Clinical Practice Guidelines for the Appropriate Use of Psychotropic Medications in People Living with Dementia and in Residential Aged Care

(Public Consultation on Draft CPGs)

May 2022

Submitted to: Professor Simon Bell
Centre for Medicine Use and Safety
Faculty of Pharmacy and Pharmaceutical Sciences
Monash University
Simon.Bell2@monash.edu

Lived Experience Australia Ltd
Contact: Sharon Lawn
Chair & Executive Director
slawn@livedexperienceaustralia.com.au
PO Box 12, Oaklands Park SA 5046
Phone 1300 620 042
ABN: 44 613 210 889

Table of Contents

Background

Lived Experience Australia Ltd (hereafter LEA) is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. Our core business is to advocate for systemic change, empowerment of consumers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion. This in includes advocacy for people with mental ill-health residing in residential aged care facilities (RACFs).

We thank you for the work you have undertaken in reviewing the existing evidence, which we recognise is an enormous task, and for the opportunity to provide feedback on these Draft Clinical Practice Guidelines (CPGs).

Context for the Clinical Practice Guidelines

In Australia, 45% of newly admitted RACF residents have symptoms of depression[1] as do 52% of all aged care permanent residents.[2] This statistic indicates that the current arrangements for treatment of mental health conditions in residential aged care are inadequate. A national Australian study found that 9.7% of RACF residents had a psychotic illness.[3]

Psychotropic medications are widely prescribed to people living in RACFs.[4] Their high and variable use in the setting is of concern for consumers, carers and families, clinicians, RACF staff and policy makers.

This review and draft revision of the existing CPGs has been prompted, in large part, by the findings of the $100 million Royal Commission into Aged Care Quality and Safety, particularly recommendation 17 (regulation of restraints) which includes the use of chemical restraints.

In South Australia, the Hon John Darley attempted to present a Bill to the South Australia parliament in which he stated:

> "The prevalence of restrictive practices in residential aged care is one of its worst aspects. The deeply disturbing fact, reported by Dementia Australia, of one-half of the residents in aged residential care receiving antipychotic medicine, is often against clinical guidelines. Physical restraint is also widespread in residential care facilities with the impact on the individual including humiliation, loss of freedom, feeling trapped, depression, withdrawal, stress, agitation, increased risk of falls from struggling to get free, decreased mobility, weakened muscles, and pressure ulcers."

[1] Australian Institute of Health and Welfare, 2013, Depression in residential aged care 2008-2012, p. 6
[2] Royal Australian College of General Practitioners, 2006, Medical care of older persons in residential aged care facilities, pp. 24-35
[3] Amare AT, Caughey GE, Whitehead C, Lang CE, Bray SC, Corlis M, Visvanathan R, Wesselingh S, Inacio MC. The prevalence, trends and determinants of mental health disorders in older Australians living in permanent residential aged care: Implications for policy and quality of aged care services. Aust N Z J Psychiatry. 2020 Dec;54(12):1200-1211. doi: 10.1177/0004867420945367.
[4] Ibid.

Response to Draft Clinical Practice Guidelines

We applaud the CPG's worthy aim of reducing inappropriate psychotropic medication use in RACFs. We also applied its acknowledged that avoidance of antipsychotics will require:

- Managerial support
- Adequately trained RACF staff to adopt person-centred approaches and monitor the individual living with dementia
- Access to appropriately resources GPs, nurse practitioners, registered nurses and/or pharmacists to conduct monitoring and review
- Successful partnerships with the person living with dementia, their carers and family

The importance of ensuring equity for sub-populations is welcomed, but it has only focused on "CALD communities, Aboriginal and Torres Strait Islander peoples and people from low socioeconomic backgrounds." There does not appear to be a documented strategy for ensuring equity or consideration for people with mental illness (or other groups who may be prescribed psychotropic medications).

It is not apparent whether the views of people with mental illness who may develop dementia whilst in RACFs or have dementia in RACFs, or their families, were sought or included in the development of the CPG.

Although recipients of high-level home care packages are noted, it is unclear from the review methodology used whether and how evidence for this population was included in the search strategies and therefore included in the review process underpinning this CPG.

There is no mention in the CPG on how RACF staff should respond when the resident has suicidal ideation.

We recognise that dementia has several stages in the disease process itself and in the person's capacity to understand, make decisions, provide consent, and cope with what is happening to them. We note that the current CPG does not attempt to describe these stages or apply guidance to good practice statements and recommendations based on these stages. This is of concern in already busy and under-resourced RACFs in which there is a risk of individualised person-centred care responses being stifled with more generic approaches, regardless of individuals needs, capacities and preferences.

We also recognise the significant resourcing pressures and regulatory environments currently surrounding the operation of RACFs. Hence, we welcome the intent of the many good practice statements and recommendations to focus first and foremost on what is best for the individual with dementia, not predominantly on what is administratively convenient for the RACF and staff in RACFs.

We would like to have seen more mention of and emphasis on the importance of staff implementation of the non-pharmacological strategies with RACF residents.

We are also aware that, in the RACF environment, individuals with mental illness (with or without dementia) have an increased likelihood of being perceived as, or actually, generating more compliance work related to their psychotropic medications being identified in compliance or pharmacist audits. This reduces the willingness of both GPs and RACFs to initiate involvement in their care or remain involved in their care.

We are concerned that, in order to avoid the aforementioned problems, RACF residents appear to face increasing risk of having effective psychotropic medications ceased, increasing the risk of relapse or poorer quality of life. We are also concerned that RACFs and GPs may choose to either not seek or follow specialist prescribing advice to avoid the potential problems. Also, that residents will be excluded from being offered treatment options recommended by other relevant guidelines.

Contact

We would be very pleased to provide further clarification around any of the points raised or further inform the discussion. Please feel free to contact:

Professor Sharon Lawn
Board Chair and Executive Director
Email: slawn@livedexperienceaustralia.com.au
Mobile: 0459 098 772