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GUEST EDITORIAL

International perspectives on dementia education, training and knowledge transfer

Dementia is on the rise and, as a result, the aged care workforce has an increasing need for up-to-date information on how to care for people living with dementia. While dementia research continues to mushroom, any research findings that have practical implications also need to be passed on to those at the coalface of dementia care as quickly as possible. This Supplement brings together a number of papers that have addressed various perspectives on dementia education, training and knowledge transfer in the U.S.A., U.K. and Australia.

Ten years ago, in reviewing service-based and tertiary institution-based education and training in dementia care in Australia, we commented on a widely held belief that carers just needed "a kind heart and common sense" in order to work in residential care (Doyle and Ward, 1998). This attitudinal barrier to effective provision of education and training in the field has begun to recede but has not disappeared altogether. Attitudinal change is not helped by the working conditions and career pathways that we provide in aged care. In Australia, nurses working in aged care are still paid at a lower rate than nurses working in the acute sector. The challenge for educators and trainers is to provide information as effectively and efficiently as possible in the face of both attitudinal and fiscal barriers. In an atmosphere of tight budget constraints, training and education are an easy target for reducing costs especially when the training is provided by external educators.

Another barrier is that education and training in dementia for personal carers who work in residential and community care is entirely voluntary as there is no legal or professional requirement for a minimum standard of training in dementia to be undertaken before commencing this type of work, in Australia at least. Health professionals with registration requirements such as physicians, nurses and allied health workers rely on tertiary institutions to supply an adequate grounding in dementia in their basic training before registration, and there are variable incentives or requirements for continuing professional education in dementia. We carried out a survey of training in dementia for staff of 98 residential care facilities in Victoria, Australia and found that 48% of 1,851 nursing home staff had attended a seminar or course on dementia (Doyle and Ward, 1998). Availability of dementia training in the late 1990s was low in all states of Australia, and there was patchy coverage, with some geographical areas having a lot of dementia training available, while other areas had little or none. There were few academic nurses in Australia with the necessary background to provide leadership in dementia education for those nurses interested in pursuing postgraduate education in the area.

In the ensuing ten years, a number of developments have improved dementia education and training in Australia. A recent census indicated that the proportion of personal care workers with Certificate III in Aged Care has increased slightly in Australia, from 55% in 2003 to 65% in 2007 (Martin and King, 2008). Initiatives funded by the Federal Government such as the National Action Plan for Dementia Care (1992–96) funded 35 facilities in 1993–94, 57 facilities in 1994–95 and six facilities in 1995–96 to demonstrate good dementia care to facilities in their area. A subsequent National Training Initiative provided funding for outside experts to give education sessions in residential care. In 2005 another major Dementia Initiative, funded again by the Federal Government, targeted education and training of the aged care workforce as a key component of the funding. Four Dementia Training Study Centres were established in 2006, and newly formed Dementia Collaborative Research Centres initiated knowledge transfer activities. In an ambitious injection of training, 17,000 aged care workers were given free training in dementia care over the period 2006–2009 (see the paper by Fleming in this supplement). A number of smaller projects were also funded, such as the Dementia Caring Pilot Project (see the paper by Eayrs), which provided innovative methods of training family carers in the skills needed to support a person with dementia living in the community. While tertiary specialist courses in dementia care have yet to be established in Australia in the intensive format used at the University of Bradford (see Downs *et al.* in this issue), some inroads into tertiary education have been made by Dementia Training Study Centre activities. Angus (this issue) describes one of the few postgraduate specialist degrees available in

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Australia for health professionals working in aged care management.

Nevertheless, as some of the papers in this Supplement indicate, there are still some significant gaps in our approaches to education, training and knowledge transfer in dementia care. Rampatige *et al.* present a review of the literature on continuing professional education, and conclude that interactive, multifaceted interventions or interventions with repeated inputs appear to be more effective in bringing about positive change, yet we do not know the extent to which this method of education is being used in continuing education on dementia. A recent project that undertook a stock take of dementia curricula and training in Australia commented that there continues to be a lack of clear articulation pathways between various programs or course levels, and a lack of designated career pathways in the field (AITEC Corporate Education and Consulting, 2006).

Another gap particularly apparent in Australia is the need for continuing dementia education for primary care physicians or general practitioners. Cherry *et al.* describe a strategy for training primary care physicians in the identification, diagnosis and management of Alzheimer's disease and related disorders. The strategy uses evidence-based practice guidelines to establish quality benchmarks and then provides training and other interventions to improve the quality of care received by these patients. Outcomes of two completed studies support the premise that it is possible to improve quality of dementia care through physician education that occurs in association with a coordinated system of dementia care management and in collaboration with community agencies to access guideline-recommended social services. The finding reflects our earlier observations that better coordination is needed between educators and trainers in different settings so that patients and their carers do not receive mixed messages, for example among primary, acute and residential care. In Australia there continues to be a lack of coordination between the technical and further education (TAFE) sector, which provides vocational training in dementia care, and the tertiary sector which provides professional training.

Leadership is an important emerging concept in dementia education, and two papers by Angus and Gould *et al.* describe the positive outcomes associated with dementia care training that emphasize the importance of leadership. The model used by the Dementia Essentials project (see Fleming *et al.* this issue) relies to some extent on leadership among trainees as it is often not possible to train everyone in a facility, and those who are educated then have to become change agents in their facilities in order to get the most benefit from the training in their everyday practice – a tall order in many facilities where the culture of the facility does not embrace new ideas. The paper by Chapman *et al.* extends the idea of leadership further in describing a model of education suitable for the ward setting in the U.K., using nurses as facilitators of group discussions. Andrews *et al.* go further into the close link between education and practice, describing an action research project with educational outcomes.

Finally, Draper and colleagues widen the discussion further to indicate that dementia education, training and knowledge transfer is an all-of-community responsibility, with key players at every level from policy-maker to family carer. In the end, we all need to take a hand in ensuring that we are as well informed in our health decision-making as possible, especially in an age of easy access to a wide range of dubious sources of information via the internet.

In Australia as in other countries, the aged care workforce and the setting is changing in nature. More people are being cared for in the community rather than in residential care, and the proportion of the residential aged care workforce who are nurses is declining (Martin and King, 2008). It is imperative therefore that education and training moves to address the changing needs of the workforce caring for people who are living with dementia in any setting.

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