Mental Health and Addiction Services for Older People and Dementia Services

Guideline for district health boards on an integrated approach to mental health and addiction services for older people and dementia services for people of any age

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Contents

The Guideline in Brief

The purpose of this document is to assist district health boards (DHBs) and the Ministry of Health (the Ministry) in surmounting barriers customarily faced by older people in their interaction with mental health, addiction, disability and chronic conditions services.

This guideline is designed to:

- encourage and disseminate good practice
- achieve greater consistency in the quality of services and the way they are delivered between DHBs
- assist DHBs to make the best use of their existing funding by providing cost-effective models of care.

This document aligns with the Nationwide Service Framework, which includes DHB service specifications and reporting requirements. Where changes are to be made to service specifications, they will be consistent among mental health and addiction, health of older people, dementia and disability service specifications.

Release of this guideline does not signify that additional funding is available. However, by implementing the guidance, DHBs will be better able to respond to their populations' needs cost-effectively.

The need for this work was identified in *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Minister of Health 2006). Development of this document involved engagement with stakeholders from the mental health, addiction, disability, dementia and health of older people (HOP) sectors.

Principal issues of concern identified by stakeholders included:

- barriers preventing people from accessing services, including assessment and treatment by primary and secondary services
- fragmentation and variability in specialist service provision across DHBs
- confusing DHB referral processes, resulting in multiple referrals and duplicate specialist assessments
- significant workforce needs.

The evidence in the literature confirms that:

- under-diagnosis and under-treatment of conditions in older people impose a considerable cost on health services and individuals and their families
- matching defined needs with service delivery in age-appropriate environments delays dependence and improves outcomes for older people
- integration and collaborative practices, such as joint assessments and care planning and shared clinical pathways, enhance services
- developing workforce capacity and capability strengthens services' viability.

Stakeholders agreed on the following strategies for addressing the identified issues.

- Raise awareness of problems associated with mental health, addiction and dementia in older people.
- Minimise barriers to accessing services by streamlining referral and triage processes.
- Implement an integrated system of care and support based on the seven-tiered model (Brodaty et al 2003; Draper et al 2006).
- Focus on initiatives to recruit, retain and train the workforce to better meet the needs of older people with mental health and addiction problems, and people of any age with dementia.

Recommendations

1. Adoption of guiding service principles

All DHBs will adopt the guiding service principles outlined in chapter 3 of this document in order to achieve consistency and quality in service delivery.

2. Services based on need, not age

a) Service specifications will be amended to ensure that older people are not excluded from mental health and addiction services because of their age.

b) Service specifications will be amended to allow flexibility in defining the age (which may be younger) at which people with similar mental health and addiction needs can access services.

c) All services will comply with the amended Nationwide Service Specifications stating that older people will not be excluded from services because of their age.

d) Mental health and addiction services will not exclude eligible people on the basis of underlying (physical or intellectual) disabilities or chronic health conditions where the presenting issue is related to a mental illness.

e) Primary mental health programmes and services will not exclude older people because of their age.

f) The National Depression Initiative will ensure that older people are not excluded from access to help with depression.

3. National consistency in service delivery and data collection

a) The service coverage document will be amended to ensure that people with serious Behavioural and Psychological Symptoms of Dementia (BPSD) are able to access appropriate services from mental health and addiction services.

b) By 2012, all DHBs will adhere to the revised mental health and addiction service specifications for purchasing and delivering mental health and addiction services.

c) All DHBs will use HoNOS 65+[1] and report to PRIMHD (Programme for the Integration of Mental Health Data) according to the file specification.

1 www.tepou.co.nz/-page/598-Outcome-Measures+HoNOS-and-other-recommended-measures

d) All older people accessing health services will be assessed with interRAI tools as available.

e) All DHBs will use the seven-tiered model presented in Chapter 3: Guideline for an Integrated System, of this document to guide funding and service planning decisions.

f) All providers will use recognised tools for assessing mental health and addiction problems among older people and dementia among people of any age.

g) Consistent with MHOP services Tier 2 service specifications, DHBs will plan and implement co-location and integration of their MHOP and HOP services.

h) DHBs will support the further development and consolidation of regional dementia (any age) behavioural support and advisory services.

4. Workforce development and clinical leadership

a) DHBs and the Ministry of Health will collaboratively establish regional and national networks.

b) DHB workforce plans will incorporate workforce training requirements relevant to mental health and addiction among older people and relevant to dementia.

c) DHB workforce plans and training programmes for staff will incorporate cultural competencies appropriate to the population being served.

d) Ministry of Health workforce contracts will include cultural competencies enabling the workforce to better respond to the mental health and addiction needs of older Māori people and Māori of any age with dementia.

e) Ministry of Health workforce contracts will include cultural competencies enabling the workforce to better respond to the mental health and addiction needs of older Pacific people and Pacific people of any age with dementia.

f) Consistent with Health and Disability Service Standards, providers will ensure that their staff have access to appropriate training. This will be monitored by audit agencies and/or DHBs.

g) DHBs will work with industry training organisations to further develop generic dementia-specific training units as part of the workforce's core training.

h) Health Workforce New Zealand will lead workforce development for primary health care practitioners in mental health and addiction and dementia, to enhance care and management at that level.

1 Introduction

Purpose of the guideline

This document is designed to guide district health boards (DHBs) and the Ministry of Health (the Ministry) on how to achieve an integrated approach to surmounting barriers often faced by older people in their interaction with services for mental health, addiction, disability and chronic conditions. It is also to ensure that such services meet the health and support needs of:

- all people affected by dementia
- people aged over 65 years affected by mental health and/or addiction problems
- people with an intellectual disability who are ageing and developing symptoms of dementia or mental health or addiction problems
- family, whānau and carers of the people identified above.

Background to the guideline

This document fulfils a requirement within *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Minister of Health 2006), which committed the Ministry and DHBs to:

- develop a policy framework for older people's mental health and addiction services
- increase access to specialist mental health and addiction services for older people
- develop national consistency in data collection on older people's access to mental health and addiction services
- build the capacity of the mental health sector to support 'ageing in place'.[2]

The *Health of Older People Strategy* (Minister of Health 2002) proposed that an integrated approach be taken to the provision of health and disability support services, to ensure that they are responsive to older people's varied and changing needs over time, and provide a continuum of care. The Strategy placed the individual at the centre of the care model and required that seamless service delivery models be applied across a variety of settings, including hospitals, residential aged care services, primary health care services, community health services and disability support services.

The *Guideline for Specialist Health Services for Older People* (Ministry of Health 2004b) supports the *Health of Older People Strategy*. The Guideline's key objectives include implementing integrated approaches to care, building multidisciplinary care teams and strengthening collaborative provider relationships in the sector.

'Better, Sooner, More Convenient' (BSMC) health care is a Government priority, and significant changes to primary health care structures are under way. This policy includes the establishment of integrated family health centres (IFHCs).

During the development of this guideline, the Minister of Health launched Alzheimers New Zealand's *National Dementia Strategy 2010–2015*. This strategy sets out eight goals including early diagnosis, support for family and carers, and workforce development.

2 Actions 2.14–2.17 in *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Minister of Health 2006).

Other relevant strategies and plans include the following.

- *Blueprint for Mental Health Services in New Zealand: How things need to be* (Mental Health Commission 1998)
- *New Zealand Disability Strategy: Making a world of difference – Whakanui Oranga* (Minister for Disability Issues 2001)
- *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan* (Minister of Health 2005)
- *Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015* (Ministry of Health 2008c)
- *New Zealand Carers' Strategy and Five-Year Action Plan* (Ministry of Social Development 2008).
- *Mental Health and Addiction Action Plan 2010* (Ministry of Health 2010a).

What the guideline provides

The guideline is structured as follows.

- Chapter 2 provides some context, identifying issues of concern and establishing the prevalence of mental health and addiction problems among older people and dementia.
- Chapter 3 proposes guiding principles and a seven-tiered service model to address the issues.
- Chapters 4 to 11 outline what the proposed framework requires of particular service types.
- Chapter 12 discusses workforce requirements.
- Chapter 13 presents recommendations for implementing the proposals presented in the guideline.

2 Context

This section provides a brief description of:

- concerns regarding services for dementia and the mental health and addiction problems of older people
- the demographic context
- the prevalence of dementia and mental health and addiction problems among older people.

Key issues

Older people failing to receive the treatment they require

As they get older, people experience health and social problems that may be related to ageing. Such problems can often be prevented, or their progression delayed. In many cases people can benefit from treatment, particularly through early diagnosis and intervention. Under-recognition and under-treatment of problems among older people imposes considerable cost on health services as well as on the individual and their family, whānau and carers. Evidence has shown that healthy lifestyles reduce the likelihood of a person developing dementia. It has also shown that treating a mental illness such as depression in older people is as effective as treating depression in younger adults. However, for a number of reasons, many older people currently do not receive the treatment they require (eg, Karlin and Fuller 2007).

Lack of services and service development

A lack of services and service development in both primary and secondary mental health care targeting the needs of older people is thought to contribute to under-recognition and under-treatment. The number of available acute beds and day hospital places for specialist mental health and addiction services has reduced over time, which is consistent with a trend toward more community home-based care. However, there has not been a comparable increase in community-based mental health and addiction services (Melding and Osman-Aly 2000; Melding 2005). Nationally, development of specialist community-based services for mental health and addiction among older people has generally lagged behind service development for younger people.

Different structures and funding streams within DHBs

Some people, and particularly those aged under 65 years who have dementia, have had difficulty accessing appropriate services due to their age or to an intellectual disability. Across different DHBs specialist services for older people are being funded from different funding streams. Most North Island DHBs fund specialist mental health of older people (MHOP) services from their mental health funding streams, while other DHBs fund such services from their 'disability support services for older people' funding stream. Services for people affected by dementia are funded predominantly from HOP funding streams but in some cases may be funded by mental health streams. The different funding streams appear to be influencing levels of access, resources and service. This complex situation has also made it difficult to make comparisons regarding the funding deployed and the services provided by different DHBs.

Workforce gaps

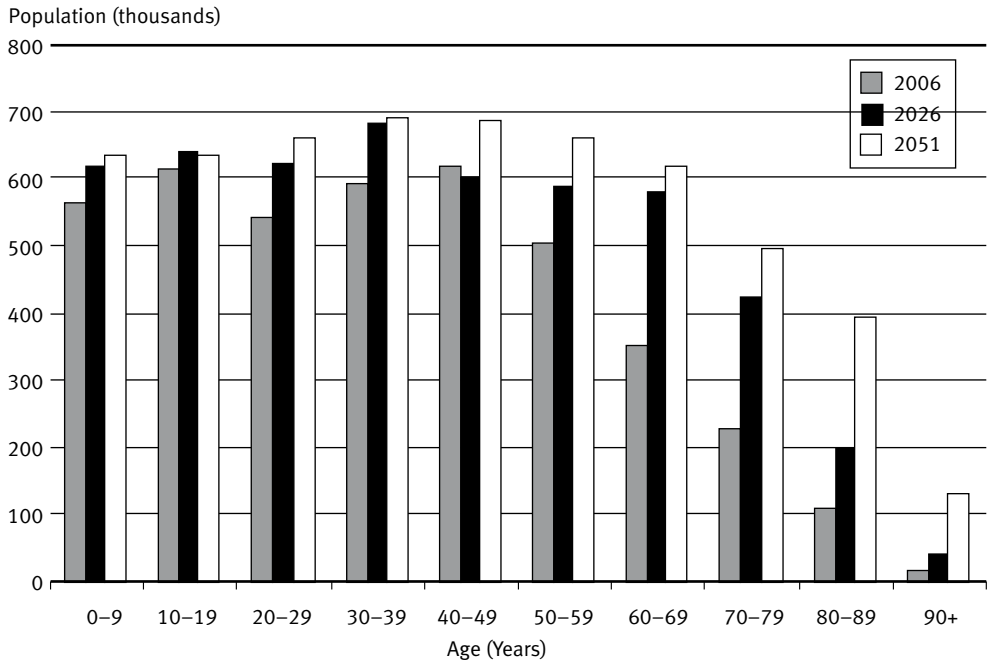
This project has identified a number of concerns relating to the workforce caring for older people and people of all ages with dementia, including:

- workforce retention and recruitment
- the need to provide training and development opportunities for the existing workforce
- the need to plan for changing demographics.

Demographic context

The number and proportion of people in New Zealand aged 65 years and over is increasing rapidly. As Figure 1 shows, the number of people aged 85 years and over will grow significantly by 2051.

Figure 1: New Zealand population by age group for the years 2006, 2026 and 2051 (projected)



By 2026 almost 18 percent of the total population will be aged over 65 years. Though people of New Zealand European and 'Other' ethnicities will continue to account for the largest proportion within this group, the proportion of older people is expected to increase among all ethnicities. This is particularly true for Māori, among whom the proportion of the population over 65 is projected to more than double from 4 percent in 2006 to 9 percent in 2026. Over the same period, the proportion of Asian people over 65 is expected to grow from 5 to 11 percent, and of Pacific people over 65, from 4 to 6 percent of that population (Statistics New Zealand 2010).

People are living longer generally, including, it is particularly noted, people with an intellectual disability. Women continue to live longer than men.

Prevalence of mental health problems

Te Rau Hinengaro: The New Zealand Mental Health Survey, which did not survey residents in hospital or assisted living facilities, assessed the 12 month prevalence rate of 'serious mental disorder' for people over 65 at 1.1 percent, and of 'any mental disorder' at 7.1 percent (Oakley Browne et al 2006). A 2007 Australian survey found a 'mental disorder'[3] among 14.5 percent of adults aged 65 to 85. (Australian Bureau of Statistics 2008). Neither survey included dementia among their diagnostic categories.

As the population ages, the number of older people experiencing mental health problems, addiction or dementia is expected to increase. There is evidence to suggest that the 'baby boom'[4] generation already has a higher rate of mental disorders than the current generation of older people.

Elliot (2002) noted that prevalence rates of mental disorders among people living in residential care facilities were much higher than those among the general population. This observation has been supported by other evidence, one United Kingdom study suggesting that rates of mental illness among rest home residents were as high as 80 percent, and that up to half of those entering a rest home had a mental health problem that was undiagnosed on entry and remained undiagnosed (Moyle and Evans 2007).

Māori have higher overall prevalence rates of mental disorders, and are 1.7 times more likely to develop a mental disorder at some time in their life than people of other ethnicities. The disparity in substance use disorders between Māori and others is particularly marked: Māori are at least three times more likely to experience such disorders (Oakley Browne et al 2006).
Māori also have higher rates of risk factors for dementia and other age related conditions, including cardiovascular conditions, depression, head trauma and substance use disorders. The higher prevalence rates at younger ages of 'age-related conditions' not only contribute to a lower life expectancy among Māori but act as common contributing factors to psychogeriatric disorders. Rates of cardiovascular conditions are also disproportionately high among Pacific people, contributing to a shorter life expectancy than the general population.

Elevated rates of depression have been found among younger and older Chinese migrants in comparison with the general population. Older Asian New Zealanders reportedly experience significant problems with access to and appropriateness of health services.

In addition, people for whom English is a second language, such as some Pacific people, migrants and refugees, may face challenges to mental health and wellbeing. These can arise as a result of communication difficulties, pre-migration experiences, the stresses of living in an alien culture, limited knowledge of or access to the health system, under- or un-employment, or disrupted family and social networks. As these groups age, DHBs will need to ensure that they are able to access effective and culturally competent services.

3 Includes 'Affective', 'Anxiety' and 'Substance Use' disorders over the previous 12 months.

4 Roughly speaking, the 'baby boom' generation comprises people born between 1946 and 1964.

Depression

Depression affects 15–20 percent of older people, and is the most common mental disorder for that age group. Severe depression affects about 3 percent of older people, and is the most common cause of suicide in older people. Depressed older people are at increased risk of developing chronic disease, and people who suffer from chronic disease are more likely to become depressed.

Delirium

Delirium is a temporary medical condition closely related to an underlying physical illness or health trauma, and can be life-threatening. It may affect up to 25 percent of older people (Royal College of Physicians; British Geriatric Society 2006). Delirium may result in a range of psychiatric and behavioural changes that can potentially contribute to misdiagnosis.

Mental illness and intellectual disability

Studies suggest that there may be a greater prevalence of mental illness among adults with an intellectual disability than among the general population (Chan et al 2004). However, there are differing views on the association between mental illness and intellectual disability. One study found that mental illness was more commonly experienced by adults with profound intellectual disabilities (Cooper et al 2007). Another found that mental illnesses – particularly anxiety, depression and psychosis – were far more prevalent among people with moderate intellectual disabilities than among those with severe and profound intellectual disabilities (Holden and Gitlesen 2004).

Dementia

Dementia is a progressive neurological disorder affecting the brain, resulting in a deterioration of cognitive functioning. It affects a person's language, memory, personality, perception and cognitive skills. The more common causes of dementia include Alzheimer's disease (accounting for 70 percent of all dementias) and vascular disease. There are also other causes, such as combinations of Alzheimer's and vascular disease, Lewy bodies, fronto-temporal dementia and Parkinson's disease (Haan and Wallace 2004). Stroke increases the risk of dementia, as does severe head injury in early adulthood.

In 2008, approximately 40,746 New Zealanders (1 percent) were living with dementia. Of these, 60.2 percent were women. Age is a recognised risk factor for dementia. Around 95 percent of dementia sufferers are 65 or older.

By 2026, it is projected that 74,821 or 1.5 percent of New Zealanders will have dementia, and this proportion is expected to continue to grow. The proportion of people living with dementia who are Māori is expected to increase from 3.6 percent in 2008 to 5.8 percent by 2026. The number of people under 65 with a dementia diagnosis is also expected to continue to grow. (Alzheimers New Zealand Inc. 2008).

Dementia and younger people

Dementia does affect younger people: in New Zealand, 2–3 percent of people under 65 years of age are affected by dementia. The types of dementia experienced by younger people vary, but are more likely to be fronto-temporal dementias, with alcohol-related dementia accounting for around 10 percent of cases (Perkins 2004).

Dementia and intellectual disability

People with Down syndrome are at greater risk of developing dementia than other people; they also present with symptoms of dementia at an earlier age than the general population. Prevalence findings vary considerably. Coppus et al (2006) found an overall prevalence of dementia of 16.8 percent among a large sample of people over 45 with Down syndrome, but numerous studies have found symptoms or evidence of Alzheimers among people with Down syndrome at very high rates (ie, more than 50 percent for those 50 + years, and 75 percent for those 60 + years) (Torr and Chiu 2002).

Another study found dementia among 22 percent of a community-based population of older people with intellectual disability *not* due to Down syndrome. This was four times the rate in the age-matched population (Torr and Chiu 2002).

Older people with intellectual disability and dementia have also been found to have high rates of physical impairment and disease (Cooper 1999).

Alcohol and other drug (AOD) disorders

AOD disorders (including alcohol-related dementia) will become more prevalent among older people as 'baby boomers' enter old age (Gupta and Warner 2008). A United States study (Bartels et al 2005) suggests there is problem drinking in that country among 15–19 percent of older people. The prevalence of substance abuse among the older age group is expected to increase, and more people are expected to seek treatment. Co-morbidity of mental disorders and substance abuse is common: 20 percent of older people receiving outpatient mental health services and 37 percent receiving inpatient mental health services also have a substance use disorder. Unreported substance use also increases the risk of negative interactions with medications.

In the New Zealand context, Khan et al's 2002 study found a high prevalence of hazardous patterns of alcohol consumption among older people in the community. A significant proportion reported patterns of alcohol consumption that put them at risk of future damage to their physical or mental health. The cohort in this study represented a group who were raised during the 1950s and 60s, in a social climate of increased use of and addiction to heroin, cocaine, tobacco and alcohol. Histories of substance dependence and continued use among this cohort will have physical and mental health consequences as it ages (Oslin 2005).

Risk of falls

One European study (Panneman et al 2003) found that injuries from accidental falls were significantly associated with benzodiazepine use, especially in those aged over 85 years. This study proposed discontinuing prescriptions of benzodiazepines for older people, or substituting them with other drugs not associated with the risk of falls.

3 Guideline for an Integrated System

This section outlines guiding principles and an evidence-based best practice approach for the delivery of an integrated range of services to meet current need.

Guiding principles

People have the right to be treated with respect, dignity and empathy without judgement; to be supported to retain as much autonomy as possible; and to access the most appropriate services to meet their needs in the least restrictive environments possible. To achieve quality and consistency in service delivery, all services need to apply a common set of principles. The service principles listed below will be attached to the revised specialist service specifications published by the Ministry of Health for mental health and addiction, and mental health of older people services.

These service principles are consistent with World Health Organization principles (WHO and World Psychiatric Association 1997), which are widely used internationally. They have been reshaped to reflect the New Zealand context.

Services should be:

- **comprehensive**: services consider the individual and their needs holistically in a person-centred and family-inclusive way
- **accessible**: services minimise barriers to accessing required care
- **responsive**: services act promptly, sensitively and appropriately when responding to a wide range of service user needs
- **individualised and personalised**: services are person-centred and seek to support the individual within their own personal context, including culture, spirituality, family and whānau, and where possible, in their own home environment
- **interdisciplinary**: services recognise and utilise a range of skills and expertise across agencies to better meet the individual's needs
- **accountable**: services accept responsibility and accountability for those people within their care
- **integrated and continuous**: services work in a connected way, flexibly, to best meet the needs of the individual and provide seamless continuity of care.

An integrated service user pathway

Services should co-ordinate to provide seamless delivery of care across the entire range of services and continuity of care as time passes. Primary health care is the first point of contact for older people who have mild to severe mental health symptoms. Primary health services should make referrals to specialist services using appropriate guidelines and screening tools. To ensure patients' smooth transition from one level of care to another, (and back again), primary, secondary and tertiary health care should be bridged through consultation, liaison and advice overseen by a specialist interdisciplinary team.

Ensuring smooth transitions is also one of the aims of 'Better, Sooner, More Convenient.' Integrated Family Health Centres will improve efficiency and effectiveness by enabling:

- better integration between primary and specialist mental health and addiction services (including increasing secondary care contact at primary care locations)
- co-location and better integration among primary health organisations, non-governmental organisations (NGOs) and agencies outside the health sector

- better co-ordination of care for people with complex or long-term physical and mental health problems
- better co-ordination of care for families with high needs.

Access to a pathway based on need

People should be able to access a range of services that meet their mental health and addiction needs, regardless of age (Minister of Health 2005) or intellectual disability. This principle applies to people:

- aged 65 and over who experience a mental health or addiction problem for the first time
- aged 65 and over who have experienced a mental health or addiction problem but have not been in contact with services for an extended period of time
- aged 65 and over who have long-term mental health or addiction problems
- who develop dementia at any age
- of any age with an intellectual disability who develop symptoms of dementia or mental disorder
- who age with a chronic health condition, organic brain disorder or brain injury and develop symptoms of dementia or mental disorder
- who have any of these conditions and a physical disability
- for whom English is a second language.

Specialist adult mental health services are expected to provide specialist services to people aged 18 years and over, including older people who have been under the care of the service, wherever there is clinical need. People with an intellectual disability and mental illness or symptoms of dementia who are under 65 should be treated by these services, unless they have accelerated frailty or age-related conditions. Such services should undertake regular reviews of their patients' needs and, when necessary, make referrals to other appropriate services, including age-related services.

Specialist mental health services for older people are expected to provide specialist services (including assessment, consultation and liaison) to meet the needs of people over the age of 65, with some flexibility in providing for those of any age experiencing serious behavioural and psychological symptoms associated with dementia and those with increased need caused by premature ageing or frailty.

A shared pathway – responsibilities

The roles and responsibilities of specialist mental health services and specialist HOP services in New Zealand need to be more clearly defined. Specialist secondary and tertiary health care providers should work in partnership (being co-located wherever practicable), should foster effective clinical relationships, and should provide joint assessments and interventions where appropriate. Alternatives to the traditional consultation-referral model of care, such as liaison models, team or individual case review models, and clinician training models, should be considered. DHBs are responsible for ensuring that no gaps exist for patients with these clinical needs.

Funding and management pathways vary greatly from region to region. DHBs are not expected to conform to the same model, but rather to establish clear guidelines for how service users will access required services in the region. DHBs should develop criteria for the division of

responsibility between specialist services. These criteria should be made available to services, other agencies and service users and should be known and accepted within and outside the DHB.

When mental health data is collected according to the file specification for HoNOS 65+,[5] DHBs can produce information to meet their own needs. The data can be used, for instance, to monitor problems related to dementia, particularly cognition. The eight standard outcome reports produced by the Ministry of Health and Te Pou can assist DHBs to understand how the information can be used in service development and improvement.

The care of older people with dementia falls to HOP services, but mental health services have a clear responsibility for assisting the other services by providing expert assistance and treatment for those people with dementia who also have BPSD.

Not all people with dementia need ongoing specialist mental health services. However, there are advantages to specialist mental health services maintaining responsibility alongside specialist HOP services for some of the needs of people with dementia. This shared responsibility requires clearly defined planning, liaison and advisory services covering consultation, clinical assessment and treatment; and may also include responsibility for support and intervention specifically related to the early progression of dementia, or inhibiting that progression.

It is essential that services to people with early-onset dementia, including alcohol-induced dementia, be accessible and effective. Establishing dementia as a partial responsibility of mental health services is likely to be of particular benefit to people with dementia who are under 65 years old, including those with co-occurring intellectual and other disabilities.

Many people with dementia or older people with mental illness have disability support/personal care needs. Service response times and outcomes could be improved with structured pathways clearly identifying how services are jointly accessed, and strong lines of communication between NASC needs assessors/service coordinators and DHB staff.

The seven-tiered model of care

The seven-tiered model of care outlined in Table 1 has been adapted from the model developed by Brodaty, Draper and Low (Brodaty et al 2003; Draper et al 2006), and provides a framework for the funding and delivery of a range of services to meet levels of need. Within the model, service types are matched with particular needs among patients, ranging from 'no mental disorder or dementia' to 'extreme mental disorder'.

The model is intended to assist with service planning, funding and delivery, not to prescribe a limit to provider configurations. People being treated at higher tiers may benefit from providers positioned at the lower tiers as well, for example, primary care and mental health promotion.

5 Health of the Nation Outcome Scales for those 65 and over: www.tepou.co.nz/page/598-Outcome-Measures+HoNOS-and-other-recommended-measures

Table 1: The seven-tiered model of care

Tier level	Focus	Patients to whom focus applies	Health care provider
Tier 1	Mental health promotion and disease prevention	People with no mental disorder or dementia	Primary health care (managing) Health promotion providers Local community councils
Tier 2	Targeted mental health prevention and promotion for at-risk groups	People presenting with risk factors for mental disorders and dementia without behavioural and psychological symptoms of dementia (BPSD)	Primary health care (managing) Health promotion providers Disability support and service providers
Tier 3	Assessment, early intervention and treatment	People with mild mental disorders or mild BPSD	Primary health care (managing) Disability support and service providers Health of Older People (HOP) services
Tier 4	Assessment, early intervention, treatment and case management	People with moderate mental disorders or moderate BPSD	Shared care: primary health care providers and specialist services, with support from disability service providers and/or HOP services
Tier 5	Assessment, treatment and case management	People with complex mental disorders or BPSD with complications such as aggression or agitation	Specialist services Case management by community MHOP services in collaboration with aged residential care (ARC) facility and/or disability service providers and/or HOP services
Tier 6	Assessment, treatment and case management	People with severe mental disorders or severe BPSD	Specialist services (specific acute mental health unit or dementia unit within ARC facility) with support from disability service providers and/or HOP services
Tier 7	Assessment, treatment and case management	People with extreme mental disorders	Specialist services (specialist unit with intensive care) with support from HOP services

In this model, there will always be fewer people being treated at the higher tiers. People move from one tier to another as their needs change; for example, once disruptive behavioural and psychological symptoms of dementia (BPSD) has been addressed at a high tier, a person is often better managed at a lower tier.

Dementia Behavioural Advisory Services should map services in their region according to the seven-tiered model. The objectives are to a) identify clear clinical pathways for each of the major mental health conditions affecting older people and b) identify gaps and duplication throughout the region.

4 Services for Māori

Whānau ora – Māori families supported to achieve their maximum health and wellbeing – is the Government's vision for Māori health. Whānau ora is also the broader vision of *Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015* (Ministry of Health 2008c).

Older people are highly valued by Māori. Health care providers should recognise them as contributors to whānau wellbeing, and not just recipients of care. Māori honour kaumātua (elders) because of their whakapapa, abilities and experience; they are the inspiration and driving force enabling kaupapa Māori service development and delivery.

A recent study of 33 kaumātua aged between 75 and 79 (Dyall and Kerse 2009) found that for the majority, being in their own homes in a familiar marae-based environment and being able to contribute to their community while pursuing their own interests engendered a strong sense of wellbeing. Most had children, grandchildren and great-grandchildren in whose lives they were involved as mentors, guardians and elders. Two-thirds of participants were involved in voluntary work, and just under one-third were in paid work. A larger study[6] is now being undertaken that will enable a better understanding of the needs and include the views of Māori in policies being developed for an ageing population.

Māori health services based on whānau ora models have been rapidly developing to meet local social and health needs. It is estimated that about 240 primary health provider organisations currently identify as Māori. These services, and the implementation of whānau ora principles, are expected to continue to develop as new evidence for good practice emerges. A recent research report commissioned by the Ministry of Health (Mauriora ki te Ao 2009) outlines Māori provider development to date and gives examples of whānau ora-inspired innovative programmes, including for kaumātua.

While Māori providers are diverse, they tend to share a common set of attributes that have a positive impact on the health of kaumātua, including the following:

- Services are based on the values and principles of tikanga Māori.
- Priorities are locally determined to best match need: for example, some services are marae-based, while others are delivered as urban kaupapa services.
- Services enshrine a holistic approach, taking into consideration both the health and the social needs of older people and their whānau.
- Providers aim to meet the needs of the whānau overall, so their access criteria is typically not based solely on specific age or disability criteria.

Initiatives designed by Māori providers to support older Māori people encourage participation (for example through kaumātua groups and programmes). They recognise and support the contributions of their community.

Prevention and early intervention are promoted through the creation of trusting relationships between the provider, whānau and older person, for example through the establishment of informal groups for exercise and other shared activities. Programmes to improve awareness, prevention and management of chronic conditions (such as asthma, diabetes and heart or lung disease) are priorities for Māori providers.

6 LiLAC (Life and Living in Advanced Age) study, Te Puawaitanga o Ngā Tapuwae Kia Ora Tonu, 2010–2013, aims to interview 600 Māori aged 80 to 90 years, alongside an equal number of non-Māori aged 85 years.

Specialist nursing and other clinical interventions in the home, marae and community must be provided to enable Māori to age in place and defer residential placement or hospital admission. Practical support can include kaumātua housing at the marae, assistance with transport, home visits, kaupapa day programmes and strategies to address the support requirements of whānau caregivers.

Not all older Māori have access to whānau support, and not all whānau support can prevent the need for residential or hospital care. Research is needed on the mental health and addiction service preferences of older Māori who can no longer be safely supported in their own or whānau homes.

There is a need for more research on Māori views of policy and service development catering for Māori with dementia and with severe and chronic mental health conditions.

Key points

- Whānau ora service delivery models allow Māori to address the health and social needs of Māori within their own social settings.
- Māori health services based on whānau ora models have been rapidly developing to meet local social and health needs.
- Service development for older people should be inclusive of Māori needs and views.
- Research is needed on Māori views of policy and service development catering for Māori with dementia and with severe and chronic mental health conditions.
- Research is needed on the mental health and addiction service preferences of older Māori who can no longer be safely supported in their own or whānau homes.

5 Mental Health Prevention and Promotion

Mental health promotion and disease prevention, Tier 1 on the seven-tiered model, is an important part of the spectrum of mental health services. It includes prevention of substance addiction and dependence, early identification of substance misuse, and promotion of physically and mentally healthy lifestyles.

Mental health promotion acknowledges that mental health entails more than the absence of mental illness, and that strategies are required that foster supportive environments and individual resilience. Mental illness prevention aims to prevent specific mental disorders, although in practice promotion and prevention are interrelated. There are social and economic benefits associated with prevention programmes, such as a reduction in demand on secondary services in the longer term and an improvement in quality of life among individuals and their families.

Determinants of mental health include: access to work, education and housing; freedom from violence and discrimination; supportive relationships and social inclusion; and individual factors such as coping skills, problem-solving skills and genetic and biological factors. Stigma attached to mental health issues can create aversion to seeking help, particularly among today's older generation.

Factors that may affect the mental health of older people include:

- absence of employment
- deterioration in physical health or ability
- chronic or recurring pain
- caring for someone with dementia or someone who is becoming frail
- changing environments
- a sense of loss of social networks, purpose or independence
- bereavement on the loss of significant others
- loneliness and social isolation
- facing the end of life: dealing with death and dying (Cattan and Tilford 2006).

Interventions that evidence has shown to be effective or promising in combating these factors include:

- physical exercise programmes
- social support and activities
- home visits
- volunteering
- early screening and intervention in primary care settings
- programmes using life review techniques (Cattan and Tilford 2006)
- attention to spiritual needs (Lawrence and Head 2009).

Many of the modifiable determinants of mental health lie outside the influence of the health sector; other government and non-government organisations (such as Age Concern) contribute significantly to addressing these determinants.

Within the health sector, mental illness prevention, anti-stigmatisation and health promotion programmes and services may be provided through public health units at DHBs, through NGOs, through primary health providers and Māori providers, and through the Ministry of Health. Programmes and services for people with dementia are available via organisations such as Alzheimers New Zealand.

DHBs and health providers work in partnership with the NGO sector to support social engagement and ageing in place, preventing or delaying disruption of older people's social networks and place in the community. Close collaboration and active communication among all of these organisations is crucial.

6 Primary Health Care

Primary health care providers are engaged at Tiers 2, 3 and 4 of the seven-tiered model. Primary health care providers are often the first point of contact for older people experiencing a mental health or alcohol or drug problem and people of any age with dementia, and provide vital early diagnosis, disease management and support in addition to treatment and referral.

Key issues

In primary health care, mental health problems can sometimes go undetected, be misunderstood, or be dismissed as part of normal ageing or disease progression. Complicating detection is the fact that older patients sometimes hesitate to signal their need for mental health treatment. As a result, many disorders can go untreated (Karlin and Fuller 2007, National Health Committee 2007). In New Zealand, stakeholders report that dementia is also often overlooked, and that early diagnosis of dementia may require discussion with a patient's primary caregiver.

The consequences of untreated mental health or addiction later in life are serious, and can include:

- increased risk of mortality – depression is as much a risk factor for death among older primary care patients as cardiovascular disease and diabetes
- poorer health outcomes – the risk of developing an initial cardiac event is twice as high among depressed older people as it is among those not suffering from depression
- greater use of medical services and significantly higher costs, even after controlling for severity of chronic medical illness
- increased disability – depression accelerates disability in dementia patients and leads to earlier placement in residential care
- reduced compliance with treatment (Karlin and Fuller 2007).

Overseas evidence suggests that when primary health care providers do detect psychological problems, they tend to rely more on pharmacotherapy, and are much less likely to refer older patients than younger ones for psychotherapy (Karlin and Fuller 2007), although psychological treatment can benefit older people as well. Stakeholders note also that primary providers need timely, local publicly funded psychotherapy services to be available for their older patients in order to make referrals.

Service requirements

The primary health care workforce requires adequate training in mental health, addiction and dementia and how they impact older people in order to identify and respond appropriately. Many but not all New Zealand general practitioners are trained in mental health issues for older people. There is currently no requirement for such training. There are opportunities for incorporating these topics into initial and continuing professional development programmes. The guide *Talking Therapies for Older Adults* provides an overview of key principles and methods for engaging older patients in a therapeutic approach, and approaches that have been developed for people with dementia.[7]

7 Developed by Te Pou and the Royal Australian and New Zealand College of Psychiatrists: www.tepou.co.nz/page/120-Publications

Primary health care providers should be aware of the illness prevention and health promotion activities that occur in their localities, and promote participation among their patients. Providers should also make themselves familiar with the health, disability and social services available for older people in their area.

Primary health care providers should undertake regular holistic reviews of the physical and psychological wellbeing of older people, and of older people who are caring for a family member. Disability NGOs and support providers are available to assist primary providers with such a routine.

Primary health care providers need to be able to assess the urgency of older people's need for mental health care, and the type of care that is required, by conducting comprehensive, holistic assessment. This may include the use of:

- the General Health Questionnaire
- the Geriatric Depression Scale
- the Centre for Epidemiological Studies Depression Scale
- the Beck Anxiety Inventory – Primary Care
- the Brief Risk Identification of Geriatric Health Tool (BRIGHT)
- Folstein's Mini Mental State Examination for cognitive impairment.

The first three tools listed above have been validated for use with a range of ethnic groups. Assistance with adapting such tools for use with people with a range of communication needs due to physical, cognitive or sensory disabilities is available from disability organisations.

Duplication should be kept to a minimum, and ideally tools and screens will be aligned across the age spectrum, to assist clinicians and others to obtain consistent longitudinal information. Arriving at a set of tools for common use would be a useful objective of a national clinical network.

Primary health care providers need to pay greater attention to detecting and treating addiction among older adults, particularly those with chronic health problems. This can have an effect on the prevention or treatment of other health issues (for example, falls in older adults can be the result of alcohol problems or drug interactions).

Identifying and treating depression in older people significantly reduces their risk of suicide (Bruce et al 2004). It has also been shown that treating depression in older people diagnosed with another chronic condition, such as arthritis, will improve their functional status and enhance their quality of life (Lin et al 2003).

Both psychological and pharmacological interventions may be used to treat older people. Psychological treatments can help to reduce problem behaviour, and/or improve cognition among people experiencing dementia.

Shared care

The aim of 'Better, Sooner, More Convenient' is to achieve 'single system, personalised care'. This is expected to be achieved through the development of new service delivery models, such as IFHCs, that focus on:

- the devolution of some specialist services to primary care
- better integration between primary and secondary services, and between primary health care and social services

- more personalised care
- stronger support for self-care
- in particular, better co-ordination of care for people with multiple chronic conditions, and families and whānau with high needs.

The success of the shared care approach will depend to some extent on the use of agreed tools, consistent data collection and national information sharing. Recommendations to support this are included in this guideline (see Chapter 13).

The new primary health care environment will foster better coordination and integration of mental health and addiction services within multidisciplinary primary health care teams and closer links with specialist mental health services. Uncomplicated dementia will be managed in the primary health care setting using a multidisciplinary approach, just as, increasingly, chronic conditions are managed. This may require the inclusion of specialist organisations, for instance, those knowledgeable about dementia or intellectual disability, in the multidisplinary team.

The further development of primary mental health care, incorporating a greater element of collaborative care (for example, through care management or by engaging the services of a primary mental health coordinator based in the same clinic as a general practitioner), may be of particular benefit for older adults. Collaborative care has been shown to:

- increase treatment rates
- improve physical functioning
- lead to more sustained symptom improvement
- produce greater treatment satisfaction
- double the effectiveness of treatment for depression among older primary health care patients (Doughty 2006; Karlin and Fuller 2007).

Primary Health Organisations, Integrated Family Health Centres and other provider organisations will have contracts for packages of care with NGOs specialising in mental health and addiction treatment, and, in the future, dementia services for older people.

In the seven-tiered service model, conditions are managed in primary health care settings in Tiers 2 and 3, and as part of a shared-care arrangement with specialist services in Tier 4.

A delegated care manager or mental health co-ordinator would be useful in ensuring that people requiring care from Tier 4 services can access the health and social services they need. To meet the specific needs of individuals, packages of care should be developed involving a range of health and disability support services.

Key points

- Mental health problems among older people can often go undetected, be dismissed as part of normal ageing or be misunderstood.
- Primary health care providers need to implement comprehensive, recognised assessment tools and have clear referral pathways.
- Multidisciplinary shared care will improve the services that older people receive.

7 Specialist Services for Mental Health and Addiction, Including Dementia

Specialist services for mental health problems, including dementia, among older people are engaged at Tiers 4–7 of the seven-tiered model. These services are funded through the mental health and addiction services framework, and people over the age of 65 and those of any age with dementia may access them.

The *Blueprint for Mental Health Services in New Zealand: How things need to be* (Mental Health Commission 1998) provides guidelines for older people's mental health services and specifies that such services should provide the following:

- assessment, diagnosis and management of new presentations of mental disorders
- treatment and disease management for people whose long-term mental illness is complicated by conditions commonly related to ageing
- education and support for service users and their families and carers.

The range of services within the continuum that the specialist service is part of should be consistent with the recommendations of the *Guideline for Specialist Health Services for Older People* (Ministry of Health 2004b), and include:

- culturally appropriate assessment and treatment by interdisciplinary teams
- acute inpatient services
- inpatient rehabilitation services
- continuity of rehabilitation – inpatient to community
- outpatient services
- aged residential care
- respite and carer support services
- consultation, liaison and advice
- education and training.

In keeping with the goal of helping people to age in place, services should be individualised to each person's needs and provided, where possible, in the person's own home (which may, in the case of those with an intellectual disability, be a residential facility). Where services can not be delivered in the home or community, they should be co-located with other services for older people where practicable, consistent with the Health of Older People Strategy (Associate Minister of Health and Minister for Diability Issues 2002).

The range of services funded by DHBs for older people affected by mental health or addiction and people of any age affected by dementia is described in service specifications. Services are delivered by DHB and NGO providers in different settings.

Key issues

DHBs have different structures and funding streams and some people have experienced difficulty accessing appropriate services due to an intellectual disability or to their age (particularly those aged under 65 who have dementia).

In October 2003, responsibility for planning and funding disability support services for the following people was transferred from the Ministry of Health to DHBs' HOP services:

- those aged 65 and over
- those between the ages 50 and 65 who have been clinically assessed as having health and support needs arising from long-term conditions more commonly experienced by older people (such as dementia).

All dementia-specific contracts and associated funding managed by the Ministry at that time were transferred to DHBs' HOP services. For this reason, meeting the needs of people with dementia (with the exception of people severely affected by BPSD) is not currently a core responsibility of specialist mental health services. However, mental health services are expected to assist wherever appropriate, including in providing services to people with early-onset dementia.

Dementia was explicitly excluded from the remit of specialist mental health services in the *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission 1998) and its calculations of the number of beds and staffing levels required to meet the mental health needs of older people. This appears to have led to a misperception that the sphere of mental health does not incorporate dementia.

Many specialist MHOP services do routinely assess and treat people with dementia. The majority of people who experience dementia can be expected to experience some BPSD as the dementia progresses. Any update to the *Blueprint* should formally include serious BPSD.

The service specification review found that different service specifications were being applied by different DHBs due to the different funding streams being used. This has contributed to service gaps, inequities and unclear responsibilities.

Service requirements

Overall service provision

A single set of service specifications should be used for the range of services funded by DHBs for older people affected by mental health or addiction problems, and people of any age affected by dementia who require mental health services. Such service specifications have already been developed, and are now available on the Nationwide Services Framework, which is accessible through the Ministry of Health website.[8]

Assessment and diagnosis

Positive outcomes and pathways to care and support services depend on early, accurate and appropriately delivered assessment and diagnosis. Conveying diagnoses with sensitivity and some degree of optimism alongside information and support can enhance quality of life for people with dementia.

The interRAI Home Care assessment is a software supported comprehensive assessment designed to assess the medical, rehabilitation and support requirements of an older person.[9] The assessment is aimed at improving access to health and support services among older people through systematic, consistent and comparable assessment processes and improved risk

8 URL: www.nsfl.health.govt.nz/
9 URL: www.interRAI.org/

identification, which is intended to lead to more timely and effective care. A shared assessment tool can provide a baseline of information for each patient to satisfy basic requirements of various disciplines and agencies, reducing the onus on service users and their families to provide the same information repeatedly.

A community-based multidisciplinary specialist team is a critical and effective component of the service continuum (Draper and Low 2005). This team should act as an entry point to specialist services, assessing people's needs and then either offering or facilitating access to an appropriate range of services. This team should also develop and maintain collaborative relationships with primary health care and relevant government, non-government, private and voluntary organisations to smooth pathways to other needed services.

Specialised clinical assessment follows initial assessment, and is conducted by a specialist team. It is desirable that the assessor is able to observe the individual within their home environment. Engaging the assistance of family members is also helpful, particularly in history-taking (Perkins 2004) and to establish partnerships for care planning. In the case of people with an intellectual disability, support workers in their residential service community home may provide this assistance.

Care and support planning

As stated previously, care planning should be individualised, person-centred and holistic, and be undertaken in partnership with service users as well as their families and whānau and carers or support people. Planning should address access to the service continuum according to the seven-tiered model. Access to a range of options, including home-based support, day programmes, respite care and social activities, is important. Plans should acknowledge the potential requirement for a higher level of care, making contingencies for referral to hospital-level services, residential care, dedicated dementia units or palliative care.

Service providers should regularly review and reassess the care they are providing to older people, to ensure patients are receiving the most appropriate treatment and support.

Interventions

Specialist psychological interventions aim to promote wellbeing and alleviate psychological concerns. The range of psychological interventions includes but is not limited to psychodynamic, cognitive behavioural, art, pet and music therapies. *Everybody's Business: Integrated Mental Health Services for Older Adults: A service development guide* (Department of Health, United Kingdom 2005) outlines foundations and key elements of good practice for older adult mental health services.

Some psychological interventions to manage severe BPSD are not effective, and pharmacological interventions will be required. However, studies have raised concerns about the overuse of pharmacological interventions, and their limited benefit for people with dementia. One recent study found over-prescription of antipsychotic drugs to control challenging BPSD in aged residential care facilities in the United Kingdom (All-party Parliamentary Group on Dementia 2008). A New Zealand study commissioned by PHARMAC had similar findings (BPAC NZ Ltd 2008). Further, it was suggested that there was insufficient evidence to support the use of any medications other than cholinesterase inhibitors for treating cognitive symptoms of dementia. A useful review of non-pharmacological interventions for people with dementia in residential care has been carried out by University of Canterbury's Health Services Assessment Collaboration (Basu and Brinson, 2010).

Anti-psychotic medications can be useful, particularly in cases of severe BPSD, but can have a significantly deleterious effect on an older person's quality of life, and increase the risk of strokes. A preference for psychological before pharmacological approaches, and effective monitoring of practice to reduce risk of harmful outcomes, are recommended.

There is evidence to show that older people respond better to a combination of psychological and pharmacological therapy than to pharmacological therapy alone, particularly in more severe cases of dementia (Department of Health, United Kingdom 2004).

Acute inpatient services

Evidence supports the benefits of specialised inpatient units for older people with severe mental disorders, where such facilities are able to separate those with functional disorders from those with organic disorders (Draper and Low 2005). Functional and organic disorders (for example schizophrenia and dementia respectively) require different treatments and different skill sets among health care workers, and involve behaviours that need to be addressed in different ways.

The separation of inpatient services according to age group is also preferable, for example, for young people with functional mental disorders, to ensure that all people are treated in environments appropriate to their needs.

Psychiatric consultation liaison services may need to acquire specialist psychogeriatric skills to match growing demand. These individuals would maintain close ties with MHOP services.

Older people may present with a blurring of psychiatric and general medical symptoms. Specialist medical and gerontology support may be needed to address medical symptoms; co-location of services is therefore desirable. The majority of people admitted for treatment show symptomatic improvements during their hospitalisation. Hospital services should continue to improve their rehabilitation focus by encouraging best practice, for instance strengthened connections with rehabilitation services. Readmissions to inpatient units are less likely where services are community-based and outpatient follow-up has been arranged.

Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a legitimate intervention offered as an effective treatment for various types of mental illness, including depressive illness, mania, schizophrenia, catatonia and other neuro-psychiatric conditions. (Melding 2006). ECT is often offered to people for whom medication therapy is contraindicated or is not providing sufficient relief of symptoms.

In the year 1 July 2007 to 30 June 2008, 203 people were treated with ECT; 40 percent of those were aged 65 years and over (Ministry of Health 2008a).

Restraints

The use of restraints in residential care facilities in New Zealand has recently received significant media attention. This practice is occasionally necessary to ensure the safety of the individual, other service users, service providers or others. It should be kept to a minimum in accordance with the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (Standards New Zealand 2008). The intention of these standards is to encourage and guide the use of the least restrictive practices. Sensory modulation approaches are also being trialled as an alternative method for de-escalation of acute symptoms.

Sub-acute services

After acute inpatient admission, some people require rehabilitative treatment in a less intensive setting before they return to their home. Sub-acute services focus on recovery and the restoration of optimal functioning, independence, mental and physical health status and quality of life.

Sub-acute services may be delivered in hospital or community-based environments, by DHB or NGO providers, and aim to assist individuals to manage their own illness.

Mental health consultation and liaison services

Mental health consultation and liaison services are important to support the high numbers of people with mental disorders accessing general hospitals and general services. Such services may be part of a general service or, if volumes warrant, may be provided specifically for older people. It is preferable that an interdisciplinary team, rather than an individual medical practitioner, offers both consultation and liaison.

Mental health consultation and liaison services offered to primary health care providers and aged residential care providers have also proven useful, particularly for those working in the case management of older people with high and complex needs. These services also need to be available to providers of residential support services for people with disabilities.

Needs assessment and service co-ordination (NASC)

NASC provision may be integrated into individual services or offered in conjunction with other NASC services within a district or region. The process involves working with service users and their family, whānau and significant others to assess needs and plan and co-ordinate appropriate support services. NASC service providers need to be aware of support services available within their district and applicable eligibility criteria and funding models.

Community support work services

Community support work services provide non-clinical assistance for older people in some locations. Aiming to enhance the independence of older people, community support work services assists them to access resources such as social networks, health and wellness interventions, education and social services. Such services also encourage and foster family, whānau and wider community support.

Peer support services

Peer support entails people with a lived experience of mental illness or addiction (peers) giving and receiving help based on key principles of respect, shared responsibility and mutual agreement (Briscoe et al 2005). Such services provide individualised support and strengthen the engagement and participation of older people in their community.

Mental health care for prisoners

Prisoners are entitled to receive an equivalent standard of health care to that available to the public (Corrections Act 2004). The Department of Corrections provides primary health care and disability support for prisoners, while DHBs remain responsible for all secondary care including specialist mental health care and addiction treatment. Prisoners are also eligible for NASC disability assessments and support.

Numbers of prisoners are growing, and they are more likely to have mental health problems, including personality disorder, depression, schizophrenia, and post-traumatic stress disorder than their contemporaries outside prison (National Health Committee 2010a). The proportion of older prisoners is also growing. The prison environment is not conducive to good mental health and has been shown to exacerbate existing mental health problems over time.

Specialist community mental health teams for older people need to liaise with prison primary health care, forensic mental health teams and general mental health teams to ensure that people in prison requiring their services are able to access them equitably alongside those with similar needs in the general population.

The prison environment is also not suitable for people with dementia or who are frail. Focused efforts, with the assistance of the Ministry of Health, will need to be made to adapt prisons to better accommodate their ageing inhabitants or to develop appropriate alternative facilities.

Dementia-specific services

Assessing and treating memory loss

People of any age who are developing cognitive decline should have access to assessment, generally in primary or home care settings, and treatment options.

A study of New Zealand memory clinics noted that the functions performed by such clinics should include:

- specialist assessment and investigation of memory disorders
- initiation and monitoring of treatment
- provision of advice and information to patients and their carer(s)
- provision of advice on care management, education and training (Cheung and Strachan 2008).

While Cheung and Strachan's study found that there appeared to be considerable service user satisfaction with the assessment and diagnostic aspects of memory clinics in New Zealand, it also noted service users' concerns that therapies and support were not always offered as part of the clinic process, and psychiatrists' concerns that they were not always aware of services to which they could refer patients after diagnosis. One resource is Basu and Brinson's 2010 review of non-pharmacological interventions for people with dementia in residential care settings.

Evidence supports the use of strengthened mobile interdisciplinary specialist community mental health teams. Such teams would provide home-based assessments, interventions and, potentially, joint assessments such as those provided by a memory clinic. They would also facilitate access to interventions provided by other disciplines (for example, chiropody, dentistry, hearing and vision clinics, general medicine, gerontology, local Alzheimer's Society services, advocacy services and legal advice on power of attorney arrangements).

Dementia behavioural advisory services

Dementia behavioural advisory services can be provided as an extension of specialist community MHOP teams. Such services focus on people who exhibit challenging behaviours due to dementia and are residing in home, aged residential care or hospital settings. Challenging behaviours may impact on the provision of care. Four dementia behavioural advisory services, one in each major region, now provide a consultation, liaison, advice, information and education service to the community (including carers and other service providers) that addresses these behaviours.

Early onset dementia services

The principle of services based on need, not age demands that services for people under 65 with dementia be planned, accessible and effective.

Treatment and support services in age-appropriate settings appear to be limited. Pre-retirement age people with dementia find it more difficult to access appropriate services, which are generally provided within a system of services for older people. Aged residential care facilities are generally not appropriate places for young people to live, yet alternatives are very limited.

It is recognised both internationally and in New Zealand that younger people with dementia have specific unmet needs, and would benefit from early assessment, diagnosis and treatment by a focused interdisciplinary team. Ideally, such a team would include but not be limited to a psychiatrist, a mental health nurse and a social worker (Royal College of Psychiatrists and Alzheimer's Society 2006). Its effectiveness would rely on close collaboration with other DHB services, including MHOP services, memory clinics, neurology services, genetic counselling services and gerontology services.

Key points

- DHBs have different structures and funding streams, and for this reason some people have difficulty accessing appropriate services.
- Any update to the *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission 1998) should include serious BPSD.
- DHBs need to use a single set of service specifications for purchasing and delivering services for older people affected by mental health or addiction problems and people of any age affected by dementia.
- A community-based multidisciplinary specialist team is an essential entry point for assessment and facilitating access to services.
- Care and support planning should be undertaken in partnership with the service user, carers, family and whānau.
- Research has raised concerns about taking a pharmacological-only approach with some patient groups.
- Inpatient units for older people are recommended, in which patients with functional and organic disorders can be treated separately, gerontology support is close at hand, and outpatient follow-up is arranged.
- A broad range of support services exists, now joined by four dementia behavioural advisory services available to advise any member of the public.
- Services for people with early onset dementia need to be age appropriate.

8 Support Services in Home and Residential Care Settings

Support services in the home are engaged at Tier 4 and support services in residential care settings at Tiers 5 and 6 of the seven-tiered model.

The services described in this section are part of the funded HOP framework, and are available to people over the age of 65 with conditions commonly associated with ageing. People with mental disorders and intellectual disabilities may be referred to these services.

Key issues

As the population ages and the number of people with dementia grows, it is expected that there will be an increase in the number of people accessing home support services and residential care services, both in the intellectual disability and aged care sectors.

Meeting expected demand will require planning, including consideration of new and different service models and the likely effectiveness of those models for the next generation.

Dementia care should be person-centred; age-appropriate services are required within both the intellectual disability and the aged care sectors. Funders and providers will need to work together in developing such services.

Most older people who experience mental illness or dementia live in the community, either in their own homes or with a family member. The majority of support is provided informally by family members, friends or neighbours.

As dementia progresses people require greater assistance from service providers to continue to live safely in their homes; providers can also assist informal carers to provide the level of care needed. Carers need to have access to appropriate information, support and relief.

Service requirements

Support services

Support services may be home-based or provided in residential care settings (for example, day programmes). NASC agencies undertake assessments to determine the complexity and relative urgency of the person's needs and his/her potential for rehabilitation. A plan of care is then developed.

Home-based support services

Home-based support services have traditionally focused on household management and personal care, such as showering and dressing. A broader range of services is now available, incorporating capacity building and wellness approaches, flexible packages of care and support for older people's participation in the community. Other key services provided in the community include respite care, equipment and modification services, day programmes and some rehabilitation services.

Community nursing services

Many older people experience co-morbidities, and their care requires skilled interventions, which may include specialist nursing services at home or the use of particular technologies and equipment (such as intravenous therapies and dialysis) at home. There is potential for all levels of service to be provided at home to meet the person's need.

Day programmes

Day programmes are an important aspect of the care continuum supporting the wellbeing of both older people and their carers. Such programmes may be either general or dementia-specific. They provide social contact, education and activities within a community setting, and aim to improve participants' social skills and social inclusion, raising their self-confidence and self-esteem, and minimising the risk of depression (Department of Health, United Kingdom 2004). Day programmes also provide some respite for carers. Day programmes for older Māori may be marae-based and, ideally, fit well with services to support the whānau. People under 65 such as early onset dementia sufferers or stroke survivors could benefit from, and should be eligible to access, day programmes as well.

Short-term and respite services

Respite services provide carers with relief from the role of providing care, usually for a defined period in a planned way. There are different models of respite service delivery. Care and support may be provided either in an individual's own home or in a residential facility.

It has been suggested that short-term admission to ARC or temporary provision of 24-hour care at home for those recovering from an acute mental illness can also obviate the need for hospital admission. For people with intellectual disability, short-term care with supervision may be provided in other accommodation. Respite facilities must be appropriate environments for the temporary resident's disability, as well as mental health, needs.

DHBs are responsible for establishing care plans for all people accessing respite care. The plan should minimise the potential for negative consequences arising from respite care when a service user returns home (Flint 1995).

Education and support for carers

For many voluntary carers, the fear of not knowing what to expect heightens concerns about caring for someone with dementia and increases their risk of burn-out. Carers need education about the condition of the person being cared for, skills training such as coping with challenging behaviour and safe lifting practice, and help planning for transition points and emergencies.[10]

Support workers employed in home support services require basic training in the needs of people with dementia and in the skills to meet those needs, to ensure services are provided safely. This workforce should have cross-service training in identification and appropriate referral, for instance, for basic addiction and mental health problem identification.

Relevant NGOs and ITOs will need to be supported to provide appropriate training sustainably as the need for carers grows.

10 For more information on the needs of voluntary carers see *How Should We Care for the Carers, Now and into the Future?* National Health Committee 2010b. www.nhc.health.govt.nz/moh.nsf/indexcm/nhc-how-should-we-care-for-the-carers?Open; and *New Zealand Carers' Strategy and Five-year Action Plan*. Ministry of Social Development 2008. www.msd.govt.nz/about-msd-and-our-work/work-programmes/policy-development/carers-strategy/

Home-based care workers also need competent oversight by qualified health professionals, but this is often hard to achieve due to workforce pressures. Recruitment, retention and training issues relating to this workforce are discussed below and in Chapter 12.

Residential care services

While care at home through a range of intensive supports may be possible, people with high and complex needs are likely to require services in a residential care setting. There are currently four levels of aged residential care: rest home, specialist dementia care, long-stay hospital care and specialised hospital care.

It has been estimated that approximately 50 percent of people in aged residential care have a level of dementia. Approximately 146 facilities nationwide provide secure level care and hospital specialised care for people with dementia. Such services are accessed following a specialist needs assessment.

Issues to address in residential care

One of the main issues in residential care is the recruitment, retention and training of an appropriate workforce. There is a need for more highly qualified health professionals in many residential care settings. In addition, all staff in all ARC settings require basic training to ensure that a person with dementia under their care may safely remain at the most independent level of care for as long as possible. Workforce issues are addressed more fully in Chapter 12.

Rates of mental illness are disproportionately high in residential care. It has been suggested that mental health services in ARCs are inadequate; particular criticism has been levelled at the 'care-as-needed' approach of engaging consultation services from specialist teams rather than providing ongoing care and support through residential care staff.

Appropriate facilities are required for people under 65 who need residential care, including accessible environments with equipment and skills on hand to support physical disability needs.

Decisions regarding aged residential care service providers are often made by families under pressure and without all the information about the types and quality of services available.

The following may help address some of these concerns:

- training experience within aged residential care facilities for all clinicians with a specialty in geriatrics to understand the culture of long-term care
- mental health- and intellectual disability-focused education and training for aged residential care staff, including behaviour management techniques to alleviate agitation and aggression among those with dementia, and in recognition and management of depression (including among people with intellectual disability)
- education for residential care staff in recognising how best to group residents to promote greater cohesion
- provision of information and education for aged care providers and their primary care prescribers on best practice use of anti-psychotics and non-pharmacological interventions
- facilitation of residential care providers' access to consultation and liaison support through specialist assessment services, NASC services, mobile experts, case management and specialist liaison roles

- regular reviews by general practitioners of the physical and mental health of residents of aged residential care facilities
- provision of regular mental health consultation, liaison and advisory services (including shared case management for complex clients) for all those within residential care, including people with an intellectual disability
- direction to the Ministry of Health HealthCERT website to all people when they, or someone they care for, is assessed as needing residential care.[11]

Specialised dementia units

People who experience severe behavioural problems as a result of dementia benefit from care in a small specialised unit where staff are specifically trained to work with such behaviours. Such units should make use of close liaison with and clinical oversight from specialist community mental health teams.

Residential care service providers should always consider the social and psychosocial needs of residents with dementia and provide stimulating activity programmes to meet individual need. Additionally, providers should adhere to nationally agreed best-practice design models for dementia-specific care in planning to build or extend residential facilities. In the United Kingdom, the University of Stirling's Dementia Services Development Centre[12] provides expertise in the development and design of environments for people with dementia.

Key points

- People experiencing dementia and older people with mental health problems may access a range of support services in home and residential care settings.
- A comprehensive needs assessment is essential before determining service options.
- Once a care option has been determined, service providers should regularly review the level of care provided, and make adjustments if necessary.
- ARC, home-based and informal carers need quality, sustained education, training and support.
- ARCs need to develop in-house competence in caring for residents with mental illness and dementia.

11 URL: www.moh.govt.nz/moh.nsf/indexmh/certification-certifiedproviders

12 URL: http://dementia.stir.ac.uk/design_welcome

9 Alcohol and Drug Services

Substance misuse is having an impact on population health outcomes in New Zealand. Internationally there is increasing incidence of cognitive impairment, including alcohol-related dementia. Binge-drinking in midlife increases the risk of developing dementia (Jarvenpaa et al 2005), and some studies suggest that around 10 percent of dementia is alcohol-related (Gupta and Warner 2008). Other substances used over a period of time also increase the risk of cognitive impairment and other physical and mental disorders; for instance, dementia is associated with longer-term tobacco smoking.

Problematic substance use (including problem drinking, illicit and prescription drug use) in older people is regarded as a hidden problem and is a growing concern. It often arises in a context of social isolation and disconnection due to bereavement and/or physical and/or cognitive decline, or as a result of social impacts such as unemployment or relationship breakdown (Mrazek and Haggerty 1994). Substance misuse exposes older people to greater physical risks and increased medical, psychological and social problems.

Older people develop an increased sensitivity to alcohol as well as some medications as they age. Symptoms of alcohol excess can arise earlier, and the recommended number of standard drinks for safe drinking is much lower for older than for younger people (McInnes and Powell 1994). Prescription drug interactions with alcohol can also be a problem.

Key issues

There is evidence that problematic substance use is poorly diagnosed in older people, and that even when it is accurately diagnosed, referral to services is less likely than it is for other problems. Medical, psychological and social problems are more likely in the absence of early diagnosis and intervention. It has also been shown that symptoms of alcohol-related dementia can be reversed with early identification and treatment (Rains and Ditzler 1993). Risks, for instance those associated with combining medications or with taking medications for long periods of time, are not always communicated to older people and their carers.

People who develop early-onset dementia as a result of alcohol misuse are not yet well catered for in the health system. Alcohol and drug abuse can also mask the onset of dementia, delaying diagnosis. People under 65 with these co-occurring problems may need specific services from the alcohol and drug service, but mental health specialists must remain available for consultation and support.

Service requirements

Early identification of and appropriate follow-up for symptoms of depression is likely to help prevent substance misuse among older patients. To reduce numbers of older people developing addiction and dependence problems, it is vital to engage primary health care providers in early identification and appropriate referral or treatment for mental health and alcohol and drug-related problems.

Specialist community teams and MHOP services need to be competent in the assessment and treatment of addiction among older people. Early assessment, diagnosis and interventions for alcohol and drug addiction are essential in aiding recovery and improving health outcomes and quality of life. The goal of the Ministry of Health's Co-Existing Problems Project is that nationwide,

both mental health and alcohol and other drug services will be able to carry out initial screening assessment and brief interventions for people with both conditions.[13]

It is more common for older people with alcohol or drug-related problems to present with other physical and psychological problems requiring investigation and treatment. It is important that services take a collaborative approach in investigation and treatment, for example involving pharmacies and social services. Older people's addictions and mental health problems should be included in DHB Co-existing Problems plans.

Key points

- Problematic substance use by older people, including the use of alcohol, prescription drugs and other drugs, is a hidden problem in New Zealand.
- Service providers and the general public need to be more aware of the impact of substance misuse among older people.
- Service providers in both primary and secondary settings should regularly screen older people for use of substances to enable early diagnosis and response.
- Specialist services and community teams need to be competent in diagnosing and treating alcohol and other drug and co-existing mental health disorders (including dementia).

13 See www.moh.govt.nz/letsgetrea; www.tepou.co.nz/page/565-welcome; http://moodle.matuaraki.org.nz/

10 Intellectual Disability

People with intellectual disability have a greater risk of developing early-onset dementia. The impact of dementia on people with intellectual disabilities and their families, carers and service providers is also becoming more apparent as people with intellectual disabilities live longer.

Key issues

Research on the association between intellectual disability and mental health problems, including dementia, has identified certain issues to be taken into account when developing services for people with intellectual disabilities (Ball et al 2006; Forbat and Wilkinson 2008; Dosen 2007; Hall et al 2006), as follows.

- Detection of dementia and mental illness among people with intellectual disabilities is often difficult due to behavioural and communication issues.
- Presentation of dementia in people with Down syndrome may differ from that seen typically in other people, the earliest changes tending to be in personality or behaviour rather than in memory.
- People with intellectual disabilities who develop mental illness or dementia have more specific needs than other people who develop such conditions.
- There is a range of screening and assessment tools for use with people with an intellectual disability. However, appropriate psychosocial interventions for adults with an intellectual disability and dementia or mental illness are not yet clearly defined In the literature.
- Also lacking are best-practice models for supporting people with intellectual disabilities who develop dementia or mental illness to stay in their own homes, or to remain in community residential care, consistent with the principle of ageing in place.

Service requirements

DHBs are responsible for providing health services for people with intellectual disability and people with a mental health problem. The complexity of behavioural and mental health problems among people with both an intellectual disability and a mental illness requires an integrated treatment approach. Collaboration among mainstream mental health services and MHOP services, and across health and social service boundaries, is necessary.

In responding to individual mental health needs, DHBs may also need to broker access to other providers of disability and social services. This co-operation is particularly important when people with intellectual disability develop symptoms of dementia, if they are to remain in their current home. People with intellectual disability who develop dementia should have access to the same services available to all people with dementia, no matter where they live.

Family carers, social care providers, primary care practitioners and specialist mental health teams all need to be able to identify signs of mental illness among people with intellectual disabilities. All carers share the role of navigating access to appropriate health services.

Specialist services should be mobilised to provide prompt and timely assessments and interventions. Service providers should make use of simple and reliable screening tools, linked to an evidence base of psychosocial interventions. Clinical training may better equip specialists to work with people with intellectual disabilities.

Appropriate support and training for all staff will support adults with intellectual disabilities who develop dementia or other mental disorders to remain in their own supported living environments as they age. Closer collaboration between disability and HOP funders, and with service providers, will be necessary to design and/or modify living environments in anticipation of service users' changing needs.

Key points

- Age-related illnesses, including dementia, among people with intellectual disabilities are an increasing concern as the life expectancy of people with intellectual disabilities lengthens.
- Detection of mental health disorders or dementia among people with intellectual disabilities can be difficult due to behavioural and communication issues.
- There is currently a lack of best-practice models for supporting people with intellectual disabilities who develop mental disorders or dementia.
- Support and training is required to enable all who care for people with an intellectual disability to identify signs of dementia or another mental illness.
- Meeting the needs of people with intellectual disabilities and mental disorders or dementia requires active collaboration among DHBs and providers.
- In responding to the mental health needs of people with intellectual disabilities and mental disorders or dementia, DHBs may need to broker access to other providers of disability and social services.

11 Long-term Conditions

This chapter addresses the service requirements of people with long-term conditions in the context of mental disorders in older people and dementia. The term 'long-term condition' is used to describe chronic illnesses and disabilities experienced by an individual over a longer period of time.

Key issues

International studies have found that depression develops among 25 percent of people who have a stroke, 20 percent of people who have coronary heart disease, 24 percent of people with a neurological disease, 42 percent of people with chronic lung disease, and 50 percent of people with Parkinson's disease. Late-life depression is often associated with chronic illness and disability, and depressed older people are at a significantly increased risk of developing chronic conditions such as ischemic heart disease (Karlin and Fuller 2007). Conditions such as chronic pain and rheumatoid arthritis are also known to be associated with mental health disorders such as depression.

Parkinson's disease

Half of people with Parkinson's disease may have depression, which in turn is associated with a faster progression of physical symptoms, a decrease in cognitive skills and a decline in their ability to care for themselves.

It has been suggested that 24–31 percent of people with Parkinson's have dementia (Aarsland et al 2005). Thirty percent of people with Parkinson's disease are likely to experience hallucinations and psychotic symptoms (Salter et al 2006). Psychosis among patients who have Parkinson's disease may lead to higher hospitalisation rates, significantly increased disability, residential nursing home placement and increased risk of mortality.

Stroke

There is a clear association between stroke and dementia. Evidence indicates that stroke increases the risk of dementia and cognitive impairments among older people, especially among the less aged (Cordonnier et al 2007). Prevalence rates of post-stroke dementia vary from 12.2 to 31.8 percent within three months to one year after a stroke (Mackowiak-Cordoliani et al 2005). Stroke also accelerates the rate of decline among people who already have dementia.

Multiple sclerosis

Mental health problems are common among people affected by multiple sclerosis, which is a chronic neurological disease (Garcia and Finlayson 2005).

Head injury

Severe head injury in early adulthood may increase the risk of dementia in older age (Luukinen et al 2005). It is also associated with mental illness, suicidal ideation, suicide attempts and completed suicide. Some populations groups are more vulnerable to head injury, for example, more than half of all prisoners and 73.6 percent of male Māori prisoners have experienced at least one head injury (National Health Committee 2010a).

Service requirements

As a general principle, risk and protective factors for dementia, particularly those factors that are common to dementia and other medical conditions (for instance, heart health and exercise), should be more widely publicised. Prevention, early detection and early intervention should be promoted.

Care providers should be alert for signs of depression whenever chronic pain or loss of function is a feature, for instance among diabetes patients. Providers should consider their choice of pharmacological treatments carefully. Some medications for chronic illness have the potential to cause depression, and some treatments have the potential to worsen physical symptoms; for example, antipsychotics are contraindicated for Parkinson's disease.

Providers, including primary care providers, need to consult and collaborate with specialists in order to provide appropriate care and support to meet the complex needs of people with long-term conditions and a mental illness or dementia. Staff in general hospital departments and residential care should be able to consult, liaise with and seek advice from mental health specialists, to ensure that the mental health needs of people with long-term conditions under their care are met.

Key points

- Mental disorders such as depression are more common among older people who also have long-term conditions such as chronic illness and disability.
- Risk and protective factors for dementia should be more widely publicised, and prevention and interventions should be promoted.
- Service providers need to collaborate to recognise and meet the complex needs of older people with long-term conditions and a mental illness or dementia.

12 Workforce Requirements

Key issues

Significant workforce recruitment, retention and training needs are affecting the provision of care and support for older people with mental health or addiction problems and people with dementia. There is consensus within the sector that the number of people currently working in the clinical and non-clinical workforce is insufficient to meet need.

The ageing population presents a major workforce development challenge for the future. Not only will there be more older people, but the workforce to care for them will be relatively smaller than it is today.

One study has shown that community-based services caring for older people consistently carry high caseloads (Melding 2005). The study also noted that bed numbers and personnel actually available (particularly community-based nurses) remained far below target. A contributing factor may be that the stressful environment and demanding nature of work in such services places considerable pressure on workers, which can lead to burn-out.

Stakeholders have confirmed that there are inadequate education and skills training opportunities within this workforce, particularly in early onset dementia care. Anyone in a position to diagnose dementia must be prepared with appropriate information and support on hand for the patient and his or her family. General practitioners require training in dementia management. A survey of specialist MHOP services and workers in DHBs has identified training needs in areas such as older peoples' needs, psychopharmacology, dementia and delirium, and assessment and screening (Te Pou o te Whakaaro Nui 2010).

Older peoples' health needs should be the core curriculum for carers in ARC, and basic training in mental health, addiction and dementia management must follow. These carers need to develop and maintain skills in depression prevention, for instance, including making efforts to maintain residents' social ties and creating familiar and engaging environments. A lack of training and leadership in residential care settings may be contributing to excessive use of antipsychotics as a 'quick and easy' response to challenging and disruptive behaviours.

Service requirements

Services at all levels require a skilled workforce. This is a responsibility of DHBs and, through contracts with them, many provider employers.

In addition to developing in-house teaching and training, DHBs should work with industry training organisations, education providers, and NGO service providers to develop means of meeting the educational and skills development needs of the workforce.

Changes to workforce training are already under way, such as enhanced education for enrolled nurses and health care assistants within the New Zealand Qualifications Authority framework. Workforce training programmes on dementia, including an online programme, are being developed. It could be useful to devise new Continuing Quality Improvement modules for primary health care practitioners to develop their skills in relevant areas.

Attracting and retaining nursing staff with suitable expertise can be difficult. Stakeholders have identified workforce retention strategies, including regular remuneration reviews and the provision of additional support, as important. This includes supervision, access to specialist nursing support through clinical nurse specialists and nurse practitioners and support for mid-career change. Regional and national clinical networks will expand opportunities for support and skills development.

The promotion of caring for older people as a desirable career pathway for job seekers is another possible strategy. The mental health workforce initiative *Let's Get Real: Real skills for people working in mental health and addiction* (Ministry of Health 2008b) is a framework outlining the knowledge, skills and attitudes required of carers and other service providers in the field. One of the specific aims of *Let's Get Real* is to enhance workforce development through education and training, human resources strategies, organisational development and research and evaluation.

Provision of education and training is important for any service planning on integrating services for older people with dementia, mental illness or addictions. This may occur through allocated funding or through subsidies. The *Talking Therapies for Older Adults* guide and other tools for building workforce capability are available through Te Pou (National Centre of Mental Health Research, Information and Workforce Development www.tepou.co.nz). Training and education must be appropriate to the needs of the targeted workforce, including the non-regulated carer workforce and voluntary carers, and should provide opportunities for upskilling. DHBs should focus on maintaining their own and their providers' skill bases.

Māori mental health workforce development needs to be tailored to increase the skills and capacity of the Māori mental health workforce. One focus should be on competence to work within a whānau ora framework.

In planning for the workforce needs of the sector, DHBs may find it useful to undertake a survey of their workforce to establish potential areas for development. DHBs should take a strategic, long-term approach to workforce development.

Health Workforce New Zealand (HWNZ) is undertaking mental health and addiction and aged care workforce service reviews through 2011 to inform workforce planning. The reviews, which are being undertaken by sector-led teams, will identify workforce and training needs. This includes developing a vision of the service and workforce for 2020 and models of care that are patient-centred, team-based and integrated across the continuum; from self care, primary, community and specialist care settings. The reviews are envisaged as the start of an iterative workforce investment planning and development process. HWNZ is currently establishing regional training hubs to co-ordinate training of health professionals.

HWNZ is also conducting a major review of general practice training, in partnership with The Royal New Zealand College of General Practitioners and the Medical Council of New Zealand. This review is intended to ensure that general practitioners receive training that will equip them for the ageing patient population and the increasingly complex co-morbid conditions they will encounter.

Key points

- The recruitment and retention of staff are challenges for the sector, particularly among NGO service providers.
- Currently, there are not sufficient education and training opportunities for the workforce.
- The Ministry of Health's *Let's Get Real* is a framework outlining the knowledge, skills and attitudes required to deliver effective mental health and addiction treatment services.
- Māori mental health workforce development needs to be tailored to increase the skills and capacity of the Māori mental health workforce appropriate to the needs of the Māori community.
- To maintain the workforce, retention strategies should be strengthened.
- Health Workforce New Zealand is undertaking service reviews that will improve planning, recruitment and retention.

13 Recommendations

This document suggests how DHBs and the Ministry of Health can achieve an integrated approach in the provision of services that cross the boundaries of HOP, MHOP, addiction, disability and chronic conditions services. The following recommendations set out specific steps to be taken in response to the issues identified.

1. Adoption of guiding service principles

a) All DHBs will adopt the guiding service principles outlined in Chapter 3 of this document in order to achieve consistency and quality in service delivery.

2. Services based on need, not age

a) Service specifications will be amended to ensure that older people are not excluded from mental health and addiction services because of their age.

b) Service specifications will be amended to allow flexibility in defining the age (which may be younger) at which people with similar mental health and addiction needs can access services.

c) All services will comply with the amended Nationwide Service Specifications stating that older people will not be excluded from services because of their age.

d) Mental health and addiction services will not exclude eligible people on the basis of underlying (physical or intellectual) disabilities or chronic health conditions where the presenting issue is related to a mental illness.

e) Primary mental health programmes and services will not exclude older people because of their age.

f) The National Depression Initiative will ensure that older people are not excluded from access to help with depression.

3. National consistency in service delivery and data collection

a) The service coverage document will be amended to ensure that people with serious BPSD are able to access appropriate services from mental health and addiction services.

b) By 2012, all DHBs will adhere to the revised mental health and addiction service specifications for purchasing and delivering mental health and addiction services.

c) All DHBs will use HoNOS 65+ and report to PRIMHD (Programme for the Integration of Mental Health Data) according to the file specification.

d) All older people accessing health services will be assessed with interRAI tools as available.

e) All DHBs will use the seven-tiered model presented in Chapter 3 of this document to guide funding and service planning decisions.

f) All providers will use recognised tools for assessing mental health and addiction problems among older people and dementia among people of any age.

g) Consistent with MHOP services Tier 2 service specifications, DHBs will plan and implement co-location and integration of their MHOP and HOP services.

h) DHBs will support the further development and consolidation of regional dementia (any age) behavioural support and advisory services.

4. Workforce development and clinical leadership

a) DHBs and the Ministry of Health will collaboratively establish regional and national networks.

b) DHB workforce plans will incorporate workforce training requirements relevant to mental health and addiction among older people and to dementia.

c) DHB workforce plans and training programmes for staff will incorporate cultural competencies appropriate to the population being served.

d) Ministry of Health workforce contracts will include cultural competencies enabling the workforce to better respond to the mental health and addiction needs of older Māori people and Māori of any age with dementia.

e) Ministry of Health workforce contracts will include cultural competencies enabling the workforce to better respond to the mental health and addiction needs of older Pacific people and Pacific people of any age with dementia.

f) Consistent with Health and Disability Service Standards, providers will ensure that their staff have access to appropriate training. This will be monitored by audit agencies and/or DHBs.

g) DHBs will work with industry training organisations to further develop generic dementia-specific training units as part of the workforce's core training.

h) Health Workforce New Zealand will lead workforce development for primary health care practitioners in mental health and addiction and dementia, to enhance care and management at that level.

Glossary

Addiction	'Addiction' is used as an inclusive term referring to the entire range of harmful, hazardous and dependent patterns of alcohol and other drug use and problem gambling. It is a complex disorder caused by multiple genetic factors interacting with multiple environmental factors, and is often a 'chronic and relapsing' condition. Treatment for addiction-related issues can be applied at various stages of addiction, from the early stages through to severe dependence or compulsion (National Committee for Addiction Treatment 2008).
AOD	'AOD' stands for 'alcohol and other drug', although this term, 'substance use' and other similar terms are used interchangeably. The concept of problematic AOD use applies to the use of a substance that may cause or exacerbate health problems based on individual physiology and psychology, including mental illness. It may include use that meets criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) IV 1 for abuse and dependence, although substance use may affect the course of a mental disorder without strictly meeting DSM IV 1 criteria for a diagnosis of substance abuse or dependence (Ministry of Health 2010b).
BPSD	Behavioural and Psychological Symptoms of Dementia. Symptoms of disturbed perception, thought content, mood or behavior that frequently occur in patients with dementia. Serious BPSD may include difficult behaviour or aggression, delusions, hallucinations and hostility.
HoNOS 65+	Health of the Nation Outcome Scales, developed by the Department of Psychiatry within the University of Manchester to measure mental health outcomes. HoNOS 65+ measures outcomes among older people. HoNOS 65+ measures are reported to PRIMHD (Programme for the Integration of Mental Health Data) on a national level according to the file specification as required by the OPF (Operational Policy Framework).
HOP service	Health of older people service.
IFHC	Integrated Family Health Centre.
interRAI	A comprehensive geriatric assessment that has an associated database designed to document older people's health status and improve their health care.
MHOP service	Mental health of older people service.
NASC	Needs assessment and service co-ordination.
Whānau	The use of the term 'whānau' in this document recognises the diversity of families represented within Māori communities. It is up to each whānau and each individual to define who comprises the whānau.
Whānau ora	Māori families achieving their maximum health and wellbeing.

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