

Interventions

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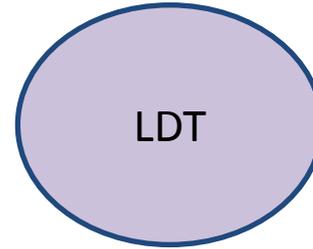
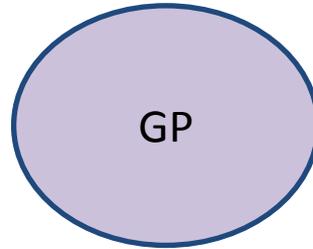
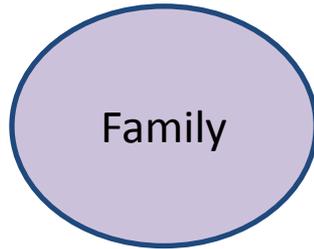
Stories about
Dementia

Politics

Organisational Values

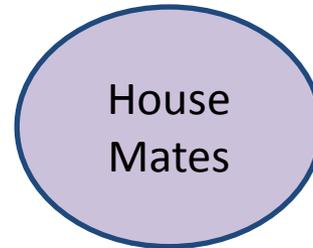
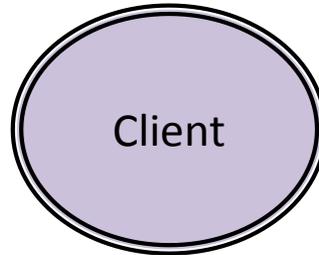
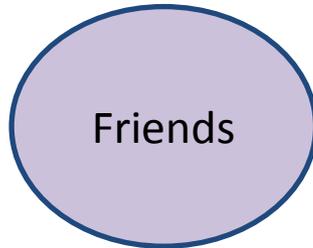
Values

Emotion



Professional
Knowledge

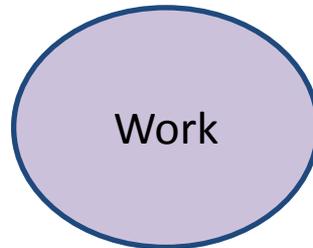
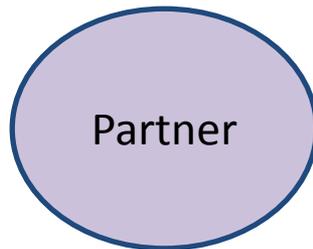
Culture



Local
Knowledge

Resources

Religion



Policy

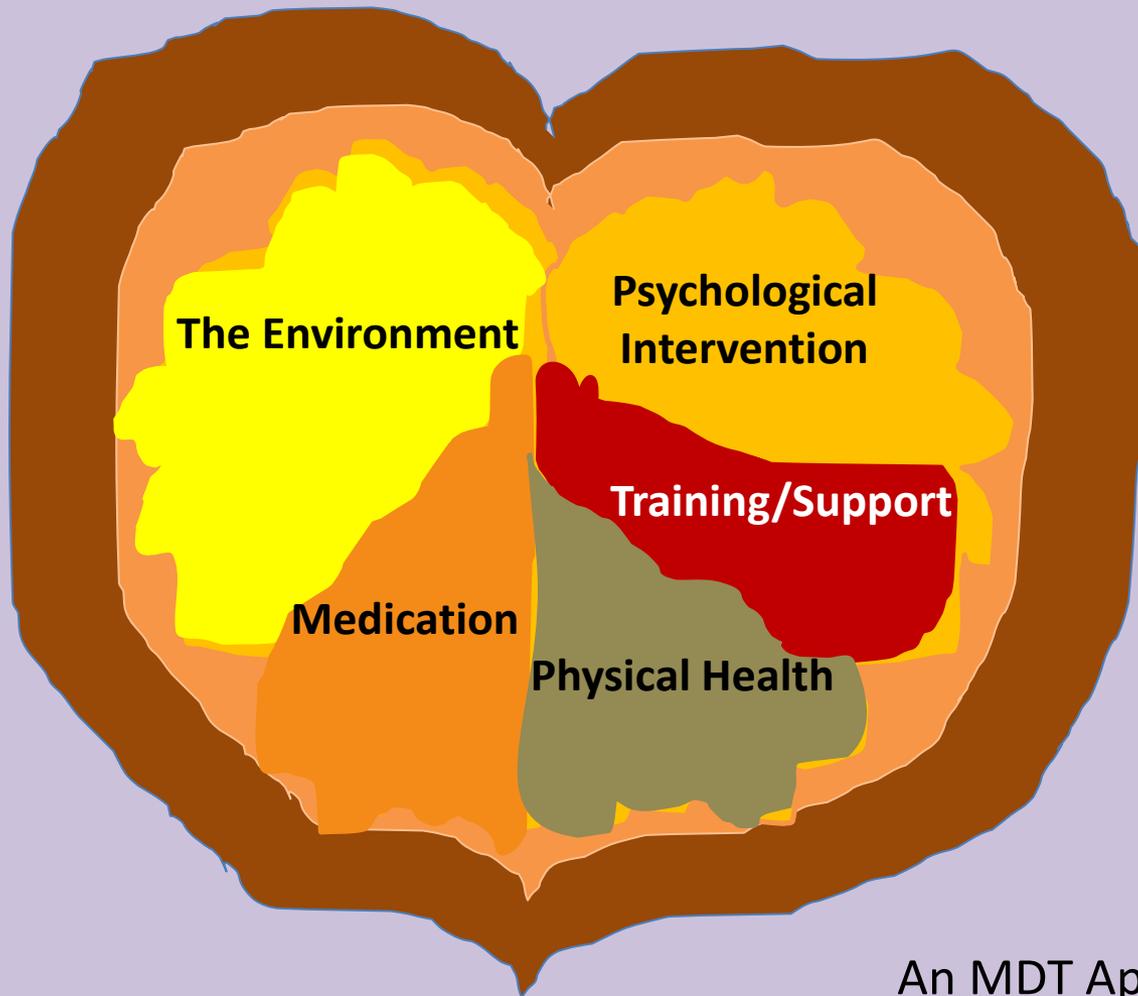
Personal
Experiences

Stories about Learning Disabilities



Interventions

in a Nutshell



An MDT Approach

What is new in Chapter 12?

- Links to PBS
- Specific interventions for different stages of dementia
- Intensive Interaction
- Staff consultation

MEMORY JAR

8

Christopher and Veronica Devas

Christopher Devas has Alzheimer's disease. He was an immensely capable businessman, magistrate and sailor. The tragedy for his wife Veronica is that not only is dementia robbing Christopher of his memory and identity, it is also destroying a large portion of their shared memories. Close couples are joint custodians of each other's experiences. Veronica has dubbed the disease 'Altzy'. I have portrayed it as a demonic figure snipping up all their family snaps.

Glazed ceramic, 2013

Courtesy the Artist and Victoria Miro, London

Grayson Perry.

Who are
you? 





Case Example: Staff Consultation

Referral from Team manager asking for support for the team due to a client being recently diagnosed with dementia.

Emma,
Team
Manager

Peter

Tracy

Adam

Sarah,
Psychologist

Sharon

Amy

Consultation

- Introductions
- How did you hear about this meeting? Was it compulsory to come?
- What do you hope to get from this meeting?
- Why are we here to talk about the diagnosis of dementia for the client?
- Who met the client first? Sharing a story about the client.
- How do you talk about your job as a support worker? How do you know when you have done a good job? How would your colleague know? Your client? Their family? Their friends? Your manager? The organisation? How similar or different are these ideas?
- How do you explain dementia to yourself?
- What are ideas are you comfortable with?
- Where do your ideas come from? Who shares those ideas? Who holds different ideas? Which ideas do you prefer?

Consultation 2

- **How does the dementia change/influence your understanding of doing a good job? How would your colleague know? Your client? Their family? Their friends? Your manager? The organisation? How similar or different are these ideas?**
- **How can we/you do your job when someone has dementia?**
- **What are our views about dementia personally and professionally? (Culture, religion, research). How do these make sense?**
- How would the client make sense of this conversation (before the dementia came into her life?)
- Is there anyone else we need to talk to?
- What would people like to happen after this meeting? Who should do this?
- How do we go on from here?

Themes

- **Change in values** (independence, choice vs failure free, caring)
- How to be a good enough support worker when the role is changing
- Is this acceptable/ appreciated by the organisation?
- How to be with someone who is less able than they were (emotional responses & practicalities)
- **Being human/sad** (is it professional?)
- Weight of history (previous clients with dementia, personal stories, relationship with client)
- Valuing a space to think, feel & reflect
- **Working within roll back memories**, collusion vs challenging vs thinking from the person's reality
- **Confusion** – what service when?

What next?

- Dementia Care Plan
- Regular review meetings with LDT staff to feel supported (OT)
- **Intensive Interaction Training** (being with)
- A 'good' death for the client. Consultation about Death & Dying (Fredman, 2007). Involvement of housemates in the funeral.
- Staff reported feeling that they were more able to talk about the challenges inherent in the work at staff meetings as they felt this was part of their work/allowed
- Some newer staff felt that more training would be useful (e.g. roll back memory) (**training levels**)
- Use of their knowledge with other homes (peer support/practice communities)

Dementia Care Plan/CPA

Dementia Intervention Integrated Care Pathway

Intervention Plan

CTPLD member responsible for Intervention Plan: _____

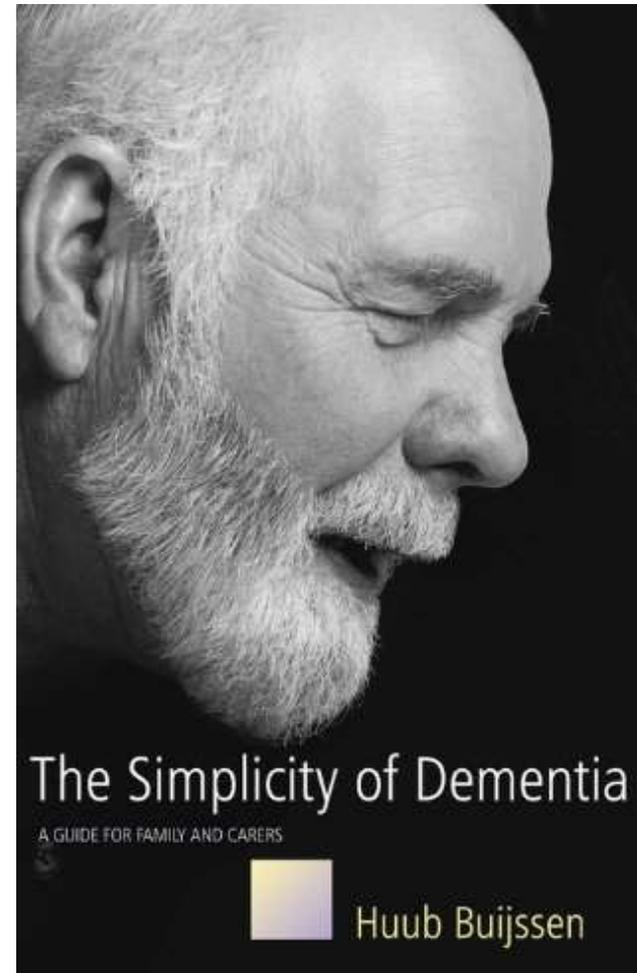
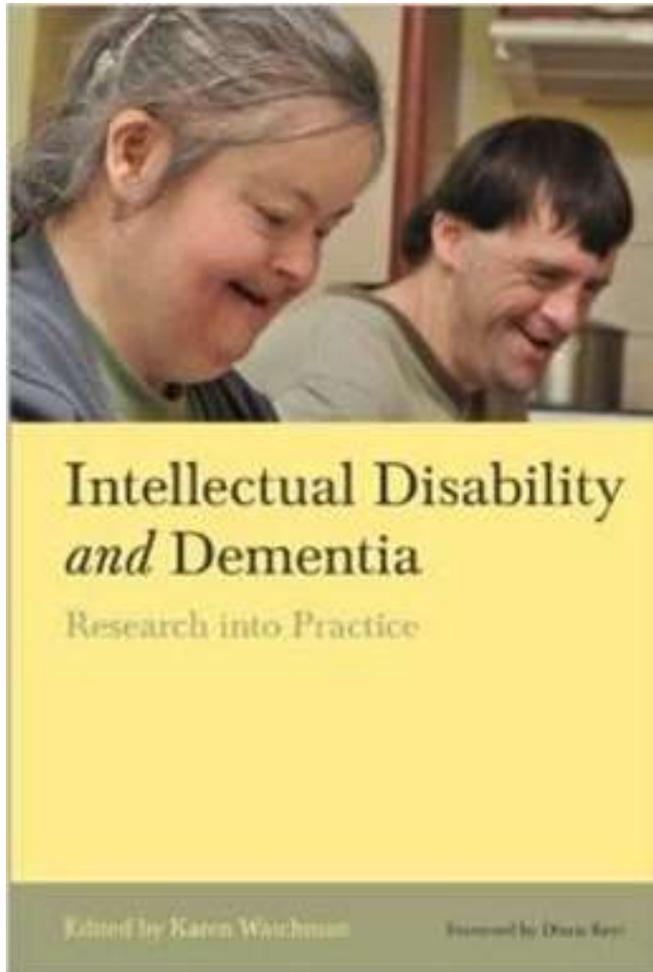
Designation: _____ Date: _____

| Potential Areas of Need | Actions needed for Interventions | Person Responsible for each action |
|--------------------------|----------------------------------|------------------------------------|
| A. Physical health/pain | | |
| B. Mobility/posture | | |
| C. Eating/drinking | | |
| D. Continence | | |
| E. Communication | | |
| F. Self-help skills | | |
| G. Environment | | |
| H. Occupation/activity | | |
| I. Orientation/confusion | | |
| J. Mental health | | |
| K. Behaviour | | |
| L. Support | | |
| M. Future planning | | |

Please continue to meet and review this Intervention Plan

Date of Plan Review: _____

Recommended Reading



Dementia Mimics I

- Physical Health issues
 - Uncontrolled Epilepsy
 - Nutrition – vitamin B12 & Folate
 - Electrolyte abnormalities
 - Hypothyroidism
- Sensory Impairments
 - Visual Impairments (recognition, lost skills)
 - Hearing Impairments (misunderstanding)
- Mental Health Problems
 - Depressive illness (pseudo-dementia)
 - Psychotic disorder (decline in function)
 - Chronic Anxiety (catatonia)

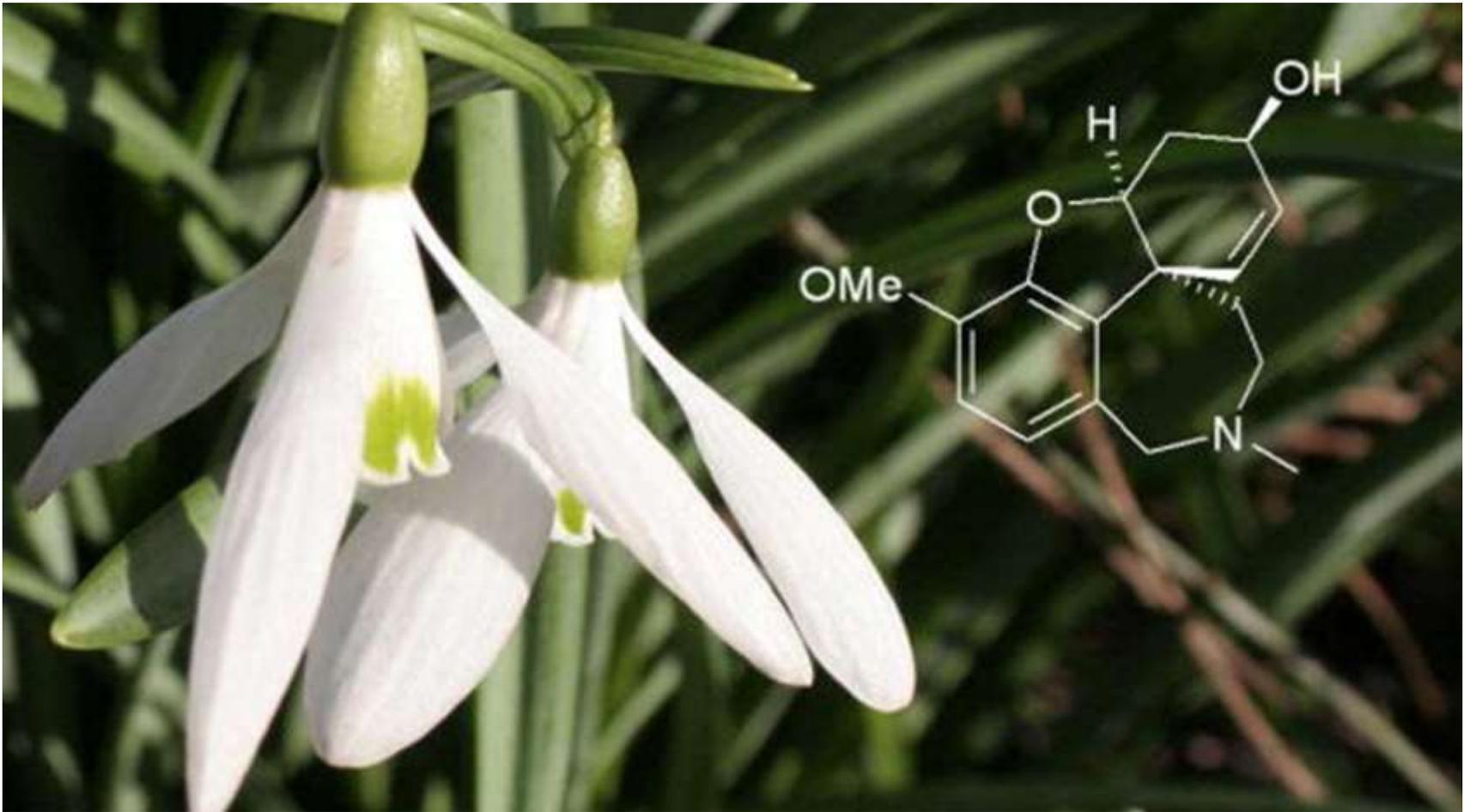
Dementia Mimics II

- Sleep Disturbance
 - Sleep Apnoea or other sleep disturbances
- Medication
 - Anticholinergics, psychotropics, AED's, Pain meds, antihistamines and benzodiazepines
- Life Events
 - Loss of parents, moves, day-care changes etc.
- Abuse
 - Loss of skills and regression
- Acute Organic Brain Syndrome
 - Confusional state secondary to pain, chronic infection or head injury

Difficulty in diagnosing dementia in LD

- Baseline functional levels are all different
 - Different levels of LD (not a homogenous group)
 - Premorbid cognitive deficits (floor effect)
- Diagnostic overshadowing
 - High levels of depression in the susceptible age
 - Physical health problems (esp. hypothyroid)
- Communication difficulties and an inability to use the standardised tests due to floor effect

Drug Treatment



| Method of Action | Drug | Evidence |
|---|--------------|---|
| Acetyl & Butyl Cholinesterase Inhibitor | Rivastigmine | <p>Prasher et al. (2005): In a non-randomised trial (17 treatment, 13 controls), people who were treated with Rivastigmine had decline over 24 weeks in global functioning and adaptive behaviours but no statistical difference.</p> <p>Prasher et al (2013): In a non-randomised trial (27 treatment, 13 controls) Both oral and transdermal Rivastigmine treatment was associated with significantly less decline in both cognitive and global functioning over a six months period.</p> |
| Acetyl-cholinesterase Inhibitor | Donepezil | <p>Prasher et al. (2002): Double blind placebo controlled trial of Donepezil, Showed that the improvement at 24 weeks was statistically non-significant. The sample size of the study was too small to explore the efficacy in the subgroups of mild to moderate disease.</p> <p>Lott et al. (2002) in their open label study on donepezil found that treatment resulted in significant improvement in scores on the Down Syndrome Dementia Scale (Gedye, 1985). However, there were methodological drawbacks.</p> <p>Prasher et al. (2003), in their open label study on donepezil treatment for people with Down's syndrome, found that treatment with the anti-dementia drug was associated with initial improvement in global functioning and adaptive behaviours. Follow up at 104 weeks found that, whilst there was deterioration in both treatment and control groups, it was significantly less in the treatment group.</p> <p>Kishnani et al (2010) published a trial of Donepezil in children and adolescents with Down syndrome to improve cognitive functioning. They finally concluded that Donepezil does not significantly improve memory and other cognitive functions after a large (n = 129) randomized placebo controlled trial in 10-17 year olds. These studies are notable in that they demonstrated that Donepezil is well tolerated, even in children with ID.</p> |
| | Galantamine | No Studies in people with Down's Syndrome |

| Method of Action | Drug | Evidence |
|------------------|--|--|
| NMDA antagonist | Memantine | Hanney et al (2012) Randomised, double-blind, placebo-controlled trial of Memantine for dementia in adults older than 40 years with Down syndrome (MEADOWS); the authors included older adults with DS who did not have clear signs of dementia but argued that due to the high risk for AD in this population and the potential neuroprotective effect of memantine such an approach was justifiable. This was a well-designed study that included N and demonstrated no difference between the active and control group and concluded that Memantine was not beneficial for people with Down syndrome and cognitive decline. |
| Antioxidants | 900 IU alpha-tocopherol, 200 mg ascorbic acid & 600 mg alpha-lipoic acid | Lott et al (2011) Randomised placebo controlled trial of antioxidants in adults with DS and dementia (n = 53). Antioxidant supplementation was found to be safe, though ineffective. |

Health in Dementia

- **Epilepsy**
 - Particularly Myoclonic epilepsy, but all types possible
- **Pain**
 - Recognition a problem, joints and falls more common, DisDAT
- **Sleep Disorders**
 - Old or new?, related to a condition (depression, pain, GORD), dementia
- **Gastrointestinal Disorders**
 - Dysphagia, Apraxia, GORD – Nasopharangeal secretions, poor mouth hygiene
- **Intercurrent Infection**
 - UTI common, URTI, LRTI, Skin, GI and eyes all common

Conclusions

- The population with LD is growing older
- PWLD have a higher risk (4x) of developing dementia
- Dementia occurs at a younger age than in the general population
- Services should have a prospective dementia pathway for adult with LD
- Treatment works in people with LD
- Look out for associated health conditions

Questions, Thoughts, Comments

