INNOVATIONS IN DIVERSITY AND EQUITY IN SOCIAL HEALTH RESEARCH IN DEMENTIA

Recommendations from the JPND INTEREST Working Group

March, 2025

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Acronyms and Abbreviations

Abbreviation	**Term**
AD	Alzheimer's Disease
ADRD	Alzheimer's Disease and Related Disorders
AT	Assistive Technologies
EDCWG	European Dementia Carers Working Group
EWGPWD	European Working Group of People with Dementia
IBPA	Intersectionality-based Policy Analysis
NDD	Neurodegenerative Diseases
PPI	Public Person Involvement
RCT	Randomised Control Trial
SG	Sub-groups
WG	Working Group

EXECUTIVE SUMMARY

Purpose

The societal challenge of dementia is the expected steep increase in the number of people with dementia in the coming years, coupled with a decrease in the workforce of professional caregivers. Despite progress in care and support, many health and social care needs remain unmet due to inequity, lack of individualized treatment, and a gap between research and practice implementation. The INTEREST Working Group aims to address these issues using a multi-level approach and an overarching framework of social health and intersectionality.

Methodology

The report employs a comprehensive literature review, public person involvement (PPI), and reviews of intervention guidelines, assistive technology, and policy. The methodology integrates findings from various sub-groups focusing on inequity, technology, and policy.

Findings

1. Inequity in Healthcare: Ethnic minorities and socioeconomically disadvantaged populations are underrepresented in dementia research and care, leading to unmet needs.
2. Limited Tailoring of Interventions: Innovations are often generic and not tailored to individual needs, requiring more culturally respectful and personalized approaches.
3. Implementation Gap: Innovations in support and care are not embedded in routine care, necessitating better connections between research, education, and practice. XXX

Recommendations

1. Strategic Policy and Best-Practice Guidelines: Develop policies and guidelines to address identified gaps.
2. Innovative Research Frameworks: Create frameworks to support transdisciplinary research for diverse groups.
3. Increased Research Capacity: Build capacity in research, including early career researchers and public participation.

Conclusion and Call to Action

The INTEREST Working Group proposes mechanisms for addressing gaps in dementia care through strategic policy, best-practice guidelines, innovative research frameworks, and increased research capacity. Future steps include implementing these recommendations to achieve equitable dementia research, care, and treatment. Policymakers, researchers, healthcare providers, and community organisations must collaborate to implement these recommendations. By doing so, we can create a more supportive and inclusive environment for people living with dementia and their carers, ultimately improving their quality of life and well-being.

INTRODUCTION

Background

Neurodegenerative diseases (NDDs) like Alzheimer's Disease (AD) and related disorders (ADRD) are major health, social, and economic challenges of the 21st century. The number of people with dementia is projected to rise from 7.7 million in 2001 to 15.9 million by 2040 [1]. The disease impacts the quality of life for individuals and caregivers, challenging their ability to live well in the community. The societal challenge includes a steep increase in dementia cases and a simultaneous decrease in professional caregivers, leading to reduced care quality [2] Despite progress in care and support, many health and social care needs remain unmet due to three urgent issues:

1. Inequities in Healthcare: Subgroups like ethnic minorities are underrepresented in dementia research and care, leading to unmet needs. More diversity and inclusivity are needed to tailor interventions appropriately, thus better meeting the needs of subgroups as well.
2. Limited Tailoring of Interventions: Innovations are often 'one size fits all' and not tailored to individual needs. To be usable, effective and implementable interventions must be tailored to specific contexts and points in the dementia trajectory. This includes the development of usable, effective and implementable technology-based interventions for dementia.
3. Implementation Gap: Innovations in support and care are not embedded in routine care, creating an implementation gap. Better regular exchange and transfer between between research, education, and practice are needed to accelerate the uptake of innovations.

Inequities in Dementia Care

Many people with dementia and unpaid carers face barriers in accessing and utilizing care due to geographical location, socio-economic status, ethnicity, sex, gender, and education [3]. These barriers include living alone without a carer and navigating digital support services [4]. Bell [5] identifies three concerns: assumed similarity of inequalities, the need for structural approaches, and political competition between inequalities.

Inequities in Dementia Research

A systematic review [6] highlighted the absence of several populations from dementia research. Socioeconomically disadvantaged populations are underrepresented, and few studies examine participants with lower socioeconomic status. Recruitment often targets people with early-stage dementia in primary care and community settings. Improved methodological standards and uniform measures are needed to evaluate recruitment, participation, and inclusivity systematically.

Limited Tailoring of Interventions

Few campaigns target ethnic minority communities, and outcomes of interventions are rarely reported. Targeted interventions are more effective than generic ones [7]. However, culturally tailored interventions face challenges such as unclear guidelines, low attention and retention rates, failure to measure processes, and poor cultural competency training. Strengths include culturally respectful care, healthy lifestyle promotion, increased family and community support, technology use for timely care, and increased disease knowledge [8].

The Promise of Technology

Technology has the potential to support dementia care by maximizing autonomy and promoting social inclusion. However, current technologies focus mainly on early-stage dementia or care robots. Ethical considerations, limited end-user involvement, and high costs restrict their wider use [9].

Implementation Gap

Despite evidence of improved dementia care models and psychosocial interventions, their implementation into routine care is limited [10]. Barriers include time constraints and increased workload, while facilitators include leadership and managerial support [11]. There is scant research on knowledge dissemination and implementation within dementia care settings. Typical drivers of practice change (e.g. professional training and education, stakeholder engagement and iterative evaluation approaches) were minimally present. Innovative research methods and frameworks are needed to guide the evaluation of dementia care models and interventions, optimizing efficiency and contributing to sustainable improvement [12].

Social Health

The 2019 INTERDEM manifesto [13] highlighted social health as a crucial area for developing new psychosocial interventions in dementia research. Defined in the JPND-funded SHARED project, social health is a relational concept where well-being is influenced by the impact individuals have on their social environment and vice versa [14-15]. Building on two decades of needs research among people with dementia in the community and long-term care facilities, and conceptual research from the INTERDEM taskforce [22] and the SHARED project, social health is framed within three domains: (i) capacity to fulfill potential and obligations, (ii) ability to manage life with some degree of independence, and (iii) participation in social activities. Using this overarching framework in INTEREST also helps identify associations between social health and cognitive functioning, which can be seen as potential risk and protective factors amenable to intervention.

Inequity and Intersectionality

Examining the complexity of multiple inequalities can be achieved through an intersectional lens. Crenshaw [16] distinguishes between structural intersectionality and political intersectionality. This approach encourages critical reflection, allowing researchers and decision-makers to move beyond singular categories like gender or socioeconomic status. Instead, it considers the complex relationships and interactions between these categories and other social locations and identities, such as indigeneity, sexuality, gender expression, and immigration status [17]. Despite its potential, an intersectional perspective is rarely used in dementia care research [18]. Applying this lens provides key tenets for analysis: human lives cannot be reduced to single characteristics, and their experiences cannot be understood by prioritizing any one factor. Social categories and locations are socially constructed and shaped by power dynamics. The intersectionality-based policy analysis (IBPA) framework [19] offers a descriptive approach to generate critical background information, focusing on the processes and mechanisms by which problems are identified, constructed, and addressed. It also provides a transformative approach to identify suitable and feasible responses aimed at reducing inequalities and promoting equity-focused solutions.

Aims and Objectives

INTEREST (INnovaTions in divERsity and Equity in Social health research in DemenTia) aimed to address three major issues in dementia care: inequity in research and care, limited tailoring of interventions, and the implementation gap. The primary objective was to establish a sustainable interdisciplinary, international working group (WG) to consolidate knowledge and share expertise across Europe, improving the balance between the supply and demand of dementia support and care. By adopting a multi-level perspective (individual, organizational, system), INTEREST analysed the unmet needs arising from the mismatch between the supply and demand of dementia care services. The initiative brought together academics, practitioners, policymakers, non-government organizations, and PPI contributors, representing a diverse mix of scientific knowledge and practical experience in dementia care. This interdisciplinary team spanned fields such as psychology, psychiatry, sociology, and health economics, offering an intersectional, multilevel, and intercultural perspective. The analyses were guided by an overarching framework of social health for people with dementia and an intersectional lens.

Specific objectives were:
O1. Identify unmet needs of people living with dementia in relation to health and social care services, with a specific focus on social health and a specific intersectional analytical lens on inequity.

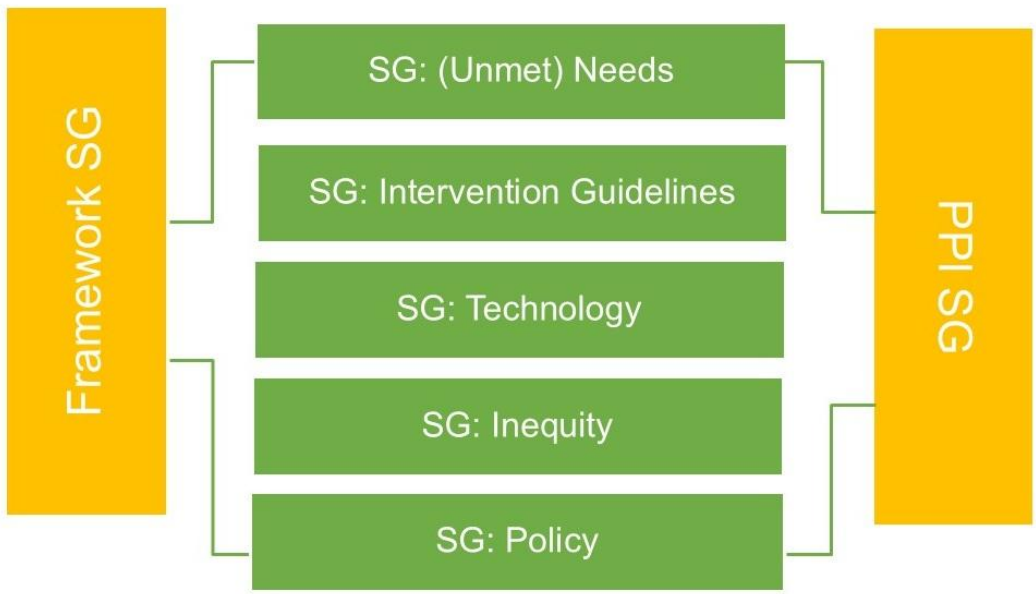
O2. Determine what is currently being delivered and identify gaps between supply and demand at three levels: (i) the overall resourcing of current dementia health and social care; (ii) the resourcing of care for those who may have specific needs or face barriers to access; (iii) the tailoring of health and social care services for individual circumstances and the role of technology in tailoring interventions.

O3. Developing mechanisms for addressing identified gaps in three ways: (i) strategic policy and best practice guidelines; (ii) research frameworks and methodologies that enable and support transdisciplinary research for diverse groups of people with dementia; (iii) build capacity in research (e.g. early career researchers (ECRs), public participation and awareness to underpin future research initiatives in the field.

METHODOLOGY

The INTEREST Working Group (INTEREST WG), led by Dr Louise Hopper, Dublin City University (DCU), served as the overarching workgroup that integrated findings from various sub-groups (see Figure 1). The focus of the WG included (a) collating outputs from each subgroup, (b) developing strategic research questions, research frameworks, methodologies, policy proposals, and best-practice guidelines, (c) delivering the INTEREST Working Group Report, and (d) disseminating the findings.

Figure 1 Organisation of the JPND Interest Working Group and sub-groups



Social Health, Intersectionality and Inequity Frameworks

A Framework group was established that provided methodological support and guidance.

Social Health (Lead: Prof de Vugt)

These have been brought together to form the concept of social health in dementia care, which is characterized by three key domains [15, 22].

1. **Capacity to Fulfill One's Potential and Obligations**: According to Dröes et al. [22] in their consensus paper on Social Health, experts in dementia care and research have outlined several key abilities that reflect a person's capacity to realize their potential and meet responsibilities on an individual (*micro*) level. These include:
   - The ability to make choices and act independently (autonomy),
   - The ability to preserve one's sense of self (personhood),
   - The ability to engage with and contribute to social groups,
   - The ability to both offer and receive support (reciprocity),

- The ability to work together with both professional and informal caregivers,
- The ability to take part in shared decision-making processes.

At a broader (*macro*) level, the ability to engage with and contribute to the community was also emphasized. When these abilities are supported, individuals with dementia are better positioned to live up to their potential and fulfill their social roles through mutual support and community involvement.

The factors influencing the capacities within this domain fall into three categories:

- **Personal factors** – These include mental health, a sense of coherence, self-confidence, resilience, and the ability to cope with stigma.
- **Disease-related factors** – These refer to the impact of dementia and any other health conditions, such as the severity of cognitive decline, changes in learning ability over time, and difficulties with daily activities.
- **Social factors** – These involve the presence or absence of social support, experiences of stigma or discrimination (which can obscure a person's strengths), the quality of collaboration with caregivers, and access to meaningful activities and professional support.

2. **Managing Life with Some Degree of Independence:** This domain involves autonomy, problem-solving in daily life, and managing the emotional and practical implications of the disease [22].

   The factors influencing this domain are:

   - **Personal factors** – These include aspects such as the individual's personality before the onset of dementia, their abilities, life experiences, and core personal and spiritual values. Also important are their involvement in activities and relationships, their sense of purpose, awareness of their condition, and their ability to acknowledge and accept the need for care.

   - **Disease-related factors -** These refer to the limitations caused by dementia as it progresses, along with any other cognitive or physical impairments and additional health conditions the person may have.

   - **Social factors -** significantly affect a person's ability to engage in meaningful activities and maintain relationships. These include the skills and support available within the person's social network—such as the competence of caregivers, the quality and mutuality of caregiving relationships, the level of formal and informal support, and cultural influences. Other relevant social aspects include the person's living arrangements (e.g., living alone or with a caregiver), whether they reside in a dementia-friendly or inclusive community, how easily they can access support services, and whether the support they receive is tailored to their specific needs.

3. **Participation in Social Activities:** For individuals with dementia, this domain can be understood as being engaged in meaningful tasks and social interactions, as well as maintaining relationships that hold personal significance [22]. The INTERDEM Social Health Taskforce emphasizes that the emotional experience of these interactions is a vital component of social health.

   The factors influencing this domain are:

   - **Personal and disease-related factors** – Engaging in social activities requires both mental and physical capabilities. Cognitive impairments may limit a person's ability to attend or engage meaningfully, while physical limitations can restrict active involvement (Kolanowski et al., 2006). Additionally, communication challenges often lead to feelings of insecurity for individuals with dementia, and caregivers may struggle to communicate effectively as the condition progresses and affects language and comprehension (Murphy & Oliver, 2013).

   - **Social factors** – The presence and quality of support from both formal and informal caregivers play a crucial role in enabling participation in everyday activities, whether at home or in care facilities. Strong social networks not only support engagement but may also help slow cognitive decline (Kuiper et al., 2015). On the other hand, stigma and discrimination can significantly hinder social involvement (see Social Health dimension 1).

   - **Material and environmental factors** – The physical environment also affects participation. Accessibility—both in private homes and institutional settings—along with transportation options to activity venues, can either support or limit a person's ability to take part in social life. These environmental conditions can act as either enablers or barriers to meaningful engagement.

Intersectionality (Prof Roes)

Intersectionality in dementia care acknowledges the complexity and multidimensionality of people's lives, highlighting how personal characteristics and social positions intersect to impact health outcomes. For example, age, comorbidities, protected characteristics such as gender and ethnicity, and cultural and linguistic diversity [19].

Inequity (Lead: Dr. Giebel)

This sub-group supported the Framework group by focusing on how to overcome research challenges related to inequities in dementia care and research. It applied an intersectionality framework to analyze structural intersectionality (e.g., access to health and social care services due to socio-economic status) and political intersectionality (e.g., national dementia care and research strategies addressing heterogeneity). Additionally, the definition of the three social health domains were critically reflected upon and updated as needed to promote equity in health and social care services and to support inclusive dementia care research. This work is based on conceptual research from the INTERDEM task forces on Intercultural Care and Inequalities in Care, contributing to strategic solutions (O2, O3).

INTEREST Sub-Groups

Five sub-groups (SG), Needs SG, Intervention Guidelines SG, Technology SG, Inequity SG and Policy SG were established to examine unmet needs and strategic solutions for addressing these needs at three levels (micro-, meso-, and macro) and through the prisms of social health and intersectionality. Each looked at an essential component of dementia care, restricting its focus to unmet needs and strategic solutions for addressing these needs to ensure that recommendations could be delivered within the time available.

SG: (Unmet) Needs (Lead: Dr Koh)

This sub-group mapped existing research evidence on the unmet needs of people affected by dementia (O1). The focus was on examining unmet needs using a social health framework [15] and through the specific lens of intersectionality [16]. As a result, this SG also addressed the secondary question of how unmet needs influenced the social health of people with dementia, along with any contributing factors.
A scoping review of reviews based on the Joanna Briggs Institute guidelines [20] was conducted. A search strategy was developed in consultation with an information specialist, and five databases were systematically searched. Next, a two-stage screening process was undertaken by at least two independent reviewers. Studies were included if they: (1) were review articles, (2) focused on unmet needs in people affected by dementia, (3) were published in the last 15 years (2009-2024), and (4) published in English, German, Dutch, Spanish and/or Portuguese languages. Data were extracted onto a standardised data extraction form. This included study characteristics, and unmet needs as characterized in the Camberwell Assessment of Needs for the Elderly (CANE) [21]. Data that was extracted was organised and presented categorically. To further understand how unmet needs influence the social health of people living with dementia, the extracted data on their unmet needs was mapped onto the social health framework [15, 22].

SG: Intervention Guidelines (Lead: Dr Neal)

The goal of this SG was to identify if, and within what framing, existing national guidelines for the management of dementia in different European countries provide clear recommendations on which psychological and social therapies are effective, and for whom (O2). Specifically, three conceptual lenses of social health, intersectionality and inequity were applied to explore how these concepts manifest in European guidelines.

A cross-sectional review of 47 national guidelines from 12 European countries was conducted. Between April and June 2024, guidelines were identified by purposely sampling documents from countries where INTEREST group members were professionally active. Guidelines were eligible if they provided specific recommendations for diagnosis, medical treatment, care, and support of people living with dementia, and were supported by non-profit or public organizations without commercial interests. Data extraction focused on whether guidelines recommended specific psychosocial interventions, referenced social health, intersectionality, or inequity. Content analysis was performed, and data were checked by native speakers and senior researchers. Counts were reported for the number of guidelines identified per country, the number recommending specific psychological or social interventions, and the number referencing aspects of social health, intersectionality, or inequity. Results were tabulated, and narrative synthesis of extracted passages was undertaken with illustrative quotations translated into English. A relational analysis resulted in a concept map illustrating interrelationships between social health, intersectionality, and inequity.

SG: Technology (Lead: Prof. Dröes, Co-lead: Dr. Neal)

This SG examined what needs to be done and further investigated to ensure the supply of usable and effective technology to promote physical, mental, and social health in dementia to equitably meet the demand (O2, O3). The focus was on assistive technologies that support people with dementia and their caregivers in a tailored way, addressing self-identified unmet needs (including memory support, social contact, daytime activities, safety, and information about their condition). Analyses were conducted on micro-, meso-, and macro levels to establish an ecosystem of usable, effective, and implementable technologies, ultimately improving the well-being and quality of life for people with dementia and their caregivers. This work was built on research from existing European networks such as the INTERDEM Assistive Technology Taskforce and the Marie Sklodowska-Curie INDUCT and DISTINCT Innovative Training Networks. The findings contribute to best practice guidance and an agenda for future research (O3).

The SG focused on two research questions: identifying personalisable and effective technologies for unmet needs related to social health and determining what needs to be done to ensure the supply of usable and effective technology equitably meets the demand. An explorative, pragmatic review of reviews was conducted to identify effective, personalisable, and usable technologies that promote social health in dementia. The inclusion criteria required that the reviews focus on people with dementia and aspects of their social health, mentioning specific assistive technologies (AT). Exclusion criteria included reviews that did not focus on dementia, targeted only informal or professional caregivers, or mentioned almost no specific technologies. Twenty-eight reviews on technology in dementia care were included. Data was extracted on year of publication, type of study, specific technologies, target groups, unmet needs, social health domains, personalisability, usability, effectiveness, and recommendations for implementation and further research. Reviews were analyzed by pairs of reviewers to ensure accuracy. Disagreements were resolved through discussion until consensus was reached. Recommendations from the INDUCT/DISTINCT Best Practice Guidance were also extracted and categorized into social health domains and on micro, meso, and macro levels.

To answer the research questions, the following analyses were conducted:

- Number and percentage of personalisable ATs per review and overall
- Division of personalisable ATs into social health domains
- Description of personalisable aspects of ATs
- Number and percentage of personalisable ATs with usability information

- Number and percentage of personalisable ATs with demonstrated effectiveness in controlled trials
- Recommendations on personalization and implementation of ATs categorized by social health domain and level
- Thematic analysis of directions for future research

SG: Policy (Lead: Dr. Comas-Herrera)

This SG adopted a multilevel perspective (research, practitioner, service management, and policy) on health and social care for people with dementia and their carers to examine policies that support meaningful and sustainable innovation in research and practice. By bringing together the multi-disciplinary expertise of the INTEREST WG, this SG formulated and disseminated evidence-based, implementable best practice guidelines for dementia-related health and social care provision, mechanisms to enhance research capacity in academia and practice, and detailed aspects relating to outcome assessment, evaluation, and monitoring approaches to promote lasting and impactful policy change and tackle the implementation gap (O3).

To determine the policy implications of the findings of the INTEREST SGs, we first considered which policies were relevant to inequities in dementia and identified the policy mechanisms through which influence was exerted. Findings from each of the SG reviews were examined alongside the inputs from the PPI discussions with members of the European Working groups of people with dementia (EWGPWD) and carers (EDCWG) and identified policy recommendations from each. Recommendations were collated, refining the policy area/mechanisms as needed. Finally, a policy brief was prepared based on the recommendations, linked to the key findings of each review.

Public Person Involvement (PPI)

Public Person Involvement (PPI) was integrated into the work of the INTEREST Working Group through consultations with members of the European Working Group of People with Dementia (EWGPWD) and the European Dementia Carers Working Group (EDCWG). With the support of Alzheimer Europe, this involvement included face-to-face sessions where members discussed their perspectives and experiences related to unmet needs and social health in dementia. Their feedback was incorporated into the analysis and interpretation of the review findings of each of the sub-groups, and into the discussion and identification of INTEREST recommendations.

SUMMARY OF FINDINGS

Public Person Involvement (PPI)

The PPI feedback highlighted the importance of addressing psychological distress, social isolation, and the need for appropriate daytime activities and company for people with dementia. Informal caregivers reported unmet needs related to information about the disease trajectory, post-diagnostic care, and practical support at home. Additionally, the discussions revealed a lack of clear and accessible information about post-diagnostic support services. People with dementia and their caregivers emphasized the importance of maintaining independence, engaging in meaningful activities, and the need for culturally and linguistically appropriate services. Caregivers also highlighted the need for better support and recognition of their role, as well as the importance of timely diagnosis and resources. The feedback underscored the need for technologies that are user-friendly, personalisable, and reflective of the diverse needs of people with dementia. It emphasized involving end-users in the design and implementation process to ensure that technologies meet their needs and preferences. Our findings emphasize that the development and implementation of assistive technologies should be user-driven and user-centered, involving people with dementia and their caregivers throughout the process. Our PPI discussions specifically highlighted the need for further research to develop technologies that are accessible, effective, and tailored to the diverse needs of people with dementia.

The involvement of people with dementia and their caregivers in the research process provided valuable insights that informed recommendations for future research, policy, and practice. The group concluded that PPI is essential for developing guidelines that reflect the priorities, needs, and values of people affected by dementia. Addressing the unmet needs of people with dementia and their caregivers requires a comprehensive approach that includes psychological, social, and practical support. The involvement of people with dementia and their caregivers was crucial for identifying and understanding these needs.

(Unmet) Needs of People with Dementia and Caregivers

A total of 85 reviews were included in this review. Most reviews explored the unmet needs of informal caregivers (n=56, 65.9%), followed by people living with dementia (n=30, 35.3%) and formal caregivers (n=20, 23.5%) Articles in the reviews were primarily from the United States, United Kingdom and countries of the European Union. Most articles included participants with any type of dementia, however some focused specifically on young onset dementia (n=5), frontotemporal dementia/frontotemporal lobar degeneration (n=4), people with dementia and other comorbidities (n=4), and advanced dementia (n=3).

The most frequently reported unmet needs of people living with dementia, based on the CANE categories of unmet needs, were psychological distress (n=13), daytime activities (n=11), company (n=11) and accommodation (n=10). In contrast, unmet needs relating to food, physical health, money, household skills, mobility and falls only surfaced in a few reviews. Additionally, unmet safety needs did not surface in any reviews. This suggests unmet needs pertaining to safety issues may have been under-investigated or not have been perceived as a priority in research studies.

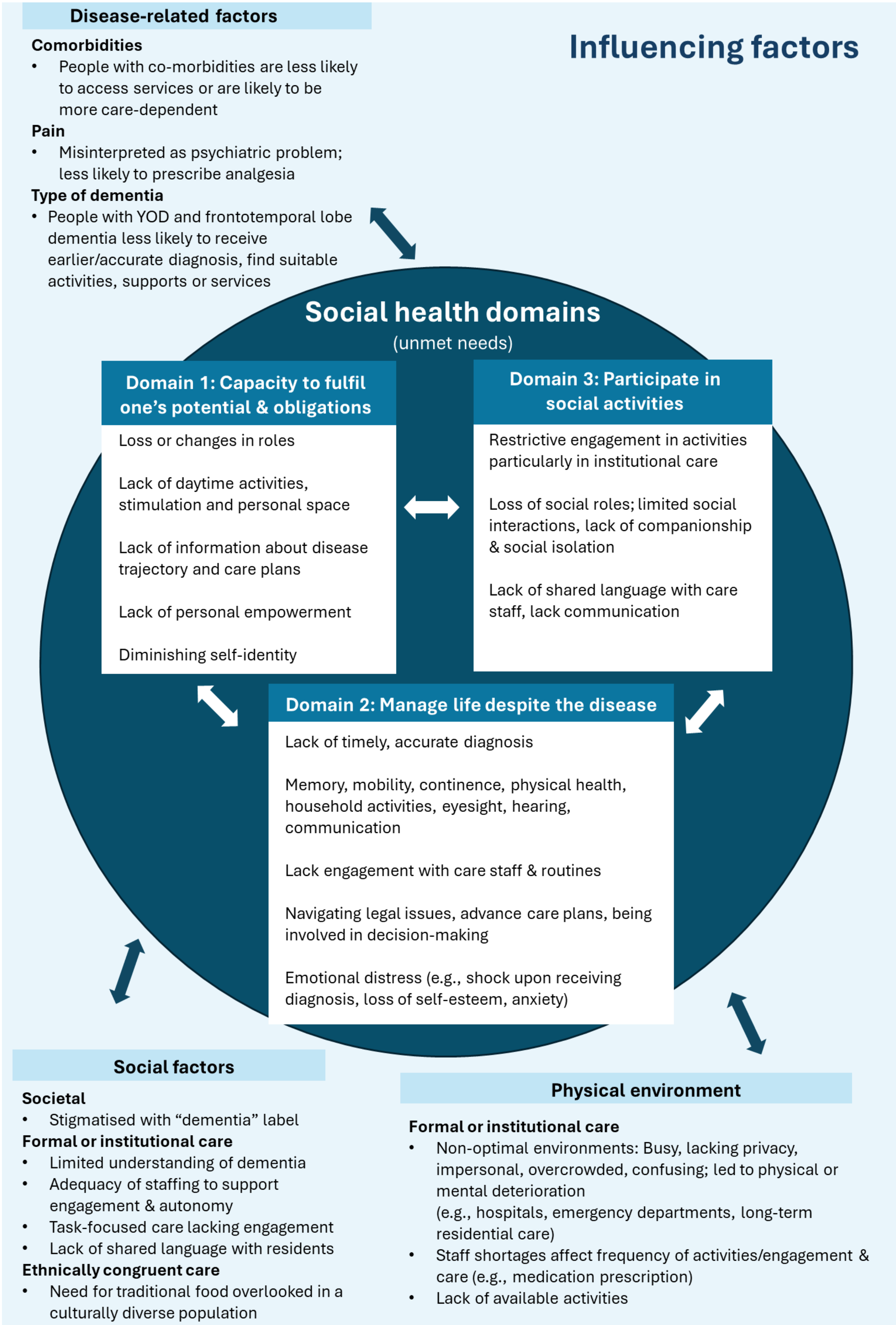
Informal caregivers included family members such as spouses, children, grandchildren or other relatives. Their most frequently reported unmet information needs included information about post-diagnostic care options (n=23), the disease trajectory (n=22), and information to support different aspects of caregiving (n=15). The most identified areas of unmet needs relating to psychological distress were social isolation (n=18), feeling overwhelmed from caregiving responsibilities (n=18) and adjustments to relationship changes (n=12).

While the CANE was not intended for use with formal caregivers, it served as a starting point to consider their unmet needs. Findings revealed that the most frequently mentioned unmet information needs included training or skills needed to provide care (n=17), knowledge about dementia (n=9) and communication, particularly in managing language barriers or cross-cultural communication (n=6). In terms of psychological distress, unmet needs most frequently pertain to feeling overwhelmed from care provision (n=6), incongruence between personal values and organizational priorities (n=4), and burnout or job strain (n=3).

The unmet needs of people living with dementia were mapped onto the social health framework, and unmet needs that can influence each social health domain are summarised in Figure 1. Unmet needs that can influence Domain 1 (i.e., ability to fulfil potential in society) include role loss and role changes, a lack of engagement in routine activities and personal space, not being provided information about the disease trajectory, care pathways and being disempowered in decision-making. Unmet needs that can influence domain 2 (i.e., ability to manage life with some degree of independence), include a lack of timely diagnosis, unmet needs pertaining to memory, mobility, continence, household activities, and sensory skills (e.g., eyesight, hearing). In addition, difficulties navigating care pathways and psychological distress can also influence this social health domain. Finally, unmet needs affecting domain 3 (i.e., participation in social and meaningful activities) include a loss of social roles, a lack of social interactions or social isolation, a lack of engagement in activities, or communication difficulties.

In conclusion, a considerable volume of research has been undertaken in the last 15 years to broadly identify the unmet needs of people affected by dementia, based on a pre-defined conceptual definition of “need”. A clear conceptualisation of what constitutes social health in people with dementia enabled considerations of how unmet needs affect their social wellbeing. These findings provide important directions for dementia care providers to address if the unmet needs of people with dementia are to be managed effectively. The conceptualisation of social health is less well-defined for caregivers. It is clear that this is an important area for further development.

Figure 2 Summary of Unmet Needs of People with Dementia mapped to Social Health Domains



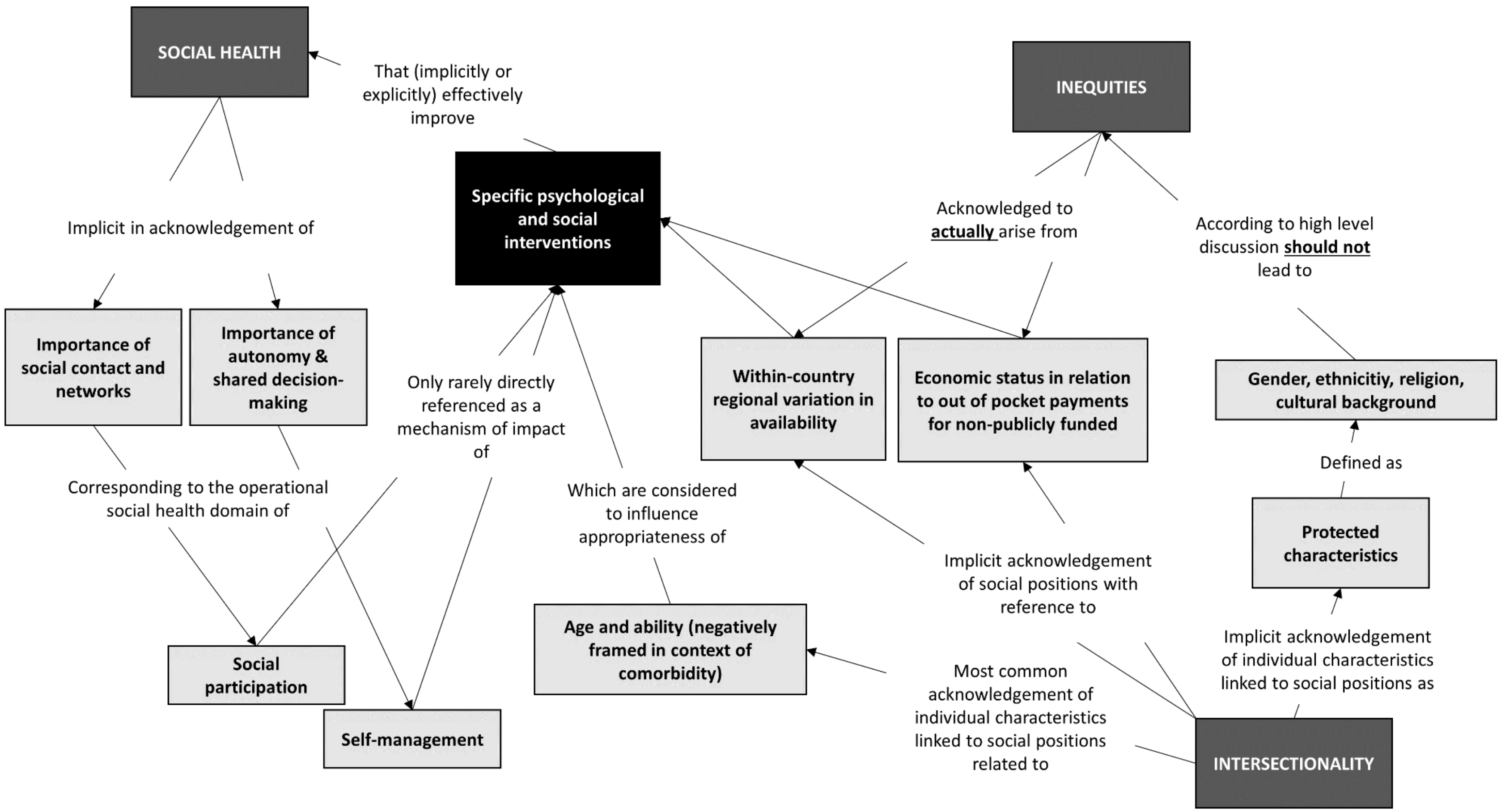
Review of Intervention Guidelines

Out of 47 guidelines, 35 (74%) recommended specific psychological or social interventions. Common interventions included cognitive behavioral therapy, cognitive rehabilitation, music therapy, physical activity, reminiscence therapy, and sensory stimulation. Less common interventions mentioned were carer interventions, conversational coaching, drama therapy, horticultural therapy, mindfulness, physiotherapy, reality orientation, and sleep hygiene. Some guidelines recommended combining interventions or conducting them in groups. Consequently, the biopsychosocial approach to dementia care reveals positive trends, with the majority of reviewed guidelines recommending psychological and social interventions, reflecting a call to reduce the divide between biomedical and psychosocial dementia research, policy, and practice. However, 27% of guidelines did not mention specific psychological and social interventions, indicating room for improvement across Europe. It is important to monitor the implementation of guidelines and support providers with information on facilitators and barriers of the implementation of psychosocial interventions.

The fragmented use of conceptual frameworks highlights gaps in addressing social health, intersectionality, and inequity. Explicit mentions of "social health" were rare, appearing only in guidelines from Ireland and the Netherlands. Social health was mostly referenced implicitly in the context of self-management and social participation, emphasizing functional capabilities, autonomy, and shared decision-making. Social participation was discussed in terms of interactions within supportive networks and broader social structures. Social interactions were discussed as important for quality of life but rarely as outcomes of specific interventions. The domain 'capacity to fulfil one's potential and obligations' was notably absent, underscoring a gap in acknowledging how dementia impacts an individual's capacity to function in society. Intersectionality was not comprehensively applied, with diversity aspects rarely addressed in intersectional terms. Explicit references to "intersectionality" were lacking. Age and comorbidities were the most commonly mentioned characteristics influencing intervention appropriateness, highlighting specific needs of people with young onset dementia and the impact of physical disabilities and other comorbidities. Some guidelines noted the need to avoid discrimination based on gender, ethnicity, and other protected characteristics. Inequity was insufficiently addressed. It was primarily represented through references to within-country regional variations in service provision, sometimes related to shortages of qualified staff. Other sources of inequity were mentioned in guidelines from Italy, Portugal, and the UK, emphasizing the need for equitable access to care regardless of ethnic background, socio-economic status, or comorbidity. Few guidelines acknowledged the (un)representativeness of primary research samples.

Relational analysis, as presented in Figure 3, revealed that social health was frequently implicitly referenced, acknowledging the importance of social networks, autonomy, and shared decision-making. Intersectionality was not explicitly referenced, with age and ability commonly acknowledged in isolation. Inequity was acknowledged through regional variations and economic status but not linked to intersectional characteristics.

Figure 3 Concept map illustrating the relationship between (components of) the concepts of social health, intersectionality and inequity, as they are represented in the guidelines analysed in this study.



Public involvement perspectives emphasize the relevance of psychosocial interventions for people with dementia and carers. Promoting autonomy, choice, and existing social networks is crucial. Efforts should be made to transfer knowledge and best practices from countries with developed guidelines to those without. Although good guidelines exist, they are often not well-implemented due to inadequate dissemination or funding. Intersectionality is a key topic that should be better addressed in guidelines. Involving people with lived experience in developing guidelines is essential to ensure they reflect their priorities, needs, and values.

In conclusion, most European dementia guidelines recommend psychological or social interventions, but they lack grounding in the theoretical model of social health as a mechanism of impact. Few guidelines consider what works for whom or address inequity comprehensively. Future research and guideline development should focus on understanding how individual, community, and societal characteristics impact access to and effectiveness of interventions, and revise guidelines accordingly to ensure equitable access to effective care.

Assistive Technology Review

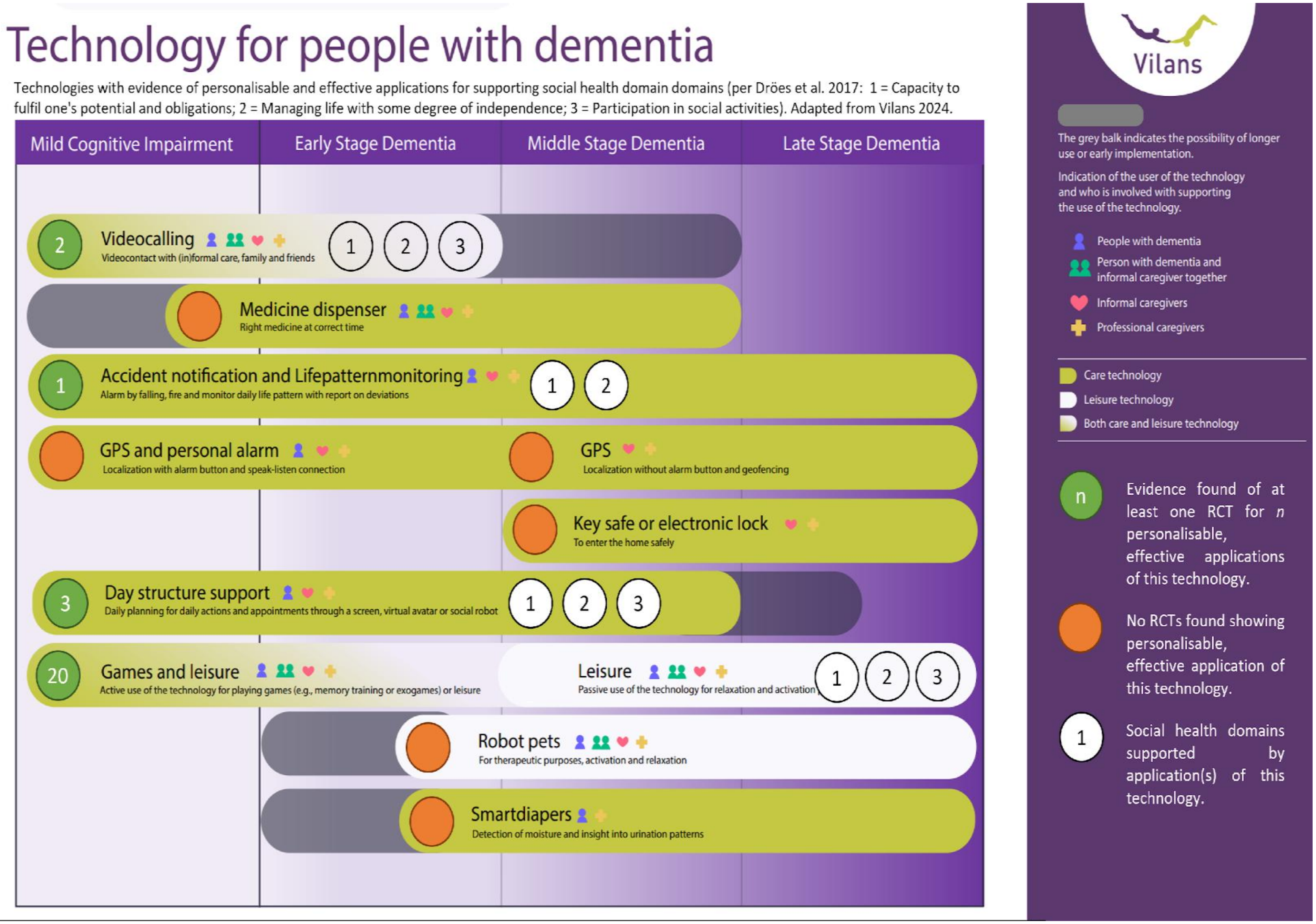
In total, 28 reviews concerning AT were included in this review. The reviews were identified from the INTEREST Unmet needs review, outputs of the EU MSCA INDUCT and DISTINCT networks, and recent searches for a review of systematic reviews being carried out by the INTERDEM AI & Assistive Technology Taskforce. Findings from this sub-group are presented in relation to the main research questions examined by this sub-group.

The first research question addressed by this review focused on identifying personalisable and effective technologies for unmet needs related to social health. Out of 329 mentions of specific technologies, 158 (48%) were considered personalisable, featuring adjustable settings and flexible content to accommodate variations in personal factors, physical, and mental health status. In terms of social health domains, 58% of these technologies supported the capacity to fulfil one's potential, 50% supported managing life with some degree of independence, and 48% supported participation in social activities. Usability information was available for 59% of personalisable technologies, although details were often limited. Furthermore, 23% of personalisable technologies demonstrated effectiveness in at least one randomized controlled trial (RCT), with the majority supporting managing life with some degree of independence, such as technologies for exergaming, reminiscence therapy and Virtual Reality interventions, followed by technologies supporting to fulfill potential and obligations (such as cognitive training, audiotapes, Virtual Reality rehabilitation, telephone and email support) and technologies for participation in social and other meaningful activities, such as YouTube videos, tablet based reminiscence therapy and web-based music.

The findings of the review show that almost half (48%) of the technologies that can promote social health are personalisable to some degree, and of those a small majority (59%) seem usable for people with dementia (See

Figure 4). However, only a minority (23%) of the referenced personalisable technologies provide evidence for their effectiveness associated with one or more of

Figure 4 Technologies with evidence of personalisable and effective applications for supporting social healthdomains (per Dröes et al. 2017: 1 = Capacity to fulfil one's potential and obligations; 2 = Managing life with some degree of independence; 3 = Participation in social activities). Adapted from Vilans 2024 [23].



the social health domains, as evaluated in an RCT. Technologies supporting managing life with some degree of independence were most often investigated and found to be effective, followed by those supporting fulfilling potential and participation in social activities.

The second research question addressed what needs to be done on a micro, meso and macro level to ensure the supply of usable and effective technology for physical, mental and social health equitably meets the demand. Findings from Research Question 2 provided several recommendations on the personalised implementation of technology for social health. General recommendations included providing clear and early information on technology, considering barriers to adoption, integrating technology into routine healthcare practice, and establishing national standards for telehealth equipment. On a *micro level* personalisation should meet individual variations in needs and abilities, simplify user interfaces, and tailor interventions to individual contexts. on a *mesolevel,* service providers are strongly recommended to consider adaptability to enable accessibility and to provide alternative non-ICT options to avoid excluding people with dementia. Also, the need of informed and trained personnel, (continuous) clinical evaluation of the usefulness, acceptability and effectiveness of technological devices is recommended; and on a *macrolevel* it is recommended that policymakers prioritise the need of older adults to participate in the community and provide technological and other services to address this; also policymakers need to be aware of barriers to access of public services (like public transport and financial services), consider adaptations to enable better accessibility and establish national standards and guidelines for, for example, communication technology.

For Social Health Domain 1, it is important to consider individual needs for every day, surveillance, and cognitive training technology, prevent discrimination, and provide alternative non-technological options. In Social Health Domain 2, recommendations included providing multidomain cognitive interventions, using monitoring with consent, and considering ecological validity and cultural context. For Social Health Domain 3, encouraging interest in technology through photographs, video calls, music, games, and art applications, and providing tools to find suitable apps were emphasized.

Overall, the review highlighted the need for individualized implementation, ecological validation, and personalisability of technologies. Recommendations for practice and future research, focused on addressing unmet needs, ensuring usability and effectiveness, and promoting equity in dementia care. The findings underscore the importance of tailored technology solutions and the need for ongoing research and policy development to support social health in dementia.

Mechanisms of Inequity

Inequity in dementia care arises from differences in access to and outcomes of care, often influenced by social positions and systemic barriers. Key findings from the reports include:

1. **Regional Variations:** Within-country regional differences in service provision are a significant source of inequity. This includes variations in the availability of activity programs and qualified staff,

which can impact the quality of care received.

2. Economic Status: Financial barriers, such as out-of-pocket payments for care, contribute to inequity. People from lower socio-economic backgrounds may have less access to necessary services and support.

3. Exclusionary Mechanisms: Guidelines often fail to acknowledge how exclusionary mechanisms are based on social positions, such as gender, ethnicity, and socio-economic status, impact on access to and appropriateness of care. This lack of acknowledgment can perpetuate inequities in dementia care.

4. Implementation Gaps: Even when guidelines exist, they are often not well implemented due to inadequate dissemination or funding. This can lead to inequity, as recommended interventions may only be available in certain areas or to certain groups of people.

These findings underscore the need for a comprehensive approach to dementia care that addresses social health, intersectionality, and inequity to ensure that all individuals receive equitable and effective care.

Policy Review

To address inequalities in dementia, we examined the relevant policy areas derived from the Rainbow model of health inequalities [24] and the Social Health models in dementia. These models provide a comprehensive range of policy areas, and we have highlighted key suggestions to focus on, based on social health factors and each of the layers of the Rainbow Model (see Table 1). By focusing on these policy areas, we can work towards reducing health inequalities and improving the quality of life for people affected by dementia.

Table 1 Public Health Actions to Increase Health Equity: The Rainbow Layers

Individual Lifestyle Factors	• Promote healthy lifestyle choices through education and support programs. • Encourage physical activity, balanced nutrition, and mental health awareness.
Social and Community Networks	• Strengthen community support systems and networks for people with dementia and their caregivers. • Facilitate social engagement and reduce isolation through community activities and support groups.
Living and Working Conditions	• Improve access to quality healthcare and social services for people with dementia. • Ensure safe and supportive living environments, including modifications to homes and care facilities.
Socioeconomic, Cultural, and Environmental Cond	• Address socioeconomic disparities by providing financial support and resources to low-income families affected by dementia. • Promote cultural competency in healthcare to ensure services are inclusive and respectful of diverse backgrounds. • Implement policies to reduce environmental stressors and enhance overall well-being.

RECOMMENDATIONS

Specific recommendations have been developed by each of the INTEREST SGs. These are presented first, followed by a summary of recommendations for policy makers and for researchers.

Addressing Unmet Needs

Dementia care providers should focus on addressing the psychological needs of people with dementia, providing appropriate daytime activities and company. For informal caregivers, there is a need for better information about post-diagnostic care options, disease trajectory, and caregiving strategies. Formal caregivers require training and information to improve their care provision skills and knowledge about dementia. Table 2 presents a summary of recommendations to address these unmet needs.

Table 2 Recommendations for future research and policy making to address unmet needs

People with dementia

- Provide equitable access to appropriate daytime activities, companionship and accommodation.
- Future research is required to develop services and supports that meet the specific needs of people with young onset dementia and frontotemporal dementia, and of those living in institutional care environments.
- Future research is required to determine how societies could meet the needs of people with dementia in the domains where unmet needs are highest.
- Attention must be paid to ensuring equitable access to research participation. People living in poverty, people without access to sufficient and safe food, people in poor physical health and with poor mobility are underrepresented in research examining unmet needs. Developing methodologies and procedures that encourage and support the participation of marginalised groups is essential.
- Future research could investigate the social health and inequity factors that aggravate unmet need.
- There is significant scope for future research to investigate the intersections of care to consider how different factors can create unique health challenges for people with dementia.

Informal carers

- The widest range of unmet needs for carers relate to 'information', painting a picture of far-reaching, multidimensional uncertainty. Research is required to determine the practical information that is required at different points on the dementia journey particularly in relation to disease progression and the availability of health and social care services and supports.
- Information that is developed for informal carers must be presented in accessible language and in a variety of media so that it can reach and be understood by people with varying levels of basic literacy, health literacy and digital literacy. Care should be taken to avoid information overload.
- Informal carers of people with young onset dementia and frontotemporal dementia have unique relational needs. Future research should highlight these differences to support the development of more appropriate services and supports for this cohort.

Improving Intervention Guidelines

Most European dementia guidelines recommend psychological or social interventions, but they lack grounding in the theoretical model of social health as a mechanism of impact. Few guidelines consider what works for whom or address inequity comprehensively. Future research and guideline development should focus on understanding how individual, community, and societal characteristics impact access to and effectiveness of interventions, and revise guidelines accordingly to ensure equitable access to effective care.

In Table 3, a summary of recommendations mentioned above is provided to advance future research and policy making. The recommendations target policy makers and committees commissioned to write guidelines for dementia care, as well as researchers, and health and care providers.

Table 3 Recommendations for future research and policy making to improve equitable access to effective dementia care in Europe.

- All countries in Europe should be encouraged to develop evidence-based guidelines for health and care providers where these do not exist.
- Guideline writers should place recommendations regarding psychological and social interventions within the context of the appropriate theoretical model of social health as a mechanism of impact, as well as an end in itself.
- Guideline writers should move towards applying an intersectional lens within recommendations, ensuring that effective psychological and social interventions are recommended, with clear indications of for whom they are effective and accessible, accounting for the impact of intersecting social positions on care needs, access and outcomes. This is an essential step to transfer knowledge to health and care providers about how to provide effective, person-centred care and actively reduce the risk of inequities arising from a one-size-fits-all approach.
- Policy makers and guideline writers should be open about all potential sources of inequity in care and outcomes and develop specific strategies to address sources of inequity.
- Attention should be paid to issues related to the implementation and access to the interventions recommended by the guidelines, with adequate funding and support for care providers.
- People with lived experience should be involved in the development of the guidelines and their implementation. Information in lay terms should be available about the guidelines for people affected by dementia and their caregivers.
- Future studies are needed to investigate how psychological and social interventions can support the social health domain “capacity to fulfil one’s potential and obligations” when living with dementia.
- Longitudinal, systematic research is needed to monitor the translation of evidence into guidelines, and from guidelines into practice, as an important influence on quality of care.

Technology for Social Health in Dementia

While many technologies are personalisable and usable, only a minority have demonstrated effectiveness in RCTs. There is a need for individualized implementation, ecological validation, and personalisability of technologies, considering user characteristics, needs, and contexts. In general, provide clear and early information on technology, consider barriers to adoption, integrate technology into routine healthcare practice and establish national standards for telehealth equipment. A summary of recommendations on personalized implementation of technology for social health in dementia are presented in Table 4.

Table 4 Recommendations on personalized implementation of technology for dementia

On a *microlevel*:

- Implementation of technologies should be individualized, technologies should be ecologically validated and personalisable, in line with user characteristics (e.g. age, interest, religion, digital literacy, physical and mental health status), user needs, preferences, abilities and diversity in people and contexts.
- Discrimination should be prevented by ensuring that public technological systems are useable for customers living with dementia.
- Tools that help people with dementia find apps for self-management, meaningful activities and social participation that match their needs, interest and abilities are recommended

On a *mesolevel*:

- Service providers are strongly recommended to consider adaptability to enable accessibility and to provide alternative non-ICT options to avoid excluding people with dementia.
- Professionals using technologies should be informed and trained, and (continuously) evaluate the usefulness, acceptability and effectiveness of technological devices for the individual with dementia.

On a *macrolevel*:

- Policymakers should prioritise the needs of older adults to participate in the community and provide technological and other services to address this.
- Policymakers should be (made) aware of barriers to access of public services, consider adaptations to enable better accessibility and establish national standards and guidelines for, for example, communication technology, while countries may need to make legal provisions to ensure that services do not discriminate against people with disabilities.

Future research should focus on developing needs-based, user-friendly, personalisable technologies, improving research methodologies, and addressing equity in access to technology for people with dementia (see Table 5).

Table 5 Recommendations regarding future research regarding technology for dementia

On a *microlevel*:

- Technologies should be developed and evaluation, that not only address the most frequently experienced unmet needs of people with dementia, but are also suitable, i.e. user-friendly and personalisable, for diverse groups in relation to age, ability, preferences, cultural background and context.
- Researchers should adopt and clearly report robust methods for evaluating usability of ATs, grounded in appropriate theoretical frameworks from human factors, engineering and human computer interaction
- Research should explore if and how personal, disease-related, social and material environmental factors facilitate or impede social health.
- The needs of people who will be implementing the technological interventions in practice should be investigated as they could contribute to equitably meeting the demand.

On a *mesolevel*:

- Research should focus on developing and adopting improved research methodologies (user-driven, user-centred, Living Lab) and guidelines for this.
- More research should be done with diverse user groups and broader global representation to account for cultural and contextual variations, into the usability, usefulness, acceptability and effectiveness of technology to promote social health,
- Research into mechanisms of impact and interaction effects should be done, as well as into facilitators and barriers of implementation of the technology.
- Evaluation research should use standardized measures (and provide effect sizes) to enable a more judicious application of outcomes by clinicians, LTC managers and researchers when trying to understand how and which technology can be used to overcome the immediate and long-term needs of people with dementia and their supporters at different stages of the disease.
- A variety of stakeholders and experts should be involved in technology research to ensure that all relevant aspects are met throughout the entire life cycle of AT for people with dementia, from scoping and initial design to dissemination and adoption.

On a *macrolevel*:

- Make public funding for development and testing conditional on involvement of people with dementia and their supporters.
- Investigate policy frameworks for reimbursing telehealth services delivered via tablets and ensuring equitable access, examine the impact of such reimbursements on telehealth adoption and healthcare equity, and evaluate how these tools can reduce healthcare costs while maintaining quality of care.

Recommendation for Policymakers

Based on the outputs of the INTEREST SGs tailored guidelines for policymakers and researchers have been developed. Recommendations for policymakers are presented in Table 6 and recommendations for researchers are presented in Table 7.

Table 6 Recommendations for policymakers

1. Address Unmet Needs

- **Equitable Access**: Ensure equitable access to appropriate daytime activities, companionship, and accommodation for people with all types of dementia.
- **Care Environments**: Promote person-centered care approaches in institutional settings. Ensure care environments are designed to reduce overstimulation and enhance privacy and comfort.
- **Support for Informal Caregivers**: Develop and fund training programs for informal caregivers on disease management and caregiving techniques. Increase availability of respite care services to alleviate caregiver burden.
- **Formal Caregiver Training**: Implement standardised training programs for formal caregivers, focusing on dementia care, cultural competency, and communication skills. Introduce certification and accreditation for dementia care training programs.
- **Public Awareness Campaigns**: Implement campaigns to reduce stigma and increase understanding of dementia.
- **Education Programs**: Integrate dementia education into school curricula and community programs.
- **Centralized Information Hubs**: Establish easily accessible information hubs for dementia-related resources.
- **Multilingual Resources**: Provide information in multiple languages to cater to diverse populations.

2. Support Research and Innovation:

- **Funding**: Increase funding for dementia research, particularly in underrepresented areas such as young onset dementia and frontotemporal dementia.
- **Collaboration**: Foster international research collaborations to address global dementia challenges.
- **Policy Implementation and Evaluation**: Develop and implement comprehensive national dementia plans with clear goals and evaluation metrics. Involve people with dementia, caregivers, and healthcare professionals in policy development and evaluation.

3. Technology Implementation:

- **Community Participation**: Prioritize the need of older adults to participate in the community and provide technological and other services to address this.
- **Transfer**: Strengthen the regular exchange and transfer between all stakeholders to facilitate acceptance and use.
- **Accessibility**: Be aware of barriers to access public services, consider adaptations to enable better accessibility, and establish national standards and guidelines for communication technology. Ensure legal provisions to prevent discrimination against people with disabilities.
- **Telehealth Services**: Investigate policy frameworks for reimbursing telehealth services delivered via tablets and ensuring equitable access. Evaluate the impact of such reimbursements on telehealth adoption and healthcare equity.

Table 7 Recommendations for researchers

1. Address Unmet Needs

- **Under researched Dementia Subtypes**: Conduct more research on the unique needs of people with young onset dementia and frontotemporal dementia.
- **Cultural Diversity**: Investigate the needs of people with dementia from diverse cultural and linguistic backgrounds.
- **Social Health and Inequity**: Explore how unmet needs impact social health and well-being. Investigate the social health and inequity factors that aggravate unmet needs.

2. Intervention Guidelines:

- **Biopsychosocial Framework**: Use a biopsychosocial framework to understand the multifaceted needs of people with dementia and develop supports and services accordingly.
- **Intersectional Lens**: Apply an intersectional lens within recommendations to ensure effective psychological and social interventions are accessible and account for the impact of intersecting social positions on care needs, access, and outcomes.
- **Longitudinal Research**: Conduct longitudinal, systematic research to monitor the translation of evidence into guidelines and from guidelines into practice.

3. Technology Implementation:

- **User-centred Design**: Develop and evaluate technologies that address the most frequently experienced unmet needs of people with dementia. Ensure technologies are user-friendly and personalisable for diverse groups.
- **Methodological Rigour**: Adopt and clearly report robust methods for evaluating the usability and efficacy of assistive technologies, grounded in appropriate theoretical frameworks from human factors engineering and human-computer interaction.
- **Implementation Research**: Investigate how personal, disease-related, social, and material environmental factors facilitate or impede social health. Focus on developing and adopting improved research methodologies (user-driven, user-centered, Living Lab) and guidelines for this.
- **Stakeholder Involvement**: Involve a variety of stakeholders and experts in technology research to ensure all relevant aspects are met throughout the entire life cycle of assistive technology for people with dementia.

By addressing these recommendations, policymakers and researchers can work together to create a more supportive and inclusive environment for people living with dementia and their carers.

DISSEMINATION and IMPACT

Members of the INTEREST WG disseminated information, updates, and findings through various in-person and online activities to reach various audiences and create impact. Below (Table 8), an overview is provided.

Table 8. Dissemination activities of the INTEREST WG.

Activity	Time, location	Audience	Message
Alzheimer Europe, newsletter https://www.alzheimer-europe.org/news/kick-meeting-jpnd-interest-working-group-takes-places-dublin	March 2024, online	International stakeholders interested in dementia research, care, and policy	Launch and aims of of INTEREST
Charles University, website post https://fhs.cuni.cz/FHS-1002.html?news=21599&locale=cz	April 2024, online	Czech student and university body	Launch and aims of INTEREST
INTERDEM, blog post https://interdem.org/?p=8786	April 2024, online	International dementia researchers	Launch and aims of INTEREST
Alzheimer Europe, newsletter https://www.alzheimer-europe.org/news/members-interest-meet-amsterdam?language_content_entity=en	June 2024, online	International stakeholders interested in dementia research, care, and policy	INTEREST update following meeting in Amsterdam
Meeting with Deputy Minister of Health of the Polish Government, Dr Wojciech Konieczny, and Mrs. Dagmara Korbasińska-Chwedczuk, director in the Departament of Public Health in Ministry of Health	June 2024, in person (Poland)	Polish policy makers	Exchange around INTEREST aims and dementia care in Poland
Several presentations at Alzheimer Europe Conference	October 2024, in-person (Geneva, Switzerland)	International researchers, health and social care professionals, policy makers, people with lived experiences	Update on INTEREST, preliminary findings
Registration in Global observatory of long-term care https://goltc.org/projects/goltc-1734516556/	December 2024, online	International stakeholders	General INTEREST information and updates
Liverpool Dementia & Aging Research Forum	Feburary 2025,	International	INTERDEM update,

and Equadem Network + webinar	online	stakeholders	preliminary findings
Webinar: INTEREST Recommendation	May 2025, online	International stakeholders	INTEREST recommendations
Dementia in Europe Magazine	June 2025, online and in print (in press)	International stakeholders	INTEREST recommendations
Several presentations at Alzheimer Association International Conference	July 2025, in person (Toronto, Canada)	International stakeholders (researchers)	INTEREST recommendations

Publications arising from this work

Casey, D., Comas-Herrera, A., Diaz, A., Hopper, L., Karl, J., Koh, W. Q., ... & Thyrian, J. R. (2024). Exploring unmet needs and inequity among people affected by dementia using an intersectionality lens: A scoping review of reviews. *Open Science Framework.* osf.io/cr2a4/

Neal, D., Bartels, S. L., Berdai Chaouni, S., Caprioli, T., Comas-Herrera, A., Chattat, R., ... & Hopper, L. (2025). Effective for Whom? A Review of Psychological and Social Intervention Recommendations in European Dementia Care Guidelines Through the Lenses of Social Health and Intersectionality. *Behavioral Sciences*, 15(4), 457. (Special Issue: Psychosocial Care and Support in Dementia) https://doi.org/10.3390/bs15040457

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Dröes, R.M., Neal, D., Bartels, S.L., Molinari-Ulate, M., Diaz B., Angie A., Szczesniak, D., Thyrian, R., Franco M., Wolf-Ostermann, K., Rymaszewska, J. & Hopper, L. (2025). How to improve technology for social health in dementia? A review of recommendations on implementation in practice and directions for future research to equitably meet the demand. [Manuscript in preparation]

CONCLUSION and CALL TO ACTION

The findings and recommendations presented in this report underscore the urgent need to address the interconnected challenges faced by people with dementia and their caregivers. By focusing on unmet needs, improving intervention guidelines, and leveraging technology, we can significantly enhance the quality of life for those affected by dementia.

Call to Action:

1. **Policymakers:** Implement the strategic policies and best-practice guidelines outlined in this report. Prioritize funding for dementia research, support international collaborations, and ensure equitable access to care and resources. Develop comprehensive national dementia plans with clear goals and evaluation metrics and involve stakeholders in policy development and evaluation.
2. **Researchers:** Focus on underrepresented areas such as young onset dementia and cultural diversity. Adopt holistic approaches using biopsychosocial frameworks and intersectional lenses. Conduct rigorous, longitudinal studies to understand the progression of needs over time and ensure research findings are translated into practical applications.
3. **Healthcare Providers:** Enhance training programs for formal and informal caregivers, promote person-centered care approaches, and ensure care environments are designed to reduce overstimulation and enhance privacy and comfort. Integrate personalisable, usable and effective technology into routine healthcare practice and provide clear, early information on its use.
4. **Community Organizations:** Strengthen community support systems and networks for people with dementia and their caregivers. Facilitate social engagement and reduce isolation through community activities and support groups.

By taking these actions, we can create a more supportive and inclusive environment for people living with dementia and their caregivers, ultimately improving their quality of life and well-being.

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