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## PRESIDENT'S MESSAGE – MARY SANO

The winter Olympics are over and winners and losers head home having been part of a truly global event that captured audiences and summoned small new hopes for peace and co-habitations. This fantastic event focuses on what the youthful human spirit can accomplish. But accomplishments are life long and I am reminded of Celina Seghi, born in March of 1920, an Italian alpine skier and Olympic medalist, who continued to ski into her nineties. She reminds us of the perseverance we need for a healthy old age. With this arc of life and age in mind, I want to update you on activities toward the objectives I had set out for IPA in my inaugural message.



As you may recall, I spoke of widening our reach to embrace professionals who serve our mission of aging mental health across the globe. Addressing this goal we have initiated planning for geriatric psychiatry training materials focusing on the needs of our colleagues in Central and South America. We will build on the opportunity afforded to IPA by the Alzheimers Association's plan to host a meeting in Buenos Aires, entitled "Discover new Pathways to Alzheimer and Dementia Research in Latin America". This meeting will bring together world experts in many areas of geriatric psychiatry. Working closely with Favaloro University Faculty of Medicine and INECO we are planning to provide state of the art training programs in geriatric mental health covering topics including delirium, depression, agitation and strategies for senior wellness and mental health. These lectures and courses will be prepared using digital medium to provide wide dissemination and high quality enduring materials. We hope this will serve as a prototype for many new professional development opportunities.

I also endorsed a mission to widen our reach to the breadth of professionals who serve the elderly in ways that enhance mental health and wellness. In keeping with that theme I am excited to tell you about the IPA plan to partner with International Physical Therapists working with Older Adults (IPTOP) and Canadian Physiotherapy Association (CPA) to support an educational program entitled: "Addressing the Impact of Cognitive Frailty and Dementia on the Rehabilitation of Older Adults". As

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## PRESIDENT'S MESSAGE

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a pre-session to the Canadian Physiotherapy Association Congress in Montreal this November, this program is for physiotherapists, and other allied health professionals working with older adults as a unique opportunity to share expertise.

The IPA experience of assembling world authorities on behavioral management in dementia has allowed us to develop and share informative guides for diagnosis and treatment of these conditions for a wide range of practitioners. More recently we provided preliminary guidelines of agitation in dementia. Recently, through its journal, *International Psychogeriatrics*, IPA members had a chance to review the latest thinking on early subtle psychiatric symptoms in the "Special issue on mild behavioral impairment and non-cognitive prodromes to dementia". This is another example of the IPA focus on the full range of mental health issues in the elderly.

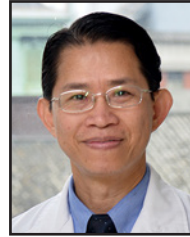
Using this "Advisor model" we are working to assemble world experts on circadian and sleep disturbances in aging people. Information on the role of sleep in healthy aging and mental health continues to grow coming forward from a range of disciplines and specialty fields. Basic and clinical science identifies multiple mechanisms through which sleep can impact the aging brain and cognitive and mental health. Behavioral and cognitive therapies can also play a critical role in the management of these conditions. There is an unmet need to provide a systematic approach for geriatric mental health providers to assess sleep, and to understand the best methods for treating disorders of sleep. We are working to bring together clinical leaders to evaluate and summarize available information. Gaps in knowledge for the translation of science to best clinical practice need to be identified. Ultimately we hope to contribute to future clinical guidelines and tools for sleep evaluation and treatment.

Hopefully you will be excited about the knowledge and opportunities IPA is offering. Share these with friends and colleagues and encourage them to join us as we strengthen the workforce that will care for our aging society.

Mary Sano  
IPA President

### EDITOR'S NOTE – TZUNG-JENG HWANG

Spring signifies the beginning of the year, with new energy flowing around. [Several national annual meetings in psychogeriatrics](#) will be held around the world in March and April, including the UK, Spain, Taiwan, the US and Italy. Recently, the IPA announced that Dr. Maria Lapid assumed the role of Digital Editor for the IPA website, beginning from January 2018. We welcome her and expect that the IPA Bulletin editorial team and Dr. Lapid to work hand in hand to bring new ideas and perspectives for our members.



In this issue, there are eight wonderful articles; three in “**Around the World**” and five in “**Research and Practice**”.

#### In “**Around the World**”:

Dr. Tomas Leon (Chile), the first IPA lifetime member from Chile, provides an overview of the current situation of aging mental health in the country, including an increasing number of elderly patients with mental health issues and inadequate psychogeriatric formal education and training. Prof. Rose-Marie Dröes (Netherlands) introduces how the Dutch Meeting Centres Support Programme (MCSP) for community dwelling people with dementia and their family carers can be transferable across European countries, has been well accepted by its users, and improves quality of life and mental health, at reasonable costs. Dr. Clarissa Giebel (UK) shares with us a new initiative, the Collaboration for Leadership in Applied Health Research and Care (CLAHRC), which facilitates translational research by creating a platform for researchers, the public and government to collaborate.

#### In “**Research and Practice**”:

Dr. Mark Rapoport (Canada) reports new rigorously developed guidelines on Mild Cognitive Impairment, including important suggestions on assessment and treatment, albeit with some concerns about applicability and involvement of clinician and other stakeholders. He also describes an interesting Cognitive Chart, analogous to growth charts in pediatrics (albeit in reverse), to standardize the Mini-Mental Status Examination (MMSE) scores by age and education, and to track progression over time. Dr. Laura Valzolgher (Italy) reviews effective interventions to support the family carers, including conventional interventions (respite care, day care, psycho-social interventions) and unconventional interventions (case-management, mindfulness training, and online-based interventions). Dr. Gillian Stockwell-Smith (Australia) discusses the important considerations in risk assessment, not only focusing on the prevention of adverse events by restricting patients’ capacities, but also promoting their capacity by taking into account outcomes such as dignity, rights, freedom and privacy. Dr. van der Spek et al. (Netherlands) reports the fascinating Dutch studies on the appropriateness of the

EDITOR'S NOTE, *continued on next page*

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## EDITOR'S NOTE

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prescription of psychotropic drugs for neuropsychiatric symptoms in nursing home patients with dementia and recommends regular medication reviews to improve the appropriateness of psychotropic drug prescriptions. Finally, Dr. Karen Reimers (US) reviews the concept of executive function, from its definition to its deficit-related outcomes.

I want to thank our editors who contribute these wonderful reports and reviews. With their devotion, we look forward to have the *IPA Bulletin* soar to a new level of excellence. We also hope that more IPA members can submit articles to express your thoughts and share experiences in this great IPA community. Please reach us at [IPABulletin@ipa-online.org](mailto:IPABulletin@ipa-online.org).

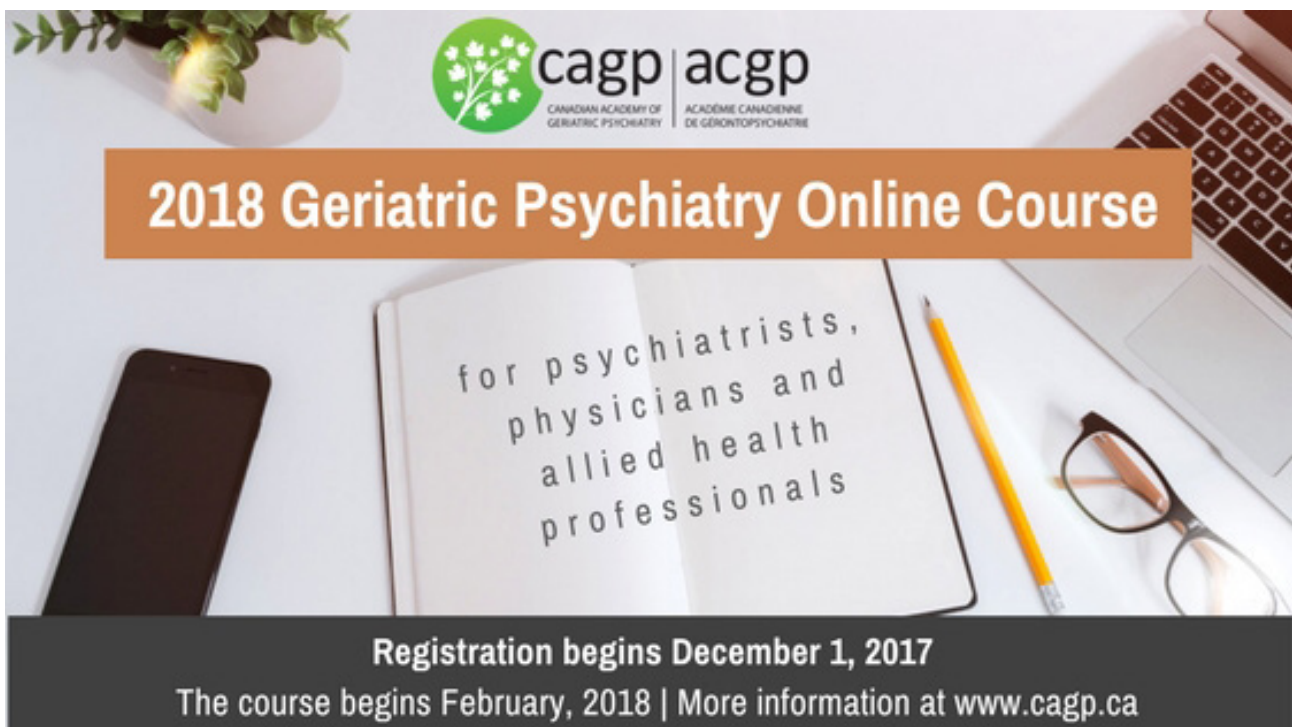



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### IPA NAMES NEW DIGITAL EDITOR

IPA is pleased to introduce Dr. Maria Lapid as the new Digital Editor. This is a two year appointment beginning January 2018.

“With so much information passing through IPA’s online platforms, Dr. Lapid’s background as a geriatric psychiatrist, palliative medicine specialist and hospice associate medical director will be a tremendous asset to ensuring our members are kept informed of the latest, most relevant materials to the field of old age psychiatry”, said Kate Filipiak, CAE, Executive Director of IPA. “Dr. Lapid represents our membership with editorial and digital experience from a regional, national and international perspective.”

Dr. Lapid holds board certifications in psychiatry, geriatric psychiatry and psychosomatic medicine, and board eligibility in hospice and palliative medicine. She also brings experience

serving on the editorial board of *Clinical Psychiatry News*, a monthly newspaper which reports clinical developments from scientific meetings as well as international perspectives through her work with the Philippine Psychiatrists in America, World Psychiatric Association and European Psychiatric Association. Dr. Lapid is currently affiliated with the Mayo Clinic and is the founding program director of the Geriatric Psychiatry Fellowship in Mayo School of Graduate Medical Education.



To contact Dr. Lapid regarding items for submission to the IPA website or other digital platforms, please email [info@ipa-online.org](mailto:info@ipa-online.org).

### CALL FOR NOMINATIONS:

The IPA is excited to announce a new initiative for Students and Early Career Professionals working in the diverse fields of geriatric mental health.

Under the direction of IPA Board members, Professor Huali Wang (P.R. China) and Professor Carmelle Peisah (Australia), this new Council will work to create sustainable opportunities and mentorships for Students and Early Career Professionals worldwide within IPA, by connecting junior/early career and senior IPA professionals. Council members will be asked to participate virtually via video or conference call up to four times annually, over a two year term.

Professors Wang and Peisah are now recruiting candidates to serve on this global leadership Council from multiple

disciplines including geriatric psychology, psychogeriatrics, nursing, social work, primary care physicians, occupational therapy and more – and your recommendations are needed.

Council members will be asked to:

- Lead the development of an IPA mentorship/ advisory program
- Provide direction & feedback for development of IPA publications, programs & events
- Foster IPA collaboration opportunities with colleagues and other organizations

To submit a candidate for consideration to this esteemed Council, please email a short overview of why you are recommending the candidate along with their CV to: [info@ipa-online.org](mailto:info@ipa-online.org)

### ASSESSING COGNITION: NEW MCI GUIDELINES AND COGNITIVE “GROWTH CURVES”

Mark Rapoport, MD, FRCPC

Professor of Psychiatry at the University of Toronto, Associate Scientist and Geriatric Psychiatrist at Sunnybrook Health Sciences Centre, Canada

#### Key highlights:

- New rigorously developed guidelines have been published on Mild Cognitive Impairment, including important suggestions on assessment and treatment, albeit with some concerns about applicability and involvement of clinician and other stakeholders.
- Researchers from Quebec, Canada have published a Cognitive Chart, analogous to growth charts in pediatrics (albeit in reverse), to standardize the Mini-Mental Status Examination (MMSE) scores by age and education, and to track progression over time.

There have been two recent publications of which IPA members should be aware, pertaining to cognition in older adulthood. One is an update of guidelines on assessment and treatment of Mild Cognitive Impairment (MCI), and the second is a publication of an age- and education-standardized cognitive chart meant to track progression of cognitive difficulties over time.

**MCI Guidelines.** The American Academy of Neurology published new guidelines on assessment and treatment of MCI in January 2018, updating an earlier 2001 guideline. A rigorous process was undertaken by the authors, who conducted a systematic review of the evidence across many topics pertaining to MCI. This included a Delphi process of ascertaining level of agreement with the strength of the evidence and confidence in the guideline recommendations. The manuscript summarizing the guidelines includes links to the full guideline methodology and results, as well as a brief summary of the recommendations. The determination of confidence in the recommendations incorporated deliberations on the cost/benefit ratio, the importance of outcomes, variation in preferences, and feasibility. Conflicts of interest were declared and well mitigated.

The recommendations include:

1. Considering MCI as a diagnosis when patients (or their close contacts) have subjective cognitive complaints, rather than assuming the concerns are related to normal aging
2. Using validated assessment tools and assessment of functional impairment
3. Ensuring that clinicians lacking experience refer such patients to specialists
4. Counseling that no accepted biomarkers are currently available
5. Weaning from medications that can contribute to cognitive impairment
6. Counseling that there are no pharmacological treatments with symptomatic benefit

The guideline also includes a helpful meta-analysis of higher quality prevalence studies, with prevalence estimates ranging from 8.4% for those aged 65-69 years (95% CI 5.2-13.4%, I<sup>2</sup>=0) to 25.2% for those aged 80-84 years (95% CI 16.5-36.5%, I<sup>2</sup>=0), and other analyses/summaries of prognostic studies.

Applicability of some of the recommendations may be debated. For instance, recommended tools for diagnosing MCI and completing neuropsychological tests after positive screens were not specified. In addition, the efficacy of certain treatments may currently lack the evidence to support definitive guidelines. For example, the statement that “for patients diagnosed with MCI, clinicians may choose not to offer cholinesterase inhibitors” seems to be broadly worded, in order to permit such treatments despite the acknowledgement that such clinicians “must first discuss with patients that this is...not currently backed by empiric evidence”.

Although the guideline was endorsed by the Alzheimer’s Association, the details of engagement of clinician, policy-maker and caregiver stakeholders are not outlined in the documents, posing some limitations to the applicability of these suggestions, as well as stakeholder involvement.

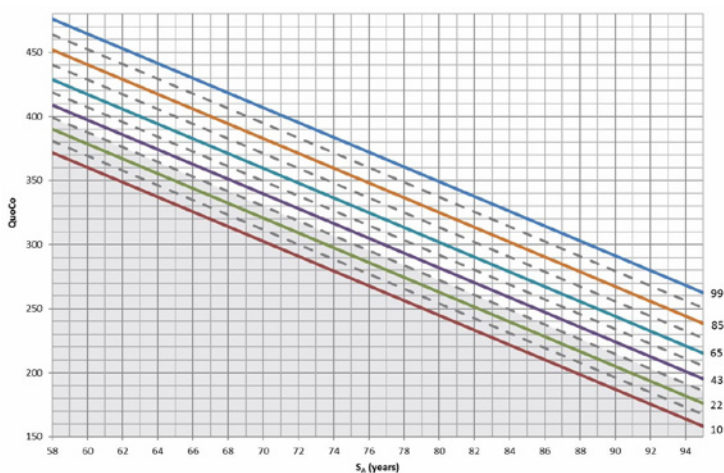
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Nonetheless, this is a high-quality set of guidelines, with rigorous development, clarity in its scope, purpose, presentation and transparency.

**Cognitive Growth Curves.** More than three decades after its first description in the literature, investigators from Quebec, Canada took the Mini-Mental Status Examination (MMSE) to the next level. Bernier et al addressed the long-established association of the MMSE with age and education, a factor that has limited its uncorrected use as a cognitive screen. They used a sample from the Canadian Study of Health and Aging that was studied longitudinally over 10 years, including the MMSE, physician examination, and case-conferences to build a model that took both age and education into account. The MMSE was used to distinguish between subjects with dementia and healthy controls. The authors then validated their model with an independent roughly comparable sample from the National Alzheimer's Coordinating Center's Uniform Data Set.

Based on their data, they suggest computing a "Cognitive Quotient" by dividing MMSE by age and multiplying this by 1000, and then calculating a "standardized age" using the formula  $age - 0.5 \text{ education}$ . These computations are graphed on a "cognitive chart," which looks similar to the "growth curves" used in pediatrics. The graph displays where the MMSE score (converted into the Cognitive Quotient) lies in percentile terms for that standardized age. When used over years, one would be able to notice clearly when a person's cognitive performance on this simple screen (using relatively simple calculations) drops off of their trajectory.



The MMSE, of course, has its limitations as a cognitive screen, and work is ongoing to create similar cognitive charts for the Montreal Cognitive Assessment (MoCA). One implication of relying on the MMSE and these cognitive charts is that this is not an instrument sensitive to MCI. Another limitation of this work is that the diagnoses of dementia in both the original and validation samples incorporated MMSE scores, which may have inflated the observed sensitivities and specificities. Nonetheless, the idea of a cognitive growth chart that is analogous to growth charts in pediatrics (but in reverse) is an intriguing one, with practical value for clinicians and educators. A [website](#) and [app \(available on iTunes\)](#) provide detailed instructions and background for ready clinical implementation.

### For further reading:

*Petersen, R.C., et al. Practice guideline update summary: Mild cognitive impairment. Report of the guideline development, dissemination, and implementation subcommittee of the American Academy of Neurology 2018; 90(3): 126-135.*

*Bernier, P.J. et al. Validation and diagnostic accuracy of predictive curves for age-associated longitudinal cognitive decline in older adults. Canadian Medical Association Journal 2017; 189 (48): e1472-1480.*



Dr. Mark Rapoport is a professor in the geriatric psychiatry division of the department of psychiatry at the University of Toronto, a clinical scientist at Sunnybrook Health Sciences Centre, and past President of the Canadian Academy of Geriatric Psychiatry. His main areas of research are traumatic brain injury in the elderly and the risk of motor vehicle collisions associated with

neurological and psychiatric diseases and their treatments. After serving as an Assistant Editor, Dr. Rapoport became the Deputy Editor for the Research and Practice section of the IPA Bulletin in 2016. He regularly writes on recent advances in the field.

### CAREGIVER BURDEN AND CAREGIVER-DIRECTED INTERVENTIONS FOR DEMENTIA: A BRIEF SUMMARY OF THE MAIN INTERVENTION STRATEGIES

By Laura Valzolgher, MD

Medical Doctor, Memory Clinic, Geriatric Department, Hospital of Bolzano, Italy

While the number of people affected by dementia is increasing worldwide and estimated to reach 152 million by 2050, the majority of people affected (50-80% in different European countries) live at home. Family members are vulnerable to great burden; depressive and psychosomatic symptoms, as well as physical, emotional, and economic pressures. Support for dementia caregivers is one of the goals of the global action plan on the public health response to dementia 2017-2025, endorsed by the WHO. Families and caregivers require support from the health, social, financial and legal systems. Therefore, governmental organizations are increasingly interested in which types of interventions most effectively support families and reduce burden -including economic costs- in order to provide efficient national and international policies.



There are different caregiver-directed interventions to support the “well-being” of dementia carers living in the community, which have been investigated in the last 15 years in several RCTs and observational studies. Outcomes of interest are, in general: caregiver psychological health, including caregiver burden, depression, and quality of life, well-being, strain, mastery (taking control of one’s situation), reactivity to behaviour problems, rate of institutionalization, and cost-effectiveness. Attempted meta-analyses have largely failed due to lack of conclusive results, and systematic reviews are also often inconclusive due to lack of high-quality studies and the variety of methodological approaches used in the different studies.

In the current literature, the main categories of caregiver-directed strategies considered are:

- Respite care and day care centres
- Psycho-social interventions: Psycho-education, Support and counselling, Multi-component and Psychological interventions
- Other non-conventional, promising interventions: case management, mindfulness training, online based interventions

#### Respite care and day care centers

Respite care is defined as a relief for the caregiver. In most cases, respite is provided in the home, through day programs, or at institutions (usually 30 days or less). Respite services can vary in delivery and duration, and are carried out by a variety of individuals, including paid staff, volunteers, family, or friends.

Summary of the evidence: Although some studies may suggest that respite and day care might help reduce incidence of behaviour problems, burden for carers, and use of psychoactive amongst persons with dementia, interpretations are limited by the lack of high-quality research. It is also unclear if the use of day care centres for people with dementia reduces or postpones admission to nursing homes or hospitals.

#### Psycho-social interventions

There are four types of interventions:

1. Psycho-education: structured presentation of information about dementia and caregiver issues, and application of this new knowledge to problems. Support may also be part of a psycho-education group but is secondary to the education content.

CAREGIVER BURDEN, *continued on next page*



CAREGIVER BURDEN, *continued from page 8*

2. Support and counselling: practical help and support with the opportunity to discuss problems and feelings.
3. Multi-component interventions: a combination of at least two of the categories above.
4. Psychological interventions: treatments such as cognitive behavioural therapy.

*Summary of the evidence:* Psycho-social interventions include a variety of interventions (information, social, educational and psychological support, counselling). Although the evidence is not conclusive among all types of psycho-social interventions, multi-component interventions, such as psycho-education and support for caregivers, may most effectively reduce caregiver burden and depression, and increase subjective well-being.

### Other interventions

*Case management* is a widely used and strongly promoted complex intervention for organising and coordinating care at the level of the individual, with the aim of providing long-term care for people with dementia in the community as an alternative to early admission to a care home or hospital. There is some evidence that case management is beneficial at improving some outcomes at certain time points, but there is not enough evidence to clearly assess whether it could reduce burden and delay institutionalisation in care homes.

**Mindfulness interventions:** Only a few studies have been investigated lately around the use of Mindfulness interventions in caregiver's wellbeing. They show some effects of improvement in depression, perceived stress, and mental health-related quality of life. No significant advantage has been shown in the alleviation of caregiver burden or anxiety. Future large-scale and rigorously designed trials are needed to confirm these promising findings.

*Online based interventions* are a very promising non-conventional intervention. The WHO, for example, is developing iSupport, an e-health solution that provides information and skills training for carers of people living with dementia. Although there is some evidence that

Internet-based interventions can improve mental health outcomes for informal caregivers of people with dementia, marked methodological variations across studies prevent the achievement of robust results. A concerted approach is required to help realise the full potential of this emerging field.

### Conclusions:

The real efficacy of caregiver-directed interventions on the caregiver's "wellbeing" (caregiver burden, depressive symptoms), social and health cost, and delay of institutionalisation is difficult to establish. The differences in population age, sex and the relationship to the person with dementia, the degree of dementia across available studies, the variety of different methodological approaches and the lack of high-quality studies make it difficult to draw a comparison and achieve conclusive results. Beside conventional strategies, there are promising interventions which have still to be further investigated.

### For Further readings:

WHO. *Dementia fact sheet updated December 2017*. <http://www.who.int/mediacentre/factsheets/fs362/en/>

Ontario Health Technology Advisory Committee. *Caregiver- and Patient-Directed Interventions for Dementia. An Evidence-Based Analysis-Ontario Health Technology Assessment Series 2008; (9): 1-51.*

Swedish Council on Health Technology Assessment. *Dementia - Caring, Ethics, Ethical and Economical Aspects: A Systematic Review*. Stockholm: Swedish Council on Health Technology Assessment (SBU); 2008 Jun. Available from <http://www.ncbi.nlm.nih.gov/books/NBK447961/>

Reinar LM, Fure B, Kirkehei I, Dahm KT, Landmark B. *Effect of day care centers for people with dementia*. Oslo: Norwegian Knowledge Centre for the Health Services. 2011; (21).

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Liu Z, Chen QL, Sun YY. Mindfulness training for psychological stress in family caregivers of persons with dementia: a systematic review and meta-analysis of randomized controlled trials. *Clin Interventions in Aging*. 2017;(12):1521-1529.

Reilly S, Miranda-Castillo C, Malouf R, Hoe J, Toot S, Challis D, Orrell M. Case management approaches to home support for people with dementia. *Cochrane Database Systematic Review*. 2015; (5): 1-4.

Egan KJ, Pinto-Bruno AC, Bighelli I, Berg-Weger M, van Straten A, Albanese E, Pot AM. Online Training and Support Programs Designed to Improve Mental Health and Reduce Burden Among Caregivers of People With Dementia: A Systematic Review. *Journal of American Medical Director Association*. 2018; (1): in Press.



Laura Valzolgher, MD, works at the Memory Clinic at the Geriatric Department of Bolzano Hospital, Italy. She is currently completing a Master of Science Degree in Psychogeriatrics at University La Sapienza Rome.

### RISK AND RESPONSIBILITY: THE ROLE OF RISK IN THE ACUTE CARE OF OLDER ADULTS

By Dr. Gillian Stockwell-Smith, RN, MN, MAP (Hons), PhD  
Menzies Health Institute Queensland, Griffith University, Queensland, Australia

#### Key highlights:

- Risk assessments conducted in hospital during a period of sickness and recovery can have a considerable impact on an older adults care choices.
- It is not uncommon for age stereotyping to dominate and for health professionals to dismiss the decision-making capacity of cognitively intact frail older people, thereby excluding them from important discussions and decisions about their future care and care settings.
- Health professionals tend to adopt a risk averse approach when assessing older adults, with a focus on weaknesses and inabilities, the primary concern being the prevention of adverse events within the hospital and on discharge.
- A commitment to supporting an older adult to make care-related decisions should be demonstrated by encouraging, rather than restricting, their capacities and wellbeing, as well as by taking into account outcomes such as dignity, rights, freedom and privacy.
- Practical suggestions on improving professional team decision-making capacity include: (1) routinely reviewing the outcomes from previous risk management decisions prior to making a new risk decision, and (2) finding a common language or common goal in relation to patient safety and risk management, both within and across healthcare organisations.

#### Introduction

One of the major issues regarding risk and older people is the need to find a balance between conflicting expectations, fulfilling organisational and professional risk management obligations and promoting an older adults right to independence and autonomy (Berke, 2014). Risk assessments conducted in hospital during a period of sickness and

recovery can have a considerable impact on the living arrangements of older adults, specifically whether they are permitted to return home or are admitted to residential aged care (Faulkner, 2012). Therefore, risk assessment should not be treated as a substitute for clear and rigorous thinking, despite what the actions of some healthcare professionals might suggest (Carson & Bain, 2008).

RISK AND RESPONSIBILITY, *continued on next page*

### **How risk is defined in acute care**

In hospital settings, there is a strong discourse regarding patient safety in relation to risk and the prevention of adverse events (Rowland & Kitto, 2014). Risk originally meant calculating the probabilities of events, both positive and negative (Barry, 2007; Carson & Bain, 2008). However, as a society, we have become preoccupied with harm and hazards (Powell, Wahidin, & Zinn, 2007). While there is no broadly recognised definition of risk, risk is commonly perceived in negative terms and associated solely with the chance of an adverse outcome or event occurring (MacLeod, 2013). In contemporary western society, risk has become a broad concept that extends over a wide range of social practices that have a negative impact on autonomy and choice for older adults (Powell et al., 2007). This is evident in an overarching emphasis on the professional role in identifying and mitigating the personal risks associated with an older adults declining functional abilities and cognitive skills (Cott & Tierney, 2013).

### **Current risk management practice in acute care**

Risk assessments of older people in the hospital commonly occur during a time of crisis, a fall resulting in harm or general deconditioning due to ill health, and are thus reactive rather than proactive (Barry, 2007). In such scenarios health professionals tend to overstate risk in order to protect themselves and their patients from harm (MacLeod, 2013), and curtail risks through avoidance strategies such that restricting choice and activities takes priority over patient choice and dignity (Digby, Lee, & Williams, 2017). In most acute healthcare settings health professionals are required to identify, assess and manage risk for older adults' while negotiating and reconciling divergent issues of safety and autonomy (MacLeod & Stadnyk, 2015). Tensions are exacerbated when differing views on the degree and likelihood of risk are expressed by clinicians, family members and older adults (Rush, Kjørven, & Hole, 2016). Establishing the older adult's capacity to make and implement decisions is considered an essential component of risk assessment (Culo, 2011). Cognitive impairment (delirium and/or

dementia) can result in fluctuating or lack of decision-making capacity, but the majority of older adults retain full capacity to make decisions regarding their ongoing care and living arrangements (Carson & Bain, 2008). If an older adult has the mental capacity to make a decision, and chooses voluntarily to live with a level of risk, they are entitled to do so (Skills for Care, 2011). However, it is not uncommon for age stereotyping to effectively dismiss the decision making capacity of cognitively intact frail older people thereby excluding them from important discussions and decisions about their future care and care settings (Carson & Bain, 2008). Organisational factors are considered to have a considerable impact on health professional risk practices. A pervasive culture of defensiveness, fed by litigation and inquiries, in health care policy and practice has been blamed for a reduction in professional autonomy with health professionals more preoccupied with avoiding criticism and protecting their professional practice than in making appropriate decisions for patients (Barry, 2007; Carson & Bain, 2008). Consequently health professionals tend to adopt a risk averse approach with a focus on the older adults weaknesses and inabilities, the primary concern being the prevention of adverse events within the hospital and on discharge (Rowland & Kitto, 2014).

### **The way forward?**

For some years now a more positive approach to risk has been recommended (Barry, 2007; Carson & Bain, 2008; Rowland & Kitto, 2014). New models of consumer directed care in disability and community aged care services have provided consumers with greater levels of choice and control over their care and services. The values of choice and control that these models promote denotes the need for professional and organisational change in the way risk is understood, managed and negotiated with the person using the service (Faulkner, 2012; Skills for Care, 2011). A commitment to supporting an older adult to make care related decisions should be demonstrated by encouraging rather than restricting their capacities and wellbeing and taking into account outcomes such as dignity, rights,

freedom and privacy (Rowland & Kitto, 2014). Carson and Bain (2008) maintain the vast majority of risk decisions taken by professionals in health settings lead to benefits, and consider that the more this is appreciated organisationally the more likely it is that a positive culture of risk management will develop. Barry (2007) recommends health professionals adopt a practice of constant and critical review, with risk assessment as a tool to complement professional judgement, rather than an end in itself. Carson and Bain (2008) offer practical suggestions on improving professional team decision making capacity which include routinely reviewing the outcomes from previous risk management decisions prior to making a new risk decision for a patient/client. The focus of this reflective practice is on identifying the success or harm that resulted from the decision, providing praise or counselling to clinical team members and concluding with 'lessons learnt' so as to learn from past mistakes (Carson & Bain, 2008). It is also apparent there are difficulties in finding a common language or common goal in relation to patient safety and risk management, both within and across healthcare organisations (Rowland & Kitto, 2014). The development of a shared organisational vocabulary of risk and risk taking terminology, a common language and common goals of risk identification and management, will go a long way to improving the quality of risk communication within an organisation and inclusion and choice for older adults (Carson & Bain, 2008).

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Dr. Stockwell-Smith is a registered nurse and works with older people in hospital, community and residential aged care settings in the United Kingdom and Australia for over thirty years. She is currently a research fellow in sub-acute and aged care nursing with Griffith University and Gold Coast Hospital and Health Service.

## APPROPRIATE PSYCHOTROPIC DRUG USE IN INSTITUTIONALIZED PATIENTS WITH DEMENTIA. THE PROPER-STUDY

By Klaas van der Spek, PhD

Department of Primary and Community Care, Centre for Family Medicine, Geriatric Care and Public Health, Radboud University Medical Centre, Nijmegen, The Netherlands

### Key highlights:

- The appropriateness of the prescription of psychotropic drugs for neuropsychiatric symptoms is rather poor in nursing home patients with dementia.
- Our new index for “appropriateness,” based on indication, evaluation, dosage, drug-drug interactions, drug-disease interactions, duplications and therapy duration, is associated with patient – and non-patient factors.
- Regular medication review improves the appropriateness of psychotropic drug prescriptions.

There is an ever-increasing interest in reducing psychotropic drug (PD) use for neuropsychiatric symptoms (NPS) in institutionalized patients with dementia. While initiatives focus on reducing the frequency (prevalence), the appropriateness (safety and efficacy) of these prescriptions has received less attention. However, this could be key for beneficial psychotropic drug use, consequently improving its effectiveness and reducing side effects.

In a recent dissertation, we address the following four research questions:

### 1. How should researchers and clinicians measure the appropriateness of psychotropic drug prescriptions?

The Medication Appropriateness index (MAI) is an index developed to measure the general appropriateness of drug use. However, it is not specifically aimed at assessing appropriateness of PD prescriptions for NPS in dementia. In addition, the MAI does not fit specific drug utilization formularies, which is preferable when drug utilization reviews are applied. Therefore, we derived the Appropriate Psychotropic drug use In Dementia (APID) index from the items of the MAI, to specifically evaluate the appropriateness of PD prescriptions for NPS among nursing home patients with dementia in clinical studies.

An expert panel reviewed the MAI items and found five suitable without revisions, adjusted the item ‘indication’, added the item ‘evaluation’, and created scoring rules based on guideline recommendations. A second independent expert panel determined all updated items contributed to the construct ‘appropriateness’. As a result, the APID index encompasses seven different domains of appropriateness, i.e. indication, evaluation, dosage, drug-drug interactions, drug-disease interactions, duplications and therapy duration. An interrater reliability study was conducted, and a summated index score, based on weighted item scores, was developed to enhance the APID index’s use in clinical studies. Information from PD prescription guidelines and the summary of product characteristics from the medication evaluation board, which was retrieved by Dutch databases for drug prescriptions, was integrated into the seven items of the APID index for each PD. The APID index score was calculated using information about individual PDs from patients’ medical records. Construct validity was explored using a representative sample of 560 medical records.

The results of this study showed the APID index is reliable and valid for measuring the appropriateness of PD prescriptions for NPS in nursing home patients with dementia in clinical studies.

### 2. How appropriate are psychotropic drug prescriptions for neuropsychiatric symptoms?

To answer this question, a cross-sectional study among 559 patients with dementia residing on Dementia Special Care Units (DSCUs) in Dutch nursing homes was conducted. Appropriateness of PD prescription was assessed using the APID index. A total of 578 PDs were used for NPS by 60% of the patients. Of the seven APID index’ items, it appeared that indication, evaluation and therapy duration contributed the most to inappropriate use. Only 10%, scored fully appropriate according to the APID index sum score, 36% scored fully

THE PROPER STUDY, *continued on next page*

THE PROPER STUDY, *continued from page 13*

appropriate for 'indication', 46% scored fully appropriate for 'evaluation', and 58% scored fully appropriate for 'therapy duration'. Antidepressants were used the most appropriate, and antiepileptics the most inappropriate. Appropriateness was not associated with the number of PDs used per patient, the percentage of use on the DSCUs, nor the percentage of prescription of the individual physicians (i.e. the number of their patients with one or more PD prescriptions).

The results imply that there is room for improvement of the PD prescriptions for NPS in patients with dementia, and that it should be optimized with a clinical focus on the appropriateness of indication, evaluation, and therapy duration. This guided us to focus on these domains in exploring the appropriateness of different individual and groups of PDs.

### **3. What factors are associated with the appropriateness of psychotropic drug prescriptions?**

In the same cross-sectional study on patient and non-patient factors associated with appropriate PD prescription, as measured by the APID index sum score, we explored these factors to answer this question.

The sample consisted of 559 patients using 147 antipsychotics, 167 antidepressants, 85 anxiolytics and 76 hypnotics/sedatives. Various measurements were carried out for patient and non-patient factors (e.g. NPS, NPS related nurses' stress, attitude to dementia care of caregivers, physicians' experience, time available per patient) using questionnaires, assessment instruments and patient records.

Linear multilevel regression analysis was used to identify factors associated with APID index sum scores. Analyses were performed for four groups of PDs separately, i.e. antipsychotics, antidepressants, anxiolytics and hypnotics/sedatives. It was found that older age and more severe aggression, agitation, apathy and depression were associated with more appropriate prescriptions. Less appropriate prescriptions were found to be associated with more severe

anxiety and non-Alzheimer's dementias. Several non-patient related factors were also associated with less appropriate PD prescriptions (more patients per physician and higher nurses' workload).

### **4. How can clinicians improve the appropriateness of psychotropic drug prescriptions?**

The effectiveness of biannual structured medication reviews to improve the appropriateness of PD prescriptions for NPS in nursing home patients with dementia was evaluated by a multi-center cluster randomized controlled trial.

More specifically, the PROPER intervention consists of a structured and repeated multidisciplinary medication review supported by education and biannual evaluation. It was conducted by pharmacists, physicians, and nurses and consisted of three components:

1. preparation and education
2. conduct
3. evaluation and guidance

The primary outcome was the appropriateness of PD prescriptions defined by the APID index sum score, lower scores indicating more appropriate use.

During this eighteen-month trial, the patients' medical files were assessed every six months. At baseline, 380 patients were included, of which 222 were randomized to the intervention group. Compared to the control group, the APID index sum score in the intervention group improved significantly for all PD prescriptions combined. This was also the case for the subscore 'evaluation' and the subscore 'therapy duration'. The subscore 'indication' did not show a significant difference.

More specifically, per PD group, the APID index sum score and indication subscore for anxiolytics and antidepressants showed a statistically significant greater improvement in the intervention group compared to the control group. For hypnotics/sedatives, antidepressants and anti-dementia drugs the evaluation subscore improved significantly in the intervention group compared to the control group. The

THE PROPER STUDY, *continued on next page*

THE PROPER STUDY, *continued from page 14*

therapy duration subscore also improved significantly in the intervention group compared to the control group for antipsychotics and hypnotics/sedatives.

Based on these results, the implementation of a structured repeated medication review for PD prescriptions into daily practice is recommended, with the essential roles of pharmacist, physician and nurse.

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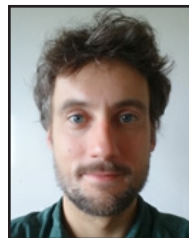
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Link to dissertation: <https://goo.gl/4NB9xK>



Klaas van der Spek (1983) graduated in 2010 in clinical neuropsychology at the VU Amsterdam. He carried out the abovementioned research at the Department of Primary and Community Care, Centre for Family Medicine, Geriatric Care and Public Health of the Radboud University Medical Centre, Nijmegen, The Netherlands. Currently he is working as a healthcare psychologist.

## CLINICAL ASSESSMENT OF EXECUTIVE FUNCTION IN OLDER PEOPLE PART 1: CONCEPT AND CLINICAL CONTEXT

By Karen Reimers, MD, FRCPC

Adjunct Assistant Professor, University of Minnesota Department of Psychiatry, United States

*This is Part 1 of an IPA Bulletin series on Clinical Assessment of Executive Function in Older People. This article explains the concept of executive function, causes of executive function deficits, and what happens when executive function is impaired. Part 2 will review commonly used clinical screening tests for executive function, their strengths and limitations.*

### Key points:

- Executive function refers to higher-order cognitive processes which coordinate planning, initiation, and control of complex, purposeful goal-directed behavior. Loss of this higher level “administrative” guidance and control can cause behavioral change. Profound deficits can lead to serious problems in safety, function, employment and emotional well-being.
- Executive function is impaired by most dementia, often before memory loss.
- Patients with “subcortical” dementia, such as vascular and neurodegenerative dementias (including Parkinson’s, Lewy Body and frontotemporal dementias) generally show more impairment on tests of executive function compared to patients with “cortical” dementias such as Alzheimer’s, who tend to have greater impairment on tests of memory and language.

Clinicians in psychiatric and primary care settings regularly encounter older patients with executive function deficits. Even in healthy individuals, aging is typically associated with a subtle decline in executive functioning. The number and proportion of older people is rapidly increasing around the world.

Since **executive function impairment often progresses to dementia**, understanding executive function deficits can help clinicians support patient and caregiver function and quality of life over time, and plan effectively. Impairment in executive function can interfere with a person’s capacity to make medical treatment decisions, decrease financial and testamentary capacity, increase vulnerability to undue influence, and threaten a person’s capacity to live independently.

### What is executive function?

It is well established that executive function plays a pivotal role in cognition, but there is no consensual definition yet. Executive function is an umbrella term for a wide range of higher-order cognitive processes that coordinate a person’s skills needed for planning, initiation, and control of complex, independent, appropriate and purposeful goal-directed behavior.

Like the CEO of a company, the brain’s executive function system continuously monitors and directs the brain’s organizing and regulating “departments” so it can proceed as

effectively and efficiently as possible. Neuroanatomically, the executive function system is situated in the frontal lobes, cortical and subcortical structures.

Executive function includes cognitive, emotional and motor abilities, including the ability to self-monitor, plan, organize, reason, be mentally flexible, and problem-solve. It guides how people organize their lives, plan, and implement their plans.



EXECUTIVE FUNCTION, *continued on next page*



## Selected domains of executive function

Organization	Regulation
attention	initiation of action
planning	self-control
sequencing	emotional regulation
problem solving	monitoring internal and external cues
working memory	initiating and inhibiting behavior
cognitive flexibility	moral reasoning
abstract thinking	decision making
rule acquisition	
selecting relevant sensory information	

## What happens when executive function is impaired?

Since the brain's executive function system organizes and regulates information across numerous cognitive domains, impairment in executive function typically involves multiple deficits. Loss of higher level "administrative" guidance and control can cause behavioral change. Profound executive function deficits can lead to serious problems in safety, function, employment, and emotional well-being.

Even in normal aging, there can be a decline in concept formation, abstraction, and mental flexibility, especially after age 70. There can also be a normal age-related decline in response inhibition (the ability to inhibit an automatic response in favor of producing a spontaneous new response), reasoning with unfamiliar material, and executive abilities requiring a timed motor component.

Damage to the executive function system can lead to:

- Difficulty with organizing, planning and initiation
- Unawareness or denial that their behavior is a problem
- Inability to multitask
- Difficulty processing, storing, and retrieving information
- Difficulty with abstract concepts and verbal fluency
- Inability to learn from consequences of actions
- Loss of interest in activities
- Socially inappropriate behavior including lack of concern for people and animals

## What causes executive function impairment?

Most dementing illnesses involve some degree of executive function impairment. Executive dysfunction may frequently even be the first area of cognitive impairment. It can precede the memory disturbances of dementia. Patients with "subcortical" dementia such as vascular and neurodegenerative dementias (including Parkinson's, Lewy Body and frontotemporal dementias) generally show more impairment on tests of executive function, compared to patients with "cortical" dementias such as Alzheimer's, who tend to have greater impairment on tests of memory and language.

Executive function deficits can also occur in other neurologic, neuropsychiatric, and neurodegenerative conditions including traumatic brain injury, cerebrovascular disease, addictions, depression, schizophrenia, ADHD and autism.



## Coming soon! Part 2: Screening Tests

Stay tuned for Part 2 of this IPA Bulletin series on Clinical Assessment of Executive Function in Older People. Part 2 will review commonly used clinical screening tests for executive function including SLUMS, MoCA, Mini-Cog and others, discussing their strengths and limitations.

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Karen Reimers, MD FRCPC is an adult psychiatrist with special interests in geriatric psychiatry, addictions, and capacity assessment. She enjoys teaching Psychiatry residents about clinical topics.

## PSYCHOGERIATRICS IN CHILE

By Tomas Leon, MD

Memory Unit, Department of Neurology, Hospital del Salvador, Chile

### Key highlights:

- The prevalence of elderly patients with mental health issues has increased in Chile
- Psychogeriatric formal education is scarce in both Psychiatry and geriatric programs
- Psychogeriatric patients are often overlooked by both medical professionals and the health system

### Aging in Chile

As with the rest of the global population, with the improvement of public health policies, the elderly population has increased in Chile in the last few years, and it is estimated that will reach up to 20% of the population by 2025, similar to the number of infants in our country. In a recent survey about disability, 33.1% of our elderly need external help in instrumental activities, and 13.8% needing help in basic life activities. Caregivers are often relatives (spouses, children) without any pay or formal education. This new reality presents a great challenge to both doctors and the health system, with the presence of complex patients with several comorbid diseases, including neurodegenerative and mental health problems

### Mental health in elderly patients

There are no statistics or national surveys on mental health in elderly patients in Chile. General population surveys report a prevalence of 10% for major depressive disorder and up to 20% for depressive symptoms. In our experience and according to international literature, our patients present an increased prevalence of psychiatric disorders, mainly mood and anxiety diseases. They also suffer neurodegenerative disorders and psychiatric symptoms that come along with them. In a recent survey about disability, the prevalence of cognitive impairment in Chile reached 8.5 % in 60 years and older and up to 40% in 85 years and older.

### Academic instruction in Psychogeriatrics

In Chile, there are no formal programs in Psychogeriatrics, whether as a direct specialty of medicine or as a subspecialty. We have 14 medical schools that provide psychiatric programs and five which teach Geriatric medicine. In these programs, Psychogeriatrics is not always a mandatory course, resulting in different levels of expertise on the subject. Currently, psychogeriatrics education in Chile is informal, and is based mainly on self-training (by both psychiatrists and geriatricians) through the care of elderly patients with psychiatric diseases in public and/or private health systems, without adequate supervision by a formally trained psychogeriatrician. This reality, in addition to the rapid aging Chilean populations are experiencing today, has generated the need to make important changes in our health systems and health education. The first changes have materialized in recent years with the creation of courses and diplomas by universities (Pontificia Universidad Catolica and Universidad de Chile) and scientific societies (Chilean Society of Mental Health and the Society of Geriatrics and Gerontology of Chile), whose purpose has been the formation of health professionals (psychiatrists, geriatricians, neurologists, nurses and psychologists), in order to face the psychiatric disorders our elderly present.

Another change which has become a reality in Chile, especially in younger psychiatrists, has been the application and completion of training in formal fellowships in Psychogeriatrics carried out abroad, in countries such as the US and England, and Master programs (with specialization in psychogeriatrics) and/or Doctorates with research that focuses on elderly patients, such as those offered by universities in countries such as Spain, France and Italy.

PSYCHOGERIATRICS IN CHILE, *continued on next page*

### Challenges for the future

The aging of the population generates a new and unanswered challenge for health systems both public and private and for the teaching of psychiatry and geriatric medicine. A deeper formation in old age physiology, psychopathology and psychopharmacology is needed to understand and treat clinical manifestations of mental health diseases in old age.

But that is not enough. Public health policies are required for prevention and early detection in primary care, as well as the creation of memory clinics to diagnose and treat patients with more serious illnesses.

Due to the evident growth of the elderly population in Chile, and the educational deficit in psychogeriatrics among psychiatrists, geriatricians, neurologists, nurses and psychologists due to the lack of training and clinical experience, we must begin to make changes in the short and medium term. There should be general obligatory courses of psychogeriatrics in the curricula of careers like medicine, nursing, psychology. Furthermore, these courses should be mandatory in specialties such as psychiatry, geriatrics and neurology. In addition to this, we must work intensively in the formation of psychogeriatricians, through the creation of a subspecialty fellowship in psychogeriatrics in different universities of our country.

The application of the National Plan for Dementia is a governmental effort to face the problem of Dementia in an interdisciplinary and multi-level way, integrating primary care with the secondary and tertiary levels. There are also resources in advertisement, such as TV spots, which can help raise awareness in the primary prevention of dementia. However, dementia is only one of the many mental health issues of our patients, so a broader program, attacking all mental health issues and preventing the common risk factors such as loneliness, metabolic diseases, and inactivity, is a priority.

### For further reading:

*"Aging in Chile and the World"* (Spanish): <http://www.ine.cl/docs/default-source/FAQ/enfoque-estad%C3%ADstico-adulto-mayor-en-chile.pdf?sfvrsn=2>

*"National Study on the Dependence of Older People"* (Spanish) <http://www.superacionpobreza.cl/wp-content/uploads/2014/01/estudiodependencia.pdf>



Dr. Tomás León R. is a Psychiatrist of the Memory Unit at Hospital del Salvador, Santiago, Chile.

### IPA AFFILIATE EVENTS

#### Royal College of Psychiatrists, Faculty of Old Age Psychiatry

Annual Scientific Conference

7-9 March 2018

NewcastleGateshead, UK

<http://www.rcpsych.ac.uk/>

#### Spanish Society of Psychogeriatrics (SEPG)

24th National Congress

8-10 March 2018

Córdoba, Spain

<https://cordoba2018.sepg.es>

#### Taiwanese Society of Geriatric Psychiatry (TSGP)

2018 Annual Meeting

10-11 March 2018

Taipei, Taiwan

<http://www.tsgp.org.tw/>

#### American Association for Geriatric Psychiatry (AAGP)

2018 Annual Meeting- Registration Now

Open

15-18 March 2018

Honolulu HI, USA

[www.aagponline.org/](http://www.aagponline.org/)

#### Associazione Italiana Psicogeriatra (AIP)

18th National Congress

12-14 April 2018

Florence, Italy

<http://www.psicogeriatra.it/congressi/>



### MEETING CENTRES SUPPORT PROGRAMME FOR PEOPLE WITH DEMENTIA AND CARERS – SUCCESSFUL IN EUROPE!

*By Rose-Marie Dröes, PhD*

*VU University medical center in Amsterdam, The Netherlands*

*Project Coordinator of the MEETINGDEM project.*



The JPND-MEETINGDEM project aimed to implement and validate the Dutch Meeting Centres Support Programme (MCSP), developed by VU University medical center (research group prof Rose-Marie Dröes), for community dwelling people with dementia and their family carers in three EU countries (Italy, Poland, United Kingdom) (Dröes et al., 2017). MCSP provides activities and person-centered interventions for people with dementia, information meetings and discussion groups for their carers, and individual consultations and plenary (social) centre meetings for both with the main scope to support people in dealing with the changes dementia brings in their lives (Dröes et al., 2004a,b, 2011; Brooker et al., 2017;). The project was carried out by the University of Bologna (led by Prof. Rabih Chattat) in Italy, the Don Gnocchi Foundation in Milan (lead Dr. Elisabetta Farina), Wrocław Medical University (led by prof. Joanna Rymaszewska) in Poland, and the University of Worcester (led by Prof. Dawn Brooker) in the UK.

After exploring pathways to care (Szczesniak et al, in press), each country established initiative groups of organizational collaborators and user representatives; inventoried country/region specific facilitators/barriers to implementing MCSP (Mangiaracina et al., 2017); and developed an implementation plan, practical guide, and toolkit, utilizing and adapting existing Dutch materials. Staff were trained and nine Meeting Centres (MC) established (Italy-5, Poland-2, UK-2), followed by six more MC in Italy (4) and Poland (2).

The first nine MC participated in the controlled pre/post study of MCSP's impact on people with dementia (behaviour, mood, quality of life/ QoL) and carers (sense of competence, mental health, loneliness, distress, experienced burden) compared to Usual Care, as well as its cost-effectiveness and user satisfaction. Positive (moderate to large) effects were found on several quality of life aspects (feelings of belonging, positive affect and self esteem) (Brooker et al., submitted). Carers experienced less burden, and carers in Italy experienced less distress from behavioural and mood symptoms of the person with dementia compared to carers who received usual care (Evans et al., submitted). The attendance in MCSP was high, and participants, people with dementia as well as carers, were highly satisfied with the program. Evidence suggests that for several quality of life measures, the MCSP may be cost-effective.

MEETINGDEM, *continued on next page*

MEETINGDEM, *continued from page 20*

**Conclusion:** The study shows that MCSP is transferable across countries, well accepted by its users, and improves quality of life and mental health for people with dementia and carers, with reasonable costs. Dissemination of MCSP in Europe and beyond is recommended.

MEETINGDEM was funded by the EU Joint Programme Neurodegenerative Diseases research (JPND), project number JPND\_HC-559-018. For more information on the project results please visit the website [www.meetingdem.eu](http://www.meetingdem.eu)

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Amsterdam, Partner of the Alzheimer center VUmc and Member of the board of the Amsterdam Center on Aging VUmc-VU. From 2012-2016 she was a member of the Advisory board of the Quality Institute of the Dutch National Care Institute (ZIN). Dröes (human movement scientist) was the developer of the successful Meeting Centers Support Programme for people with dementia and their carers (1993) which has spread throughout the Netherlands and is now being implemented in other European countries (UK, Italy, Poland; WWW.MEETINGDEM.EU).

### RAISING CAPACITY IN CLINICIANS AND CO-PRODUCING RESEARCH WITH THE PUBLIC

By Clarissa Giebel, PhD

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#### Key points:

- A new initiative, the Collaboration for Leadership in Applied Health Research and Care North West Coast (CLAHRC NWC), facilitates translational research by creating a platform for researchers, the public, National Health Service (NHS) Trusts, and local government bodies collaborate.
- Alongside researchers, this project empowers clinicians, caregivers, and people with dementia.

It has only been half a year, but I have already gained some interesting insights into how we, as researchers, can share some of our knowledge and expertise with clinicians and governmental bodies, to empower and help them to conduct research within their own services. Since last year, I have been involved with an English organisation funded by the National Institute for Health Research (NIHR): the Collaboration for Leadership in Applied Health Research and Care North West Coast, or CLAHRC NWC in short.

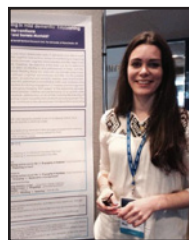
CLAHRC NWC creates a platform for researchers, the public, National Health Service (NHS) Trusts, and local government bodies to meet, create, and conduct research which can be applied directly to improve health and reduce health inequalities. Too often, the link between theory and practice is missing in research, and the translation of good research comes to a halt.

This type of collaborative structure allows clinicians at the front line to become more research savvy. This is particularly important when some service types within the NHS may provide all the care required. Looking at a geriatrics example, people suspected of having dementia attend a memory service in the UK, where their assessment takes place and where post-diagnostic support is provided. One subgroup of dementia, people with young-onset dementia (YOD) however may experience the service differently to people with dementia above the age of 65, due to their different needs.

To see whether anything could be improved to raise the standard of the dementia service, a clinician at the front line of assessing people with dementia on a day-to-day basis is being supported to evaluate the service with research tools. Whilst this may only be a small-scale study which is solely focused on one particular service, findings can potentially be directly translated into the service and inform other services to improve where improvement and change are needed. This is just one example of how the gap between research and application can be bridged.

One thing that makes this process more wholesome is the heavy involvement of the public. Having a person who has been affected by dementia themselves or through caring responsibilities can help to better ground the research and its impact into the real life experiences from the other side of the spectrum. This way we can ensure the research also meets the wishes and needs of those directly affected. But it is not only clinicians who can be empowered by this collaborative network – people with dementia and their caregivers can be equally supported in raising their research skills and engaging with all facets of the research.

This is just one example of how we researchers can give back some of our research tools and hopefully shorten the path from bench to bedside and improve implementation. Whilst the CLAHRC structure is still relatively new, there may be some knowledge to extract and implement in other countries.



Clarissa has over six years of research experience in dementia care research, having just finished her first postdoctoral position at the University of East Anglia. She has worked on multiple studies and her PhD at the University of Manchester has looked at everyday functioning and cognition in dementia.