

Memory Service, not Memory *Clinic*

the need for psychological leadership



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relaxed**Therapy**

simple accessible Clinical & Neuro Psychology

*Leslie,
not Lesley*

*Dryden,
not Leslie*

**Leslie Dryden
Badenoch**

*Bad-en-ohc,
not Bayd-en-ock*

*Learning Difficulties,
not Mental Handicap*

*Resident,
not Patient*

Social Role Valorisation

*Down's Syndrome,
not "Mongol"*

Memory Service

So when, after a year of developing the Waikato Memory Service, people were still referring to it — in every sense — as...

Memory Clinic

the Memory Clinic, I had to wonder whether they were missing something important, or whether I was just being typically picky about names.

Annette Anderson

Jan Foster

Siva Govender

Etu Mau

Robyn Riddle

Christina Russo

John Strachan

Gwyneth Williams

Verity Brown

Mary Gillooly

Fran Marsh

Colin Patrick

Angela Ross

Alison Stearn

Dianna Taylor

Ian Wright

These are the people I had the privilege to work with in the Waikato Memory Service.

Annette Anderson

Verity Brown

Jan Foster

Mary Gillooly

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Fran Marsh

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Colin Patrick

Robyn Riddle

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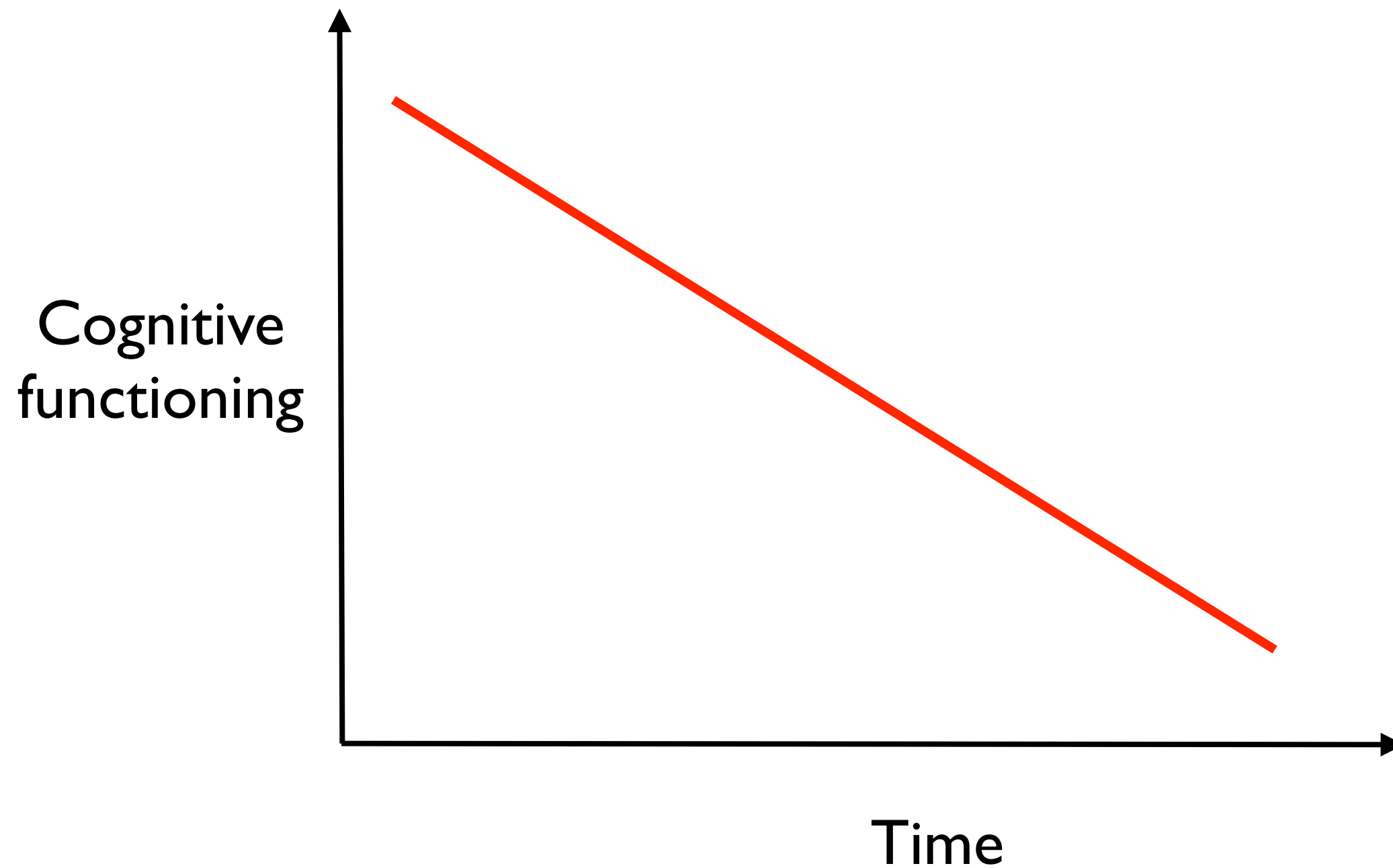
Gwyneth Williams

Ian Wright

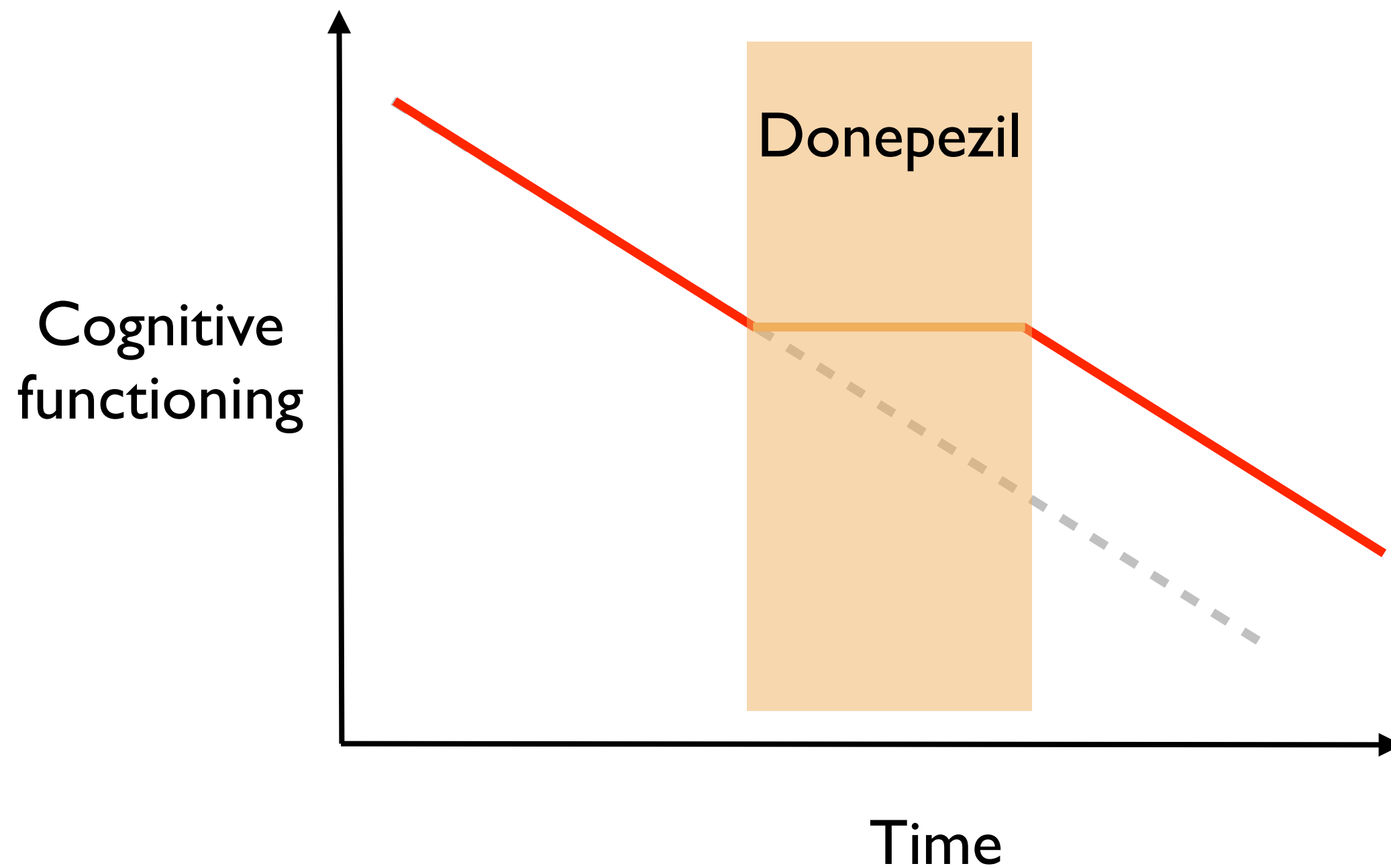
Half of them are medics, which isn't unusual. Most Memory Clinics are led by geriatricians, psychogeriatricians and (outwith NZ) neurologists. Psychologist-led Clinics are rare.



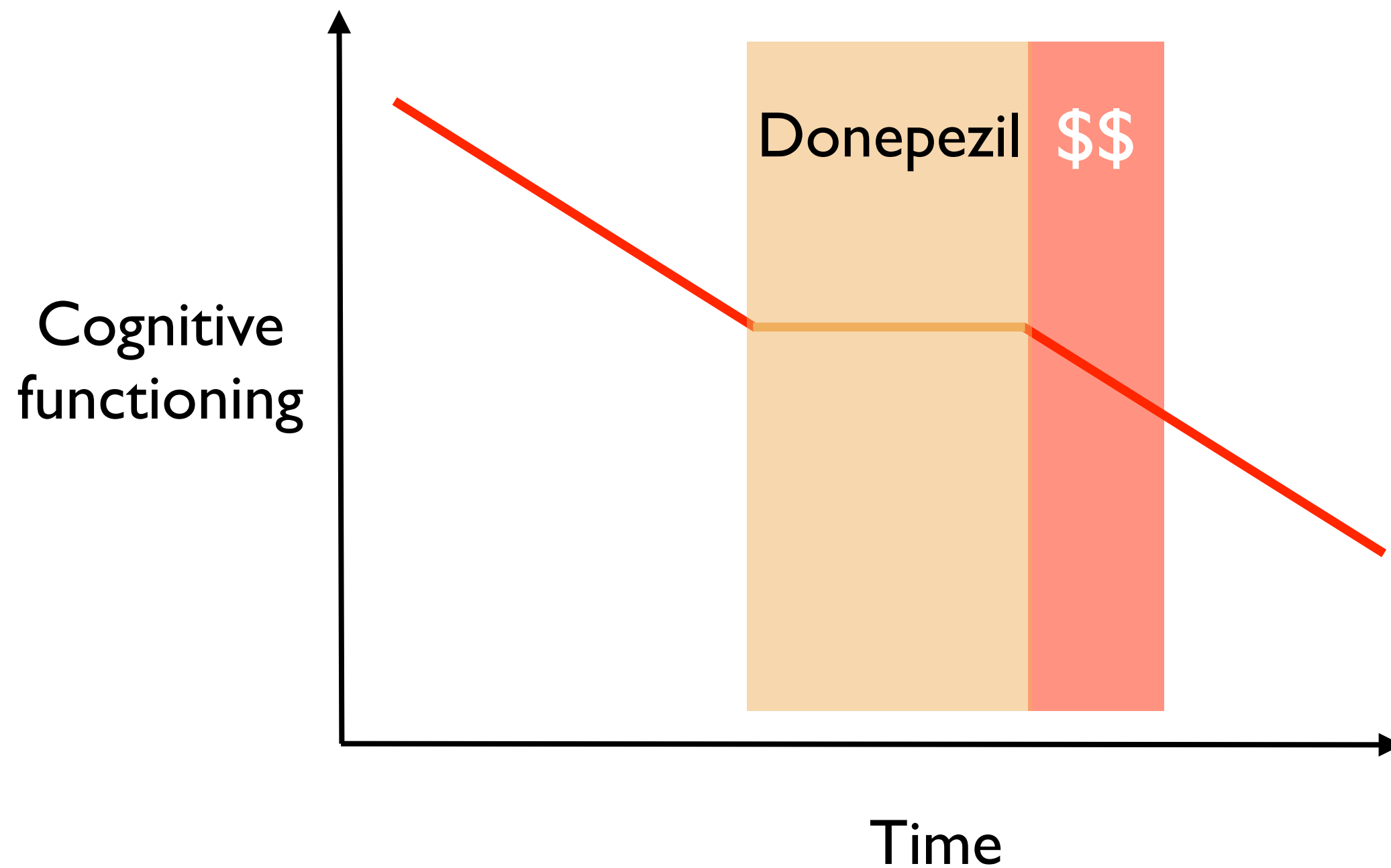
Memory Clinics have their origin in the development and testing of anti-dementia drugs, such as Pfizer's **Donepezil**.



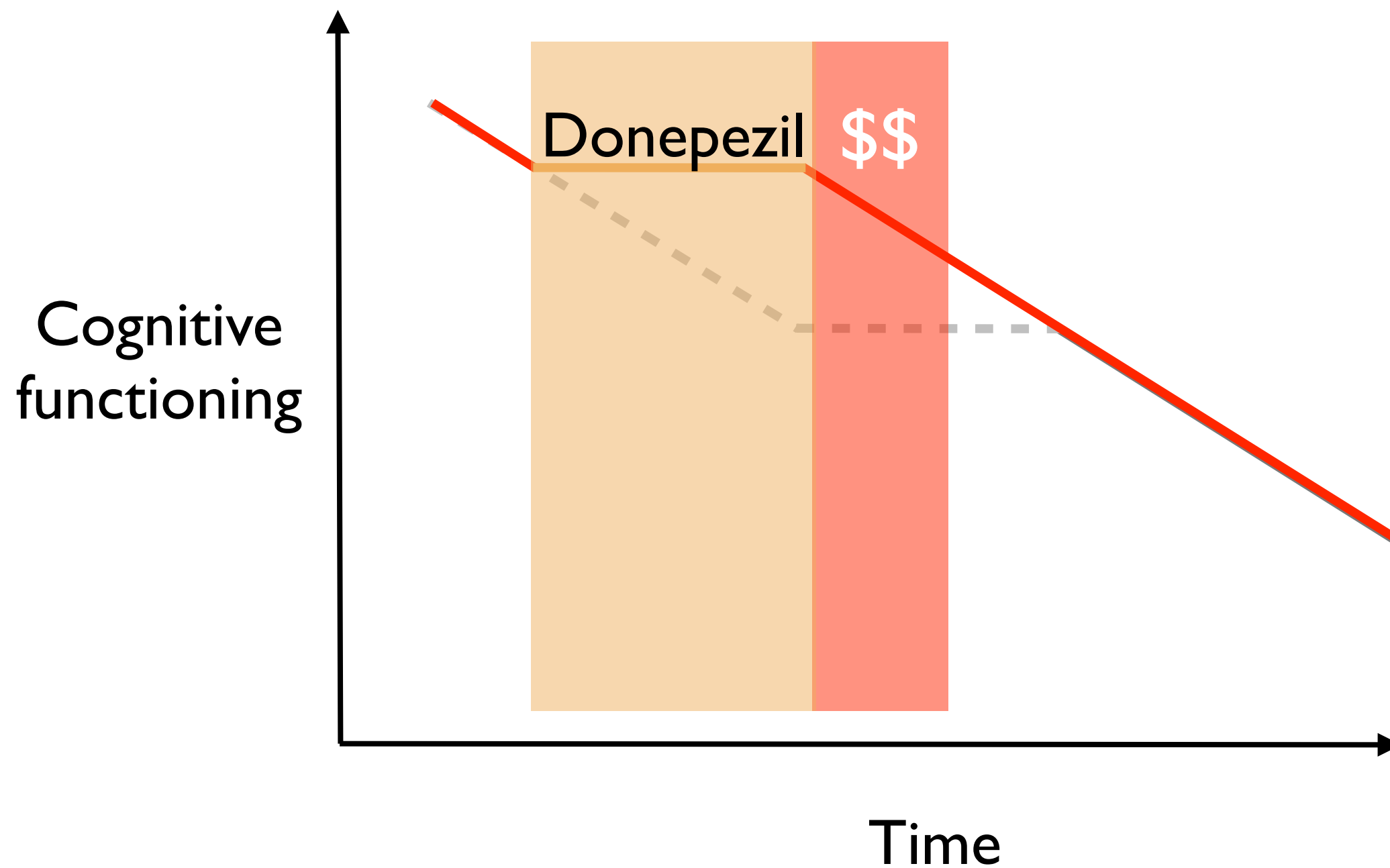
Dementia is not a diagnosis, but a syndrome:
a pattern of progressive neurological, psychological and functional impairment



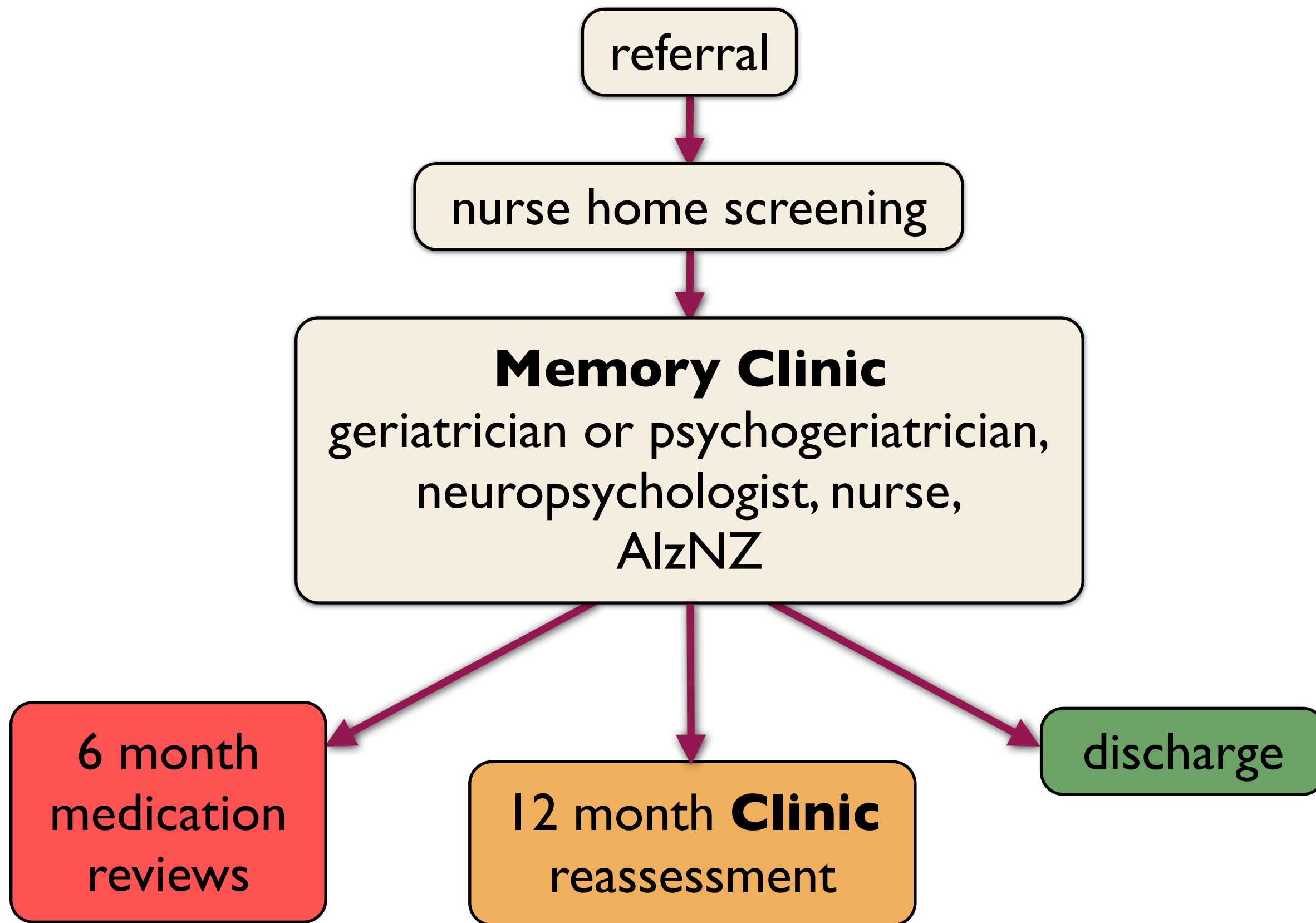
Pfizer claim **Donepezil** can arrest the deterioration in Alzheimer-type dementia for up to two years.



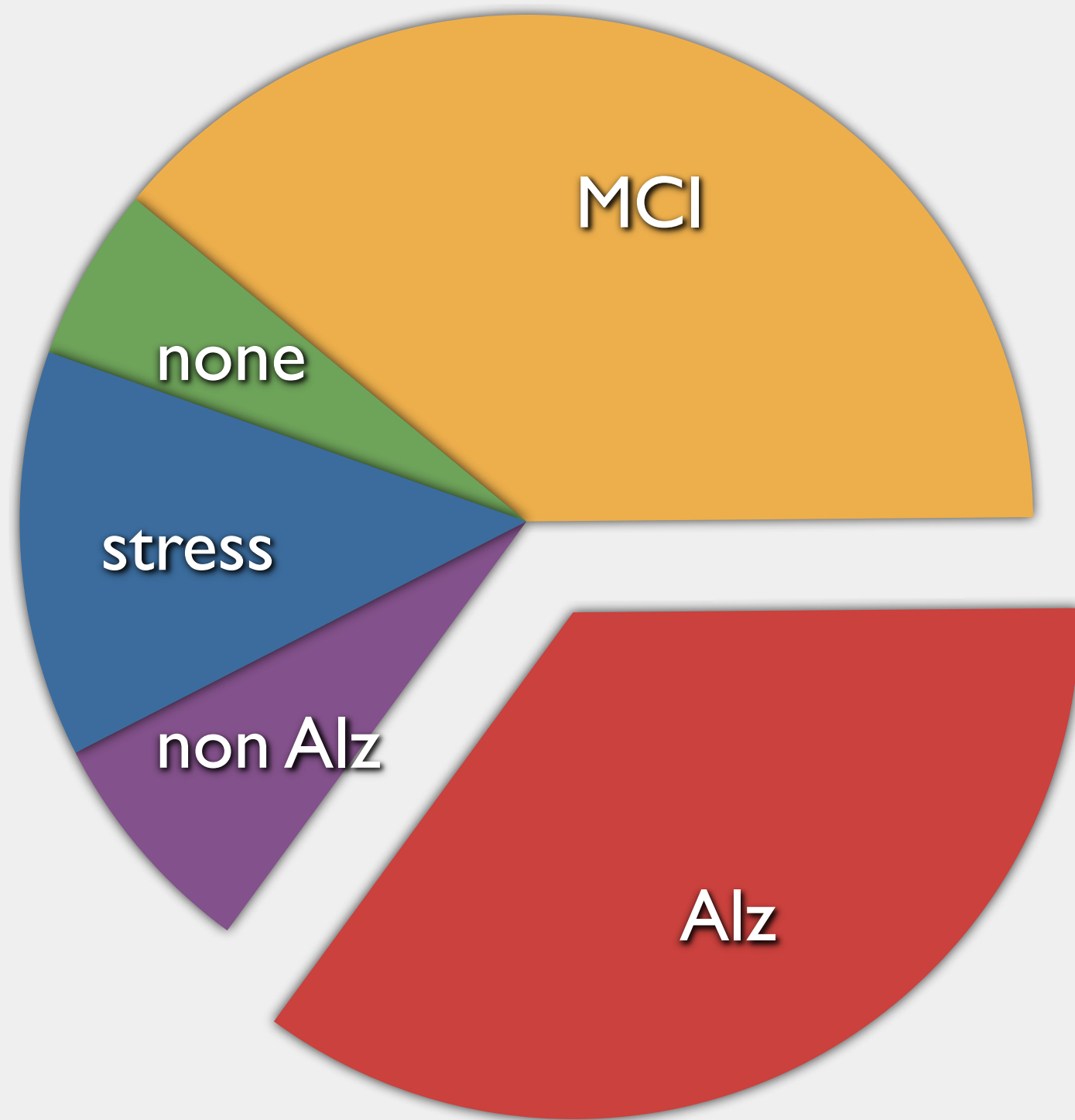
Donepezil is expensive: \$400 per month. It makes sense to discontinue the medication as soon as it's no longer having a beneficial effect, which necessitates close monitoring by the prescriber.



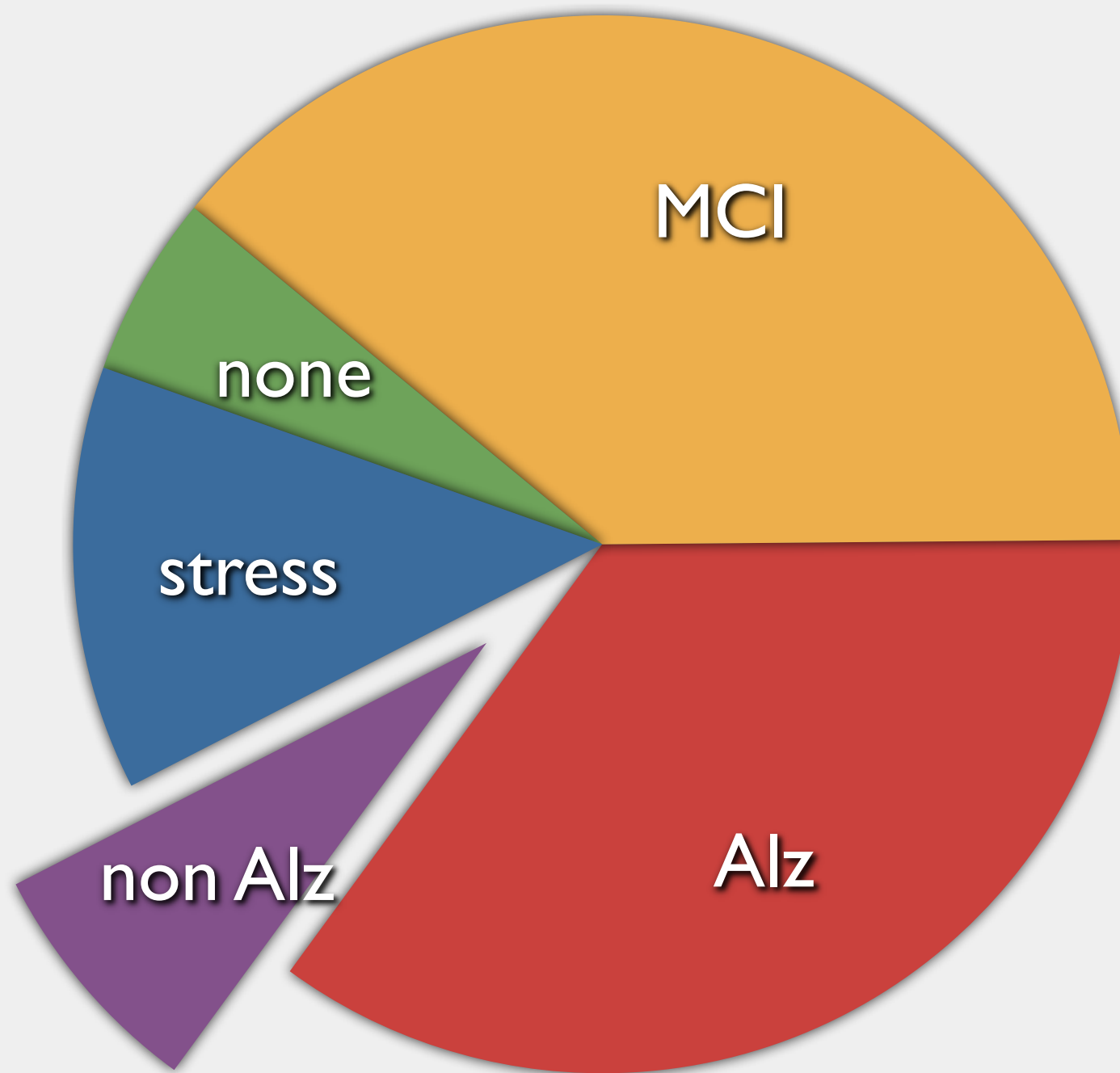
Similarly, it's in everyone's interest for the client to receive the medication as early in the progression as possible, in order that they retain the highest level of independence possible.



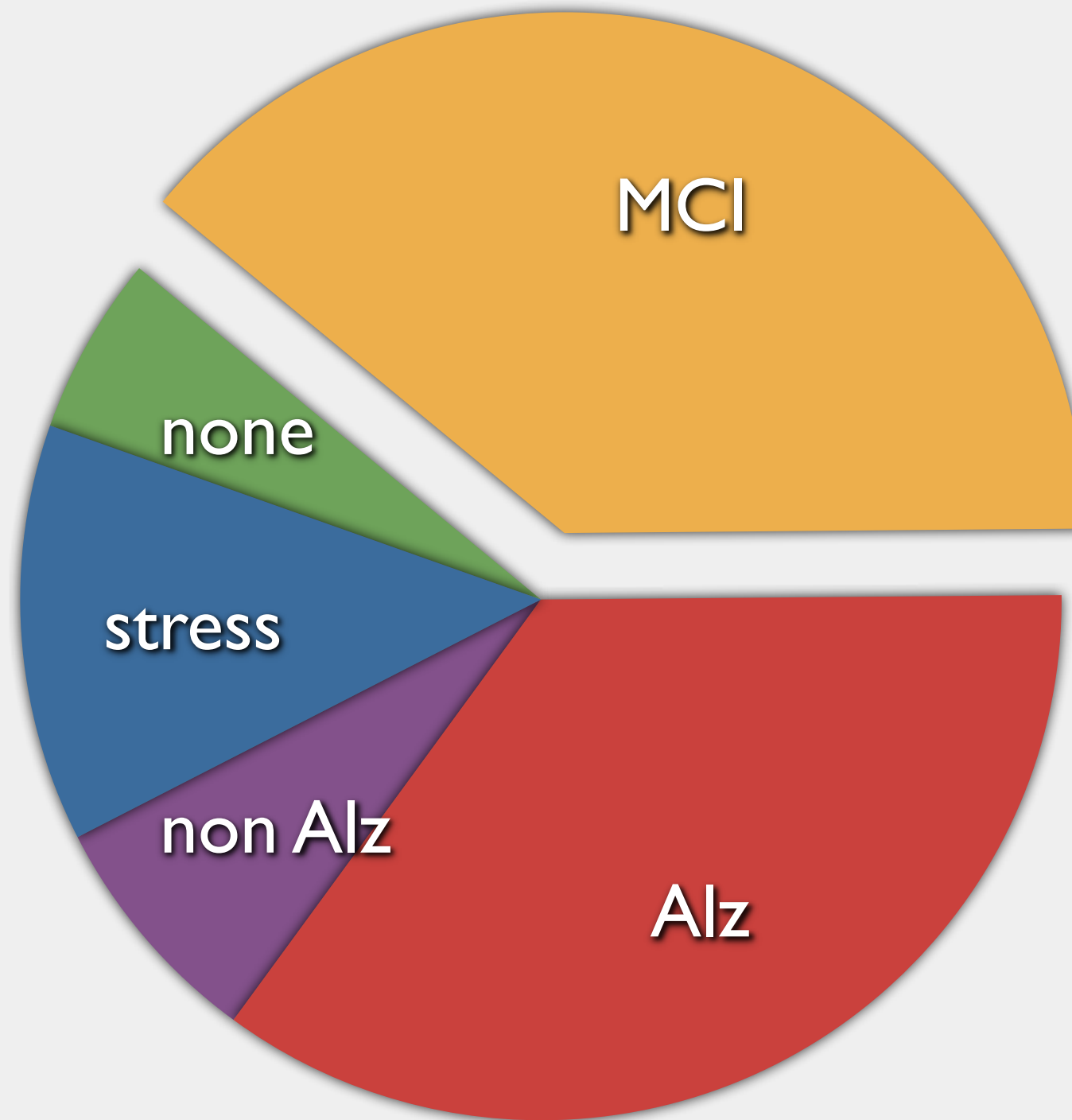
These needs dictate the form of the Memory Clinic: 6 month followup for people prescribed **Donepezil** and yearly reassessment for people at high risk of developing dementia.



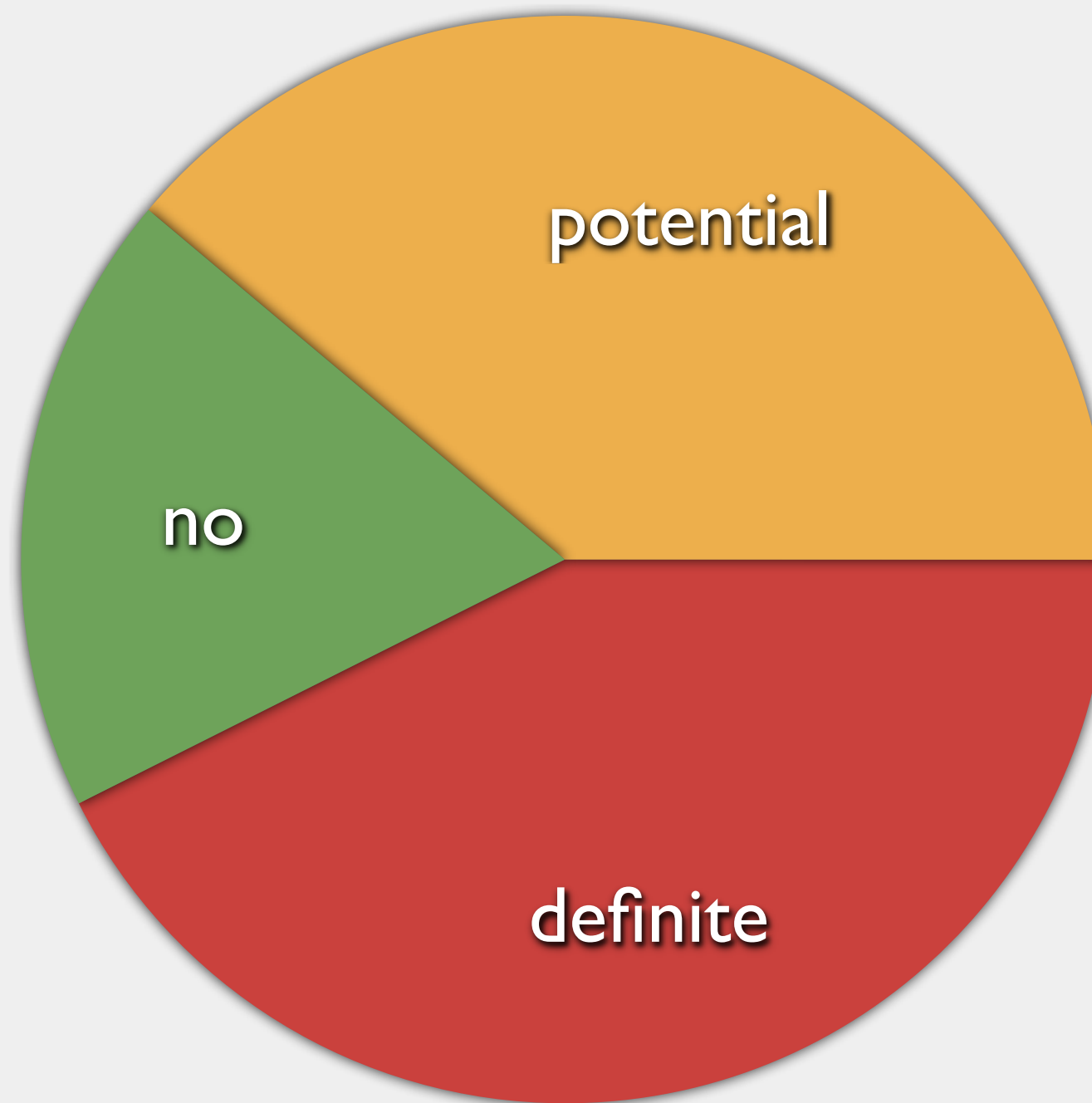
More than one-third of people attending the Waikato Memory Clinic for the first time were identified as having Alzheimer-type dementia (so were eligible for **Donepezil**).



One in ten first attenders was identified as having some other form of dementia (so was not eligible for **Donepezil**, which is licensed only for Alzheimer-type dementia).



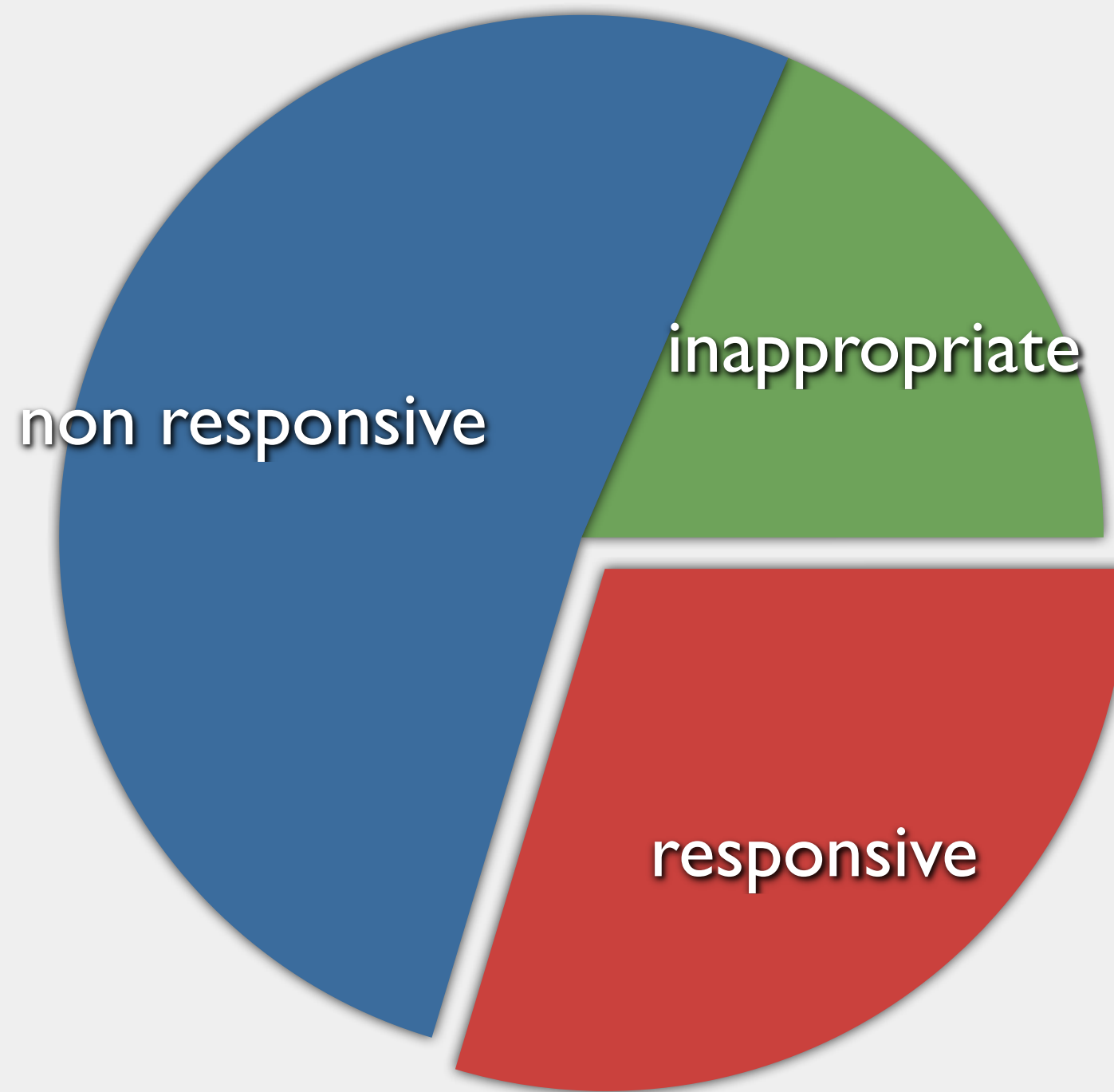
And more than a third were labelled as having “Mild Cognitive Impairment”, with a 15% risk of developing Alzheimer-type dementia in each coming year.



More than two-thirds of first-time attendees were definitely or potentially developing dementia, which looks like a strong case for medical leadership. Maybe I was just being picky about names?

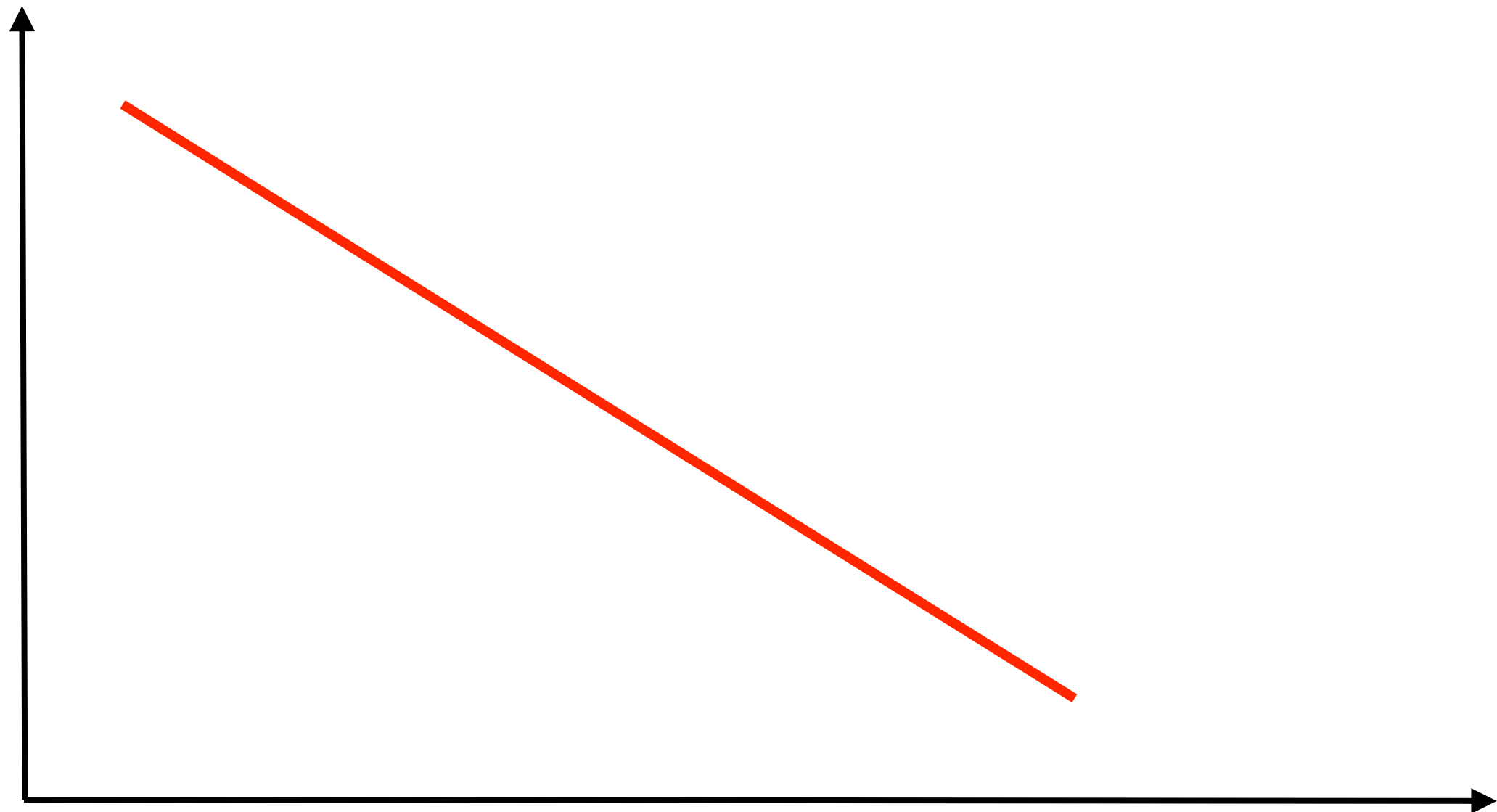


And yet... even the most optimistic **Donepezil** trials report that no more than 40% of patients “respond to” — i.e. derive any benefit from — the drug.



Even if all those at risk eventually develop Alzheimer-type dementia, the majority of Clinic attendees will derive no benefit from **Donepezil**... but are still suffering cognitive impairment.

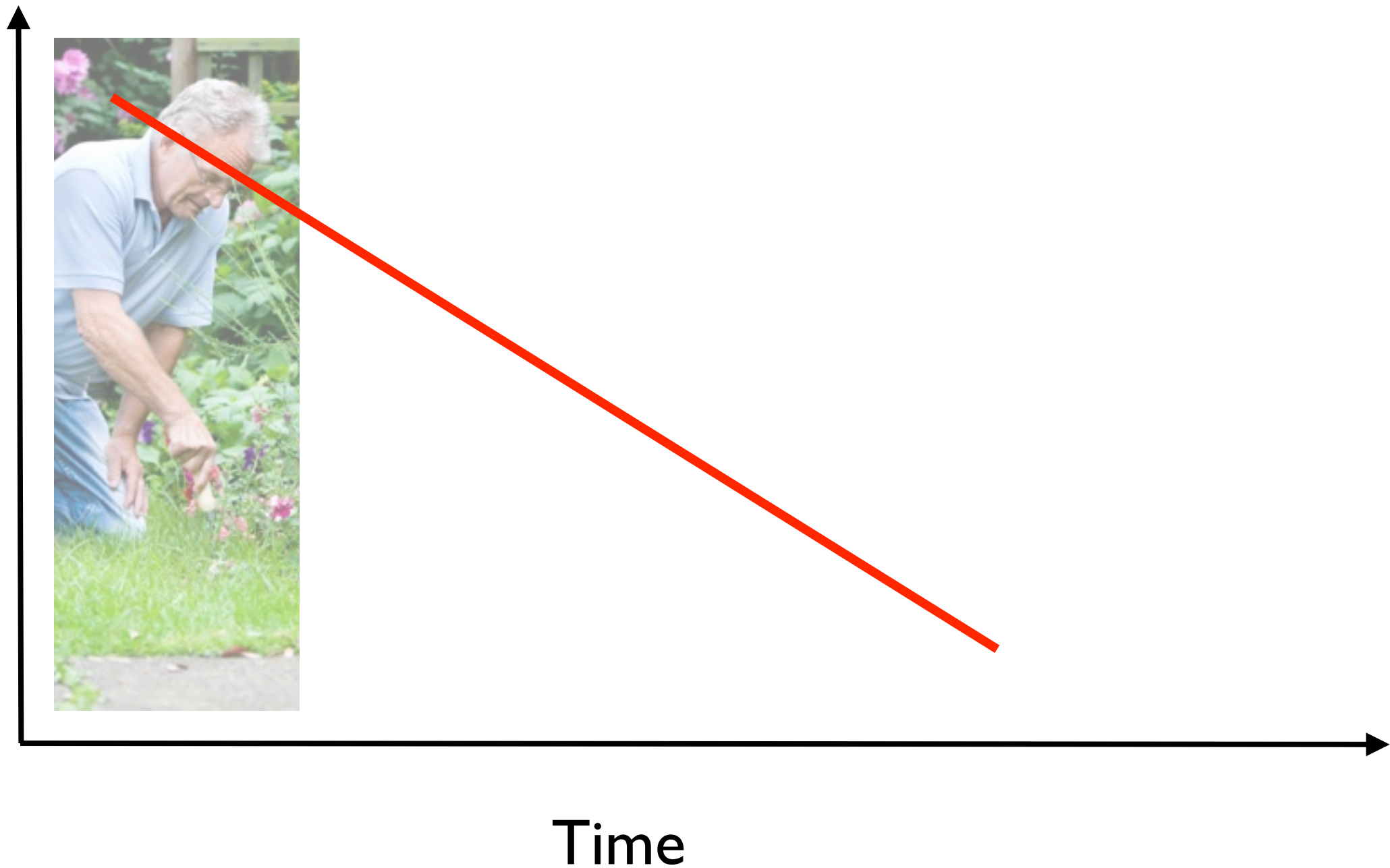
Cognitive
functioning



Time

What the majority — responders and non-responders — do have in common is progressive disconnection from society. Linda Clare has described a sociocultural model of dementia:

Cognitive
functioning



(I) a slow accumulation of minor lapses and difficulties, leading to consultation & assessment.

Cognitive
functioning



Time

(2) post-diagnosis, a period in which normal life is still possible with assistance, but there is a tendency to pre-empt social rejection by withdrawing from work, friends and leisure activities.

Cognitive
functioning



Time

(3) when independent activity is no longer possible, sheltered activity & specialist supports can preserve home life through a focus more on the family, minimising the stress of caring.

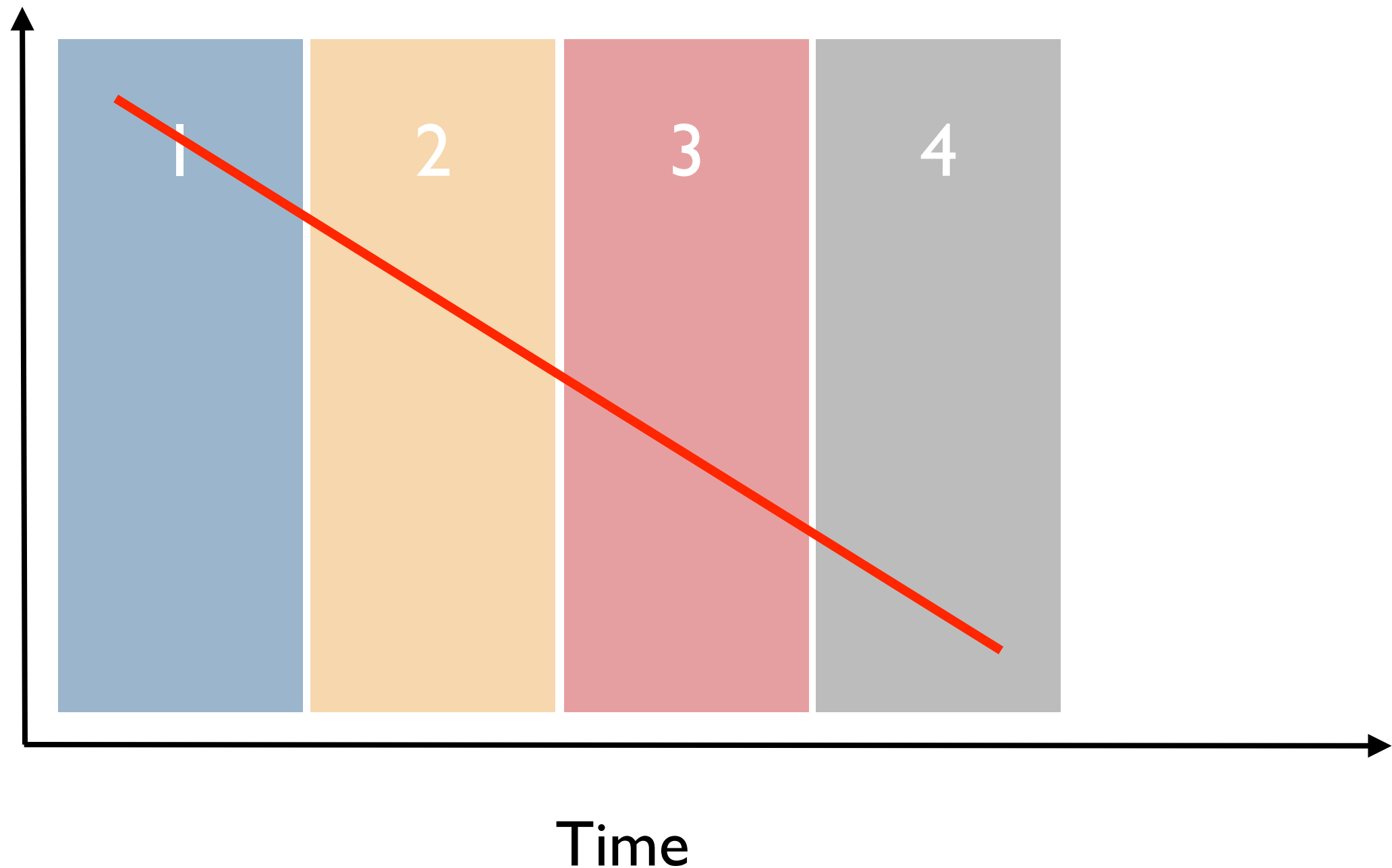
Cognitive
functioning



Time

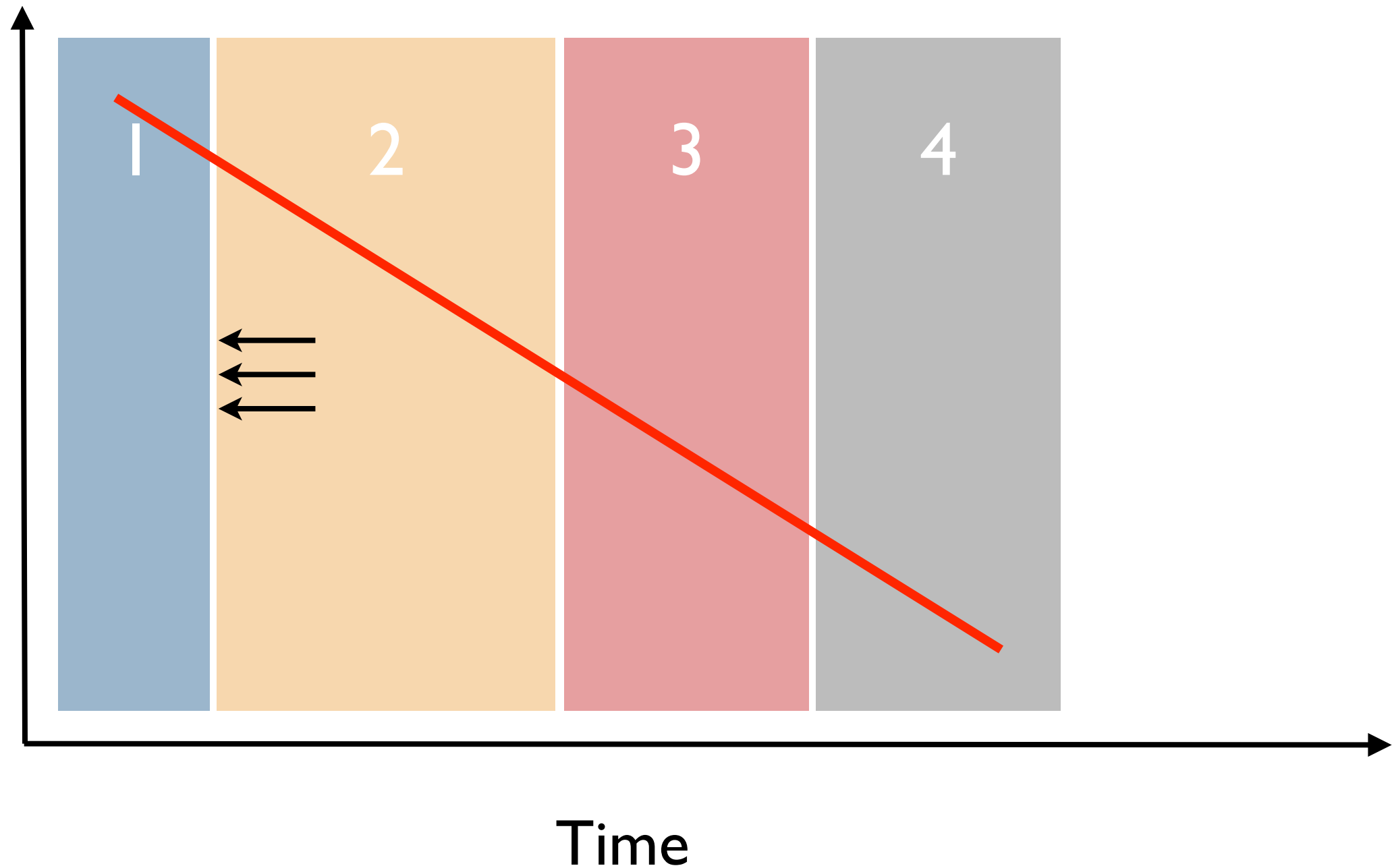
(4) when home care is no longer practical, residential care is required.

Cognitive
functioning



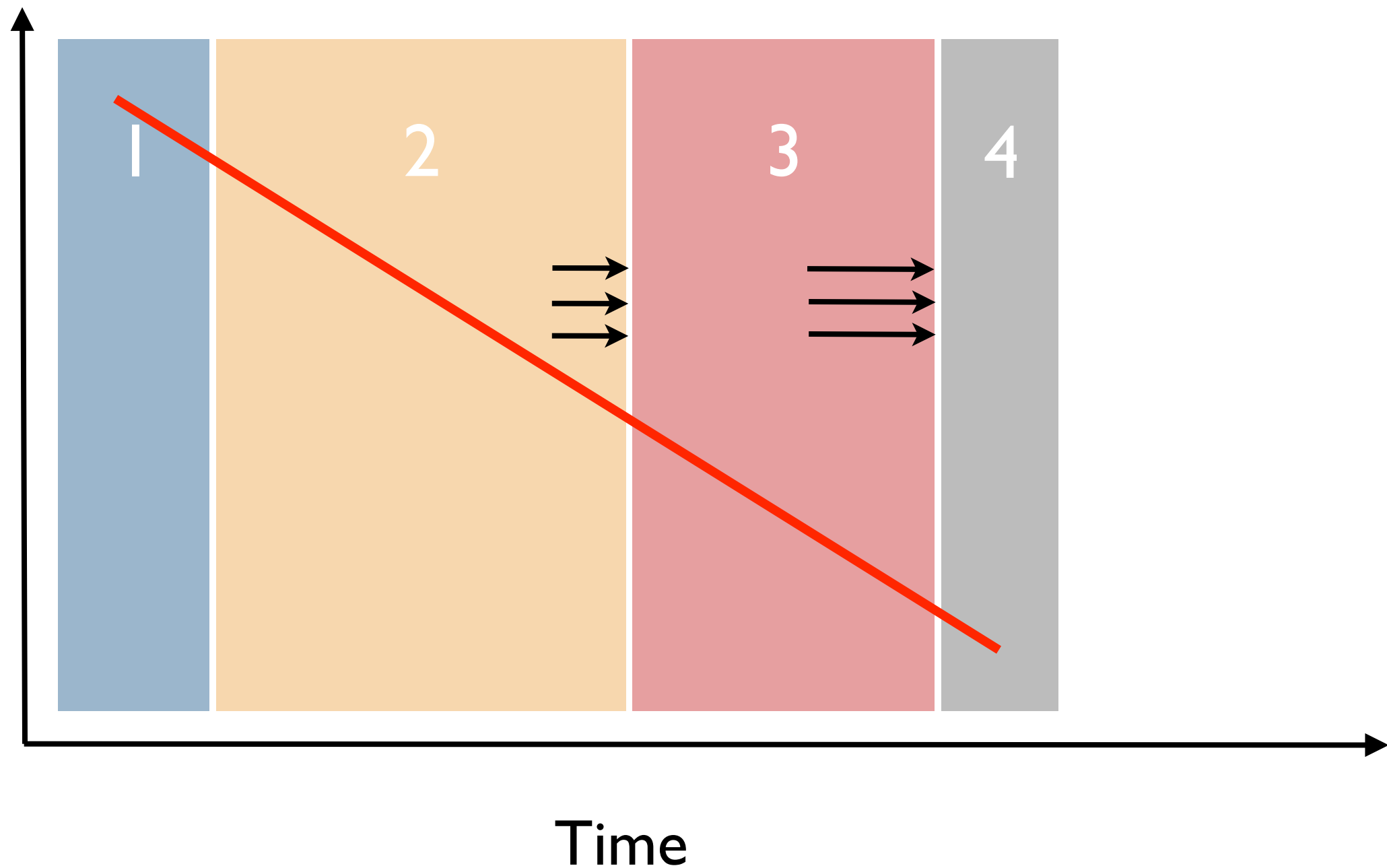
This perspective shifts the priorities of the Service: now the ideal would be to maximise stages 2 & 3 at the expense of stages 1 & 4: applied psychologists have much to contribute to this.

Cognitive
functioning



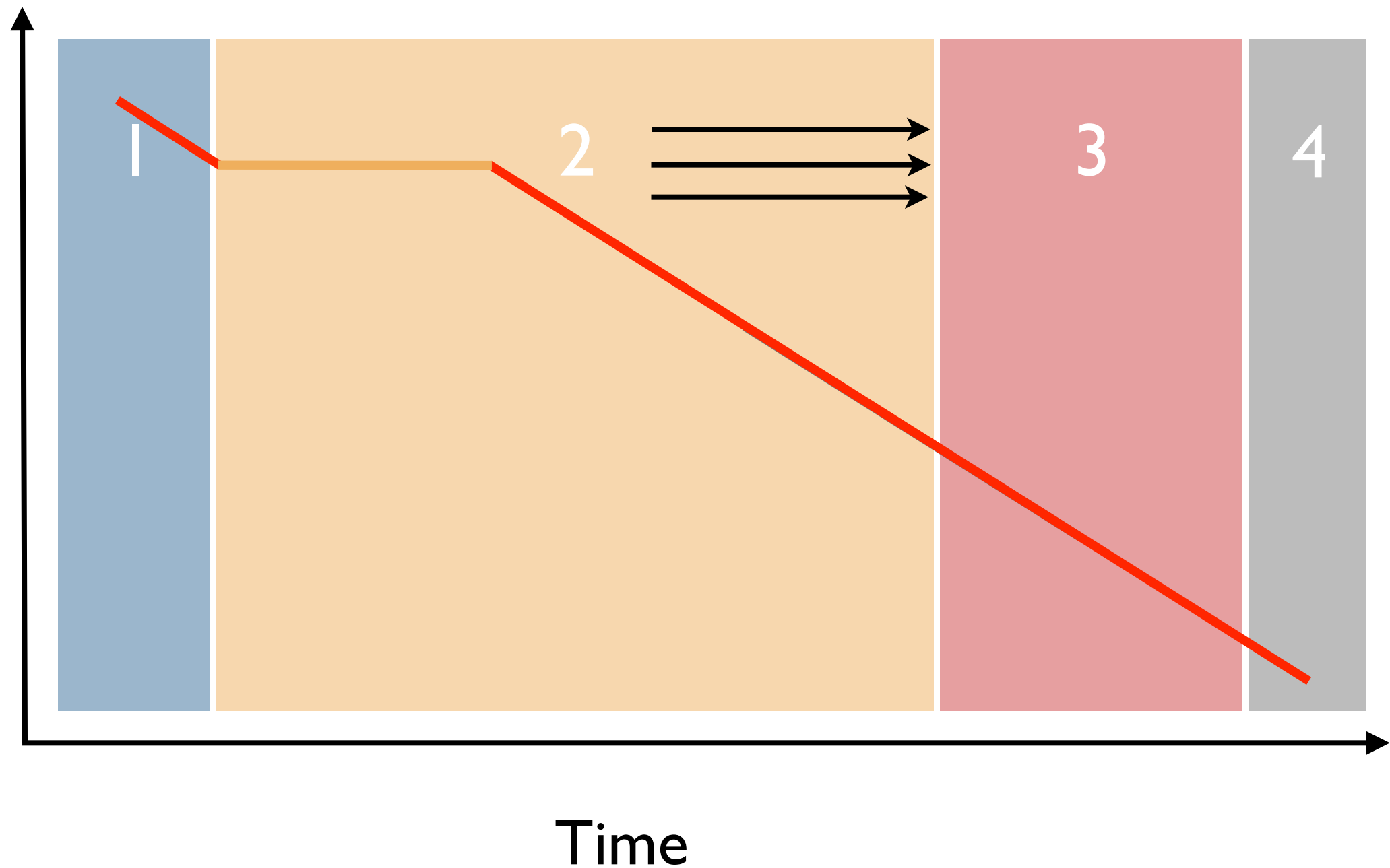
We still want early assessment, to catch clients before they abandon activities and withdraw from social contact. We can address social anxiety, resentment and communication breakdown.

Cognitive
functioning



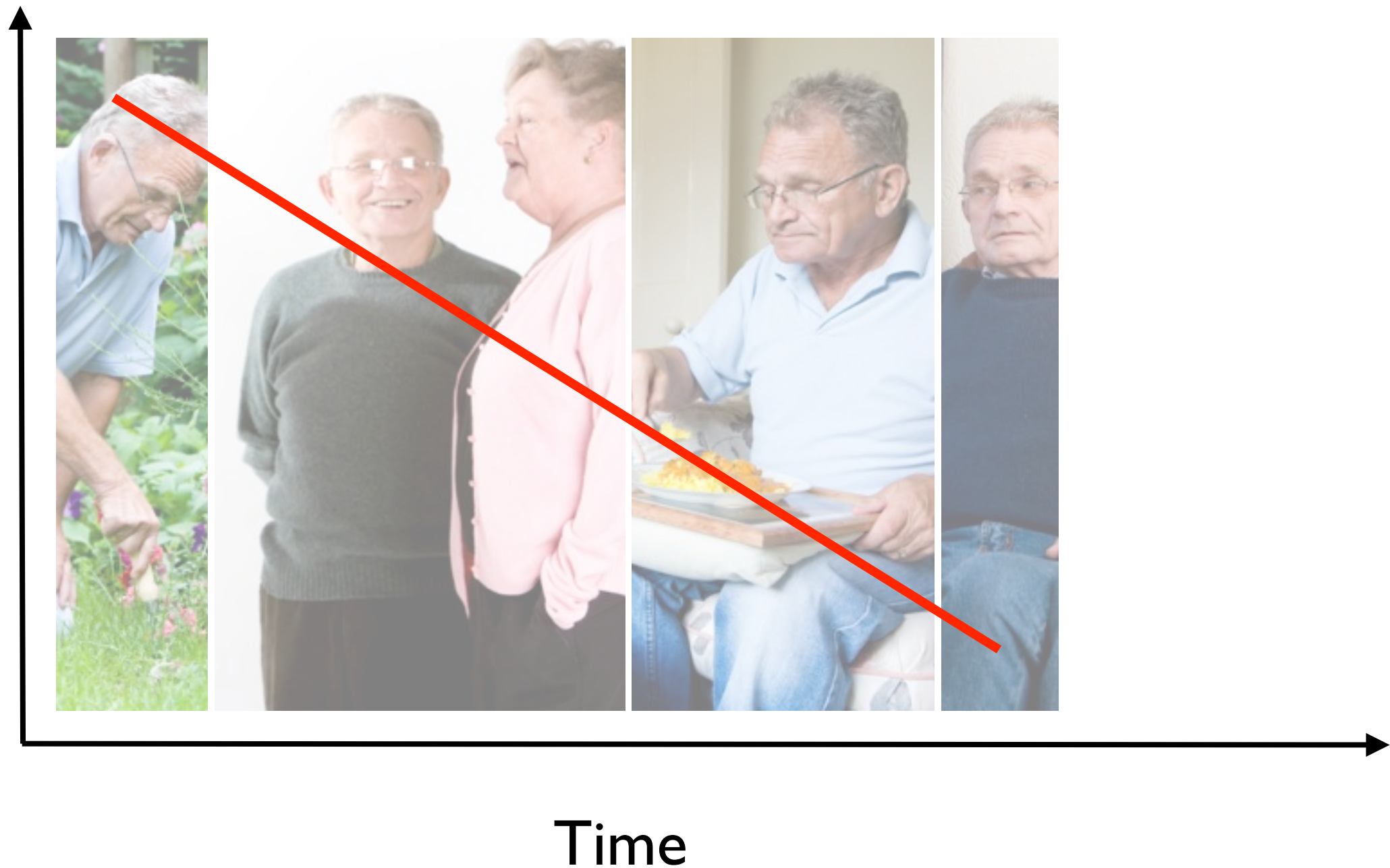
We also want to extend home care as long as possible by minimising carer burden and heading off the social withdrawal which might follow a partner's social functioning deteriorating.

Cognitive
functioning

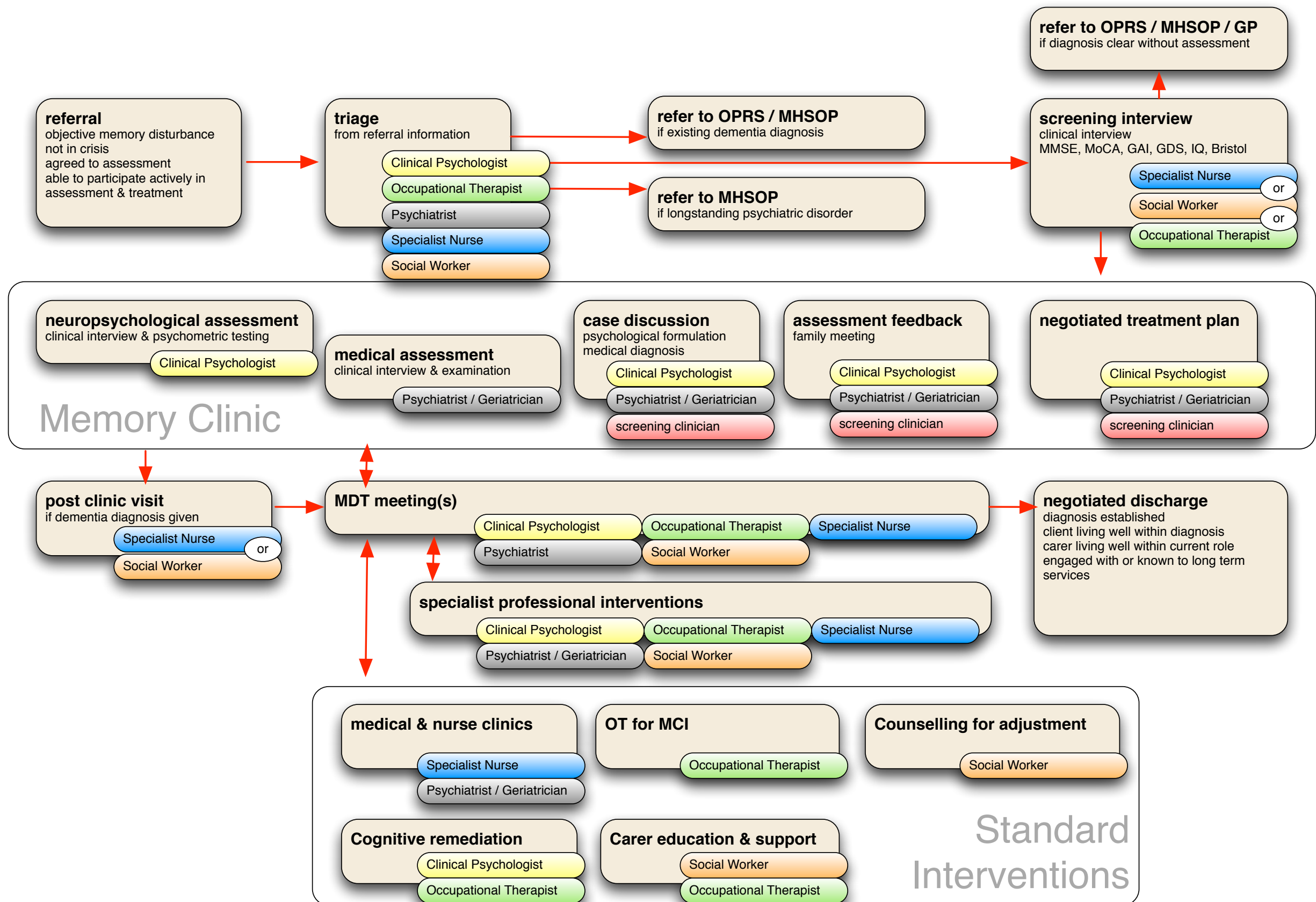


There's clearly a place for **Donepezil** in this framework,
for the fortunate minority who will benefit from it.

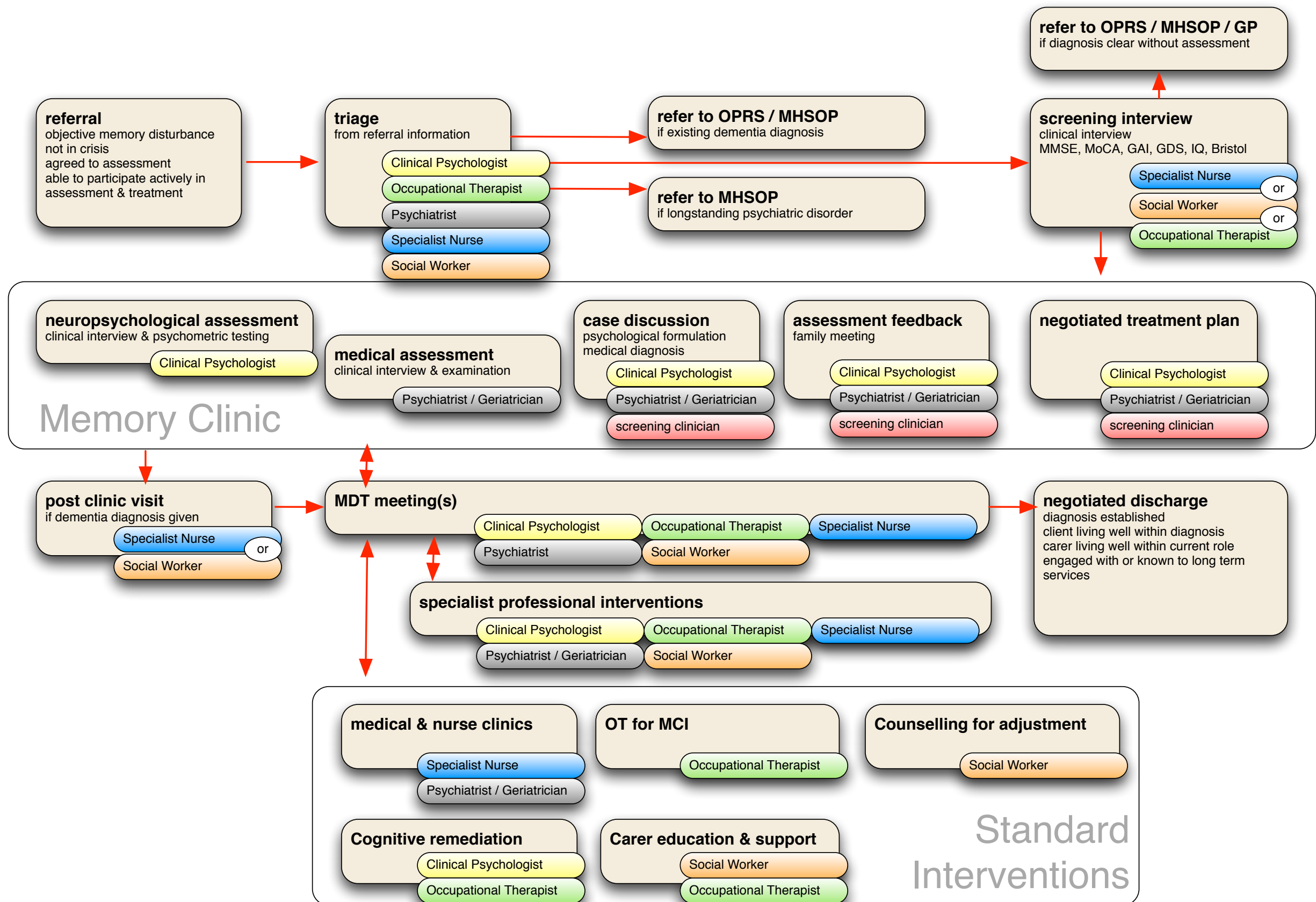
Cognitive
functioning



For the majority, however, interventions will be — of necessity— entirely psychosocial.



The client pathway for the Waikato Memory Service reflects this: the Clinic is still important, but the medical role is clearly not pivotal and the emphasis is on the psychosocial interventions.



With good links to GP, social and voluntary services, a Clinical Neuropsychologist and an experienced Occupational Therapist might suffice to deliver the core interventions.

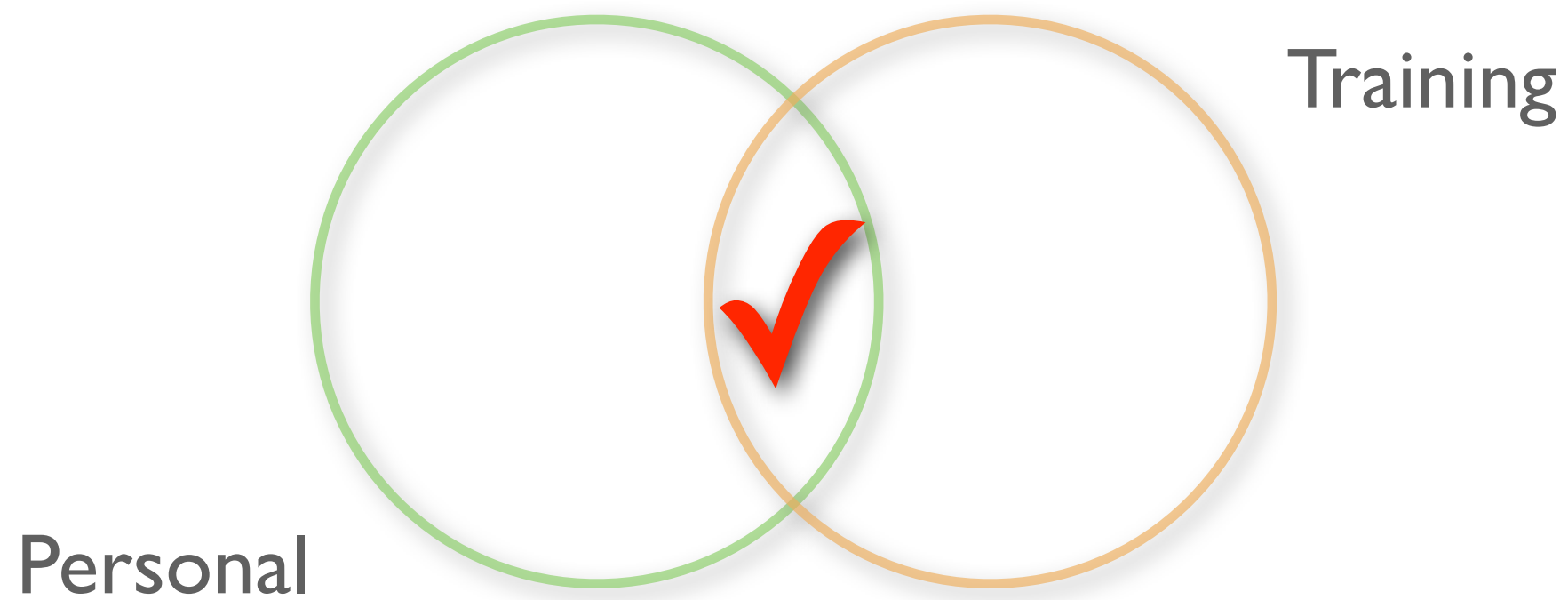


work at
the limits of
your licence

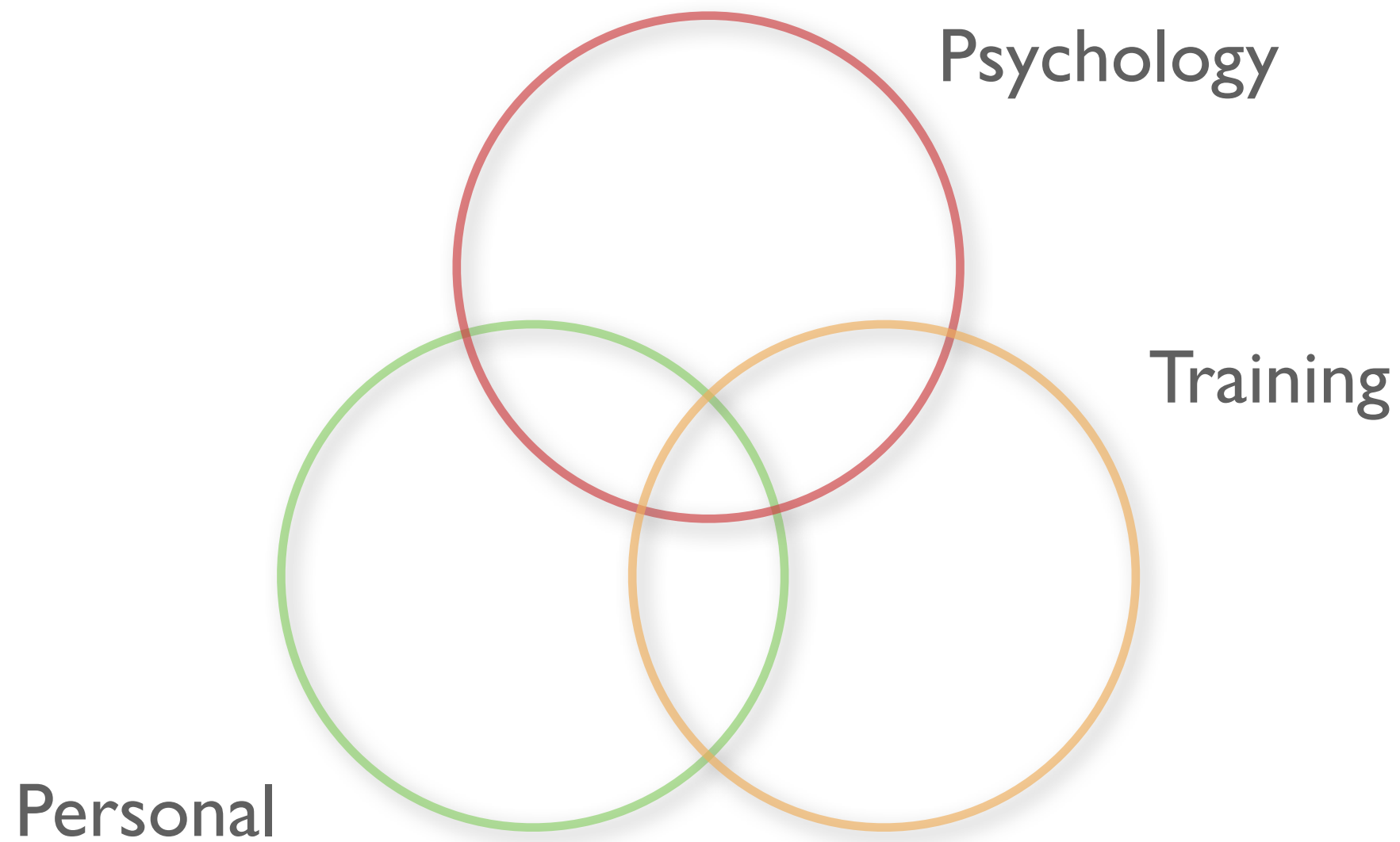
step up to
prescribing

instead of
what?

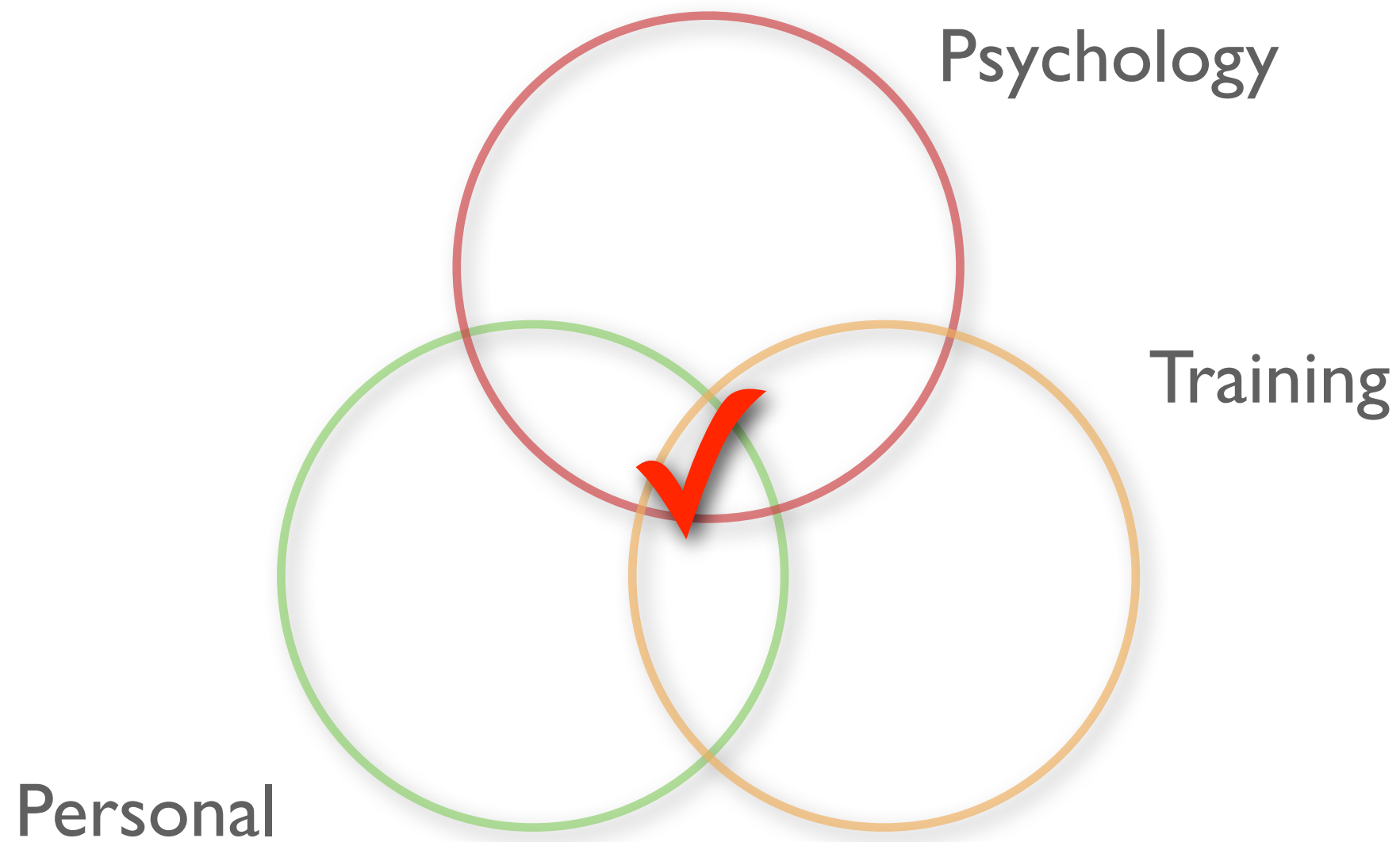
Professor Des Gorman opened the conference with some remarks, of which three are particularly relevant. I'd like to endorse the first, reject the second and answer the third:



Professional therapists should be working in the overlap between their personal social skills — listening, empathy — and the therapeutic techniques they have been taught.



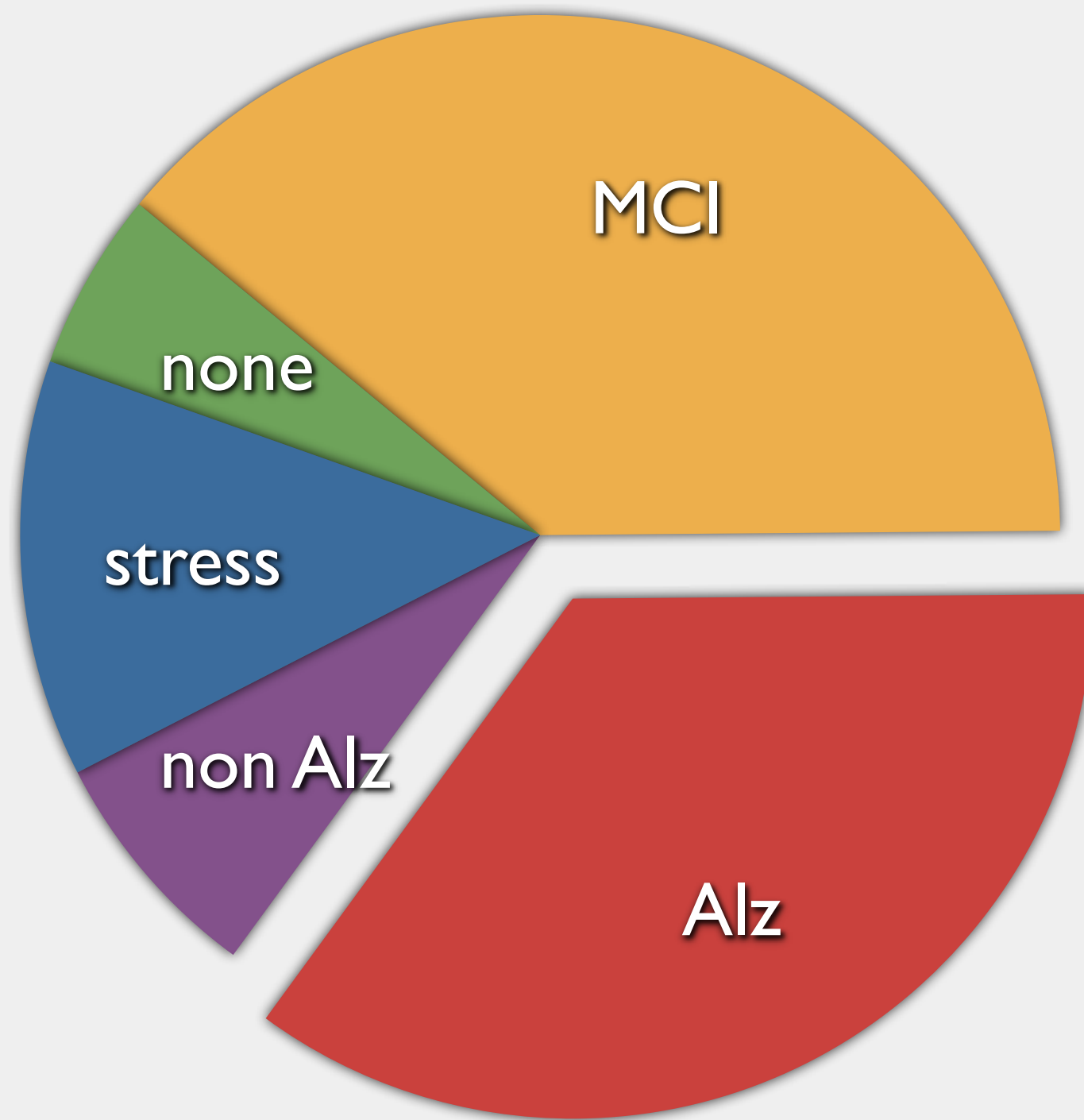
Applied psychologists are unique amongst health professionals in having, by definition, degree-level knowledge of the healthy mind and of the principles underpinning the standard techniques.



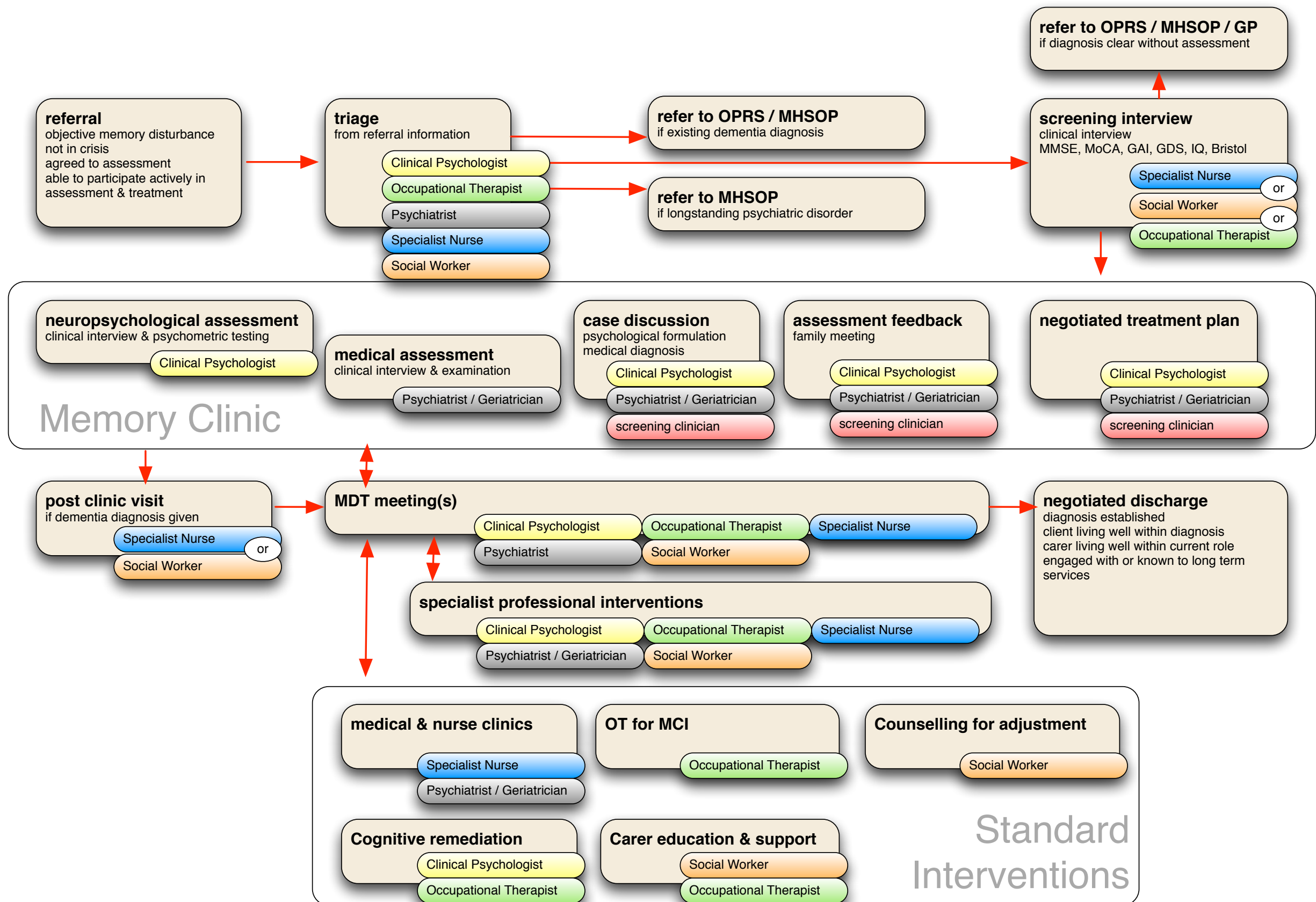
As applied psychologists, we *should* “work at the limits of our licence”, constructing tailored interventions for the unique problems experienced by our dementing clients & their families.



Prescribing is *not* a “step up”, however: if medics are “over-burdened”, they can step *aside* and follow our leadership in developing Memory Services for all, not Memory Clinics for the few.



One month's residential care for just those identified at first contact as having Alzheimer-type dementia costs as much the annual operating budget of the full Waikato Memory Service.



So, if the Memory Service delayed, by only one month, the institutionalisation of only those initially diagnosed with Alzheimer-type dementia, this would pay for the entire Service.

Social Role Valorisation

Using money earmarked for residential care to instead give clients and their families a better quality of life in their own homes is not a new idea, but is highly relevant to Memory Services.

Cognitive
functioning



Time

There is vast scope for extending the early assessment and diagnosis of memory problems *beyond* the provision of an expensive drug which benefits only a minority of patients.

Memory **Service**, not Memory *Clinic*

the need for psychological leadership



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So let's be picky about names and take the lead in establishing, developing and providing Memory **Services**, not Memory *Clinics*.

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