Older Persons - Kaumatua Mental Health Report

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Lorraine Eade

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1.0 Executive Summary

This report provides an understanding of the prevalence of older persons/kaumatua mental health in Nelson Marlborough DHB[1], identification of primary and secondary services currently available, a high level best practice summary and finally the report identifies several recommendations that synergise with the proposed Nelson Marlborough Health of Older People Strategy.

The recommendations are as follows:

1.1 Primary mental health care and specifically general practice teams are the first point of contact for older people/kaumatua who have mild to severe mental health symptoms.

1.1.1 Information sharing meetings with General Practice teams on depression, anxiety, alcohol and drugs and dementia are held on a regular basis.

1.1.2 Frequent contacts to general practice in terms of referrals and liaison over assessment, treatment and discharge.

1.2 For caregivers/family who are caring for older people/kaumatua with mild to severe mental health issues, there are minimal caregiver handbooks that provide the level of information around the illness and how to care for the older person/kaumatua, identification of the eligibility criteria to access services, and what community supports are available.

1.2.1 A caregiver handbook for the elderly is produced for caregivers, family/whanau.

1.3 It is difficult for the voluntary and community sectors, primary health and family/whanau to navigate across the range of services available.

[1] Please note this is estimated prevalence, predominantly using Te Rau Hinengaro – The New Zealand National Mental Health 2006 and extrapolated to NMDHB 2006 census population figures. Unless otherwise stated, unadjusted figures are used.

1.3.1 Explore the development of one entry point for older people/kaumatua (*or alike in age and interest)* to assist navigation through services, across the continuum of care, regardless of mental or physical disability

1.4 InterRai is a geriatric assessment tool designed to identify the medical, rehabilitation and support requirements of an older person. NMDHB is currently supporting the implementation of InterRai, which includes a validated mental health assessment tool.

1.4.1 InterRai Project Team and Mental Health Specialist Service meet to explore implementation of InterRai and how it will be embedded into existing practice.

1.5 There are a wide number of community, voluntary and Iwi/Maori groups that support the elderly. These groups are often run by volunteers, resourced through fundraising activities or small grants/donations. The Ministry of Social Development Family and Community Services division has initiated a strategy that supports the community and voluntary sector, however we do not clearly understand this sector.

1.5.1 Work with Ministry of Social Development in terms of how best to support voluntary community groups.

1.6 The voluntary and community sectors, and Iwi and Maori groupings that provide services to older people/kaumatua be kept informed on service development.

1.6.1 Regular newsletters to key stakeholders through the Health of Older People group.

1.7 The interface between specialist mental health services and psychogeriatric services works well for individual cases but there are opportunities to strengthen the interface. There remains a level of confusion about responsibility for age related mental illness, particularly for people with a history of mental illness and early onset age-related issues. In addition, it is difficult for older people/kaumatua to navigate across services.

1.7.1 As per recommendation 1.3.1, explore the development of a single entry point for older people/kaumatua (*or alike in age and interest*).

1.7.2 A process is developed that addresses disagreement on eligibility criteria; and supports joint funding decisions and options.

1.7.3 As per SHOP (Specialist Health of Older People) Guidelines, explore the development of an '*integrated specialist geriatric and psychiatry of old age, assessment and rehabilitation with a palliative approach when necessary'*. The model will be patient focused, delivered by accredited providers who meet the required certification standards. Alignment with national activity will be crucial.

1.8 NMDHB has an aging population. Accordingly the demand and need for services is likely to grow. This implies a specialist workforce with the appropriate skills to work with older people/kaumatua.

1.8.1 Understand the older people/kaumatua workforce(s) that will be required and include these findings in the Health of Older People Strategy.

1.9 Kaumatua play a pivotal role in terms of whanau, hapu, iwi and the achievement of whanau ora.

1.9.1 Explore opportunities for whanau ora to extend service provision to include primary mental health.

1.10 Resources are available to increase services within specialist mental health for older persons.

1.10.1 Three full time equivalents (*1.0 FTE Blenheim, 1.0 FTE Nelson, 1.0 FTE Tasman*) are established in 2008/2009, with identification of appropriate training programmes to support service development. Encourage appointment of Maori staff within the

team. Service to be implemented after completion of the SHOP Review.

1.10.2 Explore opportunities for mental health support workers and/or day programmes in future service development.

1.11 Older people/kaumatua who are socially isolated, are at risk of developing a mental illness.

1.11.1 Explore the development of an older persons/kaumatua health promotion programme

1.11.2 Work with key stakeholders to encourage community participation with a focus on rural areas.

It is intended that these recommendations are embedded into the NMDHB Mental Health and Addiction Action Plan 2008-2015, and/or as relevant, the NMDHB Health of Older People Plan. Both of these documents are currently under development.

2.0 Introduction

In the Nelson Marlborough region older persons mental health and addiction services have historically been resourced from two separate funding buckets. Disability Support Services funded the Psychiatry of Old Age Services, provided through Alexandra Hospital including Specialist Health of Older People (psycho-geriatric ATR), and Adult Mental Health Services cared for clients that are over the age of 65 and with no complex medical, physical or cognitive conditions associated to ageing.

The Nelson Marlborough District Health Board District Annual Plan for 2005/2006 identified the following project *'Alongside the Health of Older People, investigate the development of an integrated geriatric and psychiatry of old age services'*. From this piece of work, a Psycho geriatrician had been appointed with a 0.4 FTE service development role. In Te Roopu Tupu Tahi "*Mental Health Service Development Plan*' it acknowledges and prioritises Older Persons mental health for the development of new services.

The Nelson Marlborough District Health Board District Annual Plan for 2007/2008 identifies the following project *' a strategy and implementation plan to address mental health services for older people/kaumatua & kuia will be developed in association with Health of Older People services'*. The recommendations from this report will be embedded into the generic Mental Health and Addiction Action Plan 2008-2015 and/or the Health of Older People Plan, currently under development.

The Health of Older People team are currently undertaking a strategic analysis of the current service delivery for older people, including the development of a series of strategies and a model of care that will enable high quality and efficient services to be delivered to older people to 2020. Accordingly, this report will need to align to and inform, the model of care proposed.

Specialist mental health have blueprint funding available to develop older persons mental health services. This report will assist to determine service development opportunities for those elderly with severe mental health needs; and touch on how the community/voluntary and primary mental health sectors may support those elderly with mild to moderate mental health needs.

3.0 Government Strategies

In 2007, the Minister of Health identified as one of his priorities older persons health. He stated that *"The health of older people remains a priority and another year's change in service delivery is both needed and inevitable as we implement a new assessment tool, new models of supportive care for those choosing to live longer at home, and as we place renewed attention on training those in the sector"*. This statement solidifies a number of strategies aimed at improving the health of older people. These are as follows:

Health of Older People Strategy (2002)

The primary aim of the strategy is to develop an integrated approach to health and disability support services that is responsive to older people's varied and changing needs. The integrated continuum of care approach means that an older person is able to access services at the right time, in the right place and from the right provider.

Guideline for Specialist Health Services for Older People (2004)

The aim of the guideline is that older people and their families, whanau and others who could benefit from specialist health services have timely access to quality, culturally appropriate services and advice. The rationale underpinning this aim is that adequately resourced, culturally competent and appropriately skilled specialist health services for older people will improve the health and wellbeing of older people, enabling them to have a better quality of life, and, as a result, reduce overall health and disability costs for this age group.

This includes:

- early identification and assessment of medical and psychiatric conditions that can either be reversed or their progression slowed by treatment and/or rehabilitation
- developing and implementing treatment and rehabilitation plans with the older person and their family, whanau and appropriate others
- collaborating with other services or health practitioners to provide integrated services for older people and their family or whanau.

Te Tahuhu – Second National Mental Health and Addiction Strategy (2005)

Takes a more comprehensive approach to mental health development and outlines ten leading challenges for mental health and addiction. This includes the need to build and broaden the range and choice of services and supports which are funded for people who are severely affected by mental illness. Immediate emphasis has been given on increasing services that are funded for older people recognising that access to services for older people remains below expectations and an ageing population means that addressing the mental health needs of this group will be increasingly important in the years to come.

Te Kokiri - Mental Health and Addiction Action Plan (2006)

Identifies a number of specific actions relating to older people including: developing transition arrangements between all mental health services and addiction services and between mental health and addiction and other health services, with special emphasis on the transfers involving adult services to older peoples services; building the capacity of the mental health sector to

support ‘ageing in place’; increasing access to specialist mental health and addiction services for older people; and developing national consistency in data collection on older peoples access to mental health and addiction services.

He Korowai Oranga – Maori Health Strategy (2001)
The overall aim is whanau ora; supporting Maori families to achieve their maximum health and wellbeing. The outcomes sought for whanau include:

- Whanau experience physical, spiritual, mental and emotional health and have control over their own destinies.
- Whanau members live longer and enjoy a better quality of life.
- Whanau members (including those living with disabilities) participate in Te Ao Maori and wider NZ society.

Four pathways for action are identified; Development of whanau, hapu, iwi and Maori communities; Maori participation in the health and disability sector; Effective health and disability services; and Working across sectors.

4.0 What informed this report?

4.1 Desktop Literature Review
4.2 Mental Health Information National Collection (MHINC) data.
4.3 Consultations conducted as part of the ‘*Older Persons Services in Nelson and Marlborough DHB Report*’.
4.4 ‘*Te Tau Ihu o Te Waka a Maui Kaumatua Benchmarking – Literature Review*’, currently in draft form.

5.0 What is included in the scope of this report?

The scope of the report centers on the following issues:

5.1 Mild to moderate mental health needs of the elderly population.
5.2 Specialist mental health needs and service development.
5.3 Alignment to the Health of Older People strategy including Specialist Health of Older People Guidelines.

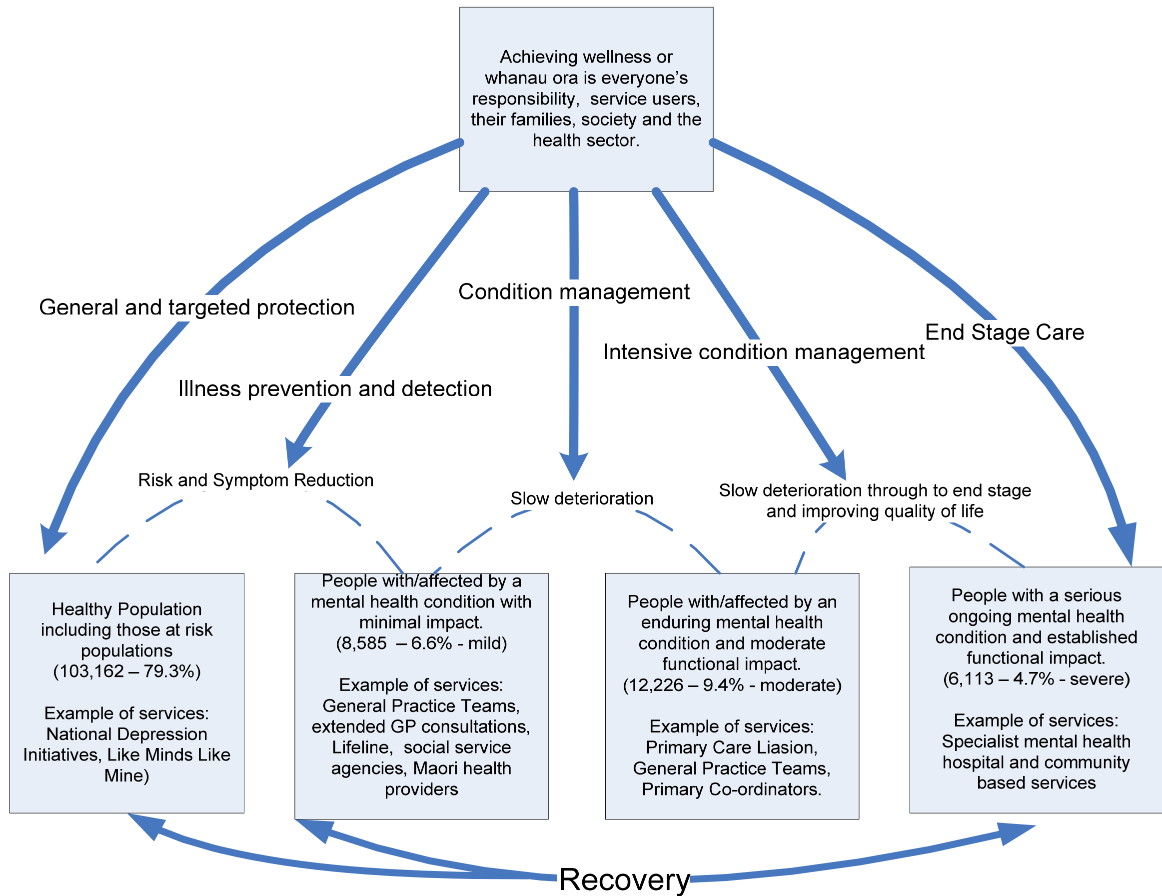
6.0 Mental Health Populations of Need

The Mental Health Populations of Need Report takes an all inclusive approach to mental health service planning, capacity and capability building and provision of services. Its intent is to blend the needs of our populations from those requiring general protection to those that require more intensive chronic condition management. The report identifies that the community/voluntary sector, public health, primary mental health and specialist mental health services must work together to provide a continuum of care. The Mental Health Populations of Need report will form the basis of engagement with the community on the development of a Mental Health and Addiction Action Plan, inclusive of older persons mental health.

The Populations of Need framework and the role of the community are identified on the following page[2]:

[2] Total volumes estimated based on Te Rau Hinengaro

Mental Health Populations of Need

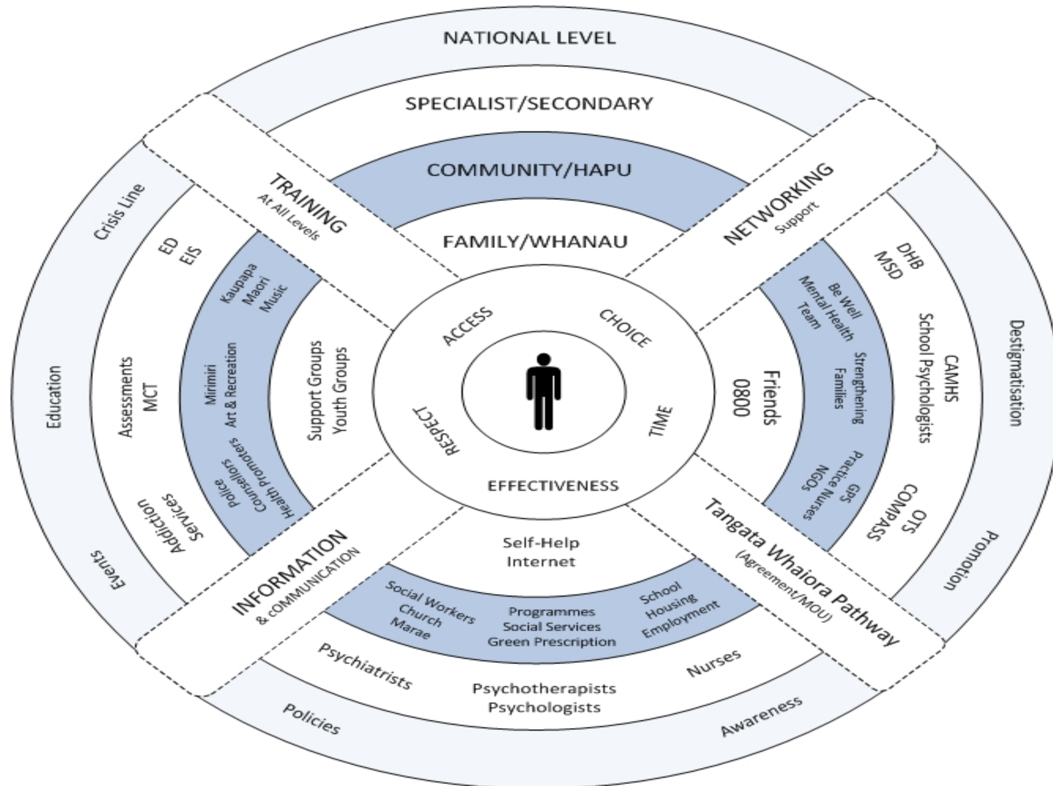


Of the Nelson Marlborough community in the previous 12 months, 79.3% of the entire population had no mental health problems, 6.6% had mild mental health problems, 9.4% moderate and 4.7% serious.

However, estimated prevalence changes when breaking down the generic population into special population groups such as Maori, Pacific and Older People.

The model recognizes the important role of health promotion for the majority of our community, the role of community services and general practice teams, and finally the blending and continuity of care required to meet mild to severe mental health needs.

A preferred integrated model of care for service user/tangata whaiora recovery, identifying the collaborative responsibility approach is as follows:



Taking a tangata whaiora/service user view, an Integrated Recovery Model of Care[3] sets the tangata/whaiora/service user at the centre of care, which is central to the modeling of services. The circles directly surrounding the person are the individuals or groups such as family, friends, partners etc who are most likely to provide support to the individual. As the service user becomes increasingly unwell, there are a number of options and choices to seek help, such as 0800 numbers, general practice, Maori health providers, voluntary and community groups. Should the need become acute, then intervention can be provided by specialist mental health services.

[3] Developed by Rob Francis, Project Manager, Primary Care Mental Health Plan.

The outer national layer, identifies a number of services that are available, but more importantly the development and implementation of national policy and strategy. The model is supported by Nga Poupou Wha (*four upright slabs that normally form the framework of a house*), which are integral to the provision of a continuum of quality care. Nga Poupou Wha are networking, training, information/communication and tangata whaiora pathways. Without Nga Poupou Wha in place, service users/tangata whaiora may experience fragmented services, poor co-ordination and collaboration and a reduced quality of care and service.

7.0 Demographics and Prevalence Data

NMDHB has an aging population. The 65 to 74 age group comprise 7.8% of our total population. The 75 and over age group comprise 6.9% of our population. Combined this is 14% of the Nelson Marlborough population.

Nelson Marlborough Elderly Population 2006 Census			
Territorial Local Authority	**65-74 years**	**75 +**	**Total**
Tasman	3345	2724	6,069
Nelson	3045	3186	6,231
Marlborough	3747	3129	6,876
Total	**10,137**	**9,039**	**19,176**

The Maori population demographics are as follows:

Maori Kaumatua/Kuia Population 2006 Census			
Territorial Local Authority	**65-74 years**	**75 +**	**Total**
Tasman	78	27	105
Nelson	69	42	111
Marlborough	150	66	216
Total	**297**	**135**	**432**

Overall within the Nelson Marlborough district, people over the age of 65 years is expected to increase from 14% to 22% by 2020. This will undoubtedly impact on existing services as this particular age range are high users of health services.

Twenty three percent of those older persons aged 65 to 74 live alone, 40.4% of 75 to 84 year olds live alone and 58.9% aged 85 years plus live alone.[4] Older Maori and Pacific people are more likely to live with family than other ethnic groups.

Te Rau Hinengaro

Te Rau Hinengaro (*NZ's first national mental health survey*)[5] identifies that overall mental health disorder is common in our population, with 46.6% of the population predicted to meet criteria for a disorder at some time in their lives, with 39.5% having already done so and 20.7% having a disorder in the past 12 months.

However prevalence changes across the differing age groups. Across all age groups the prevalence is 20.7% for having any disorder in the past 12 months, though when we take the 65 years and over age group this drops significantly to 7.1%.

For those aged 65 and over, the twelve month prevalence rates are shown as follows:

a) Anxiety Disorders at 6% (*compared to 16 to 24 years at 17.7%, 25 to 44 years at 18.2% and 45 to 64 years 13.2%).*
b) Mood Disorders at 2% (*compared to 16 to 24 years at 12.7%, 25 to 44 years at 9.2%, 45 to 64 years at 6.8%).*
c) Substance use disorder at 0.1% (*compared to 16 to 24 years 9.6%, 25 to 44 years 4.2%, 45 to 64 years 1.2%)*

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[4] NMDHB Health Needs Profile.

[5] There were limitations to the survey in that it does not provide useful prevalence rates for people with a severe low-prevalence disorder such as schizophrenia or schizoaffective disorder; the sample frame did not include people within institutions so people with such severe but uncommon disorders are likely to be under-represented; it does not provide estimates of rates of dementia and associated cognitive impairment in older people; and people living in institutions such as rest homes, hospitals, sheltered accommodation, university colleges, prisons and armed forces group, and homeless people were not included in the sampling frame.

d) Eating disorders at 0.1% (*compared to 16 to 24 years at 0.6%, 25 to 44 years at 0.7%, 45 to 64 years 0.3%).*

Suicide risk decreases with increasing age. In terms of a twelve month prevalence rate (*taking into account sociodemographic characteristics)*, for those adults aged 65 years and over, 0.8% have suicidal thoughts, 0.3% make suicide plans and 0.1% suicide attempts. However the progressive aging population suggests that the rates among older adults can be expected to increase. Findings indicate that serious suicidal behaviour by older adults is attributable in a large part to major depression.[6] Suicide attempts are more lethal in older adults as they are physically more frail and less likely to recover from an attempt, they are more likely to live alone and therefore not found in time to provide assistance, their attempts are more lethal in nature, and their suicide attempts are more carefully planned and implemented.

In terms of co-morbid conditions, Te Rau Hinengaro found that a little over one third of those with any disorder have more than one mental health disorder. There is a good deal of overlap between anxiety and mood disorders with approximately half (49.6%) of those experiencing a mood disorder, also experience an anxiety disorder. Therefore the prevalence estimates should be treated with caution in terms of double counting.

Consideration should also be given to the prevalence of chronic physical conditions. Te Rau Hinengaro found that people with mental health disorders had higher prevalence's of several chronic physical conditions. These included chronic pain, cardiovascular disease, high blood pressure and respiratory conditions. The existing mortality rate for people aged 65+ are predominantly heart disease at (31%), cancer (25%), stroke/cerebrovascular disease (12%), respiratory disease (8%), injury/suicide (< 1%).[7]

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[6] Beautrais A.L., (2003) *Suicidal behaviour in older adults; risk factors and recommendations for prevetion.*

[7] Statistics New Zealand

Primary Health Data:

There is no specific data that identifies the number of Elderly/Kaumatua/Kuia accessing primary health services for their mild and moderate mental health needs. At its most basic level, any individual accessing a primary health care service with concerns around their mental health should be able to have their mental health needs identified, assessed and to be offered effective treatments (*including referral to specialist services for further assessment, treatment and care if needed).*

Currently across all age groups only 5% of people attend a General Practitioner (GP) for a mental health problem.[8] In addition, the MaGPie study identified that 29.8% of all patients and 26.9% with current symptoms did not report their self perceived psychological problems to their GP.[9] Two of the main reasons being a belief that the GP is not the right person to speak too, and that mental health problems should not be discussed at all. For our older population, many were raised in an era where having a mental illness was considered unmentionable and often hidden by family/whanau. Creating an environment in the primary care sector where the elderly are able to articulate their mental health status, without the historical stigma associated to experiencing a mental illness needs to be addressed.

At the primary health care level, general practice services are predominantly used by the very young and older people. People aged 85 years and over visit GP services around nine times per year, compared to three to four visits for people aged 45 to 64 years[10] which is more aligned to the onset of age related illnesses.

There have been concerns for some time that the average consultation timeframe of 15 minutes is inadequate for the General Practitioner and the patient to discuss mental health issues. However, Te Rau Hinengaro found that the average duration of visits to General Practitioners were, 5.9% being less than 15 minutes, 42.1% were between 15 to 30 minutes, 16.1% were between 31 to 45 minutes and

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[8] NZ Health Survey (2002/2003)

[9] MaGPIe Research Group (2005) Do patients want to disclose psychological problems to GPs. *Family Practice, 22 (6), 631-637.*

[10] DHBNZ, ACC, Ministry of Health (2004) *Assessment Processes for Older People.*

35.8% were for 46 minutes or longer. The satisfaction of care provided also had a reasonably high rating with 81% being either satisfied or very satisfied with the service. This is specifically important for the elderly population who visit general practice more frequently than other age groups and may need a longer duration of visit given the possibility of co-morbid condition development.

Specialist Mental Health Data:

Taking a snapshot view of MHINC (*Mental Health Information National Collection)* data for specialist mental health service provision, we find that of the 3,280 clients currently case managed (*all ethnicities*):[11] [12]

- There were 113 elderly clients aged 65 years and over within specialist mental health services. 3.4 % (113 out of 3280 individuals).
- Out of the 113 clients, 3 were Maori, 110 Other and there were no Pacific or Asian clients.
- There were less elderly accessing specialist services in the Tasman area with 25 clients, Marlborough 42 clients and Nelson 46.
- Only in the Tasman region do males out number females in terms of access. There were 42 clients from Marlborough, 29 female and 13 male; 46 clients in Nelson 27 female and 19 male; and Tasman 25 clients 14 male and 11 female.
- For the Marlborough district 33.3% of elderly were living in Deprivation areas 7 to 9, in Nelson 45% and in Tasman 4%.

Peer support agencies report that older persons take up to 20% of their existing case load[13]. Support is usually ongoing or permanent.

[11] MHINC 2006/2007 Specialist Mental Health Data
[12] Please note that Alexandra Psychogeriatric Service data is not included in MHIN
[13] COMPASS Peer Support and Advocacy Service

Twelve month estimated prevalence for 65 years and over Mild to Severe[14]					
Older Persons Kaumatua Population 19,176 (2006 Census)	**Anxiety Disorders at 6%**	**Mood Disorders at 2%**	**Substance Use Disorders at <0.1%**	**Eating Disorders At 0.1%**	**TOTAL**
Tasman 6069	364	121	0	6	491
Nelson 6231	373	124	0	6	503
Marlborough 6876	412	137	0	6	555
TOTAL	1149	382	0	18	1549

Twelve month prevalence 2026 Census Estimates for 65 years and over Mild to Severe					
Older Persons/Kaumatua Population 38,200	**Anxiety Disorders at 6%**	**Mood Disorders at 2%**	**Substance Use Disorders at <0.1%**	**Eating Disorders At 0.1%**	**TOTAL**
Tasman 13,400	804	268	0	13	1085
Nelson 11,500	690	230	0	11	931
Marlborough 13,300	798	266	0	13	1077
TOTAL	2292	764	0	37	3093

Currently there are an estimated 1,549 elderly who in the past twelve months required support for mild to severe mental health problems, and based on Te Rau Hinengaro by 2026 this is estimated to nearly double to 3,093. Therefore it is important to ensure that service planning is developed and aligned to the recovery model[15], and Guidelines for Specialist Health Services for Older People.

[14] Based on Te Rau Hinengaro

[15] Recovery from a mental illness is not just about symptom reduction, but living as full a life as possible. Recovery is the *'ability to live well in the presence or absence of one's mental illness'*.

In addition there are a number of elderly parents who are caring for their adult children with a mental illness.

8.0 Setting the Context

What do we mean when we talk about mental illness? Using the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), Axis I disorders consists of clinical disorders and other conditions that may be a focus of clinical disorder e.g. (*Psychotic Disorders, Mood Disorders, Anxiety Disorders, Dementia, Eating Disorders, Adjustment Disorders, etc)*, Axis II consists of personality disorders and mental retardation (*Paranoid Personality Disorder, Borderline Personality Disorder, Antisocial Personality Disorder etc)*, Axis III consists of any physical disorder or general medical condition that is present in addition to the mental disorder (*Diseases of the Nervous, Respiratory, Circulatory, Digestive Systems etc.)*

Dementia related services are provided and funded by the Health of Older People. The prevalence of dementia in New Zealand for all people 65 years and over is 7.7%[16]. However when we break that down further by age group, 65 to 74 years is 3.8%, 75 to 79 years is 6.4%, 80 to 84 years is 11%, 85 to 89 years is 23.6% and 90+ years 40.4%. As NMDHB has an increasing elderly population, so will the need for increased service expansion.

The process of aging is inevitably associated to some decline in functional capacity. As people grow older, they experience some loosening of social and family ties, as they retire from work, as partners and friends die and as younger family members shift to other places. In addition many adults will need to adjust to chronic or acute illness which tends to increase with age. Older adults seeking psychotherapy generally access help because of lifestyle changes resulting from these events. Although many individuals face these events without distress, some older adults respond by developing symptoms of depression or anxiety.[17]

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[16] Guidelines for the Support and Management of People with Dementia (1997). Ministry of Health
[17] Gallagher-Thompson, D.Thompson, L.. (1996) Applying Cognitive Behavioural Therapy to the Psychological Problems of Later Life. *A Guide to Psychotherapy and Aging. APA.*

The importance of elderly physical activity also needs to be acknowledged as this has a strong influence on physical and mental health, including risks of cardiovascular and musculoskeletal diseases and certain cancers.

Within Nelson Marlborough, the choices available for older people aged 65+ who have moderate to severe mental health problems, are that they may attend either adult mental health or psychogeriatric services. This is dependant upon whether they were a mental health service client before turning 65 and whether they have co-morbid conditions that are better treated by a psychogeriatric team.

Psychogeriatric services are for clients 65 years and over with late onset psychiatric conditions and the behavioural and psychological symptoms of cognitive impairment (e.g. symptoms associated with dementia). This includes psychiatric conditions that are age onset but does not exclude people with an enduring illness who become frail. However there are a small number of people under the age of 65 that are accepted into the service if their needs are '*like in age and interest*'. The most common form of a psychogeriatric condition is dementia.

Currently the facility and resources available at Alexandra Hospital are limiting in terms of service provision. Alexandra Hospital are not able to take people with functional conditions into the inpatient unit, or patients with age onset psychiatric conditions. There are also challenges for the service to contain older adults with challenging behaviours that may require restraint or seclusion and in these cases, support has been requested from the Adult Mental Health Inpatient unit. This pathway however does not meet best practice.

Specialist Older Persons Mental Health Services are for clients with acute mental illness in older age.

The Mental Health Commission Blueprint suggests that per 100,000 total population that each DHB should consider the following resourcing (*whether funded from Disability or Mental Health)*:

Services for Older People	Benchmark/ 100,000 population	NMDHB Population 2006 Census 130,086 – MHC benchmark applied.
Older people assessment, treatment and rehabilitation – *beds or care packages*	4.0	5.2
Older people daytime support services – care packages.	4.0	5.2
Older people – community teams - *FTEs*	8.5	11.06

Currently there are no specific older persons specialist mental health services purchased within Nelson Marlborough, as historically older persons have been serviced by adult specialist mental health services and or disability.

As stated previously, up until 2006 Alexandra Hospital Psychogeriatric Service and Specialist Adult Mental Health Service were closely linked and both services managed under the District Mental Health Manager. Since this period of time the relationship continues to be constructive with a new structure in place, however concerns remain around eligibility criteria, interface issues, service development, therapeutic environment and the continuum of care.

From forums held with specialist mental health staff, NGO community mental health staff including consumer groups, the following wish list for mental health service development included:

- Accommodation options for older people, such as Abbey fields type services (*mental and physical health).*
- Increased capability for acute and medical assessment for the older person.
- Good physical and psychiatric assessment.
- Good family support and resourcing.

- Provision of disability support funding for people with mental health conditions.
- Dedicated continuum of care team.
- Training for staff working with older people.
- Meeting with the Psychgeriatrician on a regular basis.

9.0 Providers in Older Persons Mental Health

Health Promotion
There are a number of mental health promotion services comprising of 7.23 FTE within Nelson Marlborough. None of these are specifically centered on the elderly population. In addition there are a number of health promotion services that benefit this population wellness, such as the Falls Prevention programme, and physical activity.

Community and Voluntary and Maori Groups
There are a number of groups that provide support services to older people. Organisations such as Age Concern, Greypower. ADARDS, Alzheimers Society, Neighbourhood Support Groups, Stroke Group, Citizens Advice, Church groups to name a few. While not all are specifically centered on older persons with mental health problems, they do provide voluntary supports that compliment primary and secondary mental health services.

Primary mental health care
Primary health services are the first point of contact for the elderly with the expectation of receiving assessment and treatment of their mild to moderate mental health condition. The role of primary health is pivotal and early access has been found to decrease hospitalizations. The role of primary health care practitioners is to ensure that individuals return to their full level of functioning by identifying and subsequently managing the mental health issue.[18]

Both PHO's have recently launched a primary mental health care initiative that elderly can access for extended consultations and individual packages of care and are currently developing a Primary

[18] Ministry of Health Service Development Toolkit for Mental Health Services in Primary Health Care.

Mental Health Plan to support primary health providers address mild to moderate mental health problems.

In Marlborough there are 9 practices with 29 General Practitioners, Nelson 19 practices with 41 General Practitioners, Tasman 11 practices with 30 General Practitioners. There are 25 Pharmacies and eight Maori health providers across the service coverage area.

Assessment Treatment and Rehabilitation (ATR)
Provides a co-ordinated multidisciplinary response customized to meet the complexity of needs of people with disability and/or age related disorders in order to restore their functional ability, and to enable them to live as independently as possible.

Older Persons Mental Health Services
Service specifications are incorporated into the Adult Mental Health Service Specification, and currently there are three specific service descriptions for older persons mental health; inpatient services, community teams and day programmes.

There are no Mental Health Specialist Older Persons services currently purchased. Tangata whaiora aged 65 and over are serviced within the community adult mental health services.

Psychogeriatric Care
Recently the psychogeriatric beds located at Alexandra have shifted to a new purchasing model, where a 'service' is funded as opposed to a number of beds. Currently this facility encompasses 37 beds, made up of seven ATR beds, and 30 continuing care psychogeriatric beds. A Psychiatrist and MOSS run generic mental health outpatient clinics.

10.0 Best Practice Interventions

Depression in the elderly is under-recognized and under-treated. The diagnosis is often made more complicated by the presence of multiple medical co-morbidities and the need for medications for chronic conditions. Older adults typically do not complain of depressed mood, and depression can be brought on through social withdrawal, loss of spouse, isolation, presence of chronic medical conditions and pain,

frustration with memory loss, and decline in activities of daily living, making the diagnosis difficult to identify. These life events can also trigger anxiety. Use of alcohol or other substances can be used to self-medicate distress. This makes older adults more vulnerable to adverse drug events and premature decline in functioning.[19] The NICE Clinical Guidelines of Depression (2006)[20] in Primary and Secondary Care recommend that:

- Screening should be undertaken in primary care and general hospital settings for depression in high risk groups – for example, those with a past history of depression, significant physical illnesses causing disability or other mental health problems such as dementia.
- For patients with mild depression who do not want an intervention or who, in the opinion of the healthcare professional may recover with no intervention, a further assessment should be arranged, normally within two weeks (*'watchful waiting')*.
- Antidepressants are not recommended for the initial treatment of mild depression, because the risk-benefit ratio is poor.
- For patients with mild depression, healthcare professionals should consider recommending a guided self help programme based on cognitive behaviour therapy.
- In both mild and moderate depression, psychological treatment specifically focused on depression (such as problem-solving therapy, brief CBT and counselling) of six to eight sessions over 10 to 12 weeks should be considered.
- When an antidepressant is to be prescribed in routine care it should be a selective serotonin reuptake inhibitor (SSRI) because SSRI's are as effective as tricyclic antidepressants and are less likely to be discontinued because of the side effects.
- All patients prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping, missing doses or, occasionally on reducing the dose

[19] Melinda S Lantz, (2002) – *Depression in the Elderly – Recognition and Treatment* Clinical Journal of the American Geriatric Society

[20] The New Zealand Guidelines Group are currently developing '*Identification of Common Mental Disorders and Management of Depression in Primary Care' Guidelines'*. This is currently out for consultation with the sector and not available at this point for distribution or incorporation into this report. It has a specific section on depression in older adults.

of the drug. These symptoms are usually mild and self limiting but can occasionally be severe, particularly if the drug is stopped abruptly.

- When patients present initially with severe depression, a combination of antidepressants and individual CBT should be considered as the combination is more cost-effective than either treatment on its own.
- Patients who have had two or more depressive episodes in the recent past, and who have experienced significant functional impairment during the episodes should be advised to continue antidepressants for 2 years.
- For patients whose depression is treatment resistant, the combination of antidepressant medication with CBT should be considered.
- CBT should be considered for patients with recurrent depression who have relapsed despite antidepressant treatment, or who express a preference for psychological interventions.

The Royal Australian and New Zealand Clinical Practice Guidelines for the Treatment of Depression 2004 stress the importance of an effective therapeutic relationship and that each patient needs to be provided with good information related to the condition, the rationale for that treatment, the expected outcome from treatment, and the expected timeframes.

Where an elderly person is experiencing anxiety for the first time in their life, referral to a specialist geriatric/psychogeriatric unit for clarification or diagnosis and treatment should be considered sooner rather than later. Adjustment reactions can be due to multiple losses and grief, especially to those elderly who are poorer, socially isolated or living alone, physically disabled or recently widowed.[21]

When evaluating the anxious patient, the clinician must first determine whether the anxiety disorder antedates or postdates a medical illness or is due to a medication side effect. Approximately one third of patients presenting with anxiety have a medical aetiology for their psychiatric symptoms, but an anxiety disorder can also present with somatic symptoms in the absence of a diagnosable

[21] Guidelines for Assessment and Treatment of Anxiety Disorders (1998) National Health Committee.

medical condition. Treatment options for anxiety disorders include psychological and pharmacological therapies. No single form of cognitive-behavioural therapy is suitable for all anxiety disorders, although exposure based techniques form the core of effective treatment for many of them. Current evidence is limited but does not support the practice of routinely combining pharmacotherapy and cognitive-behavioural therapies as this generally does not increase the effectiveness of the treatment.[22]

Substance abuse among the elderly is a growing problem as the population ages. Elderly alcohol abusers can be divided into two general types: the "hardy survivors," those who have been abusing alcohol for many years and have reached 65, and the "late onset" group, those who begin abusing alcohol later in life. The latter group's alcohol abuse is often triggered by the life changes described above. Because alcohol has a higher absorption rate in the elderly, much like it does in women, the same amount of alcohol produces higher blood alcohol levels, causing a greater degree of intoxication than the same amount of alcohol would cause in younger male drinkers. In 1999, the National Health Committee produced the following guidelines for primary care:[23]

- All patients over the age of 14 years should be screened at least every three years.
- Initial screening questions within the context of a general health review. This is more acceptable to patients and lessens the problem of substance abuse feeling like a 'moral' rather than a health issue.
- Utilisation of the AUDIT (Alcohol Use Disorders Identification Test) for screening adults for alcohol problems.
- Brief intervention should be used with all people identified by screening as non-dependent but drinking more than the safe level of alcohol.
- Alcohol-dependent patients wishing to cease drinking should be referred to specialist services for detoxification.

[22] NZ Health Technology Assessment (2007)– Best practice intervention for the management of anxiety disorder: Annotated Information Package.
[23] Guidelines for Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care (1999). National Health Committee.

Dementia occurs as a result of physical changes in the structure of the brain. These changes are caused by specific conditions and affect memory, thinking, behaviour and emotion. Dementia is progressive, which means the symptoms will gradually get worse, but how quickly the disease progresses will depend on each individual. Alzheimer's disease is the most common cause of dementia. It accounts for 50%-60% of all cases. As the disease progresses, elderly people with Alzheimer's experience a gradual decline in their ability to remember, understand, communicate and reason. For management of psychiatric symptoms/syndromes in dementia, it is important to enquire specifically about psychiatric and behavioural symptoms in the diagnosis of dementia as they may not be volunteered. In terms of psychosis, symptoms stemming from this include delusions, hallucinations and misidentifications. These are often best dealt with by reassurance, re-orientation and other non-drug strategies. Low dose antipsychotic drugs may be considered if symptoms are persistent or distressing. Special care must be taken in Lewy-body dementia because of marked sensitivity to standard psychotic drugs. For depression social stimulation, appropriate activities, plus counselling when appropriate are first line strategies for depressed mood. Antidepressant drugs are worth trying for more pervasive or severe depressed states even if the clinical picture is atypical. Many clinicians feel that the new antidepressants such as SSRI's are preferable to tricyclics, due to more benign side-effect profiles. For high anxiety level states are often situationally determined and may therefore be responsive to social or environmental manipulation. Sometimes patients may benefit from more formal anxiety management strategies, behaviour modification or counselling. If these strategies have failed (or are unrealistic) anti-anxiety, anti-panic or anti-phobic drug treatment can be helpful. There is a level of controversy about how to classify behavioural concomitants of dementia. However it is agreed that behavioural problems of some sort arise in the great majority of dementia cases and that these can be associated with psychiatric symptoms, for example, aggression maybe attributable to psychosis. It is particularly important to be aware that a depressive or anxiety state may underlie behavioural disturbance, in which case management should be focussed accordingly. [24]

[24] Guidelines for the Support and Management of People with Dementia (New Zealand Guidelines Group)

11.0 Maori

There are eight iwi in Te Tau Ihu o Te Waka a Maui (Nelson Marlborough Tasman), they are Ngati Rarua, Ngati Toarangatira, Ngati Koata, Ngati Tama, Te Atiawa, Rangitane, Ngati Kuia and Ngati Apa. The unwellness and premature loss of kaumatua has a significant impact on whanau, hapu and iwi. Generically Maori view aging as positive, and special status is often accorded to those kaumatua who take leadership and advisory roles within their whanau, hapu, iwi and wider Maori community.

Bring me beyond vulnerability: Elderly care of Maori acknowledges that Maori have a strong preference for taking care of their elderly within the whanau. Care of kaumatua should be viewed within a Maori cultural context, acknowledging the important role that kaumatua play within the whanau, hapu and iwi, grounded in whanau, whanaungatanga and kanohi kitea. A reciprocal relationship is embedded in terms of caring for whanau. *Oranga Kaumatua*[25] found that 78% of kaumatua involved in their survey provided care for their whanau (*children, older whanau members etc)* and that 29% of kaumatua were worried more about their health than housing, transportation, the marae or their mobility. In addition when kaumatua were no longer able to carry out their duties, they reported declining health including poorer emotional wellbeing. Kaumatua in essence, don't retire, they often voluntarily work harder upon retirement.

Therefore, in terms of meeting the needs of kaumatua with mild to severe mental health needs, kaumatua role within whanau, hapu and iwi needs to be understood by mainstream and community services. This includes a level of flexibility in service provision, responsive follow up, co-ordinated care and earlier intervention.

The number of Maori elderly will increase from about 4% to around 9% over the next 25 years. [26] The number of kaumatua/kuia will

[25] Dr John Walden: Oranga Kaumatua: Perceptions of Health in Older Maori people. Ministry of Social development

[26] Health Research Council – Ages and stages focus for Te Pumanawa Hauora programme.

increase and therefore service planning needs to occur now to accommodate future need.

The 2006 census identified that there were 432 elderly kaumatua/kuia within the service coverage area. However, there is a valid argument that for kaumatua/kuia the age range should be reclassified to commence at 55 to 60 years given that age related illnesses are now showing earlier within the Maori population. For the purposes of this exercise ages 65+ have been utilized to align to Te Rau Hinengaro findings.

Maori Kaumatua/Kuia Population 2006 Census			
Territorial Local Authority	**65-74 years**	**75 +**	**Total**
Tasman	78	27	105
Nelson	69	42	111
Marlborough	150	66	216
Total	**297**	**135**	**432**

There are a number of findings that recognize higher acuity of mental health on presentation to primary and secondary mental health services. The MaGPIE study identified that Maori general practice attendees had higher rates of mental disorder than non-Maori (particularly for Maori women). Maori had higher rates of all common mental health disorders (*anxiety, depression and substance abuse)* and exhibited more severe symptoms.[27] Kaumatua also have disadvantaged health status in a range of health indicators compared to non-Maori. Kaumatua are less likely to have access to telecommunications, motor vehicles, less likely to own their own home, live in a crowded home compared to non-Maori. Those kaumatua aged 65+ are significantly less likely than non-Maori to report they had seen a General Practitioner five to nine times in the last 12 months in comparison to non-Maori

[27] MaGPie Research Group (2005). Mental disorders among Maori attending their GP. *Australia and New Zealand Journal of Psychiatry,* 39 (5), pp 401.

Te Rau Hinengaro identified that the lowest lifetime prevalence was for Maori age groups was in the 65 + group (22.7%). When describing the findings for twelve month prevalence by sociodemographic correlates for those 65+, 7.9% will experience a mental health disorder. With the exception of mortality rate for unintentional injury for Maori males aged 65+ years, the rates for unintentional injury hospitalisation and mortality were significantly higher among Maori than among non-Maori.[28]

The estimated suicidal behaviour twelve month prevalence for kaumatua aged 65 and over is 1.1% for suicide ideation, for 0.7% suicide planning and 0% for suicide attempts.[29]

The estimated lifetime prevalence for Maori kaumatua are as follows (mild to severe):

Territorial Local Authority - 2006	Anxiety Disorders at 14.5%	Mood Disorders at 7.8%	Substance use disorders at 16.0%	Any Eating Disorder at 0.4%	Total
Tasman (105)	15	8	16	0.4	39.4
Nelson (111)	16	8	17	0.4	41.4
Marlborough (216)	31	16	34	0.8	81.8
Total	**62**	**32**	**67**	**1.6**	**162.6**

[28] Older Persons Health Chart Book 2007
[29] Te Rau Hinengaro extrapoloation.

As part of the Kaumatua Benchmarking Literature Review Report,[30] meetings were held with the Maori community and a summary of the key service gaps that align to mental health were identified as:

(a) Improved co-ordination of care across health conditions, services and supports. Especially when kaumatua have a range of co-morbid conditions.
(b) Acknowledging that spiritual health is as important as physical and mental health.
(c) Acknowledging the need for Rongoa Maori, mirimiri and other traditional components of Maori health.
(d) Mental health supports and services for kaumatua, particularly depression.
(e) The provision of timely information on entitlements to health care and supports. What options are available and how these can be easily accessed.
(f) Recognising that kaumatua are part of the whanau, and providers should accommodate this in their service delivery.
(g) Improved access to general practice services.
(h) Development of kaumatua day programmes.

There are eight Maori health providers across Te Tau Ihu that deliver a range of whanau ora (wellbeing), disability, health promotion and mental health contracts. For any Kaupapa Maori health service, special emphasis is given to kaumatua/kuia health and they benefit from a service that is based on Tikanga Maori and Maori values.

12.0 Commentary

The estimated mental health prevalence rates (*excluding dementia)* for the elderly population are relatively low in comparison to other age groups. However, this does not detract from the importance of providing appropriate services and continuum of care that improve recovery and quality of life. In the past twelve months there were an estimated 1,549 elderly people over the age of 65 that currently experienced some form of mild to severe mental illness. This volume is likely to double by the year 2026.

[30] NMDHB Maori Health Directorate

Not everyone will seek help. However, for those with mild mental health problems who do, older people/kaumatua are likely to be supported by their partners, family/whanau, hapu, iwi, Marae, friends, church groups, recreational or sporting groups and other voluntary/community agencies.

For those with moderate to severe mental health problems, older people/kaumatua are likely to be serviced initially by general practice teams followed by specialist mental health or psychogeriatric services if the need is acute/severe.

One of the key questions is how to support early recognition, assessment and treatment for this target group. Acknowledging that the individual, family/whanau are best placed to pick up early symptoms, more information needs to be available in terms of recognizing symptoms and then knowing where to seek help.

General practice teams also play a pivotal role and continually sharing information on best practice as part of the Primary Mental Health Plan could benefit.

Specialist Mental Health and Psychogeriatric Care while historically separately funded, provide services to the same target group. Therefore a close association and interface needs to occur from Senior Medicals right through to the support worker roles.

Across both general practice and specialist service provision, a process needs to be developed that ensures a continuum of care for older people/kaumatua.

13.0 Service Gaps and Recommendations (as per Executive Summary 1.0)

13.1 Primary mental health care and specifically general practice teams are the first point of contact for older people/kaumatua who have mild to severe mental health symptoms.

13.1.1 Information sharing meetings with general practice teams on depression, anxiety, alcohol and drugs and dementia are held on a regular basis.

13.1.2 Frequent contacts to general practice in terms of referrals and liaison over assessment, treatment and discharge.

13.2 For caregivers/family who are caring for older people/kaumatua with mild to severe mental health issues, there are minimal caregiver handbooks that provide the level of information around the illness and how to care for the older person/kaumatua, identification of the eligibility criteria to access services, and what community supports are available.

13.2.1 A caregiver handbook for the elderly is produced for caregivers, family/whanau.

13.3 It is difficult for the voluntary and community sectors, primary health and family/whanau to navigate across the range of services available.

13.3.1 Explore the development of one entry point for older people/kaumatua (*or alike in age and interest)* to assist navigation through services, across the continuum of care, regardless of mental or physical disability

13.4 InterRai is a geriatric assessment tool designed to identify the medical, rehabilitation and support requirements of an older person. NMDHB is currently supporting the implementation of InterRai, which includes a validated mental health assessment tool.

13.4.1 InterRai Project Team and Mental Health Specialist Service meet to discuss implementation of InterRai and how it will be embedded into existing practice.

13.5 There are a wide number of community, voluntary and Iwi/Maori groups that support the elderly. These groups are often run by volunteers, resourced through fundraising activities or small grants/donations. The Ministry of Social Development Family and Community Services division has initiated a strategy that supports the community and voluntary sector, however we do not clearly understand this sector.

13.5.1 Work with Ministry of Social Development in terms of how best to support voluntary community groups.

13.6 The voluntary and community sectors, and Iwi and Maori groupings that provide services to older people/kaumatua be kept informed on service development.

13.6.1 Regular newsletters to key stakeholders through the Health of Older People group.

13.7 The interface between specialist mental health services and psychogeriatric services works well for individual cases but there are opportunities to strengthen the interface. There remains a level of confusion about responsibility for age related mental illness, particularly for people with a history of mental illness and early onset age-related issues. In addition, it is difficult for older people/kaumatua to navigate across services.

13.7.1 As per recommendation 13.3.1, explore the development of a single entry point for older people/kaumatua (*or alike in age and interest*).

13.7.2 A process is developed that addresses disagreement on eligibility criteria and supports joint funding decisions and options.

13.7.3 As per SHOP (Specialist Health of Older People) Guidelines, explore the development of an *' integrated specialist geriatric and psychiatry of old age, assessment and rehabilitation with a palliative approach when necessary'*. The model will be patient focused, delivered by accredited providers who meet the required certification

standards. Alignment with national activity will be crucial.

13.8 NMDHB has an aging population. Accordingly the demand and need for services is likely to grow. This implies a specialist workforce with the appropriate skills to work with older people/kaumatua.

13.8.1 Understand the older people/kaumatua workforce(s) that will be required and include these findings in the Health of Older People Strategy.

13.9 Kaumatua play a pivotal role in terms of whanau, hapu, iwi and the achievement of whanau ora.

13.9.1 Explore opportunities for whanau ora to extend service provision to include primary mental health.

13.10 Resources are available to increase services within specialist mental health for older persons.

13.10.1 Three full time equivalents (*1.0 FTE Blenheim, 1.0 FTE Nelson, 1.0 FTE Tasman*) are established in 2008/2009, with identification of appropriate training programmes to support service development. Encourage appointment of Maori staff within the team. Service to be implemented at the completion of the SHOP Review.

13.10.2 Explore opportunities for mental health support workers and/or day programmes in future service development.

13.11 Older people/kaumatua who are socially isolated, are at risk of developing a mental illness.

13.11.1 Explore the development of an older persons/kaumatua health promotion programme

13.11.2 Work with key stakeholders to encourage community participation with a focus on rural areas.

14.0 Summary

This report explores the estimated prevalence of older persons mental health, looks briefly at service provision, older persons mental health best practice, service gaps and finally suggests recommendations to improve existing mental health service provision.

NMDHB currently have over 19,000 older people/kaumatua over the age of 65, with over an estimated 1,500 experiencing mild to severe mental health problems. Up to the year 2026, this is likely to double to an estimated 3,000 older people. In terms of service provision, given the aging population and the onset of age related disabilities, providers of health and community services need to implement the Health of Older People Strategy to ensure that older people/kaumatua are able to access the needed services at the right time, in the right place and from the right provider.

15.0 Appendices

15.1 Older Persons Mental Health Service Specifications
15.2 ATR Service Specifications including Mental Health.
15.3 Perspectives to Create an Older Persons Strategic Plan

15.1 Older Persons Mental Health Service Specifications

ADULT INPATIENT SERVICES
SERVICE TYPE DESCRIPTION FOR OLDER PEOPLE INPATIENT BEDS

<table>
<tr>
<td>Older People Inpatient Beds

MHIS02</td>
<td><u>Function:</u>
To provide inpatient care for Eligible People in the acute stage of psychiatric illness, or who are in need of a period of close observation and/or intensive investigation and/or intervention, where this is unable to be safely provided within a community setting

<u>Nature of the Service:</u>
Inpatient services are:
• provided in a general hospital setting;
• well integrated with intensive care, day hospital, community mental health services and adult services, and form part of this continuum of services;
• focussed to ensure active intervention, crisis intervention and prevention of the escalation of development of the Service User's illness, prevention of disability, and the prevention of the development of dependency;
• conscious of the safety needs of the patients and of the broader community including staff, reflecting that some Service Users may present a risk of suicide, self harm or danger to others;
• delivered in accordance with a comprehensive system of risk management within which least restrictive intervention strategies will be determined.

Individualised care plans are developed for each person admitted to the service. These plans are comprehensive, based on assessed needs, and include identified goals for the period of inpatient care. Plans are developed in conjunction with the Service User concerned, with relevant community service involvement and, where appropriate, with other caregivers.

Special arrangements are developed to meet the needs of</td>
</tr>
</table>

	particular sub-groups, wherever possible. Hotel and personal care services are provided at no cost to the Service User, including the provision of personal care items when such items are lacking on admission. **Key Processes:** Services Users accessing this service can expect, as a minimum to be able to access all of the following processes: Advocacy, Assessment, Case Management, Discharge Planning, Hotel Services, Legal Compliance, Management of Risk, Peer Support, Service Handover, Support, Therapy, Treatment and Rehabilitation. These processes are described in the Service Specification titled "Process Descriptions". **Services Provided By:** Refer to the "Treatment and Rehabilitative Services" section of the Process Descriptions Service Schedule. **Access:** Access is through community mental health teams for older people providing acute community-based care. Some referrals will be from other inpatient services (for people in adult inpatient mental health services or general health services for older people, where their needs are such that admission to mental health service for older people is appropriate).

COMMUNITY SERVICES FOR OLDER PEOPLE SERVICE TYPE DESCRIPTION FOR ADVOCACY/PEER SUPPORT – CONSUMERS (OLDER ADULTS)

<table>
<tr>
<td>Advocacy/Peer Support – Consumers (Older Adults)

MHCS21.2</td>
<td><u>Function:</u>
To provide advocacy, peer and social support and, where necessary, a programme for life skills development.

<u>Nature of the Service:</u>
A support service run by Service Users of mental health services which provides:
• formal and informal support;
• peer support networks;
• information and access to life skills/work skills programmes;
• information and access to a range of community resources and services;
• advocacy which enhances Service User empowerment and upholds the legal and human rights of Service Users and/or caregivers.

Informal individual and group activities may be included as part of a drop in service or day programme.

<u>Key Processes:</u>
Services Users accessing this service can expect, as a minimum, to be able to access all of the following processes:

Advocacy, Peer Support and Support.

These processes are described in the Service Specification titled "Process Descriptions".

<u>Access:</u>
Referral by Eligible Persons/Service Users directly or referral from community support services or other mental health services.</td>
</tr>
</table>

COMMUNITY SERVICES FOR OLDER PEOPLE
SERVICE TYPE DESCRIPTION FOR ADVOCACY/PEER SUPPORT –
FAMILY/WHANAU (OLDER ADULTS)

<table>
<tr>
<td>Advocacy/Peer Support - Family/Whanau (Older Adults)

MHCS22.2</td>
<td><u>Function:</u>
The provision of information, social and emotional support and advocacy services to the families/whanau/informal carers of older people Service Users.

<u>Nature of the Service:</u>
The following services will be provided to family/whanau/informal carers of older people Service Users:

• accurate and timely information about mental illnesses, the service system and mental health professionals, as well as the community resources and supports available to both Service Users and family members;
• assistance with the development of strategies for coping with the Service User’s illness and its impact on their family life, including problem solving and self advocacy skills;
• advocacy and mediation with other mental health service providers or support agencies;
• peer support networks either family-to-family or in support groups;
• the provision of information regarding relevant legislation, rights and responsibilities.

A range of options will be offered by the service provider. These will be implemented in accordance with the particular requirements of the family/whanau/informal carers concerned. Service provision may include the development of a family support plan, which reflects the family’s needs emphasising progress and recovery.

The service is community based. It will be provided to the family/whanau/informal carers at the place that they prefer (unless safety or inaccessibility are an issue) and will be flexible in its hours to allow contact with family/whanau/informal carers who work during the day.</td>
</tr>
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	It is not a 24-hour service. The service will enhance the ability of families/whanau informal carers to assist a person who either has or may be developing a major mental illness. **Services Provided By:** Services will be provided by trained family support workers with a significant proportion of staff who have family/whanau experience of mental illness. **Key Processes:** Services Users accessing this service can expect, as a minimum, to be able to access all of the following processes Advocacy, Peer Support and Support. These processes are described in the Service Specification titled "Process Descriptions". **Access:** Access may be from any source, including by families and whanau or other caregivers directly or upon referral from primary practitioners or workers within mental health services.

COMMUNITY SERVICES FOR OLDER PEOPLE
SERVICE TYPE DESCRIPTION FOR COMMUNITY SERVICE – OLDER PEOPLE

<table>
<tr>
<td>Community Service - Older People

MHCS18</td>
<td><u>Function:</u>
To provide a community or outpatient based assessment and treatment service for older adults.

<u>Nature of the Service:</u>
These services will be fully integrated with other mental health services. The service may include, but will not be limited to:
specialist assessment (see Process Description “Assessment”) and diagnosis;
provision of medication (including such new agents as are approved for use, in accordance with funding and safety protocols) and other treatment and rehabilitation services in accordance with a documented comprehensive management plan with identified desired outcomes;
ongoing monitoring of symptoms and regular review of progress and treatment at specified intervals;
provision of access to cultural services in accordance with the needs of the Service User;
consultation and liaison services to other health or disability support services for older adults.
Provision will be made for specialised assessments and intervention for particular sub-groups, including:
people with combined problems of mental illness plus drug and alcohol use, or intellectual disability, or brain injuries;
refugees.
Where possible, care will be provided in conjunction with primary health services. At the least, there will be documented clear communication with any primary health providers regarding the treatment plan and progress, and its completion, unless specifically refused by the Service User.</td>
</tr>
</table>

	Relationships will be established with rest homes and other providers of supported accommodation for older people to ensure appropriate care for their residents. Training, advice and supervision will be provided to primary health workers and accommodation providers to support the assessment/treatment/management of Service Users in community and residential care settings. Care will be co-ordinated by a specified person (key worker/case manager), with a number of staff of varying backgrounds being available to contribute to care in accordance with identified needs. **Key Processes:** Services Users accessing this service can expect, as a minimum, to be able to access all of the following processes: Advocacy, Assessment, Case Management, Discharge Planning, Early Identification, Legal Compliance, Management of Risk, Peer Support, Screening, Service Handover, Support, Therapy, Treatment and Rehabilitation. These processes are described in the Service Specification titled "Process Descriptions". **Service Provided By:** Services will be provided by a multi-disciplinary team including specialist psychiatrists, registered nurses, psychologists, occupational therapists, social workers, cultural advisors and/or cultural support workers and other professional staff in accordance with the needs of the Service User. **Access:** Access may be from any source, including referral by Eligible People directly or referral from primary practitioners, family, caregivers, community members, and inpatient services.

COMMUNITY SERVICES FOR OLDER PEOPLE
SERVICE TYPE DESCRIPTION FOR OLDER PERSONS DAY HOSPITAL PROGRAMME

Older Persons Day Hospital Programme **MHCS45**	**Function:** To provide an assessment, treatment and recovery oriented rehabilitative programme for people requiring specialised programmes and/or more intensive care than can be provided within outpatient services, but who do not or who would otherwise require inpatient care. **Nature of the Service:** A range of services are provided, including: • assessment or re-assessment of clinical conditions/functional abilities; • medication review and stabilisation; • specific programmes for symptom reduction, enhancement of function, and education and information; • consultation/support to family and significant others. Day Hospital programmes are fully integrated into the spectrum of acute and rehabilitative services to ensure smooth transition for individuals from one service to another. Where required, transport to and from the facility is provided by or arranged by the service. Meals are provided at no cost to the Service User. **Key Processes:** Services Users accessing this service can expect, as a minimum, to be able to access all of the following processes: Advocacy, Assessment, Case Management, Discharge Planning, Legal Compliance, Management of Risk, Peer Support, Service Handover, Support, Therapy, Treatment and Rehabilitation. These processes are described in the Service Specification

	titled ”Process Descriptions”: **<u>Services Provided By:</u>** A multi-disciplinary team of specialist clinical staff with appropriate health qualifications, skills and experience in accordance with the nature of the service required. **<u>Access:</u>** Referral from community or inpatient mental health services for older people.

Appendix 15.2

ATR

SERVICE SPECIFICATION

Assessment, Treatment & Rehabilitation Services

DSS235	ATR Inpatient – Mental Health Services for Elderly	Multidisciplinary inpatient age-related assessment treatment and rehabilitation for people with an identifiable or suspected psychiatric disorder (as defined in DSM IV, or other generally recognised diagnostic classification): 1) Which has a significant impact on that person's ability to function, or 2) Which is likely to result in long term impairment with the aim of enabling them to live as independently as possible in the community.

Appendix 15.3

Combining Evidence and Consumer and Provider **Perspectives to Create a Strategic Plan for Older Adults with Mental Health Problems - CLANZ**

This is the older persons wish list for growing recovery-focused services:

1. First of all involve us actively, *ab initio* in the planning and implementation of a recovery-based service. Ask yourself why shouldn't we be there? We have a vested interest in achieving the best outcomes for wellness.
2. Recognise that we are the experts in being older and the ‘lived experience’ of recovering from mental illness. Your service is trying effect recovery. The unique contribution that we have to make is based on our knowledge of what works.
3. We take our consumer job seriously and will need a job description which clarifies the roles and responsibilities. We need to develop this collaboratively. Envision that together we may have to tackle bigger issues and work systemically. We are going to have to tackle the social control issues in psychiatry and the safety and security agenda for older persons’ services. Plan to take me along. Pay us real money for real work.
4. A recovery-focused service will be build on a shared vision and shared values and a common philosophy. In the end, we will all use the same measure "will it contribute to the clients wellness"?
5. Be prepared to share power. You don't have a monopoly on all the good ideas. Together lets be innovative and provide a range of treatment choices.
6. We want to remain in our homes, so work towards creating a seamless service in which we can have access to a range of services without

having to "run the gauntlet". Staff the community services with people who are reliable and treat us with courtesy and respect.

7. Be inclusive of family, if that is what we want. Provide support for families and encourage and inform families about the process of recovery.
8. Be prepared to share information. Information is empowering. Ignorance is not bliss! We want to make informed decisions for ourselves; they may not always be the ones that you think are best for us, but we have the right to be wrong, like the rest of the world.
9. If we become unwell, actively assist us to reintegrate with our community. The discharge plan needs to be holistic and support us to return and 'to be the best that we can now be'.
10. Commit to staff education and supervision. Change and innovation require new knowledge and time for reflection. Staff who feel they are valued and a part of a dynamic service remain. Staff who know us promote recovery.
11. Develop stigma reduction initiatives that challenge the assumptions and attitudes towards older people. We need strong ties at every level of governance within the community to ensure the interests of older clients are voiced.
12. Encourage and support consumer-operated initiatives and services.
13. Employ consumers as clinicians. Working with consumers who have identified themselves as recovered can stimulate hope.
14. Develop systems that monitor and evaluate the service provided. Build in an independent complaint procedure.
15. Be committed to innovation and be prepared to not get it right, sometimes.