Section A: CPH to complete	
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Guidance title:	Disability, dementia and frailty in later life - mid-life approaches to prevention
Committee:	PHAC D
Subject of expert testimony:	Promoting Brain Health: Developing a prevention agenda linking dementia and other non-communicable diseases
Evidence gaps or uncertainties:	The extent to which to dementia prevention (or risk reduction) policies are being undertaken in the UK and elsewhere, particularly with respect to integration with prevention of other non-communicable diseases.
What are current dementia prevention policies and practices with regard to the four behavioural risk factors of alcohol consumption, diet, physical activity and smoking?	
How does this contrast to other non-communicable diseases?	
Section B: Expert to complete	
Summary testimony:	[Please use the space below to summarise your testimony in 250 – 1000 words – continue over page if necessary]

A variety of UK and international documents and websites were reviewed for their content concerning policies (or other measures) to reduce the risk of developing dementia. The review was restricted to policies/measures aiming to influence behavioural risk factors (alcohol consumption, diet, physical activity and smoking) or vascular risk factors. The documents were grouped into those concerned primarily with dementia, those concerning other non-communicable diseases (that share risk factors with dementia), and those concerning behavioural risk factors (that are risk factors for dementia).

<u>Documents concerned primarily with dementia</u>

National dementia strategies or plans tend not to include risk reduction. This is changing. Some notable examples of national plans that do include risk reduction are: Finland, Wales, Northern Ireland, Canada and India. Raising awareness among the public about behaviours that can reduce risk is advocated by all these countries, some countries also express a willingness to invest in public health policies that will support behaviour change. The recent WHO report (Dementia: a public health priority) was particularly explicit on the need to adopt effective public health policies. It stated “the message that dementia, alongside heart disease, stroke and cancer, may be prevented through increased adoption and more effective implementation of these public health strategies is one that policy-makers and the public need to hear.”

Clinical guidelines on the management of dementia seldom make reference to opportunities for risk reduction. A survey of the (public health) workforce suggested that knowledge and awareness of dementia risk reduction was low, and consequently any action limited in extent.

Documents concerning other non-communicable diseases

Unsurprisingly primary prevention is a significant component of response to other non-communicable diseases in the UK. Strategy documents tend to focus on the benefits for that particular disease, and show limited integration between diseases and virtually no acknowledgement of the potential contribution to reducing dementia risk. The pattern for non-integration tends to be mirrored by UK charities representing different diseases, although some do discuss the wider health benefits of adopting healthy behaviours (e.g. British Heart Foundation, Breakthrough Breast Cancer).

Documents concerning other non-communicable diseases

Considering strategies and guidelines focused on healthy behaviours, there seems to be a marked difference between physical activity and other behaviours. Strategies and guidelines focused around physical activity tend to make the connection with dementia. This may reflect the clearly worded statement in the recent UK physical activity guidelines concerning mental well-being (including dementia) and physical activity. In contrast, links between dementia and alcohol, smoking and nutrition are not made in either strategy documents or guidelines.

Effective public health policies to reduce the incidence of dementia

While education (around what behaviours may reduce risk of dementia) has inherent benefit and should be offered to the public, past experience suggests education alone tends to be relatively ineffective at changing behaviour. In terms of developing effective policies, parallels may be drawn with the prevention of cardiovascular disease, and the adoption of both individual level behaviour change programmes (e.g. smoking cessation programmes) and population-level initiatives (e.g. plain packing). It may be appropriate to implicitly or explicitly (e.g. by modelling the benefits and cost savings) include dementia within the decision making process as to whether to adopt such programmes (and the resources to be invested in such programmes). Similarly it may also be sensible to include dementia within programmes (e.g. a benefit to be discussed in counselling about smoking cessation) or when advocating for population-initiatives (e.g. Sustrans currently cite the importance of reducing dementia risk, alongside other health benefits, when seeking investment in walking and cycling infrastructure).

Three arguments have been made against the inclusion of dementia within these public health policies. First that the evidence that dementia risk can be reduced comes only from observational studies (although it is not uncommon to use such evidence to support public health action). Second that the addition of dementia (alongside the other health benefits) may add very little to the broader argument (although given the human and economic significance of dementia many have argued that it can be important). Third that there is a risk of introducing harm (stigma or blame culture for people who develop dementia, scaring or worrying people unnecessarily, and diversion of resources). This later argument may suggest care should be taken to how information is used and presented. It is noticeable that risk reduction messages around cancer, rather than increase stigma, helped to de-stigmatise cancer.

Recommendations

In light of this review (and the previous science review), a series of recommendations were offered to the PHAC for discussion:

1) National-level documents should emphasize that dementia risk can be reduced
2) Information on how to reduce one's risk of developing or delay onset of dementia (e.g. by modifying behaviours +/- appropriate medical treatment of vascular risk factors) should be widely available (in different formats)

3) When working with individuals and discussing behaviour change, information on the co-benefits in terms of wider health (including dementia and mental well-being) should be available
4) Healthcare workers should be aware that dementia risk may be modified; and (where appropriate be able to) offer advice on risk reduction
5) Publicity campaigns seeking to promote healthy living should consider including information about the benefits in terms of dementia (and mental well-being)
6) Advocacy for investment in behaviour change programmes or population health initiatives should include the benefits in terms of reduced risk or delayed onset of dementia
7) Dementia should be included as an outcome when modelling the health benefits of behaviour change programmes /initiatives. (Need for development of tools to do this)

References (if applicable):

Promoting Brain Health: Developing a prevention agenda linking dementia and other non-communicable diseases. UK Health Forum, 2014 [In Press]

Knowledge and awareness among the public health workforce in the UK about the prevention of dementia. UK Health Forum, 2014 [In Press]