Midland Region

Mental Health and Addiction Service

for Older People Continuum

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HealthShare
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Midland district health boards' shared services agency

Midland
District Health Boards
MENTAL HEALTH & ADDICTION REGIONAL NETWORK
Service Development • Workforce Development • Partnerships & Relationships

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Executive Summary

This project was commenced in 2011 to support Midland region DHBs in their planning and service development to address the needs of a growing older population. Consistent with the Ministry of Health's Guideline on Mental Health and Addiction of Older people and Dementia (2011), an integrated and coordinated approach was sought to improve access to services, and the quality of services provided.

DHBs provided data on current service provision, consistent with the Seven Tiered Model (Draper, Brodaty & Low, 2006), in response to a devised questionnaire. This data was used to demonstrate the gaps in service provision and areas where needs were being addressed. Further to this, a swap shop day was held with key stakeholders to discuss and debate what was working well and where further development was warranted. This information together with a scan of the literature was collated in this report.

This information provided a foundation for a set of draft recommendations to be developed for implementation. Key stakeholders were invited to critique them at a further swap shop day.

The recommendations included:

Pathway and Service Model Development

- Develop regional pathways and service models for the service continuum that span primary, secondary and tertiary care, consistent with the Draper, Brodaty& Low's Seven Tiered Model, that are integrated and person and whanau centred, commencing with a regional dementia care pathway.

- Pathway development will aim to provide clarity about what services including diagnostics, and models of care are required to meet the person and their carers' needs from pre-diagnosis to advanced care.

- Attention will be given to the linkages, interfaces and risk management of primary, secondary and tertiary providers working collaboratively to deliver care at the right level in the right place by the right health professional.

The client group with multiple co-morbidities resulting in a complexity that doesn't fit well with local service provision will be identified and regional options investigated. For example, mental health clients who experience dementia/significant cognitive decline in relation to their mental illness, people under the age of 65 who experience cognitive decline due to neurological disorders, and dementia, and people with intellectual disability who also experience mental illness or dementia..

Workforce

Support the identification of learning competencies required by staff and people caring for older people accessing services in the Midland region, and recommend training that includes: dementia, delirium, depression, managing complex clients with multiple co-morbidities, elder abuse and neglect, legislation, PPPR Act, and cultural perspectives in ageing.

Introduction

The proportion of older people in the Midland region is expected to increase with an "ageing of the population", consistent with other regions in New Zealand and internationally. It is predicted to be a move from a younger to an older population structure, with an increase in the over 65s and also an increase in the 'oldest of the old', the over 85s. This older population is likely to have higher health needs and consume more health services than younger age groups, thus is likely to place a higher demand on health and disability services (Cornwall & Davey, 2004).

The Midland region covers a large area geographically and includes the Tairawhiti DHB, Lakes DHB, Taranaki DHB, Bay of Plenty DHB and Waikato DHB.The total population of the region is 738,918, comprising of 171,213 (21.9%) Māori, 11,844 (1.6%) Pacific People, 17,235 (2.3%) Asian, and 538,596 (72.9%) Other. Tairawhiti DHB serves 44,499 people, Lakes DHB serves a population of 102,000 people, Taranaki DHB serves a population of 104,280 people, Bay of Plenty DHB serves a population of 200,000, and Waikato DHB serves a population of 360,000 people (NZ Census, 2006). The focus of this project is the older proportion of those populations and more specifically those with mental health, addiction and dementia needs.

Table 1: Populations by Age and Ethnicity in the Midland region (2001)

Age	Asian	Māori	Pacific People	Other	Grand Total
<15	4,296	64,416	43,960	107,856	180,528
15-24	3,714	28,878	2,124	59,793	94,509
25-64	8,547	71,178	5,271	284,088	369,084
>65	678	6,771	489	86,859	94,797
Total	17,235	171,243	11,844	538,596	738,918

Project Statement

The MoH Mental Health and Addiction Services for Older People and Dementia Services: Guideline for District Health Boards was released on 6 July 2011. The guideline aims to improve access to services and provide consistency across all District Health Boards and aged care providers. A key area of focus is the need for greater coordination particularly at the transitions between at primary, secondary and tertiary levels of care.

There is a clear need for both Older People and Mental Health & Addictions services to work in an integrated way to ensure the needs of this growing population are addressed. This project proposes:

1. A regional Swap Shop day that confirms the needs, and identifies innovative and creative cross sector best practice, including integrated service models to address current and future need.
2. A strategic development stakeholder consultative process that builds on work commenced at the Swap Shop day, bringing together and confirming common themes across the region.
3. A further Swap Shop day to critique the draft report capturing the themes and proposing recommendations.

Objective

The objective is to deliver, a report with recommendations for the Midland region which will provide an evidence base to inform and support the following work, with specific focus on mental health and addiction of older people and dementia.

Managers, Planners and Funders – regional and local:

- strategic planning
- prioritisation decisions
- identifying specific requirements for new or existing contracts
- workforce development planning
- funding bids

Service managers and clinical leaders (provider arm and NGOs)

- identifying gaps in their own services
- identifying particular quality or responsiveness issues in their own services
- identifying services or approaches that may be needed to meet the particular demographic needs in their area
- workforce development planning
- funding bids

Consumers

- advocacy for re-focusing or re-designing funding and services to provide a more user-centred approach
- advocacy for meeting service gaps
- advocacy for addressing service responsiveness or quality

Family/Whanau

- advocacy for meeting service gaps
- advocacy for addressing service responsiveness or quality

Local, regional and national workforce planners

- local, regional and national workforce development planning
- competencies that require particular attention

Policy makers at the local, regional and national level

- advice to government on services
- information to support budget bids at a local, regional and national level

Strategic Accountability

The project will be guided by:

- Ministry of Health: Mental Health and Addiction Services for Older People and Dementia Guidelines, 2011
- Ministry of Health: Health of Older Peoples Strategy, 2001
- Ministry of Health: Guidelines for People with Dementia, 2007
- Ministry of Health: National Service Specifications for Mental Health Services for Older People, 2010
- Ministry of Health: Te Tahuhu, Improving Mental Health 2005-2015, The Second NZ Mental Health and Addiction Plan, 2005
- Ministry of Health: Te Kokiri, The Mental Health and Addiction Action Plan 2006-2015
- Midland Region Mental Health and Addiction Needs Assessment 2010
- Midland Region Mental Health and Addictions Strategic Plan 2008-2015
- Midland Region Mental Health Workforce Development Plan 2010 – 2014
- Midland Regional Clinical Services Plan 2010
- Midland Regional District Annual Plan 2011/12
- Ministry of Health: Te Rau Hinengaro, The New Zealand Mental Health Survey 2006
- Te Pou: Mental Health and Addiction Services for Older People: Workforce Survey, 2011.

Background

The Midland region completed a regional mental health and addiction needs assessment in January 2011. Within the report it identified that across the Midland region services for older people based on Blueprint (1998) benchmarks, were overprovided. However it was later confirmed that this was not the case. It was widely recognised that the Blueprint benchmarks were outdated and that Te Rau Hinengaro (2006) would provide more up to date benchmarks. But even this recent publication failed to capture all older people as data that was collected using a door to door survey excluded aged residential care facilities.

Furthermore the benchmarks did not factor in the significant future growth that the Midland region is expecting over the next 10 years in the older population. Given this, there was a pressing need to undertake a specific project that clearly identified MHSOP future needs and allowed planning and funding and provider divisions within DHBs to have a clear direction and influence their funder, the Ministry of Health.

There is a body of literature which details the methodological reasons why a community survey such as Te Rau Hinengaro significantly underestimates rates of mental disorder in older people (O'Connor, 2006).

Approach and Methodology

This has included the following processes:

- Approval of the project scope and the proposed content of the report
- Identifying a key Clinical Reference Group to support the Project Consultant
- Bringing the MHSOP sector together to recognise and celebrate innovation
- A scan of the literature including Ministry of Health strategic documents

- A stocktake questionnaire conducted with DHB Planning and Funding mental health portfolio managers from across the region
- Data analysis
- Consulting with key stakeholder groups on current services, gaps, needs, priorities and risks
- Receiving additional information at the stakeholders Swap Shop Day
- Utilising Dementia services stocktake undertaken by Ruth Thomas
- Collecting, analysing and presenting the information to stakeholders and the key reference group
- Report writing and editing
- On-going checking of processes to ensure that the information, and the way it is presented is going to be useful for those in the Midland region
- Regular reporting to the project sponsor
- Submitting the final critiqued report to the project sponsor

Literature

For the purpose of this report key material was drawn from the literature review made publicly available by the Ministry of Health for the Mental Health and Addiction of Older People and Dementia project (2011) and other relevant literature and documents submitted to the author by Midland region stakeholders.

Ageing population

People experience health and social problems as they age, and the numbers of people over 65 years and over 85 years is expected to increase significantly in future years, adding further burden to the health and social services (Boston and Davey, 2006). By 2026 almost 18% of the total New Zealand population will be aged over 65 years (Richmond et al., 1995). This proportion of older people is expected to increase among all ethnicities, including Māori, for whom the over 65 group is projected to more than double from 4% in 2006 to 9% in 2026. Over the same period, the proportion of Asian people over 65 is expected to grow from 5 to 11%, and of Pacific people over 65, from 4% to 6% of that population. Women continue to live longer than men (Ministry of Health, 2011;Statistics New Zealand 2010).

Many age related and non-age related 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 pressures on health services as well as on the individual and their family, whanau and carers. Active and healthy lifestyles reduce the likelihood of a person developing such problems for example, dementia and depression. It has also been shown that treating a mental illness such as depression in older people is as effective as treating depression in other age groups. However, for system and individual reasons many older people currently do not receive the treatment they require (Karlin & Fuller 2007).

Prevalence

Studies that have suggested that the prevalence of mental disorder is lower in older people generally have not included older people living in rest homes and private hospitals (Oakley Browne, Wells & Scott, 2006), and therefore it is likely that the prevalence is much higher than reported. It has been estimated that 40% of rest home residents have depression and of those 10% have a major depressive disorder (Snowdon, 2007). Tynan's (2009) review of the literature found the prevalence of psychiatric disorders in residents of aged residential care to be between 80-90 %.

A research study titled Older Persons Ability Level Census (OPAL) 10/9/2008 was conducted in the Auckland region and investigated the changes in aged care residents characteristics and dependency between 1988 and 2008 (Boyd et al, 2009). The research showed a 43% increase in the population of people over 65 years but only a 3% increase in aged residential care beds resulting in the proportion living in aged residential care declining. The research also found those who were residents had increased dependency in domains including mobility, continence and cognitive function, with more residents with a high dependency. Decline in cognitive function may be due to mental conditions. The most common conditions that are referred to specialist mental health services for older people are depression, delirium and behavioural and psychological symptoms of dementia (Chiu, 2005).

Dementia

Dementia is a cognitive condition described by the World Health Organisation as a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgment. The impaired cognitive function often presents with deterioration in emotional control, social behaviour, or motivation (Finkel, 1996, 2003; W.H.O., 2007).

Dementia is likely to be a huge burden on communities and society as a whole. An economic impact report published in 2008 by Alzheimer's New Zealand, found that there were over 40,000 people with dementia in New Zealand and this number was predicted to nearly double by 2026 (Alzheimer's ,NZ, 2008). This prediction does not include dementias from other causes such as diabetes, obesity and stroke which are also expected to increase. Dementia brings about impairments that affect the person's ability to perform basic activities of daily living. This also impacts the family and carers with potentially high physical, emotional, and financial costs (Perkins, 2004).

Alzheimer's disease, a cause of dementia, (accounts for 70% of all dementias). Vascular disease also causes dementia along with such combinations as Alzheimer's and vascular disease, Lewy bodies, fronto-temporal dementia and Parkinson's disease (Perkins, 2004). Parkinson's disease, head injury and depression are all regarded as risk factors for dementia.

People under 65 years of age may also be affected by dementia. However the types of dementia experienced by younger people vary, but are more likely to be fronto-temporal dementias, with 10% of cases being alcohol-related (Perkins 2004). Melding and Osman (2000) reported that 5% of people seen in older people services were under the age of 65 years and more commonly they were presenting with premature dementia, which may be related to a brain injury, stroke or Down syndrome. Those at even greater risk of developing dementia were people with Down syndrome, also presenting with symptoms of dementia at an earlier age than the general population (Torr & Chiu, 2002).

Depression

Depression is the most common mental disorder for older people and affects between 15 to 20% of them. More severe depression affects about 3% 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 (Ministry of Health, 2011). Older people are more likely to complete their suicide attempts than younger people (Beeston, 2006). The risk of suicide can be significantly reduced by treating depression (Bruce et al 2004) and wellbeing to enhance the quality of life.

Delirium

Delirium may affect up to 25% of older people and is a temporary medical condition that can be life-threatening closely associated to an underlying physical illness or health trauma (Royal College of Physicians; British Geriatric Society, 2006). A range of medical conditions including cardiac events, stroke, metabolic imbalances and infections can cause delirium and it can also be triggered by an adverse response to some medications. Furthermore people with dementia are more likely to experience delirium particularly when medical conditions are present (Perkins, 2004).

There are a number of surgical procedures that are common in older people and are more likely to trigger a delirium response post operatively. For older people, 60% experience symptoms of delirium following a hip replacement, 50% following cardiac surgery.

Furthermore dementia is a major risk factor for delirium. Delirium and its associated cognitive impairment usually persist for months (Girard, 2010) and in those with Alzheimer's dementia accelerate the trajectory of cognitive decline (Fong, 2009). The early identification and treatment of delirium within the general hospital is an important area of secondary and tertiary prevention.

Delirium may manifest itself in psychiatric and behavioural changes that resemble other conditions which may frequently lead to not being diagnosed or misdiagnosed. The symptoms commonly associated with delirium include:

- Disturbance in level of consciousness (reduced clarity of awareness of the environment)
- A change in cognition (such as memory, orientation, language disturbance) or the development of a perceptual problem (usually hallucinations-seeing or hearing things that are not there)
- The disturbance develops over a short period of time (hours to days) and tends to fluctuate over the course of the day
- Evidence from history and examination that there is something medically wrong

(The American Psychiatric Association, 1994, cited by Perkins 2004).

Alcohol and drugs

It is believed that the prevalence of substance misuse, be it moderate alcohol consumption, illicit drugs or prescription medicines mismanagement is grossly under-estimated in the older population (Paech & Weston, 2009; Bartels S.J. et al., 2005). As people age they may well continue to consume alcohol at consistent levels without realising a changing effect this has on them. It is suggested that older people who drink alcohol regularly should reduce their alcohol intake by about half. However an increase in alcohol intake may be triggered by sources of stress affecting older people such as loneliness, grief and loss, financial concerns, elder abuse or being a long term carer for a spouse. Falls, memory loss and confusion in older people may be symptoms of alcohol intake not only of other aging conditions (Alcohol Advisory Council of NZ, 2008).

It is predicted that as the baby boomers enter old age alcohol and other drug misuse disorders will become more prevalent (Gupta & Warner, 2008; Oslin, 2004). The New Zealand Health Survey found that 125,393 people in the Midland region had a potentially hazardous drinking pattern and 13,964 people smoked marijuana regularly.

This is likely to have an impact as a history of escalating alcohol consumption abuse and dependence have been found to increase mental health problems in older people. Particularly men over 65 years who have been heavy drinkers for at least 5 years at some time are six times more likely to experience a mental disorder, four times more likely to

experience depression and five times more likely to experience dementia (Saunders et al., 1991).

Older people often consume quantities of prescription and non-prescription medications. Poly-pharmacy and its associated problems such as adverse reactions with alcohol, errors in dosage and misuse affect the wellbeing of older people (Health Canada, 2002).

Health and social care providers should become more skilled at identifying and responding to alcohol and drug issues in older people (Oslin, 2004). This may include incorporating screening for substance misuse in regular check ups in primary care settings (Dawe, 2002).

Complex co-morbidities

Older people often have a mix of conditions rather than strict diagnoses (Melding, 1997), and may present with complicating physical illnesses as well as depressive, cognitive and anxiety symptoms. Comorbidity contributes to a higher risk for dependency, falls, injuries, acute illness, delayed recovery, and death (Fried & Walston, 2003). Furthermore, older people tend have more medical diagnoses and suffer the consequences of chronic conditions such as hypertension, renal failure, Parkinson's Disease, heart disease, amongst many other physical health problems (Inventor et al, 2005).

Elder abuse and neglect

Elder Abuse occurs when a person aged 65 years or more experiences harmful physical, psychological, sexual, financial and/or social effects caused by another person with whom they have a relationship with. Elder abuse is associated with distress and increased mortality in older people and caregiver psychological morbidity. Statistics from services in New Zealand show that the majority of abusers are members of the older person's family/whanau (partners, sons, daughters, in laws, siblings, and grandchildren). Other abusers include people employed in positions of trust – residential facility staff or paid carers (Tynan, 2009).

Service principles to support older people

Service principles consistent with World Health Organization principles (WHO and World Psychiatric Association 1997), which are widely acknowledged internationally, have been reshaped to reflect the New Zealand context in the Ministry of Health Guideline (2011). It states:

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 whanau, 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 (Ministry of Health, 2011).

An integrated service user pathway

Services ideally are integrated to provide smooth seamless delivery of care across the entire range of services (Department of Health, 2005).

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 or intellectual disability or complexity (Minister of Health, 2005). 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
- of any age who develop dementia
- of any age with an intellectual disability who develop symptoms of dementia
- 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 (Ministry of Health, 2011).

The seven-tiered model of care

The seven-tiered model of care 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. The needs of people ranging from 'no mental disorder or dementia' to 'extreme mental disorder' are matched with the service types. The model is intended to assist with service planning, funding and delivery.

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 & 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 & Tilford, 2006)
- attention to spiritual needs (Lawrence & Head, 2009).

Table 2: The Seven Tiered Model (Ministry of Health, 2011)

Tier level	Focus	Patients for whom focus applies	Health Care Provider
Tier 1	Mental health prevention and promotion	People with no mental disorder or dementia	Primary Health Care Health promotion providers Local Community Councils
Tier 2	Targeted mental health prevention and promotion	People presenting with risk factors for mental disorders and dementia without Behavioural and Psychological Symptoms of Dementia (BPSD)	Primary Health Care Health promotion providers Disability Support and service providers
Tier 3	Assessment, early intervention, treatments	People with mild mental disorders or mild BPSD	Primary Health Care Providers Disability Providers Health of Older People services
Tier 4	Assessment, early intervention, treatment, case management	People who have moderate mental disorders or moderate BPSD.	Shared Care: Primary Health Care providers and Specialist services Disability Support Health of Older People services
Tier 5	Assessment, treatments, case management	People who have complex mental disorders or BPSD with complications such as aggression or agitation.	Specialist services (Case management by Community MHSOP team in collaboration with ARC facility with support from Disability providers and/or Health of Older People
Tier 6	Assessment, treatments, case management	People who have severe mental disorders or severe BPSD.	Specialist services (Specific acute mental health unit or dementia unit within ARC facility) with support from Disability providers and Health of Older People services
Tier 7	Assessment, treatments, case management	People who have extreme mental disorders	Specialist services (specialist unit with intensive care) with support from Disability providers and Health of Older People services

Midland DHB Stocktake

The five DHBs submitted data for the year 2010-2011 on services that they provided according to the seven tiered model (Draper, et al, 2006). The data confirmed that a range of services were being provided for older people funded from funding streams from both Mental health and Health of Older People portfolios within DHBs and the Ministry of Health.

At Tier 1, services and service activity was not recorded in the questionnaire response. More commonly health promotion and disease prevention are part of nationally funded campaigns and not directly DHB funded.

At Tier 2, three DHBs had contracts with Alzheimer's NZ for the provision of information, education and advice to individuals, their carers and the wider community. Additionally, the Midland Regional Behavioural Support and Advisory Service responded to referrals from the early onset dementia (Tier 2) through to more advanced stages (Tiers 3-7).

At Tier 3- 5

- One DHB had a primary integrated mental health service
- Two DHBs had Memory Clinics (one a pilot project)
- All DHBs had respite options - some activity programmes, carer relief etc
- One DHB had a Dementia Field Officer
- One DHB had a Peer Support service
- All DHBs had Specialist Mental Health of Older People Community Teams
- All DHBs had day care and day activity programmes
- Most had MHSOP Inpatient beds - some local, some regional, some attached to acute unit, some separate
- One utilised an assessment bed in rest home setting
- Some had access to Packages of Care
- All DHBs were able to access rest home care

At Tier 6-7

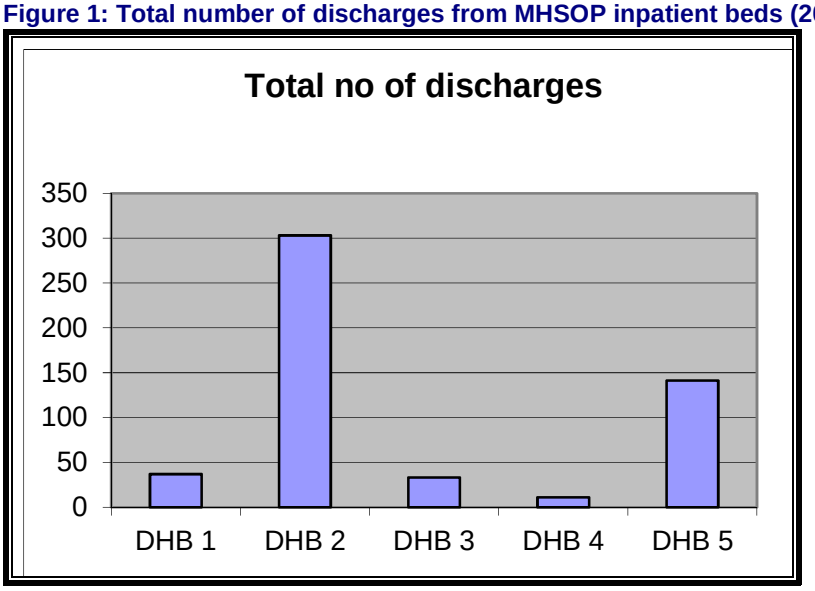
- Some dementia specific inpatient beds, others combined within MHSOP inpatient beds
- Some psycho-geriatric beds
- Some secure dementia beds
- All had access to private hospital beds

Utilisation data was submitted for analysis by DHBs for the 2010/11 year. The DHBs have been labelled: DHB 1: Taranaki DHB, DHB 2: Waikato DHB;DHB 3: Lakes DHB, DHB 4: Tairawhiti DHB, DHB 5: Bay of Plenty DHB.

MHSOP Specialist Inpatient bed usage across the region varied, from one facility providing access for other DHBs from across the region.

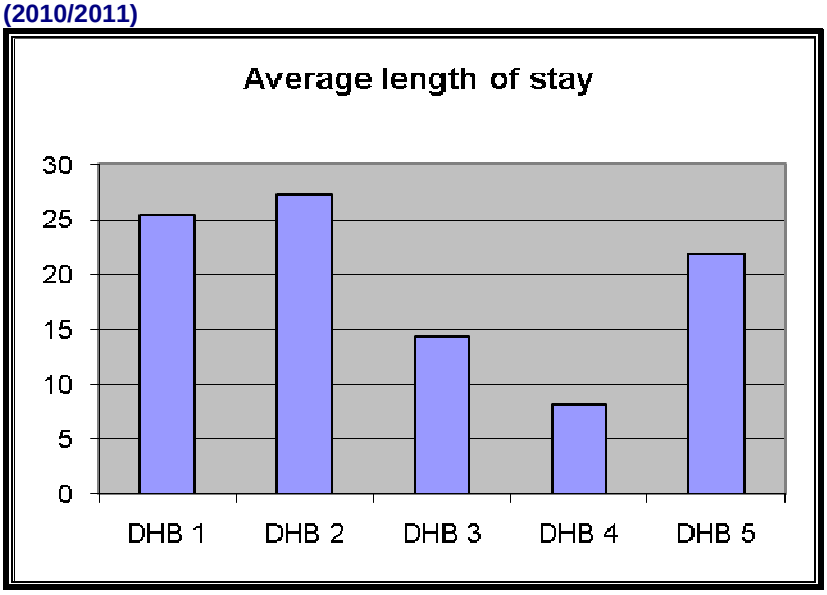
The total number of discharges varied from DHB to DHB and this was influenced by the preferred model of care and the size of population served. Models of care varied across the region with one smaller DHB referring the more complex to another DHB for specialist inpatient provision. This is shown in figure 1.

Figure 1: Total number of discharges from MHSOP inpatient beds (2010/11)



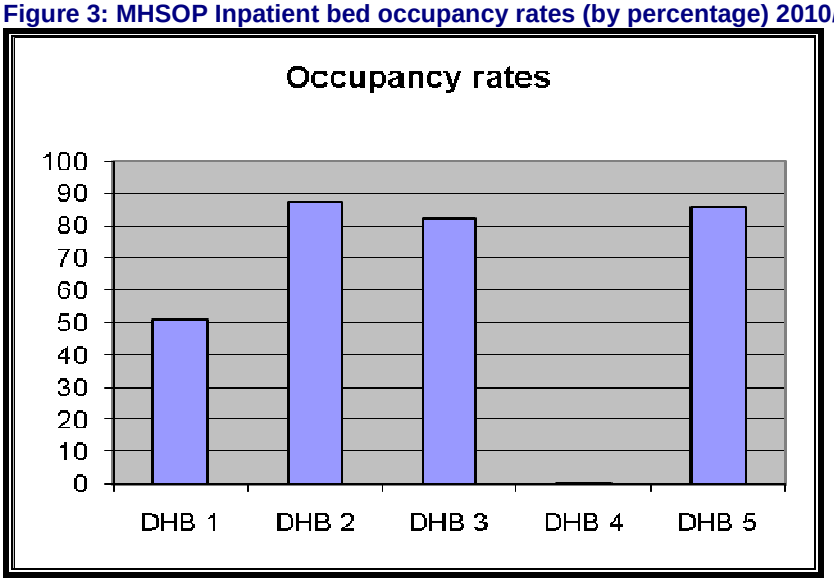
Inpatient stays for mental health conditions tended to be longer than for physical health conditions. DHBs' average length of stay varied from 8 days to 27 days, as shown in figure 2. In one DHB this related to not having adequate psycho-geriatric beds to discharge clients rather than necessarily more complex clients requiring a longer inpatient stay.

Figure 2: MHSOP Inpatient bed average length of stay measured in numbers of bed days (2010/2011)



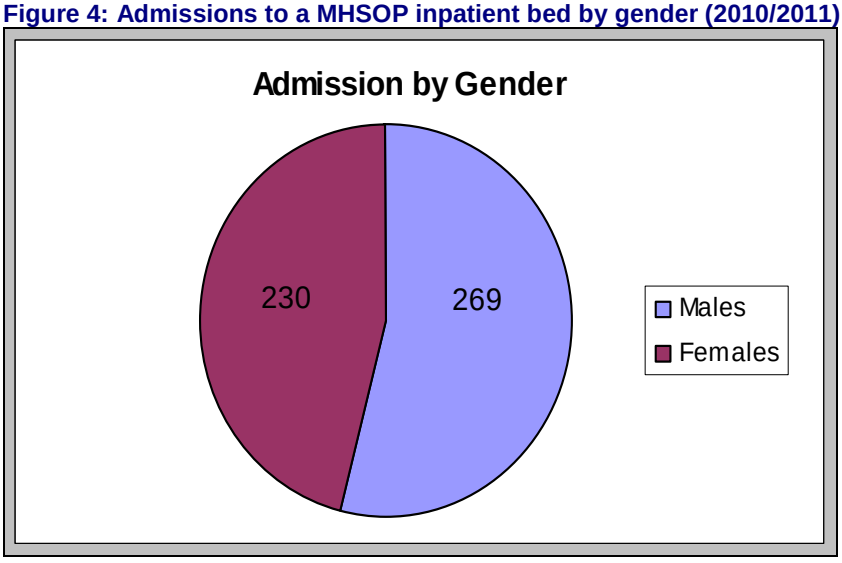
The dedicated beds within the inpatient facilities varied in their occupancy. One DHB didn't have beds and referred people out of the area. This was measured in occupied bed days. This is shown in figure 3.

Figure 3: MHSOP Inpatient bed occupancy rates (by percentage) 2010/11



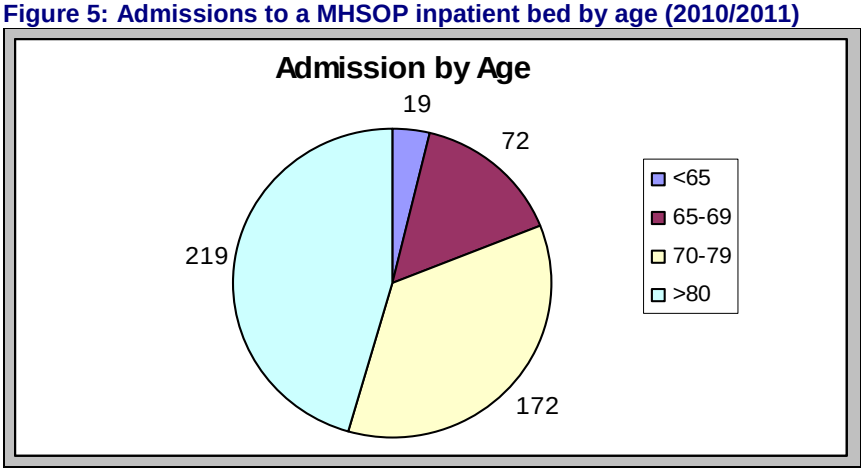
More males than females accessed the inpatient beds as shown in figure 4. There were 269 males and 230 females.

Figure 4: Admissions to a MHSOP inpatient bed by gender (2010/2011)



Most people admitted to the inpatient beds were over 65 with the largest age group being over 80 years, as described in figure 5.

Figure 5: Admissions to a MHSOP inpatient bed by age (2010/2011)



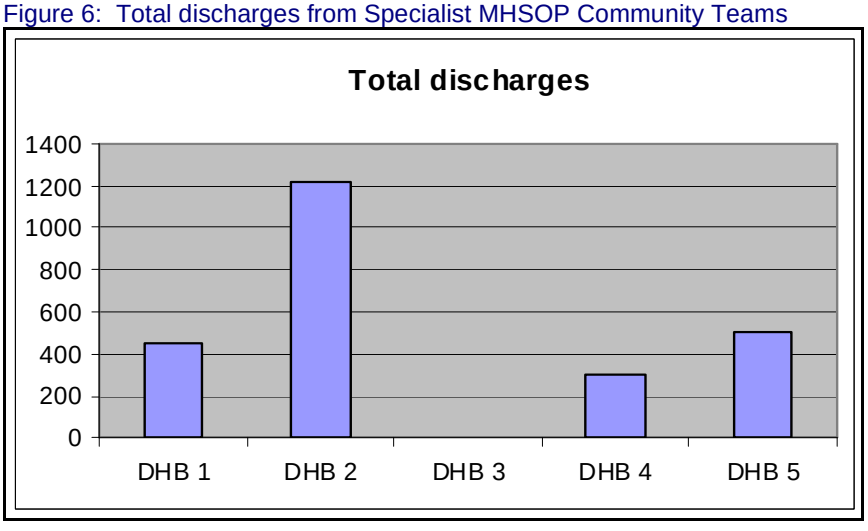
There were 19 people admitted that were under the age of 65, 72 people between the ages of 65 and 69, 172 people between the ages of 70 and 79 and 219 people over the age of 80.

The largest group of people who were admitted to the MHSOP inpatient beds were categorised as “other” ethnicity and the second largest was New Zealand European. Some DHBs collected ethnicity data for a greater number of categories. The most common categories across the 5 DHBs were Māori, Pacific, NZ European and Other. Of the total inpatient admissions for 2010/11 year, 33 were Māori, 1 Pacific, 192 NZ European, and 293 other ethnicities not specified.

Each DHB in the Midland region had a MHSOP Community Team. These teams tended to be multidisciplinary and clinically led by a Psychiatrist specialising in disorders of older people. The teams were community based and linked with primary care providers, NGOs and other specialist providers.

The data recorded the numbers of people discharged from the MHSOP community team. One DHB had significantly more discharges than the other DHBs. Another DHB was not able to report on the discharge volumes at that time. This is described in figure 6.

Figure 6: Total discharges from Specialist MHSOP Community Teams



Three DHBs did not have a stand-alone psycho-geriatric inpatient unit as part of their respective district general hospital services. The DHBs without a stand-alone psycho-geriatric unit admitted MHSOP patients to the adult psychiatric unit or into residential care facilities and this was a major factor in the variation in discharge rates between DHBs. This regional variation is a gap in service provision and whilst resources are scarce DHBs need to balance resource issues against unmet needs for older persons particularly for those patients whose needs aren't easily met on an adult psychiatric unit such as patients with Dementia and BPSD.

The specific DHB findings by service type and utilisation are described in the next section. Additionally DHBs MHSOP and HOP representatives were invited to comment on what was working well in their DHB and where there were opportunities for development or improvement. Their responses are documented.

Waikato DHB

Current Investment by Service Type

Adult mental health and addiction services at Waikato DHB continue to provide support to people over the age of 65 who have been with the service before turning 65. However adult services may seek the support of MHSOP if required. MHSOP are for complex cases or first presentation of Mental illness over the age of 65 years.

Adults under the age of 65 with disabilities (e.g. intellectual disabilities, dementia, head injury) and mental health issues have access to all adult mental health services and MHSOP expertise is sought as required. MHSOP works in conjunction with Disability Support to undertake needs assessments (MHSOP complete the MH component). Both services are now using InterRAI for NASC.

Additionally, there is a specific Community mental team for people who have dual intellectual and mental health issues. A table describing these services and others provided by Waikato DHB is in Appendix C.

The DHB Health of Older People portfolio funds Community Day Programmes in the Waikato district, and DHB Mental Health Services for Older People also fund a Community Day Programme. While new services were currently being planned for Matamata and smaller townships through new funding for 'Dementia Respite in 2011-2012; DHB-funded CDP providers are currently located in:

- Thames (BUPA Tararu Village)
- Te Aroha (TeAroha District Hospitals Charitable Trust)
- Te Awamutu (Te Ata Rest Home)
- Taumarunui (Avonlea Rest Home; Taumarunui Hospital)
- Morrinsville (Rhoda Read Hospital)
- Hamilton City and environs (Tamahere Eventide Rest Home; BUPA Rossendale Sunflower House; Presbyterian Support Enliven Day Care; Rauawaawa Kaumātua Charitable Trust)
- Cambridge (Resthaven)
- Otorohanga (Beattie Home)

Additional to this, community day programmes and in facility day respite were also offered as described in table 5 on page 22.

Utilisation

Table 3: Utilisation of Waikato DHB Specialist MHSOP Inpatient Beds

Specialist MHSOP Inpatient Service **PU Code: MHO98** **Available contracted beds**	
Average occupancy in 2010/11	87.25%
Average length of stay in 2010/11	27.23
Total number of discharges in 2010/11	303
Total number of admission in 2010/11	296
Admissions by ethnicity	1 = African (Or Cultural Group Of African Origin) 5 = Asian No Further Definition 2 = Chinese 97 = European No Further Definition 2 = Indian 7 = Māori 2 = Not Stated 161 = NZ European / Pakeha 17 = Other European 2 = Response Unidentifiable
Age by Admission	56 yrs = 1 59 yrs = 1 62 yrs = 1 63 yrs = 1 65 yrs = 1 66 yrs = 1 67 yrs = 1 68 yrs = 3 69 yrs = 5 70 yrs = 5 71 yrs = 14 72 yrs = 4 73 yrs = 11 74 yrs = 4 75 yrs = 16 76 yrs = 6 77 yrs = 5 78 yrs = 9 79 yrs = 34 80 yrs = 15 81 yrs = 11 82 yrs = 101 83 yrs = 1 84 yrs = 7 85 yrs = 5 86 yrs = 9 87 yrs = 7 88 yrs = 6 89 yrs = 1 90 yrs = 2 91 yrs = 2 92 yrs = 5 93 yrs = 1
Admission by Gender	133 = Female, 163 = Male
Staff to patient ration (eg.1:5)	(*Information not available*)

Table 4: Utilisation of Waikato DHB Specialist MHSOP Community Mental Health Service

Waikato DHB Specialist MHSOP Community Service **PU Code: MHO99A-E**	
Total number of discharges in 2010/11	1213
Total number of new referrals 2010/11	894
Admissions by ethnicity "Referrals" by Ethnicity	2 = African (Or Cultural Group Of African Origin) 1 = Asian No Further Definition 2 = Chinese 3 = Cook Island Māori 23 = European No Further Definition 3 = Indian 63 = Māori 1 = Niuean 24 = Not Stated 646 = NZ European / Pakeha 1 = Other Ethnicity 97 = Other European 27 = Response Unidentifiable 1 = Samoan
Admission by age "Referrals" by age	Average age is: 79 51 yrs = 2 56 yrs = 3 59 yrs = 2 60 yrs = 2 61 yrs = 3 62 yrs = 5 63 yrs = 4 64 yrs = 5 65 yrs = 9 66 yrs = 12 67 yrs = 13 68 yrs = 19 69 yrs = 20 70 yrs = 25 71 yrs = 24 72 yrs = 21 73 yrs = 16 74 yrs = 11 75 yrs = 24 76 yrs = 19 77 yrs = 27 78 yrs = 35 79 yrs = 28 80 yrs = 32 81 yrs = 48 82 yrs = 32 83 yrs = 42 84 yrs = 42 85 yrs = 38 86 yrs = 60 87 yrs = 37 88 yrs = 46 89 yrs = 35 90 yrs = 28 91 yrs = 18 92 yrs = 28 93 yrs = 11 94 yrs = 13 95 yrs = 19 96 yrs = 10 97 yrs = 7 98 yrs = 7 99 yrs = 4 100 yrs = 1 101 yrs = 4 102 yrs = 3
Admissions by gender Referrals by gender	548 = Female, 346 - Male
Staff to patient ration (eg.1:5)	?

Table 5: Waikato DHB Community Day Programmes and In-facility Day Respite

Average Days Paid per month 2010-2011	Community Day Programme	In-facility Day Respite	
TLA	HOP1011	HOP1042	Grand Total
Hamilton City	352	12	364
Hauraki		73	73
Matamata-Piako	160	41	201
Otorohanga		21	21
Ruapehu	98	0	98
South Waikato		80	80
Thames-Coromandel	17	72	89
Waikato	278	104	382
Waipa	70	131	201
Waitomo		36	36
Grand Total	**975**	**570**	**1545**

Significant gaps are in the South Waikato and North Waikato. Demand is increasing in Waipa and Hamilton City.

Waikato DHB Areas working well

(Waikato DHB MH&A , HOP Planner & Funders and Provider Arm Perspectives)

- A well established and evaluated memory clinic which operated as an inter-disciplinary clinic shared between MHSOP and HOP.
- The linkages the DHB had developed with alcohol and drug providers, GPs and mental health services were proving effective.
- There was greater emphasis on shared working with higher care dementia beds being managed jointly by MHSOP and HOP. Consultation and liaison functions bridge the gaps between services ensuring a tailored response to need rather than strictly age related.
- A model of integration between community and inpatient service within the DHB Provider Arm facilitated consistency of care with the same staff following up clients and reviewing regardless of location.
- Referrals were receiving a timely response be it routine or crisis. The Inter Rai programme was rolling out and efficiencies in assessment expected.
- Investment was made in a number of secure dementia care beds as described in Table 6

Table 6: Waikato DHB Long-term Care Secure Dementia Beds

ARC Bed Capacity	Dementia Secure Unit	Psycho-geriatric	High Dependency Psycho-geriatric	TOTAL
Cambridge Resthaven	13			**13**
Eastcare Residential Home	34			**34**
Hetherington House	10			**10**
Hilda Ross Retirement Village	40			**40**
Kenwyn Home	10			**10**
Kimihia Home & Hospital	8			**8**
Kintala Lodge	30			**30**
Malio House	21			**21**
Ohinemuri Home	12			**12**
Raeburn Residential Care	20			**20**
Rangiura Rest Home	20			**20**
Rossendale Home & Hospital	40	50	10	**100**
Tamahere Eventide Home Trust	21			**21**
TeArahina o Arahina Rest Home	7			**7**
Tokoroa Aged Care	13			**13**
The Booms Lodge Limited	22			**22**
Radius Windsor Court	20			**20**
Total	**341**	**50**	**10**	**402**

In general there had been strong clinical support for this aspect of the sector from MHSOP staff, the Regional Behavioural Support coordinator, a Clinical Nurse Specialist, Special interest Groups, and Alzheimer's.

Areas for development

- The need for more advice and education for rest homes and primary care providers regarding mild to moderate mental health problems and dementia. Greater explanation was required on criteria for accessing specialist services.
- The service considered national developments such as the Service Development Plan and Blueprint 2 as helpful, but overdue. Questions remained such as how many beds were required per 100, 000 for complex dementia. The original Blueprint (MHC, 2008) only included complex mental health beds and not dementia.
- There were challenges finding appropriate care for people with mental health issues who had developed problems associated with ageing including dementia. This had resulted in longer stays in mental health acute units while waiting for an appropriate option to be found. The rest home environment was problematic for these people who were usually in their forties and fifties, active but needing support with complex mental health needs and symptoms of ageing. Much older and frail people residing in rest homes were considered at risk when cared for in the same environment.
- Alcohol related or induced dementias were affecting a group with complex needs who were difficult to accommodate appropriately.
- Future planning – there is an opportunity to work in a more collaborative and integrated way with a new build that will see MHSOP and HOP more integrated.

However a dedicated MHSOP unit of 2 additional beds may not be sufficient to meet future need.

- Areas to look more closely are Whanau Ora and how this is applied for older people. Rural respite and how it could be delivered in a cost effective yet appropriate way. The incidence of elder abuse was also of concern and it was being considered how best to focus energies to address this.

Bay of Plenty DHB

Current Investment by Service Type

This DHB had just completed a Memory service pilot project. The Memory service will continue with business cases to be forwarded – to fully establish a dementia service. Current investment by service type is outlined in Appendix F.

Utilisation

Bay of Plenty DHB commented on a marked increase in occupancy rates and length of stay for MHSOP Inpatient beds. It was thought this may have been due to the increased complexity of those people admitted and not having adequate psycho-geriatric beds to discharge people to. This is described in table 7. A safe staffing initiative has been underway.

Table 7: Bay of Plenty DHB Specialist MHSOP Inpatient Beds

Specialist MHSOP Inpatient Service **PU Code: MHO98** **Available contracted beds**	
Average occupancy in 2010/11	86% Marked increase this year
Average length of stay in 2010/11	21.91 days increase this financial year
Total number of discharges in 2010/11	141
Admissions by ethnicity	15 Māori all other patients European
Admissions by age	28 yrs = 1 40-64 yrs = 6 65-84 yrs = 82 85+ yrs = 32
Admissions by gender	55 = Female, 66 = Male,
Staff to patient ratio (eg. 1:5)	2 RN/2 HCA am/pm shift 1Rn/1 HCA – 10 patients increasing if requiring safety watches. Min staff if patient numbers decrease would be 2 RN/1 HCA For restraint. Would always depend on patient acuity.

The MHSOP Community Team provided assessment and treatment to more people in the over 80s age group than younger age groups, and to more females than males.

Table 8: Utilisation of Bay of Plenty DHB Specialist MHSOP Community Services

Specialist MHSOP Community Service **PU Code: MHO99A-E**	
Total number of discharges in 2010/11	502
Admissions by ethnicity	43 Māori, 3 Pacific Islander,3 Asian & 835 European
Admissions by age	25-39 yrs = 1 40-64 yrs = 36 65-79 yrs = 386 80 Plus yrs = 461
Admissions by gender	491 = Female, 393 = Male
Staff to patient ratio/caseloads	Ave 20 patients to each case manager excludes Medical SMO. Caseloads vary due to demand max 28 patients is our aim at any given time.

Bay of Plenty DHB Areas working well

- An enhanced community-based acute response with dedicated DAO and intake nurse. The service had a focus on need not age, developed good relationships with service providers, and participated in multi-disciplinary case conferences resulting in positive impacts such as reduction in waiting lists.
- There was demonstrable commitment to research and innovative projects. D-Cat tool based on the Inter Rai assessment was introduced.
- Reduction of length of stay project in the inpatient unit, a 4 year piece of work has been progressing but challenged by clients with dementia with behavioural and psychological symptoms. This client group had increased the length of stay due to a lack of community bed availability.
- Audit process to assess prescribing in dementia care. The data had been collected and a tool to assist practice to be implemented.
- Linkage with the Regional Dementia Behavioural Support and Advisory service based at this DHB had raised the profile and interest locally. MHSOP was a Bay wide team providing consult liaison at the hospital, an outreach service, day programme and a range of meaningful activities.

Areas for development

- Co-location of MHSOP and Older people services would support efficient specialist and joint assessments.
- To have a formalised dedicated Dementia Service as part of this joint working.
- Improve care facility response, to client need, including crisis. This would require greater coordination and staff training.
- Redesigning or reconfiguring the Inpatient Unit, which was an outdated design, and presented risks? It could be better geared up for the needs of older people, acuity levels and challenging behaviours.

Lakes DHB

Current Investment by Service Type

This DHB had a primary integrated mental health service that while it was not specific to dementia or older people, DHB had noted that an older age group featured highly in the volumes of presentations to the service. Other information about Lakes DHB investment by service type is in Appendix G.

Utilisation

Lakes DHB MHSOP beds were 2 allocated beds within the Adult Mental Health unit. While the data suggests the beds are well utilised with 82% average occupancy, it is thought that the service would benefit more older people if the environment was more conducive to the needs of older people and dedicated staff were allocated and trained.

Table 9: Utilisation of Lakes DHB MHSOP Inpatient Service

Specialist MHSOP Community Service **PU Code: MHO99A-E**	
Total number of discharges in 2010/11	33
Admissions by ethnicity	7 Māori, 26 Other
Admissions by age	67 yrs = 4 68 yrs = 8 70 yrs = 2 79 yrs = 1 80 yrs = 3
Admissions by gender	14 = Female, 19 = Males
Staff to patient ratio/caseloads	We have 2 MHSOP beds within our 14 Inpatient Unit so there are no dedicated staff/patient ratio, staffing is allocated based on need & out of overall staffing numbers

Table 10: Utilisation of Lakes DHB MHSOP Community Services

Specialist MHSOP Community Service **PU Code: MHO99A-E**	
Total number of discharges in 2010/11	299
Admissions by ethnicity	Māori = 57; European = 270; Pacific = 1
Admissions by age	41-50 yrs = 5 51-60 yrs = 8 61-70 yrs = 65 71-80 yrs = 124 81-90 yrs = 83 91-100 yrs = 19
Admissions by gender	Male = 138, Female = 193
Staff to patient ratio/caseloads	Varies - 10 - 15

Lakes DHB Areas working well

- A reasonably well functioning multi-disciplinary team with initial assessments not generally undertaken by the psychiatrist. In addition to this, risk assessments are undertaken but by the whole team
- Strong advocacy for patients
- Responsive community dementia service (but minimal)
- Referral rates relatively high
- Strong linkages with community based organisations such as Alzheimer's, NGOs– Hinemaru and NASC.

Areas for development

- Smoother processes at the interfaces with Lakes DHB NASC and Support Net. NASC functioned separately with two further divisions within isolating mental health NASC from Older Persons NASC
- More services for Substance/Alcohol abuse disorders for elderly, abuse/dependency treatment and improved interface with NGO Provider
- Culturally appropriate assessments
- Development and purchase of specialty psycho-geriatric assessment beds with access to inpatient and residential facilities, and community dementia assessment beds
- Staff training on psychological therapies/talking therapies. Older people would benefit in being able to access psychological assessment and therapies
- Ensuring clarity about what dementia clients would benefit most from MHSOP input as unrealistic and unnecessary for the MHSOP to see all.

Tairawhiti DHB

Current Investment by Service Type

This DHB provides a range of service types and these are outlined in Appendix H.
For some services the DHB purchased from neighbouring DHBs, such as people are referred to MHSOP at Waikato for specialist services.

Utilisation

Table 11: Tairawhiti DHB Inpatient Service

Specialist MHSOP Inpatient Service **PU Code: MHO98** **Available contracted beds**	
Average occupancy in 2010/11	0.24 (89 days total/365 days of the year)
Average length of stay in 2010/11	8.09 days
Total number of discharges in 2010/11	11 (Note: 5 of these discharges were for the same person. All 5 of these discharges had the same admit/discharge date, i.e. O days LOS)
Admissions by ethnicity	1 Māori, 10 Non Māori
Admissions by age	66 yrs = 2 67 yrs = 2 70 yrs = 1 75 yrs = 1 82 yrs = 5
Admissions by gender	9 Female, 2 Male
Staff to patient ratio (eg. 1:5)	14 Staff

Table 12: Tairawhiti DHB MHSOP Community Service

Specialist MHSOP Community Service **PU Code: MHO99A-E**	
Total number of discharges in 2010/11	Due to referrals historically not being closed once services have been completed, calculating the number of discharges is difficult. Efforts to get this issue sorted should allow for a better result at a later stage.
Admissions by ethnicity	105 Non Maori, 25 Maori
Admissions by age	65-69 yrs = 25 70-74 yrs = 29 75-79 yrs = 19 80-84 yrs = 30 85-89 yrs = 16 90-94 yrs = 9 95-99 yrs = 1 100+ yrs = 1 Total = 130
Admissions by gender	72 Female, 58 Male
Staff to patient ratio/caseloads	

This service was implementing new systems to ensure referrals were dealt with in a consistent manner and closed off according to business rules.

Note: New referrals that had contacts against them were used to calculate the number of admissions

Tairawhiti DHB Areas working well

- Over the past 12 months the Multidisciplinary team has seen significant growth. The team now includes an occupational therapist, and clinical psychologist. Smooth transition for people between Adult Mental Health and Mental Health Services for Older People.
- Cultural assessments
- The integration of the Cultural Team and the Crisis Service has enabled a more holistic approach
- A clearer referral pathway had been developed, with triage and referral processes. Provider pathways were becoming more organized and communicated. PAT, physical health was screened.

Areas for development

- The DHB is seeking to include a registered nurse as part of the Mental Health Service for Older People's Team
- There were no dedicated beds, and this was not ideal. Considering access to acute beds designated for older people and external to adult ward
- Intake procedures with primary care/liaison from GP practices were sub-optimal and there was interest in developing this as a region
- A pathway is required to access more timely specialist psycho-geriatric assessment and long term placement

Taranaki DHB

Current Investment by Service Type

This DHB offered a range of service types for people living in their district detailed in Appendix I. Of particular note is the dementia care pathway which had engaged primary care practitioners in early diagnosis and management of people with dementia.

Utilisation

The occupancy rate for this DHBs inpatient beds was relatively low at 51% with an average length of stay of 25.4 days. This is described in Table 13.

Table 13: Taranaki DHB Utilisation of MHSOP Inpatient Beds

Specialist MHSOP Inpatient Service **PU Code: MHO98** **Available contracted beds**	
Average occupancy in 2010/11	51%
Average length of stay in 2010/11	25.4 days
Total number of discharges in 2010/11	37
Admissions by ethnicity	3 Māori, 1 Pacific Islander, 31 NZ European, 3 Other
Admissions by age	<65 yrs = 5 65 -69 yrs = 9 70-79 yrs = 18 80-89 yrs = 6
Admissions by gender	19 Female; 19 Male
Staff to patient ratio (eg. 1:5)	1:4

Table 14: Utilisation of Taranaki DHB MHSOP Community Service

Specialist MHSOP Community Service **PU Code: MHO99A-E**	
Total number of discharges in 2010/11	451
Admissions by ethnicity	32 Māori, 350 NZ European, 2 Pacific Islander, 44 Other
Admissions by age	<65 yrs = 17 65-74 yrs = 100 75-84 yrs = 174 85-94 yrs = 127 >95 yrs = 10
Admissions by gender	236 Female, 192 Male
Staff to patient ratio/caseloads	I:35.3

Interesting to note the age groups displayed in table 14. In the 85 to 94 years group, there were 127 admissions to the service, and there were 10 in the 95 and over age group.

Taranaki DHB Areas Working Well

- The development and implementation of a dementia pathway consistent with the 7 tier model. Educative presentations to Taranaki GPs and Practice Nurses and an improved link with GPs, offering them phone and email consultation with a specialist psycho-geriatrician, had been achieved. Additionally, GPs were provided with a "tool kit" which contained relevant information for an individual and their carer. It also assists with informed discussion at the point of diagnosis. This pathway has now been evaluated.

- Established a *Living Well with Dementia* group for those newly diagnosed and their main carer. This educative and supportive group is held on 7 mornings over a seven week period. To date, evaluations have been positive and it is also intended to roll out a Living Well group in the more rural area of South Taranaki.

- Link workers were established offering support and education to Aged Residential Care providers. This included a *Changed Behaviour Guide*, developed 2 years ago, and Dementia interest groups established in some facilities.

- Crisis respite was provided for those more complex dementia clients that were cared for at home. An increase in the number of care facilities contracted to provide residential respite has been negotiated. An In-Home Dementia Carer's Respite Service has also been established.

- A project looking at ways of utilising existing Rest Home beds in a more conductive way was completed.

- Involvement in cases of Older Abuse highlighted the need for clear internal policies and procedures and this work is now ongoing.

- A single point of entry - Referral Hub - has been established for Older Peoples Health. Care Managers have now been appointed and InterRAI introduced.

Areas of Development

- The allocated inpatient beds are in the adult ward without designated staff or an physical environment this is not conductive to the needs of the older person A pilot confirmed the benefits of a designated nurse and psychiatric nursing assistants.

- Training provided to staff in managing challenging incidents is generic and not specific to the needs of the older person. Ongoing work required in establishing policies and procedures surrounding Elder Abuse and Hoarding and Squalor.

- Community based dementia day programmes are limited and therefore had attracted a large waiting list. Field officers are stretched and although a 3rd day has now been funded, further development is required.

Midland Dementia Behavioural Advisory Service Coordinator

The dementia behavioural advisory service coordinator role was introduced late in 2010. The underpinning principle for the role is to support people living with dementia and those that are caring or supporting them with a specific focus on any troubling behavioural and psychological symptoms of dementia.

The support provided includes:

- Education for anyone with either professional or carer interest in dementia
- Assistance in developing and promotion of dementia care pathways
- Provision of advice and reports for care providers, DHBs and /or support agencies such as Alzheimer's society NZ regarding environmental factors for new builds, existing, and /or reconfiguration of dementia specific residential or day/care area/units
- Provision of advice and support for DHB commissioning bodies (portfolio managers) for new and/or existing dementia care services and facilities
- Direction for individuals to the most appropriate service in their area e.g. MHSOP teams, HOP teams, Alzheimer's society, NASC, dementia specific care facilities etc
- Support to family/whanau of individuals living with dementia (the service has an 0800 number)
- Develop and strengthen supportive and collaborative relationships with other dementia specific services eg. Alzheimer's society
- Ad hoc dementia specific project work.

The role has no direct care component, and individual case management of people experiencing BPSD remains the responsibility of the MHSOP teams. However the role has, to a lesser extent, been used by members of the public to gain clarity and support regarding family/whanau members that are currently using either DHB or NGO services.

NASC Services in the Midland Region

Access to community services required a comprehensive needs assessment often undertaken by a Needs Assessment and Service Co-ordination (NASC) service. The assessment determined the complexity and relative urgency of the person's needs and his/her potential for rehabilitation. A plan of care was then developed.

The five DHBs in the Midland region all had a slightly different combination of contracted providers to deliver NASC services. Some had a mix of DHB and NGO contracted providers, others had DHB alone or NGO alone. The most number of NASC providers contracted by a DHB was five with sub-contracting arrangements to other providers, and the least number was one. It is expected with the introduction of Inter Rai, an electronic assessment tool, the NASC processes will become more efficient.

Aged Care Providers in the Midland Region

Aged Care providers in the Midland region offered a range of community based services incorporating capacity building and wellness approaches, flexible packages of care, day programmes, respite and support for older people's participation in the community.

For those older people requiring a greater level of care beds in a residential care setting were contracted. There were four levels of aged residential care: rest home, specialist dementia care, long-stay hospital care and specialised hospital care.

Stakeholder Feedback

Stakeholders at the Swap Shop Day held in February 2012 (refer to recorded minutes) discussed and debated how best to address the needs of the older people in the Midland region given the information provided by DHB and NGO participants about what was working and where opportunities for improvement could be implemented. Commencing with better defining the problems they reached conclusions and made recommendations. The following themes emerged:

- Confirming the gaps and considering the future
- Developing a dementia care pathway
- Managing risk
- Integration and interfaces.

Confirming the gaps & considering the future

It was acknowledged again that Mental Health clients were living longer and as they aged, a significant number of them experienced multiple comorbidities. Unfortunately in the Midland region it was identified that the particular levels of care and associated funding may come from more than one funding stream. This impacted coordination and delayed access to appropriate services.

It was suggested that a single funding stream would be beneficial. How to achieve that was given some consideration, particularly with DHB Planning and Funding portfolio managers present. It was thought that within DHBs there was an opportunity to look at more flexible funding solutions across traditional divisions.

It was thought that the levels of care categories weren't always well understood by funders and others involved in the decision making, and this needed to be revisited and made explicit. NASC practices had impacted pathways and could create system delays. NASC agencies needed to collaborate with single assessments, and specialised assessors that were registered health professionals and face to face reassessments were desirable. Implementing new changes to NASC assessment had impacted on pathways but it was expected over time to improve efficiency.

Specific areas of need may benefit from a coordinated regional approach or even sub-regional. This included alcohol and cognitive impairments requiring psycho-geriatric non dementia units, intellectual impairment requiring assessment and appropriate care, head injury, mental health 'graduates' with severe and enduring illness and those people that experienced more than one of those states. Investment in facility was costly and there were gains to be made by collaborating.

Stakeholders thought there was a gap of specific community living support that was holistic and tailored towards the need of the ageing mental health client. They reported system issues that created delays to care including access to equipment, and home modifications.

Stakeholders thought staff skills would benefit from strengthening, including the knowledge and skills in the management of Delirium.

Developing a Dementia Care Pathway

There was a priority expressed to develop a dementia care pathway before service models and other aspects were looked at and those involved needed to be mindful that one pathway led to or connected with another. The pathway would be developed under the umbrella of the Midland Regional Network and collaboratively with SLAT. Linked in to the MH Clinical

governance group, geriatricians, psychologists, primary providers, NGO aged care providers/ARC, Regional Dementia coordinator, IHC/ABI/Other AOD providers and Whanau and carers.

It would seek out pathways already developed and build on the learning to create a pathway unique to the Midland region. Taranaki, Counties Manukau, Waitemata, and Canterbury DHBs provided examples. Any development would need to involve all the key stakeholders including primary care and NGOs it was thought.

GP appeal and interest would have to be incorporated, as it was suggested that they were critical to the success of the pathway. GPs should be supported to diagnose and treat, with guidance on assessment tools, risk assessment, use of informants and access to diagnostics. This would speed up the process and the point of diagnosis allowing for early intervention in a timely way the group had thought. This was consistent with the literature (Kerse, Scott & Boyd, 2012).

The pathway would be based on MoH guidelines, with underpinning principles, using common language and definitions, with local prioritisation processes and variation according to local context. However emphasis on broader service types and function eg memory clinic, consultation liaison or one point of entry, and Inter Rai assessments. Local development would then mirror regional development but cognisant of local needs and current services to support the pathway.

Managing risk

Stakeholders acknowledged that risks were different for the older person and what were needed were clear guidelines and procedures, particularly on elder abuse and neglect. The group were reminded that these had been produced nationally by the Ministry of Health and could be easily accessed. Local protocols and procedures however to support implementation of the national guidelines was thought to be helpful. No training had been rolled out nationally for Elder Abuse, and to date the emphasis from the Ministry of Health had been on partner and child abuse.

Stakeholder comments:

- *More information on Elder Abuse and neglect needed*
- *There is evidence of financial / verbal / physical / sexual / psychological / institutional abuse impacting the whole family*
- *Older people may not want to ask for help and may fear being placed in a rest home.*

Primary care workforce was thought to be positioned to identify the socially isolated and respond quickly in the community setting. Unfortunately the older population didn't like asking for help and feared being admitted to a rest home. There were cultural expectations of caring for whanau yet there was also a lack of an ability to do that, with some whanau living at a distance for example, in Australia.

Learning competencies for those working in the sector had become quite complex including understanding the legal framework. MH Act may have been required to be enacted to remove someone from their home for their safety. The PPPR Act was thought to be very cumbersome and information on this would be useful to those working in the environment.

High risk behaviours and the environments in which older people live were thought to be a fine balance between being risk averse and limiting independence to managing living with the risks. In some districts this is more of a concern and some perceive it as inadequately funded in order to be effectively managed.

Stakeholder comments:

- *Older people may experience social Isolation and a loss of independence*
- *Services may have a dominant focus on physical functioning*
- *Voluntary services may be unsustainable in the future*
- *There are issues of grief and loss resulting in depression*

Access to GPs was thought to be difficult due to costs and that it may not be viable for the person to leave their home. Access to crisis respite was also thought to be difficult.

Stakeholders thought quality resources on risk management should be developed for the region that were flexible and easily accessed, and supported by training.

Integration & Interfaces

Stakeholders identified essential components of care that all DHBs should provide access to and that were part of a service model to support older people with mental health, addiction and dementia. Features of the model would include:

- GP led and championed with an early assessment and referral
- Implementation of Inter Rai and/or Mental Health module
- Development of an appropriate health target for older adults to ensure priority
- An agreed access criteria for psycho-geriatric care across the region recognising that this would not be a home for life but care for the period of time required subject to regular review and transition to the next appropriate level of care. This will enable easier access to the level of care and responsible cost management
- Integration with existing models within PHOs & NGOs
- Embraced the entire spectrum
- NGO, primary and secondary integration providing effective interfaces
- Access to up to date information available to everyone (GPs, NGOs, HOP)
- Evidence based models
- Consistent with *Better, sooner, more convenient*
- Well educated carers / caregivers (ability to cope). Knowledge of available resources and how to access them and available right from the beginning through to the illness develops
- How to find and access free services
- Health promotion focus (mental & physical) – for the general population
- Proactive vs reactive
- Basic “first aid for the brain” (hydration, dietary requirements, self -care)
- Long term packages of care
- Green and purple prescription
- Appropriate facilities
- Early assessment – education for GP, general public, reduce 8week wait
- Comprehensive Dementia Service inclusive of a Memory clinic
- Early comprehensive care plan, crisis planning and advanced care planning
- Increase individual carers capacity
- Increase workforce around what to do and when

The stakeholders confirmed that any model needed to be planned, evidence based and proactive.

Discussion

This project alerted providers to the urgency and priority in which the issues for older people should be considered and addressed. The numbers of older people are expected to increase and therefore the proportions of mental illness, alcohol and drug problems and dementia will also increase. DHB services however were found to be at various stages of planning and preparation for this, and each DHB was able to identify outstanding areas for development.

The Ministry of Health's Mental Health and Addiction of Older People and Dementia Guideline (2011) reiterated service principles to be applied in the delivery of services. Therefore in any proposed service development it would be useful to be cognisant of them.

1. **Services should be: comprehensive: services consider the individual and their needs holistically in a person-centred and family-inclusive way**

The stocktake aligned with the 7 tiered model showed that some DHBs struggled to provide a comprehensive range of services and some DHBs were not able to offer age appropriate environments or dedicated staff with training in aged care, in the provision of specialist MHSOP inpatient care. The literature confirmed that the needs of older people were complex and needed more focused attention (Draper, Melding &Brodaty, 2005).

2. **Services should be: accessible: services minimise barriers to accessing required care**

Some DHBs identified service access difficulties and delays related to inflexible access criteria and NASC processes. Where NASC functions were managed separately, with HOP NASC and MH NASC there appeared to be more difficulties. Other barriers to access were related to funding streams being diagnosis specific and the individual experiencing co-morbidities. This sometimes resulted in delays accessing the required care.

3. **Services should be: responsive: services act promptly, sensitively and appropriately when responding to a wide range of service user needs**

Some DHBs were challenged by individuals that presented with the most complex and severe mental health and dementia needs and had limited facilities that could be accessed locally.

4. **Services should be individualised and personalised: services are person-centred and seek to support the individual within their own personal context, including culture, spirituality, family and whanau, and where possible, in their own home environment**

The project processes confirmed that the services did need to be more person-centred and family focused and that home and local contexts varied. While investment had been made in rest home and private hospital care there appeared to be less supports for those remaining in their own homes. Where investment in carer respite had been made for one DHB, the uptake had been poor due to associated access processes.

Understanding the cultural needs of the person and their family/whanau was being recognised as important with one DHB having identified cultural competencies as an area for development.

5. **Services should be interdisciplinary: services recognise and utilise a range of skills and expertise across agencies to better meet the individual's needs**

One DHB had looked more closely at the specific roles, tasks and responsibilities of those within the team and delegated them where most appropriate. This had freed up psychiatrists to spend more time with the most complex of clients.

The appointment of the dementia behavioural advisory support coordinator had provided linkage and education across DHBs in dementia care. In addition, one DHB had a dementia field worker and others actively engaged other NGO partners.

6. **Services should be accountable: services accept responsibility and accountability for those people within their care**

This project did demonstrate that services did accept responsibility for people within their care. However workshop participants identified a number of risk areas that warranted urgent attention. There was anecdotal evidence of increasing elder abuse and neglect. Ministry of Health guidelines on Elder Abuse were available for implementation.

7. **Services should be integrated and continuous: services work in a connected way, flexibly, to best meet the needs of the individual and provide seamless continuity of care.**

Integration was seen as an aspiration of this project's stakeholder participants. However they described aspects of care within services that were not connected or flexible. They believed that connected pathways and service models would address this.

In summary, this project has shown that there are opportunities to deliver care more consistently with the service principles as outlined in the Ministry of Health's Guideline (2011), to improve health outcomes for older people living in the Midland region.

Conclusions

In the course of this project stakeholders together considered the literature and the evidence. They contributed stocktake information to confirm what services were being provided and who was utilising them. Stakeholders further discussed and debated at a Swap Shop day what was working well and where there were opportunities for further developments. Four specific themes emerged at the Swap Shop Day:

1. Confirming the gaps and considering the future
2. Developing a dementia care pathway
3. Managing risk
4. Integration and interfaces

Stakeholders further defined the issues and considered the options under each of those four themes. Recommendations consistent with the discussion were then proposed, to enhance the service provision for older people and their carers (and those of any age with dementia) with attention to service pathway and model development, managing risk and strengthening the workforce.

Recommendations

Pathway and Service Model Development

- Develop regional pathways and service models for the service continuum that span primary, secondary and tertiary care, consistent with the Draper, Brodaty & Low's Seven Tiered Model, that are integrated and person and whanau centred, commencing with a regional dementia care pathway

- Pathway development will aim to provide clarity about what services including diagnostics, and models of care are required to meet the person and their carers' needs from pre-diagnosis to advanced care

- Attention will be given to the linkages, interfaces and risk management of primary, secondary and tertiary providers working collaboratively to deliver care at the right level in the right place by the right health professional

- The client group with multiple co-morbidities resulting in a complexity that doesn't fit well with local service provision will be identified and regional options investigated. For example, mental health clients who experience dementia/significant cognitive decline in relation to their mental illness, people under the age of 65 who experience cognitive decline due to neurological disorders, people with intellectual disability and dementia. The focus in the first instance is dementia for people over the age of 65.

Workforce

- Support the identification of learning competencies required by staff and people caring for older people accessing services in the Midland region, and recommend training that includes: dementia, delirium, depression, managing complex clients with multiple co-morbidities, elder abuse and neglect, legislation, PPPR Act and cultural perspectives in ageing.

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Appendices

Appendix A – Project Scope

Project Title	Midland Region Mental Health Service for Older People Continuum
Prepared by	Eseta Nonu-Reid, Midland Regional Director –MH&A
	MR MHSOP Clinical Directors
Date	30 October 2011
Version	4

Project Statement

The MoH Mental Health and Addiction Services for Older People and Dementia Services: Guideline for District Health Boards was released on 6 July 2011. The guideline aims to improve access to services and provide consistency across all District Health Boards and aged care providers. A key area of focus is the need for greater coordination particularly at the transitions between at primary, secondary and tertiary levels of care.

There is a clear need for both Older People and Mental Health & Addictions services to work in an integrated way to ensure the needs of this growing population are addressed. This project proposes:

A regional Swap Shop day that confirms the needs, and identifies innovative and creative cross sector best practice, including integrated service models to address current and future need.

A strategic development stakeholder consultative process that builds on work commenced at the Swap Shop day, bringing together and confirming common themes across the region.

A further Swap Shop day to critique the draft report capturing the themes and proposing recommendations.

Submission of the Final report.

Objectives

The objective is to deliver, by 15TH April 2012 a report with recommendations for the Midland region which will provide an evidence base to inform and support the following work, with specific focus on mental health and addiction of older people and dementia.

Managers, Planners and Funders – regional and local:

- strategic planning
- prioritisation decisions

- identifying specific requirements for new or existing contracts
- workforce development planning
- funding bids

Service managers and clinical leaders (provider arm and NGOs)

- identifying gaps in their own services
- identifying particular quality or responsiveness issues in their own services
- identifying services or approaches that may be needed to meet the particular demographic needs in their area
- workforce development planning
- funding bids

Consumers

- advocacy for re-focusing or re-designing funding and services to provide a more user-centred approach
- advocacy for meeting service gaps
- advocacy for addressing service responsiveness or quality

Family/Whanau

- advocacy for meeting service gaps
- advocacy for addressing service responsiveness or quality
- *Local, regional and national workforce planners*
- local, regional and national workforce development planning
- competencies that require particular attention

Policy makers at the local, regional and national level

- advice to government on services
- information to support budget bids at a local, regional and national level

Strategic Accountability

The project will be guided by:

Ministry of Health: Mental Health and Addiction Services for Older People and Dementia Guidelines, 2011

Ministry of Health: Health of Older Peoples Strategy, 2001

Ministry of Health: Guidelines for People with Dementia, 2007

Ministry of Health: National Service Specifications for Mental Health Services for Older People, 2010

Ministry of Health: Te Tahuhu, Improving Mental Health 2005-2015, The Second NZ Mental Health and Addiction Plan, 2005.

Ministry of Health: Te Kokiri, The Mental Health and Addiction Action Plan 2006-2015

Midland Region Mental Health and Addiction Needs Assessment 2010.

Midland Region Mental Health and Addictions Strategic Plan 2008-2015.

Midland Region Mental Health Workforce Development Plan 2010 – 2014

Midland Regional Clinical Services Plan 2010

Midland Regional District Annual Plan 2011/12

Ministry of Health: Te Rau Hinengaro, The New Zealand Mental Health Survey 2006

Te Pou: Mental Health and Addiction Services for Older People: Workforce Survey, 2011

Background

The Midland region completed a regional mental health and addiction needs assessment in January 2011. Within the report it identified that across the Midland region services for older people based on Blueprint benchmarks, were overprovided. However it was later confirmed that this was not the case. It is recognised that the Blueprint benchmarks are outdated and that Te Rau Hinengaro provides more up to date benchmarks. It is also recognised that within the Midland region the most significant growth over the next 10 years will be in the older population. Given this, the need to undertake a specific project to clearly identify MHSOP future needs will allow planning and funding to have a clear direction and influence the Ministry of Health.

Approach

The approach will include the following processes:

- Approval of the project scope and the proposed content of the report
- Identifying a key Clinical Reference Group to support the Project Consultant
- Bringing the MHSOP sector together to recognise and celebrate innovation
- Consulting with key stakeholder groups on current services, gaps, needs, priorities and risks
- Collecting, analysing and presenting the information to stakeholders and the key reference group
- Report writing and editing
- Ongoing checking of processes to ensure that the information, and the way it is presented is going to be useful for those in the Midland region
- Regular reporting to the project sponsor
- Submitting the final critiqued report to the project sponsor

Options Considered

1. Do nothing

Regionalisation is one of the main drivers of the current government. It is likely that there will be more expectation to regionally develop strategies that are well connected to all stakeholders. The Midland Needs Analysis 2011 provides the most up to date national and regional information but is based on outdated benchmarks. For that reason it is seen to be of limited use for this client group.

2. Each Midland DHB gather its own information as required

This option is not as cost effective as carrying out this work once for the whole region.

3. Undertake a Midland Regional Project

This option is seen by the region to be a cost effective way of providing all

	Midland DHBs with good regional and local information for planning and funding decisions. Option 1 would result in decisions being based on out of date information. Option 2 would result in high cost to individual DHBs and could result in inconsistent decision making across the region. Option 3 is a cost effective way to carry out this work.
The project will include	Key areas to be covered in the report include *(this is subject to discussion with the key stakeholder groups):* Mental Health and Addiction of Older People and Dementia Interfaces with other areas of health that affect people with mental health and addiction issues Work already undertaken in this area by DHBs in the Midland region will be collated and considered within the parameters of this project.
The project will not include	The report will not, include information about DHBs from outside the region. The project will exclude doing original research. The project will not conduct a prioritisation process based on the information.
Completion Criteria	The project will be completed once the final report is signed off by the project sponsor
Internal Stakeholders	Project Sponsor, Eseta Nonu-Reid Project Reference Group to provide direction and advice to the project
External Stakeholders	Midland regional has a number of existing regional groups representing key stakeholders who will be consulted as part of the project: He Tipuana Nga Kakano "Growing the Seeds". The Midland Regional Consumer Advisory Group Nga Purei Whakataa Ruamano. The Midland Regional Māori Advisory Group. Established early in 2001 this forum meets four times a year The Midland Regional Clinical Leadership Forum. A forum of Clinical Directors and Provider Service Managers to provide clinical leadership to the Midland Region The Midland Regional Generating Action for Families. A forum to provide peer support and mentorship to Family advisors, advocates and peer support workers working in the sector The Midland Regional Mental Health & Addictions Portfolio Managers Group. A forum to provide support and operationalise activity across the region The Midland Regional Addictions Forum Midland Region Workforce Strategic Advisory Group Others as identified during the process. Key stakeholders will be invited to identify, from their knowledge and experience, the gaps, needs, priorities and risks for the region and for their

particular DHBs.

The Ministry of Health, Mental Health Commission and other Government agencies as required e.g. Public Health

Implications for Māori

Māori are over-represented in prevalence data and in mental health and addiction services. This project will ensure that good information is provided to support planning to meet the needs of Māori in the Midland region.

IM Implications

The regional network meetings, email and Midland website will be utilised to convey information about the project to the sector.

Resource and Project Structure

The project will be led by a project consultant who will be responsible for carrying out the work, consultation, communication and writing the report. The project consultant will report directly to the Midland Region Director, Mental Health and Addiction Service Development.

Midland/DHB staff to be involved in this project are:

Belinda Walker (Midland region) who will provide project advice and assistance, administrative support, minute taking, peer review etc

A reference group to provide advice and direction to the project will be established through an expression of interest (EOI) which will be sent to the regional advisory groups/forums.

Key milestones and timeline

Date	Deliverable
End of October 2011	Initial teleconference with Clinical Directors
31 October	Draft project scope/communication plan to Clinical Governance – CDs & P&F Portfolio Managers
4 November	Plan signed off by project sponsor
7 November	Project Consultant contracted
21 November	Reference Group members will be identified utilising a competency skill set criteria
29 November	Present process to Portfolio Managers
2 December	Reference Group established and meeting dates set
8 December	MHSOP Swap-shop day- info gathering
12 December	Further stakeholder discussions as required
19 December to 2 February 2012	Draft report prepared
26 February	MHSOP Swap-shop day to critique draft
15 March	Final draft report to project sponsor for regional consultation
15 April 2012	Final report signed off by project sponsor

Project relationships and linkages

Other projects or initiatives that this project relates to and key contact people that provide liaison:

Project	Contact
Link with other individual DHB or regional projects relevant to this project	Midland Portfolio Managers
Midland Region Clinical Plan	Midland Regional Director

Financial Summary

Budget (one-off costs)

The project consultant will be contracted for up to 360 hours.

In addition to the project consultant, other costs are estimated as follows:

Costing Activity	Indicative Costs
Travel	$2,500
Meeting costs	$2,000 (nil if the project uses existing meetings)
Accommodation/meals	$1,000
Printing/Publication	$2,000 (nil if the project uses electronic distribution only)

Ongoing cost: Nil

Cost Savings: The cost of carrying out this project as a regional project will be significantly less than the cost of all 5 DHBs carrying out their own projects.

Risk management

Risks associated with the project	Risk Mitigation
Too much information available resulting in a document that is difficult to use -Medium	Assess which information is most useful for the purposes of the report. Distinguish between performance information and needs assessment information. Discuss this with the Reference Group.
Stakeholder meetings do not match up with project timeframe - Medium	Build timeframes for project around and consistent with stakeholder meeting times
Delays in receiving information from the various information sources – Medium	Build sufficient time into project plan or renegotiate timeframes with project sponsor
Information about workforce may be difficult to access or not available – Medium	Start collecting workforce information early in the project
Not using the blueprint model (while there is yet no model replacing it), will mean that a key planning tool is not available and will make the document less useful – Medium	Discuss this with the Reference Group and in the document.

Risks the region is exposed to if the project does not proceed.

The Midland DHBs continue to have out of date information on which to base their planning and funding decisions.

There will be an inconsistent basis for decision-making across the region.

Adhoc DHB responses to the Ministry of Health Guideline for DHBs on Mental Health and Addiction Services for Older People and Dementia Services. There is an expectation that DHBs will utilise the Guideline.

Quality

Quality will be facilitated through

- Establishment of a small focused Clinical Reference Group with representation from the regional stakeholder groups
- Sector involvement throughout the project
- A project consultant who has knowledge of mental health and addiction and is able to access information from key stakeholders
- A signoff process for both the project scope and the final document following final consultation

Project Opportunities and benefits

DHBs are at different stages of developing their services to better meet the needs of older people with mental health and addiction issues and dementia. At a national level systematic reviews on these matters have been undertaken, Dementia Behavioural Advisory Services have been established, including one specifically for the Midland region, and revised national service specifications have been developed for implementation. This project has the opportunity to build on these national initiatives, to draw together the local DHB and Midland regional initiatives and facilitate service developments that lead to more effective services.

Assumptions

The following assumptions have been made:

- The project will be funded by Midland Regional Network, Mental Health and Addictions
- The project will be sponsored by Midland Regional Director, Mental Health and Addiction Service Development
- The project is supported by Midland GM Planning and Funding
- The Midland regional networks will actively participate in and support the project

Constraints

There are no particular constraints.

Communication Plan

There will be at least two written communications with stakeholders, one at the start of the project, outlining the project and its objectives (and seeking representation on the Reference Group) and another at the end of the project, thanking stakeholders for their contribution to the project and providing the final report.

During the project, stakeholders will be consulted at their scheduled meetings on gaps, needs and priorities and risks.

Some of the key messages to be included in communications with stakeholders will be:

- The purpose of this project
- We want this to be a report that is well used and contributes to meeting the identified needs in the region
- Consultation will occur across the Midland region in each of the five DHB areas.

Sign-off (signatures required)

Project Consultant: Roz Sorensen

_____

Project Sponsor: Eseta Nonu-Reid

_____

GM Planning & Funding Lakes DHB: Mary Smith

_____

Date:

Appendix B – Questionnaire for DHB MHSOP Clinical Directors & DHB Mental Health Portfolio Managers

Midland Region
Mental Health Service for Older People Continuum
Project 2011/2012

Introduction

The Ministry of Health Mental Health and Addiction Services for Older People and Dementia Services: Guideline for District Health Boards was released on 6 July 2011. The guideline aims to improve access to services and provide consistency of care for mental health and addictions and dementia care across all District Health Boards and aged care providers. A key area of focus is the need for greater coordination particularly at the transitions between at primary, secondary and tertiary levels of care, as per the Seven –Tiered Model of care. There is a clear need for both Older People and Mental Health & Addictions services to work in an integrated way to ensure the needs of this growing population are addressed.

The Midland region Mental Health for Older People services are participating in a project that seeks to provide an evidence base to inform and support developmental work in the region,. Information is required about the current investment in the services at DHB level. We would ask you to kindly assist us with the collation of this information by completing the questions below and emailing your response to roz.sorensen@xtra.co.nz by **Monday 30TH January 2012**. The information in a summarised form will be presented at the MHSOP Swap Shop Day on **Wednesday 8th February 2012.**

Name of DHB:

Contact Person:

Date:

1. Current Investment by Service Type

Questions to consider when completing template: What services do you provide that cater for dementia with BPSD? Are there separate wards for dementia? How does staffing requirements differ? How are under 65s catered for? What services for people with disabilities? What cultural specific services?

Tier Level	Focus	DHB Mental Health contracted service type Eg. Community Team, Package of Care, Peer Support, Memory Clinic, Day programme	DHB Mental Health contracted Numbers of Beds/FTE	DHB HOP contracted service type eg, ARC rest home beds, private hospital beds, day programmes	DHB HOP contracted numbers of beds/FTE	Other contract arrangements or general comments
Tier 1	**Mental health promotion and disease prevention**					
Tier 2	**Targeted mental health prevention and promotion for at risk groups**					
Tier 3	**Assessment, early intervention and treatment (mild disorders)**					
Tier 4	**Assessment, early intervention, treatment and case management (moderate disorders)**					
Tier 5	**Assessment, treatment and case management (complex disorders)**					
Tier 6	**Assessment, treatment and case management (severe disorders)**					
Tier 7	**Assessment, treatment and case management (extreme disorders)**					

(Refer to The seven-tiered model of care, Mental Health and Addiction Services for Older People and Dementia Services, page 14)

2. Utilisation

2.1 Specialist MHSOP Inpatient Service **PU Code: MHO98** **Available contracted beds**	
Average occupancy in 2010/11	
Average length of stay in 2010/11	
Total number of discharges in 2010/11	
Admissions by ethnicity	
Admissions by age	
Admissions by gender	
Staff to patient ratio (eg. 1:5)	

2.2 Specialist MHSOP Community Service **PU Code: MHO99A-E**	
Total number of discharges in 2010/11	
Admissions by ethnicity	
Admissions by age	
Admissions by gender	
Staff to patient ratio/caseloads	

Appendix C – Waikato DHB Investment by Service Types

Tier Level	Focus	DHB Mental Health contracted service type Eg. Community Team, Package of Care, Peer Support, Memory Clinic, Day programme	DHB Mental Health contracted Numbers of Beds/FTE	DHB HOP contracted service type eg, ARC rest home beds, private hospital beds, day programmes	DHB HOP contracted numbers of beds/FTE	Other contract arrangements or general comments
Tier 1	**Mental health promotion and disease prevention**					
Tier 2	**Targeted mental health prevention and promotion for at risk groups**					
Tier 3	**Assessment, early intervention and treatment (mild disorders)**	**Memory Clinic**, - intensive assessment and treatment and follow-up which will identify the cause of memory loss and refer to appropriate care - 3.5 clinical FTEs & .4 FTE senior medical **Regional dementia co-ordinator** 1 FTE **Community Mental Health team** provide consult liaison to all Waikato DHB rest homes		Health of Older People funded Medication Oversight for people with mild dementia living alone in their own home	FFS – price capped, volume uncapped As at 10 January 2012 **5** Clients receiving Medication Oversight as a unique Service **10** Clients receiving Medication Oversight as well as Home-based Support Services	
Tier 4	**Assessment, early intervention, treatment and case management (moderate disorders)**	**Memory Clinic**, - intensive assessment and treatment and follow-up which will identify the cause of memory loss and refer to appropriate care - 3.5 clinical FTEs & .4 FTE senior medical **Day programme** -4.0 FTEs "Community Support for over 65" (Hauraki only) 1.32 FTEs **Access to Crisis Respite** **Access to acute home treatment**	**13 inpatient beds**, funding is available for 15 beds which is expected to increase with the build of the new facility due for completion in 1213 *Note:* ***There is no separation of beds specific to dementia. The 15 beds cover the full range of MHSOP for tier's 4 – 7***	1) Health of Older People Community Day Programmes – There are no 'dementia specific day programmes' although some do 'specialise' in this level of care. High needs premium is applied to those clients with higher behavioural support needs due to a diagnosis of dementia See Appendix: Health of Older People 1 2) Community-Based Education and support strategies for primary	Health of Older People services Funding does not purchase services by FTE The majority of services are funded on a FFS basis so volumes are uncapped – see appendices	Access to all Health of Older People funded services is through needs assessment People aged between 50 – 65 years assessed as 'close in age and interest' by a geriatrician or psycho-geriatrician are able to access Health of Older People services

		Access to community support **Access to Packages of care** **Access to supported accommodation** *Note: There is no facility specifically for over 65 yrs although there are supported accommodation providers who have a focus on older people with ageing related issues.* **Community Mental Health team** – 12.7 clinical FTEs & 3.9 FTEs SMO		informal caregivers of people with dementia = the 'ALZWELL' Service 3) In-facility respite – all 55 ARRC facilities have residential respite contracts that enable them to offer both residential and day in facility respite (DHB- funded through allocated carer support days)	'ALZWELL' has a capped price based on estimated volumes Carer Support days are needs assessed and allocated by Disability Support Link (NASC) on a needs basis. People with dementia referred to the ALZWELL service usually have a high level of allocated carer support days	
Tier 5	**Assessment, treatment and case management (complex disorders)**	*Note:* ***There is no separation of the above services specific for dementia. The 15 beds cover the full range of MHSOP for tier's 4 – 7***		See Health of Older People Appendix Two for current bed capacity (as at November 2011) for secure dementia units	There is no managed bed policy. Packages of home-based care are available for people assessed at rest home level of care (May include people with mild – moderate dementia) in Hamilton City and Te Awamutu	Dementia secure units are contractually limited up to 20 bed units (providers may operate more than one unit on the site) with extension subject to DHB approval
Tier 6	**Assessment, treatment and case management (severe disorders)**			DHB currently has a 50 bed capacity under the Hospital Specialised Services agreement (Psycho-geriatric)	a/a – other funders are also able to access these beds	Planned to extend this capacity by 17 – 20 beds over the next 3 – 5 years
Tier 7	**Assessment, treatment and case management (extreme disorders)**			DHB currently has a 10 bed high needs capacity under the Hospital Specialised Services agreement (Psycho-geriatric		This is a medium term service with an expected reassessment to a lower level of care once the extreme behaviours have been managed

Appendix D – Bay of Plenty DHB Current Investment by Service Type

Tier Level	Focus	DHB Mental Health contracted service type Eg. Community Team, Package of Care, Peer Support, Memory Clinic, Day programme	DHB Mental Health contracted Numbers of Beds/FTE	DHB HOP contracted service type eg, ARC rest home beds, private hospital beds, day programmes	DHB HOP contracted numbers of beds/FTE	Other contract arrangements or general comments
Tier 1	**Mental health promotion and disease prevention**					
Tier 2	**Targeted mental health prevention and promotion for at risk groups**					
Tier 3	**Assessment, early intervention and treatment (mild disorders)**	This project is being completed within usual budget past year. Completing memory service pilot project – this service will continue with business cases to be forwarded – until establish service is in place. Currently MHSOP/Alzheimer's Only due to staff limitations in HIA. Service proposal will be service provided by staff from both teams with appropriate funding from both services.				
Tier 4	**Assessment, early intervention, treatment and case management (moderate disorders)**	MHSOP multidisciplinary community team that covers whole BOPDHB FTE Budget 2 Psycho-geriatricians 1 MOSS 1 Registrar 1Senior Nurse(manages whole MHSOP service) 7.80 RN 1 Occupational Therapist 1 S/W (plus 1 FTE over Recruitment) 2 Psychologist Communication outreach service – rehab/assessment programme which will cater for early onset dementia and those clients with dementia requiring assessment and support while transitioning to community programmes				
Tier 5	**Assessment, treatment and**	MHSOP multidisciplinary community team that covers whole BOPDHB	MHSOP 10 bed inpatient unit caters for both functional and			

	case management (complex disorders)	Community outreach service – rehab/assessment programme which will cater for early onset dementia and those clients with dementia requiring assessment and support while transitioning to community programmes. MHSOP have limited budget to provide packages of care – clients with dementia those that live alone who cannot access Support net funding, deterioration in functioning not requiring hospital admission but acute support to assess.	organic disorders, accepts admissions for under 65 group for assessment for dementia – usual presentation head injury or intellectual disability and ? early onset dementia FTE budget: 1 Senior Nurse 7.29 RN 5.27 HCA This staffing is inadequate We are currently completing a safe staffing project to assess real patient nurses/acuity and actual staff requirement and at what time of day. Currently use approx 9.50FTE HCA in any given month period			
Tier 6	**Assessment, treatment and case management (severe disorders)**	MHSOP multidisciplinary community team that covers whole BOPDHB Community outreach service – rehab/assessment programme which will cater for early onset dementia and those clients with dementia requiring assessment and support while transitioning to community programmes. MHSOP have limited budget to provide packages of care – clients with dementia those that live alone who cannot access Support net funding, deterioration in functioning not requiring hospital admission but acute support to assess.	MHSOP 10 bed inpatient unit caters for both functional and organic disorders, accepts admissions for under 65 group for assessment for dementia – usual presentation head injury or intellectual disability and ? early onset dementia			
Tier 7	**Assessment, treatment and case management (extreme disorders)**	MHSOP multidisciplinary community team that covers whole BOPDHB	MHSOP 10 bed inpatient unit caters for both functional and organic disorders, accepts admissions for under 65 group for assessment for dementia – usual presentation head injury or intellectual disability and ? early onset dementia			

Appendix E – Lakes DHB Current Investment by Service Type

Tier Level	Focus	DHB Mental Health contracted service type Eg. Community Team, Package of Care, Peer Support, Memory Clinic, Day programme	DHB Mental Health contracted Numbers of Beds/FTE	DHB HOP contracted service type eg, ARC rest home beds, private hospital beds, day programmes
Tier 1	Mental health promotion and disease prevention	Nil		Dementia specific education, information contracted to Alzheimer's Society at national level, delivered locally
Tier 2	Targeted mental health prevention and promotion for at risk groups	Nil		Dementia specific client / carer centred education, support contracted to Alzheimer's Society local field worker services
Tier 3	Assessment, early intervention and treatment (mild disorders)	PRIMHIS (Primary Integrated MHS). MH Nurses located in GP practices. Not specific for dementia or older persons but have noted that older age group feature highly in the statistics for presentation.	2.2 FTE contracted for PRIMHIS overall	No dementia specific primary health contracted services. Open referral for HOP NASC – inter Rai assessment - information shared with GP, Access to community support services an option Respite options: Day Activity Programmes Carer Support Through NASC / inter Rai access to NGO community rehabilitation services where rehab potential, carer stress identified.
Tier 4	**Assessment, early intervention, treatment and case management (moderate disorders)**	As per PRIMHIS above	2 dedicated Inpatient beds (as part of a 14 bed Unit)	HOP NASC Inter Rai assessment MDS HC for people with dementia 65 + or close in age & interest 50 + Access to: Day Activity Programmes Carer Support Short Term Residential Respite Home Based Support Services
Tier 5	**Assessment, treatment and case management**	Tiers 5,6& 7 are managed via the MSOP Community team based with the DHB. They have availability of 2 x older persons	MHO99 A 2.0 FTE Psycho-geriatrician MHO99C 8.0 Community nursing/allied health staff	As per Tier 4 Additional HOP contracted services accessed through HOP NASC include

	(complex disorders)	beds as part of a mixed acute psychiatric unit. They can also access up to 6 weeks of an "assessment bed" within a rest home environment (funded via NASC) for people who present but don't need acute bed. Respite and transitional placements available.	MHIS02 730 inpatient bed days Package of care funding via NASC – up to $2500 depending on needs. Has been applied for 1:1 support to transition from ward, assessment in secure dementia environment. No specific FTE allocated but services with MHA20 Community Support Services will provide support hours and medication support at NASC request. MHA21 Day activity program 2.0 FTE funded for older persons – will take someone with dementia as assessed. MHA19 FTE funded contract for older persons will provide respite for dementia clients referred from MHSOP.	capacity for: 460 beds in 14 rest homes 275 beds in 9 private hospitals 82 beds in 5 dementia units 6 beds in 1 psycho geriatric unit Note: HOP does not contract specific bed numbers but an ARC service - therefore reference is to capacity not purchased beds. Older Persons & Rehabilitation Service includes: 1 FTE Geriatrician 0.6 FTE Geriatrician vacancy Inpatient and outpatient allied health service
Tier 6	**Assessment, treatment and case management (severe disorders)**			See Tier 4 & 5 82 bed capacity in 5 dementia units 6 bed capacity in 1 PG unit - if full would expect inter Rai / NASC transfer to another DHB PG unit
Tier 7	**Assessment, treatment and case management (extreme disorders)**	Nil		See Tier 4 , 5 & 6 - 1 6 bed PG Unit Or another DHB PG unit, or acute mental health service

Appendix F –Tairawhiti DHB Current Investment by Service Type

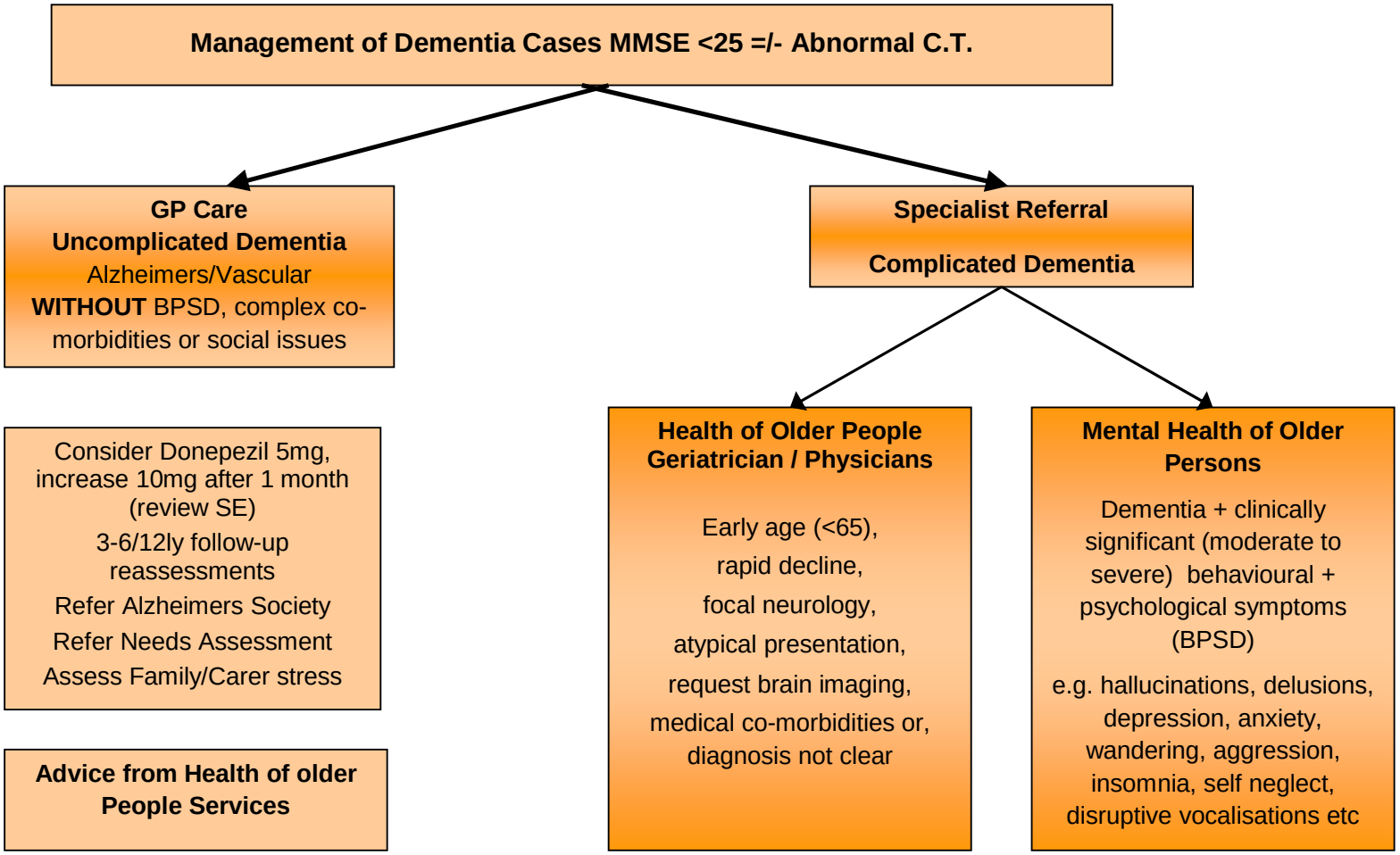
Tier Level	Focus	DHB Mental Health contracted service type Eg. Community Team, Package of Care, Peer Support, Memory Clinic, Day programme	DHB Mental Health contracted Numbers of Beds/FTE	DHB HOP contracted service type eg, ARC rest home beds, private hospital beds, day programmes	DHB HOP contracted numbers of beds/FTE	Other contract arrangements or general comments
Tier 1	**Mental health promotion and disease prevention**					
Tier 2	**Targeted mental health prevention and promotion for at risk groups**	4 education sessions to be delivered by Alzheimer's society 2012/2013				
Tier 3	**Assessment, early intervention and treatment (mild disorders)**	Community mental health team Acute mental health In patient care Activity based day programs Midland regional support and advisory role	3 FTE 1 contracted bed on adult mental health ward 69 day places per week provided by 2 service providers Education and training to service providers			
Tier 4	**Assessment, early intervention, treatment and case management (moderate disorders)**	Community mental health team Acute mental health inpatient care Activity based day programs	3 FTE 1 contracted bed on adult mental health ward 48 dementia day placements provided by 1 provider			
Tier 5	**Assessment, treatment and case management (complex disorders)**	As Tier 4. Plus long term dementia beds	50 beds in total across region			
Tier 6	**Assessment, treatment and case management (severe disorders)**	Referral to MHSOP at Waikato for specialist services				Individuals can access psycho geriatric beds out of the region
Tier 7	**Assessment, treatment and case management (extreme disorders)**	Referral to MHSOP at Waikato for specialist services				

Appendix G –Taranaki DHB Current Investment by Service Type

Tier Level	Focus	DHB Mental Health contracted service type Eg. Community Team, Package of Care, Peer Support, Memory Clinic, Day programme	DHB Mental Health contracted Numbers of Beds/FTE	DHB HOP contracted service type eg, ARC rest home beds, private hospital beds, day programmes	DHB HOP contracted numbers of beds/FTE	Other contract arrangements or general comments
Tier 1	**Mental health promotion and disease prevention**	Peer Support offered by MHSOP Team 8.5 FTE 4 RNs, 1 OT, 1 Social Worker, 1.5 Psychologists, 1 Team Leader/Social Worker		ADARDS (Alzheimer's Taranaki) field officer providing information & advice to carers of people with dementia.		Taranaki DHB contributes towards 5 hours per week of South Taranaki dementia field officer
Tier 2	**Targeted mental health prevention and promotion for at risk groups**	Living Well with Dementia Group for those recently diagnosed with dementia and their main caregiver. Provided by existing MHSOP FTE		Activities Programme (Day Care) for clients with early dementia (residential setting)		Uncapped fee for service contract with 6 residential care providers in Taranaki. Approx 90 clients in total per week. 0.5 Social Worker and 0.5 Cultural Support Worker employed by Māori provider and based within MHSOP.
Tier 3	**Assessment, early intervention and treatment (mild disorders)**	Email and telephone consultation offered to GPs by MHSOP psycho-geriatricians. Assessment, early intervention and treatment (complex cases) provided by existing MHSOP FTE		ADARDS (Alzheimer's Taranaki) Specialised dementia day care programme for clients with more complex dementia (non residential setting) Carer support and respite services including residential respite placements (at all levels of care in ARRC) and community or		Uncapped fee-for- service contract. Approx 40 clients per week Currently administered through Carer Support payments with intention to move to a service package allocation approach from March 2012 (with Carer Support payments only used

				residential based day care programmes. Planned introduction of a home based respite service aimed at clients with dementia for implementation by July 2012.		for informal care arrangements). Residential respite via uncapped fee for service contract.
Tier 4	**Assessment, early intervention, treatment and case management (moderate disorders)**	Existing MHSOP team FTE	4 in-patient beds. 1designated RN in in-patient unit. Existing MHSOP FTE provide treatment, therapy and support for patients admitted to ward. 3.0 FTENASC Assessors undertaking InterRAI Contact assessment and service coordination with non complex clients.			
Tier 5	**Assessment, treatment and case management (complex disorders)**	Existing MHSOP team FTE	7.0 FTENASC Care Managers (to be recruited by Feb 2012). Undertake InterRAI MDS-HC assessment and care management with complex clients			
Tier 6	**Assessment, treatment and case management (severe disorders)**	Existing MHSOP team FTE		ARRC Dementia Beds	115 x Dementia Beds	
Tier 7	**Assessment, treatment and case management (extreme disorders)**	Existing MHSOP team FTE		ARRC Continuing Specialised Care (Psycho-geriatric) Beds	57 x Psycho-geriatric Beds	

Appendix H – Dementia Care Pathway



Clock Test

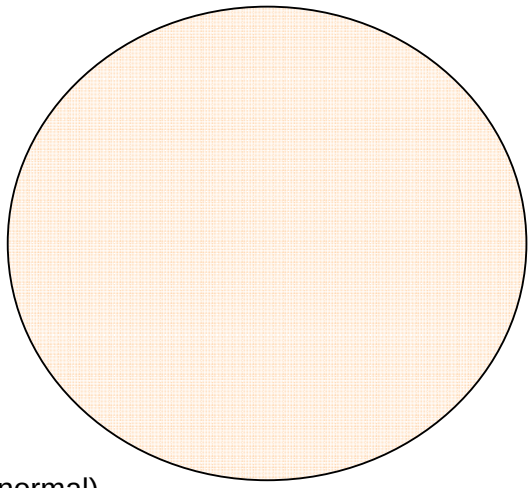
Patient Name: _____

Patient ID: _____

Date: _____

1 Inside the circle, please draw the hours of a clock as they normally appear

2 Place the hands of the clock to represent the time: "ten minutes after eleven o'clock"



(Scored normal or abnormal)

Instruct the patient to draw the face of a clock, either on a blank sheet of paper, or on a sheet with the clock circle already drawn on the page. After the patient puts the numbers on the clock face, ask him or her to draw the hands of the clock to read a specific time, such as 11:20. These instructions can be repeated, but no additional instructions should be given. Give the patient as much time as needed to complete the task.

Scoring

The Clock Test is considered normal if all numbers are present in the correct sequence and position, and the hands readably display the requested time.

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