EDITORIAL

Implementation science in psychogeriatrics

It is a pleasure to have been the guest editor for this special issue of International Psychogeriatrics focused on Implementation Science. Although the field of psychogeriatrics is relatively young, there is an ever-increasing wealth of research on topics of long-standing interest – such as mental well-being in later life – and topics for which our knowledge of etiologies and best-practice interventions is expanding exponentially – such as dementia. Novel and innovative approaches to diagnosis, assessment, and treatment of older persons are required at all times, but perhaps now more than ever during the time of COVID-19. But none of this research, none of this hard-won knowledge, has meaning if it fails to be disseminated and fails to be taken up in clinical practice. The potential for both success and failure to translate knowledge into practice can be empirically evaluated, and this in turn provides an important contribution to both research agendas and clinical practice and policy considerations.

This special issue includes a wide variety of papers, which touch on dissemination, knowledge translation, and implementation science. Each paper is accompanied by a commentary by an expert in the area, to add another dimension to, and illuminate the context of, the topic under discussion. There are also two letters, brief reports which appear without a commentary. These letters, papers, and commentaries may be loosely taken as forming three groupings: those with a focus on mental health in later life, interventions for those living with dementia, and older persons in acute care settings.

With respect to mental health, Li *et al.* (2020) describes results from the Chinese Older Adults Collaborations in Health (COACH) study, a randomized controlled trial measuring the effectiveness of using a primary care-based collaborative care management approach to treat older patients with comorbid hypertension and depression in rural China. In the COACH model, a village doctor, aging workers who provide support, and a psychiatrist consultant deliver the collaborative care, and the model has been both successfully implemented and accepted within its regions of use. In their commentary, Browning and Thomas (2020) note that this research makes an important contribution to the argument to upskill workers and systems within primary care settings to meet the needs of the individuals served.

The paper by Dobbins *et al.* (2020) contributes to the growing body of evidence available on the effects of physical activity in people with severe mental illness. The authors describe how a novel video game-based physical activity program may be implemented into practice at mental health facilities, with implementation to practice categories including the critical importance of staff involvement. Cohen (2020), in his commentary, highlights the difficulties with improving physical activity for this population, and notes that bringing to bear both quantitative and qualitative approaches to program evaluation in a rigorous manner is required to move this area forward

Rounding out the pieces on mental health, Hilton (2020) describes the results of the MindEd (mind-ed.org.uk, Health Education England, 2018), a free, widely used, online learning resource funded by the National Health Service (NHS), producing modules for older persons. MindEd modules are co-authored by a content expert and a layperson, to ensure accessibility of the materials. Hinton describes the process of collaborating on the 20 modules co-produced in this fashion, giving a window into a productive process characterized by the usual vicissitudes of any co-authoring partnership, as well as a reminder of the power differentials which must be considered in such a collaborative exercise.

Four researchers have contributed work on dementia to this special issue. Scott and colleagues (2020) describe finding on how GPs manage the challenging transition of patients living with dementia to cease driving. Qualitative interviews with GPs revealed that their relationships with their patients could either help or hinder such a transition, and that ethical considerations and dilemmas abounded in this area. O'Neill (2020) points to the sense of professional isolation of the Australian physicians in this decision-making process, noting that they appear to not be taking full advantage of colleagues in other disciplines such as occupational therapy, who might assist with referrals, nor to be fully considering potential comorbidities that might help guide efforts to ameliorate functionality and perhaps extend driving capability.

Bray *et al.* (2020) describe the development of a representative full cost model for the U.K. version of the multicomponent, nonpharmacological Namaste Care intervention for care home residents with advanced dementia (Simard, 2013). They note as well that the positive impacts on resident and staff well-being resulting from the receipt of this innovative, evidence-based approach to end-of-life care will contribute their own associated costs and benefits, which must be factored into any final implementation. Livingston and Rapaport (2020) laud the cost model for its clear and explicit methods which allow those who would use it in other care systems to consider how it would apply in a different country.

Dementia education has been the focus of much research in psychogeriatrics.Heward *et al.* (2020) describe a mixed-methods approach to measuring the effectiveness of a simulation-based dementia education program to support the development of interpersonal skills in care staff. Their adaptation of the Dementia Education and Learning Through Simulation 2 (DEALTS 2) has been commissioned by Health Education England. In his commentary, McCarthy (2020) underscores the importance of the DEALTS 2 project's focus on changing knowledge, skills, and attitudes of care staff in acute settings, a prerequisite to behavior change in staff, in his opinion.

Berenbaum (2020) contributes the final brief report to this collection of research on dementia.

A pilot of a continuing medical education course for primary care physicians aimed to increase knowledge of how to better manage early diagnosis and management of dementia, boosting confidence, and addressing attitudes of the physicians involved. The evaluations of this tool demonstrated better knowledge of diagnostic tools and nonpharmacological intervention strategies post-intervention. The course contents were highly valued and recommended to colleagues, underscoring the important place of such dissemination vectors in putting evidence-based knowledge into practice.

The final paper in this special issue examines the Intensive Care Unit (ICU) survivors with the potential to experience post-intensive care syndrome (PICS). Wang and colleagues (2020) describe the development of the Critical Care Recovery Center (CCRC), using an eight-step process known as the Agile Implementation (AI) Science Playbook (Boustani *et al.*, 2018). Such targeted treatment of PICS is highly relevant in light of the current COVID-19 pandemic, with large numbers of patients exposed to often prolonged mechanical ventilation, with myriad physical and cognitive sequelae. The AI Playbook is specifically designed with the purpose of rapidly implementing evidence-based medicine into healthcare practices, as Andrews and Wilson (2020) note in their commentary.

Frameworks and tools such as the AI Playbook and robust economic models of the costs of implementation are key to helping translate knowledge into practice in psychogeriatric settings.

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