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Submission

House of Representatives Inquiry on Dementia

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Terms of Reference

Australia's population is ageing and over the next 20 years the number of people with dementia is predicted to more than double. Early diagnosis and intervention has been shown to improve the quality of life for people with dementia, as well as for family members and carers.

The Committee will inquire into and report on the dementia early diagnosis and intervention practices in Australia, with a particular focus on how early diagnosis and intervention can:

- improve quality of life and assist people with dementia to remain independent for as long as possible;
- increase opportunities for continued social engagement and community participation for people with dementia;
- help people with dementia and their carers to plan for their futures, including organizing financial and legal affairs and preparing for longer-term or more intensive care requirements; and
- how best to deliver awareness and communication on dementia and dementia-related services into the community.

Response

Dementia is a growing problem in Australia as the population ages into life stages where degenerative brain conditions leading to dementia are common. The medical and health professions and the social services of Australia are not well prepared for this increasing challenge.

The most common forms of dementia in older cohorts of Australians are Alzheimer's disease, vascular cognitive impairment, combined Alzheimer's disease and vascular cognitive impairment, Lewy body dementia, frontotemporal dementia, Parkinson's disease related dementia, and dementia conditions symptomatic of underlying (and occasionally reversible) medical conditions and psychiatric disorders.

While much good work about educating the public has been done by Alzheimer's Australia and similar community organizations, the problem is that the medical profession often has a negative or fatalistic attitude to dementia. Some doctors regard the condition as having no hope and therefore treatment approaches are minimal or limited in scope.

A new approach is required so that clinical advances can be made in the management of these conditions and realistic hope given to patients and carers struggling with the situation. An analogy is appropriate here.

I suggest the approach to dementia (at least for the most common conditions suffered by older Australians) should change to be similar to the approach to type II diabetes. While much is known about the pathophysiology of this condition, we are still unclear about the actual cause and we have no specific way of preventing the disorder or providing a cure. But that has not led to a negative approach to this condition as characterizes some of the attitudes to dementia.

The medical approach to type II diabetes now involves positive interventions to identify and reduce general risk factors, establish early diagnosis, provide symptomatic treatments (blood sugar control), identify complications early and prevent them, educate the patient, carer and community about the condition, and encourage and support community organizations to provide assistance for patients suffering from the condition and its complications.

This model is sometimes called 'chronic disease management' or a 'rehabilitation approach'. It has as its aims to improve the quality of life for sufferers and to assist them remain as independent as possible, to increase the capacity for continued social engagement of sufferers, to help patients and carers plan for the future, and to improve community education and services for this condition.

A similar model of response to the challenge of dementia can be applied in Australia.

I have developed a disease management or rehabilitation model based on my Memory Clinic on the Gold Coast, Queensland. This clinic offers assessment and diagnosis for individuals with early memory and cognitive problems. The clinic is run in collaboration with local general practitioners and is based in the private sector, which facilitates increased access for members of the public.

The clinic first provides an assessment and diagnosis service. At the first appointment a comprehensive cognitive/memory, medical, psychiatric, and social history is taken followed by a cognitive and memory examination, a psychiatric examination and a targeted physical examination. Patients are then sent for appropriate urine and blood tests, and brain imaging studies. In a small number of cases neuropsychological testing or speech pathologist assessment will be required to assist diagnosis and management planning.

At a second appointment the results of all these investigations are discussed with the patient and carer. At this consultation a management plan is developed for the unique circumstances of each patient. The management plan addresses reducing risk factors and enhancing protective factors for dementia, it provides symptomatic treatment using the available anti-dementia medications, the plan anticipates and provides early intervention for the common medical, psychiatric, social and legal (eg. will, enduring power of attorney, guardianship matters and driving capacity) complications of dementia, and it provides a program of education for sufferers and carers.

The management plan is constructed in collaboration with the patient's general practitioner, nurse, psychologist counselor, and allied health care clinicians and specialists and takes into account the patient's accommodation settings (eg. home, residential aged care facility or nursing home). Follow up appointments are made to monitor and modify the management plan as necessary.

The rehabilitation approach of my clinic is different to most of the public sector memory clinics that are located in capital cities. These clinics focus on assessment and diagnosis and have less emphasis on a disease management or rehabilitation approach to dementia. The memory clinic model I have developed is capable of being established in regional and rural cities and towns – a satellite clinic is operating in a regional Queensland city.

The dementia disease management model I have crafted will improve the quality of life for sufferers and assist them remain as independent as possible, will increase the capacity for continued social engagement of sufferers, and help patients and carers plan for the future, as well as improve community education and services for this condition.

Implementation of this model around Australia will materially improve the quality of health and social services for dementia suffers. I recommend these suggestions to the House of Representatives Committee. I would be pleased to provide further information to the Committee or appear in front of the Committee if asked.

Yours sincerely,

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