

Older adults in New Zealand

Population changes, health, service use and workforce needs
September 2011

The health of older people is a national priority.^{10, 11} New Zealand along with societies elsewhere, is currently in the midst of a population transition. We face new challenges due to an increasing number of older people. This document is an introductory guide to older persons' health needs. It outlines challenges for leaders, managers, planners and funders. It explores characteristics of the older adult population along with caregiving, health care needs, service use, workforce demand and interventions to improve older persons' and caregivers' quality of life. Implications for informal caregivers, services and workforce development are highlighted.

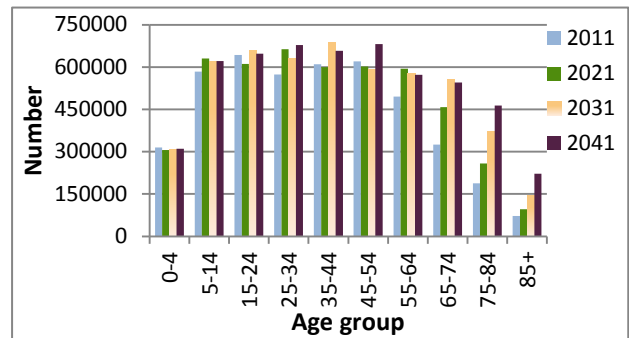


Figure 1. New Zealand age group projections, 2011-2041.⁵

Older adults make up 13 per cent of the general population and this percentage will grow steadily from 2011. Over the next 50 years the older adult population is expected to level out at 20-21 per cent. While all district health board (DHB) area populations will become older on average, variations exist and each DHB will face their own unique challenges. Older people often rate their health as very good or excellent. However, the risk of chronic disease and dementia increases with age. Older adults are more likely to have comorbid and complex mental health problems. Furthermore the risk of suicide among older males increases with age.

Family members play a key role in supporting older people. Traditionally caregivers were wives and daughters, but increasingly, men play important roles. As people get older and have higher levels of illness, disease and support needs they are more likely to move into residential care. About one-third of adults aged over 85 live in residential care. Furthermore, health care use is higher among older adults compared with other age groups.

While the current health system has been able to adapt until now, there are indications it will not be sufficient to cope with older adult population changes. Workforce demand is expected to dramatically grow. A capable workforce is also required to respond effectively to older persons' needs. However, in line with the general population, the health/mental health workforce is growing increasingly older. Key workforce groups providing support to older adults include, but are not limited to, support workers, caregivers, nurses, psychiatrists, occupational therapists, social workers, and psychologists. The paid workforce and informal caregivers require access to relevant training, particularly training in supporting people with dementia.

The provision of support to older adults will become increasingly challenging as the workforce, caregivers and population of older adults changes. The growing number of older adults will increase the prevalence of mental illness, addiction, dementia and disability for this population group. This is expected to lead to greater demand for residential support and health and disability services, including specialist services for older people. This has implications for workforce planning, training, recruitment and retention, as well as DHB, community, primary health, and residential care services. Implementing effective policies and strategies now will ensure the right people, with the right skills, are in the right place to address the high level of need for services in the future.

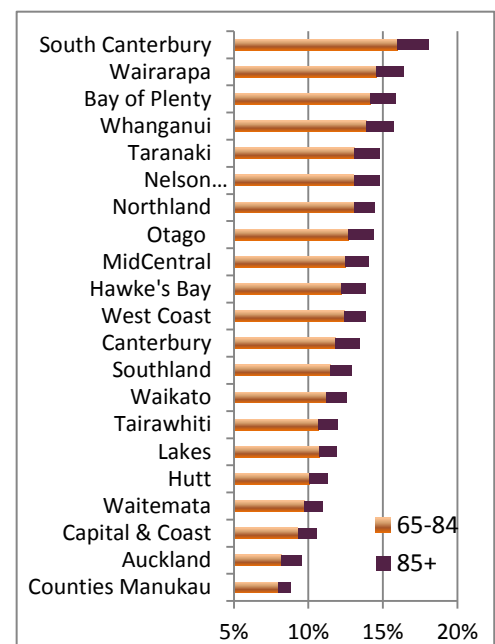


Figure 2. Older adults by DHB, 2006.²

OLDER ADULT POPULATION

Over the last 100 years an increasing number of people live to old age as a result of fewer deaths from infectious diseases with better control arising from public health (such as, sanitation and diet) and medical advances (for example, antibiotics and better health care). Furthermore, the number of older adults is expected to nearly double over the next 30 years.[†] The proportion of older adults in the population will rise from 13 per cent in 2011 to about 20 per cent in 2031. As illustrated in Figure 1, the largest percentage growth is expected in the 75-84 and 85+ age groups.^{3,12} The overall population will change from a triangular shape, with a small number of people in the oldest age groups, to becoming more parallel, with a larger number of people in the oldest age groups.

While all DHB area populations will become older on average, variations exist.² The largest number of older adults currently live in the Canterbury and Waitemata DHB areas, followed by Waikato, Auckland, Counties Manukau, Bay of Plenty, and Capital and Coast DHBs.² Figure 2 shows the proportion of older adults in the general population is highest in the South Canterbury, Wairarapa, Bay of Plenty and Whanganui DHB areas, including the 85+ age group.

The population age spread differs within each region. The Kapiti Coast District currently has the highest proportion of older adults. By 2026 more than one-third of people living in the Waitaki and Central Otago Districts are expected to be aged over 65.¹² Access to specialised health care is often better in urban areas and will contribute to population changes.¹² Each DHB will therefore experience their own unique challenges as the population ages.

ETHNICITY

The ethnic mix and birth places of older adults will change over time and become more diverse.[†] Currently 87 per cent of older adults are New Zealand Europeans/Other. Over the next 15 years, the number aged 65+ is expected to double for Māori and Pacific population groups, and triple for the Asian population (see Figure 3). However, overall the Māori, Pacific and Asian populations will remain relatively younger than New Zealand Europeans.^{12 ‡}

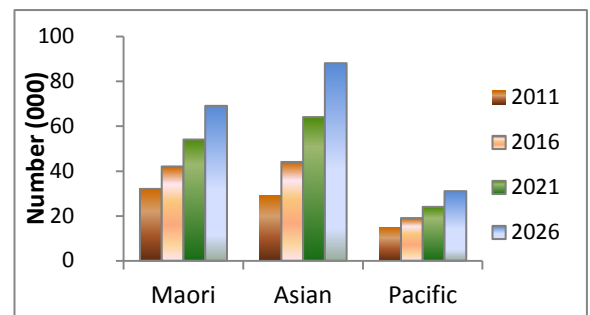


Figure 3. Older adult ethnic mix and projections.²

AGEING WORKFORCE

The median age of the workforce is increasing in line with the general population and is currently 42 years.^{12 13} New Zealand has a multigenerational workforce that includes generation Y (born after 1980), X (30-45 years), baby boomers (46-65 years) and mature workers/veterans aged 65+. There are a number of myths about older workers.[§] Nevertheless, this group often brings a great deal of experience, an ability to adapt and produce high quality work, and tend to stay in their roles for longer.¹⁴

Currently New Zealanders are eligible for superannuation when they reach the retirement age of 65 years. However, in 2011, 70 per cent of 60-64 year olds and 18 per cent of people aged 65+ continued working.¹⁵ By 2036, the proportion of older adults working is expected to double.³ Many who continue working will be males, have a higher level of education, better health, a partner who also works and owe money on their mortgage.^{12 16 17 **} Many adults reaching retirement age make changes to their working lives including reducing the number of hours worked, the amount of responsibility, working more flexible hours, and moving to less physically demanding work.¹⁸⁻²⁰

[†] From about 573,600 in 2010 to 1,072,000 in 2031. Factors influencing population size include births, deaths and migration.¹²

[‡] There is less certainty about ethnic population projections, partly due to non-demographic factors such as self-identification.¹²

[§] Due to the ethnic differences in fertility, mortality and migration.

[§] See <http://www.dol.govt.nz>

^{**} This may be explained in part by health status, potential earnings, and the performance of physically demanding tasks.¹⁶

SOCIO-DEMOGRAPHIC CHARACTERISTICS

Socio-demographic characteristics of older adults are summarised in Table 1. As illustrated in Figure 4, net wealth increases with age* and peaks in the 55-59 age group, before declining slightly. Most older adults live with their spouse, alone or in non-private settings, such as retirement homes.¹² There are some differences between males and females as summarised in Table 1, largely due to longer female life expectancy. The death of family members, sickness and increasing support needs often lead to changes in older adults' living situation. Nevertheless, one-third of older adults with a disability live alone.²¹

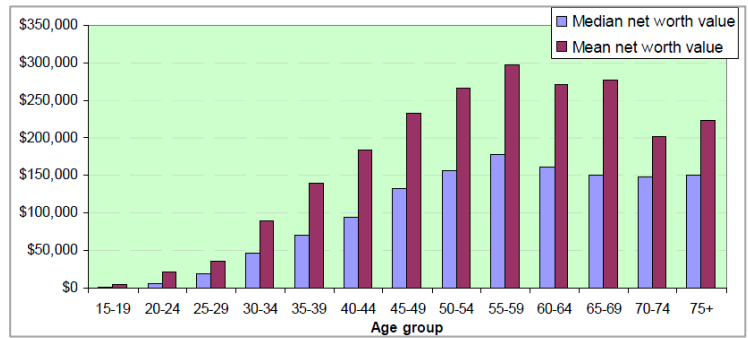


Figure 4. Individual net worth by age.¹

A key policy objective of the current government is to support older people to live in the community. Ageing in place contributes to greater wellbeing among older adults, independence and participation, and as is more cost-effective than long-term care.²⁶

Table 1. Older Adult Socio-demographic Characteristics^{9 22 23-25}

Characteristic	Details
Age	<ul style="list-style-type: none"> Females have a longer life expectancy, living four more years on average compared with males.
Income	<ul style="list-style-type: none"> Older adults have lower than average incomes. In 2006 the median income for people aged 65 to 69 was \$17,100 compared with \$24,000 for all New Zealanders, and ranged between 14,800 and 15,400 for those aged 70+.
Home ownership	<ul style="list-style-type: none"> Home ownership increases with age with about 80 per cent of 70-74 year olds owning or partly owning the dwelling they live in.
Living situation	<ul style="list-style-type: none"> Males are more likely to live alone as they get older, especially between the ages of 75 and 90. The number of males living in non-private dwellings rises sharply from age 80 on. The number of older females living alone continues to rise until about 85 years. Females living in residential care or other non-private settings increases from about age 75 on.

In summary, the planning and funding of services for older adults needs to consider their characteristics, predicted population changes and support needs. The proportion of older adults in the general population will grow over the next 40 years and become more ethnically diverse. DHBs will face unique challenges due to the composition and location of older adults in their area.

CAREGIVERS

Family members play an important role in supporting older people.²¹ Traditionally caregivers have tended to be wives and daughters. However, males are increasingly providing support. Changes in caregiving roles partly reflect changing work patterns (such as more women working), and smaller families that are more geographically mobile. Family dynamics appear to influence the caregiving roles individual family members take on and in addressing family issues.²⁷

Informal caregiving for disabled people in New Zealand has been examined.²¹ Findings indicate:

- overall, 1 in 5 disabled adults aged 15 years and over living in their own home receive support from informal caregivers with activities of everyday living
- nearly half of disabled adults aged 85+ receive informal support (47 per cent) mainly with shopping and housework
- 10 per cent of disabled adults aged 85+ receive help with personal care (compared with five per cent overall).

Caring for an older person can be stressful, and increase caregivers' risk of mental illness and poor health.^{28 29 30} In addition, many caregivers have competing demands, work commitments, experience social isolation and conflicts in relationships with family

* Given the greater number of years to accumulate wealth.

members and friends.²⁹ While the demand for caregivers is expected to increase, there are concerns over the number of future caregivers available due to the composition and size of modern families.³

Caring for family members with dementia appears to be particularly challenging. While Alzheimer’s disease gradually progresses overtime, its course is unpredictable and uncertain, and may be associated with comorbid mental illness.²⁷

New Zealand Carer’s Strategy²¹

The *New Zealand Carer’s Strategy and Five-year Action Plan 2008* aims to promote greater recognition and understanding of the needs of individuals, families, whānau or aiga who support people who need help with their everyday living (Ministry of Social Development, 2008). The strategy also aims to ensure that carers have choices and opportunities to participate in family life, social activities, employment and education, and that carers’ voices are heard in decision-making that affects them. Objectives of the strategy include providing information, protecting the health and wellbeing of carers to take a break, and providing carers with financial support, training and pathways to employment (Ministry of Social Development, 2008).

RESIDENTIAL CARE

As people get older and have higher levels of illness, disease and support needs, they are more likely to move into aged care support settings (see Table 2). About one-third of adults aged 85 years and over live in residential care.³¹ By 2026, around 20,000 more people will require residential care, with the greatest demand in the 80+ age groups.³² * The predicted demand for specific types of services is illustrated in Figure 5.

Table 2. Health Status in Residential Care Settings^{33 34}

Health domain	Findings
Mental illness	• the prevalence of mental illness is estimated to be three to six times higher compared with the community
Dementia	• the prevalence of dementia is estimated to be more than 60 per cent
Disability	• nearly all people in residential settings have a disability.

In summary, family members play an important role in supporting older people, especially to live in their own homes in the community. As older adults experience higher levels of illness, disease and greater support needs, they are more likely to move into residential care, especially those in the oldest age groups.

HEALTH AND WELLBEING OF OLDER ADULTS

GENERAL HEALTH PROFILE

Over the last 50 to 55 years life expectancy in New Zealand has increased by about 11 years.³⁵ This is largely due to medical advances and the delayed onset of disease from improvements and healthier lifestyles.³⁶ However, Māori and non-Māori life expectancy differs (see Figure 6).[†] While official figures are not available for other ethnic groups due to their smaller population size, Pacific peoples have significantly higher age-standardised death rates compared with the total population.

* The total cost of aged residential care in 2008 was estimated to be \$1.05 billion, two-thirds of which was government-funded.⁶

† The lower Māori life expectancy is attributed in part to differing rates of diabetes and smoking, and lower socio-economic status.

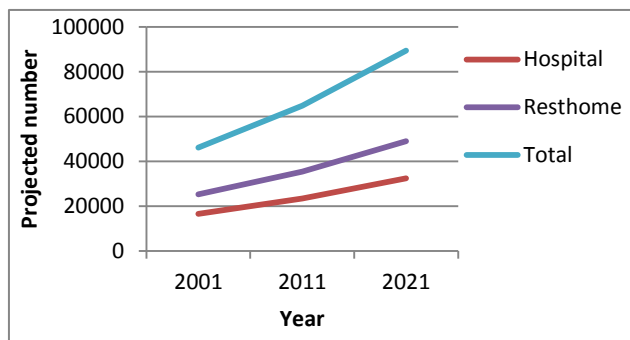


Figure 5. Projected number of people in residential care.⁴

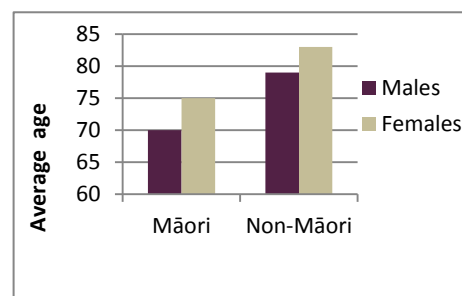


Figure 6. Average life expectancy.⁹

Ideally, older adults will experience good health throughout their life and morbidity or disability only in a short period of time before death.³⁷ Results from the [New Zealand Health Survey 2006/07](#) indicate more than half of adults aged between 65 and 74 years rate their health as very good or excellent, and about 45 per cent of those aged over 75.³⁸ *

The normal ageing process involves a gradual loss of functioning overtime.³⁷ Age also increases the risk of chronic diseases, such as high blood pressure and cholesterol, ischaemic heart disease, stroke, diabetes, arthritis and osteoporosis. With medical advances more people are living with chronic diseases without necessarily being disabled. However with age, older adults are more likely to have a disability. In total, 45 per cent of adults aged 65 and over have a physical, sensory or intellectual disability.³⁹ The predicted rise in the number of older disabled people requiring support is illustrated in Figure 7.[†]

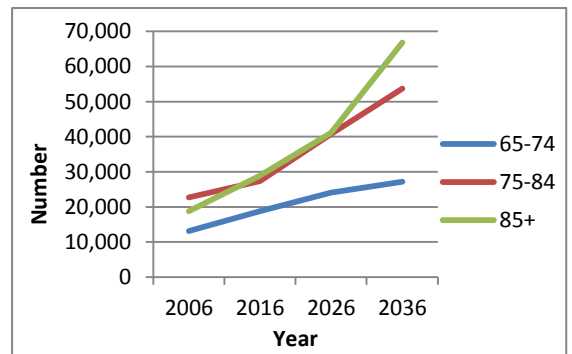


Figure 7. Projected number of older disabled people with high support needs.³

MENTAL HEALTH AND ADDICTION

Older adults may have experienced lifelong mental illness and/or substance abuse problems. Late life onset of mental illness or addiction problems (such as schizophrenia and depression) can also occur and may be exacerbated by the death of family members, injury or chronic illness.⁴¹ Both these groups have specific needs that require support for optimal care.⁴²

Over seven per cent of older adults living in the community experience mental illness and/or addiction each year.⁴³ † Anxiety disorders are most common (six per cent; two per cent mood disorders). Many older adults may have comorbid mental and physical health conditions, which are associated with a higher level of disability.⁴³ While the risk of mental illness is lower among older people compared with other age groups, complex mental conditions are more common.[§] In addition, the prevalence of mental illness among older adults is expected to increase as the population ages.⁴²

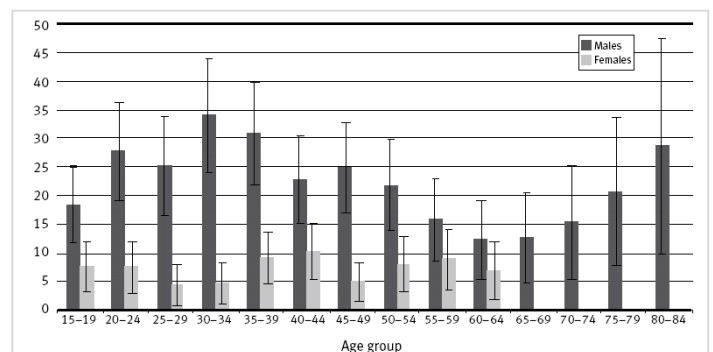


Figure 8. Suicide age-specific death rates, by group, 2007.⁷

Suicide among older men is a concern. Males in New Zealand are three times more likely to commit suicide compared with females.⁷ As illustrated in Figure 8, male suicide peaks between the ages of 30-39 and rises again from age 70 on.

DEMENTIA

Dementia is a condition due to disease of the brain, which is usually slow and relentlessly progressive. It involves multiple disturbances of higher brain functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Awareness or consciousness is not clouded. Often impairments in mental or cognitive function are accompanied, and occasionally preceded, by declines in social behaviour, emotional control, or motivation.

A diagnosis of dementia is based on four criteria, which include (a) disturbance of COGNITION, (b) that has CONSEQUENCES, (c) that is PROGRESSIVE, and (d) is occurring in the ABSENCE of DELIRIUM.^{**}

* While Māori, Pacific and Asian peoples rated their health lower on average, specific information is not available for older adults in these populations.

† One-third of people with a disability are aged 65+. Some evidence suggests disability is a stronger predictor of health care utilisation than age.⁴⁰

‡ This figure does not include mental illness or distress experienced by those living in residential facilities.

§ One of the reasons that the prevalence of serious and persistent mental illness declines with age is that the life expectancy of people with these disorders is lower than the general population.⁴¹

** Delirium is an acute reversible impairment in brain functioning due to physical illness.

Dementia results from brain cell deterioration or death. The manner in which an individual person presents with dementia is not determined by the cause. Factors influencing individual presentation include the interaction between one’s personality, social situation, and nature and extent of their brain damage.

The management and support of people with dementia is often complex. People are often unaware they have memory problems, and may refuse offers of help. The sufferer may find it more difficult coping with change than they used to, and can become quite confused if they develop a physical illness. They are also very susceptible to the side effects of prescribed medications, and other substances used.

A better understanding of the cause and frequency of dementia is being gained with medical advances, such as neuroradiology and neuropathology. Alzheimer’s disease alone likely accounts for up to 70 per cent of new dementia cases amongst those aged 80 years and over in New Zealand. Other causes of new onset dementia include cerebro-vascular disease (with or without associated Alzheimer’s disease), and to a lesser extent Lewy Body disease*, frontal dementias† and other rarer disorders.

While older adults are more likely to be diagnosed with dementia, early onset cases before the age of 60 also occur. Some types of dementia are more common among younger people including Lewy body disease, frontal dementia, vascular dementias, and rarer conditions such as Creutzfeldt-Jacob disease and Huntington’s disease. However, the most common cause of dementia among younger people is likely to be Alzheimer’s disease. A diagnosis of dementia among younger people can have a particularly negative impact on individuals and their families, especially those who are still working and have dependent children.

An estimated 41,000 people currently live with dementia in New Zealand.⁶ While estimates depend in part on assessment methods used, a consistent finding is that the prevalence of dementia among adults aged 65 and over doubles every five years.³⁰ The characteristics of people with dementia are summarised in Table 3.

Table 3. Characteristics of People with Dementia⁶

Characteristic	Details
Age	<ul style="list-style-type: none"> The risk of dementia and Alzheimer’s disease increases with age. The prevalence among people aged under 60 years is <1 per cent and about one-third for those aged 90+.
Gender	<ul style="list-style-type: none"> 60 per cent of those with dementia are females (40 per cent males). This is largely due to their greater population size in the oldest age groups as a result of higher life expectancy. It is predicted that by 2026 (assuming the current projected gains in both male and female life expectancy happen), that the percentage of males with dementia will increase (43 per cent; 57 per cent females).
Ethnicity	<ul style="list-style-type: none"> Currently in New Zealand, the vast majority of people with dementia are New Zealand European/Other (93 per cent) with Māori accounting for four per cent, Asians three per cent, and Pacific peoples two per cent. Māori and Pacific life expectancy is projected to significantly increase, as well as the ethnic diversity of people with dementia. By 2026, of the 75,000 people predicted to have dementia, six per cent will be Māori, eight per cent Asian, and three per cent Pacific (85 per cent New Zealand European/Other).

The risk of dementia is higher for some groups, including disabled people. For example, the risk of dementia is higher among adults with Down syndrome.⁴⁴ Evidence also suggests the prevalence of dementia and mental illness is higher among people with an intellectual disability.⁴⁵ The age of onset of dementia also tends to be younger among disabled people.⁴⁴

The number of people with dementia is expected to double over the next 20 years (see Figure 9). This reflects an increased risk of dementia with age and the predicted growth in the oldest age groups. The number with

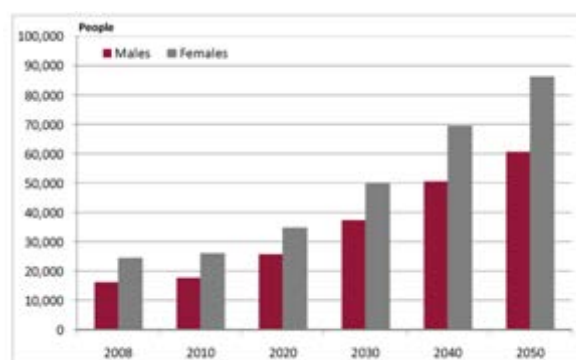


Figure 9. Projected prevalence of dementia by gender.⁶

* A condition related to Parkinson’s disease.

† Frontal dementias involve a specific deterioration of the frontal lobes, the site of insight and judgement.

dementia is projected to continue rising until the population pyramid stabilises, which is expected to happen over the next 50 years or so. The dramatic rise in dementia over the coming years will have a large impact on services and workforce training needs (see Figure 10).

...[even optimistic projections have] profound implications for the funding and provision of dementia care services, as well as for patients, their families, informal carers and the psychogeriatric workforce. (p. 828)⁴⁶

The Ministry of Health has recently published guidelines for DHBs on services for older adults with mental health, addiction and/or dementia which are accessible on their [website](#).

OTHER SOCIAL ISSUES

A number of older adults may experience loneliness due to low social support. Contributing factors may include:⁴⁷

- family and friends moving away
- loved ones becoming ill, dependent, or dying
- retirement from paid or voluntary employment
- decline in physical function or disability*
- low income which limits participation in social activities
- a loss of social skills over time
- ageist attitudes
- rural isolation
- a small network of friends.

A minority of older adults may experience abuse or neglect.^{47 48} The most common types are psychological (humiliation, harassment, controlling choices) and financial (misusing the older person's resources). Physical abuse also occurs. [Age Concern](#) found the most common abusers were sons and daughters.⁴⁹ Abuse and neglect can have wide ranging and long-term effects on physical and mental health.

In summary, while many older adults experience good health, this age group is most likely to experience complex health conditions, including chronic disease, disability, dementia, mental illness and/or addiction. Suicide among older males is also a concern. In addition, some older people may experience loneliness and/or abuse. The workforce therefore requires the right knowledge and skills to respond effectively to older persons' needs.

HEALTH CARE USE

Health care use among older adults was examined in the [New Zealand Health Survey 2006/07](#).³⁸ Findings indicate older adults are more likely to use health care services compared with other age groups.† Each year:

- nearly all older adults visit a primary health care provider about four times‡
- about half visit a medical specialist
- over one-quarter of 65-74 year olds make a public hospital visit, more than one-third of those aged 75+.[§]

The medical care of the elderly is becoming the core activity of general hospital-based medicine and surgery in New Zealand and this will become increasingly evident over the next 50 years.⁵⁰

* May prevent participation in social activities or necessitate move away from community.

† However, some evidence suggests disability is a stronger predictor of health care utilisation than age.⁴⁰

‡ Evidence also indicates people with dementia make more primary health care visits on average than those without dementia.⁶

§ Excluding emergency departments.

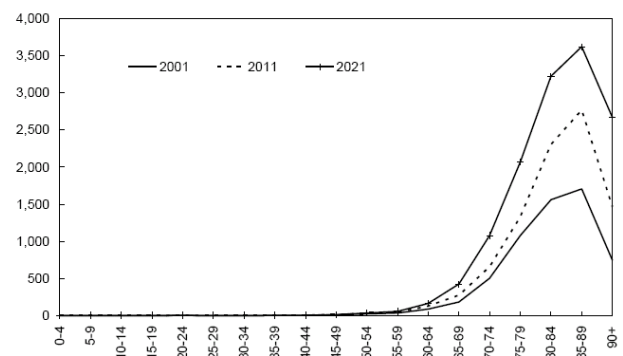


Figure 10. Predicted hospitalisations for dementia.⁴

A key concern of population ageing is the impact this will have on future demand for health and disability services.¹⁰ More than 80 per cent of medical costs are incurred after the age of 65.⁵¹ “A 100% increase in the needs of older people is projected in the next 15 years to 2026 with only a projected 30 per cent increase in the means (money and personnel) to support this” (p. 5).⁵²

The projected demand for support by older adults will impact on mental health and addiction services. Currently, about half of DHBs across New Zealand provide specialist mental health and addiction services for older people. In other DHBs, support is provided by older adult health services or general mental health and addiction services.* In the future, psychogeriatric services are likely to be increasingly called upon to manage challenging behaviour among people with dementia.

It is... inevitable that, as the population ages, an increasing number of older people will suffer mental illness and require aged care mental health services specific to their needs. Groups that particularly require attention are those with behavioural and psychological symptoms of dementia (BPSD), those vulnerable to depression and suicide in later life, and those growing older with a mental illness that they have suffered throughout life. (p. 2)⁴²

Old age mental health services and aged care services will need to work closely together to ensure the best treatment and care of older people, many of whom suffer from complex combinations of mental and physical health.⁴²

Disclosure

Support required for mental health and addiction problems among older adults may be even higher than expected.

Older adults experience the double jeopardy of a culture that traditionally has stigmatized mental illness and advanced age. Older adults are less likely than younger persons to self-identify mental health problems or seek specialty mental health services [Mickus, Colenda & Hogan, 2000]. This problem is compounded by family members and professional providers who share the misperception that mental disorders are a "normal" part of aging [Gallo, Ryan & Ford, 1999]. Without addressing stigma, systematic reforms designed to improve access are unlikely to be successful.²⁸

WORKFORCE PROVIDING SUPPORT TO OLDER ADULTS

CHARACTERISTICS

Key workforce groups providing support to older adults include, but are not limited to, support workers, caregivers, nurses, psychiatrists, occupational therapists, social workers and psychologists.† Workforce planning and development is required to build a sufficient workforce capable of responding effectively to older persons' needs.

Workforce issues may prove to be the greatest challenge facing health systems in the future (p. 80).⁵⁵

In line with the general population, the workforce providing support to older adults is becoming increasingly older. More than half the workforce in DHB mental health and addiction services for older people is aged 50+ years and will reach retirement age within the next 5-15 years (see Figure 11). A similar profile was found for nurses in residential care settings⁵⁶ and the aged care workforce.^{3,12} Furthermore, the average age of the DHB health workforce is 45 years.⁵⁷

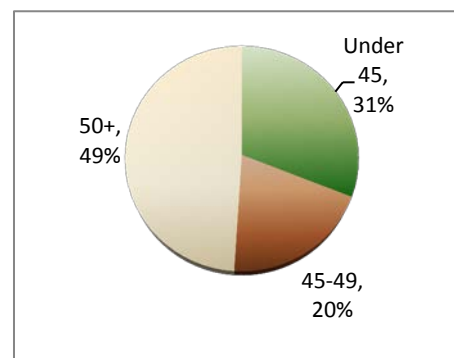


Figure 11. Age profile of DHB mental health and addiction older adult workforce.⁸

* Funding for older adult services varies, with those in the Northern and Midland DHB regions being primarily funded by Mental Health and others funded by general health services.⁵³ In addition, DHBs are responsible for purchasing long-term residential and home-based care for elderly people in their populations.⁵⁴ In 2004/05, DHBs spent just under NZ\$600 million on residential care for older people. In contrast, disability support services for those aged less than 65 are funded by the Ministry of Health.

† Support workers are critical to the disability workforce, making up 85 per cent of staff providing services.⁴

Workforce demand is expected to grow. By 2021, there is predicted to be a 30 to 40 per cent greater health and disability workforce demand than available.⁴ * The unregulated workforce is expected to have an even greater mismatch between supply and demand.⁴ For example, 48,200 more caregivers will likely be required by 2036 to meet the needs of older people requiring a high level of support.³ That is, about 30,000 more paid caregivers compared with 2006 (17,900).[†]

RECRUITMENT AND RETENTION

Building a sufficient workforce with the right set of skills and knowledge depends on workforce recruitment and retention. However, there are often challenges in recruiting to older adult services including long-term care, as other areas of health are often perceived as more attractive to work in.⁵⁴ ‡ A recent review has highlighted the importance of regular remuneration reviews, the provision of additional support, including access to supervision in retaining DHB staff.⁴⁵ Additional factors which may support work with older adults include interest, training, knowledge and attitudes towards older people.^{58,59} Greater experience and exposure to older adults by students and trainees, and the inclusion of older persons' mental health in training curricula are therefore important. Means of supporting mid-career changes should also be considered, particularly in specialist mental health services for older people.

Several studies have looked at older adult workforce retention.⁶⁰ ⁶¹ Evidence suggests nurses reaching retirement age are more likely to work part-time, and in less acute and community settings. Furthermore, factors influencing nurses to stay in their organisations include recognition and respect, having a voice, and ongoing performance feedback.[§] These factors likely apply to other workforce groups as well.

Additional areas for consideration in maintaining a sufficient workforce include further development of the unregulated workforce, recruitment and retraining of the non-active workforce, and ensuring there are sufficient opportunities for workforce knowledge and skill development.⁵²

TRAINING

A number of reports and strategies have called for better training of the workforce supporting older adults and informal caregivers.^{3,52,63} For example, the Ministry of Health guidelines for DHB services providing older adult mental health, addiction and dementia support recommend staff have access to appropriate training.⁴⁵ The need to build primary health care workers' knowledge and skills has also been recognised, including early detection and treatment.^{42,45} ⁵² **

“Recovery”⁴¹

A “recovery” orientation is as essential to work with older adults as with the younger population. Important goals may include volunteering, social participation, improved relationships with family members, spiritual goals, management of physical health conditions, and housing.

The [Let's get real](#) framework indicates it is important for people working in mental health and addiction treatment services to:⁴⁷

- ensure older adults understand their recovery plan and have access to other relevant information
- include older adults in all decisions about their treatment
- encourage older adults to share their views about their health goals and quality of life perceptions
- provide older adults with opportunities to describe their own situation and current problems
- support older adults to become active partners in their own care.

Training in dementia is a particular workforce need identified.^{8,63} The importance of enhancing health professionals' cultural competency and skills when communicating with family members and close friends has also been recognised.^{42,52} Other key training

* Over this period health and disability workforce demand is predicted to increase between 40 to 69 per cent.

† Caregivers themselves tend to be older and are most likely to be women.³

‡ Long-term care providers have an especially difficult time recruiting and retaining lower skilled workers for whom the combination of low wages, insufficient benefits, heavy caseloads, inadequate training, and limited career opportunities make recruitment and retention a particular challenge (Decker et al., 2002).⁵⁴

§ For information on factors contributing to nursing workforce shortages see ⁶².

** Health Workforce New Zealand is conducting a review of general practice training in partnership with the Royal New Zealand College of General Practitioners and the Medical Council of New Zealand.⁴⁵

needs reported by the workforce in DHB mental health and addiction services for older people include training in death, dying, loss and grief; psychopharmacology; and law, policy and practice.⁸ Furthermore, skilled DHB clinicians may play a key role in future training and development of the workforce in primary and community settings.⁵²

In summary, a sufficient workforce capable of responding effectively to older persons' needs is required. The need for recruitment and retention policies has been highlighted, as a large proportion of the health workforce reaches retirement age within the next 5 to 15 years. In addition, over the next 10 years workforce demand is expected to outstrip supply. The workforce and informal caregivers also require relevant training to develop the right knowledge and skills to respond effectively to older adults. Key training areas identified include dementia; cultural competency; and family communication, as well as death, dying, loss and grief; psychopharmacology; and law, policy and practice for specific workforce groups.

INTERVENTIONS

OLDER ADULTS' QUALITY OF LIFE

A number of challenges will be faced by New Zealand's ageing population. The fear of chronic illness, pain, loss of mobility, memory loss, and increased dependence upon others are also key concerns reported by older people.³⁷

A number of strategies may help improve older adults' quality of life. The ideal according to Fries⁵¹ is a compression of morbidity or disability into a short period of time before death. Along with medical advances and pharmacological treatments, environmental and lifestyle factors play a critical role, especially in reducing the risk of dementia. Delaying the onset and progression of disease is important in reducing morbidity and the future level of support required.⁶⁴

Potential interventions which may improve older adults' wellbeing, reduce their risk of dementia, and delay the onset and level of symptoms include:^{37 65 66}

- participating in creative vocational opportunities and cognitively stimulating activities*
- continuing to work past retirement age due to the health and wellbeing benefits
- adopting healthy lifestyle behaviours including physical exercise, eating a healthy diet, and not smoking
- controlling diabetes, hypertension, dyslipidaemia and obesity
- recognising and treating depression and other mental health conditions
- seeking the most independent living options possible for an older person
- the provision of programs that support older adults' independence[†]
- maintaining and supporting older adults' social contacts
- providing incentives for older adults to use their abilities and remain healthy.

Although requiring ethical debate, several innovations may provide people with dementia more freedom in the future without risking their security, such as surveillance technology monitoring their movement and location.^{29, 67}

CAREGIVERS

Informal caregivers provide a large proportion of support received by older adults for dementia, physical disabilities and mental illness.²⁸ However, caregiving can negatively impact on individual health and wellbeing. A number of interventions have been used to reduce caregiver burden and stress, improve skills and knowledge, and delay the transition of older people into residential care. Strategies used include counselling, support groups, respite services, skills training, and family-directed treatments.²⁸ Key components of effective interventions appear to include a combination of strategies, particularly social and/or cognitive components, such as social support and problem solving, and group based interventions.^{29 68}

* Day care services may provide an opportunity for this.

† A false dichotomy is sometimes raised between "caring" and "curing" and there is some risk that our elderly may be smothered by good intentions.³⁷

IMPLICATIONS

CAREGIVERS

- Caregivers require training and support to enable older people to live in the community for longer.

SERVICES

- There will be an increased demand for services able to respond to older persons' needs, including community and residential care services.
- Services need to become more culturally competent as the population of older adults becomes more ethnically diverse overtime.
- Current models of service delivery require review to identify effective and sustainable models.

WORKFORCE

- There will be an increased demand for people with the right knowledge and skills capable of working with older adults.
- Recruitment to services will likely become more competitive due to the smaller pool of workers available.
- Workforce planning is required to maintain a sufficient workforce able to respond to older adults.
- The workforce may need to consider how their own attitudes and beliefs impact on the support provided to older adults.

TRAINING

- The health and mental health workforces require relevant training to respond effectively to older adults.
- Students and trainees could benefit from opportunities to learn and gain experience working with older adults.
- Training programmes and curricula should be relevant to service and population needs.

POLICIES

- More strategic research focusing on older persons' needs, health care and service delivery models is required.
- The growing number of older adults will have an associated impact on health care costs.

INFORMATION AND SUPPORT FOR OLDER ADULTS

Te Pou website

<http://www.tepou.co.nz>

Provides information on some workforce training resources available.

Ministry of Health website

<http://www.moh.govt.nz/moh.nsf/indexmh/hop-supportservicesaccess>

Provides information on how older persons can access support services. Further information on elder health services is available from <http://www.healthpages.co.nz>.

The *Mental Health and Addiction Services for Older people and Dementia Services* DHB guidelines can be accessed [here](#).

Mental Health Foundation website

www.mentalhealth.org.nz

Phone (09) 300 7030 or email info@mentalhealth.org.nz

Free service to anyone who would like information on mental health.

Age Concern

www.ageconcern.org.nz

Provides services, education, resources and national leadership. Age Concern runs an Accredited Visiting Service (AVS), which pairs volunteer visitors to lonely or isolated older adults. See their website for more information.

FOR MORE INFORMATION

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REFERENCES

1. Cheung, J. (2007). *Wealth disparities in New Zealand*. Wellington: Statistics New Zealand. Retrieved from <http://www.stats.govt.nz>.
2. Statistics New Zealand. (2008). *District health board area summary tables*. Wellington: Statistics NZ. Retrieved from <http://www.stats.govt.nz>.
3. Department of Labour. (2009). *The future demand for paid caregivers in a rapidly ageing society*. Wellington: Department of Labour. Retrieved from <http://www.dol.govt.nz/>.
4. NZIER. (2004). *Ageing New Zealand and health and disability services: Demand projections and workforce implications, 2001-2021*. Wellington: Ministry of Health. Retrieved from <http://nzaca.org.nz>.
5. Statistics New Zealand. (2009). *National population projections: 2009 (base) - 2061*. Wellington: Statistics New Zealand. Retrieved from <http://www.stats.govt.nz/>.
6. Alzheimers New Zealand. (2008). *Economic impact of dementia in New Zealand 2008*. Auckland: Alzheimers NZ. Retrieved from <http://www.alzheimers.org.nz/>.
7. Ministry of Health. (2009). *Suicide Facts: Deaths and intentional self-harm hospitalisations 2007*. Wellington: Ministry of Health. Retrieved from [http://www.moh.govt.nz/moh.nsf/Files/suicide/\\$file/suicidefacts2007-16dec.pdf](http://www.moh.govt.nz/moh.nsf/Files/suicide/$file/suicidefacts2007-16dec.pdf) -.
8. Te Pou. (2011). *Mental health and addiction services for older people: Workforce survey* Auckland: Te Pou. Retrieved from <http://www.tepou.co.nz>.
9. Statistics New Zealand. (2009). *New Zealand life tables: 2005-07*. Wellington: Statistics New Zealand. Retrieved from <http://www.stats.govt.nz/>.
10. Ministry of Health. (2002). *Health of older people strategy*. Wellington: Ministry of Health. Retrieved from <http://www.moh.govt.nz/publications/hops>.
11. Ministry of Health. (2007). *Statement of intent 2007-2010*. Wellington: Ministry of Health. Retrieved from <http://www.moh.govt.nz/moh.nsf/indexmh/soi0710>.
12. Statistics New Zealand. (2006). *Demographic aspects of New Zealand's ageing population*. Wellington: Statistics New Zealand. Retrieved <http://www.stats.govt.nz>.
13. Statistics New Zealand. (n.d.). Population age and structure. Retrieved from <http://www.stats.govt.nz/>
14. Department of Labour. (n.d.). *Too old for the job? No Way!* Retrieved from <http://www.dol.govt.nz>.
15. Statistics New Zealand. (2011). *Household labour force survey: March 2011 quarter*. Wellington: Statistics New Zealand. Retrieved from <http://www.stats.govt.nz/>.
16. Leopold, R.S., et al. (2010). Disability management: Addressing the multidisciplinary workforce. *White paper*, Retrieved from <http://www.cdms.org>.
17. Ministry of Social Development. (2009). *To Work, or Not to Work? Findings from a Survey of 65-year-old New Zealanders*. Wellington: MSD. Retrieved from <http://www.msd.govt.nz/>.
18. McGregor, J. and L. Gray. (2002). Stereotypes and older workers: The New Zealand experience. *Social Policy Journal of New Zealand*, (18), 163-177. Retrieved from <http://www.msd.govt.nz/>.
19. Department of Labour. (n.d.). *Workforce 2020*: Retrieved <http://www.dol.govt.nz/>.
20. Davey, J.A. (2007). *Maximising the Potential of Older Workers: Update to 2007*. Wellington: New Zealand Institute for Research on Ageing, School of Government, Victoria University. Retrieved from <http://www.victoria.ac.nz>.
21. Office for Disability Issues and Statistics New Zealand. (2009). *Disability and informal care in New Zealand in 2006*. Wellington: Statistics New Zealand. Retrieved from <http://www.stats.govt.nz/>.
22. Statistics New Zealand. (2004). *New Zealand Family and Household Projections 2001 (base)-2021*. Wellington: Statistics New Zealand. Retrieved from <http://www.stats.govt.nz/>.
23. Statistics New Zealand. (2007). *Quickstats about education and training*. Wellington: Statistics NZ. Retrieved from <http://www.stats.govt.nz/>.
24. Statistics New Zealand. (n.d.). *Quickstats about incomes*. Wellington: Statistics New Zealand. Retrieved from <http://www.stats.govt.nz>.
25. Statistics New Zealand. (2011). *Quickstats about housing*. Wellington: Statistics New Zealand. Retrieved from <http://www.stats.govt.nz/>.
26. King, A. and M. Parsons. (2005). An evaluation of two respite models for older people and their informal caregivers. *New Zealand Medical Journal*, 118(1214), Retrieved from <https://researchspace.auckland.ac.nz/>
27. Globerman, J. (1994). Balancing tensions in families with Alzheimer's disease: The self and the family. *Journal of Aging Studies*, 8(2), 211-232.
28. Bartels, S. (2003). Improving the system of care for older adults with mental illness in the United States. *American Journal of Geriatric Psychiatry*, 11, 486-497. Retrieved from <http://www.cmhda.org/>.

29. Schulz, R. and L.M. Martire. (2004). Family caregiving of persons with dementia: prevalence, health effects, and support strategies. *American Journal of Geriatric Psychiatry*, 12(3), 240. Retrieved from <http://www.ucsur.pitt.edu>.
30. Bond, J. (1992). The medicalization of dementia. *Journal of Aging Studies*, 6(4), 397-403.
31. Ministry of Health and Minister of Health. (2007). *Health and Independence report 2007*. Wellington: Ministry of Health. Retrieved from <http://www.health.govt.nz/>.
32. Grant Thornton. (2010). *Aged residential care service review*. Wellington: Grant Thornton. Retrieved from <http://www.grantthornton.co.nz/>.
33. Melding, P. (2005). New Zealand's psychiatry of old age services. Revisiting 'the view from the bottom of the cliff'-have we made any progress since 1998? *New Zealand Medical Journal* 118(1214). Retrieved from <http://www.nzma.org.nz>.
34. Ministry of Health. (2002). *Dementia in New Zealand: Improving the quality in residential care*. Wellington: Ministry of Health. Retrieved from <http://www.moh.govt.nz/>.
35. Statistics New Zealand. (n.d.). *New Zealand life tables: 2005-07*. Wellington: Statistics New Zealand. Retrieved from <http://www.stats.govt.nz/>.
36. Howse, K. (2006). *Increasing life expectancy and the compression of morbidity: A critical review of the debate*. UK: Oxford Institute of Ageing. Retrieved from <http://www.ageing.ox.ac.uk>.
37. Fries, J.F. (1983). The compression of morbidity. *The Milbank Memorial Fund Quarterly. Health and Society*, 61(3), 397-419. Retrieved from <http://www.wealthandhealth.ltd.uk>.
38. Ministry of Health. (2008). *A Portrait of health: Key results of the 2006/07 New Zealand health survey*. Wellington: Ministry of Health. Retrieved from <http://www.moh.govt.nz/>.
39. Statistics New Zealand. (2007). *2006 disability survey*. Wellington: Statistics New Zealand. Retrieved from <http://www.stats.govt.nz>.
40. McColl, M.A., et al. Disentangling the effects of disability and age on health service utilisation. *Disability & Rehabilitation*, (00), 1-9.
41. Friedman, M.B., et al. (2006). Meeting the mental health challenges of the elder boom, in *Community mental health: challenges of the 21st century*. J. Rosenberg and S. Rosenberg, Editors. NY: Routledge.
42. Royal Australian and New Zealand College of Psychiatrists. (2010). *Caring for older Australians: Working with the community*. Melbourne, Australia: RANZCP. Retrieved from <http://www.ranzcp.org/>.
43. Oakley Browne, M.A., J.E. Wells, and K.M. Scott. (2006). *Te rau hinengaro: The New Zealand mental health survey*. Wellington: Ministry of Health. Retrieved from <http://www.moh.govt.nz>.
44. Strydom, A., et al. (2007). Prevalence of dementia in intellectual disability using different diagnostic criteria. *The British Journal of Psychiatry*, 191(2), 150-157. Retrieved from <http://bjp.rcpsych.org/cgi/content/full/191/2/150>.
45. Ministry of Health. (2011). *Mental health and addiction services for older people and dementia services: Guideline for district health boards on an integrated approach to mental health and addiction services for older people and dementia services for people of any age*. Wellington: Ministry of Health. Retrieved from <http://www.moh.govt.nz/>.
46. Tobias, M., L.C. Yeh, and E. Johnson. (2008). Burden of Alzheimer's disease: Population-based estimates and projections for New Zealand, 2006-2031. *Australian and New Zealand Journal of Psychiatry*, 42, 828-836.
47. Te Pou. (2010). *Talking therapies for older adults: Best and promising practice guide for mental health and addiction services*. Auckland: Te Pou. Retrieved from <http://www.tepou.co.nz>.
48. Cooper, C., A. Selwood, and G. Livingston. (2008). The prevalence of elder abuse and neglect: A systematic review. *Age and Ageing*, 37, 151-160. Retrieved from <http://ageing.oxfordjournals.org/content/37/2/151.full.pdf+html>.
49. Age Concern. *Elder Abuse and Neglect*: Retrieved from <http://www.ageconcern.org.nz>.
50. Croucher, M. (2010). Geriatric medicine is becoming the core of hospital business. *New Zealand Medical Journal*, 123(1317). Retrieved from <http://www.nzma.org.nz>.
51. Fries, J.F. (2000). Compression of morbidity in the elderly. *Vaccine*, 18, 1584-1589. Retrieved from <http://aramis.stanford.edu/downloads/FriesCOMVaccine.pdf>.
52. Health Workforce New Zealand. (2011). *Workforce for the care of older people*. Wellington: Health Workforce New Zealand. Retrieved from <http://www.healthworkforce.govt.nz>.
53. Mental Health Commission. (2007). *Community mental health and addiction services: Staffing levels in 2005/06*. Wellington: Mental Health Commission.
54. Miller, E.A., M. Booth, and V. Mor. (2008). Meeting the demographic challenges ahead: Toward culture change in an ageing New Zealand. *Australia New Zealand Health Policy*, 5(5).
55. Cornwall, J. and J. Davey. (2004). *Impact of population ageing in New Zealand on the demand for health and disability support services, and workforce implications*. Wellington: Ministry of Health. Retrieved from <http://www.moh.govt.nz>.
56. Kiata, L., N. Kerse, and R. Dixon. (2005). Residential care workers and residents: the New Zealand story. *New Zealand Medical Journal*, 118(1214), Retrieved from <https://researchspace.auckland.ac.nz/bitstream/handle/2292/4703/15886740.pdf?sequence=1>.
57. Future Workforce Group. (2008). *Health workforce information: base data report (Snapshot at 30 September 2008)*. Wellington: DHBNZ. Retrieved from <http://www.dhbnz.org.nz>.
58. Cozort, R.W. (2008). Student nurses' attitudes regarding older adults: Strategies for fostering improvement through academia. *Teaching and Learning in Nursing*, 3(1), 21-25.
59. Koder, D.A. and E. Helmes. (2006). Clinical psychologists in aged care in Australia: A question of attitude or training? *Australian Psychologist*, 41(3), 179-185.
60. Robert Wood Johnson Foundation. (2006). *Wisdom at work: The importance of the older and experienced nurse in the workplace*: Retrieved from <http://www.rwjf.org>.
61. Palumbo, M.V., McIntosh, B., Rambur, B., Naud, S. (2009). Retaining an aging nurse workforce: Perceptions of human resource practices. *Nursing Economics*, 27(4).
62. Goodin, H.J. (2003). The nursing shortage in the United States of America: an integrative review of the literature. *Journal of Advanced Nursing* 43(4), 335-350. Retrieved from <http://www.journalofadvancednursing.com>.

63. Alzheimers New Zealand. *National Dementia Strategy 2010 – 2015*. Wellington: Alzheimers New Zealand. Retrieved from <http://www.alzheimers.org.nz>.
64. Graham, P., et al. (2004). Compression, expansion, or dynamic equilibrium? The evolution of health expectancy in New Zealand. *Journal of Epidemiology and Community Health* 58, 659-666. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1732857/pdf/v058p00659.pdf>.
65. Middleton, L. and K. Yaffe. (2009). Promising strategies for the prevention of dementia. *Archives of neurology*, 66(10), 1210. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2762111/>.
66. Becker, J.T., et al. (2007). Gene-environment interactions with cognition in late life and compression of morbidity. *American Journal of Psychiatry*, 164(6), 849-852. Retrieved from <http://ajp.psychiatryonline.org/cgi/content/full/164/6/849>.
67. Niemeijer, A.R., et al. The ideal application of surveillance technology in residential care for people with dementia. *Journal of Medical Ethics*, 37(5), 303-310..
68. Thompson, C.A., et al. (2007). Systematic review of information and support interventions for caregivers of people with dementia. *BMC Geriatrics*, 7(1), Retrieved from <http://www.biomedcentral.com/1471-2318/7/18>.