THE UNIVERSITY OF MELBOURNE

Cognitive Impairment and Dementia

Janaya Charles & Dr Jo Hughson
The University of Melbourne

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GETTING HEALTH CARE
HIGH QUALITY HEALTH CARE, EVIDENCE-BASED GUIDELINES
WHOLE PERSON, WHOLE OF LIFE
FAIRNESS, EQUITY, EVERYONE

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Acknowledgment of Country

We acknowledge the traditional owners of the lands on which we are meeting and the traditional owners of all the lands on which we are working in this project, and pay our respect to Elders past and present.

We also acknowledge the Stolen Generations and their families.

For Aboriginal and Torres Strait Islander people present, please note that the presentation contains images of deceased people.

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Learning objectives of this session

- To understand what cognitive impairment and dementia are
- To understand the value of detecting cognitive impairment as early as possible
- To know what signs to look out for
- To know what to do if you think a community member might have cognitive impairment or dementia

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Background

- Older people and Elders are deeply respected and have important roles in families, communities and on Country
- Most people do not develop dementia and live well to older age

But…

- 1 in 5 Aboriginal and Torres Strait Islander people over the age of 50 years has some form of cognitive impairment including dementia
- Dementia currently has no cure and is the second most common cause of death in Australia today.
- As more people live to an older age, the number of people with dementia will increase.

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Case study: Aunty Molly

- Aunty Molly is 68 years old and lives with her son Frank
- Health conditions: diabetes, hypertension, obesity.
- Aunty was taken from her family as a young child (*Stolen Generation*).
- Molly & Frank are community members and recently ran into Lydia, an Elder Care Connector, in the street and had a chat.
- Frank is worried because his mum has been forgetful & acting out of character. She gets angry when she wouldn't usually, including with her grannies, who she used to love having around.

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What is cognitive impairment?

Refers to problems with brain functioning, especially:

- memory
- thinking
- confusion

Cognitive impairment:

- is not part of ordinary, healthy ageing
- may be
  - Reversible (eg delirium, medications, depression, PTSD & others)
  - Mild Cognitive Impairment (MCI)
  - Dementia
- requires careful clinical assessment

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https://www.youtube.com/watch?v=fmaEql66gB0

What is dementia?

- Not one specific disease
- Not a normal part of ageing
- Umbrella term for a group of conditions that:
  - affect how the brain works
  - get worse over time
  - impact on thinking, memory, behaviours
  - affect physical functioning and the ability to do everyday tasks.
  - Family or others have noted changes

Healthy Brain

Severe Alzheimer's

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What causes dementia?

Risk factors:

- Age
- Genetics (family history of dementia)
- Stroke and other vascular conditions
- Smoking
- Serious/repeated head injury
- Low physical activity
- SEWB factors such as: depression, childhood trauma, social isolation
- Low education
- Hearing impairment in mid-life
- Excessive alcohol use
- Obesity

Protective factors:

- Regular exercise
- Good diet & healthy weight
- Cultural & social connection
- No smoking
- Low alcohol intake
- Education and employment
- Cognitive stimulation

Live well, age well

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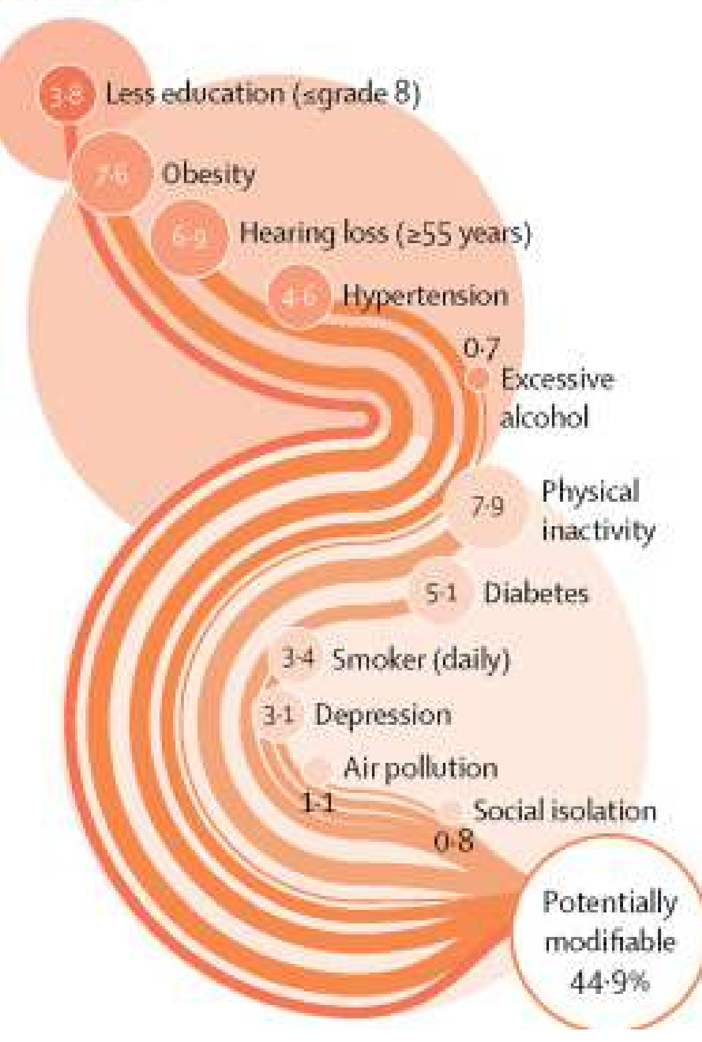
Factors that increase risk of dementia across the life course



Childhood trauma

Early life (<45 years)

- Less education
- Obesity

Midlife (45-65 years)

- Hearing loss
- Traumatic Brain Injury
- Hypertension
- Alcohol >21 units per week

Later life (age>65years)

- Physical inactivity
- Diabetes
- Smoking
- Depression
- Air pollution
- Social isolation

Why we want to pick it up early

- We might be able to ***slow down disease progress***
- To ***support quality of life***: we can make sure people are getting the right health care and support services
- So that people can ***discuss their preferences*** and have a say in how decisions will be made as dementia progresses
- To identify ***carers***, and consider their needs and the support services that are appropriate for them
- To find out whether ***potentially reversible factors*** are contributing (eg depression, medication, delirium)

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What signs might give a clue …

- Forgetting appointments
- Chronic disease not well managed (e.g. diabetes)
- Not taking medications properly
- Word finding difficulties
- Repeating things
- Seem different, more grumpy,
- Saying things wouldn’t normally say (e.g. sexually inappropriate)
- Seem depressed and withdrawing from activities
- Dressing less well
- Losing weight
- Multiple hospital admissions
- Family are worried

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Case Finding

Passive

- Patient or family member/friend raises concerns about thinking, memory or confusion
- You or a health practitioner has concerns about thinking, memory or confusion

Active

Recommended from the age of 50 due to high prevalence:

- Check risk factors
- Ask questions about thinking, memory and confusion

If concerns have been raised, proceed to cognitive screening.

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Sometimes people might not talk about it because…

- People might think that changes in memory or thinking are a normal part of ageing
- They might think that a diagnosis won't make any difference because there's no cure
- They are afraid of what might happen or what people might think
- They might not know they are having problems
- Sometimes people think they have to 'tough it out' and deal with it themselves

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Tips on how to approach talking about memory and thinking problems

It can be uncomfortable talking to an Elder about memory problems

- Prepare well so you feel as comfortable as possible
- Make time and space to have the conversation
- Explain that there are many things that the health service can help with to keep your brain healthy, and prevent memory problems getting worse
- Explain that it’s part of routine health care, just like getting your blood pressure checked.

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Aunty Molly and Frank…what happened next

- Lydia encouraged Frank to take Aunty Molly to the health service.
- Lydia spoke with Karen, one of the Aboriginal Health Practitioners. Karen thought it would be a good idea for Aunty to do an annual health assessment including the KICA screen, where Aunty had an obvious memory problem (KICA Screen score 18/25 and KICA Carer was 5/16)
- The findings were discussed with Aunty and Frank and then with her GP
- More tests were organised
- Aunty was referred to a specialist and diagnosed with mild Alzheimer's Disease and the diagnosis discussed with both of them.
- Medications for dementia were started (with Frank monitoring her tablets)
- Karen had a yarn with Frank about dementia and how to help Aunty but also how to look after himself

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Thank you!

Questions?

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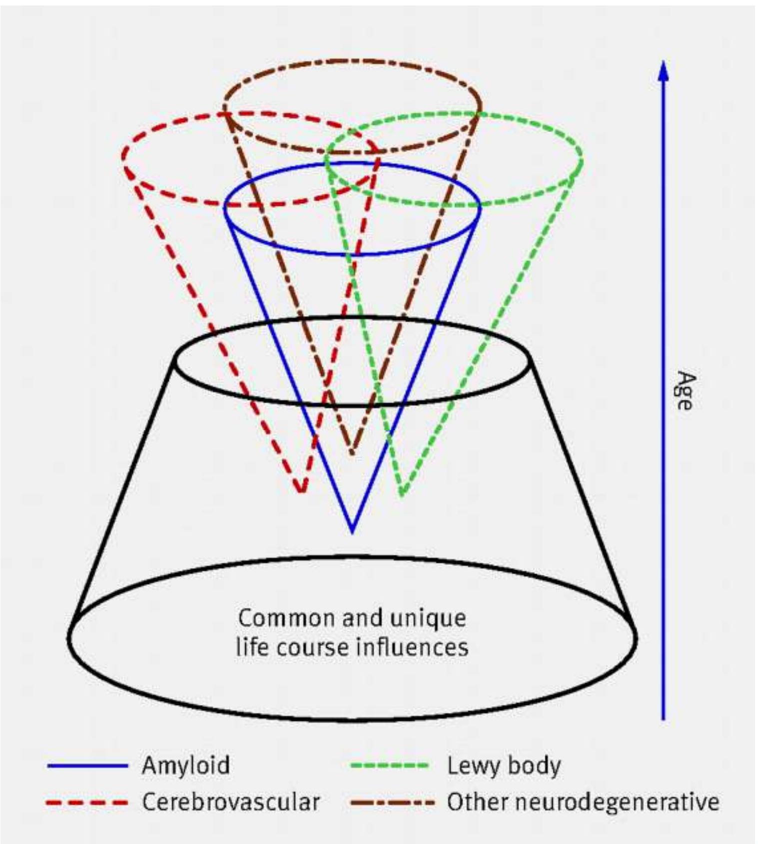
Types of dementia

- **Alzheimer's Disease (50-70%)**
- Vascular (10-20%)
- Lewy Body (10%) and Parkinson's related
- Frontotemporal (<5%)
- **Mixed**
- Alcohol-related (less than thought)
- Head injury-related



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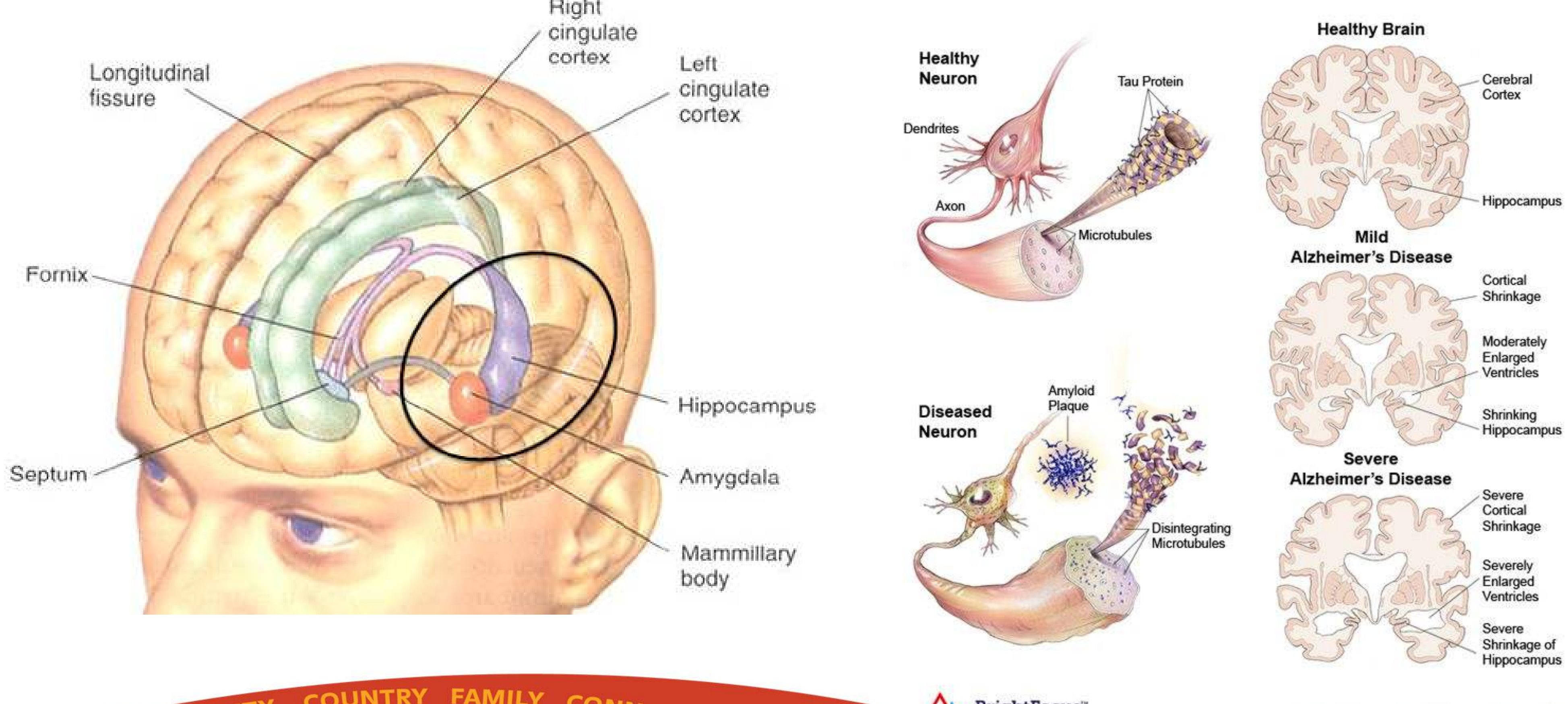
Types of Dementia - Alzheimer's Disease



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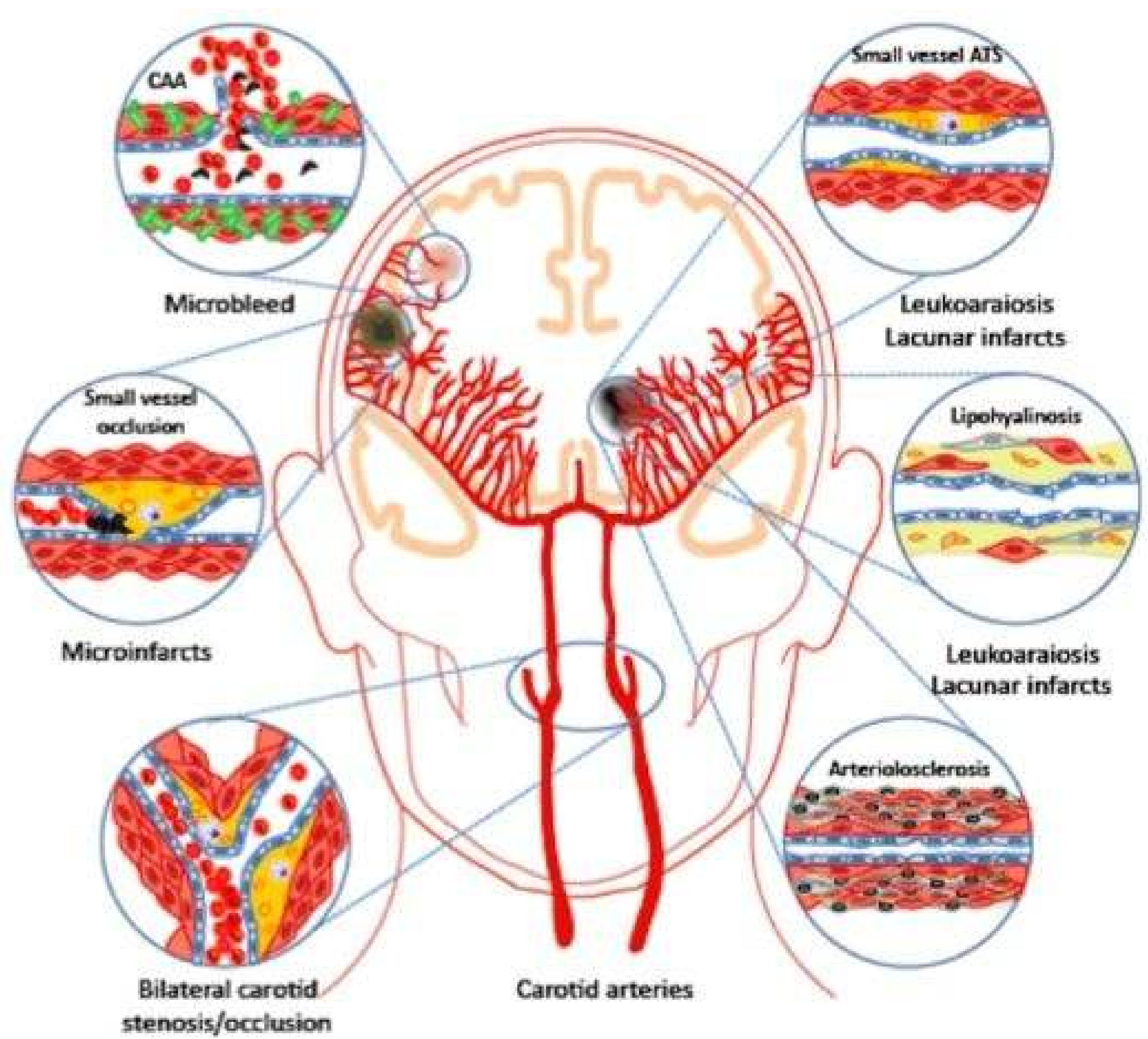

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How are cognitive impairment and dementia detected?

1. Case finding
2. Cognitive screening
3. Full clinical assessment

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Questions to ask

Evidence supports thinking about cognition checks for everyone 50 and over.

Asking questions could form part of the cognitive component in the Aboriginal Health Assessment (MBS 715), or be stand-alone.

Suggested questions:

‘Do you have any worries about your memory or thinking?’

‘Does anyone in your family have any worries about your memory or thinking?’

Other suggestions?

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Stages of cognitive impairment and dementia

	Mild cognitive impairment	Early dementia	Mid-stage dementia	Late-stage dementia
General profile	Not dementia. Able to function fairly normally but friends & family usually notice the person is having thinking problems. May revert to normal cognitive functioning	Thinking is noticeably affected.	Cognitive & behavioural problems from early stages become more pronounced. Physical function declines.	Progressively unable to speak or communicate.
Cognitive symptoms include	Increased forgetfulness, some difficulty concentrating, trouble finding words	Changes in memory, judgement, planning, mood & insight, episodes of confusion. Denial might be a factor.	Forgetting home address, names of close family, recent events	
Possible functional impacts	Getting lost, decreased work performance	Problems travelling alone to new locations, socialising (withdrawal from family & friends), managing finances, driving, completing more complex tasks easily or correctly	Needing assistance with ADLs, ranging to extensive assistance. BPSD. Onset of physical issues: incontinence, speech problems.	Assistance needed with most activities (e.g., using the toilet, eating). Loss of psychomotor skills, eg. ability to walk.
Average duration	2-7 years	2 years	4 years	1.5 – 2.5 years

BPSD clusters

Aggression - aggressive resistance, physical aggression, verbal aggression

Agitation - trailing, Wandering, walking aimlessly, disturbed sleep wake cycle, culturally inappropriate , sexual disinhibition, dressing/undressing behaviour, repetitive actions, restlessness, Vocalising

Apathy - withdrawn, lack of interest, amotivation, inability to initiate

Depression - sad, tearful, hopeless, low self esteem, anxiety, guilt

Psychosis - hallucinations, delusions, misidentification

Resources

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Clinical Resources – Best Practice Guide

The University of Melbourne

Best-practice guide to cognitive impairment and dementia care for Aboriginal and Torres Strait Islander people attending primary care

Version 1.2.4

16 May 2022

Accepted clinical resource RACGP

Dementia Training Australia

NACCHO

A Guide to Cognitive Impairment & Dementia Care for Aboriginal & Torres Strait Islander Peoples

An Overview for Primary Health Care Teams

HEALTH PROMOTION & PREVENTION

Strengthening protective factors

Social & emotional wellbeing & cultural connection
Education & learning
Healthy diet, healthy weight
Not smoking
Moderate or no alcohol
Good hearing
Physical activity & exercise

Reducing risk

Preventing diabetes, stroke, high blood pressure, kidney disease, head trauma, depression, social isolation

DETECTION

Concerns about memory or thinking OR Risk factors present

Cognitive screening

FULL CLINICAL ASSESSMENT

LIVING WITH DEMENTIA

Optimise quality of life
Maintain function
Maximise comfort

HEALTH CARE

Regular, multi-disciplinary primary health care including social & emotional wellbeing, acute health care & chronic disease management

Dementia-specific care including regular review & timely specialist referral

Coordination & case management

END-OF-LIFE CARE

Preparation
Care
Support
Consider palliative care services

PERSONAL PREFERENCES & DECISION MAKING

Now and in the future

At all stages of cognitive capacity

Consider decision makers and powers of attorney (finances, wills)

Advanced care planning & directives

CARERS & FAMILY

Health care
Support services
Education & information
Advocacy & companionship

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Older person’s health check

Aboriginal and Torres Strait Islander health check –
Older people (≥50 years)

MBS items 715 VR/228 non-VR

A good health check:

- is useful to the patient
- identifies health needs including patient health goals and priorities
- supports patients to take charge of their health and wellbeing
- provides a framework for primary and secondary disease prevention through healthcare advice, risk assessment and other measures
- is provided by the regular healthcare provider
- includes a plan for follow-up of identified health needs, priorities and goals.

Disclaimer: This is an example health check template that includes recommended core elements and is intended for use as a general guide only. Health checks should always be completed based on clinical judgement of what is relevant to individual patients and settings. Adaptation to local needs and priorities is encouraged, with reference to current Australian preventive health guidelines that are culturally and clinically suitable to Aboriginal and Torres Strait Islander needs, evidence-based and generally accepted in primary care practice, for example:

- *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*, 3rd edition, The Royal Australian College of General Practitioners (RACGP) and National Aboriginal Community Controlled Health Organisation (NACCHO)
- *CARPA standard treatment manual*, 7th edition, Central Australian Rural Practitioner's Association (CARPA).

Where an individual practitioner or service has skills and capacity to provide culturally safe healthcare, the range of elements in the health check, and use of clinical screening and assessment tools, may be extended.

Key:

- Relevant to nKPIs
- Relevant to QI PIP

About the health check	Yes	No	N/A	
Eligible for health check (not claimed 715 or 228 in past nine months):				Date of last health check:
Consent				
Consent given after discussion of process and benefits of a health check:				
Consent given for sharing of information with relevant healthcare providers:				Who/details:
Date:	Doctor:		Nurse:	
Aboriginal and/or Torres Strait Islander Health Worker / Health Practitioner:				

We worked with services to introduce questions about memory & thinking to the older person’s Aboriginal Health Check.

Assessment

Memory and thinking

Do you have any worries about your memory or thinking?

☐ Yes ☐ No Details:

Does anyone in your family have any worries about your memory or thinking?

☐ Yes ☐ No Details:

If any concerns are raised and/or high risk for cognitive impairment identified, follow up with cognitive screening (eg clock test, GPCOG, KICA-Cog, MMSE)

Details:

Clinical resources:
- GPMP recommendations
- Cognitive impairment and dementia protocol

Kimberley Clinical Protocols

Cognitive Impairment and Dementia

Case Definitions

Cognitive Impairment
May be due to **reversible causes** (e.g. delirium, medications, depression) or indicate **dementia**.

Mild Cognitive Impairment (MCI)
- Objectively assessed cognitive impairment
- Modest cognitive deficits that **generally do not impact on a person's capacity to function in daily life**
- Conditions such as Alzheimer's and cerebrovascular disease, pain, depression, polypharmacy or delirium can lead to MCI.
- Not static- can improve or decline with time.

*Note that MCI overlaps with the DSM-5 classification **Mild Neurocognitive Disorder**.*

Dementia

Dementia can occur in Aboriginal populations at 3 – 5 times the rate of other populations

- Progressive, non-reversible condition
- Encompasses disordered thinking, executive function and memory
- **Severe enough to interfere with a person's life** that is a change from previous levels
- Diagnosis should only be made after depression and delirium as causes for symptoms are excluded, although both commonly co-exist with dementia
- Most common causes are Alzheimer's disease and vascular dementia, although a mixture of varying pathologies are often present.

*The DSM-5 term for this condition is **Major Neurocognitive Disorder**.*

Risk Factors
Risk factors for cognitive impairment and dementia include;

- Impaired hearing
- Lower education levels
- Family history of dementia
- Smoking
- Depression
- Social isolation
- Traumatic brain injury
- Hypertension, ischaemic heart disease, atrial fibrillation
- Childhood trauma
- Physical inactivity
- Air pollution
- Diabetes
- Obesity
- Heavy alcohol consumption
- Cerebrovascular disease
- Epilepsy
- Psychosocial stressors
- Polypharmacy

A life-course approach is recommended to prevent or delay cognitive impairment or dementia.

Refer to *Healthy Lifestyle Protocol* and *Chronic Disease Protocols* (*Type II Diabetes*, *Hypertension*, etc.).

In addition, regular review of vision, hearing, social and emotional well-being (SEWB) and medications with potential cognitive side effects is recommended.

Case Finding

A case finding approach to detecting MCI and dementia is recommended in **Aboriginal and Torres Strait Islander patients 50 years and over.**

Case finding may be facilitated by:
- Assessing risk factors for dementia (see above)
- Asking questions about memory or thinking problems (e.g. do you have any worries about your memory? Does anyone in your family have any concerns about your memory or thinking?)
- Staff raising concerns (e.g. due to missed appointments, patient appearing vague, etc)
- Family or other community (members) raising concerns.

Always consider using an interpreter, and/or involving an Aboriginal Health Practitioner

Note, that especially in those under 50 years, other causes may need to be considered (e.g. brain injury).

Initial Assessment

When cognitive impairment is identified or suspected:
1. Use **cognitive screen** e.g. KICA-Screen (< 21/25 indicates possible dementia) or KICA-Cog (< 34/39 indicates possible dementia)
2. Take **collaborative history** from patient and family including onset and progression of symptoms, medications, other illnesses and associated behavioural and psychological symptoms (BPSD). See KICA-Carer within full KICA (> 2/16 suggest further investigation)
3. **General examination** including cardiovascular, neurological and gait assessment
4. Differentiate from **depression or delirium** (see Box 1, Table 1)
5. Review **medication list** and adherence
6. Standard **pathology tests:** FBC, UEC, LFT, calcium, magnesium, HbA1c, B12, thyroid function and syphilis serology
7. Conduct **CT brain** where possible
8. When cognitive impairment is confirmed or highly suspected consider **referral to a geriatrician or physician** for further assessment and management of comorbidities.

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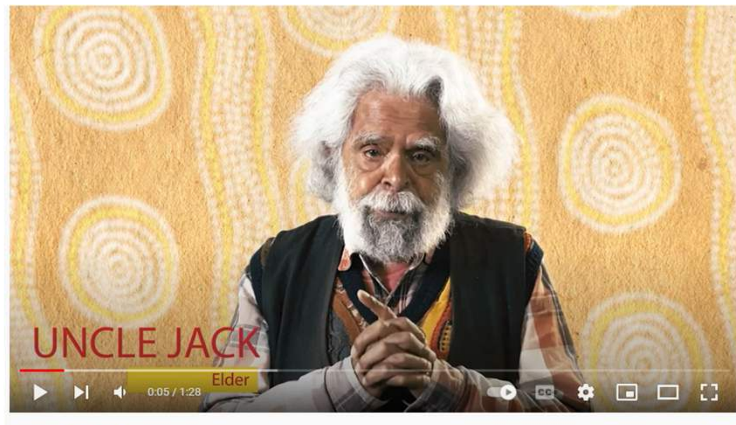
Community Outreach: Elders Breakfast for BRAMS

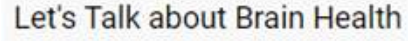
Six-part Webinar Series

Five-Part Video Series: Yarning about memory and thinking problems and conducting a cognitive assessment

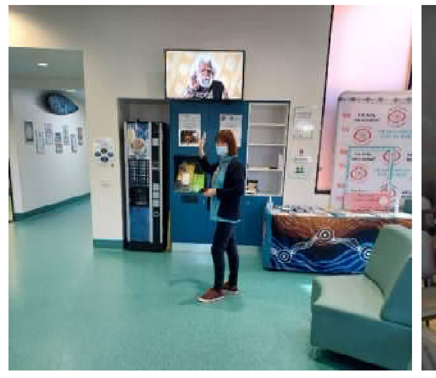
Part 1 - Memory and Thinking Problems and Our Mob

Let's CHAT Brain Health Ads

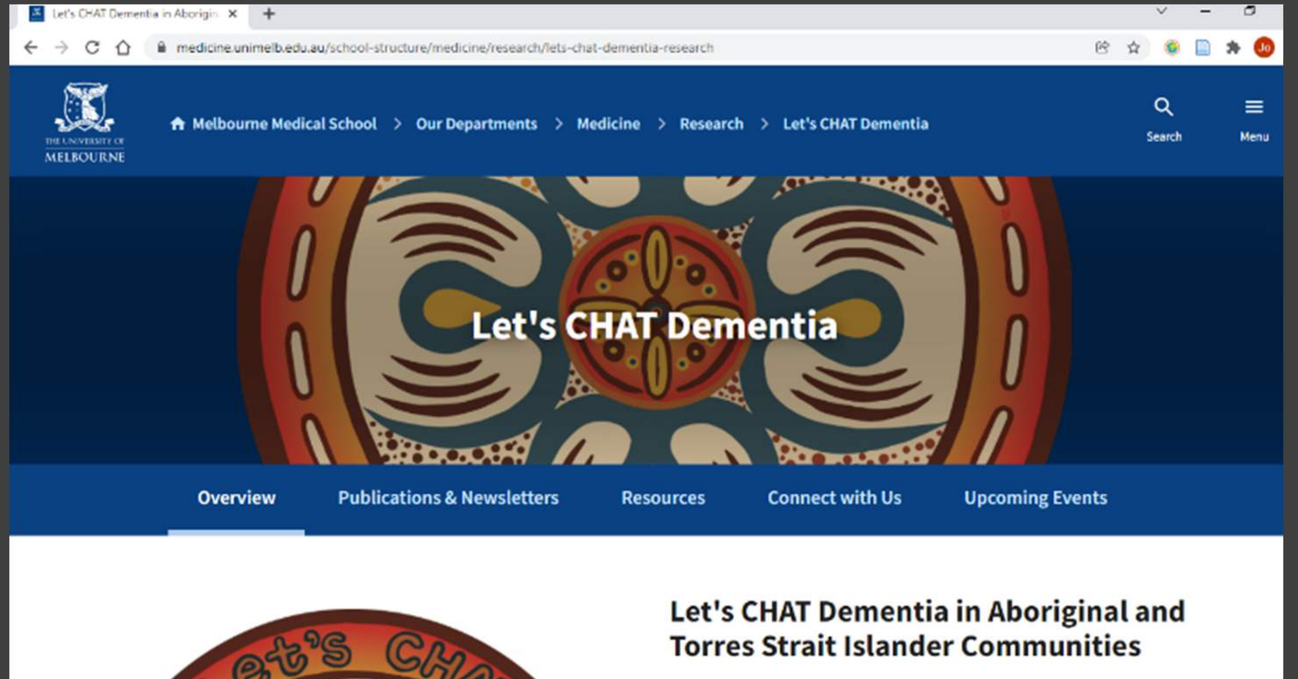




Let's Talk about Brain Health



Let’s CHAT Dementia Project Website



Please visit our website for more information about the project and to check out all of our resources, including:

- The Best-practice guide
- Other clinical support resources
- Webinars
- Videos
- And more…

Caring for Spirit Website

WWW.CaringForSpirit.org.au

HOME | ABOUT THE PROJECT | LIVING WITH DEMENTIA | RESEARCH AND OTHER RESOURCES | TRAINING MODULES | CONTACT US

Growing old well is something we all want for our communities. What we know, is that growing old well is influenced by many things that happen throughout our lives. Getting dementia can have an effect on our mind, body and spirit.

Dementia and Our Mob

What is dementia and how does it affect our mob?

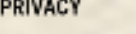
Healthy Mind, Body and Spirit

There are many reasons why people get dementia. But there are things that we can do that help keep our mind, body and spirit well.

Still Me, Still Deadly: Living with Dementia

When someone has dementia it can seem like the real them has gone missing. But having dementia, or caring for someone with dementia can be easier when we know about the signs and symptoms.

We pay our respects to the Traditional Owners of the land on which we live and work, and acknowledge that Aboriginal people are the first peoples of Australia.
We pay our respects to the Elders both past and present.
Aboriginal and Torres Strait Islander people should be aware that this website may contain images, voices or names of deceased persons in photographs, film, audio recordings or printed material.

CONTACT | PRIVACY | DISCLAIMER | 

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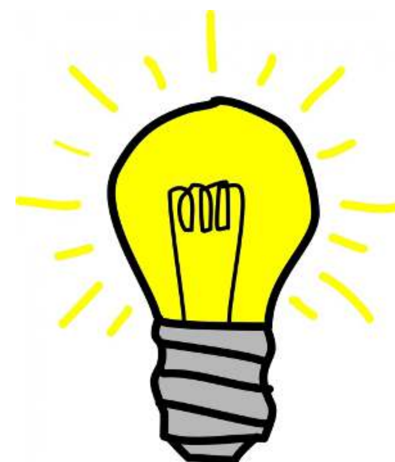
Caring for Spirit
Online Training Modules

- Targeted for Aboriginal and Torres Strait Islander Health Care Worker and Aged Care Staff
- Four Modules
  - What is Dementia?
  - Dementia Assessment and Professional Support
  - Supporting People Living with Dementia
  - Strong and deadly - Looking after yourself (for a person with Dementia and for carer)

Supporting detection in the health service

- ***Think about*** brain health
- ***Be aware*** of risk factors, especially in 50+ patients
- ***Take notice*** of concerns about memory, thinking & confusion and follow them up
- ***Ask questions***



CULTURE COMMUNITY COUNTRY FAMILY CONNECTION
KINDNESS, COMPASSION
LIVING WELL AGEING WELL
RESPECT FOR ELDERS
ENGAGEMENT, TRUST, HEALTH LITERACY
SEEN, HEARD, RESPECTED, VALUED
WHOLE PERSON, WHOLE OF LIFE
GETTING HEALTH CARE
HIGH QUALITY HEALTH CARE, EVIDENCE-BASED GUIDELINES
FAIRNESS, EQUITY, EVERYONE

Grahics by Sherry Johnson | Gunditjmara