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Committee Secretary
Senate Standing Committees on Community Affairs

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Dear Committee Secretary

Re: Care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD) Inquiry

My submission to this important inquiry is based upon my 30 years of clinical and research experience in assessing and managing people with dementia with a particular interest in BPSD. I am currently the Chair of the International Psychogeriatric Association (IPA) Shared Interest Group on BPSD, am a Board Member of the IPA and Past Chair of the Faculty of Psychiatry of Old Age of the Royal Australian & New Zealand College of Psychiatrists.

I was also the Chair of the Commonwealth's Psychogeriatric Care Expert Reference Group (PERG) (2008-12) that was set up to address these issues upon the recommendations of a 2008 DoHA 'Report to the Minister of Ageing on Residential Care and People with Psychogeriatric Disorders'. The PERG brought together Commonwealth and State jurisdictional representatives alongside experts from old age psychiatry, geriatric medicine, general practice, nursing and residential care service providers to report to the Australian Ministerial Conference on Ageing.

In addressing the **first Term of Reference** 'the scope and adequacy of the different models of community, residential and acute care for Australians living with dementia and BPSD', I would like to draw the Senate Committee's attention to the attached report (attachment A) from the PERG to the Ministerial Conference on Ageing from December 2010. This report includes a 'Framework for Service Planning and Care Delivery for People with Psychogeriatric Disorders'. The Framework was endorsed by the Ministerial Conference. It contains four important principles that are described in more detail in the report:

1. Integration at all levels within the broader health care system with appropriate facilities to assist older people with BPSD and/or mental health issues
2. On-going access to and utilisation of specialist clinical expertise and care
3. Appropriate assessment mechanisms and placement to ensure best 'client fit'
4. Appropriate staff levels and skills mix across the continuum of care

The Framework drew attention to the lack of appropriate facilities in Australia for younger people with BPSD. It also recommended that the Framework be considered alongside the implementation of the 4th National Mental Health Plan. This

Framework provides the starting point for improving the care of people with BPSD and other mental disorders in late life.

When the Ministerial Conference on Ageing was dis-established in 2011, the PERG no longer functioned as it lost its reporting lines and indeed its terms of reference have now expired. This was unfortunate as the PERG was commencing work on looking at the training needs for staff across all professional disciplines in Australia in assessing and managing people with dementia including those with BPSD.

I firmly believe that it is essential that there be a peak Expert Reference Group in Australia that, in a similar fashion to the PERG, has expert members across the spectrum of relevant stakeholders (old age mental health, geriatric medicine, nursing, general practice, psychology) and including Commonwealth, State and Industry representatives. Because of the complexities of mental health and behavioural issues in late life it would need to not just be restricted to dementia but also include other mental disorders. Hence it would need to straddle Ageing and Mental Health portfolios at a Commonwealth level and ideally report to the Minister of Mental Health and Ageing.

With regards to the **second Term of Reference** 'resourcing of those models of care', I would simply state that this should be a combined Commonwealth & State responsibility due to the overlap of ageing and mental health issues. An important barrier has been the difficulty in resolving the 'security of tenure' issue for those individuals with severe BPSD admitted to a facility for perhaps 6-12 months but no longer needing that type of care. Although some local solutions have been developed (e.g. including a Special Care Unit within a broader residential complex) they are not able to be generalised across the whole system. This requires a more fundamental change to what is meant by 'security of tenure' as it is essential for an efficient system to use its limited resources appropriately and effectively by transferring people to a less intense level of care when required.

In the third Term of Reference 'the scope for improving the provision of care and management of Australians living with dementia and BPSD', I will focus on the issue of chemical restraint. Firstly, it is important to realise that 'chemical restraint' really only applies to the use of drugs to control behaviour and that people being treated for serious mental illnesses such as schizophrenia and mood disorders with the same drugs should not be included in this definition.

The overuse and misuse of psychotropic medication in residential care is not a new phenomenon. Research that I undertook with Henry Brodaty in the 1990s showed that 52% of nursing home residents in eastern Sydney were regularly prescribed psychotropic drugs including 21% on antipsychotics (Draper et al, 2001). Our data also suggested that the drugs had limited effect.

I am firmly of the view that this long term overuse of psychotropic drugs in residential care is largely indicative of a combination of a number of factors – poor facility design, poorly trained staff, inadequate numbers of staff and lack of suitable activity programs for residents. The behaviours being treated by drugs are exacerbated or indeed at times caused by these issues. Psychotropic drugs are used because GPs and residential care staff can see no other solution.

I would recommend

1. That antipsychotic drug prescription in residential care be regularly audited. I do not know what an 'appropriate' level of prescription could be but I would suggest that national standards be developed in which all facilities are expected to attain in terms of the proportion of residents on the medication.
2. Antipsychotic prescription be required to be accompanied by a rationale for prescription along with a behavioural management plan
3. All antipsychotic drug prescriptions have a 3 month duration with aim to discontinue at this point unless there is strong clinical evidence upon review that ongoing usage is essential.

Of course there is an absolutely essential need to improve training across the spectrum of health professionals involved.

I trust that these opinions will assist the Standing Committee.

Yours Sincerely

Brian Draper

Cc Attachment A – Report of Psychogeriatric Care Expert Reference Group to the Ministerial Conference on Ageing, December 2010