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# The Blackfriars Consensus on brain health and dementia

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## Blackfriars consensus on promoting brain health:

### Preventing and delaying dementia

1. Following a meeting of public health practitioners, policy makers, voluntary and community representatives, and researchers hosted by the UK Health Forum and Public Health England in London on 30 January 2014, consensus was reached on the need for a new, integrated agenda for the prevention of dementia along with other non-communicable diseases (NCDs). Some components of dementia now appear to share common causal links with other non-communicable diseases. However, despite the apparent and emerging associations, current NCD policies and prevention strategies focusing on risk factors fail to acknowledge their relevance to dementia, and prevention has been largely absent from many dementia policies.

### HEADLINE CONSENSUS MESSAGE

2. Dementia is a common but not an inevitable part of ageing and in some cases it can be prevented or its progression delayed. The scientific evidence is evolving rapidly and is now sufficient to justify considered action and further research on dementia prevention and risk reduction, both by reducing the modifiable risk factors and improving the recognised protective factors.

### CONTEXT

3. Public health measures to modify risk factors have contributed to a large decline in deaths from heart disease and stroke over the past 50 years, but more needs to be done to build on these gains and accelerate health impact. There is some evidence that the same primary prevention approach might have led to a reduction in age-specific dementia prevalence in some countries.<sup>1</sup>
4. The most common form of dementia is Alzheimer's disease which together with vascular disease is a pathological process that contributes to most dementias. About half of cases worldwide might be attributable to known risk factors. In the absence of modelling the precise impact, it is thought that action on these risk factors could perhaps prevent between 3% and 20% of predicted new cases in 20 years.<sup>23</sup>
5. Given the evidence that vascular risk factors contribute to most dementias, interventions to address these risk factors (such as tobacco, poor diet, physical inactivity and alcohol; and intermediate disease precursors such as raised blood pressure, raised blood cholesterol, obesity and diabetes which arise from behavioural and other factors) should also help reduce the risk, progression, and severity of dementia.
6. Direct evidence to support this is lacking in some areas such as diet, but for others such as physical activity it is more compelling. For example, epidemiological studies

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<sup>1</sup> Matthews FE, Arthur A, Barnes LE, Bond J, Jagger C, Robinson L, Brayne C; Medical Research Council Cognitive Function and Ageing Collaboration. A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II. *Lancet*. 2013 Oct 26;382(9902):1405-12

<sup>2</sup> WHO and Alzheimer's Disease International. 2012. Dementia: a public health priority. Geneva: World Health Organization

<sup>3</sup> Smith D. and Yaffe K. 2014. Letter: Dementia (Including Alzheimer's Disease) can be Prevented: Statement Supported by International Experts. *Journal of Alzheimer's Disease* 38: 699–703 DOI 10.3233/JAD-132372

show that greater amounts of physical activity are associated with a reduced risk of dementia in late life, and randomised studies, and longitudinal studies using neuroimaging tools, show that participation in physical activity increases the size of areas of the brain which are involved in memory<sup>4</sup>.

7. Costs to the UK economy from dementia are currently estimated to be £23 billion. It is expected these costs will rise in future as the population ages. The effects of worsening trends in obesity, diabetes, physical inactivity and heavy drinking could make things worse and, in turn, dementia can itself act as a risk factor for poor diet, for example, thus increasing the risk of poor health. The predicted burdens of dementia in the future will present significant social and economic costs.
8. Recognising the scale and urgency of the problem, there is a need to take immediate, targeted action on the emerging and known risk factors such as physical inactivity (including upstream policy measures). The precautionary principle also requires that, even for those risk factors for which the evidence is less robust, we should recommend actions that could reasonably be presumed to reduce the risk of some types of dementia at least, whilst at the same time carrying out scientific evaluations of their effects. We should also facilitate further research into links between these risk factors and dementia (see 20b below).
9. Given the emerging evidence that some types of dementia and many NCDs likely share common risk and protective factors, future primary prevention policies for NCDs could be greatly strengthened if framed within a broad approach to health and wellbeing that explicitly supports the promotion of good brain health throughout life. Such an approach could combine policies and interventions which tackle the known risk factors for NCDs with those which promote the range of factors that are increasingly being shown to be protective against dementia.
10. Adopting an integrated health and wellbeing approach to NCDs prevention, which is inclusive of the emerging opportunities for dementia prevention, would not cause any harm. Indeed this may offer an opportunity to strengthen and expand existing prevention programmes and research in these areas with potential benefits to both conditions and beyond.

## **POLICY**

11. As the evidence on prevention of dementia grows, we should ensure national approaches to dementia going forward place greater emphasis on prevention of dementia. Population level measures should improve protective factors and reduce behavioural and intermediate risk factors linked, for example, to tackle physical inactivity, tobacco, alcohol use and poor diet.
12. As with so many other diseases, the impact that dementia has on people's function, and their lives, depends on their overall state of health and the balance between protective and risk factors across the life course. The evidence also suggests that the prevalence of dementia and /or its effects may be affected by protective factors such as good maternal and child health and nutrition; parenting skills and formative development in the early years; educational attainment; improved workplace health in mid-life; supporting social interactions and lifelong learning and stimulation in later life; delayed use of medication; and supportive care from services and from

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<sup>4</sup> Kirk I. Erickson,a,b Andrea M. Weinstein,a,b and Oscar L. Lopez. Physical Activity, Brain Plasticity, and Alzheimer's Disease. Archives of Medical Research 43 (2012) 615e621

carers/families. Many of these may be amenable to targeted action to tackle the upstream social, economic, and environmental factors that determine them.

13. Other actions which may prevent dementia more directly could include preventing alcohol and substance abuse and head injuries in adolescents and young people, and the impact in early life of these and other risk factors (including maternal health and behaviours and parental skills, physical activity levels etc.) and protective factors (including educational attainment) should be urgently examined from a policy and research perspective.
14. Dementia prevention and risk reduction should begin to be incorporated into both national and global policies and strategies to tackle NCDs, beginning with the interventions where the evidence is most robust, but recognising that this will likely evolve rapidly. There are already examples where this integration is occurring and lessons may be learned from the Finnish approaches to promoting brain and heart health.
15. There needs to be greater collaboration between clinical practitioners, public health and prevention experts, researchers and policy makers concerned with dementia or with other NCDs. This will lead to better integration of policy development and programme implementation and evaluation.
16. Policies for dementia prevention should include upstream population level actions as well as community and individual level interventions. Personalised interventions to encourage behaviour change, such as education and awareness campaigns, would need to be supported by upstream policies such as regulating and taxing unhealthy products.
17. Any new policies, strategies and interventions to reduce the risk of dementia and NCDs should carefully assess the potential impact on health inequalities and not widen health inequalities. Population-wide policies might reasonably be expected not to widen inequalities, however this will need to be combined with targeted interventions in marginalised or socially excluded communities.
18. National policy guidelines aimed at translating evidence on preventing and reducing the risk of NCDs and dementia into practice will aid implementation as would the use of tools such as audit, standards and kite marks to facilitate increased awareness and practice change amongst professionals.

## **RESEARCH**

19. There is a disproportionately small research focus on the prevention of dementia. Currently relatively little research funding (estimated at less than 1%) for dementia in the UK since 2006 has been committed to dementia prevention, which is disproportionate to its burden and impact.
20. Whilst future research needs to be strategic, coordinated and focussed on areas where the likelihood of return on investment is greatest (e.g. the causes of “non-vascular” dementia), a number of research approaches on dementia prevention are potentially needed: a) research into the mechanisms for the development and progression of dementia, including identifying new risk factors; b) epidemiological studies to understand the importance of risk factors in the development of dementia, particularly in early and mid-life c) epidemiological and modelling studies to help describe and predict the burdens of dementia in the UK population and the potential returns on investment that will accrue from prevention policies d) follow up existing

trials and cohort studies - such as those for diabetes and cardiovascular disease - to examine long term implications on dementia outcomes e) better ways to achieve early diagnosis, and prevent deterioration using different models of provision and support.

21. Good evidence underpinning sound prevention strategies comes from a variety of sources. Randomised Controlled Trials are important to test the role of risk and protective factors, but need to be urgently complemented by other approaches as illustrated by the work on physical activity referred to above<sup>3</sup>.
22. Consideration should be given to ensuring national health and population surveys are designed to be able to detect trends in dementia disease prevalence and incidence in a way which can be related to changes in behavioural risk factors and protective factors, and which are able to provide information to inform action at national and local level. Population surveys should also improve recruitment and data collection among the over 75s, as well as those currently in care.
23. Research is needed into the nature and extent of social inequalities in dementia risk. This should include studies on the on the social patterning of dementia, how it has changed in the last 20 years, and which individuals and groups bear the biggest burden in society.

## **COMMUNICATION**

24. The general public, health professionals and policy makers are increasingly aware of the links between behavioural risk factors and non-communicable diseases (such as tobacco and lung cancer or diet and cardiovascular disease). But very few people are aware that many of the same risk factors could impact on the risk of dementia. It is therefore imperative to communicate more clearly the emerging evidence about dementia risks, protective factors and preventive actions to the public and relevant health and care professionals and policy makers.
25. Communications must be informed by behavioural science and insights in order to maximise impact at all opportunities across the life course.
26. The emerging evidence suggests that the risk of developing dementia can be reduced but it cannot be eliminated. Communications should continue to tackle the myths and misinformation about dementia and to reduce stigma and should be carefully framed to avoid the impression that individuals who develop dementia are at fault. Lessons learned from the experience of communicating the risks of other NCDs such as cancer may be valuable.
27. Communications on reducing dementia risk should be fully aligned with those on living well with dementia, ensuring that the public receive balanced messages that enable them to respond and plan appropriately.

## **PROFESSIONAL DEVELOPMENT**

28. The rapidly evolving potential for dementia prevention and risk reduction should be incorporated into the training and development of the wider public health, health care and social care workforces. This may be most efficient when integrated into existing training programmes on NCDs prevention. However, given the pace of change in this field, bespoke awareness and training programmes on the prevention opportunities for dementia will need increasingly specialised focus.

Signatories:

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- Professor Kevin Fenton, National Director of Health and Wellbeing, Public Health England
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