

## Case Study 3: Occupational Therapy for People with Dementia

1. Describe the evidence to be translated and its relation to a health problem.

- a. What evidence (health-related behavior, test, procedure, treatment, intervention, program) will be translated?

The Australian Clinical Practice Guidelines and Principles of Care for People with Dementia (2016) state that people with dementia in the community should be offered occupational therapy interventions which should include “environmental assessment and modification to aid independent functioning; prescription of assistive technology; and tailored intervention to promote independence in activities of daily living which may involve problem solving, task simplification and education and skills training for their carer(s) and family”.

- b. Justify the evidence is ready to be translated (including in the local context).

This guideline recommendation is based on a number of high quality randomised trials which have shown improved functional independence outcomes and quality of life in people receiving the intervention. Effect sizes for the intervention are small to moderate (0.17 for ADL outcome and 0.62 for quality of life) (Gitlin et al., 2012).

Unfortunately, occupational therapists do not routinely implement an evidence-based approach. A survey of occupational therapists working with people with dementia revealed that they spent considerable time on assessment and did not provide the type of multicomponent occupational therapy intervention described in the recommendation which has been shown to be effective in research studies (Bennett, Shand, & Liddle, 2011). Only 25% of therapists saw clients for 4-5 consultations which would be considered the minimum amount of intervention that would be beneficial (Bennett et al., 2011) and thus 75% of therapists are not routinely providing evidence based care.

- c. What health problem will translation of the evidence improve? Justify selection of this health problem as a priority in the setting you plan to work.

Functional decline is one of the key features of dementia (Burns, 2009). While pharmacological treatments are largely ineffective, there are non-pharmacological treatment programs delivered by occupational therapists that have been shown to delay functional decline (Laver, Dyer, Whitehead, Clemson, & Crotty, 2016). These intervention programs typically involve: home assessment, carer education and stress reduction techniques, problem solving, carer skills building and engaging the person with dementia in meaningful activities (Laver, Cumming, et al., 2016).

2. Identify stakeholder communities and conduct outreach to work with them.

- a. List key communities/stakeholders involved in translating your evidence
- b. Consider vested interests of key communities/ stakeholders

This project will involve a number of stakeholders. The programs will be delivered to people with dementia and their carers. While there is good evidence for the intervention, information is needed from this group of people as to needs and access issues (for example, what, where, when and at what cost?). The main stakeholders involved in the intervention aspect of the program is occupational therapists. In many organisations occupational therapists are funded to provide services for people with dementia. It is

their behaviour that we are trying to change so need to understand the barriers to implementation and possible enablers. We need to understand which approaches to upskilling will work best (eg face-to-face training, webinar) and what will help with fidelity (eg checklists, reminders). Occupational Therapy Australia is the national association for occupational therapists in Australia and will be a useful body to involve. As dementia care is typically multidisciplinary the project may impact on other disciplines. Most aged care services in Australia are either directly or indirectly funded by the government. Purchasers will need to be consulted about the nature of the intervention (ie evidence for programs delivered by occupational therapists), dose (five to ten consultations) and value of the intervention.

Stakeholders will be engaged in the project from the outset. The main community partners will be the providers (occupational therapists) and the research team has connected with local relevant activities (dementia forum, aged care interest group) to establish initial contact, meet face to face and develop rapport. Individual face-to-face meetings will be held subsequently to discuss the research specifically and invite organisations to participate in the project. These discussions will acknowledge that the therapists have expertise in their own setting and are best placed to decide whether or not the research program fits well with their organisation.

There are also existing connections to Alzheimer's Australia Consumer Dementia Research Network and individuals with dementia and their caregivers who have nominated an interest in being on a steering group. Regular meetings, acknowledgement of ideas and regular feedback regarding outcomes will be the main mechanisms of engagement.