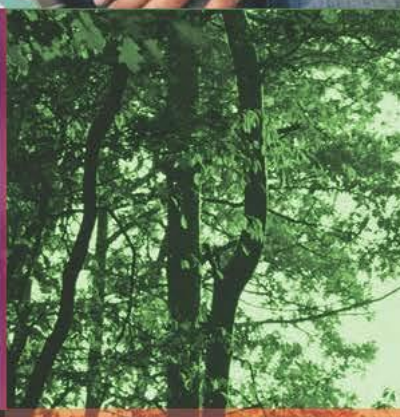
Working with older people

Mental health and addiction workforce development priorities



Te Pou o te Whakaaro Nui

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Te Pou o te Whakaaro Nui is a national centre of evidence-based workforce development for the mental health, addiction and disability sectors in New Zealand.

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Preface

Older people are often invisible in conversations about mental health and substance use problems. In this report, there is overwhelming evidence to suggest that while older people may experience such problems differently to younger adults, their needs are equally as important.

The feedback Te Pou received about this project from people working in this sector has highlighted increasing numbers of older people are experiencing mental health and substance use problems, and dementia. This is contributing to growing demand for services, as well as increasing complexity in service delivery.

To fully understand the impact of mental health and substance use problems on older people, we need to hear more about their experiences, both in their own words and those of whānau. Service development needs to be informed by older people's views as well as up-to-date information about service use and access. The workforce delivering services to older people needs to be situated in age-friendly environments with the right capacity and capabilities.

He Ara Oranga, the report of the Government Inquiry into Mental Health and Addiction (2018) urges system transformation to increase choice and access to mental health and addiction services for everyone. It is important that older people are included in all our efforts to meet the Inquiry's recommendations. The 10 priorities highlighted in this report represent a call to action to improve access for, and service responses to older people.

Will Ward
Interim Chief Executive
Te Pou o te Whakaaro Nui
June 2019

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Executive summary

The Ministry of Health has contracted Te Pou o te Whakaaro Nui (Te Pou) to identify workforce development priorities and initiatives for the mental health and addiction[1] workforce working with older people (aged 65 years and over).

Phase One of this project was to develop a better understanding of the older people's population, their experience of problems with mental health and substance use, service access and workforce trends over time. A review of existing literature was conducted and discussed with sector leaders at a consultation day.

This report summarises key findings from Phase One and describes high-level priorities across the Ministry of Health's five domains of workforce development. These priorities relate to sectors working with older people who have high mental health and addiction needs. These sectors include aged care, disability support and dementia care services; primary and secondary healthcare for older people; and specialist mental health and addiction services for adults and older people in line with the recommendations of the 2018 Government Inquiry into Mental Health and Addiction.[2]

Older people, services and workforce

New Zealand's population is ageing. The number of people aged 65 years or over is expected to grow by nearly 40 per cent over the next 10 years. Average life expectancy is increasing, and the population of older people is increasingly diverse across a range of factors including culture and

[1] The term addiction is used in this report as a generic term to denote problematic substance use including alcohol and other drugs.
[2] Primary healthcare is the provision of first point of contact services by general practice teams and other community health services provided by NGOs. Secondary healthcare is the provision of specialist health services by DHBs and NGOs, most often accessed by people following referral from primary care providers.

ethnicity; religion and spirituality; and gender identity, relationships and sexuality (people from LGBTQIA+ communities).

Older people have diverse experiences of ageing, mental health, problematic substance use and neurodegenerative conditions like dementia. Older people's unique vulnerabilities, presentation and complexity mean that problems with mental health and substances can go unrecognised and have tended to be underestimated. There are considerable barriers to older people's access to mental health and addiction services. These include misperceptions that older people do not have such problems, lack of knowledge of the signs and symptoms, and confusion with ageing.

New Zealand data and international literature suggests as many as 1 to 2 in every 6 older people may experience problems with mental health, or problems with alcohol. Older people who are unwell, in hospital, or living in aged care or residential facilities are most affected by mental health problems. Older men have high rates (per population) of suicide compared to men in other age groups and women. In terms of problematic substance use, older people have high rates of hazardous or harmful alcohol consumption and while rates of other substance use are currently low, these are expected to increase over time.

Older people's access to secondary care mental health and addiction services is low compared to younger adults, children and youth. Consequently, there may be substantial unrecognised and unmet need among older people, particularly those who are unwell, in hospital care, and those living in aged care and other residential facilities.

Evidence suggests primary prevention and early intervention activities can be effective at reducing the number of people whose problems escalate, in turn reducing demand on secondary mental health and addiction services. There are effective treatment and support options for older people accessing secondary mental health and addiction care.

Currently, there are gaps in the evidence about older people's service utilisation in primary and secondary healthcare settings. Studies have argued that access to secondary care services is low. Development of the workforce is needed in mental health and addiction services for adults and dedicated services for older people (MHSOP),[3] as well as health of older people services. This should include building capacity and capabilities to meet future increased demand.

[3] Acronyms for mental health and addiction services dedicated to older people vary by DHB-locality. For the purposes of this report the acronym "MHSOP" describes these services.

Workforce development priorities

Based on the literature review and sector consultation, 10 priorities were identified across the Ministry of Health's five domains of workforce development.

- Workforce development infrastructure priorities aim to ensure older peoples' needs are visible and their diverse views inform strategy and policy, service design and workforce development activities. A primary prevention and early intervention strategy is needed to address unmet need earlier, and reduce demand on secondary care services.
- Information, research and evaluation provides quality data to inform workforce planning and development. Priorities include developing a better understanding of the prevalence of mental health and substance use problems, and dementia among older people across the range of living situations, including aged care; and modelling workforce demand and supply.
- Learning and development reduces barriers to service access and builds workforce capability for working with older people and whānau. Priorities include developing relevant mental health, addiction, cultural and other capabilities across the workforces in the aged care, disability and dementia care, and wider health sector including through new graduate programmes and interprofessional learning.
- Recruitment and retention priorities build workforce capacity across secondary care mental health and addiction workforce, including growing ethnic and LGBTQIA+ representation, enhancing ability to work to top of scope, and worker wellbeing.
- Organisational development priorities focus on building age-friendly cultures in organisations to reduce older people's experiences of ageism, increase service diversity, and develop leadership and networking opportunities for the whole workforce.

Concluding comments

This report presents 10 workforce development priorities for working with older people who have problems with mental health or substance use, based on the findings of a literature review and sector consultation. There may be substantial unmet need among older New Zealanders. We urgently need to grow the range and capacity of mental health and addiction services for older people and increase access to mitigate suffering and harm. Particularly given the anticipated high population growth over next 10 years.

Achieving better mental health and substance use outcomes for older people will require workforce development changes across multiple levels and sectors. Te Pou will work with the Ministry of Health, and collaborate with mental health and addiction services, the workforce centres, and representatives from other sectors like aged care to design workforce development activities to address these priorities.

Introduction

Like other developed nations, New Zealand's population is ageing. The proportion of the population aged 65 years and over is increasing, due to a number of factors including reduced birth rates and mortality, and increased life expectancy.[4] Maintaining good health and wellbeing for older people as they live longer is a national priority (Minister of Health, 2016).

The World Health Organization (WHO, 2015, p. 228) defines healthy ageing as "the process of developing and maintaining the functional ability that enables wellbeing in older age". Older people age in different ways and their experience of health issues varies enormously from person to person, as does their access to appropriate treatment and support (Minister of Health, 2016; World Health Organization, 2015).

The report of the Government Inquiry into Mental Health and Addiction (2018), *He Ara Oranga*, calls for transformation of the mental health and addiction system. Key recommendations from the Inquiry include growing effective prevention and early intervention initiatives to reduce demand for secondary services; addressing disparities in service access; and increasing choice of services. Although the Inquiry panel did not make specific recommendations in relation to older people, its vision aligns with the goals of New Zealand's *Healthy Ageing Strategy* (Minister of Health, 2016).

[4] http://archive.stats.govt.nz/browse_for_stats/population/estimates_and_projections/projections-overview/nat-pop-proj.aspx

Ensuring that system changes inspired by the Inquiry are appropriate for, and bring benefit to, older people requires consideration of their particular needs and characteristics in workforce planning and development (Cheung, Sims, et al., 2018; Croucher, 2016).

Currently, older New Zealanders may access mental health and addiction treatment and support through a range of health and social services, depending on their geographic location and needs. They may be seen by primary healthcare providers; and a range of secondary care services including health of older people services; disability support services; adult mental health and addiction services; and MHSOP (Ministry of Health, 2011).

The Ministry of Health has contracted Te Pou to undertake a 3-year project to identify workforce development priorities and workforce initiatives to grow and develop the mental health and addiction workforce for older people; see Figure 1.

This report summarises key findings from Phase One of the project, based on a literature review and consultation with sector leaders (Te Pou o te Whakaaro Nui, 2019b, 2019c). These activities aimed to develop a better understanding of older people in the population; the incidence of mental health and substance use problems; service providers, access and delivery; and secondary care workforce trends over time. Ten workforce development priorities are described, across the five domains of workforce development; see Figure 1. These focus on key sectors working with older people who have high needs, including the aged care, disability support and dementia care sectors; and primary and secondary healthcare.

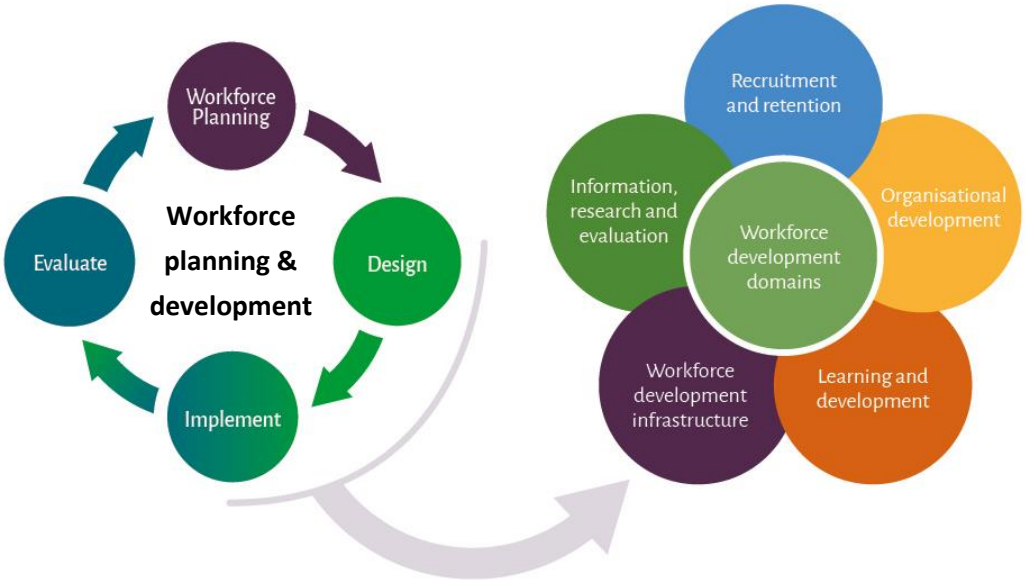

Figure 1. Steps in the workforce planning and development approach using the five domains of workforce development.
Source: Te Pou o te Whakaaro Nui (2017b).

Older people, services and workforce

A literature review and sector consultation day (Te Pou o te Whakaaro Nui, 2019b, 2019c) provided background information about older people in the population, the incidence of mental health and substance use problems, service access and delivery, and workforce. Key findings are summarised in this section.

Population health needs

In 2018, older people comprised 15 per cent of the New Zealand population at 736,000 people. Around 6 per cent of older New Zealanders identified as Māori; 3 per cent in a Pasifika ethnic group; 8 per cent in an Asian ethnic group; and 83 per cent in other ethnic groups.[5] The number of older people in the population is expected to grow by nearly 40 per cent over the next 10 years, and average life expectancy is increasing over time (Statistics New Zealand, 2018).

Older people are a population group that is becoming more diverse. Over the next 10 years there will be substantially higher population growth among older people who identify as Māori, or in Pasifika or Asian ethnic groups (61 to 120 per cent) compared to others (29 per cent; Statistics New Zealand, 2018). Māori older people experience the compounded negative effects of

[5] Based on prioritised ethnicity as specified by the Ministry of Health.

intergenerational disadvantage (compared to non-Māori peoples) that continue to impact wellbeing and quality of life as they age, and contribute to lower average life expectancy (Allport et al., 2018).

With the Baby Boomer generation (people born between 1946 and 1964) comes greater diversity in gender identity, relationships and sexuality compared to their parents and grandparents' generations (Department of Health, 2015; Westwood et al., 2015) . There is also increasing religious and spiritual diversity among older people, due in part to greater religious freedom and openness among Baby Boomers, as well as immigration into New Zealand of people from a range of non-Christian religions, many of whose primary spoken language is not English (ChangeMakers Refugee Forum, 2011).

Diversity among older people extends to their experience and understandings of wellbeing as well as their experience of mental health and substance use problems in later life. Older people with long-standing problems continue to use services as they age. Others develop problems for the first time in older age due to various factors including physical health problems, physiological or neurological changes, current or previous experiences of adversity, social changes such as loss of independence and as a side effect to medications (Fiske et al., 2009; Gershon et al., 2013; Jamieson et al., 2018; McKay et al., 2015; Panza et al., 2010).

The incidence of mental health and substance use problems among older New Zealanders has tended to be underestimated as previous surveys have excluded older people living in aged care and people with dementia (Croucher, 2016). *Te Rau Hinengaro: The New Zealand Mental Health Survey* (Oakley Browne et al., 2006) identified around 1 in 14 older New Zealanders experience any mental health problems each year. However, recent analysis of 72,000 interRAI assessments (2017/18) found 1 in 4 older New Zealanders living in long term care had a depression diagnosis.[6] Likewise, suicide rates are high among New Zealand men aged 85 years and over compared to men in other age groups and women (Cheung, Merry, et al., 2018).

International literature suggests each year as many as 1 in 3 older people who are unwell, in hospital, or living in aged care and other residential settings may experience severe mental health problems like major depression or anxiety (Goldberg et al., 2012; Seitz et al., 2010). Other international literature focused on older people who are well or living in the community found up to 1 in 6 may have severe mental health problems; and 1 in 5 older people may have depressive symptoms (Büchtemann et al., 2012; Luppa et al., 2012).

It is likely that high population growth among older people will result in a large increase in the number of people needing mental health support for the impact of neurodegenerative conditions like dementia. It is estimated that dementia affects around 3 per cent of people aged 65 to 69 years,

[6] interRAI is a suite of clinical assessment instruments that are used in aged residential care and home and community services for older people. See https://www.interrai.co.nz/assets/Documents/Publications-and-Reports/Aged-Residential-Care-FINAL.pdf

increasing with age to nearly 40 per cent of people aged over 90 years (Deloitte, 2017). There are complex relationships between depression, anxiety and dementia. Evidence suggests older people's experience of depression and anxiety may be early signs of future cognitive impairment and dementia (Byers et al., 2012; Panza et al., 2010). Most people diagnosed with dementia will experience behavioural and psychological symptoms of dementia at some stage over the course of their remaining life (Cerejeira et al., 2012).

In relation to substance use problems, New Zealand studies have found up to 2 in every 5 New Zealanders aged 60 years and older engage in hazardous or harmful alcohol consumption (Towers et al., 2017; Towers et al., 2018a, 2018b). Rates of other substance use among older people are currently low compared to younger adults, but are expected to increase over time (Jones, 2017; Kuerbis et al., 2014).

Consequently, there may be substantial unrecognised and unmet mental health needs and problematic substance use among older New Zealanders. These problems can have profound impact on older people's quality of life, including their ability to live independently; relationships with family and whānau; and participation in cultural, leisure, employment and wider community activities (Fiske et al., 2009; Kuerbis et al., 2014).

For Māori people, older people's experience of mental health or substance use problems may have intergenerational impacts due to lost opportunities to share their knowledge and wisdom (Allport et al., 2018).

Service access and delivery

As a group, older people have diverse experiences of ageing, mental health and substance use problems, and neurodegenerative conditions like dementia. Older people's unique vulnerabilities, presentation and complexity mean that problems with mental health or substances may be under-recognised by themselves, whānau, and others including aged care and health providers (Anderson et al., 2017; Home and Community Health Association & Lattice Consulting Ltd, 2018; McKay et al., 2015; Wuthrich, 2015).

Other barriers to service access include perceptions that older people do not experience problems with mental health or substances; and current or historical fear, stigma and discrimination discourages help-seeking (Choi et al., 2014; Kuerbis et al., 2014; Stark et al., 2018; Westwood et al., 2015). When older people do access services, lack of appropriate attention to their cultural, spiritual or gender-specific needs can impact their engagement and long-term service outcomes (Minister of Health, 2016; Westwood et al., 2015).

Evidence suggests older people who experience problems with mental health or substances respond well to a range of primary prevention and early intervention activities (Okereke et al., 2013;

Schoevers et al., 2006), and to secondary care treatment and support (Bhatia et al., 2015; Choi et al., 2014; McKay et al., 2015; Stark et al., 2018).

Appropriately delivered, effective primary and early interventions can substantially reduce the number of older people whose problems escalate, thereby reducing demand on secondary care services. These activities include routine depression screening, health education, primary mental health collaborative care, psychotherapy, problem-solving therapy, increasing social engagement, exercise and improving diet (Alexopoulos et al., 2009; Fiske et al., 2009; Okereke et al., 2013; Schoevers et al., 2006; Unützer et al., 2002).

Currently, there are gaps in the evidence about older peoples' mental health and addiction service utilisation. Primary care activities are mainly reported in PHARMAC[7] prescription data. About 1 in 5 older New Zealand women and 1 in 8 older men were prescribed antidepressants in 2015. Prescribing rates to older people have been increasing over time, and are high compared to those for younger adults across all ethnic groups (Wilkinson, 2018a, 2018b). Gibb et al. (2018) report older people had low rates of primary mental health service use and were especially unlikely to use psychologist services.

Information about older people's access to secondary care mental health and addiction services is incomplete. PRIMHD[8] data is not consistently collected in the Central and South Island regions due to different funding models for MHSOP (Cheung, Sims, et al., 2018). Just over 2 per cent of older people in the Northern and Midland regions access secondary care mental health and addiction services (both adult and MHSOP). These rates are low compared to access rates for children and youth (under 18 years) and younger adults (18 to 64 years), which are nearly 4 per cent each (Te Pou o te Whakaaro Nui, 2019b).

There are ethnic variations in service access recorded by the Northern and Midland regions that highlight the need for culturally relevant services, and more attention to cultural barriers to service access. Māori people in the older age ranges access services at slightly higher rates than their share of the population, whereas Asian older people access services at substantially lower rates compared to their share of the population (Gibb et al., 2018; Statistics New Zealand, 2018).

Since 2008, various service delivery challenges have been identified, that are still relevant in 2019 (Carew, 2018; Cheung, Sims, et al., 2018; McKay et al., 2015; Te Pou o te Whakaaro Nui, 2019c; The Royal Australian & New Zealand College of Psychiatrists, 2018). These include:

- lack of a nationally consistent approach to mental health and addiction services for older people
- inadequate service capacity to address older people's currently unmet needs

[7] PHARMAC is the Pharmaceutical Management Agency of New Zealand.
[8] PRIMHD is the Programme for Integration of Mental Health Data.

- gaps in service delivery to people living with dementia, and to older people with substance use problems
- the need for more specialist residential options tailored to older people's needs, including for people living with dementia
- the need for primary prevention and suicide prevention tailored to older people
- concerns that future services will lack the capacity to meet the increased demand associated with our ageing population (Carew, 2018; Cheung, Sims, et al., 2018; McKay et al., 2015; Te Pou o te Whakaaro Nui, 2019c; The Royal Australian & New Zealand College of Psychiatrists, 2018).

Workforce development

Studies suggest the MHSOP workforce has had little growth since 2010 (Cheung, Sims, et al., 2018; Te Pou o te Whakaaro Nui, 2011a). Previous workforce development activities have focused mainly on training (Matua Raki, 2012).[9] Various workforce development needs have been identified previously, many of which are still relevant in 2019. These include:

- increasing MHSOP capacity
- building workforce capabilities across sectors
- increasing capability to deliver services to older people in the community at higher levels of acuity
- more appropriate tertiary education content
- improving professional development opportunities focused on working with older people (Cheung, Bailey, et al., 2018; Cheung, Sims, et al., 2018; McKay et al., 2015; Ministry of Health, 2011; Te Pou o te Whakaaro Nui, 2008, 2011a, 2019c; The Royal Australian & New Zealand College of Psychiatrists, 2018).

[9] See also the Northern Regional Alliance *HOPE – Health of Older People E-resource*, available at http://www.networknorth.org.nz/e-resources/; health navigator e-resources https://www.healthnavigator.org.nz

Workforce development priorities

Based on the findings of the literature review and sector consultation, 10 workforce development priorities were identified using a workforce planning and development process. The following sections describe each of these priorities with supporting evidence. Priorities are grouped within the five domains of workforce development: workforce development infrastructure; information, research and evaluation; learning and development; recruitment and retention; and organisational development.

Workforce development infrastructure

Workforce development infrastructure progresses workforce development through sector relationships, funding, legislation and regulation, and other infrastructure (Ministry of Health, 2017). Attention to this workforce development domain is vital to the success of activities across the other four domains (Te Pou o te Whakaaro Nui, 2017a). The literature review and sector consultation identified areas where the workforce development infrastructure can be strengthened to ensure older people and whānau are visible and can inform decision-making.

Older people are a priority group

A key theme emerging from both the literature and sector consultation is the relative invisibility of older people in discussions about mental health and addiction, and the invisibility of older people's

mental health and substance use problems in discussions about the health of older people (Matua Raki, 2012; McKay et al., 2015; Te Pou o te Whakaaro Nui, 2019c).[10]

Older people are the fastest growing age group in New Zealand's population, and diversity in this age group will increase over time (Statistics New Zealand, 2018). Mental health and substance use problems among older people have tended to be under-identified and underestimated (Croucher, 2016; Wuthrich, 2015). International literature suggests such problems are common among older people (1 in 6 people living in the community), and rates are highest among those who are unwell or living in aged or residential care (up to 1 in 3 people); (Büchtemann et al., 2012; Goldberg et al., 2012; Luppa et al., 2012; Seitz et al., 2010). Older people are also likely to have complex, overlapping physical, neurological, and mental health and substance use problems (McKay et al., 2015; Panza et al., 2010; Te Pou o te Whakaaro Nui, 2011b, 2014a).

Older people's mental health and substance use problems may not be well recognised as they present differently to younger adults, common diagnostic tools may not be effective, and there is considerable overlap between mental, physical and neurological health (Carew, 2018; Cheung, Bailey, et al., 2018; Fiske et al., 2009). Because of older people's varying experiences of ageing and health needs, and their differing needs based on culture, language, spirituality, gender and sexuality, the workforce for older people need to have a range of cultural, social, and health knowledge and skills. For these reasons, the Royal Australian and New Zealand College of Psychiatrists recommends planning and delivery of older people's services should not be subsumed within services for younger adults (McKay et al., 2015). In addition, they recommend that suicide prevention strategies should be tailored for older people (The Royal Australian & New Zealand College of Psychiatrists, 2018).

It is therefore recommended that future mental health and addiction workforce and service development plans, policies and strategies should reference older people as a priority group and utilise the best available evidence to provide appropriate cultural, social and health solutions, recommendations or guidelines to meet their diverse needs.

Nationally consistent approach to services

Lack of a nationally consistent approach to MHSOP funding and service delivery is a key challenge identified by both the literature (Cheung, Sims, et al., 2018; Te Pou o te Whakaaro Nui, 2008) and sector consultation (Te Pou o te Whakaaro Nui, 2019c). This is also the case for some other key services such as memory clinics (Stone et al., In press). MHSOP are currently funded differently by region. Services in the Northern and Midland regions are funded from mental health and addiction expenditure. In contrast, services in the Central and South Island regions are funded from a mix of adult mental health and addiction, health of older people, and disability support expenditures. There

[10] For example, older people's needs are not discussed in the report of the Government Inquiry into Mental Health and Addiction (2018).

is wide variation in DHBs' provision of inpatient and community services dedicated to older people, and only three DHBs provide dedicated addiction services (Cheung, Sims, et al., 2018).

Reporting of service utilisation to PRIMHD is incomplete for the Central and South Island regions, making it difficult to understand service access nationally and monitor change over time (Te Pou o te Whakaaro Nui, 2019b). In the Northern and Midland regions where PRIMHD reporting is more complete, service access rates for older people are substantially lower than for younger adults and children (Te Pou o te Whakaaro Nui, 2019b). This suggests older New Zealanders may have considerable unmet needs for mental health and problematic substance use.

A nationally consistent approach to planning and funding mental health and addiction services for older people is recommended. This approach should reflect the best available information about the incidence of mental health and substance use problems among older people; include and promote services that are relevant to differing ethnocultural understandings of the status and roles of older people; and should be annually updated against population growth. All DHB and NGO services funded under this model should be required to report to PRIMHD.

Older people and whānau advisory group

The relative invisibility of older people and their whānau in conversations about mental health and addiction has tended to limit access and choice – the subject of key recommendations from the Government Inquiry into Mental Health and Addiction (2018).

As the New Zealand population ages, the number of people experiencing co-existing mental health, substance use, and neurodegenerative problems like dementia is also expected to increase (Te Pou o te Whakaaro Nui, 2019c). Mental health and addiction services need to be sensitive to older people's broader cultural, social and other health needs. Recent studies recognise the need to identify and vocalise cultural discourses around ageing and wellbeing, as these frequently do not align with medical conceptualisations (Allport et al., 2018; Kerse et al., 2014). Likewise, there is a need to recognise that, in their lifetimes, some older people have had inappropriate, unhelpful or discriminatory experiences of mental health and addiction services, for example people from LGBTQIA+ communities (Westwood et al., 2015).

To ensure responsive service design and health systems good mechanisms are needed to identify and hear older people's voices across the diversity of identity and experience, and those of whānau.

It is therefore recommended the Ministry of Health explore ways to ensure the voices of older people and their whānau inform MHSOP and adult mental health and addiction service design, workforce planning and development. This process should be structured to be reflective of the diversity of cultures, spirituality, gender and sexuality represented among older people and should inform system changes in response to the Government Inquiry.

Primary prevention and early intervention strategy

The Government Inquiry into Mental Health and Addiction (2018) recommended increasing primary prevention and early intervention activities and prioritising non-pharmaceutical responses. A cross-sector primary prevention and early intervention strategy for older people is needed; as changes to the secondary healthcare sector alone will not keep pace with future demand due to population growth.

The strategy needs to include health promotion and education (Fiske et al., 2009; Okereke et al., 2013; Schoevers et al., 2006; Whyte, 2006). This will support older people, their whānau and carers to better understand the signs of mental health and substance use problems, where to go and how to get help (James, 2008; Stark et al., 2018). It should include building basic mental health and addiction capability in the workforce delivering aged care, disability support and dementia care. This is because New Zealand aged care and home healthcare providers report increasing demand for mental health and addiction capabilities in the workforce (Home and Community Health Association & Lattice Consulting Ltd, 2018).

In primary healthcare settings, there are a broad range of effective primary prevention and early intervention options that can be delivered to older people. These include health education and promotion; routine depression screening; primary mental health collaborative care; access to psychotherapy; and behavioural interventions such as increasing social engagement, improving diet and exercise (Alexopoulos et al., 2009; Fiske et al., 2009; Okereke et al., 2013; Schoevers et al., 2006; Unützer et al., 2002; Whyte, 2006). Evaluated primary prevention and early intervention initiatives have been shown to reduce the number of older people experiencing escalation in severity of mental health and substance use problems, improve quality of life, and help maintain functional ability (Cody, 2013; McKay et al., 2015; Okereke et al., 2013; Schoevers et al., 2006; Whyte, 2006).

Older New Zealanders experiencing problems with mental health and substances are most likely to seek help from medically-trained healthcare providers (James, 2008; Oakley Browne et al., 2006). They also have very high prescription rates for antidepressant and antipsychotic medications compared to younger adults (Wilkinson, 2018a, 2018b). Because of their unique vulnerabilities, the medication burden for older people tends to be high and is associated with increased risk of falls and other adverse events. It may also be a factor in people choosing to end their life (Coupland et al., 2011; Jamieson et al., 2018). Therefore, it is important to ensure that prescribing is only used where

necessary (Coupland et al., 2011) and alternatives are available (Government Inquiry into Mental Health and Addiction, 2018).

It is recommended the Ministry of Health implements a primary prevention and early intervention strategy for older people that can be tailored to meet the diverse cultural and social needs of local populations. This should include health education and promotion activities aimed at older people and their whānau in the general public with specific focus on building cultural prevention initiatives for Māori, Pasifika and Asian elders. It should also build appropriate workforce capability in the primary healthcare workforce to deliver evidence-based initiatives to older people; and include guidelines for primary healthcare providers around prescribing of mental health medications and monitoring.

Information, research and evaluation

The information, research and evaluation workforce development domain provides the evidence to support understanding the population, mental health and substance use incidence and prevalence, and quality information about service use and workforce (Te Pou o te Whakaaro Nui, 2017c).

National mental health survey

Te Rau Hinengaro: The New Zealand Mental Health Survey (Oakley Browne et al., 2006) was undertaken over 15 years ago. The survey underestimated prevalence and incidence of problems with mental health and substances among older people in the general population as it did not include people living with dementia nor those who live in aged care and other residential services (Croucher, 2016). Notably, New Zealand interRAI assessments,[11] and several overseas studies indicate substantially higher rates of depression and anxiety among older people, particularly among people who are unwell or living in residential care facilities (Büchtemann et al., 2012; Byers et al., 2010; Seitz et al., 2010). Recent studies of suicide indicate high rates among older New Zealand men (Cheung, Merry, et al., 2018). Older New Zealanders have very high rates of hazardous or harmful alcohol use (30 to 40 per cent and 13 per cent respectively). These rates were reported to be high both nationally and internationally (Towers et al., 2017; Towers et al., 2018b).

The Government Inquiry into Mental Health and Addiction (2018) recommends undertaking a new population health survey to better understand incidence across ethnic groups. It is recommended that information is collected to identify mental health and substance use problems, and dementia prevalence and incidence rates for older people across ethnic groups and a range of relevant living situations. Methodologies should consider existing information sources such as interRAI assessment data, the *New Zealand health survey*, and recent research.

[11] See footnote 6 on page 10.

Model workforce supply and demand

The Government Inquiry prioritised increasing access to and choice of mental health and addiction services (Government Inquiry into Mental Health and Addiction, 2018). MHSOP and adult mental health and addiction service capacity needs to grow as it is likely there is currently unmet need among older people, and future demand will increase due to high population growth (Te Pou o te Whakaaro Nui, 2019b).

Adoption of new models of care, as recommended by the Royal Australian and New Zealand College of Psychiatrists (2018) and the Government Inquiry into Mental Health and Addiction (2018), will require review of the current workforce status against that needed to deliver future services, using a workforce planning and development approach. For example, half of the DHB mental health and addiction workforce is aged 50 years and over (Te Pou o te Whakaaro Nui, 2019a), and MHSOP employees tend to be older than those working in adult services (Te Pou o te Whakaaro Nui, 2011a). So while current turnover is low in the DHB mental health and addiction workforce, this is likely to change in the near future as DHB employees consider retirement (Te Pou o te Whakaaro Nui, 2019a). Another example raised in sector consultation was the shortage of qualified health professionals in smaller urban and rural areas (Te Pou o te Whakaaro Nui, 2019c).

It is recommended there be investment in modelling workforce demand and supply using the best available information about the MHSOP and adult mental health and addiction workforce, and service use to support planning and development to increase capacity for working with older people locally, regionally and nationally.

Learning and development

Workforce learning and development opportunities can help build appropriate knowledge and skills for recognising and responding to older people who have problems with mental health and substances. Building workforce capabilities will support the success of primary prevention strategies (as previously described in the Workforce development infrastructure section see page 15), as well as resourcing secondary care health services.

Build mental health and addiction capabilities

Lack of understanding of the signs and symptoms of mental health and substance use problems is a key barrier to older people accessing primary and secondary healthcare services (Anderson et al., 2017; Choi et al., 2014; Kuerbis et al., 2014; McKay et al., 2015; Stark et al., 2018; Wuthrich, 2015). The relationship between ageing and declining mental and physical health status is complex and interconnected. So a good understanding of the overlap between mental, physical and neurological health problems experienced by older people is required in the secondary care health workforce (Cheung, Bailey, et al., 2018).

Because of older people's unique presentation and vulnerabilities and high population growth, it is vital that all sectors working with older people build workforce capabilities to recognise problems and respond appropriately. Relevant skills might include screening and referrals; brief interventions; knowing how to access community support services; understanding suicide risk factors and the interactions between physical, neurological and mental health, and substance use (Jamieson et al., 2018; Kuerbis et al., 2014; Tan, 2019; World Health Organization, 2015). To be effective, the workforce across sectors working with older people also needs to have basic cultural, social and whānau engagement competencies relevant to the diversity of older people in the population (Minister of Health, 2016).

It is recommended the Ministry of Health invests in professional development for the following groups. This development should include examining and understanding the educational needs of each group and formulation of competencies (including cultural) and learning outcomes.

- People working in aged care, dementia care and disability support services, both home-based and residential. This development should equip them with basic mental health and addiction competence relevant to their work with older people and whānau.
- Students in undergraduate health and social practice training, to ensure there is enough coverage of common problems associated with mental health and substance use impacting older people in curricula.
- Health and social practitioners working with older people in primary and secondary care health settings to equip them to recognise and respond appropriately to older people who have mental health and substance use problems. Development activities should incorporate the values and attitudes of *Let's get real: Real Skills for working with people and whānau with mental health and addiction needs* (*Let's get real*), (Te Pou o te Whakaaro Nui & Ministry of Health, 2018).
- Clinical and non-clinical workers in MHSOP and in adult mental health and addiction services to equip them with specialist knowledge and skills for working with older people. This should incorporate the values and attitudes of *Let's get real* and build capability to provide evidence-based alternatives to medication. This might be achieved by increasing mental health and addiction new graduate programme placements in DHB and NGO MHSOP.
- Creating opportunities for interprofessional learning and sharing knowledge across mental health and addiction, health of older people, emergency medicine, palliative care, neurology, and primary care services (Cheung, Bailey, et al., 2018).

There are existing professional development initiatives, for example Blueprint for Learning can provide tailored MH101 and Addiction 101 workshops;[12] and the *Walking in Another's Shoes* programme that builds competency among dementia care workers.[13] E-resources include the Northern Regional Alliance *HOPE – Health of Older People E-resource*, based on the original *Let's get real* framework;[14] and there are health navigator resources relevant to working older people with dementia and depression for example.[15]

It is further recommended the Ministry of Health invests in scoping, review and update of existing professional development initiatives relevant to working with older people to identify gaps; improve alignment with each other and with the updated *Let's get real* framework; update relevant cultural and social competencies, for example working with older people from LGBTQIA+ communities; improve accessibility and availability; and provide for future evaluation and continuous improvement.

Recruitment and retention

Effective recruitment and retention activities help to build capacity and efficiency through appropriate workforce growth, skill mix and roles. Best practice in recruitment and retention literature indicates a focus on internal and external environment is needed (Duraisingam, 2005). For example, working to reduce stigma and discrimination against mental health and addiction in the community.

Build workforce capacity

As the mental health and addiction sector responds to the Government Inquiry into Mental Health and Addiction (2018), there will be pressure on secondary mental health and addiction services. These will need to deliver greater access and choice, within the constraints of the available specialist clinical workforce – which for MHSOP is already under pressure (Cheung, Sims, et al., 2018). Sector consultation day participants spoke of the need to grow capacity in community mental health and addiction services to be responsive to older people at higher levels of acuity (Te Pou o te Whakaaro Nui, 2019c).

[12] These are one-day mental health and addiction awareness workshop for New Zealanders; see https://www.mh101.co.nz/

[13] See https://ako.ac.nz/assets/Knowledge-centre/good-practice-publications/247424db44/An-appreciative-inquiry-into-supporting-culturally-diverse-dementia-care-workers-as-learners.pdf

[14] This is an online resource for mental health and addiction clinicians and others that identifies the skills needed to work with older people and their whānau and provides an e-learning platform to assess and develop competencies. See http://www.networknorth.org.nz/e-resources/. The Alliance suggests that the resource may be of use to older people and their whānau as well as clinicians.

[15] See for example resources for dementia and depression, at https://www.healthnavigator.org.nz/health-a-z/d/dementia/ and https://www.healthnavigator.org.nz/health-a-z/d/depression-later-life/

These changes can be supported by activities aimed at working to top of scope to enable better utilisation of limited clinical resources, by matching tasks and roles to appropriately skilled workers. Achieving this will likely include recruitment to grow the non-clinical support and cultural workforce in MHSOP and adult services (Ministry of Health, 2011; Te Pou o te Whakaaro Nui, 2014b, 2017c).

With high population growth expected among older people who identify as Māori, Pasifika or Asian, building workforce capacity needs to consider how to improve ethnic representation in the workforce (Ministry of Health, 2011) and cultural capability across the whole workforce. Likewise, there will be a need to build workforce capacity to work with older people from a wider range of cultures, languages and religions, and LBGTQIA+ communities.

Attention to retention will ensure services get the most benefit from recruitment activities. Sector consultation day participants signalled the MHSOP workforce is under pressure from high demand and high complexity. Workforce retention will be enhanced by strategies to grow and protect workforce wellbeing and prevent burnout during the forthcoming period of system transformation (Schoo, 2005).

It is recommended the Ministry of Health supports DHBs and NGOs to use workforce planning to develop their mental health and addiction workforce capacity using recruitment and retention activities. These activities should include increasing workforce representativeness in ethnicity and language, gender and sexuality; improving employees' opportunities to work to top of scope; building new roles; developing recruitment and retention strategies; and enhancing worker wellbeing.

Organisational development

Organisational development supports workforce development activities by building the culture and climate needed for success, and improving choice of services (Te Pou o te Whakaaro Nui, 2017a).

Age-friendly cultures

Let's get real (Te Pou o te Whakaaro Nui & Ministry of Health, 2018) provides the foundation for developing supportive systems and cultures, and workforce values and attitudes. Embedding age-friendly cultures and values in organisations and mental health and addiction services will help to make older people and their needs more visible. It will also help to reduce negative experiences of ageism and healthcare rationing (World Health Organization, 2015), and ensure that older workers are retained in the workforce for longer.

The WHO (2015) states best practice in health services for older people is person-centred integrated care that shifts the focus from treating disorders to building age-friendly systems and practices; and transforming service delivery to support older people's quality of life according to their diverse worldviews, aspirations and perceived needs. For example, Māori worldviews about ageing and

health, and service models such as Whānau Ora and kaupapa Māori mental health and addiction services provide alternatives to the constructs of western medical science. These models are built on indigenous values and aspirations for health and wellbeing including self-determination, cultural identity and tikanga, and the four cornerstones of Te Whare Tapa Whā: whānau, physical health, mental health, and spiritual health (Te Rau Matatini, 2015).

To meet the needs of an increasingly diverse population of older people, growing the number of kaupapa Māori, Pasifika and Asian cultural services will be increasingly important. This is particularly so for people who need or want to receive services according to their own customs and culture, and in their own language. Likewise, it is also important to grow appropriate services for people from LGBTQIA+ communities.

It is recommended that organisational development be supported to enable age-friendly cultures and practices, such as person-centred integrated care systems, and services that are appropriate to and relevant for the diverse groups that comprise older New Zealanders now and into the future. Organisational development should be accompanied by relevant workforce development using the values and attitudes, knowledge and skills promoted in *Let's get real*.

Networks and leadership

A whole of workforce approach is needed to ensure that appropriate workforce development opportunities are available to people in the clinical and non-clinical workforce, as well as organisation leaders and managers and other key stakeholders such as professional bodies and academia.

At organisation-level, leadership includes development of career pathways and specialisms for people in clinical and non-clinical roles who work with older people across all levels of service provision and across health, cultural and social practice. Sector consultation day participants identified the need for dedicated resourcing to support the development of older people's mental health and addiction networks (Te Pou o te Whakaaro Nui, 2019c). At regional and national level, building networks, forums and conferences dedicated to older people's health will support developing workforce leadership across all levels through the sharing of ideas and practices.

It is recommended the Ministry of Health invests in a programme of networks and leadership development for the workforce working with older people. This should include national meetings of DHB and NGO MHSOP workforce to provide opportunities for networking and support; workforce development activities aimed at identifying career pathways and specialisms in mental health and addiction services for older people; academic research to identify and promote effective practices and services; and ensuring appropriate mechanisms are in place for information sharing and evaluation.

Concluding comments

This report presents 10 workforce development priorities for working with older people who have problems with mental health or substance use. These priorities were developed following review of national and international evidence and mental health and addiction sector consultation.

The evidence suggests there may be substantial unmet need among older New Zealanders. Each year, up to 1 to 2 in every 6 older people may experience mental health or substance use problems. Actions that will grow the range and capacity of mental health and addiction services for older people and increase access are urgently needed to mitigate current and future suffering and harm. Particularly given the anticipated high population growth over next 10 years.

Achieving better mental health and substance use outcomes for older people will require workforce development across multiple levels and sectors. Te Pou will work with the Ministry of Health, and collaborate with mental health and addiction services, the workforce centres, and representatives from other sectors like aged care to design workforce development activities to address these priorities.

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