

# Mental Health and Addiction of Older People & Dementia Project

Teleconference - Monday 2 February, 2009

The purpose of this teleconference was to seek feedback from Aged Care providers to inform the Mental Health and Addiction of Older People & Dementia Project currently being undertaken by the Ministry of Health. The teleconference was facilitated by Anne Foley, advisor to the Ministry of Health assisted by Grace O'Sullivan on behalf of HCPNZ. Service providers (large and small) from around New Zealand participated in the teleconference including: Judith Johnson, (The Oceania Group); Judi Strachen, (Guardian Health Care); Myreen Lawrie-Bevan, (Gardenview – Dementia care); Vonnie Saunders, (Accadia Rest Home).

Other service providers (urban and rural) who contributed comment include: Jackie Simkins, Claud Switzer Memorial Trust, Kaitaia; Sue Billington, Karmo Home, Whangarei; Ross Neale, Marvon Downs Rest Home, Auckland; Chris Dale, Jo Roberts, Colleen Gabor, Marguerite Crickmer, St Andrew's Village, Auckland.

Three questions were asked of the care service providers. These are presented below along with the responses.

## **1. What are the issues and challenges facing clinicians, managers, and service users in the care of older people and those with dementia?**

- Funding
  - pay equity with DHB's
  - lack of qualified staff
    - staff undervalued and underpaid
    - low wages make it difficult to recruit skilled staff
    - staff wages take up to 50% of income and that is a minimum rate
  - silos
  - contract bed rate is too low to allow financial independence – sinking lid policy
  - investment in infrastructure. No room for improvements (NGO's and private facilities have no flexibility in the use of funding)
  - tertiary funding restricts the numbers of health professionals being trained.
- Services
  - lack of acute mental health beds especially in Auckland
  - need for ongoing access to advice related to psycho-geriatric care
    - pre-existing condition still present when people are admitted to residential care
    - underlying medical problems often not treated.
  - maintaining services or quality of care to achieve compliance with standards is an ongoing challenge due to a lack of resources - financial, staff, accommodation, infrastructure, and equipment .
  - no choice of provider or type of service – particularly in rural areas

- Work force
  - shortage of qualified staff with essential skills – RN's, OT's, Physios, GP's, specialists
  - standards of education for staff are inadequate – complex field of practice
  - there are no NZQA unit standards which address psycho-geriatric care.
  
- Ageing in place strategies – huge impact
  - people are not coping at home alone
  - not enough appropriate services to meet current needs
  - drug and alcohol use/abuse often poorly monitored
  - people being kept in the community too long then entering residential care at an older age, with higher needs, because they are more frail.
  
- Protectionism
  - NGO's, DHB's, and Government agencies need to work together and share resources
  - lack of willingness to trial a shared risk approach to investment across the government and NGO sectors.
  
- NASC assessments
  - lack of consistency in assessment process
  - the quality of information and the weight given to it.
  
- Lack of support
  - multiple issues can arise when caring for people with dementia
  - GP's not always experienced in diagnosis and intervention
  - no one to turn to for advice when an acute episode occurs
  - clinical support is often patchy.
  
- Family
  - poor information from family with reference to the person's abilities
  - historical issues related to addiction, alcohol abuse, sexually inappropriate behaviour often undisclosed.

## **2. What are the potential barriers to implementing an integrated approach for older people?**

- Funding
  - poor remuneration
  - limited funding to support access to specialist knowledge
  - people assessed as level 2 care when in reality their need is level 3 which requires more funding
  - insufficient secure dementia units
  - not seen as cost effective to develop services for people with dementia
  - in rural areas home support can be unreliable because of the distances involved
  - in rural areas there is no choice of provider or type of service

- no funding available to enable older people living alone to access short term care while they recover from an acute episode of illness
- payment for carer support has fallen behind inflation - \$75.56 per day towards the full cost of care which is \$103.75 per day. Too expensive for many people.

- Services
  - lack of dementia specific units to care for the numbers of people being referred.
  - lack of people with appropriate skills and knowledge.
- Workforce issues
  - working with older people is the bottom of the barrel – no glamour in caring for older people
  - scope of practice for EN's too restricted – caregivers can give medications and dress wounds, EN's cannot draw up a care plan
  - knowledge base of staff employed to care for older people is often limited
  - staff afraid of the unknown.
- Support
  - availability of health professionals with appropriate knowledge
    - resident's personal GP/professional intervention
    - no sense of urgency from agencies when asked for help to deal with issues arising/acute episodes
  - no follow up to monitor resident's who have a history of mental health problems
  - lack of willingness to share vital resources across government and NGO sectors.
  - lack of community support related to ADL's.
- NASC
  - relationship between NASC and Health Care Providers can be dysfunctional
  - lack of consistency in assessments
  - resistance to people being reassessed when initial assessment is shown to be inaccurate
  - incorrectly assessing the required level of care i.e. hospital, rest home, secure dementia unit
  - inadequate history of issues/problems.
- Family
  - family members fail to recognise the level of need and so mis-inform NASC
  - family members may hide historical information, that is very pertinent to the health care provider, out of a sense of shame.
- Placement
  - availability of secure dementia units.

### 3. If this project could achieve three things what would they be?

- i. Recognition of the complex nature of client group
  - appropriate education programmes i.e. unit standards for the psych geriatric population
  - pay parity
  - need for flexible service provision
  - access to a multidisciplinary team
- ii. Coordination of services
  - integrated notes
  - follow up system for call back
  - help line for older people's health
  - clinical pathways similar to the chronic care pathways project.
- iii. Aged care contract
  - different contract agreement
  - transitional contract agreement
  - integrating into one contract.

Of note:

1. Great team work between the Mental Health of Older People and Older People's Health in Levin. Multidisciplinary teams have joined together and work from one office. This was said to have made a huge difference to service provision.
2. All participants expressed concern about the acute shortage of secure/specialized dementia care beds.
3. Lack of specialized care and knowledge.
4. Of major concern is the idea that DHB's may increase RN ratios in residential care.

Suggestion:

Participants in the teleconference strongly recommended / felt it would be very helpful to have access to a telephone advisory service.

Comment from Ross Neale – Marvon Downs Rest Home.

1. If this project could achieve three things, what would they be?
  - Basic funding which includes recognition of capital cost.
  - Secure dementia units recognized as requiring specialized support, knowledge, and trained staff.
  - Query - A pilot scheme.

Comment from Jackie Simkin – Claud Switzer Memorial Trust, Kaitaia, Northland.

We need to develop a model of care that both supports older people to live in their own homes for as long as that is possible/realistic, and enables them to access local support and care at those times in their life when it may be necessary (regardless of ability to pay). In small rural

environments it seems sensible to develop hubs (supported by primary health/secondary health/DHB funded services) to manage a range of different types of service provision. Special attention to appropriate environment for age difference/needs would be required but possible with planning and consideration.

Need to work together to find smart solutions to the challenges we face. For example, Aged Care providers are under-utilised in terms of training the Health Care Assistant workforce and providing a high standard of education for both home based support and residential care.