A CASE FOR NATIONAL CLINICAL PRACTICE GUIDELINES FOR DEMENTIA IN AUSTRALIA

DEMENTIA

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Dementia is a National Health Priority.

- ***Dementia is the second leading cause of death and fourth leading cause of burden of disease. (ABS 2015; AIHW 2012)***

Small audits reveal room for improvement:

- ***Legal matters (driving, EPOA or EPOG, will) discussed with patient or family in less than half of cases. (Speechly)***
- ***Management plan for BPSD in place for fewer than half of cases. (Speechly)***
- ***Frequent use of antidepressants (36%), antipsychotics (33%), daytime anxiolytics (11%) and hypnotics (10%) in nursing homes. (O'Connor 2010)***
- ***International studies reveal lengthy gaps between onset of symptoms and diagnosis (approx 1-3 years). (Cattel 2000)***

CLINICAL PRACTICE GUIDELINES FOR DEMENTIA IN AUSTRALIA

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Australia does not have NHMRC approved guidelines for dementia.

<u>Existing Australian Guidelines</u>

- ***State based guidelines (eg NSW).***
- ***Guidelines for GPs (being updated).***
- ***Guidelines for particular groups (Aboriginal people in remote communities, community dwelling people with dementia (2008)).***

<u>International Guidelines</u>

- ***NICE (2006).***
- ***Scottish Guidelines (2006).***
- ***European (2010 and 2012).***

- ***Could having an available guideline improve care ?***

DEVELOPMENT OF GUIDELINES FOR AUSTRALIA

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- ***Funding via NHMRC Partnership Centre for Cognitive Decline.***
- ***ADAPTE methodology.***
- ***NICE Guidelines (2006) identified as being the most appropriate for adaptation.***
- ***An update of the evidence 2006-2014 was required.***
- ***NICE addresses 29 key questions. The Committee prioritised 17 for systematic review.***
- ***Guidelines developed in accord with the 2011 NHMRC Standards for Clinical Practice Guidelines.***

GUIDELINE ADAPTATION COMMITTEE REPRESENTATION

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Geriatric Medicine
General Practice
Epidemiology
Palliative Care
Anthropology and sociology
Psychology
Psychogeriatrics
Psychiatry
Nursing
Occupational therapy
Rehabilitation medicine
Social work
Multicultural aged officer
Carer representatives

Additional consultation on the recommendations and draft Guidelines with two people living with dementia

GUIDELINE ADAPTATION COMMITTEE

COGNITIVE DECLINE PARTNERSHIP CENTRE

Prof Robert Cumming

A/Prof Meera Agar

Prof Kaarin Anstey

Prof Elizabeth Beattie

Prof Henry Brodaty

Prof Tony Broe

Prof Lindy Clemson

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Ms Margaret Dietz

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Prof Leon Flicker

Ms Meg Friel

Ms Louise Heuzenroeder

A/Prof Susan Koch

Prof Sue Kurrle

Prof Rhonda Nay

Prof Dimity Pond

Dr Jane Thompson

Ms Yvonne Santalucia

A/Prof Craig Whitehead

A/Prof Mark Yates

PURPOSE

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To provide recommendations for the optimal diagnosis and management of dementia in Australia.

Intended users: staff in the health and aged care settings (medical, nursing, allied health, care workers).

Scope: assessment and management in community, residential care and hospital settings.

SCOPE

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Ethical and legal issues

Barriers to care

Diagnosis and assessment

Models of care

Training for staff and students

Promoting independence

Cognitive training/rehabilitation

Acetylcholinesterase inhibitors/memantine

Nutritional supplements

Management of BPSD Support for carers

Palliative and end of life care

Considerations for CALD populations

Considerations for ATSI peoples

TYPES OF RECOMMENDATIONS

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Type of recommendation	Number
Evidence based recommendations *"Recommendation formulated after a systematic review of the evidence, with supporting references provided"*	27
Consensus based recommendations *"Recommendation formulated in the absence of quality evidence when a systematic review has failed to identify any quality studies meeting the inclusion criteria"*	4
Practice points *"A recommendation outside of the scope of the search strategy for the review and based on expert opinion"*	78

- ***GRADE approach used to rate the quality of the evidence.***
- ***Quality ratings ranged from 'very low' to 'moderate'.***

PRIORITIES FOR RESEARCH TRANSLATION

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- *People with a possible diagnosis of dementia should be referred to **memory assessment specialists or services** for a comprehensive assessment. EBR (Low)*

- *Health system planners should ensure that people with dementia have access to a **care coordinator** who can work with families and carers from the time of diagnosis. If more than one service is involved in the person's care, services should agree on one provider as the person's main contact, who is responsible for coordinating care across services at whatever intensity is required. EBR (Very Low)*

PRIORITIES FOR RESEARCH TRANSLATION

COGNITIVE DECLINE PARTNERSHIP CENTRE

- *People with dementia living in the community should be offered **occupational therapy interventions** which should include: environmental assessment and modification to aid independent functioning; prescription of assistive technology; and tailored intervention to promote independence in activities of daily living which may involve problem solving, task simplification and education and skills training for their carer(s) and family. EBR (Low)*

- *People with dementia who develop behavioural and psychological symptoms should be offered a **comprehensive assessment at an early opportunity by a professional skilled in symptom assessment and management**….PP*

PRIORITIES FOR RESEARCH TRANSLATION

COGNITIVE DECLINE PARTNERSHIP CENTRE

- *Health and aged care organisations should ensure that **all staff working with people with dementia receive dementia-care training** (attitude, knowledge and skill development) that is consistent with their roles and responsibilities. Training should reflect programs that have been shown to optimise care for the person with dementia……. EBR (Low)*

PRIORITIES FOR RESEARCH TRANSLATION

COGNITIVE DECLINE PARTNERSHIP CENTRE

- *People with Alzheimer's disease, vascular dementia or mixed dementias with mild-to-moderate behavioural and psychological symptoms of dementia* ***should not usually be prescribed antipsychotic medications*** *because of the possible increased risk of cerebrovascular adverse events and death. EBR (Mod)*

PRIORITIES FOR RESEARCH TRANSLATION

COGNITIVE DECLINE PARTNERSHIP CENTRE

- ***Carer(s) and family should have access to programs designed to provide support and optimise their ability to provide care for the person with dementia****. Programs should be tailored to the needs of the individual and delivered in the home or at another accessible location. Programs should be delivered over multiple sessions and include…. Education, information re services, referral, development of individualised strategies, training in providing care and communicating, coping strategies, training in the use of pleasant and meaningful activities to engage the person with dementia. EBR (Low)*

OTHER RECOMMENDATIONS OF NOTE

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- *Any one of the three **acetylcholinesterase inhibitors** (donepezil, galantamine or rivastigmine) could be considered for managing the symptoms of **Dementia with Lewy Bodies, Parkinson's Disease dementia, vascular dementia or mixed dementia**. EBR (Low)*

- *Larger trials conducted in people with dementia have not shown benefit (in group data) for antidepressants for treatment of depression per se. **People with dementia who also have depression without agitation may not benefit from antidepressant medication**. EBR (Mod)*

METHODOLOGICAL CONSIDERATIONS

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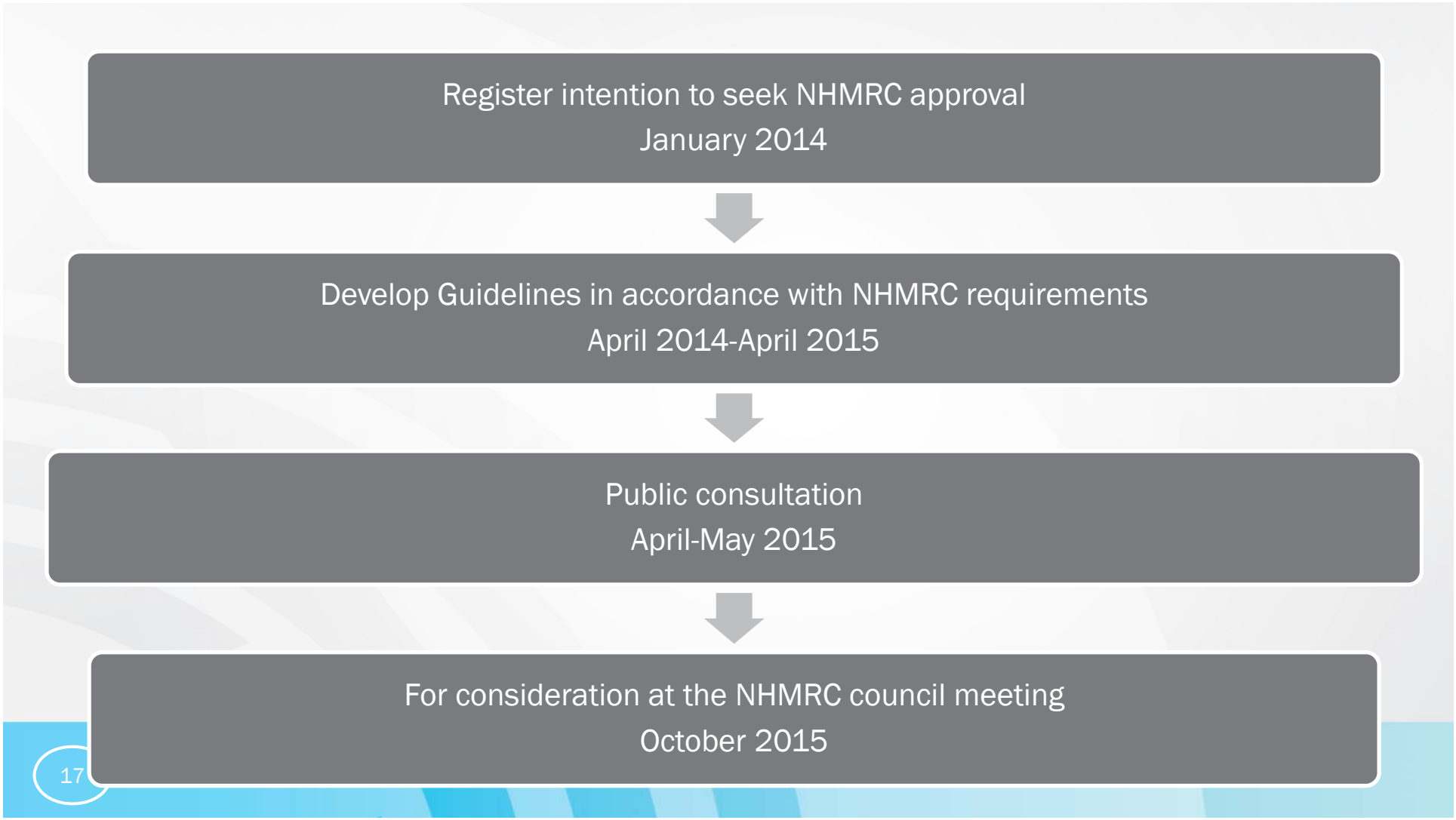
- ***Areas for further research listed in the Guideline.***
- ***There are a lot of Practice Points (similar in other NHMRC Guidelines).***
- ***GRADE used as is the international standard and acknowledged by NHMRC (clinicians will be more familiar with Levels of Evidence A, B, C etc).***
- ***When considering the body of evidence some interventions (eg carer interventions) are rated as low quality.***
- ***GRADE says that 'Low' evidence means that further research is very likely to have an important impact on our confidence in the estimate of effect.***
- ***GRADE says that 'High' evidence means that further research is very unlikely to change our confidence in the estimate of effect.***


Register intention to seek NHMRC approval
January 2014
Develop Guidelines in accordance with NHMRC requirements
April 2014-April 2015
Public consultation
April-May 2015
For consideration at the NHMRC council meeting
October 2015

CONCLUSION

- ***There is potential to improve the quality and consistency of care***
- ***Clinical Practice Guidelines provide a starting point***
- ***Implementation must follow***

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Our partners

Thank you