Supplementary Material

Dementia Risk Reduction in Primary Care: A Scoping Review of Clinical Guidelines Using a Behavioral Specificity Framework

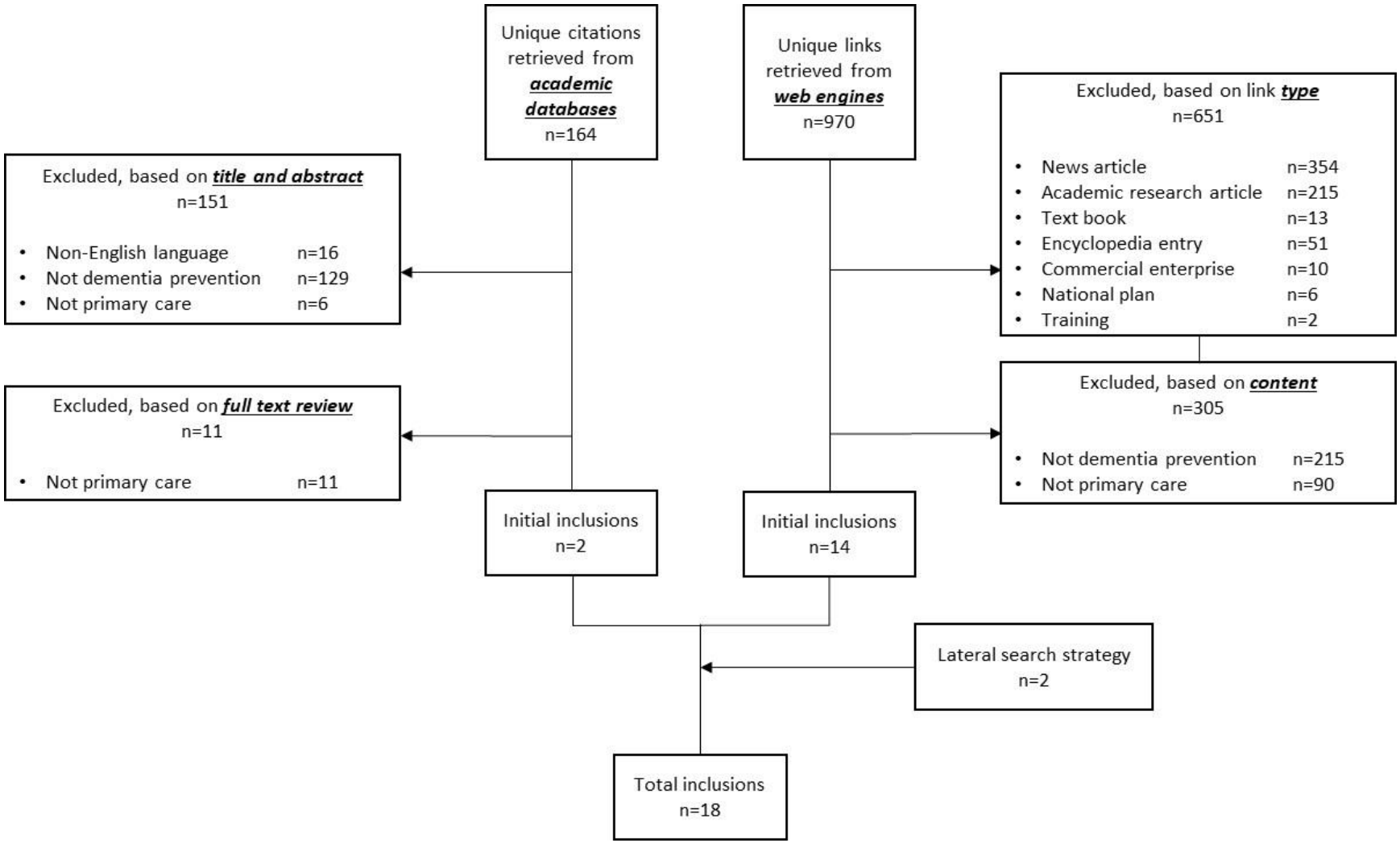
Supplementary Material 1. Detailed description of the search strategy and identification of guidelines

Supplementary Table 1 summarizes the search strategy used with Google (http://www.google.com), Duckduckgo (http://www.duckduckgo.com), PubMed, and CINAHL (Cumulative Index to Nursing and Allied Health Literature). Search terms were based on terms used in previously published scoping reviews concerned with dementia risk reduction [1, 2] and recommended in literature on searching for practice guidelines [3].

Supplementary Table 1. Search strategy

	Search term category	Boolean terms
1	Dementia	dementia
2		cognitive decline
3		cognitive impairment
4		Alzheimer
5	Guideline	policy
6		recommendation
7		best practice
8		guideline
9		health check
10		primary healthcare
11		primary care
12		general practice
13		healthcare professional
14	Risk reduction	risk
15		prevent
16		protect
17		onset

We used signed-out mode for Google so the search was unlinked to any personalized search history; Duckduckgo results are automatically independent of search history. Links retrieved from web search engines were copied using Linkclump software and exported to a Microsoft Excel spreadsheet while citations retrieved from the academic databases were exported to EndNote.



Supplementary Figure 1. Flow diagram of guideline identification

Two lateral search techniques were used to identify additional guidelines. First, for web links to parent pages considered likely to contain clinical guidelines (e.g., https://www.racgp.org.au/), we used site-specific search boxes and site maps to check child pages for relevant guidelines. Second, for web links to lists of resources (e.g., https://www.alz.org/professionals/health-systems-clinicians/clinical-resources), we manually checked hyperlinked resources for relevant guidelines.

Supplementary Figure 1 depicts the process of guideline identification. In total, 18 guideline documents were included in the review.

Supplementary Material 2. Coding manual

Part A: Text to Include/Exclude

Criteria	**Definition**	**POSITIVE examples from included guidelines**	**NEGATIVE examples from included guidelines**
For people working in primary care	Include text for: - general practitioners - general practice nurses - non-clinical staff working in primary care (e.g., practice managers and reception staff). Include text that is for health professionals generally, so long as it does not *exclude* primary care professionals. Exclude text only for: - healthcare professionals working in settings other than primary care (e.g., psychologists, neurologist, psychiatrists, geriatricians) - policy makers or commissioners of health and social care services - members of the community or consumers of health care services	"Public Health England, commissioners, local authorities, providers of NHS services, NHS Health Checks and other providers of behaviour change programmes should emphasise the need for, and help people to maintain, healthy behaviours throughout life". "Public and third sector providers (such as local authorities, leisure services, emergency services and health and social care providers) should use routine appointments and contacts to identify people at risk of dementia". "Health care professionals should use patient visits to encourage individuals and family members to discuss their concerns and questions regarding cognitive health"	"National organisations and local government departments that influence public health should continue to develop and support population-level initiatives to reduce the risk of dementia, disability and frailty by making it easier for people to stop smoking …". "Individuals and families: • Be physically active and intellectually and socially engaged, monitor medications, and engage in healthy lifestyles and behavior; • Talk with health care professionals about cognitive aging concerns". "Health care systems and private and public health insurance companies should develop evidence-based programs and materials on cognitive health across the life span".
For primary prevention	Include primary prevention (actions for preventing dementia before it ever occurs). Includes reducing risk factors and increasing protective factors. Exclude secondary prevention (actions for detecting cognitive decline early and preventing it from worsening). Screening or testing for cognitive impairment is secondary prevention.	"Early intervention and prevention: There is sufficient evidence now for clinicians to recommend the following strategies for early intervention and prevention of dementia. Increased physical activity (e.g., 150 minutes per week of moderate-intensity walking or equivalent)". "Preventing well: Advising people that their risk of developing dementia can be	"Case finding and confirmation: Ask 'How is your memory?' and obtain information about dementia and other cognitive problems from others who know the person (e.g., repeating questions, forgetting conversations, double buying, unpaid bills, social withdrawal)". "Diagnosing well: Knowing where to direct people for timely diagnosis, health and care services, and to

	Exclude tertiary prevention (actions for improving quality of life and reducing dementia symptoms once diagnosed).	reduced by looking after their health, communicating that 'what's good for the heart is good for the brain'".	personalised support and adaptations that will help them remain independent. If appropriate, checking if a person is suffering from delirium or dementia". "For the secondary prevention of dementia, vascular and other modifiable risk factors (for example, smoking, excessive alcohol consumption, obesity, diabetes, hypertension and raised cholesterol) should be reviewed in people with dementia, and if appropriate, treated" "Encourage older patients to consider advance care planning" "When there is concern for cognitive decline on the basis of patient or informant report or the clinician's own observations, the clinician should gather pertinent history and consider testing with a validated cognitive assessment instrument"

Part B. Codes

Category	Definition	POSITIVE examples from included guidelines	NEGATIVE examples from included guidelines
Action 1: Invite	Any discrete, observable behavior for letting patients know that they can/should discuss dementia risk reduction with their clinical care team - asking patients to have an assessment of their risk factors for dementia - offering to discuss dementia risk reduction with patients Can be: - written or verbal - formal or informal - individual or directed more broadly to eligible patients attending the primary care service	"Encouraging annual health checks (MBS 715) to ensure regular identification of health risk factors is one way to support primary and secondary disease prevention". "Health care professionals should use patient visits to encourage individuals and family members to discuss their concerns and questions regarding cognitive health".	
Action 2: Identify	Any discrete, observable behavior for identifying patients with modifiable risk factors for dementia Include new assessment of risk factors as well as review of existing medical records Include patient self-report (e.g., asking patients about risk factors) as well as direct measurement of biomedical risk factors. Exclude testing for non-modifiable risk factors (e.g., genetic testing for people likely to have a genetic cause for their dementia)	"Assess alcohol consumption". "Vascular and other modifiable risk factors for dementia (for example, smoking, excessive alcohol consumption, obesity, diabetes, hypertension and raised cholesterol) should be reviewed and, if appropriate, treated". "Public and third sector providers (such as local authorities, leisure services, emergency services and health and social care providers) should use routine appointments and contacts to identify people at risk of dementia". "The patient's hearing can quickly be checked by asking them to repeat a few softly whispered words, or if they can hear some strands of hair being rubbed behind their ear".	"Healthcare professionals working with people likely to have a genetic cause for their dementia … should offer to refer them and their unaffected relatives for genetic counselling".

Action 3: Discuss	Any discrete, observable behavior for imparting education or advice, usually with the purpose of raising awareness Includes two sub-actions: Educate - Provide general information about dementia risk - Provide personalized information on individual dementia risk Advise: - Provide advice on strategies to reduce risk - Offer an opinion on what to do or what not to do - Recommend actions as wise or prudent - Give warnings, e.g., advise against smoking Excludes encouragement (coded under Action 4). Encouragement is considered actively working with the patient. Can be written or verbal. Code instances of blanket, non-personalized "advice" when there is no suggestion of attempting to work with the patient to reduce their risk factors. Rule of thumb: If it could be done passively with a flyer or website (even if tailored to presenting risk factors), it's probably discussion. If it can only be done in a PCP-patient interaction, it's probably management.	"Everyone who has an NHS Health Check should be made aware that the risk factors for cardiovascular disease are the same as those for dementia. What is good for the heart is good for the brain". "Physical activity should be recommended to adults with normal cognition to reduce the risk of cognitive decline". "Framing the issue positively in terms of maintaining and improving brain health may help to overcome any reluctance to discuss this topic". "Provide brief, non-judgemental advice with patient education materials".	"People aged 65-74 should be made aware of the signs and symptoms of dementia" *Rationale: advice relates to secondary prevention (early detection of dementia) rather than primary prevention.*

Action 4: Manage	Any discrete, observable behavior for actively working with the patient to reduce their personal risk factors. - Encouragement to change behavior - Negotiation of goals and targets - Motivational interviewing to overcome barriers - Treatment of biomedical risk factors for dementia (e.g., pharmacotherapy, brief targeted interventions) About "dealing with" or influencing (or attempting to influence) the patient's risk factors for dementia Includes referral. Referral involves a medical practitioner taking some responsibility for contacting other organizations (e.g., by referral letter), usually with follow-up. Excludes signposting (coded under Action 5). If advice includes goals and targets BUT there is no indication that these have been negotiated with the patient, then code as "discuss" rather than "manage".	"Treat as per guidelines". "Optimal management of co-morbidities". "Offer referral to a proactive telephone call-back cessation service (e.g., Quitline)". "Work with the patient to set agreed goals".	"Recommend 150 mins exercise per week" *Rationale: despite including goals and targets, this is not a personalized goal but a reference to existing guidelines for managing risk factors*
Action 5: Signpost	Any discrete, observable behavior for imparting general information about relevant local or online services to support risk reduction. - allied health - community programs - phone information/ counselling services - dementia organizations - risk calculators	"Signpost to local healthy lifestyle services available for person's level of risk and GP practice" "Brief advice … is mainly about giving people information or directing them where to go for further help… For example, brief advice on smoking would involve recording the person's smoking status and advising them that stop smoking services offer effective help to quit. Then, depending on the person's response, they	"Examples of some of the resources available for patient education specifically on brain health and implications of cognitive aging on functioning and safety in older adults: • Brain Health. Patient education resources about cognitive aging and protective factors for maintaining brain health (Alzheimer's Association, 2014)".

	Signposting is about the patient taking (or being given) responsibility for contacting other organizations to help them reduce their risk. Excludes referral (coded under Action 4: Manage).	may be directed to these services for additional support"	*Rationale: no indication that someone working in primary care is supposed to signpost patients to this resource.*
Action 6: Follow up	Any discrete, observable behavior for reinforcing or further developing a preceding DRR action with patients. Includes: - Setting up disease registers - Phone and email recall - Flagging records for follow-up	"Arrange – Regular follow-up visits to monitor maintenance and prevent relapse".	
Actor	Any description of people working in primary care e.g., doctor, nurse, receptionist, practice manager, other support staff	"Primary care providers" "For General Practitioners" "GPs and their teams"	
Context	Any description of the emotional, organizational, or social setting in which the action(s) occur. The circumstances surrounding or prompting the action. Note: physical setting (primary care) was prespecified in the inclusion criteria. Include: - Consultation context (e.g., already discussing cardiovascular health, patient asking for health advice) - Health events (e.g., hospital stay, change in medication, chronic disease management) - Events in the patient's life (e.g., retirement, moving house)	"During the management of long-term conditions, e.g., depression or diabetes". "The key recommendations can be effectively integrated into programmes for tobacco cessation, cardiovascular disease risk reduction and nutrition".	
Target	Any description of the patient group. - Age	"Middle-aged and older people"	

	- Presence of risk factors for dementia - Presence of concerns about dementia *risk* Note: patients must not yet have symptoms of cognitive decline	"People of all ages" "Everyone who has an NHS Health Check" "Adults who use tobacco"	
Time	Any description of when to promote DRR. - How often (frequency) - How long (duration) - Timing (opportunistic vs formal health check) Excludes socioemotional contexts (coded under Context).	"Routine appointments and contacts". "Whenever the opportunity arises". "Regular medical and wellness visits". "Recall for health checks". "Brief advice can take from 30 seconds to a couple of minutes to deliver".	

Supplementary Material 3. Detailed description of the content analysis method

Each document was read superficially and then more thoroughly, to ensure familiarization with the subject matter. Content related to primary prevention of dementia by people working in primary care was identified using criteria from the coding manual. On discussion with all co-authors, the many discrete actions contained within the included content were synthesized into six broader bundles of actions for the coding manual.

Coding was performed by two authors with subject matter knowledge in either DRR (KG) or the AACTT framework (LG). KG initially defined the 10 codes in the coding manual (six actions, plus one code each for actor, context, target, and time) and coded all included guidelines, adding examples to the manual throughout coding to ensure consistent application. LG then used this first iteration of the coding manual to independently code all included guidelines. KG and LG then met to compare coding, reconcile differences, and refine the coding manual. JF contributed to consensus discussions as needed.

There is debate on the propriety of calculating intercoder reliability in qualitative research [4]. Given that all guidelines were coded by the same two coders, we chose not to calculate intercoder reliability; instead, consensus discussions examined the reasons for differences in coding decisions and ensured the logic underlying subtle coding discriminations was explicit in the final, published, coding manual (Supplementary Material 1). Consensus discussions therefore had similar benefits to calculating intercoder reliability, by ensuring consistency in coding decisions, fostering reflexivity and dialogue within the research team, and improving the quality and transparency of coding [4].

Once consensus on coding was reached, the included text segments were charted according to the AACTT framework. This aspect of the analysis was displayed in a matrix, whereby every guideline was allocated a row and each column denoted a separate code. The matrix formed the basis for further inspection of the data to identify links, patterns, and contradictions within and between guidelines. Finally, we synthesized the data into actionable DRR behaviors for PCPs, highlighting gaps according to the AACTT framework.

The two coders (KG and LG) overlapped well in identifying whether guidelines included content relevant to each code. There was less consistency between coders in the specific segments of text that were assigned to each code. Points of divergence between the two coders typically reflected different subject matter knowledge compounded by ambiguity within the guidelines and draft coding manual (e.g., LG sometimes coded text related to secondary prevention).

Supplementary Material 4. Organizations producing guidance on dementia risk reduction

Supplementary Table 2. Included guidelines

	Title	Publication year	Organization	Country
1	Primary prevention recommendations to reduce the risk of cognitive decline [5]	2022	UsAgainstAlzheimer's	USA
2	A Primary Care Agenda for Brain Health: A Scientific Statement from the American Heart Association [6]	2021	American Heart Association (AHA)	USA
3	Promoting Excellence 2021: A framework for all health and social services staff working with people with dementia, their families and carers [7]	2021	NHS Education for Scotland (NES) and the Scottish Social Services Council (SSSC)	Scotland
4	Best-practice guide to cognitive impairment and dementia care for Aboriginal and Torres Strait Islander people attending primary care [8]	2020	Royal Australian College of General Practitioners (RACGP)	Australia
5	Age-related cognitive decline: prevention and future planning [9]	2020	Best Practice Advocacy Centre New Zealand (bpac^{nz})	New Zealand
6	Recommendations of the 5th Canadian Consensus Conference on the diagnosis and treatment of dementia [10]	2020	Canadian Consensus Conference on the diagnosis and treatment of dementia (CCCDTD)	Canada
7	Risk reduction of cognitive decline and dementia: WHO Guidelines [11]	2019	World Health Organization (WHO)	Global
8	NHS Health Check Best practice guidance [12]	2019	Public Health England (PHE)	England
9	People with Dementia: A Care Guide for General Practice [13]	2019	Cognitive Decline Partnership Centre (CDPC)	Australia
10	National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people [14]	2018	Royal Australian College of General Practitioners (RACGP)	Australia
11	NHS Health Check Dementia Training [15]	2018	National Health Service (NHS) England	England
12	Dementia: Applying all our health [16]	2018	Public Health England (PHE)	England
13	Guidelines for preventive activities in general practice (the Red Book) [17]	2016	Royal Australian College of General Practitioners (RACGP)	Australia
14	Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset [18]	2015	National Institute for Health and Care Excellence (NICE)	England
15	Cognitive aging: Progress in understanding and opportunities for Action [19]	2015	Institute of Medicine (IoM)	USA
16	Dementia Risk Reduction: A Practical Guide for General Practitioners [20]	2010	Alzheimer's Australia	Australia

17	Dementia: A NICE-SCIE Guideline on supporting people with dementia and their carers in health and social care [21]	2007	National Collaborating Centre for Mental Health (NCCMH)	England
18	Guidelines for the Treatment of Alzheimer's Disease from the Italian Association of Psychogeriatrics [22]	2005	Italian Association of Psychogeriatrics (AIP)	Italy

GLOBAL

The World Health Organization

The World Health Organization is a specialized agency of the United Nations responsible for international public health. Part of its broad mandate includes setting international health standards and guidelines. "Risk reduction of cognitive decline and dementia: WHO Guidelines" aimed to provide evidence-based recommendations on lifestyle behaviors and interventions and the management of specific physical and mental health conditions for dementia risk reduction [11].

AUSTRALIA

The Royal Australian College of General Practitioners (RACGP)

The RACGP is the professional body for GPs in Australia. The RACGP is responsible for maintaining standards for quality clinical practice, education and training, and research in Australian general practice. We included three sources of guidance on dementia risk reduction from the RACGP.

The RACGP has published "Guidelines for preventive activities in general practice" since 1989 to support evidence-based preventive activities in primary care [17]. Known colloquially as 'The Red Book', it is widely accepted as the main guide to the provision of preventive care in Australian general practice. The Red Book has included guidance on early intervention and prevention for dementia since 2012 (updated 2016).

The Red Book's companion publication, "National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people" is intended for all health professionals delivering primary healthcare to Aboriginal and Torres Strait Islander (ATSI) peoples [14].

The third resource, "'Best-practice guide to cognitive impairment and dementia care for Aboriginal and Torres Strait Islander people attending primary care", is an accepted clinical resource of the RACGP [8]. Produced by a Melbourne University Consortium, the guide was developed as part of the Let's CHAT (Community Health Approaches To) Dementia Research

Project, funded by the National Health & Medical Research Council (NHMRC). The guide aimed to include cultural principles in the translation of clinical evidence into recommendations on health promotion and prevention, detection and management of cognitive impairment and dementia.

Alzheimer's Australia

Alzheimer's Australia (since renamed Dementia Australia) is the national peak body for people impacted by dementia in Australia. It provides trusted information, education, advocacy, and support services. In 2010, the Dementia Centre for Research Collaboration (itself funded by the Australian Government from 2006 to 2021 through the NHMRC) funded Alzheimer's Australia in Victoria to prepare a practical guide for GPs on dementia risk reduction [20]. The guide provided information for GPs about modifiable risk and protective factors for dementia, explaining the evidence for the association of each factor with dementia risk and providing a practical guide to the resources available to GPs to assist them to work with their patients to address factors of concern.

Cognitive Decline Partnership Centre (CDPC)

The Cognitive Decline Partnership Centre (CDPC) is part of the Faculty of Medicine and Health at the University of Sydney. It is a multidisciplinary dementia research center that focuses on developing evidence-based guidelines and tools to implement best practice dementia care in the clinical, care and community environments. Under its "care service pathways" theme, it published a consensus guide for primary care in 2019 that includes a chapter on dementia prevention [13].

ENGLAND

National Collaborating Centre for Mental Health (NCCMH)

The NCCMH is a collaboration between the Royal College of Psychiatrists and the Centre for Outcomes Research and Effectiveness at University College London (UCL). The NCCMH aims to promote the role of evidence synthesis in making informed judgments about healthcare policy. The NCCMH has a history of developing guidelines, conducting systematic reviews, and developing implementation guidance for commissioners and service providers. In 2016, the National Guideline Alliance took over the clinical guideline program run by NCCMH.

In 2007, commissioned by the Social Care Institute for Excellence and National Institute for Health and Clinical Excellence, NCCMH produced National Clinical Practice Guideline Number 42 on supporting people with dementia and their carers in health and social care [21]. While the guide was developed ostensibly to advise on supporting people with dementia and their carers in health and social care, it includes a brief section on risk factors, prevention, and early identification.

National Institute for Health and Care Excellence (NICE)

NICE is an executive non-departmental public body of the Department of Health and Social Care in England. NICE aims to improve outcomes for people using the National Health Service (NHS) and other public health and social care services. Part of this role is producing evidence-based guidance and advice for health, public health and social care practitioners. Their 2015 guideline, "Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset", was directed at commissioners, managers and practitioners with public health as part of their remit, working in the public, private and third sector [18].

Public Health England (PHE)

PHE was an executive agency of the Department of Health and Social Care in England which operated between 2013 and 2021 to protect and improve health and wellbeing and reduce health inequalities. The PHE guide "Dementia: Applying all our health" was part of the 'All Our Health' resource that aimed to help health and care professionals prevent ill health and promote wellbeing as part of their everyday practice [16]. The information was intended to help frontline health and care staff promote the benefits of focusing on dementia. It was identified for inclusion in this review as part of the lateral search strategy.

The National Health Service (NHS) England

The NHS is the publicly funded healthcare system in England. Overseen by the Department of Health and Social Care, the NHS provides healthcare to all legal English residents and residents from other regions of the UK, with most services free at the point of use.

The NHS Health Check is a five-yearly 20-minute health check-up for adults in England aged 40 to 74 without pre-existing chronic disease. Eligible adults receive an invitation letter from their GP surgery or local council. The check is conducted by a health professional (often a nurse or healthcare assistant) and is designed to spot early signs of stroke, kidney disease, heart

disease, type 2 diabetes, or dementia. Since 2018, following a PHE-commissioned qualitative evaluation of practitioners' and patients' experiences of the dementia component in the NHS Health Check for patients over 65, the NHS health check has included a short dementia awareness raising conversation with all patients over the age of 40.

We have included two NHS guidelines for analysis. The first is the NHS Health Check Best Practice Guidance [12]. The document aims to support providers of the NHS Health Check program with the information needed to commission and deliver a high-quality program. It was identified for inclusion in this review as part of the lateral search strategy.

The second NHS guideline included for analysis is a combined suite of training resources designed for NHS Health Check practitioners to improve the quality of their delivery of the dementia component of the check [15]. The suite includes the "Helping your brain stay healthy" slide set, a short guide for NHS Health Check practitioners on how to use the NHS Health Check Dementia leaflet, the NHS Health Check Dementia Component Prompt resource for Health Care Practitioners, and NHS Health Check Top Tips: Talking About Dementia. In keeping with our exclusion criteria, we excluded the NHS Health Check dementia eLearning tool and the short films intended for use with training.

UNITED STATES

UsAgainstAlzheimer's

UsAgainstAlzheimer's is a non-profit, non-governmental organization working to find effective treatments and the prevention steps to stop Alzheimer's disease. The organization convened a risk reduction workgroup to review existing evidence and develop recommendations for primary care clinicians discussing cognitive decline and risk reduction with their patients [5].

The Institute of Medicine (IoM)

IoM (renamed the National Academy of Medicine in 2015) is a non-profit, non-governmental organization providing national and international advice on issues relating to health, medicine, health policy, and biomedical science. In 2013, the McKnight Brain Research Foundation, the National Institute on Aging, the National Institute of Neurological Disorders and Stroke, the Retirement Research Foundation, AARP, and the Centers for Disease Control and Prevention (CDC) commissioned the Institute of Medicine report, "Cognitive Aging: Progress in Understanding and Opportunities for Action" [19]. Released in 2015, the report characterizes cognitive aging and provides evidence-based recommendations that health care providers and

systems (as well as individuals, families, communities, financial organizations, community groups, and public health agencies) can take to help promote brain health.

The American Heart Association (AHA)

The AHA is a non-profit organization that funds cardiovascular medical research, educates consumers on healthy living and fosters appropriate cardiac care in an effort to reduce disability and deaths caused by cardiovascular disease and stroke. They typically publish guidelines on cardiovascular disease and prevention. In 2021, the AHA released a scientific statement for primary care providers summarizing the assessment and modification of risk factors at the individual level that maintain brain health and prevent cognitive impairment [6].

CANADA

5th Canadian Consensus Conference on the Diagnosis and Treatment of Dementia (CCCDTD)

The 5th CCCDTD was sponsored by the Canadian Consortium on Neurodegeneration in Aging, the Réseau des Cliniques Médicales du Québec, and the Réseau Québecois de Recherche sur le Vieillissement. The 5th set of guidelines were intended to update and extend guidelines produced in previous consensus conferences. The guidelines were developed by eight working groups, including one working group specifically for risk reduction/prevention. Working groups included representatives from neurology, psychiatry, geriatric medicine, primary care, and experienced researchers in the field. A semi-structured consensus building methodology was used to develop the guidelines. Recommendations were accepted if they met the threshold of 80% endorsement by a voting panel of over 50 Canadian experts from various backgrounds. Recommendations obtaining between 60% and 80% endorsement were reviewed, revised, and voted upon at an in-person conference assembly with two delegates per working group, with the same 80% threshold for acceptance.

ITALY

Associazione Italiana di Psicogeriatria (AIP)

The Italian Association of Psychogeriatrics is a non-profit, non-governmental organization which promotes continuing education programs aimed at doctors and members of other health professions on psycho-neuro-geriatrics, as well as disseminating information on the subject of psycho-neuro-geriatrics through various communication tools (magazines, newspapers, books, Internet). The AIP also aims to promote policies and provide scientific advice in the field of the

problems of elderly people with neuro-psychiatric diseases. Ordinary members of the AIP have academic qualifications in medicine, surgery, psychology, or other disciplines, and have recognized interests and skills in the neuro-psycho-geriatric and gerontological field; honorary members may not have academic qualifications but have acquired particular scientific and cultural merits in the field of geriatrics, neurology, psychiatry or psychology.

Guidelines for the Treatment of Alzheimer's Disease from the Italian Association of Psychogeriatrics [22] were developed by a committee of experts from the AIP, which were then approved by a Steering Committee (comprising 20 specialists in neurology, psychiatry or geriatrics) from AIP and by two Alzheimer associations representing patients and families (the Italian Association for Alzheimer's Disease and the Italian Federation for Alzheimer's Disease). The guidelines were based on a review of the scientific literature on the treatment of Alzheimer's disease, integrated with experience and opinions from experts working in clinical settings.

NEW ZEALAND

The Best Practice Advocacy Centre New Zealand (bpac^{nz})

bpac^{nz} is an independent, non-profit organization delivering educational and continuing professional development programs to medical practitioners and other health professional groups throughout New Zealand. General Practice NZ and The Royal New Zealand College of General Practitioners are shareholders in bpac^{nz}. In 2020, bpac^{nz} published an article including key practice points on strategies to maintain brain health, thereby preventing or slowing cognitive decline [9].

SCOTLAND

NHS Education for Scotland (NES) and the Scottish Social Services Council (SSSC)

NES is an education and training body and a special health board within NHS Scotland. It is responsible for developing and delivering education and training for those people who work in NHS Scotland. The SSSC is responsible for registering people who work in the social services in Scotland and regulating their education and training.

In 2011, the NES and SSSC developed the first version of "Promoting Excellence". It was a national workforce development framework designed to support the strategy and implementation of the Scottish Government's "Standards of Care for Dementia in Scotland". The second version of "Promoting Excellence" reflects progress made since 2011, including new research on preventing dementia [7]. The framework sets out the knowledge and skills all health and social

care staff should achieve in their roles in supporting people with dementia, their families and carers.

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