Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

COLLEGE SUBMISSION

Feedback on the Clinical Practice Guidelines for the Appropriate Use of Psychotropic Medications in People Living with Dementia in Residential Aged Care
May 2022

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is *the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care.* It progresses this through the provision of quality vocational training; professional development education programs; setting and upholding practice standards; and through the provision of support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

Initial Comments

The College welcomes the opportunity to provide feedback on the Clinical Practice Guidelines for the Appropriate Use of Psychotropic Medications for People Living with Dementia in Aged Care (the Guidelines).

Rural Generalists and other General Practitioners are often the only provider of aged care services in rural and remote areas, and in areas where other services do exist, are often the first point of contact for dementia patients and Residential Aged Care Facilities (RACFs) in need of assistance. These doctors are also often called upon to support patients in the case of health emergencies.

Rural and remote general practitioners work under unique circumstances and with a scope of practice and working environment which can be very different to urban practice. These doctors are often the only readily available health care practitioners and as such, they may need to take on a range of roles which would ordinarily fall to psychiatrists, allied health professionals, or health care teams in larger areas. These doctors work in local healthcare teams that are small in number and supported by minimal resources.

The distinctions of these rural and remote contexts have important implications for what represents the safest and best clinical care. Overall, the College considers that the current Guidelines do not give appropriate consideration to these distinctions and without some modification are likely to lead

to considerable perverse outcomes for patients, carers, and health professionals in rural and remote areas.

We have provided a response to the *Conditional Recommendations* pertinent to the work of the College.

Response to Conditional Recommendations

Benefits and Harms of Antipsychotic Medications

Conditional Recommendation 1 *First-generation antipsychotics are not recommended for people living with dementia and changed behaviours.*

Conditional Recommendation 2 *For people living with dementia and changed behaviours, the Guideline Development Group recommends against routine use of second-generation antipsychotics as the risk of harms outweigh the potential benefits.*

Whilst the College agrees with the general principles outlined in Good Practice Statement 1, that care for all people living with dementia and changed behaviours should cater for their specific needs and provide non-pharmalogical strategies to assist, the reality is that the aged care sector in rural and remote Australia faces many challenges compared to city counterparts.

There is generally poorer access to and availability of a range of services, including psychiatry and allied health services. Recruiting and retaining a skilled aged care workforce becomes increasingly difficult with remoteness.

Our members indicate the importance of being able to have the option of prescribing antipsychotic medication in the treatment of psychotic and agitated elderly patients. This often avoids transferring patients to busy emergency departments or acute medical wards. In addition, antipsychotics are often used for nausea control, comfort and in some instance's sedation. The consequences for patients who have no reversible causes for their unsafe behaviour and for whom one-on-one nursing is not an option would be increased personal distress and risks to the safety of healthcare staff, other residents, and patient carers. This is important in all contexts but especially pertinent in rural contexts of geographic isolation and generally low levels of in situ staff and resources including local police and emergency services. The Position Paper of the remote area nurses' peak body, CRANA Plus highlights these issues.[1]

The Guidelines must acknowledge that urgent problems often require an immediate response, including prescribing psychotropic medicines. Dementia or Alzheimer's patients can often become disturbed or agitated at night, which is a common consequence of brain deterioration in these diseases. Caring for hyperactive patients with dementia carries with it risks for the safety of the patient, other residents, and staff.

Conditional Recommendation 3 *If a person living with dementia is exhibiting distressing psychotic symptoms and/or aggression/agitation that represents a direct threat to themselves or others, short-term use of risperidone may be considered. The prescriber should conduct an individual harm-*benefit analysis*. The specific target symptoms should be documented in the medical record, behaviour support plan and nursing progress notes as applicable. Antipsychotics do not benefit symptoms such as calling out, wandering or disinhibition*

There are many instances where a resident is acutely distressed, confused, and agitated, when using short term antipsychotics - for a few doses, a few days, or weeks only – may be appropriate.

[1] CRANA Plus (2020) Remote Health Workforce Safety and Security Position Statement. https:/www./s3.ap-southeast-2.amazonaws.com/cranaplus-website-assets/files/CRANAplus_SS_PS_2020.pdf

This may be because of a recognised acute illness or for a yet to be diagnosed illness. Either way, careful sedation is often an important aspect of management for reasons of safety, comfort, and dignity of the patient, as well as for the sake of other patients in the facility who may become distressed by the agitation, and also for family members who are concerned and often trying to assist with management. It is important that risperidone can continue to be used in these, and in other emergency circumstances where there is a risk to the patient, to others or to both.

Discontinuation of Antipsychotic Medications

Conditional Recommendation 4 *For people living with dementia who have been using antipsychotics for changed behaviours, review the benefits and harms of continuation in consultation with the person living with dementia and/or their substitute decision-maker and discuss the option of discontinuation.*

As stated previously, careful sedation is often an important aspect of management for reasons of safety, comfort, and dignity of the patient, as well as for the sake of other patients in the facility who may become distressed by the agitation, and also for family members who are concerned and often trying to assist with management.

The consequences for patients who have no reversible causes for their unsafe behaviour and for whom one-on-one nursing is not an option would be increased injuries and increased distress. The consequences for other residents and staff would also be injuries and distress.

Aged care work for GPs is challenging, time consuming and poorly remunerated, and having additional rules is a further deterrent to skilled GPs providing services in aged care facilities. One of our members notes the following:

> *"I fear that this may see many GPs leave the aged care sector. To be honest if I was considering entering true primary care I would now choose not to provide services to RACs as I am unable to provide care that keeps myself, my staff and my patients safe should a patient develop behavioural disturbance."*

Similarly, aged care work for nurses is hard work, poorly remunerated compared to work in the State health system, and nurse to resident ratios are low. If they are recurrently subject to patient aggression, then there is the risk that many nurses will choose to find work elsewhere in less challenging areas. In the rural and remote context, where workforce shortages are already at critical levels across this sector, the problem is more acute.

Benefits and Harms of Anti-depressant Medications

Conditional Recommendation 7 *For people living with dementia and agitation, the Guideline Development Group recommends against routine use of antidepressants, on the basis of evidence of adverse events and limited effectiveness. If a person living with dementia is experiencing agitation and has not responded to adequate non-pharmacological strategies and a medication is considered, a trial of selective serotonin re-uptake inhibitors (SSRIs) may be safer than antipsychotics depending on the individual's risk-benefit profile. Citalopram has the strongest evidence for agitation in people living with dementia.*

Conditional Recommendation 8 *For people living with dementia who develop depressive symptoms or mild-to-moderate major depressive disorder, the Guideline Development Group recommends against routine use of antidepressants. For people living with dementia who develop moderate major depressive disorder AND who have previously responded to an antidepressant, consider prescribing an antidepressant when an adequate trial of non-pharmacological strategies*

alone has been unsuccessful. The Guideline Development Group does not recommend routinely using antidepressants for people who develop moderate major depressive disorder who have not previously responded to an antidepressant. For people living with dementia who develop severe major depressive disorder, including risk of self-harm, consider prescribing an antidepressant alongside non-pharmacological strategies. Assessment by a psychiatrist is recommended for people who develop severe major depressive disorder including the risk of self-harm.

Conditional Recommendation 9 *For people living with dementia and sleep disturbance, the Guideline Development Group recommends against the routine use of antidepressants on the basis of lack of available evidence of efficacy and indirect evidence of harm.*

The distribution of mental health professionals rapidly decreases with remoteness. Psychiatrists are six times less prevalent; psychologists five times less prevalent and mental health nurses three times less prevalent in rural and remote areas.[2]

Based on the issues as outlined, the College considers a more appropriate approach would be to enable trained practitioners to apply their clinical judgement in relation to psychotropic prescribing with a clear indication that these should be used as little as practicable. Although members appreciate the need for stricter guidelines around antipsychotics and sedative agents further consultation and discussion is required, particularly around guidelines purporting to restrict a broader range of medications including antidepressants.

We see need for a more considered analysis of the implications of this proposed Guideline when applied in small, geographically isolated communities with access to only minimal staff and resources in situ.

Discontinuation of Antidepressant Medications

Conditional Recommendation 10 *For people living with dementia using an antidepressant for major depressive disorder, the Guideline Development Group recommends a regular review of the benefits and harms of continuation, in consultation with the person living with dementia and/or their substitute decision-maker, and to discuss the option of discontinuation. For people with a first-time episode of moderate or severe major depressive disorder who respond to treatment, the antidepressant should be continued for six months then a trial of discontinuation considered. For people with a history of episodes of severe major depressive disorder, including at risk of self-harm, consider continuing treatment and reviewing regularly for harms. This review should be undertaken by, or in consultation, with a psychiatrist.*

Further consultation is required in relation to this guideline, particularly the suggestion that review should be undertaken by, or in consultation with, a psychiatrist. In rural and remote areas, Mental Rural Generalists who have completed their Advanced Specialised Training in Mental Health should be given similar authority in the Guidelines.

Rural and remote clinicians are generally unable to access psychiatric services in their area, with our members indicating that wait times to see a psychiatrist can be as much as two years. Testimony by a representative of RANZCP to the New South Wales Senate Inquiry into rural healthcare services, suggested that access decreases rapidly with remoteness, with psychiatrists being seven times less prevalent in rural areas.[3]

[2] CRANA Plus (2020) Remote Health Workforce Safety and Security Position Statement

[3] NSW Legislative Council (2022) Health Coucomes and access to health and hospital services in rural, regional, and remote New South Wales: Report 57: May 2022. (page 117)

Where a specialist psychiatrist is not available, allowances must be made for the specialist GPs and Rural Generalists providing regular care to manage patients to keep them safe and well. This should include the short term use of antipsychotics and sedation if considered necessary by the treating doctor.

Polices and protocols must be developed to either facilitate swift access to such consult services or to include alternative sufficiently expeditious mechanisms for enabling use as required, including facilitating access to telehealth Psychiatry services, otherwise rural and remote general practitioners will be left in a situation where Guidelines require them to conduct a review of medications prior to continuation, but access to the relevant psychiatrist prohibits that review from taking place.

Conditional Recommendation 11 *For people living with dementia using an antidepressant for agitation, without evidence of concomitant acute or chronic major depressive disorder, the Guideline Development Group recommends that discontinuation be considered.*

As stated previously, if discontinuation reviews are to be conducted by or in consultation with a relevant specialist, such as a psychiatrist, access to those specialists must be in place before the Guidelines require this course of action to be followed by GPs.

Interventions to Improve Use and Appropriateness of Psychotropic Medications

Conditional Recommendation 13 *People living with dementia and in residential aged care should have their medication regimen reviewed regularly. The medication review is likely to be more valuable when people living with dementia and/or their substitute decision-maker are involved in discussions and medication-related goals of care are documented. Review recommendations may be more likely to be implemented when the review is multidisciplinary and involves the resident's usual prescriber.*

We agree that medication regimens should be reviewed regularly, however Conditional Recommendations 13 and 14 do not mention psychiatric involvement in the review process, whereas earlier recommendations relating to discontinuation require psychiatrist involvement.

Either way, with wait times for psychiatrists in rural and remote areas being as long as two years, the Guidelines must acknowledge that long-term antipsychotic use is likely to continue until such time as a specialist psychiatric assessment and plan for continuation or weaning can be put in place.

This policy inconsistency and confusion particularly within the more prescriptive regulatory environment proposed by the Guidelines, will provide further disincentive to doctors and health professionals for providing aged care services in rural and remote areas.

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