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FURTHER RESTRICTIONS OF ANTIPSYCHOTICS IN RESIDENTIAL AGED CARE

Policy changes may be hit-and-miss.

There is no one panacea for optimising treatment of Behavioural and Psychological Symptoms of Dementia (BPSD) in Australian aged care. New policies must be clinically relevant in terms of each medicine or class, the realities of prescribing in aged care, individual diagnoses, and existing industry standards.

In response to public reports and research findings of overuse of antipsychotics in residential aged care and the associated harms, the Aged Care Royal Commission advocated for further restrictions on prescribing antipsychotics in aged care to treat BPSD.

In its 65th recommendation, the Royal Commission suggested a specialist-restrictive model similar to that used for prescribing of antipsychotics for children with autism, to ensure that a specialist reviews people in residential aged care before antipsychotic medicines are prescribed (1).

In its response, the Government agreed in principle to this recommendation and referred the matter to the Pharmaceutical Benefits Advisory Committee for consideration (2).

Is this good policy?

Prima Facie this step seems reasonable as the policy implies improved appropriateness of prescribing through specialist knowledge and collaboration with primary care prescribers.

However, in Australia and the US, policies that restrict access to medicines have shown mixed outcomes, and there is no evidence that restriction of antipsychotic prescribing to specialists will improve collaborative care and outcomes for residents (3-7).

In addition, a one-year timeframe for exposure seems generous without requiring regular review for effectiveness and safety. The Royal Australian College of General Practitioners recommends three-monthly reviews for opportunities to deprescribe (8).

Insufficient specialists

Management of BPSD is a constant challenge for carers, which requires flexible access to medical practitioners and in many cases, immediate access.

In 2017, there were approximately 800 geriatricians (400-560 FTE) in Australia, which fell short of the 925 FTE required to meet service requirements with significant shortfalls predicted for regional areas (9).

There are approximately 180,000 Australians living in aged care of which 50 per cent have a diagnosis of dementia (10). At some point in the disease course, people with dementia will have at least one experience of BPSD (11). These data suggest that there will be challenges with accessing a suitable specialist to initiate medication in a timely manner.

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Research has shown barriers to optimising prescribing in Australian aged care include the following, which will not be solved with proposed policy changes (6, 7, 12):

- Lack of support for GPs to make medication changes especially if the initial prescription was written by another prescriber and/or specialist.
- Pressure for GPs to switch to alternative medicines or prescribe 'off-label' (use without an approved diagnosis) due to multiple competing interests from aged care staff, families and prescribing restrictions.

Alternative approaches

The process of introducing new policies must consider the intended and unintended consequences of each policy and how policies and aged care regulations interplay. Restricting prescribing of risperidone to specialists risks delaying care and further promotion of off-label prescribing.

Other approaches include:

- Permit GPs to initiate four weeks of risperidone on the PBS to maintain timely access to care.
- Consider specialist prescription for treatment longer than four weeks after specialist and GP review with a treatment plan. A written care plan for the proceeding three months should be provided to the aged care provider. This should be recorded in the resident's case notes and the aged care home psychotropic register.
- Have an accredited clinical pharmacist undertake a medication review within four weeks from initiation with a report to both the initiating GP and specialist involved in the resident's treatment. This timeframe is sufficient to determine efficacy and safety of the medicine and inform ongoing treatment. The current medication management programs will permit two clinical pharmacist follow-up reviews to track progress over nine months.
- If medication is intended to continue after three months of initiation, conduct a case conference including an aged care representative, family member (where possible), the GP, specialist, and accredited clinical pharmacist to plan management for the next six to nine months.

Future considerations for optimising treatment of BPSD in aged care

More must be done to address the prescribing issues in aged care which lead to high use of antipsychotics. We suggest the following be considered.

- There is no financial barrier to using antipsychotics via private scripts. The private costs of risperidone and quetiapine are similar to the PBS concessional costs.
- While Alzheimer's type dementia is the most common in Australian aged care, vascular dementia and mixed-dementia are also prevalent. There are currently no medications funded on the PBS for treatment of BPSD in these types of dementia.
- Regardless of the pharmacological choice, all medicines used for BPSD should be subject to the same clinical review process as advised by the Royal Commission.

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