



The Royal Australasian
College of Physicians

House Standing Committee on Health and Ageing Inquiry into *Dementia: Early diagnosis and Intervention*

Response by The Royal Australasian College of Physicians and the Australian and New Zealand Society for Geriatric Medicine to the Questions on Notice

August 2012

The Royal Australasian College of Physicians (RACP) and the Australian and New Zealand Society for Geriatric Medicine (ANZSGM) are pleased to provide the following response to the questions on notice from the 22 June 2012 public hearing for the Inquiry into *Dementia: Early diagnosis and Intervention*.

Ms O'NEILL asked the following questions on notice:

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?

The RACP and ANZSGM have prepared a response to the question about the geriatrician workforce and the management of the behavioural and psychological symptoms of dementia (BPSD). We understand that the Faculty of Psychiatry of Old Age within the Royal Australian and New Zealand College of Psychiatrists have also prepared a separate response to the Inquiry as they are best placed to provide information about the psychogeriatrician workforce and further detail about the assessment and management of BPSD.

The geriatrician workforce

A geriatrician has expertise in the diagnosis and management of complex and/or multifactorial internal medicine disorders impacting on the cognition and functional status of the older person. Geriatricians work across the continuum of care and often as part of a multidisciplinary team to assess, diagnose and manage older people's complex health care needs and age-related conditions.

The most recent estimates of the geriatrician workforce from the Australian Institute of Health and Welfare's Medical Labour Force Survey 2009 state that there are approximately 390 geriatric medicine specialists in Australia.¹ A report from the RACP's database indicates that there are over 500 Fellows who have listed geriatric medicine as their primary or secondary specialty. The ANZSGM currently has 547 members across Australia who are either qualified geriatricians, specialists in a field providing services to geriatric patients such as neurology or rehabilitation, or general practitioners who have a high proportion of geriatric patients. Assessment of these figures suggests that the geriatrician workforce in Australia in 2012 is around 450.

With the ongoing demand for geriatric medical expertise, there is a need to maintain and expand the geriatrician workforce through increased numbers of physician trainees specialising in or undertaking dual-training in geriatric medicine. In 2011, the number of advanced trainees in geriatric medicine in Australia was around 137 trainees. This is an increase of 22 trainees from 2009. There are approximately 45 trainees undertaking dual-training in geriatric medicine and another specialty, such as general medicine.

The RACP and ANZSGM consider there is a shortage of skilled medical practitioners in the area of geriatric medicine, particularly given the increasing numbers of older people in Australia and the rising rates of comorbid chronic disease. Consultant posts, especially outside capital cities are hard to fill. At this time, we do not have accurate data on the extent of the unmet need. As such, other medical practitioners including general physicians, palliative medicine specialists, rehabilitation medicine specialists and general practitioners often provide care to older people to fill this gap, and should receive specific training in the care of older patients with complex health care needs.

The Australian Government's Specialist Training Program (STP) is a worthwhile program for increasing the exposure of the specialist medical workforce to the care needs of older people by enabling trainees to rotate through an expanded range of settings, including aged care. We encourage the Australian Government to continue to prioritise specialist training posts in general and geriatric medicine, and in aged care settings, through the STP.

Management of the behavioural and psychological symptoms of dementia

People with dementia can experience a range of distressing symptoms over the course of the disease. Symptoms such as screaming, physical aggression, agitation, wandering, inappropriate behaviour, hallucinations and delusions are generally referred to as the behavioural and psychological symptoms of dementia (BPSD). Estimations of the number of people with dementia who demonstrate BPSD are typically high, with one study finding that

over 90% of residents in Sydney aged care facilities demonstrated at least one behavioural disturbance.²

The distressing nature of BPSD means that it has a severe impact on the person with dementia, their carers and families, care workers, and the broader health system. Left untreated, BPSD can reduce quality of life, increase carer burden, and risk premature entry into residential aged care or inappropriate admission to hospital.

As stated in our submission, there may be triggers for BPSD including biological, social, psychological and environmental factors. The best practice approach for treating and managing BPSD involves recognising and responding to the causes of the symptoms. Observation and assessment of a person with BPSD by an appropriately skilled and resourced care team, with medical specialist input, can identify the triggers for BPSD, which can then allow the team to develop individually tailored strategies to prevent, overcome or manage BPSD.

Carers, families, and health and aged care services must be appropriately trained and resourced to better understand and respond to BPSD. Without sufficient time, specialist input and capacity to identify the triggers and put in place a tailored strategy, management of BPSD might fall back on pharmacological treatment using anti-psychotic medication, which is associated with poorer health outcomes and reduced quality of life for the person with dementia.

The RACP and ANZSGM supports the existing body of evidence with regard to models of service delivery for people with BPSD and older people with complex psychogeriatric disorders and behaviours including:

- The Brodaty et al. (2003) seven-tiered model of service delivery for the management of BPSD.³
- The 2008 *Report to the Minister for Ageing on residential care and people with psychogeriatric disorders*.⁴
- The Psychogeriatric Care Expert Reference Group, which provides advice about appropriate care and services for people with psychogeriatric disorders who live in aged care facilities.
- The Dementia Behaviour Management Advisory Services (DBMAS) to provide appropriate clinical interventions to help aged care staff and carers caring for people with BPSD.
- Examples of innovative and effective service models including the BASIS and T-BASIS (Transitional Behavioural Assessment and Intervention Service) services and high dependency units such as Linden Cottage in NSW, and the aged persons mental health nursing homes and hostels in Victoria.

With the rising rates of dementia, we can expect that there will be ongoing and increased demand for services that can respond to BPSD. There will also be need for improved training opportunities for carers and care workers to learn how to manage BPSD in an appropriate and person-centred manner. The RACP and ANZSGM recommends a systematic review of the evidence and service models for providing care to people with BPSD, and an audit of the services that are currently available across Australia. We understand that there are a number of services available but that current service levels are insufficient to meet the need. We encourage ongoing investment in the resourcing of

specialised programs and services for people with BPSD, coupled with research and evaluation of existing services, and consideration of opportunities for wider implementation.

The RACP and ANZSGM support the establishment and resourcing of specialist residential care units across Australia that can provide specialist multidisciplinary care for people with severe BPSD. Mainstream residential aged care facilities and even dementia specific facilities often do not have the capacity to care for people with BPSD within the existing service model, staffing levels and the design of the facility. The specialist units should be staffed by a specialist dementia nurse or nurse practitioner with specific training in BPSD supported by registered nurses and personal carers with expertise in managing BPSD. The units should link in with primary, specialist and allied health services to deliver holistic, person-centred care to manage the complex care needs of people with severe BPSD.

References

¹ Australian Institute of Health & Welfare. (2011). Medical labour force 2009. AIHW bulletin no. 89. Cat. no. AUS 138. Canberra: AIHW. Available at: www.aihw.gov.au/publication-detail/?id=10737419680.

² Brodaty H, Draper B, Saab D, Low LF, Richards V, Paton H, Lie D. (2001). Psychosis, depression and behavioural disturbances in Sydney nursing home residents: prevalence and predictors. *Int J Geriatr Psychiatry* 16(5); 504-12.

³ Brodaty, H., Draper, B., Low, LF. (2003). Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery. *Med J Aust* 178(5): 231-234.

⁴ Report to the Minister for Ageing on residential care and people with psychogeriatric disorders. (2008). Available at: www.health.gov.au/internet/main/publishing.nsf/Content/ageing-quality-report-psychogeriatric-disorders.htm.