House of Representatives Inquiry into Dementia: early diagnosis and intervention.

Faculty of Psychiatry of Old Age supplemental submission

September 2012

The Royal Australian & New Zealand College of Psychiatrists

Submission No. 045.1
(Dementia)
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The information contained in this submission is being provided in response to questions on notice that were asked during the House of Representatives Inquiry into Dementia: early diagnosis and intervention public hearing which was held on 22 June 2012 and was attended by Dr Leslie Bolitho, AM, President, Royal Australasian College of Physicians, Dr Robert Prowse, President, Australian and New Zealand Society for Geriatric Medicine and Dr Catherine Yelland, Fellow, Royal Australasian College of Physicians

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is providing subsequent information to the response provided by the Royal Australasian College of Physicians and Australian and New Zealand Society for Geriatric Medicine.

Question on Notice

Question: Ms O'NEILL: *Could I ask a question on notice about the numbers of geriatricians and psychogeriatricians that you look after and support, and an outline of your forward planning for how you engage with that workforce. I would just be interested to get some facts on the state of play there. Then I have a couple of questions, and I think that there is an overlay, particularly in terms of attending to migrant and Indigenous communities but generally as well. You note in your submission concerns with behavioural and psychological symptoms of dementia, and my questions are about how these are managed by families and carers; what difficulties you see families and carers facing; what happens with this in aged-care facilities; whether the training is adequate; what is going on in that space; and what facilities are there to respond to the realities that emerge when people are in aged care and develop dementia or present with dementia. If BPSD conditions exist prior to a diagnosis of dementia, can they be treated? What impact does it have once a person's mental state deteriorates? I think you have answered on the comorbidities. It is a fairly broad-ranging response, I guess.*

Response to Question on Notice

These responses are provided by Dr Roderick McKay, Chair Binational Executive Faculty of Psychiatry of Old Age (FPOA), Royal Australian and New Zealand College of Psychiatrists.

Responses have been provided under sub-headings to address each of the elements of the questions above.

Workforce

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand. The College is responsible for training, examining and awarding the Fellowship of the College qualification to medical practitioners. All psychiatrists are trained to be able to care for people with mental health problems at any age, but the College also has a Faculty of Psychiatry of Old Age (FPOA). FPOA members are recognised as having special expertise in practicing psychiatry with older people. Currently there are 239 members of the FPOA in Australia, with 65 doctors in Advanced Training, completion of which would qualify them for membership.

The RANZCP is progressively introducing a new competency based training programme, commencing in 2013. Of particular relevance to the questions asked is that, whilst still being finalised, one of the basic 'Entrustable Professional Activities' in this new program is planned to be focussed on the management of BPSD. This is the first time that there have been explicit competencies required to be demonstrated by all psychiatric trainees in the practice of psychiatry with people with dementia.

The FPOA is also in the process of completing a contract to collaboratively develop a handbook for all NSW Health Clinicians: *Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia*.

Assessment and Management of BPSD

Overall adequacy of services

The RANZCP has significant concerns regarding the lack of coordinated planning and service development for all older people with mental illness, including those with BPSD. These concerns are described in the Position Statement *Priority must be given to investment that improves the mental health of older Australians. (attached).* These issues are explored further in the paper *Is it too late to prevent a decline in mental health care for older Australians?* McKay and Draper Med J Aust 2012; 197 (2): 87-88.

The FPOA is also concerned that the Ministerial Conference on Ageing Communiqué of 15th December 2010 stated "The Ministerial Conference endorsed the Framework for Service Planning and Care Delivery presented by Professor Draper noting that it will inform broader service planning in relation to mental health planning and reform and referred the report to the AHMAC Mental Health Standing Committee for this purpose.". However the framework has not been publicly released, nor any further consultation occurred regarding it the FPOA is aware of. The FPOA is not aware of any further work of the Psychogeriatric Expert Reference Group that prepared the framework presented by Professor Draper.

An international perspective on these problems, with in depth analysis relevant to Australia can be found in *The mental health and substance use workforce for older adults: in whose hands?* Eden, Jill; Institute of Medicine. National Academies Press; 2012. One of their major conclusions is that "A health care workforce that is not prepared to address either MH/SU [Mental health/ Substance Use] problems or the special needs of an aging population is a compelling public health burden." We would see this conclusion as equally relevant to Australia, and the needs of people with dementia and their carers.

Benefits of specialist services for people with dementia and BPSD

The potential for a positive impact of adequately funded mental health services for older people has been highlighted in recent research regarding the treatment of depression in people with dementia. *Limited antidepressant efficacy in depression in dementia, in the context of limited evidence ....* McFarlane et al. Aust N Z J Psychiatry July 2012:595-597 discuss the implication for Australian services of recent United Kingdom based research questioning the efficacy of antidepressants in this context; and the importance of good multidisciplinary care. *Specialist mental health consultation for depression in Australian aged care residents with dementia: a cluster randomized trial.* McSweeney et al. International Journal of Geriatric Psychiatry first published online: 17 FEB 2012 highlighted the efficacy of such care. They found the following "Multidisciplinary specialist mental health consultation was significantly more effective than care as usual in treating the clinical depression of aged care residents with dementia ($p < 0.05$, partial $\eta 2 = 0.16$). At follow-up, the mean Cornell Scale for Depression in Dementia score for the intervention group was 9.47, compared with 14.23 for the control group. In addition, 77% of the intervention group no longer met criteria for major depression."

"If BPSD conditions exist prior to a diagnosis of dementia, can they be treated?

It is important to realise that more severe BPSD most commonly occurs as a complication of later stages of dementia; and by definition BPSD can only occur in the context of dementia.

However, it also worth recognising that milder personality or behavioural changes are commonly recognised by families and carers before the diagnosis of dementia. Without either appropriate public and professional awareness of the significance of these changes, they are easily dismissed as due to 'old age' or seen as possible mental illness other than dementia. In the presence of inadequate mental health services for this population, this can contribute significantly to delays in appropriate diagnosis.

It is probably worth highlighting that there has been recent Australian research clarifying the patterns of personality change that are most common on dementia; and their differences from 'normal ageing'. *Personality changes in Alzheimer's disease: a systematic review*. Robins et al Int J Geriatr Psychiatry2011;26: 1019–1029.

It is also important to be aware that there is active research into the interaction between depression in later life and the development of dementia. Whilst this is still an area of active debate, one of the more recent significant studies (*Temporal Relationship Between Depression and Dementia: Findings From a*

Large Community-Based 15-Year Follow-up Study Li, et al Arch Gen Psychiatry. 2011;68(9):970-977.) concluded "This study confirmed that late-life depression is associated with increased risk of dementia and supplied evidence that late-life depression may be an early manifestation of dementia rather than increasing risk for dementia." Again this highlights the importance of the adequacy of overall mental health services for this population.

Conclusions

I have not commented in depth on the adequacy of services within residential aged care facilities and community aged care services. The FPOA is aware of the significant work that is occurring in attempting to improve the capacity of the Aged Care workforce, but still has significant concerns regarding both the level of staffing available, and the overall skill levels of staff. Whilst the Dementia Behaviour Management Advisory Service is a welcome recognition by the Commonwealth of the needs of these staff for further support; the funding is significantly inadequate to provide this in a manner that supports adequate access by people with dementia to interventions shown to be effective. This is further exacerbated by MBS regulations that limit access of people in residential aged care, or with dementia, to MBS funded non-psychiatrist mental health services.

The combination of the deficits of staff within Aged Care, and inadequate access to specialist services has a marked impact on the quality of life of people with dementia; and in increasing the stress and mental health disability of their carers. The FPOA is happy to communicate further as is of assistance.

ADDITIONAL INFORMATION

Since the original submission to this inquiry the FPOA has participated in the Ministerial Dementia Advisory Group Primary Care Forum and been contacted by the Australian and New Zealand Society for Geriatric Medicine (ANZSGM) to assist them with a response to a question on notice at the Inquiry.

After discussion with the ANZSGM the material in the second part of the report is provided separately to assist this purpose. The first section of this report provides material recommending that early detection and intervention for people with dementia would be most appropriately achieved though a health promotion strategy that promotes keeping the brain healthy with ageing, combined with early detection of people who have a range of common problems with 'brain health' in older people. After a review of available web domain names, we propose such a strategy could be promoted as 'Ageing Wisely'.

Ageing Wisely - Why take an alternate approach to the early identification of dementia:

Stigma is a key issue in regard to both ageing and dementia. The work led by Alzheimer's Australia and others in raising awareness of the prevalence and impact of dementia on older people has been powerful, effective and necessary. However it does not appear to have addressed the fear people have of dementia and may have inadvertently increased such fear. It also may have inadvertently reinforced some stereotypes of ageing being associated with an inevitable decline in cognition (even if due to a disease). An *Ageing Wisely* strategy could emphasise that most older people age without dementia and that positive action can be taken when people worry about their memory or other aspects of brain function.

People hope for a cure for dementia, but still see it as a disease associated with inevitable poor outcomes. These are essential issues that need to be addressed if there is to be effective early identification and intervention for people with dementia. People who are fearful of a disease (in themselves or someone they care for) are most likely to seek help if they believe it can lead to effective action. If they do not believe this they are more likely to try to ignore the issue, or try to rely on family resources to address it.

This is particularly important as symptoms people interpret as signs of possible dementia may often be due to other conditions that can be effectively treated or managed. Such problems include

- Delirium due to medical conditions
- Polypharmacy
- Depression
- Alcohol misuse
- Anxiety

Delaying treatment for these conditions has very adverse outcomes for the individual, and is costly for society.

Due to the overlap in presenting symptoms it would appear very feasible for screening to encompass these issues - and so maximising the potential for initiating effective action.

This should be considered in the context that:

- Our oldest men have the highest rates of suicide in Australia;
- Older people have markedly higher prescription of psychotropic medications than younger people;
- Analysis of ACFI data suggests that 50% of people entering residential aged care have a diagnosed mental illness, alone, or in the presence of comorbid dementia. Knowledge of primary care suggests this is likely to be an underestimate; and
- Older people become more susceptible to adverse effects from alcohol consumption.

We suggest that a Health Promotion message is developed such as below:

Age Wisely!

Don't let the fear of dementia rob you of the wisest years of your life!

Did you know?

- Wisdom *does* increase with age
- Most people who worry about their memory don't have dementia
- Medications, poor sleep, stress and alcohol can all affect your memory or concentration
- Most older people never have dementia
- if you are worried about your memory or dementia, help is near at hand

For more information

- See you GP
- Call ....
- Or go to www.ageingwisely.org.au

This could be supported by branding opportunities e.g. a blue brain tick trade mark, and an *Ageing Wisely* Website. Such a website would have material such as:

- *Things that may hinder ageing wisely*
  - Information about common related conditions: depression, anxiety, polypharmacy (? With checklist to discuss with doctor of medications that 'may help or hinder'
- *Are you worried about someone else?*
  - Eg IQCODE, Psychogeriatirc Assessment Scale informant questionnaire, or depression/ anxiety questionnaire adapted for this usear
- *Are you worried about your own 'brain health'?*
  - With the potential to develop web 'self test' for cognition, depression, anxiety, alcohol
- *Things to increase the chance of ageing wisely!*
- *Where to get help.*

It would also appear feasible to develop a positively framed Healthcare professional incentive - *Ageing Wisely* healthy brain check.

This could consist of screening through questionnaire, directly to a person and/or an informant, plus cognitive testing if indicated/no informant, then w*ith agreed post check actions.*

This could include:

- *Carer rated*
    - Psychogeriatric Assessment Scale informant component
    - IQ Code

- *Patient rated*
    - 'Brain health' activity and relevant physical health checklist
    - Geriatric Depression Scale or similar
    - Geriatric Anxiety Instrument or similar
    - Alcohol screen
    - Beers criteria based medication screen
- *GP completed*
    - Agreed cognitive screen

This should be supported by healthcare provider education:

- Based on key *Ageing Wisely* Health Promotion messages
- How to encourage participation in ageing wisely screen, or respond to queries resulting from using website
- How to interpret instruments in Ageing Wisely Screen
- agreed initial interventions
- when/ how to refer

Priority must be given to investment that improves the mental health of older Australians

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The Royal Australian & New Zealand College of Psychiatrists

Definition

Mental health is much more than the absence of mental illness[i]. Mental health maximises each older person's quality of life, the quality of life of those around them, and their contribution to Australia.

Background:

Australia is unprepared to meet the mental health needs of an ageing population

By 2026 the number of Australians aged 65 years and over will more than double from around 2.1 to 5 million people[ii]. An ageing Australia needs the wisdom and contribution of healthy older Australians. Yet for too long the mental health care of older people has been largely ignored in the mental reform agenda. As noted in 2009 by the National Health Hospitals Reform Commission: "As a matter of some urgency, governments must collaborate to develop a strategy for ensuring that older Australians, including those residing in aged care facilities, have adequate access to specialty mental health and dementia care services. [iii]

The Faculty of Psychiatry of Old Age (FPOA) has serious concerns regarding the inadequacy of planning for the mental health needs of the older person. In particular:

- In 2006 reforms to increase access to mental health care included Medicare reimbursement for GP Mental Health Services and access to psychologists but excluded treatment for dementia, and with lack of clarity regarding access for people living in residential aged care
- In 2009 the Fourth National Mental Health Plan identified no priority actions targeting older people
- in 2010 The Psychogeriatric Expert Reference Group developed a Framework for Psychogeriatric Services which was endorsed by the Ministerial Conference on Ageing but nothing further has ensued
- In 2011 the Productivity Commission Report into Aged Care[iv] recommended that Governments expand inreach mental health services to residential aged care; but without funding proposals or inclusion in the 10 page Summary of Recommendations. In 2011 the Independent Mental Health Reform Group's (IMHRG) 'Blueprint' for mental health services in Australia largely ignored older people
- That the mental health needs of older Australians have been repeatedly ignored may in part relate to the methodological failings of the 1997 and 2007 National Surveys of Mental Health and Wellbeing that used methods unsuitable for older people[v] and excluded people with dementia or living in residential aged care.

With unacceptable results

There is ongoing considerable evidence that older people have inadequate access to mental health care and poor mental health outcomes

- Access of people 65 years and older to GP Mental health Services at 34% of the rate for those aged 33 to 44 years[vi]
- Access to psychologists by people 65 years and older at 21% of the rate for those aged 33 to 44 years
- The highest age-specific suicide death rate for men being in the 85 years and over age group[vii]
- the elderly having anxiolytic, hypnotic and sedative drug prescription rates approximately 500% that of the general population [viii]

Australia cannot continue to ignore the needs of older Australian with mental illness

Untreated mental illness robs older Australians of their quality of life, physical health and independence at significant cost to individuals, family and community. While there are effective evidence based mental health treatments for older people in Australia, limited resources deny them equitable access. Action must start now to address this deficiency. Australia owes its older citizens and their families adequate support. respect, and dignity.

Priority actions to improve the mental health of older Australians

To improve the quality of mental health care for older people

1. Develop national benchmarks for the availability and quality of mental health services for older people across the spectrum of care with specific steps to achieve these benchmarks in all national and state mental health plans.
2. Develop and implement national principles for providing coordinated care across different services for older Australians with mental illness.
3. Mandate the inclusion of a national, person centred, curriculum for basic mental health literacy in the training for people working with older Australians,
4. Commit to the application of these principles within all health services to improve the identification, initial management and appropriate referral of older people with mental illness.

To remove discrimination against older people with mental disorders

1. Commitment to the development of community and residential aged care services that are inclusive of the needs of people with mental illness including removal of care exclusions in the Aged Care Act that are based on the presence of a mental health condition.
2. Removal of all barriers to older Australians in residential aged care accessing the same mental health services as the rest of the community
3. Removal of all exclusions from access to mental health services on the basis of having a diagnosis of dementia
4. Fund effective and accessible mental health care that meets the specific needs of Aboriginal and Torres Strait Islander older people, and those from culturally and linguistically diverse backgrounds.

To obtain a better understanding of the mental health needs of older Australians

1. Commission a Survey of Mental Health and Wellbeing of Older Australians using appropriate tools for *all* older people
2. Conduct of an audit of regional access to multidisciplinary mental health care specialised on the needs of older people, and prioritise funding to redress the largest gaps.
3. Fund research on effective mental health interventions in older people
4. Fund mental health promotion activities focussed upon the needs of older people.

To ensure that these actions are carried out

1. Explicit monitoring and advocacy for progress in the mental health care for older Australians by the national and state Mental Health Commissions

The Faculty of Psychiatry of Old Age will monitor and report on progress against these priorities.

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[i] WHO Fact Sheet No 220. *Mental Health: Strengthening our response.* September 2010 Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community"

[ii] ABS, *Population Projections Australian 2006 to 2101.* 2008, Australian Bureau of Statistics: Canberra.
[iii] A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission – June 2009: Canberra
[iv] Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra
[v] O'Connor, D.W. and R.A. Parslow, *Different responses to K-10 and CIDI suggest that complex structured psychiatric interviews underestimate rates of mental disorder in old people.* Psychological Medicine, 2009. **39**(09): p. 1527-1531.
[vi] AIHW Mental Health Services in Australia 2009-10, Australian Institute of Health and Welfare: Canberra
[vii] ABS, *Causes of Death, Australia, 2009.* 2011, Australian Bureau of Statistics: Canberra.
[viii] Hollingworth, S.A., et al., *Psychiatric drug prescribing in elderly Australians: time for action.* Australian and New Zealand Journal of Psychiatry. **45**(9): p. 705-708.

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