Submission to the Inquiry into Dementia: Early Diagnosis and Intervention

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The Royal Australian & New Zealand College of Psychiatrists

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Executive Summary

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide a submission to the Inquiry into Dementia: Early Diagnosis and Intervention. The RANZCP is committed to improving health outcomes of older people and commends the Standing Committee on Health and Ageing for commissioning this Inquiry.

Psychiatrists have a role in providing support, advice and treatment to dementia sufferers, their families and carers to ensure they are given the best possible care and support. The RANZCP has written a position statement *Priority must be given to investment that improves the mental health of older Australians*, which outlines the RANZCP concerns that Australia is unprepared to meet the mental health needs of older Australians. The RANZCP supports the need into early diagnosis and intervention of dementia and would like the inquiry to consider the following:

- Accurate diagnosis to ensure appropriate interventions are provided
- Services should be multi-disciplinary and mobile
- Removal of all exclusions from access to mental health services on the basis of having a diagnosis of dementia

If you would like any further information, or to set up a meeting, please contact Dr Anne Ellison, General Manager, Practice, Policy and Projects, via claire.bellett@ranzcp.org or 03 9601 4958.

About ageing and dementia

Untreated mental illness robs older Australians of their quality of life, physical health and independence at significant cost to individuals, family and community. By 2026 the number of Australians aged 65 years and over will more than double from around 2.1 to 5 million people (ABS, 2008). An ageing Australia needs the wisdom and contribution of healthy older Australians. By providing adequate mental health services and support, this will contribute to ensuring the continuing health of older Australians.

Dementia represents a special case where a specialist psychiatric service for the elderly can fulfill many roles. General practitioners commonly have long-term contact with, and clinical responsibility for people who have developed dementia. However, support and advice from mental health specialist services are usually required at some or several stages during assessment and management. Many patients with dementia suffer from co-morbid psychiatric syndromes during their illness and these often improve with treatment. Specific behavioural problems are common and require specialist assessment and management. Old age psychiatrists have special expertise in the assessment of cognitive decline and the differentiation of mild dementia from other psychiatric conditions. This has become especially relevant with the introduction of acetylcholinesterase inhibitors, and with other anti-dementia drugs becoming available. Lastly, the psychiatrist can play a special role in assisting carers of dementia sufferers as they often have high levels of psychological distress and are at increased risk of medical and psychiatric morbidity. In areas where there are no old age psychiatrists, geriatricians may be requested to assess or take on care of people with dementia. Telepsychiatry may be helpful in advising health care staff in remote areas.

The management of dementia is complicated by behavioural and psychological symptoms of dementia (BPSD), such as psychosis, depression, agitation, aggression and disinhibition (Brodaty, Draper, & Low, 2003). Rates of BPSD vary according to how symptoms are ascertained, thresholds of severity, and setting. For example, rates of BPSD have been estimated at 61% - 88% among people with dementia in a community setting, 29% - 90% in residents of Australian nursing homes, and 95% among hospitalised patients in long-term acute care (Brodaty et al., 2003). The importance of BPSD in people with dementia is that it is the major clinical factor that causes stress in carers and often leads to the breakdown of

community care leading to institutionalisation. Within institutions, BPSD is a significant challenge for staff and requires the right mix of facility design, staff skills and resources to provide appropriate person centred care.

While important, dementia is only part of the mental health story for older Australians. Functional disorders like schizophrenia, anxiety disorders and clinical depression are more common. Older Australians will bring pre-existing and new mental illnesses into old age and dementia. It is essential that our service system reconfigures and expands to meet the known need.

Current infrastructure

Australia is unprepared to meet the mental health needs of an ageing population. While there are effective evidence based mental health treatments for older people in Australia, limited resources deny them equitable access. 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." (National Health and Hospitals Reform Commission, 2009).*

Facilities in Australia, including hospitals and emergency departments, and residential aged care facilities (RACF) are often unable to adequately and humanely care for people with severe BPSD. Aged care reform needs an integrated system that does not discriminate against those individuals needing care. Accessibility and affordability are key issues along with simply having enough quality facilities available to meet the demand. In addition, in most parts of Australia, staffing ratios and skills are inadequate to provide care for these older people. Moreover, a higher skills-base than is currently provided in RACF is needed to provide individualized, person-centred (rather than task-orientated) care - the gold standard of care for meeting the complex needs of people with dementia with and without BPSD. Particularly for those requiring care at the top tiers, service provision will be a potential ongoing gap unless it is determined which service should have responsibility for this group (i.e. private, public or a mix). As in the tiered model for general mental health care, the importance of prevention, requires greater emphasis on such person-centered approaches to care that prevent the development of BPSD (Chenoweth et al., 2009).

In the light of recent evidence demonstrating the adverse outcomes of hospitalisation of people with dementia (Draper, Karmel, Gibson, Peut, & Anderson, 2011), there is an urgent need for commensurate skilled primary care, specialised geriatric "nursing home medicine" (in line with programs provided overseas such as in the Netherlands) and community support services for treating patients out of hospital. In particular, attention needs to be paid to early identification and treatment of delirium and provision of palliative care in nursing homes.

Early diagnosis and intervention

Accurate diagnosis of dementia is important. Misdiagnosis or missed early diagnosis means there is a missed opportunity to treat other conditions including, depression. This can have serious and unnecessary adverse consequences. Misdiagnosis or missed early diagnosis hinders dementia-specific interventions which can ultimately be harmful for the patient. There is danger that a person can be misdiagnosed with dementia, which could lead to unnecessary restrictions in lifestyle, under the National Transport Commission's *Assessing Fitness to Drive*, people with dementia triggers a restricted driving license (Austroads, 2012). Moreover, missed diagnosis of dementia can render people open to exploitation and abuse, particularly financial abuse (O'Neill & Peisah, 2011) and to family conflict and fractured relationships (Peisah, Brodaty, & Quadrio, 2006).

The RANZCP recommends that early diagnosis should focus on early identification of cognitive impairment rather than dementia, which is less threatening to older patients. Furthermore, there is some evidence that these early stages may be associated with psychiatric symptoms (Forsell, Palmer, & Fratiglioni, 2003; Lopez, Becker, & Sweet, 2005) and impairment of higher level complex functions such

as complex financial management (Griffith et al., 2003). By focusing on early identification of cognitive impairment, this could trigger assessment for conditions that can be improved or stabilized, such as depression or hypertension. Early diagnosis of dementia and the associated co-morbid psychiatric conditions would assist with provision of appropriate care, providing education and information to both the patients, their families and carers. It will also provide appropriate care giving intervention, if required. This will also assist families and carers with better understanding of dementia and provide them with education and better mechanisms to deal with changes associated with dementia.

It should be noted that rates of dementia in Aboriginal and Torres Strait Islander populations is much higher than in other groups. It is estimated that 26.8% of indigenous people over 65 years have dementia (Australian average 6.5%) and 12.4% of indigenous people older than 45 years have dementia (Australian average 2.4%). To ensure Aboriginal and Torres Strait Islander populations are treated appropriately, mental health services must provide culturally appropriate services in the treatment and education of dementia. Culturally appropriate services are also necessary for people from culturally and linguistically diverse backgrounds.

Recommendations
To assist with the Inquiry, the recommendations are listed under the Inquiry's terms of references items:

Improve quality of life and assist people with dementia to remain independent for as long as possible

- Commit to the application of these principles within all health services to improve the early identification, initial management and appropriate referral of older people with dementia
- Provide psychiatric assessment prior to admission to nursing homes to ensure appropriate treatment
- The service should be multi-disciplinary and mobile. Appropriate staff should be available to make home and institutional visits when indicated, usually prior to hospital admission
- Telepsychiatry may be helpful in advising health care staff in remote areas
- 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
- 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.
- Establish specialist mental health consultation and liaison advisory services for health services treating older people, including RACF. These should be resourced to provide consultation, advice, liaison and professional development for specified services and catchment areas utilizing video-conferencing, telephone and face to face contact as appropriate.
- Develop and implement national principles for providing coordinated care across different services for older Australians with mental illness

Increase opportunities for continued social engagement and community participation for people with dementia

- 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.
- Removal of all barriers to older Australians in residential aged care accessing the same mental health services as the rest of the community
- Removal of all exclusions from access to mental health services on the basis of having a diagnosis of dementia

Help people with dementia and their carers to plan for their futures, including organising financial and legal affairs and preparing for longer-term or more intensive care requirements

- Better understanding and treatment of BPSD, with better education and information provided to health services and RACF staff and management , patients' families and carers

- Wherever possible, old age psychiatry and geriatric medical services should be co-located to promote ease of access and continuity of care for patients, carers and referring agencies. However, it is imperative, that old age psychiatrists maintain close professional and educational links with their colleagues in general psychiatry (Royal Australian and New Zealand College of Psychiatrists, 2010).

How best to deliver awareness and communication on dementia and dementia-related services into the community

- Fund mental health promotion activities focused upon the needs of older people and their carers.
- Investment in a national three-year anti-stigma campaign that incorporates lessons learned from the New Zealand campaign
- Investment in a national mental health literacy campaign to promote recognition of early signs of illness, the need to seek help and the value of early action.

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