How allied health can help

In the first of a two-part series, geriatrician **Dr Clair Langford** discusses the vital contribution that allied health professionals make to the support of people living with dementia and their carers (below). On the following pages, three allied health professionals (dietitian **Lilliana Barone,** occupational therapist **Donna Horan,** and neuropsychologist **Penny Steele**) explain what this support looks like in practice. Part two, in the next issue of *AJDC*, will focus on the role of physiotherapists, speech pathologists, clinical nurse specialists and dementia advisors

Allied health is a term used to describe a range of health professionals who are not doctors, dentists or regular nurses. Allied health professionals aim to prevent, diagnose and treat a range of conditions and illnesses and work with doctors and nurses to optimise patient outcomes.

They include: physiotherapists and exercise physiologists, occupational therapists, social workers, neuropsychologists and clinical psychologists, dietitians, speech pathologists, Aboriginal and cultural and linguistically diverse health workers, counsellors, podiatrists, dental hygienists, dementia advisors, diversional therapists, music therapists, pharmacists, optometrists and audiologists.

The different types of dementia and different stages of dementia may require the input of different allied health professionals at different times.

It is not uncommon for dementia to be first flagged by an allied health professional while seeing a person for a routine issue. For example:

- A pharmacist may notice the person is missing tablets in a blister pack or that scripts are being renewed too often or not enough.
- A physiotherapist might notice the person is not remembering an exercise from one visit to the next or not remembering to use their walking aid.
- An optometrist or audiologist may not be able to fix a sight or hearing problem because the brain is not understanding what the person sees and hears – it is not processing the information correctly.
- The person may be losing weight and a dietitian realises that they are forgetting to eat.

These allied health professionals will then contact the person's GP and recommend further assessment.

As a geriatrician, working at the Bulli Hospital and Aged Care Centre (see box right), I often contact our allied health professionals early in the assessment and treatment process. When assessing

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patients, our clinical nurse specialist, Alexia Bradley, particularly looks for issues that could be addressed with allied health support. For example:

- I might ask a **physiotherapist** to assess and treat balance and walking problems for people experiencing falls because of vascular dementia or Lewy body dementia.
- A **neuropsychologist** might help because the type of dementia isn't clear or the person needs to understand what aspects of their brain are still working well and where there is difficulty, especially if it is a more uncommon type of dementia.
- I often call the person's **pharmacist** to clarify their medication history. I may ask them to track back as far as 20 years to understand why someone is on a particular medication and how it might be impacting their health, and most especially their brain.
- An **audiologist** may be engaged if it becomes clear the person is not hearing what is said, is guessing poorly but often guessing incorrectly, and so giving bizarre answers. So many people are too proud to wear hearing

A team approach to care

Bulli Hospital and Aged Care Centre is a new, purpose-built facility for aged care services, operated by the Illawarra Shoalhaven Local Health District (ISLHD), in NSW.

Opened in August 2020, it's designed to meet the needs of the region's ageing population and provides inpatient, outpatient and allied health services.

There are currently six geriatricians (including Dr Clair Langford, author of the accompanying article) who work within the centre's outpatient services clinic, which runs Monday to Friday. Each week the clinic sees an average of 10 new clients and reviews a further 25 clients.

The clinic provides a team of health professionals including allied health, geriatricians and clinical nurse specialist, working together to provide comprehensive care for older clients and their carers living in the community. A neuropsychology team works externally to the clinic on a referral basis. Similar clinics operate in other NSW area health services. Typically, people are referred to the clinic by their GP if they are over the age of 65, with one or more of the following:

- Concerns with memory decline
- Concerns with increasing confusion
- Recurrent falls
- Assessment and opinion on driving
- Concerns about functioning at home alone
- Concerns with multiple medications
- Concerns with multiple health conditions.

On their first visit, new clients will undergo a comprehensive geriatric nursing assessment by a clinical nurse specialist before seeing a geriatrician. The areas assessed include: eyesight and hearing, falls history, exercise, continence, nutrition, medication use and management, pain, functional ability and independence, home environment, cognitive ability, mood and social activity.

Illawarra Dementia Forum

The articles on these pages are edited versions of presentations given at the 2021 Illawarra Dementia Forum – *Dementia Support: How Allied Health Can Help You* – live-streamed on 10 March 2021. The annual forum is aimed at people living with dementia, their families and carers living in the community. The articles are published here with the permission of the speakers and the Illawarra Shoalhaven Local Health District (ISLHD). Information relating to clients and carers has been de-identified.

Geriatrician Dr Clair Langford was the forum's keynote speaker, with other presentations given by the allied health professionals featured in the articles in this series (parts 1 and 2), along with clinical nurse specialist Alexia Bradley. Dementia Training Australia (DTA) Executive Director, Professor Belinda Goodenough, hosted the forum's panel discussion.

This year's event was supported by Dementia Australia, DTA, ISLHD, University of Wollongong and the Multicultural Communities Council of Illawarra.

A webinar recording of the forum is available to watch at https://dta.com.au/resources/illawarra-dementia-forum-2021/

aids, but it can make them appear to have dementia when in fact they are just not hearing correctly and are misunderstanding people all the time.

- A **psychologist** or **counsellor** might be asked to help if the diagnosis is extremely distressing, particularly if past experiences of someone close to them having dementia is traumatic.
- As the dementia progresses, we may need to offer help to enable the person to navigate the My Aged Care system by providing a **CALD worker** for culturally and linguistically diverse patients or an **Aboriginal support worker** for someone from our Indigenous community. Sometimes I ask one of our **hospital nurse specialists** or consultant to help if the person has no one else that can help them.
- A **dietitian** might assist with creating healthier food plans.
- A **speech pathologist** may be called on to help if the person has communication difficulties or swallowing problems.
- **Music therapists** or **diversional therapists** usually assist at day centres and facilities and occasionally at home to help a person engage in new things or old things differently, when the ability to do past music, craft and sports activities has declined.

THE NEUROPSYCHOLOGIST

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A neuropsychologist is a psychologist who specialises in understanding the relationship between the physical brain and a person's behaviour and thinking.

People are typically referred to a neuropsychologist to help understand whether there has been a change in brain functioning – particularly if there are concerns about the way someone is thinking, remembering, or acting – and, if there has been a change, why that might be the case. For example, someone with dementia might have difficulties with their thinking skills, such as memory, language, concentration, visual skills, or they might have changes to their mood or personality (eg, be more irritable or more impulsive).

For people with dementia, a neuropsychologist is mostly involved in the early stages of the disease, including assisting with diagnosing the particular type of dementia, determining the progression of symptoms, and identifying cognitive strengths and weaknesses to assist with implementing tailored strategies to compensate for difficulties on a day-to-day basis.

At the initial appointment, we ask some questions about the problems the individual may have, as well as other background details (eg, medical information, schooling, occupation history) to get a better understanding of their personal history.

We then complete tests to measure many functions of the brain, for example memory, attention, language, problem solving, and other thinking skills. The testing may involve completing paper- and pencil-based tasks, doing puzzles, remembering information, and answering questions. The pattern of test scores is then compared to those of other people of a similar age and education, as well as the person's own baseline ability. This tells us whether or not there has been a change in any thinking skills and can help us better understand a person's current abilities.

How can a neuropsychologist help?

The following is an example of someone with dementia and who I saw recently and who benefited greatly from neuropsychology input.

This elderly gentleman had recently received a dementia diagnosis during an admission to hospital following a several-year history of cognitive decline. He and his wife hadn't received much information about how dementia would affect his day-to-day life, and his family requested my help in understanding his diagnosis.

I saw him over several sessions, beginning with an initial cognitive assessment to understand how his dementia was affecting the different areas of his thinking. This helped to identify his main weaknesses, which included learning and recalling information, as well as his personal strengths, which included his ability to recall information when prompted by others. I then worked with the family to come up with some ideas which incorporated this area of strength. For example, the family purchased a calendar whiteboard to remind him of upcoming appointments. They also wrote a list of instructions for common household tasks, like brushing his teeth, preparing small snacks, and getting ready for bed. He could look at these lists whenever he was having trouble doing one of these tasks.

In summary

Neuropsychologists are like detectives. We use a wide range of information about a person's history and cognitive ability to determine whether a person has dementia and understand how dementia impacts that person's day-to-day functioning.

No two people with dementia have the same difficulties or strengths. Some might have problems with learning, others memory, others language skills. By better understanding a person's specific strengths and weaknesses, we can empower them and their carers to compensate for their daily challenges by developing a personally-tailored set of recommendations to fit their specific circumstances.

A dementia diagnosis can seem daunting at first, however there is still so much that someone with dementia can achieve with a good understanding of their current ability level, and with the right supports and strategies in place.

- There may also be the need to support the carer with **counselling and education** about strategies and the help available.
- Special equipment might be needed as physical function declines, and so we call in our **occupational therapist** (OT). If I'm unsure if it is safe for the person to drive their car or electric scooter I will refer them to an OT for further assessment.

In the future, we hope to slow the onset of dementia and there is a lot of exciting work being done around diet and lifestyle interventions. Allied health professionals are very likely to help us all take some of these strategies on board.

At any time, other health events for a person living with dementia may complicate the journey and the interaction with these allied health professionals may need to be modified. Carers may need to prompt the person with dementia to do their exercises or assist and motivate them to attend classes after a significant fall and fracture or a stroke. Communication boards or technology may need to be used to help those with loss of speech indicate their needs. A transitional care package of support might be needed to work out what will and will not work for a client and their carers in their own home, along with counselling support from social workers and advisors.

Conclusion

Sadly, sometimes I have heard people make comments like "This patient doesn't need to see a therapist because they have dementia" and "They will not be able to remember the therapy or follow instructions". So often there can be innovative ways of addressing these issues by thinking outside the square and learning from each other ways of solving the problems. It is always better to have more than one head trying to work out possible solutions for the person with dementia and their carer.

There is no one-size-fits-all in dementia. Every person has their own unique experience and may need assistance and interventions from different professionals at different stages of their disease course. It is true that we can't fix everything, but we must look at the individual and what they still can do, as well as the willingness and abilities of their support team before dismissing an opportunity. ■

■ Dr Clair Langford is a geriatrician, based at Bulli Hospital and Aged Care Centre, Illawarra Shoalhaven Local Health District, NSW

THE DIETITIAN

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Dietitians can offer practical ways to support a person with dementia with eating and drinking across all stages of the disease, often in collaboration with other allied health professionals, especially speech pathologists.

To illustrate, take the case of John*, who is living with dementia, and Mary* his wife and carer. John was referred to me because he was not eating as much as usual and had lost weight. Mary was also struggling with the stress of care and not eating properly herself.

Here are some of the strategies we discussed and that Mary and John adopted:

- I encouraged Mary to eat with John, rather than do some jobs around the house whilst he ate at the table. This way both focused on eating with no other distractions.
- We created a shopping list of nourishing snack foods that Mary could leave on John's TV table and on the deck. These included cheese and biscuits, yoghurt, dairy snack desserts, peanut butter sandwich fingers, fruit toast, hummus with vegetable sticks and crackers, and fruit pieces. I also encouraged Mary to have some too.
- I gave Mary ideas to organise the fridge so that John could easily see what was there and access as he wanted.
- I gave ideas on how to make 'every mouthful count' and add more nutrition to their meals and drinks (eg, by adding oil, margarine and/or grated cheese to cooked vegetables and mashed potato; sour cream to soups; grated cheese to omelettes and scrambled eggs; skim milk powder to a glass of milk; and avocado on sandwiches).

As a result, Mary became less stressed about what food to offer John, was able to look after herself better and John was eating more in the day.

**The information presented here is de-identified*

THE OCCUPATIONAL THERAPIST

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As an occupational therapist (OT) my job involves an initial assessment to establish a person's needs within their own home environment (functionally, cognitively and socially) and then equipping them with the tools to carry out their everyday tasks as independently and safely as possible.

The shared goal is generally to establish safer, easier routines for the person with dementia and their carer, finding the most cost-effective solutions for equipment and modifications, and accessing the services they need to thrive at home.

Pam's* story illustrates how occupational therapy helped overcome some of the difficulties she faced due to rapidly progressing Alzheimer's disease. When I first saw her, Pam was predominantly non-verbal, unable to walk, and she sat in a wheelchair for most of the day. She could be assisted to stand and step to transfer from wheelchair to bed or toilet. Her husband John* saw to all Pam's care needs.

Because Pam was seated in the wheelchair for most of the day she was at increased risk of developing a pressure injury. One of the first things I did was prescribe a pressure relief cushion for her wheelchair. I also helped John apply for other equipment to assist them, including an adjustable bed base, pressure relief mattress, a transfer aid, sling, hoist and shower commode chair.

John and I then practised together to use the equipment until he felt comfortable. We also trialled a more supportive and comfortable wheelchair for Pam, which provided benefits of pressure care, pain management, eating safely and manual handling.

Pam was later approved for a Home Care Package and Pam has been able to remain at home. It is a successful example of a Home Care Package supporting a devoted carer to keep someone out of hospital with the help of allied health.

**The information presented here is de-identified*

***Donna has recently taken up another position within the aged care sector.**