that some people did perceive the care they deliver to have a positive impact on their mental health. However, the vast majority recognised that they struggled to separate the impact of their work from their personal and home life.

“I’ve done what I can, contacted folk, documented, but I go home and worry because I know it’s leaving a person and staff who’ve relieved me in a really awful situation.”

“I am physically and mentally drained after a 15 hour shift, then I go home and try to switch off.”

It is therefore crucial to understand the variety of ways in which social care staff are affected by their working experiences in order that they can be supported effectively.

Recognition

However what became clear in the course of the research was that very few of the participants had given their own mental health much thought at all. Therefore if they aren't even able to identify or acknowledge how their mental health is affected, it is extremely difficult for others to do so on their behalf.

“I eat, drink and sleep my job and give no consideration to my own mental health. I see the signs, but I ignore it. I have ups and downs.”

In every single example of a participant stating they hadn't thought about their own mental health, they expressed this in terms of a higher prioritisation of the needs of others.

“I check things in other people’s lives more than my own. You put everything else on the backburner, your self comes second. I went to pick up everyone’s medication and forgot to get mine when I was there.”

Some recognised that this was probably not a good thing to do and that they needed to dedicate more time for themselves. However others strongly believed that their own needs were of far lesser importance and that they needed to focus their attention on the care they provide.

“It’s not about you, it’s about the people you support.”

A striking discovery from the research was how much more comfortable participants were when discussing other people's mental health needs - whether those of a supported person, a colleague or a family member - than they were discussing themselves. Whilst this was expressed in quite subtle ways, it appeared that there was still a degree of stigma within the focus groups to speak about one's own mental health. All four groups showed clear signs of this and whilst some people opened up over time, other people obviously still didn't acknowledge it as an issue despite talking in general terms in ways that demonstrated the impact on them and on their role. As previously stated, the research groups were not an appropriate forum for prompting disclosure so it may be that some participants' lack of acknowledgement and outward shows of resilience was a coping strategy they consciously or unconsciously utilised.

Switching off

The most obvious representations of the mental health impact on care workers were in descriptions of work-life balance and being able to separate work from other aspects of one's life. In most cases, participants found this to be extremely difficult.



“Your conscience bothers you all the time. You’re trying to do your best. It’s so hard to switch off.”

“Working with relatives and staff... it’s when you go home, you think about the repercussions for other people, not yourself. You lie awake, it’s a loop. There’s no time to think about yourself, it can be exhausting.”

These admissions and others were largely communicated in the context of worrying about how well they were able to do their job and whether they had met the needs of the people they support in the best way. This again illustrates the ways in which the positive qualities embodied by care workers can risk impacting on them in more negative ways.

For others, their home lives were significantly disrupted by work experiences and some found it almost impossible to separate the two.

“I care for people with dementia and now my mum’s been diagnosed too so I live with it 24 hours. It’s very stressful.”

“I hear the call buzzer in my sleep... my partner now sleeps in the other room.”

Whilst it is not achievable for all care workers to be able to switch off from their work when they leave given the different ways in which people deal with experiences, a number of participants did say they manage to rationalise, ‘train’ themselves or use tools and techniques to enable them to distinguish between the two elements of their lives. It would perhaps be beneficial for care staff to learn more about some of these ways, as well as having access to more formal forms of support, in order that we can minimise these examples of mental ill health in practice.

Managers

Again, a worrying trend was identified around the abilities of managers to achieve some separation between work and home life and this largely related to their concern for others.

“I tend not to turn off. Constant thoughts in my head, that I’ve got workers out there around the clock. I don’t give my own mental health needs enough thought because of that.”

Whilst care staff identified difficulties in switching off between shifts because of their own thought processes and worries, managers additionally highlighted that their role in supporting others prevented them from being able to switch off, even when they actively try to achieve some distance.

“As a manager, you are the ultimate contact. Even on days off and holidays.”

“It’s not worth going on holiday... you have to leave the country for a real holiday so you’re not within driving distance of the home.”

Again, this demonstrates the existence of unhealthy working practices for those employed in social care. Whilst it is highly unlikely that employers would in any way promote or condone managers being constantly available and therefore unable to protect their own mental wellbeing, it is the unintended consequence of both the caring and committed nature of those working in the care sector and the realities of the pressures on the sector. Regardless of this, it is not a justification for not supporting our managers to look after themselves and simply means more concerted effort and attention needs to be paid to finding solutions to this challenge.

The consequences of not addressing this issue were also discussed by participants.

“We’re going to get to a stage where there’s no managers left to choose from, they’ll all be in a pile.”

“I used to be a care home manager but decided to go back to nursing. You don’t have a life.”

At a time when care staff, including managers, are in short supply it is absolutely critical that those already working in the sector are supported and enabled to have experience of a positive working environment which is sensitive to their mental health needs and prioritises a degree of work/life balance. Otherwise, more people will be driven to the decision that a career in care is incompatible with positive mental health when the opposite should be true.

Coping mechanisms

Despite the many articulated challenges associated with mental health in a social care context, thousands of people choose to come into and remain in the sector and almost all participants expressed a passion for their roles and enjoyment in their work. There must therefore be a range of ways in which care staff manage the negative elements and build resilience to enable them to return to work and deliver high quality care on a daily basis.

For some, their tools for coping with work demands are very much bound up in their working environment. For instance, many expressed a reliance on colleagues and work friends for discussing challenges.

“I could not do it without her. I can’t imagine it... to be able to offload and say ‘that was a mess’.”

There was a real mix in terms of the people whom participants chose to speak to about mental health challenges, from work colleagues who understand the realities of care to spouses and those detached completely from the sector. Interestingly, this did not seem to extend to a preference amongst any participants to speak to strangers about challenges they face. For example a number of care workers highlighted that their organisation had a helpline in place that they could access for mental health support, yet no one indicated that they had either used it or were likely to opt to use it if required.

“I don’t want people to think I can’t cope.”

“If you talk to the team it helps you bond but if you use the helpline, there’s a stigma... like I let it get too bad.”

It is concerning that much of this was expressed in terms of ‘stigma’ and that participants themselves appeared to perceive a degree of stigma associated with more significant mental health needs than, for instance, having a bad day. It is also possible that some people simply did not want to disclose that they had used this support mechanism. Either way, this highlights that issues do still exist in terms of what care workers think of as ‘acceptable’ support tools, whether this particular option was suited to them or not.

Humour was another coping strategy openly demonstrated within the focus groups, and this was particularly prominent when discussing the use of alcohol as a mechanism for dealing with work strains.

“You drink a lot of wine.”

Whilst many people did say that they drank alcohol as a coping mechanism, this was always expressed in a light hearted, tongue in cheek way when in reality, it may very well be a significant coping tool adopted by some people. Again, it was clear that there were degrees of acceptability of what participants felt were disclosable insights within the group. One of these reasons may be a fear that sharing an insight which hints at unhealthy coping mechanisms or particularly poor mental health might leave them open to judgements about their ability to do their job or at risk of something being ‘on their record’.

A wide range of other coping mechanisms were displayed within the group, with some finding comfort in the nuances of their roles.

“It is the smallest things that matter. Personalisation of people’s care can give you personal strength.”

What this demonstrates is the individuality of mental health and ways in which people manage their own wellbeing. In the same way that person-centred care of others is promoted, we must ensure that care workers feel comfortable adopting strategies that work for them and that where appropriate, they are supported to handle these in a healthy way. The insights gleaned from this research point to ongoing issues of stigma and personal acceptance of mental health. It is therefore critical that work continues to address these and ensure more care staff are able to look after themselves whilst at the same time supporting others.



8. MENTAL HEALTH & SOCIAL CARE

“The reality of care is there are huge emotional demands on people who do it... I love my job and hate it equally.”

Many of the voices shared through this research may appear to be negative in nature despite a number of people expressing positive relationships between their work and mental health. The reality is that these were the most common articulations because the provision of care and support to older people in Scotland is extremely challenging. Rewarding? Absolutely, but also testing in every possible way.

“The increase in public awareness of mental health needs has not changed public perception of the role of the care worker.”

Together with the ongoing elements of stigma relating to both older people and mental health, there remains a stigma associated with working in care. Participants spoke not only of the lack of value placed on their roles but also of the degrees of misunderstanding of what they do and the imbalance in public reporting on social care – with the thankfully few examples of unacceptable practice being the parts that hit the headlines and creating a culture of fear and suspicion related to care work. This makes the care of older people an extremely difficult area to navigate in terms of addressing the ongoing challenges of mental health.

What’s more, care workers themselves identified their own deficiencies in ‘walking the talk’ around mental health and this was highlighted more subtly in the discussions that developed through the research groups.

“As a caring profession we should be better at talking about mental health, but we’re not. We are atrocious to ourselves.”

Consequences

The challenges associated with improving mental health amongst the care workforce are exacerbated by the ever-present awareness of the weight of responsibility resting with these individuals.

“If you make a mistake, you’re dealing with people’s lives.”

“There might come a time where there’s one phone call you miss, and that’s it. It always plays on my mind.”

“If someone isn’t there, it’s not a tin of beans not put on a shelf. It’s a person sitting on their own. It can be a matter of life or death.”

The impact on the individual receiving support is compounded by the sense of blame culture surrounding care work, with some individuals conveying a sense of fear in relation to regulatory processes because of the perceived focus on finding fault.

“If something goes wrong, we’re in the firing line.”

If care workers do not feel supported to do their best and to be able to admit weaknesses and struggles without fear of consequence, we will not succeed in changing the mental health culture that pervades the sector.

The reality of care delivery

To again consider care as the Jenga™ tower, the very foundations of care provision are so precarious that the block that is the mental health of the workforce is teetering ever closer towards collapse. These strains are extremely wide ranging but relate significantly to time, resources, capacity and partnership working.

“How can you be compassionate when there’s so much time pressure on staff? They’re crying because they can’t do the job.”

“They all talk about joint working but people just aren’t available... and we watch people crumble and stand by to pick up the pieces.”

“In our sector, no one has an addiction problem from 5pm until 9am.”

In the course of further exploring some of the reasons why these factors - none of which are new - are particularly acute now, participants emphasised the changed nature of the care they now deliver.

“10 years ago, somebody would get 25-30 hours in their package of care and it met their needs. The same person with these needs would be lucky to get 10 hours a week.”

“I’m running a mini hospital, not a care home anymore.”

“I came into nursing to care. My role is a HR job, not a nurse. I’m dealing purely with the stresses of the job.”

It is clear that the climate in which care is provided in Scotland is one of tension, uncertainty and a sense of being constantly stretched beyond what is tolerable. At the same time, more people require care and support and the quality of that care is paramount. The care needs of individuals have changed but the systems around this have not necessarily adapted in a responsive way. Therefore to continue to face personal mental health strains, whilst supporting the mental health of others, within a sector which seems to be constantly facing barriers restricting the ability to do this well will take its toll on even the most resilient care worker unless positive and time-critical solutions can be found to securing sustainable, quality care.

The workforce cost

In fact, a worrying number of participants embodied that sense of physical and mental exhaustion associated with working under such strain.

“After twenty years, this is the most challenged I’ve felt in my whole career.”

“I’m ready to walk away.”

“I’m a strong character but I can honestly say I’m reaching burnout.”

The reality is that care staff cannot continue to endure the mental health costs of delivering care in the way it is currently configured, and they’re not. With retention statistics continuing to cause concern, it is evident that more and more people are faced with having to put their own mental health and wellbeing above their innate desire to care for others.

“I’m considering going part time. I got offered a huge pay increase, but I would rather have the time.”

“Why would you go and work where you constantly feel ‘I’m not doing a good enough job’?”

“I go home and I don’t actually know what I’ve done today, why am I doing this?”

If we fail to adequately recognise and better support the mental health needs of care staff, we will ultimately fail to recruit and retain the number and calibre of staff required to support our older people and the care sector in its entirety will inevitably crumble. This is an outcome we must strive to avoid at all costs, because the

costs to the workforce and to older people are beyond comprehension.

The positives

So how do we even begin to tackle the enormity of this challenge when everything appears to be reaching the point of disrepair? We focus and build on the multitude of positive aspects of care delivery which do support mental health and wellbeing and which keep dedicated care staff coming to their work and going above and beyond expectations despite the many problems they face.

“I’m amazed at how someone trusts me enough to tell me something they don’t even tell their own families – it’s amazing how close a relationship can become even if you’re told not to.”

“It’s more than just a job, it’s a passion.”

These include harnessing the qualities and attributes which enable people to flourish in their role and to treat care as a vocation rather than simply a career or even just a job. Part of this is ensuring that care staff are able to spend time with people and build relationships, which requires widespread recognition of the invaluable ways in which these interactions can support and strengthen positive mental health for all involved.

Participants in the research also highlighted that what makes care unique is what attracts and retains them in the sector.

“I always think that I couldn’t do a ‘Tesco’ job. I wouldn’t cope with doing the same every day.”

“You’ve got stress in any job. I can’t imagine the abuse you must get working in a supermarket or a pub.”

The flexibility and variance of care provision can, within a compassionate workplace culture, act as a supporting factor in promoting positive mental health. This involves recognising the areas in which stresses and strains are inevitable but ensuring that appropriate supports are in place to make these tolerable, as well as working to eliminate the unnecessary and unacceptable pressures put on care staff through partnership based solutions.

Finally, the range of experiences, skills and relationships acquired through the provision of care was perceived to be an extremely positive element of employment, none more so than in providing mental health support. A number of participants shared instances whereby their work-acquired talents had served them in a number of ways, including enabling them to act as an ambassador for promoting positive mental health and wellbeing.



“I feel my job has given me a better understanding of mental health. I was even able to identify a family member who was struggling and they were able to get help.”

We know just how rewarding care provision can be, and the innumerable ways in which quality care can have significant and lasting positive effects on all those involved in that care relationship. We cannot continue to allow these elements to be eroded through the under-recognition and undervaluing of mental health, of older people and of the social care workforce,

Research impact

One of the most illuminating outcomes of the research was the extent to which participants in the focus groups appeared to value the time to discuss a subject which can be easily overlooked in their daily work. Almost all participants arrived with an obvious sense of trepidation and some were clearly more reluctant about their agreement to take part, particularly in light of their workloads and various other work pressures.

“I’m already thinking, ‘this is two and a half hours away from my work.’”

However, the researchers were surprised and inspired by how quickly people opened up about the challenges they face in relation to mental health, as well as the respect

they paid other colleagues and their enthusiasm to speak to and learn from each other.

Towards the end of every session, a similar sentiment was expressed.

“Wow, it’s not just me.”

Whilst it was disappointing to reflect on how few, if any, other opportunities most participants had had to speak about mental health with colleagues from other organisations, it was also extremely encouraging to see the value of the sessions for most people. If the groups were able to positively contribute to supporting mental health, in a small way, by making people feel less isolated and alone in their challenges, then that is an extremely helpful outcome of the research.

“People should get the chance to do sessions like this in the workplace. Just to open up, have discussions.”

It highlights the value of providing time and space for care staff to network and provide each other not only with information but with informal support mechanisms. Whilst the challenges of undertaking such initiatives in the current care climate have been articulated in this report, it is hoped that the range of benefits to both care staff and the people they support are also clear. If we don’t care for our workforce, we will have no one left to care for the older people of Scotland.



9. CONCLUSIONS

The independent sector is key to the delivery of health and social care in Scotland. What this research has shown is that its structure is being weakened and eroded by the system, and organisations as well as the workforce are being pulled apart in their endeavour to deliver high quality care and support to older people. They are increasingly losing their capacity and resilience to cope with these imposed pressures, and are being stripped of and denied their ability to do what they want to do – deliver compassionate care. One participant spoke of the system being broken. This report and concluding analysis explores to what extent that is true, and how we go about putting strength back into care's foundations.

Having the building blocks in place: Recruitment and retention

This research further underlines the significant recruitment and retention challenges which are facing both the care home, care at home and housing support sector in Scotland. Elsewhere Scottish Care has argued how challenging it is to recruit individuals with experience, emotional maturity and sensitivity into a sector where the work is demanding at both a psychological and physical level. The impact of effectively losing a third of the workforce each year is felt both by those who remain in the sector to work and those who are in receipt of care and support. The very real and growing mental health challenges of older individuals who are supported to live at home or in a care home are negatively impacted by situations where there is a lack of continuity amongst the staff who support them. It is well recognised that the ability to form relationships, to be consistent and to embed trust and continuity are key elements in mental health recovery and support. Care organisations as a result of the constant flux and movement within the workforce are being prevented from achieving what in large measure is a preventative approach to care. All of those involved in the embedding of the Scottish Government's 2016 *Health and Social Care Delivery Plan* will acknowledge the importance of moving resources and supports to the community from acute settings to enable independence, and to foster autonomy, choice and control. Achieving this policy outcome significantly rests on our ability to maintain sustainable support within the local community and thus on the independent sector's workforce.

This research has illustrated the extent to which the existing workforce is being negatively affected by the growing need to respond to mental health challenges

in older people for whom it is not equipped, and the consequential impact on workforce retention. The effect of ever demanding requirements and tasks placed upon the workforce is compounding this fragility. All stakeholders need to act collectively to consolidate this critical workforce foundation, and be mindful not to add additional stress and weaken it still further.

Building resilience

The research has painted a picture of a growing population of older individuals who are struggling to deal with the challenges of life and the impacts these have upon their own mental health and well-being. The degree to which individuals are supported to 'hold things together' is in no small part due to a workforce that sacrificially gives of its own self and time to go the extra mile. It has to be asked, however, whether it is adequate that the mental health support and their resilience to crisis and challenge of a growing number of increasingly vulnerable people should be dependent upon individuals who are 'going above and beyond'.

Despite all the pressures the current workforce is experiencing this study also found evidence of astonishing resilience and coping mechanisms within that workforce. It has shown measures which had been adopted and adapted to ensure well-being and foster positive health. Within a very fragile and vulnerable workforce it is remarkable that individuals are managing themselves in ways which foster collective support and enables well-being. These approaches are often despite the system rather than being enabled by the way in which we currently commission, and subsequently deliver, care and support.

Creating solidarity and sustainable structures of support

It is also clear through this study that staff working in social care settings are significantly dependent upon the experiences and professional skills of mental health specialists. Where there are positive relationships within community and acute psychiatric and mental health supports then there is a clear benefit to individuals and also to the workers who support them. Regrettably, however, those who took part in the research indicated that there are still too many instances where the distinctive contribution of social care staff is neither recognised nor valued.

The space between

Any physical construction is not only constituted by the solid elements which comprise its structure but by the spaces, air and matter between. In a social care context relationships are at the heart of care and support. Care is not a series of tasks and functions to be completed within a specified time but rather the dynamic of inter-personal interaction which enables people to relate to and encounter one another. Throughout this study it has become very evident that real and meaningful exchange and support for those with mental health challenges is only possible where workers spend time, initiate conversation, address questions, listen, observe and give space to those who require it to off-load and express concerns. It is this *space between* which is essential in relationships that seek to foster emotional well-being and which promote recovery from mental health distress or disease. Too often it is the lack of time, the lack of opportunity, the lack of space which staff have recited as a key barrier in their care delivery regardless of the context in which that support is offered.

Piling things on top: creating overload and imbalance

The social care workforce interviewed in this and other studies Scottish Care has undertaken in the last year is a workforce upon which increasing demands are continually placed. To date and with some exceptions it has been a workforce, which despite the challenges, has not yet buckled under the strain. This report suggests that that continued responsiveness and ability to be resilient to increasing demands is coming to an end and has ceased in some areas. It involves all stakeholders to appreciate that the deficits in one part of the health and social care system cannot become the responsibility of another part without an adequacy of resource and prioritisation. The care at home sector in Scotland is now supporting individuals living independently but with increasingly acute and chronic mental and physical health challenges.

The care home sector faced with a huge increase in levels of dependency in the last five years is today supporting individuals with a diversity of high clinical needs which less than a decade ago would have been undertaken by staff in a local hospital. As austerity bites yet further there might be a temptation to depend more on informal carers and care in our communities. Care at local level is under immense stress and pressure and it is a very real risk that any additional stress will bring things tumbling down around us.

Risk of collapse

It is to be celebrated that older Scots are living longer. That brings with it the challenges of co-morbidities and the development of mental health conditions into older age which we have not previously seen to the extent and degree we are now witnessing. It is therefore critically important that there is robust older people mental health support both within an individual's own home and in homely settings. This research has uncovered a number of instances where the integrity of that provision has been undermined by inappropriate diagnosis, by the blanket use of a dementia diagnosis to cover underlying mental health conditions, and the failure to properly assess the mental health needs of older persons, especially those in receipt of social care. Any system of health and care relies on the inter-relationships between the different parts; the integrity of the whole is threatened and challenged where one part of the system is not undertaking its distinctive role and placing inappropriate and unsustainable pressure upon another part.

Unlike the game of Jenga™ where participants can walk away from the table, supporting and caring for the most vulnerable in our communities is not a game. It is a business of immense seriousness that requires appropriate risk taking on the one hand, but also a thorough and thoughtful analysis of the levels of intervention, resource and innovation required to make the whole work.

10. RECOMMENDATIONS

In what follows we offer what we consider, are some of the potential building blocks which will help to stop collapse and to promote the construction of a truly person-centred, rights-based system of care. Such a system has to have at its foundation a workforce who are professionally valued and who in turn give a sense of value and respect to those who are supported.

Building block 1:

Increased recognition of older people's mental health issues as a human rights issue

The absence of a robust recognition and acknowledgement within the *Mental Health Strategy* of the mental health challenges faced by older persons is, as has been stated above, a significant oversight. This research has not only highlighted that such an absence is regrettable but has suggested that there needs to be concerted and collaborative effort to identify the scope of mental health issues facing older individuals in our communities, the interventions and supports which are currently working, and the capacity and ability of the system as it is at present to support well-being. We would further recommend that Integrated Joint Boards should include a specific focus on older persons mental health within their Strategic Plans and that this should be a key priority area for commissioning both within existing and potentially new models of care and support.

This research has illustrated interventions which have brought about positive results and impact. Such interventions emphasise the ability and empowerment of staff to identify developing conditions, support individuals enduring stress and distress and who have the capacity and skills to respond, support and refer. This cannot be achieved under current contractual systems. The right to health includes the right to have one's mental health supported and addressed regardless of the age in which mental health distress and challenges may occur.

Building block 2:

Increased resource to prioritise mental health and well-being amongst older Scots

The findings of the report have highlighted that there are serious issues relating to transition from adult to older people's mental health provision and support. There is a sense of individuals 'falling through the gaps' and of

over dependence being placed on parts of the social care system, notably homecare and care homes. These services are not currently resourced or enabled to meet these increasing and specialist mental health needs. A strategic emphasis on maintaining individuals within the community and encouraging independence must be supported by an adequacy of resource. Scottish Care would like to encourage Scottish Government together with other key stakeholders to initiate an Improvement Plan centred around addressing the distinctive needs of older Scots which would form part of developing existing work around other age categories within the *Mental Health Strategy*. This should be a key component of the focus of health and social care integration over the next period of time.

Building block 3:

Increased recognition of the distinctive contributory role of the social care workforce

Throughout this report the reader will have become aware of the extent to which mental health provision and support is being delivered day in and day out by the independent sector workforce. Put simply the well-being and mental wellness of thousands of Scots is daily the concern and preserve of social care staff.

Faced with current strains on public finances the capacity of care organisations to continue to deliver what they currently do, never mind to innovate to better meet the mental health needs of those being supported is diminishing and declining. Scottish Care believes that home care contracts and any revised National Care Home Contract have to give attention to the essential mental health role currently being undertaken by care staff. In particular we would like to see the development of Guidance to commissioning and procurement authorities which explicates in more detail what this means in practice and that such Guidance should be statutory in nature.

The necessity of reforming current contractual and procurement arrangements has been articulated both in this report and in *Bringing Home Care*¹⁹. We must all work collectively to move beyond an emphasis upon time and task contracting to models which are reciprocal, rights-based, centred around the needs of the supported person, which are relationship focussed and time-flexible. Good mental health support has huge preventative potential which benefits both the individual's personal outcomes and reduces the financial costs for the wider

¹⁹ <http://www.scottishcare.org/wp-content/uploads/2017/05/SC-Bringing-Home-Care-FINAL-LoRes.pdf>



community. However, such interventions cannot be achieved without a degree of initial investment.

Building block 4:

Greater emphasis on multi-disciplinary working

Effective mental health interventions result from an extensive multi-and inter- disciplinary approach where each professional is valued in their role, given appropriate autonomy, responsibility and authority, and where there is a mutuality of respect, understanding and professional knowledge. All too often the critical role of homecare and care home staff is diminished, ignored or marginalised. This research has articulated a clear message and that is that all professionals have to learn to work better together, share more efficiently, develop trusting relationships, value and bestow appropriate authority to all colleagues. This research illustrates what good can look like and we would recommend the establishment of clearly defined tests of change which would model for others how positive mental health outcomes can be achieved. There is a significant improvement challenge here not only for local authorities, IJBs and providers but also for improvement bodies such as the Care Inspectorate and Healthcare Improvement Scotland.

Building block 5:

Encourage organisations to draw up mental health resilience systems for their existing workforce.

The research has highlighted the extent to which the social care workforce is a workforce under acute strain and pressure. This relates both to their ability to support older people in their own mental health distress but also more widely to the increasing demands being placed upon the workforce. As has already been stated we expect so much more from home care and care home staff than we did ten or twenty years ago. Yet whilst expectations may have grown substantially our willingness to recognise increased responsibility and professionalism by increased financial reward has not followed.

We have heard evidence in this report of provider organisations who have engaged in proactive measures to support the mental health and wellbeing of the workforce. These measures have included use of professional counsellors, structured de-briefing sessions, improvements to supervision practice and the development of mental health staff plans. We recommend that providers prioritise their activities in this area. Whilst recognising it may be increasingly challenging to recruit new staff we should all seek to ensure the health and

stability of the staff already working in the sector.

Building block 6:

Greater focus on the needs of those under 65.

Many of those interviewed in this research highlighted the growing number of individuals who are under the age of 65 and who are either being supported at home or in older people's care homes. Scottish Care supports the work of the Sue Ryder's *Rewrite the Future* campaign²⁰ which seeks to ensure the development of appropriate supports for individuals living with neurological conditions. Being supported by home care staff who are not trained or resourced to work with individuals with neurological conditions is not appropriate. Being placed in an older person's care home whilst living with a neurological condition because no other provision exists to cater for your needs is neither appropriate for the individual, for other residents nor for the staff of such care homes.

Whilst we acknowledge the Scottish Government's commitment to develop a strategy around neurological support, this report shows the extent to which more needs to be done to enable those currently being supported in communities and care homes to receive adequacy of care and support in the short term. This involves a focus on the training and development needs of such individuals and a recognition of the particular needs during assessments before individuals are placed or contracts developed.

Building block 7:

Extending mental health and well-being support to the social care workforce

The valuing of the workforce is recognised as fundamental to the enabling of the mental health and wellbeing of that workforce. For some time now significant work has been undertaken in this area, and with notable success within NHS Scotland, most especially through the *Everyone Matters* programme²¹. Scottish Care is aware of discussions to extend this work to all those who are involved in the delivery of integrated care services. We strongly encourage the speedy conclusion of these discussions and the urgent identification of resource to extend the supports of *Everyone Matters* to the social care workforce. The identification and development of a strategy to support the physical and mental wellbeing of the social care workforce is, we would contend, critical to the success of Integration and to the maintenance of the social care system in Scotland. We call upon colleagues

²⁰ <http://www.sueryder.org/how-we-help/policy-and-campaigns/our-campaigns/dont-write-me-off>

²¹ <http://www.gov.scot/Topics/Health/NHS-Workforce/Policy/2020-Vision>



in Scottish Government, COSLA and the Integrated Joint Boards to work with us in achieving this objective.

Building block 8:

Development of specific supports to support the workforce

The ability to develop resilience in the workforce is central to dealing with the stress and distress of care especially as these strains are likely to increase rather than diminish in the years to come. This research has highlighted that there are many coping strategies being adopted by frontline workers and managers to ‘survive’ and cope. More work needs to be undertaken to identify what is considered and recognised as best practice, to address coping mechanisms that may actually be causing additional harm, and to develop adequate support mechanisms around supervision, management and team-leadership which address some of the challenges within this report. There is particular potential in exploring the development of self-managing teams and self-autonomy in the frontline workforce in this regard. Scottish Care wishes to work with other key stakeholders including the regulatory bodies such as the Scottish Social Services Council to develop appropriate supports and resources. In addition it is important that we work collaboratively to ensure that existing registration, regulatory and

qualification mechanisms are sufficiently flexible to and sensitive of the needs for on-going mental health support for the social care workforce.

Building block 9:

Maximising the potential of Self-directed Support

A continual concern in this research amongst those working in our communities and care homes was the extent to which older individuals were being disproportionately disadvantaged in their mental health support compared to those under 65. In no small measure the failure to be adequately supported is a human rights and equality issue. The *Social Care (Self-directed Support) Act* offers very real potential for ensuring the development of innovative and creative supports and services built around the needs of the person and not those of the system, be that the commissioner or the provider. Addressing mental health challenges, both in those who receive support and those who offer it, will significantly be enhanced if there is specific work undertaken to identify the way in which Self-directed Support can support the mental health of older individuals. Scottish Care would encourage Scottish Government to work with us and with appropriate stakeholders in developing support models alongside providers which would specifically identify mental health amongst older Scots as a priority.



11. THANK YOU

Scottish Care would like to sincerely thank everybody who contributed to this report.

This research and the resulting report would not have been possible without the willingness, openness and honesty of the care staff who participated in both the focus groups and the Care in Mind event. Sincere and heartfelt thanks are due to each and every participant. You shared with us emotional, challenging and extremely personal insights and experiences and we hope this report in some way does them justice.

We also want to thank the organisations who supported this piece of research by enabling staff to attend and offering to host the focus groups. We are aware how difficult it can be to release staff, particularly at a time of staff shortage, but your flexibility and involvement in this process are appreciated not only by Scottish Care but

by your staff. Your commitment continues to be a vital element of ensuring the voices of the front line workforce are heard.

We would also like to thank the Scottish Care Local Integration and Improvement Leads who helped to organise the focus groups in their localities, participated in the discussions and captured data. Your support and help, as always, was invaluable and the focus groups would not have been a success without you.

The focus groups were conducted by Becca Gatherum, Karen Hedge, Katharine Ross, Paul O'Reilly and Dr Donald Macaskill.

This report was written by Becca Gatherum, with invaluable support from Karen Hedge, Katharine Ross and Dr Donald Macaskill.

12. ABOUT SCOTTISH CARE

Scottish Care is a membership organisation and the representative body for independent social care services in Scotland.

Scottish Care represents over 400 organisations, which totals almost 1000 individual services, delivering residential care, nursing care, day care, care at home and housing support services.

Our membership covers both private and voluntary sector provider organisations. It includes organisations of varying types and sizes, amongst them single providers, small and medium sized groups, national providers and not-for-profit voluntary organisations and associations.

Our members deliver a wide range of registered services for older people as well as those with long term conditions, learning disabilities, physical disabilities, dementia or mental health problems.

The Scottish independent social care sector, across care home, day care, care at home and housing support services for adults, contributes to:

- The employment of over 102,000 people (over half of the total social services workforce)

- The employment of over 5,000 nurses
- The provision of 89% of care home places in Scotland
- The delivery of over 55% of home care hours for older people.

This report has been produced as part of the Workforce Matters project.

Workforce Matters is the workforce planning & development arm of Scottish Care.

Funded by the Scottish Government, this project:

- Supports independent sector providers to build their capacity for workforce development
- Engages with the workforce at a local and national level to ensure the independent sector can contribute to policy and practice development
- Supports providers to meet regulatory and registration requirements
- Ensures providers are updated with the latest employment and workforce news.



13. APPENDIX 1 - PARTICIPATING ORGANISATIONS

- **Abbey Dale Court Care Home**
- **Abbeyfield House**
- **Abbotsford Care**
- **Abercorn Care Group**
- **Affinity Trust**
- **Avenue Care Services**
- **Avondale Care - Lister House**
- **Bandrum Nursing Home**
- **Bluebird Care**
- **Caledonia Social Care**
- **Cameron Park Nursing Home**
- **Care Concern - Mossview Care Home**
- **Carr Gomm**
- **Carrick Home Care**
- **Cowal Care Services**
- **Crossreach**
- **Crossreach - Wellhall Care Home**
- **Gibson Training & Care**
- **Harmony Care & Support Service**
- **Keane Premier Support Services**
- **Larchwood Care - Kingsgate Care Home**
- **Mariner Support**
- **Mears Care**
- **Northcare - Rosaburn Care Home**
- **Prime Care Health**
- **Sutton Care Solutions**
- **Third Life Care - Northwood House**
- **Thistle Healthcare - Southview Care Home**
- **Windmill House Nursing Home**

14. APPENDIX 2 - RESEARCH QUESTIONS

Session details	Possible prompt questions
<p>Icebreaker: Participants asked to select and discuss one of the following statements in pairs.</p>	<p>Selection of statements to choose from:</p> <ul style="list-style-type: none"> • I feel comfortable talking about mental health • When someone is distressed or depressed I'm not sure if I am much use being there • When somebody is displaying behaviour which is challenging I feel scared • I am comfortable with supporting people who are in mental distress • I feel as if I am reasonably well trained in supporting mental health issues • I get personally very down with the range of emotions I have to deal with at work • I tend to find it easy to switch off after work • I haven't given my own mental health and wellbeing much thought • The job I do has a positive impact on my mental health • My work has given me a better understanding of mental health • The sheer demands of the job make it impossible for me to have 'time' to process all that is happening at work
<p>General working experiences of mental health, focused on the mental health of people they support</p> <p>Small group discussions of up to 5 participants.</p>	<p>Discuss your involvement, if any, caring for people with mental health issues</p> <p>What has your role been?</p> <p>What are you being asked to do?</p> <p>What training have you done?</p> <p>When did this training take place – during induction, on the job, on-line, combination, none at all?</p> <p>Who was involved in the delivery of the training?</p>



<p>Personal explorations: participants asked to share their experiences of their own mental health and wellbeing and how this has been affected – positively or negatively - by the work they do.</p> <p>Small group discussions of up to 5 participants</p>	<p>How did you feel about this – are there any particular behaviours or characteristics you find especially hard to deal with?</p> <p>What are your coping strategies and mechanisms when you feel ‘under pressure’?</p> <p>Do you feel that some elements of work make you more likely to feel depressed, stressed or emotional?</p> <p>Is the sheer workload something which is resulting in your own mental wellbeing being affected? How do you manage this – if at all?</p> <p>Does this experience change as you care and support a person?</p> <p>Do you feel equipped to care for people with mental health issues?</p> <p>Do you think your organisation could do more to support you – emotionally and well as practically? Could other people or organisations perhaps support you?</p>
<p>Looking to the future: group discussions of up to 7, with opportunities to write responses as well as discuss them</p> <p>Group feedback and a facilitated discussion</p>	<p>‘A good mental health and wellbeing experience for people I care for would look like’</p> <p>‘A good mental health and wellbeing experience for me would look like’</p> <p>What needs to change to allow this to happen?</p>

15. APPENDIX 3 - CARE IN MIND STATEMENTS

Delegates were asked to stick post-its next to as many or as few of the following statements as they chose, indicating agreement or disagreement as well as having the opportunity to provide their own comments:

- I feel comfortable talking about mental health
- I haven’t given my own mental health and wellbeing much thought
- The job I do has an impact on my mental health
- The demands of the job make it hard for me to process all that happens at work

- I feel as if I am well trained in supporting mental health issues
- I tend to find it easy to switch off after work
- I have my own ways of coping with the pressures of my work
- I am unable to support the mental health needs of people as well as I’d want to (colleagues or supported people)



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