

INTERVAL OF NEED ↔ INTERVAL OF SUPPORT

By

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The #1 Geriatric principle of care is to maximize the “individual and family” before looking at service options. For a PWD (person with dementia) this involves appropriate assessment to confirm a diagnosis of dementia; what type and level of severity. This can usually (80-90%) be established by the person’s family physician; referral for specialist care is only needed in approximately 10%.

It is important to rule out reversible causes/components to recognize and treat delirium and particularly to review medications (which can often affect cognition, especially sedatives and anticholinergic drugs. The local pharmacist can perform a “med-check”. A PWD may not seek out care for concomitant chronic diseases or comply with medications/care recommendations. ‘Tuning up’ of conditions: diabetes, hypertension, heart failure, lung problems and controlling pain may make a big difference.

In terms of specific antidementia drug therapy the recent Canadian Consensus Guidelines advocated that all PWD should have a 3 month trial with a cholinesterase inhibitor (unless contraindicated). This was based on over 30 comprehensive scientific trials and expert consensus by Geriatricians, Geriatric Psychiatrists, Neurologists and GPs. My own clinical experience with thousands of PWD is that 25% improve and 50% “stabilize” often for 1-2 years and sometimes longer. There can be significant benefits in cognition, function and behaviour.

The issue of Caregiver support is critical: helping with primary caregiver stress, ill health, burnout and depression. Involving other family members (secondary caregivers) to help out may provide welcome respite. Education is very important. One study with education of caregivers and a dementia care hotline showed families were able to keep their loved ones at home 1 ½ extra years (Mary Mittelman: Neurology 2006). Referral to the local Alzheimer’s Society via “First Link” is critical for education, counselling and advice. There are also many books and on line resources (www.Alzheimer.ca/on). Remember 90% of support for PWD is family and friends. Do Power of Attorney for Finances/Personal Care AND do discuss advance health directives EARLY.

Once the PWD and their family/caregiving situation has been maximized, then look at formal and/or paid services and how the interval of need can be matched to the interval of support. If the “match” cannot be paid relocation to Retirement Home or Longterm Care will need to be considered (Senioropolis.com – RH/LTC guide).

Driving safety must be assessed if the PWD is still driving. At the time of diagnosis, 85-90% are unsafe to drive (see Family Guide re driving www.rgpeo.com). The Community Care Access Centre (www.ccac-ont.ca) can provide important support: Personal Support Workers but only if the PWD needs personal care help (bathing, dressing, etc.), access to Case Management for services and system navigation, specialized therapists (Occupational and Physical Therapists,

Social Workers), access to Day Away Programs, respite and Long Term Care Homes. Retirement Homes are increasingly specializing in care for PWD, including short term respite. Respite is very important to ease caregiver burden: a day, overnight, a weekend or several weeks can make a huge quality of life difference. Other useful services include senior's centres, Meals on Wheels, private meal delivery services and community services. For complicated situations, referral to Geriatric Medicine or Psychiatry services can help.