Submission to Department of Health
on
A National Strategy on Dementia

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Introduction

The Institute of Public Health in Ireland

The remit of the Institute of Public Health in Ireland (IPH) is to promote cooperation for public health between Northern Ireland and the Republic of Ireland in the areas of research and information, capacity building and policy advice. Our approach is to support Departments of Health and their agencies in both jurisdictions, and maximise the benefits of all-island cooperation to achieve practical benefits for people in Northern Ireland and the Republic of Ireland.

IPH welcomes this opportunity to submit its views on the development of a National Dementia Strategy. Dementia has been identified by the World Health Organization as a public health priority. The development of a population health based strategic approach as recommended by the World Health Organization is therefore particularly timely (WHO, 2010; WHO, 2012). Considerable benefits can accrue from government leadership and the development of a public health approach that is strategic, evidence-based, comprehensive and patient-centred.

Following from the recent publication of the UK strategy ‘Living Well with Dementia’, the Department of Health, Social Services and Public Safety published a regional strategy on ‘Improving Dementia Services in Northern Ireland’. This strategy incorporates a detailed action plan to enhance dementia services and identifies lead organisations. The development of a similar strategic approach to the prevention, treatment and care of dementia in the Republic of Ireland is welcome. High level strategic approaches are needed to guide actions which can optimise quality of life and care outcomes for dementia patients and their families on the island.

Dementia – a public health priority

Dementia has been defined as a syndrome due to disease of the brain – usually of a chronic or progressive nature – in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. These impairments are commonly accompanied and occasionally preceded by deterioration in emotional control, social behaviour, or motivation. Alzheimer’s disease is the most common form of dementia and is estimated to contribute to between 60% and 70% of cases. Vascular dementia, dementia with Lewy bodies, and a group of diseases that contribute to fronto-temporal dementias are other major contributors to overall dementia prevalence. The boundaries between subtypes are indistinct and mixed forms often co-exist (WHO, 2012).

Demographic ageing has been characterised by changes in fertility patterns, increasing urbanisation, the feminisation of later life and a rise in life-expectancy, with significant proportions of people living well into their 80’s and older. Another key feature of population ageing is the increase in chronic disease (HSE, 2011). It has also been proposed that a further epidemiological transition is underway as a result of demographic ageing, characterised by an increase in neurodegenerative disorders which will gradually come to replace the current burden of chronic degenerative disorders as the primary cause of morbidity and mortality in the 21st century (Broe 2003). This transition will be characterised in part by increases in the
population prevalence of dementia in the coming decades. In Europe, it is estimated that 7.7 million people are living with dementia with higher prevalence in Western Europe (Ferri et al 2005; Prince 2009). Adequate epidemiological studies on dementia are not available; however Cahill et al (2012) have estimated that over 40,000 people in Ireland are living with dementia. This prevalence is expected to rise to 147,015 by 2040. The scale of the dementia burden in Ireland is outlined in ‘Creating Excellence in Dementia Care’ (Cahill, O’Shea and Pierce, 2012).

The disease burden of dementia has significant economic implications globally and in Ireland. The cost of care for dementia patients draws significantly on a variety of public and private resources including the health services, the social care services, the psychiatric services, families, and the voluntary sector (O’Shea, 1999). A recently published update of the economics of dementia care in Ireland cited evidence from the UK showing that, at individual level, the economic burden of dementia ranks higher than stroke, heart disease and cancer combined, however resources allocated to dementia care continue to be substantially lower than each of these individual disease groups (Lowin, 2001; Trepel, 2012)

Dementia patients are a very significant group in terms of health service utilisation, in primary care and hospital settings but most particularly in public and private residential long-term care facilities (Cahill et al 2012). Cahill et al (2012) demonstrate that levels of unmet need of dementia patients living in the community are substantial with the burden of care falling disproportionately on family carers in many cases. It is estimated that up to 50,000 carers in Ireland (based on 2006 Census data) are currently caring for relatives with at least one symptom of dementia, relatively few of which receive formal State support and many who are older people themselves. The actual level of homecare provision to people with dementia remains unclear (Cahill 2012). Accurate information on day care services in Ireland is also limited. Although, it is estimated that currently less than 4% of people with dementia in the community are benefitting from dementia-specific/focused day care centres (Cahill, 2012). Cahill et al (2012) contend that when older people with dementia in Ireland need advanced care, there are few options available other than residential care and the majority of people with dementia are being cared for within generic care facilities for older people. It has been suggested that Ireland has approximately half the OECD average services available for dementia patients (Knapp, 2007, Trepel, 2012).

Dementia is a complex disorder which inevitably entails a significant loss of function for the sufferer. Appropriate strategy is important to ensure that appropriate evidence-based, quality controlled services are in place for existing dementia patients and appropriate planning is in place for the future. Dementia strategy can also provide a policy framework which supports dementia patients, their carers and health service providers in making difficult decisions about diagnosis, care, independence and associated legal aspects. The current prevalence of dementia and its associated economic and social burden presents a challenge for the configuration of dementia care services at present. The development of a strategic approach to this challenge is welcome.
Response to Consultation Questions

**Question A**

What is your particular interest in/experience of dementia, e.g. health-care professional/ diagnosed with dementia/ caring for someone with dementia?

IPH is responding in its role as an organisation committed to supporting the development of public health policy that is evidence-based, effective and equitable.

**Question B**

The report, Creating Excellence in Dementia Care: A Research Review for Ireland’s National Strategy (Cahill et al, 2012) has outlined the following elements for inclusion in the Strategy, which have been grouped below under 6 broad headings. Of the areas outlined, what should the main priorities for the Strategy be?

**Awareness**
- Primary prevention and ways of avoiding or delaying the illness
- Public awareness about dementia

**Early diagnosis and Intervention**
- Early diagnosis
- Specific training in dementia for health care professionals
- Appropriate services for people with early-onset dementia, including people with Down Syndrome Community-based services
- Dedicated and flexible community-based services Long-stay residential care
- Psychosocial approaches to complement existing medical and neurological models of service delivery
- Dementia-specific residential care units

**Acute care**
- Awareness, ownership and leadership of dementia in acute hospitals

**Community/Acute/Long-stay residential care**
- Case management models of integrated care
- End of life care services for people with a dementia

**Research**
- Information systems on the number of people with dementia, severity of disease, placement patterns and quality of life
IPH supports the development of a National Strategy on Dementia that is comprehensive and holistic in scope and that is supported by robust arrangements for governance, implementation, monitoring and review. We recommend that the strategy encompasses aspects of prevention as well as optimal management at all stages of the disease.

IPH would encourage the development of a social determinants of health approach encompassing primary, secondary and tertiary prevention of disease and disability as one strand of the strategy. We have emphasised the scope for improvements in the domain of prevention in line with our own organisational context and expertise and offered less guidance on the design and delivery of dementia care services on the island, on the premise that commentary on those areas will be adequately covered by those agencies directly engaged in health service management, delivery and evaluation. IPH would support the core elements of the new Strategy as proposed by Cahill, O’Shea and Pierce (2012) arising from recent research on dementia prevalence and care in Ireland (Appendix 1). In addition, IPH would emphasise the following key priorities for inclusion in the new Strategy.

1. **Adoption of a public health approach within the National Strategy on Dementia as set out by World Health Organization and accompanied by clear structures supporting effective governance, implementation, monitoring and review**

   - A co-ordinated, multi-sector approach to dementia that identifies synergies with existing strategies and programmes relating to health, housing, income, social protection in later life and the overall development of communities supportive of healthy and positive ageing.
   
   - A life course approach to tackle the social determinants of dementia in the context of the overall burden of disease and disability in later life
   
   - Development of a monitoring and evaluation framework with clearly defined quality of life and quality of care indicators linked to the strategy including the number of people living with dementia, severity of the disease, disability, carers and needs-based resourcing
   
   - Guidance on ethics and legal aspects of dementia and patient rights in Ireland
   
   - Establishment of a Taskforce to oversee and report on progress with the implementation of the new National Strategy on Dementia within a set timeframe

2. **A commitment to primary, secondary and tertiary prevention of dementia.**

   - Enhanced awareness in the general population and within the health and social care services to increase understanding about the risk factors and signs and symptoms of dementia
   
   - A focus on addressing risk factors for vascular disease, including diabetes, hypertension, obesity, smoking and physical activity across the life course and enhancing the effectiveness of current strategies and programmes relating to prevention and optimal management of these disorders or health behaviours.
• Clarifying and valuing the specific roles of key health care workers in terms of the prevention, diagnosis, management and care of persons with dementia and their families

• Specifying standards in the domains of assessment, review and monitoring of care outcomes

• Ensuring equity of access (and outcomes where possible) for designated vulnerable dementia patients and their families, for example those living in disadvantaged communities, ethnic minorities, adults with learning disability, those with existing mental health or physical disabilities etc

• Workforce planning and designated pathways for professional development for relevant health and social care service providers directly involved in the diagnosis and care of those with dementia and their carers, with an emphasis on primary care and integration with the primary care programme

• Ongoing development and evaluation of the case management model of integrated care for dementia guided by a HSE Clinical Programme

• Appropriate planning, delivery and evaluation of a range of options for end of life care for dementia patients.

3. Development of a programme of research to support primary, secondary and tertiary prevention of dementia population. Research priorities to include:

• Enhancing information systems on dementia at a national level and a commitment to improved population health intelligence on dementia.

• Inclusion of data relevant to dementia and dementia care within appropriate national health information systems and surveys

• Development of meaningful indicators linked to the strategy to capture information on key aspects of dementia care including health, social and economic aspects

• Supporting evaluations of interventions with the potential of delaying the onset and progression of dementia, including clinical trials of new pharmaceutical therapies as well as evaluation of general and dementia-specific services.

4. Supporting carers for people with dementia

• Promoting community capacity to maintain people with dementia living a meaningful life in their homes for as long as possible

• Resourcing carers through training, effective information provision and formal support for their caring commitments.
IPH supports the development of a National Dementia Strategy that is comprehensive and holistic encompassing aspects of prevention as well as optimal management at all stages of the disease.

There is widespread agreement that the development of dementia prevention strategies within a public health approach (WHO, 2010) is of paramount importance in reducing the impending burden of dementia on health and social care. Adopting a three stage approach has been recommended - primary prevention through health behaviour modification; secondary prevention to ensure early diagnosis followed by appropriate intervention and treatment to delay the progress of dementia; and tertiary prevention to promote quality of life and optimum functioning and well-being of the individual as their condition progresses.

Primary prevention

A. Non-modifiable risk factors

These include:

- **Age**
  Increasing age is associated with the development of dementia however it can and does occur in younger age groups. Dementia does occur in younger age groups and their needs are far more complex than those affected in later life (Haase 2005).

- **Gender**
  Currently, there is a marked gender difference in dementia prevalence in Ireland, reflecting the general trend across Europe. Males have a higher prevalence up to age 75, after which, dementia is far more common among females. More women than men have dementia in Ireland, reflecting international prevalence rates and the higher proportion of women represented in older age cohorts.

- **Learning disabilities**
  People with Down's syndrome have high rates of Alzheimer's type dementia.

- **Genetic factors**
  Several genetic mutations have been identified which are associated with an increased risk of certain dementias. In addition, there are other rare forms of dementia associated with genetic disease. Specific provision should be made to ensure optimal
outcomes for patients with rare dementias within the forthcoming first National Rare Disease Plan for Ireland under development by the Department of Health. Access to appropriate information and specialist care would be critical for this group including access to specialist services abroad where appropriate. NICE/SCIE clinical review guidelines (2010) recommend genetic counselling for people likely to have a genetic cause of dementia and at risk relatives.

B. Modifiable risk factors

- **Vascular health**
  High blood pressure, high cholesterol, diabetes and obesity in midlife are associated with the onset of dementia in later life. These factors seem to affect the risk of Alzheimer’s disease as well as vascular dementia (Gorelick 2004). Recent research has found an independent association between obesity and accelerated cognitive decline in later life (Singh-Manoux et al 2012). By 2020 the rate of hypertension in adults aged 45+ is expected to rise by 28%, increasing the prevalence rate in this age group to 63.1% (IPH, 2012a). It is also expected that a 31% increase in rates of coronary heart disease will be observed in the same age group by 2020 (IPH, 2012b).

- **Smoking**

- **Alcohol consumption**
  Heavy consumption of alcohol is associated with an increased risk of dementia. Although, moderate alcohol consumption has been shown to have a protective effect on dementia risk compared to no alcohol consumption. (Anstey KJ, et al 2009)

- **Diet**
  Several studies have investigated the link between dietary factors and the risk of dementia in later life. However, it is acknowledged that diet as a whole and healthy eating in general may be more important than any one nutrient or food. (Scalco and Reekum R 2006; Hughes and Ganguli 2009)

C. Protective factors

- **Participation in physical activity**
  In a review of factors that demonstrate a positive relationship to the maintenance of brain health, Cherry and Reed (2007) identify regular physical activity as a protective factor likely to decrease dementia risk.

- **Participation in mental activity**
  Consistently studies have found that education, mentally demanding occupations and participation in mentally demanding leisure activities such as reading and pursuing intellectual and cultural pursuits have a positive effect on dementia risk (Gatz, Svedberg et al.2001). However the mechanisms underpinning this association are not well understood. The cognitive reserve hypothesis is one explanatory mechanism put
forward by Stern (2002) with reasonable evidence to support it (Morgan and Bhugra 2010).

- **Participation in social activity**
  Participation in more social activities, having larger social networks, and a reduced feeling of loneliness reduces the risks of dementia (Woodward et al 2007). Emotional support through increased social connectedness is also protective of dementia (Morrison-Borgorad, et al 2007; Beland, Zunzunegui et al. 2005).

Public health interventions to modify risk factors have the potential to reduce the prevalence and delay the onset of dementia. The modifiable risk factors associated with dementia in later life are often associated with a variety of other chronic conditions. Taking the NICE/SCIE clinical guidelines (2006) into consideration, priority should be afforded to countering risk factors for vascular disease (including diabetes, hypertension, obesity, smoking and physical activity). It would therefore seem important to emphasise and enhance current Dept of Health and Health Service Executive strategies and programmes in the domains of tobacco control, the prevention of alcohol-related harm, promoting physical activity and improving nutrition. The appropriate management of cardiovascular risk factors in primary care, particularly hypertension, atherosclerosis and thromboembolic disease may be important in the context of many dementias and most notably in the context of vascular dementia. Implementation of the primary prevention measures as detailed in the National Cardiovascular Health Strategy, are likely to reduce the prevalence of dementia as well as coronary heart disease. This is with a view to either preventing or delaying the onset and progression of dementia in our ageing society.

To ensure a healthier ageing population with a decreased risk of dementia, IPH recommends a cross-disciplinary, integrated, comprehensive life course approach to risk factors as a priority. Embedding preventative health practices into primary care services in Ireland is essential to support the prevention of dementia and several chronic conditions in later life. Several countries have developed initiatives to increase dementia risk awareness in the general population. The Australian Dementia Prevention Policy (Farrow 2010) provides a useful listing of these resources (summarised in Appendix 2). Currently, the evidence does not support the prescribing of statins, HRT, non-steroidal anti-inflammatory drugs or antioxidants in the primary prevention of dementia (NICE/SCIE, 2006).

The majority of late life disorders have determinants that stretch back across the life course (Morgan and Bhugra, 2010). This is also the case for the development of dementia. Many risk factors for dementia including level of education, health behaviours and vascular health display strong associations with social determinants. There is increasing evidence that deprivation in earlier life is a predictor of less healthy behaviours throughout the life course, resulting in reduced physical, social, emotional and brain health in later life (Pollard 2005). A substantial body of evidence also supports the association of hardship in early life with disruptions to brain growth and functioning (De Bellis 2005; Anda, Felitti et al 2006) with a resulting susceptibility to dementia in later life. Recent research also points to the impact of child maltreatment and early life stress on brain development (De Bellis 2002; De Bellis 2005; DeBellis and Kuchibhatla 2006; Watts-English, Fortson et al 2006).

The concept of “brain health” is emerging as an important paradigm on the neuroscience and public health agenda. Further research including clinical trials and intervention studies are needed to establish causal pathways of compromised brain health and effective interventions
to promote brain health. Such interventions need to occur across the life course and may need to precede cognitive decline (Morrison-Borgorad et al. 2007). To date the concept of brain health has not been incorporated into broader health promotion campaigns however; it is rooted in the social determinants of health and may have significant potential to reduce the incidence of many chronic conditions in later life, including dementia

- **Secondary prevention**

**Raising awareness in the general public**
Providing information and guidance on possible signs and symptoms of dementia and encouraging individuals and their families to seek help is the first step in early intervention. GPs continue to rely on family and patients to bring memory loss and impairment to their attention (Moore and Cahill 2012), however many are reluctant to do so. De-stigmatising dementia is essential to ensure those living with dementia in the community are diagnosed but this must be accompanied by clear referral pathways to timely and appropriate diagnostic services.

**Raising awareness and promoting intervention in primary care**
The role of primary care professionals in diagnosing and providing appropriate intervention for people living with dementia in the community should be recognised and addressed in the new strategy, outlining adequate training and supports to underpin an effective seamless spectrum of care service for dementia.

In a survey of Irish GPs, only 19% stated they often or always disclosed a diagnosis of dementia (Cahill et al 2006). The most commonly reported barriers were the differentiation from the normal ageing process, lack of confidence, and fear the impact of the diagnosis. More recent research findings indicate that Irish GPs were less likely to have undergone training, were more equivocal about its value and were very dissatisfied with community services compared to their Swedish counterparts (Moore and Cahill 2012). Appropriate access to memory clinics and enhanced multidisciplinary training and education in dementia for primary care workers, hospital staff and people working in long-stay settings is critical if early diagnosis is to be promoted and the benefits of early diagnosis are to be realised. Patients presenting to healthcare services with cardiovascular conditions may be at higher risk of developing a dementia. This setting therefore has potential for early diagnosis and intervention on modifiable risk factors. The role of health care workers in terms of diagnosis, management and care of persons with dementia and their families should be clearly defined within the new Strategy, as well as the supports available in health and social care services to fulfil these roles.
• Tertiary prevention

Improving access to information and support
Clear information provision and signposting to services for people diagnosed with dementia and their families/carers are critical. Consistent advice on the most appropriate supportive practices should be developed and promoted to ensure comprehensive care of the person with dementia; including training and supporting families and carers.

Improving access and equity in healthcare for people living with dementia
People with dementia who require healthcare are quite likely to require the services of other specialists in the course of their illness in addition to that of their GP, geriatrician/specialist in psychiatry of old age team. Appropriate protocols are needed to support the achievement of fair access and outcomes for dementia patients in this sort of circumstance. Ageist attitudes and practices have the potential to present barriers in access to appropriate healthcare. Such practices reduce the ability of healthcare services to provide effective secondary prevention.

Raising awareness of the care needs and preferences of people with dementia
Care for people with dementia should be age appropriate and person-centred. The heterogeneity of the dementia patient group makes it difficult to prescribe a specific care regimen. Ensuring that health and social care provision for people with dementia are comprehensive, flexible and adapted to their needs and preferences will promote and maintain the individual's quality of life. Case management should be an essential component of integrated dementia care with a core focus on patient preferences as guided by the individual or the carer to ensure preferences are embedded in their care process.

A focus on end of life care
People dying from and with dementia are an especially vulnerable group. Their end-of-life journey can be complicated by fluctuating levels of cognitive impairment, behavioural and communication difficulties, challenging behaviours and, often, the absence of staff specifically trained to manage complex end-of life and dementia care issues (CARDI 2010). Guidelines to help care homes and health service providers develop policies and practices in end-of-life care for residents with dementia have been outlined by Centre for Ageing Research and Development in Ireland.

It is noteworthy that insufficient evidence of many preventative interventions at present is due to a paucity of high level research programmes and the lack of coordination of preventive strategies. Polidori et al (2010) argues that waiting for the evidence to emerge should not be used as a reason to disregard key components of a public health approach to dementia care.
Development of a programme of research to support primary secondary and tertiary prevention of dementia in Ireland.

The development of epidemiological and intervention studies on dementia prevention is critical to inform better care in an Irish context. In addition to the enhancement of information systems to provide reliable data on dementia cases in Ireland, as recommended by Cahill et al (2012), IPH recommends the establishment of a clearly defined and comprehensive research and data programme linked with relevant policy indicators.

Prince (2009) recommends that nationally representative population surveys provide one of the most useful resources for policymaking and planning. High quality longitudinal data on health behaviours linked to health outcomes is essential to inform prevention of dementia. Specifically, the Irish Longitudinal Study on Ageing (TILDA) and other national health and well-being surveys should be utilised to their full extent to investigate the potentially modifiable risk factors associated with the onset of dementia. Although TILDA to date has not been designed to include people with a dementia diagnosis in its sampling frame, questions on cognitive impairment in the study provide useful insights. Results from the cognitive impairment assessment tools indicate that cognitive impairment rises sharply with age. Of adults aged 80 and over, 35% have cognitive impairment compared to 4% of adults aged between 50 and 64 (O’Regan, Cronin and Kenny 2011). Results on self-rated memory indicate a high level of memory impairment in the first wave sample, particularly in the older groups. Of adults aged 80 and over, 42% forgot to carry out an action they had earlier been instructed to perform. The wealth of information on health and social care utilisation, combined with data on social and economic circumstances and biological measures, places TILDA in a potentially unique position with regards to research on dementia. While the U.S. and Canada have both included people living with dementia in longitudinal ageing studies, this has not yet been done in any European country.

Question D

Is there anything else that should be considered for inclusion in the Strategy?

While caring for the projected burden of dementia in the coming decades presents significant resource implications, adopting a public health approach as advocated by the WHO provides many opportunities to ‘invest to save’.

The public health approach as outlined by the World Health Organization (2012) centres on four key goals:

- early diagnosis
- optimising physical health, cognition, activity and well-being
- detecting and treating behavioural and psychological symptoms
- providing information and long-term support to caregivers.
It advocates sustained action and coordination across multiple levels and with all stakeholders at international, national, regional and local levels. To achieve this, the WHO sets out a framework for action centred around four key actions:

- advocacy and awareness raising
- developing and implementing dementia policies and plans
- health and social systems strengthening
- research and evaluation.

A co-ordinated approach that identifies synergies with existing public health strategies will be most effective. In particular, the forthcoming public health strategic framework has stated a specific action on the sustained expansion on the continuity of care services for people with disabilities and older people; and the forthcoming Positive Ageing Strategy provides a platform for addressing the wide ranging challenges of population ageing in the Irish context. In addition, several recent strategies provide potential for alignment with priorities in the new Dementia Strategy including:

- ‘Changing Cardiovascular Health: National Cardiovascular Health Strategy’ (Department of Health and Children)
- ‘Strategy to Prevent Falls and Fractures in Ireland’s Ageing Population’ (Health Service Executive, National Council on Ageing and Older People and Department of Health and Children)
- ‘National Disability Strategy’ (Department of Health and Children)
- ‘A Vision for Change’. (Department of Health and Children)
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Appendix 1

Several core elements for the new Dementia Strategy arising from the research are proposed by Cahill, O’Shea and Pierce (2012) on page 29 of the document ‘Future Dementia Care in Ireland’. These are:

- Greater emphasis on primary prevention and on ways of avoiding or delaying the illness
- Enhanced public awareness about dementia
- Early diagnosis through improving access to memory clinics and enhanced multidisciplinary training and education in dementia for primary care workers, hospital staff and people working in long-stay settings
- Case management models of integrated care
- Expansion of dedicated and flexible community based services, for example, day care services and family support programmes, for people with dementia and their carers
development of new and expanded psychosocial approaches to complement existing medical and neurological models of service delivery in the community and in residential care units
- Development of small-scale, appropriately designed, residential care units
- Greater awareness, ownership and leadership of dementia in the acute care sector
- Further expansion and availability of palliative care services for people dying of and with a dementia
- Development of appropriate services for people with early onset dementia, including people with Down syndrome
- Enhanced information systems on the number of people with dementia, severity of the disease, placement patterns and quality of life.
Appendix 2

- Alzheimer’s Australia’s Mind your Mind program aims to educate the general community that mental, physical and social activity, healthy diet and habits, regular health checks and control of vascular risk factors, and avoiding head injury may help to reduce the risk of developing dementia (See www.mindyourmind.org.au)

- Alzheimer Scotland’s dementia risk reduction education program, Good for You, Good for Your Brain, concentrates on the benefits of healthy eating, physical activity, mental activity and social activity. It also recommends having regular health checks for vascular risks, maintaining a healthy weight, not smoking and drinking alcohol moderately (See www.goodforyourbrain.org)

- The Alzheimer’s Society of the UK’s dementia risk reduction education program is called Be Head Strong. Their program concentrates on the same four factors as Alzheimer Scotland’s, i.e. healthy eating, physical activity, mental activity and social activity. It also recommends not smoking, drinking in moderation and regularly checking blood pressure and cholesterol (See www.alzheimers.org.uk)

- The Canadian Alzheimer Society provides information on brain health and reducing the risk of dementia. The messages include challenging the brain, being socially active, eating healthily, being physically active, reducing stress, avoiding smoking and excessive alcohol, managing vascular risk factors and protecting against head injury. (See www.alzheimer.ca)