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AMA submission to the Pharmaceutical Benefits Advisory Committee – Restricted prescription of antipsychotics in residential aged care

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Introduction

The AMA does not support the restrictions proposed by the Royal Commission into Aged Care Quality and Safety (Royal Commission) in relation to restricting the prescription of antipsychotics to geriatricians and psychiatrists. This simplistic solution to the use of chemical restraints in aged care fails to acknowledge the environmental factors that have driven the use of antipsychotics and will make access to care for patients in residential aged care facilities (RACFs) unnecessarily difficult. GPs are well qualified to prescribe these medications and it is the environment in which antipsychotics are prescribed that needs to change as opposed to the imposition of ill-considered restrictions on prescribing.

The AMA has provided significant input into the work of the Royal Commission, providing seven written submissions in total. The AMA President appeared before the Royal Commission three times.

In these submissions, the AMA has extensively elaborated on what medical practitioners, AMA members, perceive as the key issues in aged care in Australia and how they can be improved. While the AMA welcomed most of the Royal Commission's recommendations, there were also areas of disagreement on the Royal Commission's proposed way forward.

The AMA supports methods to reduce inappropriate prescribing of antipsychotics. However, the AMA is concerned that restricting antipsychotic prescriptions to geriatricians and psychiatrists will create a bottleneck of care for residents in RACFs that are not appropriately set up to deal with the consequences.

This proposal lacks an understanding of Australia's health system, particularly the current climate in aged care and mental health care. The government must implement changes to aged care that support the delivery of high-quality care and that will in turn reduce the risk of inappropriate prescribing. The AMA regards this proposal as attempting to deal with the symptoms of a broken aged care system while ignoring the causes.

The AMA's report on *putting health care back into aged care* details what must be done in this space to ensure older people have their human right to healthcare recognised in RACFs[1].

Implications of specialist geriatric and psychogeriatric access in residential aged care for psychotropic prescribing

AMA position on the use of restraints in aged care

The AMA has continuously expressed concern around the inappropriate use of chemical and physical restraints in aged care settings in submissions to the Royal Commission and other Department of Health and Parliamentary inquiries[2]. AMA members have reported on aged care staff requesting chemical restraints so older people are easier to handle, effectively using antipsychotics as chemical restraint.

It is the AMA position that restrictive practices should only be used as a last resort – where any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained. We maintain that the older person's GP, along with the aged care provider, the older person's family and substitute decision maker should be involved in any decision to use a restraint.

Workforce capacity is limited in aged care

The quality use of medicines can be impacted by the prescribing environment. It is internationally recognised that fatigue, poor working conditions, and workforce shortages are all factors increasing the risk of medication errors[3]. The most essential way to ensure the quality use of medicines in RACFs is to ensure that an appropriately qualified and experienced clinical workforce is available to respond to resident's needs in a timely manner.

Non-GP specialists

While the AMA supports and has called for greater involvement of geriatricians and psychiatrists in aged care, our members expressed concern that if this recommendation is implemented, specialist services, which are limited in aged care, will be overburdened and patients with a legitimate need for antipsychotics and non-GP specialist services will suffer as a result.

The AMA called on the Royal Commission to investigate the small numbers of specialist geriatricians and psychiatrists who provide services in aged care, seeking to address this issue so that they can better support GPs. The Department of Health should carry out an audit on geriatricians and psychiatrists available to visit RACFs and a regulatory impact statement should be carried out before this proposal is seriously considered. Access to geriatricians and psychiatrists can be difficult even in metropolitan areas for the general population. Access is particularly difficult for older people in aged care due to limited numbers of private specialists

[1] Australian Medical Association (2021) *Putting health care back into aged care.*
[2] Australian Medical Association (2019) *Submission to the Royal Commission into Aged Care Quality and Safety*
[3] World Health Organization (2017) *WHO Global Patient Safety Challenge: medication without harm.*

who visit RACFs and the small pool of these specialists available in the public hospital system. In Canberra for example, there are only two full time employed psychiatrists in the public system who specialise in working with older patients, who cover both residential aged care and community[4]. The population of over 65s in Canberra is around 50,000 people[5], with over 2000 older people in residential aged care[6].

Importantly, limiting prescribing to geriatricians and psychiatrists will severely impact health services in rural and remote areas, where we know there is a critical need for doctors in a range of specialities, including geriatrics[7]. Restricting prescribing in a manner that is simplistic will have detrimental effect to patients in rural and remote areas where there may be a genuine need for these medications, in order to ensure their safety and the safety of those around them.

Other medical specialists, including but not limited to geriatricians, psycho-geriatricians and psychiatrists work together with GPs to ensure continuity of care for older people. Specialist services should work in close consultation with the GP and residential aged care staff directly responsible for the older person's care and particularly if significant changes to care are recommended. Existing outreach services work on the model of care that requires the GP to be the primary and sole prescriber in aged care. For example, the AMA is aware that Queensland Health and NSW Health operate outreach geriatric services to RACFs, that provides support to GPs by facilitating geriatric reviews of the patients[8,9]. The reviews are initiated by GPs, who can also reach out to the service to ask for advice on specific issues. These are examples of good practice, that should be encouraged and expanded, as they provide collaborative and coordinated care without undermining the role of primary medical specialists in the care of older people – their GPs. The capacity of outreach services currently varies considerably across the country.

Furthermore, the AMA calls for improved funding for non-GP specialist services in aged care, through increased MBS rebates for geriatricians and psychiatrists, including through devising separate MBS items for case conferencing with GPs.

General Practitioners

GPs are suitably qualified to prescribe antipsychotics in line with clinical guidelines[10]. GPs are the primary medical specialists for the care of older people, and as such should be better supported to provide medical care in aged care. However, with its final recommendation the Royal Commission went to the extreme, diminishing the role of GPs in caring for their patients in aged care. Taking the prescribing rights from GPs risks further deterring these key medical specialists from working in aged care, when we know that the numbers of those willing to continue to care for their patients once they enter aged care have been dropping for years[11]. It will also inevitably

[4] Based on the information received from AMA members in Canberra
[5] Australian Bureau of Statistics (2016) *Population by Age and Sex, Regions of Australia, 2015 - Canberra.*
[6] Productivity Commission (2020) *Report on Government Services – Aged Care Services* Table 14.A13
[7] Rural Doctors Association Australia (2019) *Submission to the Royal Commission Into Aged Care Quality and Safety*
[8] Queensland Government (2019) *Radar Prince Charles*
[9] New South Wales Government, Agency for Clinical Innovation (2021) *Spotlight on virtual care: Geriatric Medicine Outreach Service*
[10] Royal Australian College of General Practitioners (2019) *RACGP aged care clinical guide (silver book) 5th edition.*
[11] Australian Medical Association (2017) *AMA Aged Care Survey*

lead to the deskilling of GPs in the prescribing and use of antipsychotic medication for their older patients[12].

It is internationally recognised that GPs are the cornerstone of a successful primary healthcare system, and countries with a strong general practice have better health outcomes[13]. The patient-centred medical home model (PCMHM) is a well-regarded system of integrated care that is more efficient, reduces hospital admissions and provides better support for patients[14,15]. GPs must be appropriately supported to continue to care for their patients once they enter a RACF. Continuity of care is crucial to improving health outcomes. For example, residents with dementia who had to change their GP once entering a RACF has been associated with an increase in polypharmacy and prescribing medicines such as antipsychotics, benzodiazepines, and antidepressants[16].

GPs know their patients in aged care and are best informed to decide when prescribing of certain medication is warranted. Visiting geriatricians and psychiatrists lack that connection with the patient that the GP has. This is a position universally expressed by AMA geriatrician and psychiatrist members. For situations where GP transfer is unavoidable, support for full clinical handovers and medication reviews are needed.

The AMA also calls for the establishment of a federally funded Liaison Officers coordinating primary care within RACFs. The AMA is aware that the Government accepted the Royal Commission's recommendation for improvement of access to primary care in aged care by providing "additional funding for the Primary Health Networks to expand access to palliative care services, support best practice on-site care and accessible telehealth care in residential aged care facilities, and enhanced out-of-hours support"[17]. The AMA sees the Liaison Officers linked to (or employed by) Primary Health Networks, with their tasks including those listed in the Government's response and expanded to include supporting clinical pathways, system development for care in place, education, policy development, support for GPs and registered nurses, review of clinical care issues, including support to medication auditing.

Aged care staff and allied health professionals

The most effective way to manage Behavioural and Psychological Symptoms of Dementia (BPSD) is with sufficient skilled staff. Access to well-trained and experienced aged care staff and allied health professionals are crucial to ensuring effective quality use of medicines by enabling preventative care and other non-pharmaceutical strategies for patients who would otherwise require antipsychotics. For example, AMA members report the importance of adequate measuring and documentation of BPSD before, during, and after the use of antipsychotics by a

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[12] JCL Looi et al (2021) *Psychiatric care implications of the Aged Care Royal Commission: Putting the cart before the horse*, Australian and New Zealand Journal of Psychiatry 1-3
[13] The World Health Organisation (2008) *The World Health Report 2008 - primary Health Care (Now More Than Ever).*
[14] NSW Government (2021) *Navigating the health care neighbourhood – What is the patient centred medical home model?*
[15] NSW Government (2021) *Navigating the health care neighbourhood – benefits for health professionals.*
[16] Welberry et al (2021) *Psychotropic medicine prescribing and polypharmacy for people with dementia entering residential aged care: the influence of changing general practitioners.*
[17] Department of Health (2021) *Government response to the final report of the Royal Commission into Aged Care Quality and Safety.*

registered nurse as crucial to appropriate prescribing. Despite this, access is limited. RACFs need registered nurses available on-site 24/7 under minimum staff to resident ratios that reflect the needs of residents. Aged care staff, including personal care attendants and nurses, must have access to dementia management and behavioural training.

Better access to allied health services in RACFs is one strategy that could lead to reduced prescribing. Allied health professionals trained in behaviour support can help to avoid reliance on restraints for residents who are diagnosed with dementia[18]. Person-centred care provided by allied health professionals such as psychologists and occupational therapists to people living with dementia has proven to reduce use of antipsychotic drugs in aged care[19].

The AMA has continuously argued for the need for mandated staff to resident ratios in RACFs, mandated presence of registered nurses in aged care 24/7 and increased involvement of allied health professionals. These are, in the AMA view, key strategies to reduce reliance on antipsychotic medication in aged care. Limiting prescribing to a small group of specialists will not resolve this issue.

Clinical governance in aged care

Appropriate clinical governance in RACFs ensure that the older person's clinical needs are met, including adequate use of medication. RACFs are expected to have "appropriate governance structures, including committee and reporting structures to effectively monitor and improve clinical quality and safety"[20].

However, currently there is no link between clinical governance in aged care and medication management. The current Aged Care Quality Standards – Standard 8 Organisational Governance[21] does not include medication management as a requirement for RACFs to prove they implement effective clinical governance standards.

In its Final Report the Royal Commission proposed that the Aged Care Quality Standards be urgently reviewed and amended to ensure "best practice oral care, medication management, pressure injury prevention, wound management, continence care, falls prevention, and infection control, and providing sufficient detail on what these requirements involve and how they are achieved" and "implementing the new governance standard" (recommendation 19)[22]. The AMA is supportive of this recommendation and sees it as a crucial step forward to ensuring appropriate use of medication in aged care, including antipsychotic medication.

Clinical Governance Committees in RACFs should include representation of registered health practitioners, including medical practitioners, pharmacists, and registered nurses. The resident's

[18] Allied Health Professionals Australia (2019) *Submission to the Royal Commission into Aged Care Quality and Safety*

[19] GJ Andrews (2006) *Managing challenging behaviour in dementia - A person centred approach may reduce the use of physical and chemical restraints*

[20] Aged Care Quality and Safety Commission (2019) Clinical Governance in Aged Care *Fact Sheet 3: Core elements of clinical governance*

[21] Aged Care Quality and Safety Commission (2021) *Standard 8: organisational governance.*

[22] Department of Health (2021) *Government response to the final report of the Royal Commission into Aged Care Quality and Safety*.

usual GP is also a valuable source of advice for medication management and clinical governance.

Auditing and education for antipsychotics

Rather than introducing a 'blanket restriction' on GPs regarding prescribing antipsychotics, the AMA calls for alternative solutions to reducing prescribing, such as regular audits on prescribing/de-prescribing rates in aged care. The AMA envisages such audits to address all other strategies applied by the aged care providers to reduce the distress in the older person before prescribing of antipsychotics is required, reasons why those strategies failed, how long the older person was kept on antipsychotic medication and why. This type of auditing will require an adequate number of appropriately skilled staff available in RACFs at all times, including to document behaviours before and after the use of antipsychotic medication, specifically: the type and magnitude of the behaviour before the treatment, goal of treatment, whether the goal was achieved, etc. This type of auditing also provides an educative experience to aged care staff, clinical governance committees and prescribers on how to improve their services.

The Department of Health should also work with medical colleges to consider strategies for increasing GP education and awareness around antipsychotic prescribing as a more practical alternative to restricting their prescribing rights.

Non-pharmacological options

Non-pharmacological management plans are also crucial to preventing the need for antipsychotics and RACFs must be supported and trained to enable this. For example, reducing distressing noises or lighting and ensuring that the resident's rooms are comfortable and sensory aids are provided[23].

Medication reviews

Medication reviews are important safety mechanisms to reduce the use of unnecessary medications. They are available to older people living in residential aged care (Residential Medication Management Reviews, RMMRs) and to patients in their home (Home Medicines Reviews, HMRs). A study conducted in 2021 showed that MBS claims for RMMRs are lodged for only a small number of residents who enter residential care, even though the program has significant potential for identifying and resolving medication-related problems in aged care facilities[24].

The AMA has called for medication reviews to occur annually, and then on an as-needed basis to ensure medications are appropriate for older people. Pharmacists who work with doctors have an important role in assisting with medication adherence; improving medication management; and providing education about medication safety. The AMA welcomed the Government's

[23] Royal Australian College of General Practitioners (2019) *RACGP aged care clinical guide (silver book) 5th edition.*
[24] K Sluggett et al (2021) *Residential medication management reviews in Australian residential aged care facilities*, *Medical Journal of Australia*

announcement following the Royal Commission's interim report[25], introducing up to two follow up reviews for both residential medication management reviews and home medicines reviews. The AMA is also aware that the 7th Community Pharmacy Agreement includes funding for Residential Medication Management Reviews[26]. The AMA supports any framework that allows for medication reviews to happen routinely for all recipients of aged care services (as above) that can be initiated by either the GP, the aged care provider or the pharmacist.

The scope of antipsychotic medicines that should be considered

The Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine, Royal Australian and New Zealand College of Psychiatrists and the Australian and New Zealand Society for Geriatric Medicine are best placed to comment on the scope of antipsychotic medicines that should be considered should this proposal proceed. The AMA also encourages PBAC to consult the Aged Care Clinical Advisory Committee (Department of Health) that was working on advice around restraints in the context of the amendments to the Aged Care Act, resulting from the recommendations by the Royal Commission[27].

While non-pharmacological measures should be considered before the use of antipsychotics, which have a limited role in managing behaviour, the AMA notes that some patients still have a legitimate need for them[28]. The prescribing intent is important, as the aim of antipsychotics is not always to restrain. Antipsychotics are used for diagnosed physical or mental health conditions, most commonly for patients with behavioural and psychological symptoms of dementia such as agitation, physical aggression, paranoia, delusions and hallucinations[29]. If the RACF is not adequately set up to foster non-pharmacological strategies and patient symptoms are not managed, patients may pose a serious risk to themselves, other residents, and staff.

There is also a risk that if the patient legitimately requires antipsychotics but cannot get access to a specialist in time, private prescriptions may increase, which increases the cost for the patient. Antipsychotics are preferable to other pharmacological options that may be considered instead.

Doctors must be able to maintain clinical independence in order to make the best treatment recommendations for patients, based on current evidence, preserving their own clinical judgments regarding treatment recommendations.

Any unintended consequences should amendments to the PBS listings for antipsychotics be made according to recommendation 65

See above.

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[25] Prime Minister of Australia (2019) *Response to Aged Care Royal Commission Interim Report*
[26] Department of Health (2020) *7th Community Pharmacy Agreement*
[27] Australian Government (2021) *Aged care and other legislation amendment (Royal Commission Response no 1) Bill 2021*
[28] Royal Australian College of General Practitioners (2019) *RACGP aged care clinical guide (silver book) 5th edition.*
[29] Royal Australian College of General Practitioners (2019) *RACGP aged care clinical guide (silver book) 5th edition.*

Conclusion

The AMA does not support the proposed restriction of prescribing of antipsychotics in aged care to geriatricians and psychiatrists as recommended by the Royal Commission. The AMA believes there is a whole spectrum of other strategies that should be implemented before any prescribing is restricted to a small group of specialists. Those strategies include staff to resident ratios, registered nurse presence in RACFs 24/7, improved access to allied health professionals and better integration of aged care with healthcare in general, primarily through ensuring that greater numbers of GPs work in aged care and that GPs continue to care for their patients after they enter aged care, guaranteeing continuity of care. GP education modules and RACF auditing of antipsychotic use should also be explored.

Before this proposal is considered further, the Department must carry out an audit of the available geriatricians and psychiatrists to carry out this work and regulatory impact statement should be developed.

The AMA also calls for more research in this area to ensure evidence-based policy making in aged care. AMA members note that there is minimal research and available information to describe the effects of use of antipsychotic medication in RACFs. For example, there is some research that indicates that antipsychotic medication can decrease lifespan for older people, but very little detailed research on why antipsychotic medication is used older people with broad spectrum of diagnoses.

Finally, the AMA argues that the Government relied heavily on medical information when dealing with Covid-19. It should be no different when it comes to treatment with antipsychotic medication in aged care. In this case the unanimous medical advice from AMA members, Geriatricians, Psychiatrists and GPs is that restriction of antipsychotic prescribing to small group of specialists should not go ahead. Instead of implementing this change, the Government should invest more resources into clinical research on antipsychotic prescribing to better inform evidence-based policy making.

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