RURAL DOCTORS ASSOCIATION OF AUSTRALIA

Submission to the Pharmaceutical Benefits Advisory Committee

Royal Commission into Aged Care Quality and Safety
Recommendation 65: Restricted prescription of antipsychotics in residential aged care

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About RDAA

The Rural Doctors Association of Australia (RDAA) is the peak national body representing the interests of doctors working in rural and remote areas and the patients and communities they serve.

RDAA's vision for rural[1] and remote communities is simple – excellent medical care. This means high quality health services that are: patient-centred; continuous; comprehensive; collaborative; coordinated; cohesive; and accessible, and are provided by doctors and other health professionals who have the necessary training and skills to meet the needs of their communities

Introduction

RDAA thanks the Pharmaceutical Benefits Advisory Committee (PBAC) for the opportunity to provide input into its consideration of the Royal Commission into Aged Care Quality and Safety (the Commission) *Recommendation 65: Restricted prescription of antipsychotics in residential aged care* (the Recommendation) that states:

By 1 November 2021, the Australian Government should amend the Pharmaceutical Benefits Scheme Schedule so that:

a. *only a psychiatrist or a geriatrician can initially prescribe antipsychotics as a pharmaceutical benefit for people receiving residential aged care, and*
b. *for those people who have received such an initial prescription from a psychiatrist or a geriatrician, general practitioners can issue repeat prescriptions of antipsychotics as a pharmaceutical benefit for up to a year after the date of the initial prescription.*

RDAA has been made aware of members' significant concerns with regard to the appropriateness and implementation of the Recommendation in rural areas. In light of these concerns, RDAA, as the only medical peak body focused on rural doctors and the communities they serve, requests an urgent meeting with representatives of PBAC to discuss these concerns. We suggest that representatives from the Australian College of Rural and Remote Medicine (ACRRM) also be invited to attend.

[1] Within this document the term 'rural' is used to encompass locations described by Modified Monash Model (MMM) levels 3-7. Rural doctors are rural GPs, Rural Generalists and consultant specialists (resident and visiting) who provide ongoing medical services in these areas.

Summary of Recommendations

If the Recommendation is enacted specific strategies to mitigate inequitable access to psychiatric and geriatric services and other rural Residential Aged Care (RAC) issues will be required as a matter of urgency, with evidence of how rural patient care will be delivered to support positive patient outcomes and access. Strategies will need to take into account the specific context and workforce availability in rural areas, and provide improved timeliness and access. Given the current recommendations, it is unclear whether an implementation plan has been developed.

RDAA recommends that the PBAC:

- Recognise and redress access to psychiatric and geriatric services issues in rural areas by
    - making improved access to psychiatric and geriatric services in rural areas a clear priority, and
    - clearly demonstrating this access prior to changing requirements.
- Undertake a full consultation process with rural RAC clinicians to understand both jurisdictional and rurality differences and identify which drugs should be listed as within scope.
- Develop a clear and transparent implementation plan that outlines how recommendations will be actualised and how improved patient care will be measured.
- Authorise rural GPs and Rural Generalists with demonstrable experience in RAC or with advanced skill qualifications in psychiatry to initiate antipsychotic medication.
- Develop processes and protocols to
    - facilitate psychiatrist or geriatrician approval of initial antipsychotic prescribing by a rural GP or Rural Generalist, and
    - enable timely emergency prescription of antipsychotic medication by rural GPs and Rural Generalists.
- Develop appropriate safeguards for rural GP and Rural Generalist prescribing of antipsychotic drugs.
- Develop mechanisms to support consistent interpretation and implementation of the Recommendation, including guidelines (and education) specifically for RAC providers, management and nurses in these facilities on antipsychotic drugs and prescription for reasons other than chemical restraint.

Background

RDAA makes the following comments to provide some context for its feedback to the PBAC.

While the Australian Government has only accepted the Recommendation in-principle, implementation appears to have been uncontrolled.

- Insufficient consultation has been undertaken with General Practitioners (GPs) and Rural Generalists providing services in RAC facilities (RACFs) and stakeholder organisations, including with the representatives from the GP colleges and the Australian Medical Association on the Department of Health Aged Care Clinical Advisory Committee (ACCAC). RDAA understands that this committee has recently met for the first time after a gap of many months.
- Significant changes have already been introduced by some RACFs in expectation of amendments to the Pharmaceutical Benefits Scheme schedule regulations being finalised by 1 November 2021 that are having a detrimental effect on the care of patients in rural areas. These anticipative requirements are not patient-centred. They potentially undermine the quality of care for patients in rural RACFs. Although the rapidity of the process may have been well-intentioned, the outcome is unworkable in rural areas

Patient-centred health care should be the first principle for any policy and for any subsequent legislative and regulatory change and should underpin implementation. Adequate consideration has not been given to what this means for rural people and to possible unintended consequences that may occur.

The Recommendation is open to interpretation, particularly in relation to what drugs are considered to be “antipsychotics” and what will be required to demonstrate compliance. Requirements governing GPs and Rural Generalists providing services in RACFs are being developed and implemented that are impracticable, and must be reconsidered to ensure that patients in rural RACFs are able to receive the care that they need when they need it.

A full consultation and comprehensive implementation plan, including guidelines for RACFs and a mechanism for the evaluation of impacts, should have been undertaken before any changes were introduced.

Recommendation:

Develop a clear and transparent implementation plan that outlines how recommendations will be actualised and how improved patient care will be measured.

Response to issues

Concerns raised with RDAA include: psychiatry and geriatric workforce shortages and other rural access issues; the risks to patients if they do not receive the intended treatment in a timely manner; the implied criticism of rural GP/Rural Generalist care (some GPs/Rural Generalists have been made to feel that their prescribing actions are deliberately not in the best interests of their patients); the overwhelming and inflexible administrative requirements; and the legal implications when doctors are asked to sign off on drugs listed as chemical restraint drugs even when they are not being used for that purpose.

These issues have implications for future actions and are described more fully in the RDAA's response to the PBAC's identified issues below.

Access

There is concern that the widely acknowledged access inequities between rural and urban communities will result in an imbalanced system that is disadvantageous to people in rural RACFs and the primary care doctors who treat them.

If these prescribing restrictions are introduced, there must be caveats to ensure workability in rural areas where there is significantly less access to all specialist and subspecialist care (including for geriatric and psychogeriatric care) than there is in urban centres.

Restricting the initial prescription of antipsychotic medicines to psychiatrists and geriatricians means that GPs cannot initiate the use of antipsychotic medicines for their patients in RACFs. This will result in greater demand for specialist psychiatric and geriatric services that are already in extremely short supply in rural areas. Patients needing these drugs may be waiting for some time for an appointment before such medication can be prescribed and may experience worsening symptoms, including potentially serious physical and psychological distress, as a result.

If a visiting psychiatrist or geriatrician appointment can be obtained in rural areas, the time impost and cost to patients can be considerable. Many of these specialists require that patients have standard barrage of blood and urine tests, and sometimes a CT brain scan as well, before seeing them. They also frequently charge considerable out-of-pocket fees.

Referral pathways in rural areas can be problematic. Travel for the aged patient cohort can be difficult, creating physical and mental stresses that can heighten symptoms. Sending patients in an ambulance to a local rural hospital if they are experiencing a psychotic episode (or a range of other psychogeriatric symptoms) puts the patient, doctors and other health professionals, including attending paramedics, at risk of physical harm and emotional distress. Even if there is an on-call psychiatrist or geriatrician at that hospital, transferring these patients would be not be reasonable, practical, nor in the best interests of patients.

Where there is a lack of access to specialist care telehealth has a more prominent role, but increased demand could overwhelm existing services. Access to telehealth appointments may not be possible within an acceptable time frame. Also, telehealth should always be complementary to face-to-face care, never used as a substitute, and may be less appropriate for the aged patient cohort who are likely to have multiple conditions and complex drug regimens.

While members acknowledge that unnecessary use of behaviour management drugs can be cause for concern, this Recommendation does not address the drivers of the problem. Suggested non-pharmaceutical measures for dementia behaviour management are not possible in many rural sites due to staffing shortages. Many of the non-drug treatments require one-on-one diversional therapy, which requires many hours of an individual's time. Unlike metropolitan RACFs, most rural RACFs have no capacity to provide access to diversionary therapists (they struggle to staff basic nursing and care rosters) and diversional therapy cannot he done via telehealth. If the prescribing restrictions on rural GPs and Rural Generalists is introduced as is, significant investment in appropriate staffing ratios in rural RACFs and increased access to diversional therapists will be necessary to support residents in these facilities.

Models of care which are team-based, align specialist care with local GP or Rural Generalist care, and allow the on-site clinician to make decisions about initiating or changing medications when needed, are necessary in rural areas for continuity of care and for telehealth to be optimal.

Lack of access also means that there is a shortage of available specialists at critical times. RAC is a 24-hour proposition. Even where an existing specialist geriatric or psychiatric service has been established, connecting with a specialist using telehealth channels can be more difficult if, for example, the patient is experiencing a psychotic episode during unsociable hours.

Delayed use of antipsychotics for patients experiencing intense paranoia, hallucinations, or severe agitation among other symptoms due to bureaucratic requirements could result in a marked increase in patient distress and suffering, and physical danger for all residents, staff, and visitors within RACFs. Such severe symptoms may require emergency initiation of antipsychotic medication be initiated to alleviate patient distress, and prevent the unnecessary transportation to acute care or more secure facilities.

Emergency initial prescription by rural GPs or Rural Generalists may be necessary in some instances and should be governed by appropriate safeguards.

Recommendation:

Recognise and redress access to psychiatric and geriatric services issues in rural areas by making improved access to psychiatric and geriatric services in rural areas a clear priority, and clearly demonstrating this access prior to changing requirements.

Scope of antipsychotic medications

A significant proportion of residents in RACFs will experience psychotic symptoms as part of their ageing or dementia progression that may need to be managed with antipsychotics. It must also be recognised that these drugs may be prescribed for other reasons (such as the management of breathlessness in palliative care). Any proposed listing of drugs must also be accompanied by clear guidelines to ensure that the interpretations are consistent with the intent of the regulation.

RDAA understands that the GP representatives on the ACCAC advised that if anti-psychotics were prescribed for behavioural reasons, then there should be a review

after three months by which time the drug may or may not be continued, depending on the patient's progress. This advice was not sought as part of the prescribing restriction initiative but is pertinent.

This Recommendation has given rise to requirements based on whether or not a medication is on a list of drugs identified as "antipsychotics". Once drugs are on this list, the requirements are inflexible generating a significant administrative burden. Concerns have also been raised about possible medicolegal implications if a medication that is listed as an "antipsychotic" is being prescribed for the management of symptoms that are not related to behaviour management (for example, palliative symptoms). What is needed is a common sense approach that recognises that drugs are multi-purpose and this should be made explicit in the guidelines. There have been some reports that RACF management and nursing staff have been intractable with respect to administrative requirements due to a lack of understanding about drug function. Reason for prescription must be the trigger for reporting and compliance mechanisms to be enacted. If the reason for prescription is not to manage behavioural problems there should be no further action.

It also appears that, in some RACFs, the list of antipsychotics has morphed beyond what these GP advisors recommended to incorporate a range of other medications, including anti-depressants and anti-nausea drugs. Doctors are being asked to complete and sign paperwork for a range of drugs that are not being used for behaviour management.

It is inappropriate for antidepressant medications to be considered as "chemical restraints" for dementia behaviours. In the broader community, many people are prescribed antidepressants for management of their mental health conditions who *would be alarmed to hear that these medications were described as "chemical restraints" and would be very reluctant to take them if they discovered this description of their prescribed medication. If antidepressants are not considered "chemical restraints" in the community, they should not be considered "chemical restraints" in RACFs.*

RDAA has not undertaken a full consultation process to identify which drugs should be listed as within scope. Further consultation with rural GPs and Rural Generalists is necessary.

Recommendation:

Undertake a full consultation process with rural RAC clinicians to understand both jurisdictional and rurality differences and identify which drugs should be listed as within scope.

Unintended consequences

RAC providers' interpretation of the Recommendation has also led to the following:

- A number of RACFs now require extensive paperwork to be completed for conditions where it is inappropriate for doctors to do so. Behavioural problems are very often a phase of dementia that may also include psychiatric diagnoses such as depression and anxiety in some of these patients. The intent of the Recommendation does not extend into the management of non-psychotic illnesses, nor into the palliative care realm. Hence, it will be important to

distinguish specific diagnoses or conditions that Recommendation 65 is designed to address in order to assist in managing the excessive demands of some RACFs.

- For example, in some places if a specific drug is labelled a behavioural management drug under service rules, any time it is prescribed it must be accompanied by a behavioural management plan. Medications used for Behavioural and Psychological Symptoms of Dementia (BPSD) may also be used for other conditions. In this latter case, prescribers should not be required to complete the reporting and compliance paperwork necessary for BPSD medications.
- In some RACFs, requirements are above and beyond what is necessary in order to cover themselves and to simplify rules for the treating staff. The lack of Registered Nurses in RACFs means that there are fewer staff with the requisite knowledge and understanding of medications (and their varied clinical uses) to make informed decisions about bureaucratic processes. Clinicians are met with responses such as “We can’t have something that is used for different reasons” if the drug is listed as a behavioural management drug.

Recommendation:

Develop mechanisms to support consistent interpretation and implementation of the Recommendation, including guidelines (and education) specifically for RAC providers, management and nurses in these facilities on antipsychotic drugs and prescription for reasons other than chemical restraint.

There has been a significant reaction to the implied criticism of the motivations and prescribing behaviours of GPs and Rural Generalists providing services in RACFs. While acknowledging that they face pressure to prescribe from RACF staff, members noted that many GPs and Rural Generalists have worked effectively in rural RACFs for many years. These doctors have long and trusted relationships with patients and their families and are more than capable of using a full range of medications successfully and appropriately.

If the restrictions to GP and Rural Generalist prescribing are enacted there is a risk that they will become de-skilled and no longer provide services in RACFs. Some have suggested that this, together with the increased red tape, will accelerate the movement of these professionals out of service provision in RACFs. There is already a serious shortage of GPs willing to attend RACFs. With the rapidly ageing population in Australia, such shortages are becoming critical. It is vital to work collaboratively and respectfully with GPs and Rural Generalists to retain their essential skills and services in the aged care sector.

Restrictions on GP prescribing without significantly increasing access to specialist care is likely to lead to unnecessary referrals to already stretched hospital emergency departments (and unnecessary patient transport). Rather than banning rural GPs and Rural Generalists from initially prescribing antipsychotics for people in RACFs entirely, a range of safeguards could be instituted to prevent any clinically unnecessary use of drugs for behaviour management purposes.

These could include:

- Processes and protocols to enable psychiatrist or geriatrician approval of initial antipsychotic prescribing by a rural GP or Rural Generalist.
- Protocols to govern emergency prescription of antipsychotic medication by rural GPs and Rural Generalists.
- Establishment of a three-month review protocol following the prescription of antipsychotics specifically for behaviour management reasons to decide whether the drug regimen should be continued.
- A Case Conference for a resident with the RACF staff (and a family member of the resident wherever possible) within three months of a GP initiating antipsychotics.
- A Residential Medication Review involving a pharmacist within six to twelve months of a GP initiating antipsychotics for a resident.
- Continuation of the usual three-monthly review of medications used for Behavioural and Psychological Symptoms of Dementia (BPSD).
- A specific training program with Continuing Professional Development requirements to prescribe (like for medical termination of pregnancy) that is designed by rural GPs and Rural Generalist experienced in RACF care with geriatric and psychiatric input, and supported by an online portal that monitors prescribing (like Safe Script) would also provide an avenue to rural GPs and Rural Generalists to prescribe. This could be time limited before a mandatory review by a geriatrician or psychiatrist. This would also allow time for appointments (including via telehealth) and, where possible, other therapies to be arranged.

Recommendations:

Develop processes and protocols to facilitate psychiatrist or geriatrician approval of initial antipsychotic prescribing by a rural GP or Rural Generalist and enable timely emergency prescription of antipsychotic medication by rural GPs and Rural Generalists.

Develop appropriate safeguards for rural GP and Rural Generalist prescribing of antipsychotic drugs.

Other issues

The impact of the Recommendation on paperwork and administrative burden is immense, and includes filling in of multi-page documents, meeting expectations about consultations with family members and others, getting permissions for drugs that are not being used for chemical restraint and other onerous bureaucratic processes. This work is usually not remunerated appropriately.

Rural doctors are concerned that if they do not complete paperwork there is a risk that the patient does not get the intended treatment but their legal obligations prevent them from stating an incorrect reason for prescription: *Being asked for the purpose for prescription to be changed is worrisome. It [requirements] is an error that must be fixed not compounded – it's illegal for a doctor to write the wrong reason for a prescription.*

There is also a lack of clarity in the recommendation with respect to Rural Generalists with advanced skill in psychiatry. Will these doctors be exempt from the blanket rule that *only a psychiatrist or a geriatrician initially prescribe antipsychotics as a pharmaceutical benefit for people receiving residential aged care* given their skill and experience?

Recommendation:

Authorise rural GPs and Rural Generalists with demonstrable experience in RAC or with advanced skill qualifications in psychiatry to initiate antipsychotic medication.

The enactment of this Recommendation poses significant risks of emotional distress and physical harm to residents, visitors, doctors, nurses and other RACF facility staff alike that must be considered going forward.

Conclusion

The Royal Commission into Aged Care Quality and Safety (the Commission) *Recommendation 65: Restricted prescription of antipsychotics in residential aged care* (the Recommendation) will lead to negative health outcomes for people if rural RACFs without precautionary measures being developed and implemented to mitigate inequities.

RDAA strongly advises that the PBAC conduct further consultations with rural GP and RACF stakeholders to begin this process.