Submission by the Australian Psychological Society

Senate Community Affairs Legislation Committee

Aged Care (Living Longer Living Better) Bill 2013 and Australian Aged Care Quality Agency Bill 2013

Contacts:
Mr David Stokes, Executive Manager, Professional Practice

Mr Bo Li, Senior Policy Advisor, Professional Practice

Level 11, 257 Collins Street
Melbourne VIC 3000
PO Box 38
Flinders Lane VIC 8009
T: (03) 8662 3300
F: (03) 9663 6177
www.psychology.org.au

Introduction

The Australian Psychological Society (APS) welcomes the opportunity to provide feedback to the proposed Aged Care Bill (Living Longer Living Better) 2013 and the Australian Aged Care Quality Agency Bill 2013. The APS has previously provided extensive submissions in 2010 and again in 2011 to the Productivity Commission's Caring for Older Australians Inquiry. In addition, the APS also appeared before the Commission in its hearing in Melbourne in 2011. This submission draws on the extensive evidence base for psychological services for older Australians. A review of the evidence is attached as Appendix 1 of this submission.

Aged Care Bill (Living Longer Living Better) 2013

The APS welcomes the removal of the distinction between low level and high level residential care. This is consistent with APS submissions to the Productivity Commission's study. The additional dementia supplement and a new veterans' mental health supplement is also welcomed.

In order for the veterans' mental health supplement to be focused and targeting those in need, the APS urges the Bill to be more explicit in the assessment and diagnosis of dementia. In particular, references should be made in the Bill in relation to:

- Medical specialists and psychologists as clinicians eligible to assess and diagnose dementia;
- Early intervention for people diagnosed with dementia; and
- The use of evidence-based interventions for people diagnosed with dementia.

Without a clear and accurate diagnosis, early interventions, suitable medications, sound prognosis, future planning and well-informed carers are not possible. Correct diagnosis is also vital in order to minimise misdiagnosis, thereby increasing the effectiveness of medications and other therapeutic interventions.

One of the essential components of the diagnostic and the intervention options are evidence-based, non-medical psychological processes often overlooked and under-utilised by medical practitioners. The diagnostic contributions of clinical neuropsychologists enhances the investigative process by applying sensitive and active measures of cognitive and brain state that are powerful diagnostic tools. In addition, these tests of brain function provide an accurate characterisation of current functioning that provides a solid foundation for prognosis and informed planning and interventions. Psychological interventions for behaviour management, mood disorders and enhancing carer effectiveness throughout the dementia disease progress add significantly to quality of life and can noticeably reduce the reliance on drugs and avoid the complications of polypharmacy.

Early interventions should not be not limited to medications as the brain is a highly adaptive organ that can engage in repair. Rehabilitation via targeted and individualised cognitive, behavioural and emotional strategies delivered by qualified psychologists should be included as standard options.

Issues such as social isolation and depression remain under-recognised and under-diagnosed among older Australians. Depression in the elderly is also often misdiagnosed as dementia and only skilled

clinicians such as geriatricians and clinical neuropsychologists can make the accurate differential diagnosis.

Depression and dementia present with similar symptoms (e.g., poor concentration, poor memory, low mood, and irritability) therefore depression must always be eliminated as a differential or diagnosed as a co-morbid disorder as depression in the elderly is treatable.

The APS also welcomes the expansion of the existing community visitors' scheme for people receiving residential care to be extended to home care. Again, the APS urges greater clarity regarding the need for training and ongoing support for community visitors by health professionals such as psychologists on issues such as mood disorders, behavioural management and carer education in order to maximise the effectiveness of the scheme. The rules for community visitors regarding their eligibility, training and support are best articulated in the associated Regulations once the Bill is passed.

While the APS appreciates the proposed change to establish home care, to replace community care, it urges clearer definition of "home" in the Bill. For example, people who are homeless or are not living in their own "home" (rental accommodation, short and long term) may feel excluded under the emphasis on "home care". Finally, there needs to be a "no disadvantage test" to ensure people currently receiving flexible home care will not be worse off under the proposed new arrangements.

Australian Aged Care Quality Agency Bill 2013 (the Bill)

The proposed Aged Care Quality Agency is a very significant development as it will serve as a "one-stop-shop" for aged care providers, in both residential and home care settings. As previously stated by the APS to the Productivity Commission, ageing is a normal biological process and the majority of older Australians live and function independently. Therefore "ageing in place" must be at the core of aged care policy. It follows therefore that services provided in the community must be accessible and equitable for older Australians to maximise their opportunities to participate in community life thus ensuring their wellness and quality of life. This should be a strategic goal for the Agency as it commences its operations in relating to home care services from 1 July 2014.

The APS contends that the Agency has three distinct roles:

1. Assess and fund quality evidence-based services to older Australians, irrespective of the setting in which those care services are delivered;
2. Promote the use of evidence-based interventions through collaboration with research institutions, peak bodies and service providers; and
3. Improving the overall quality of life of older Australians through improving and reporting system effectiveness.

It is vital that the Agency recognises that the cost burden associated with care for older Australians can be minimised by pursuing policies focusing on evidence-based interventions. This would allow the Agency not only to systematically assess, review and fund services that have an evidence base, it would also empower the Agency to discontinue or replace interventions which are shown to be

ineffective. This would not be dissimilar to the operations and the methodology of drug listings on the Pharmaceutical Benefits Scheme.

As a regulator and a purchaser of services, the Agency must be in a position to examine how evidence-based interventions can be used to drive system efficiency. This requires the Agency to work with key stakeholders to assess, evaluate and disseminate evidence at all levels of service provision.

Interventions which are non-invasive and/or have minimal side effects should be given higher priority. For example, behavioural interventions for people with depression or some forms of dementia are strongly supported by evidence as both effective and cost efficient compared to medications. The Agency should therefore be in a position to direct service providers to apply the evidence, drive system efficiency and thus providing optimal care for older Australians.

For older people living in residential care facilities, packages of care must be customised to maximise their function based on accurate assessment of their need. Allied health professionals, including psychologists, can play key roles across all aspects of aged care from service provision, through to staff education and training.

Conclusion

The APS is supportive of the proposed Aged Care and Aged Care Quality Agency Bills. These Bills should provide for greater clarity regarding the use of clinicians to provide accurate and timely diagnosis; the use of evidence based practice to promote quality care and improve system efficiency; and to refocus and reaffirm the notion of ageing in place and supporting quality of life all older Australians, irrespective of the setting in which they receive they care.

Appendix 1: Psychology in Aged Care: A Review of Evidence

Introduction

There is universal agreement that residential aged care facilities (RACF) are under increasing pressure from an ageing population. Compounding this problem are the difficulties experienced by residents of RACFs in accessing allied health service providers due to the separation of funding between most health services and aged care services. As a result, a range of evidenced-based interventions by psychologists that are shown to decrease health service demand, improve quality of life and markedly decrease disruptive features among this client population are not available to residents. Examples of such interventions from psychologists include:

- Work in collaboration with medical staff in the accurate diagnosis of mental health or neurological conditions;
- Non-drug interventions for behaviour management that can be less disruptive and just as effective as medication;
- Strategies for better understanding, management and potential prevention of disruptive behaviour by RACF staff;
- Chronic disease interventions that can reduce symptoms and improve adherence to treatment programs by residents while decreasing the incidence of associated distress in both residents and carers.

Evidence-based and cost-effective interventions

The incidence of psychological disorders is at much higher rates in RACFs than in the community (Rovner et al., 1990). There have been several studies into the mental health status and well-being of older adults who are residing in long-term care facilities. In one study prevalence of any psychiatric illness was 76.3% at admission to a RACF (Wancata et al, 1998). After dementing conditions, depression and anxiety are probably the most common psychiatric conditions in nursing home residents (e.g. Smalbrugge et al, 2005). Anxiety symptoms have been estimated at approximately 30% of nursing home samples (Smalbrugge et al., 2005). Studies in Australian residential care facilities have found the prevalence of depression was 32% (Anstey et al., 2007). These are significantly above non-institutional or community prevalence rates. All of these researchers have suggested that risk assessment and targeting of intervention strategies to prevent depression and anxiety in late life should be a priority, and should target improving functional capacity and well-being, areas in which psychologists are well-placed to offer their expertise.

Currently these problems are commonly treated with psychoactive medication which is expensive, frequently has undesirable side effects and requires regular adjustment in order to deal with issues relating to poly-pharmacy. There is also an extensive literature showing that staff in these facilities, who routinely undertake extremely difficult and emotionally fraught care tasks, are often stressed and relatively unsupported, which affects quality of care (Edberg et al., 2008; Evers, Tomic, & Brouwers, 2002; Moniz-Cook, Woods, & Gardiner, 2000).

When pharmacological treatment is supplied for the behavioural disturbances, which are very common in residential care, the medications used are frequently inappropriate or ineffective (Ramadan, Naughton, & Prior, 2003). Meta-analyses over the last two decades have repeatedly shown that anti-psychotics, the most common intervention, have modest efficacy at best and

frequent side effects (Schneider, Pollock, & Lyness, 1990; Schneider et al., 2006; Sink, Holden & Yaffe, 2005). Psychosocial interventions in aged care services are shown to be effective (Cohen-Mansfield, 2003; Opie, Rosewarne, & O'Connor, 1999), and cost significantly less than conventional forms of treatment.

An Australian example is a multi-disciplinary trial funded and published by the Commonwealth Government (Bird, Llewellyn-Jones, Smithers & Korten, 2002) and led by a clinical psychologist. Psychotropic medication was used in a minority of cases, but most cases employed a mix of psychosocial interventions tailored to the individual needs of the case. Over the course of the trial, only one patient was hospitalised (for a total of two days) compared with more than 20% (total hospital days 93) of a control group which was treated mainly with anti-psychotics. Drug side effects were reported in 12 cases in the psychosocial group, and in 32 cases in the conventional treatment group - a threefold reduction. Visits by general practitioners to deal with behavioural problems were reduced by half, an average of 4.5 visits in the psychosocial group, and 9.4 visits in the conventional treatment group. Visits by consultant psycho-geriatricians were also less common, an average of 1.2 visits in the psychosocial group, as against 4.8 visits in the conventional care group. Use of anti-psychotics declined in the psychosocial group and increased in the control group.

Similar trials, all led by clinical psychologists, are now being reported in the international literature (Bird, Llewellyn-Jones, Smithers & Korten, 2007; Cohen-Mansfield, Libin & Marx, 2007; Davison et al., 2007; Fossey et al., 2006). The case-specific approach is essentially the method advocated by the Commonwealth Government in the Dementia Behaviour Management Advisory Services programme (DBMAS), which was co-authored by a clinical psychologist.

Contributions by specialist psychologists in aged care can also lead to increased overall cost-effectiveness of interventions through decreased reliance on medications, or their more focussed use. For instance, the introduction of effective drugs for cholinesterase inhibition, such as Aricept®, and the placing of these drugs on the Pharmaceutical Benefit Scheme (PBS) has led to a substantial increase in the quality of life of an older person with dementia that is caused by Alzheimer's disease, as well as an increase in the length of time in which a person can remain at home in the community.

Correct diagnosis is of vital importance as these medications will only work in cases of Alzheimer's disease, very likely benefit in cases of mixed dementia involving Alzheimer's disease, but not other in forms of dementia. One of the main diagnostic tests used in prescribing patients with such medication is the Mini-Mental State Examination (MMSE) (www.pbs.gov.au), which is known to have significant variations in the procedures for its administration and scoring that affect the end score. Misdiagnosis through inappropriate administration of MMSE is less likely to occur with proper training of physicians and others who administer them. Such training could be provided by experts in the field who are familiar with the standard forms, including neuropsychologists, who are well versed in methods of assessment. This will lead to reduced rates for misdiagnosis, thereby increasing the effectiveness of the medication and the overall cost effectiveness of therapeutic interventions.

The consequences for a lack of provision of adequate psychological services for older adults can be profound. For example, a recent study in the UK found that 80 per cent of older adults who were suicide completers had received no referral to mental health services, and 15 per cent completed despite being under a psychiatrists' care (Salib & El-Nimr, 2003). In this study, among those who had successfully committed suicide, older males and older adults who were widowed were less likely to be known to mental health services. Similarly, within the framework of the World Health

Organization (WHO/EURO Multicentre Study of Suicidal Behaviour), results showed that older attempters were characterized by a much higher rate of female attempters, hard methods (especially among older males), and higher proportion of depressive and organic disorders. The authors point out that *"the recognition and treatment of depression plays a very important role in suicide prevention in the elderly population, and adequate emotional and psychosocial support by family and health care systems seems to be essential"* (Osvath, Fekete, & Voeroes, 2002, p. 3).

Psychological services have been shown not only to be effective with older adults for conditions such as depression (Scogin & McElreath, 1994; Leff et al., 2000) and anxiety (Koder, D. A., 1998; Weatherell, 2002; Pachana, Woodman & Byrne, 2007), but also incontinence (Burgio, 1998) and chronic pain (Cook, 1998). One US study found that every dollar spent on psychological treatment for chronic pain led to a five dollar saving in medical costs (Gonick, Farrow, Meier, Ostmand & Frolick, 1981). Recommendations for the management of pain in residential care facilities are being prepared by the Australian Pain Society and these include non-pharmacologic treatments (www.apsoc.org.au/pdfs/Draft1APSRACPMG.pdf).

Many chronic physical conditions interfere with both current medical treatment and impair the quality of life of those with such conditions. Psychological services can be of substantial benefit in these cases by addressing some of the underlying factors or assist in minimising the psychological impact of such chronic conditions. Stress management techniques for patients with hypertension found that following treatment over 50% of patients were well controlled without any need for medication. The average total medical costs saved per patient over a 5-year period were over US$1,300 (Fahrion, Norris, Green and Schar, 1987).

In another study of 700 patients with heart disease, hypertension and diabetes receiving psychological services were tracked for a three-year period and compared to a group of 1300 patients who did not receive psychological treatment. Those patients who received psychological treatment showed a 40% reduction in annual medical costs when compared to patients who were not given psychological services. Once the cost of psychological intervention was taken into account there was still a 5% net saving (Schlesinger, Mumford, Glass, Patrick, & Sharfstein, 1983).

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