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# Linking DemenTalent to Meeting Centers for people with dementia and their caregivers: a process analysis into facilitators and barriers in 12 Dutch Meeting Centers

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ABSTRACT

**Objectives:** There have been relatively few interventions on an individual level to support community-dwelling people with dementia to continue to fulfill their potential in society. This study investigated the implementation of DemenTalent, an intervention in which people with dementia become active as volunteers in society based on their talents. The intervention was linked to existing Meeting Centers for people with dementia and their informal caregivers.

**Method:** We conducted a qualitative multiple case study. Semi-structured interviews regarding experienced facilitators and barriers were conducted with 22 key figures/stakeholders in 12 Meeting Centers during the preparation, starting and continuation phases of the implementation of DemenTalent.

**Results:** Several influencing factors were found on a micro level (e.g. Public Relations, training, management involvement), meso level (e.g. finances, collaborating with others) and macro level (e.g. laws and regulations, national and regional policy) during the different phases of the implementation process. Factors mentioned by most stakeholders were human and financial resources. Another important factor appeared to be the culture of the region.

**Conclusion:** The insight into facilitating and impeding factors in the implementation of DemenTalent provided by this study will inform and enable other Meeting Centers to adopt a fitting strategy to implement DemenTalent in their own center. This is expected to help disseminate the intervention further, giving more people with dementia the chance to fulfill their potential, find a meaningful and pleasant way of spending their time, and actively participate in society. This will contribute to a more inclusive society and less stigmatization of people with dementia.

**Key words:** dementia, psychosocial intervention, qualitative research, day programs

As the number of elderly people in our society, and therefore also the number of people with chronic diseases, increases, interest in living with a chronic disease also grows. Some years ago Huber *et al.* (2011) proposed a new definition of health, as the ability to adapt physically, mentally and socially to the consequences of diseases. In this definition social adjustment involves three domains: the ability to (continue to) fulfil your own potential and social obligations, the ability to manage your own life, and the ability to participate in social activities. Recently, the Social Health Taskforce of INTERDEM, a pan-European network of researchers in the field of psychosocial interventions in dementia, operationalized Huber's concept of social health for people with dementia (Droes *et al.*, 2017). Focusing not on deficits but on remaining capacities, they operationalized the first domain ("fulfilling potential and obligations") as the ability of a person living with dementia to optimally function in society according to their competencies and talents ("potentials"), and to meet social demands ("obligations") on a micro- and macro-societal level. The second domain ("ability to manage life") was operationalized as the ability to preserve autonomy, to solve problems in daily life, and to adapt to and cope with the practical and emotional consequences of dementia. The third domain ("participate in social activities") was

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operationalized as being occupied or involved in meaningful activities and social interactions, and having meaningful social ties and relationships. In their paper, Dröes *et al*. present an overview of interventions that were successfully applied in recent decades to improve adaptation and functioning of people with dementia in these three domains. It shows that, apart from community-oriented initiatives to make the city or neighborhood more dementia friendly (Cantley and Bowes, 2004; Droes *et al.*, 2004), there have been relatively few interventions on an individual level for community-dwelling people with dementia regarding the first social health domain, i.e. to continue to fulfill one's potential and social obligations. Examples of (facilitating) interventions include: interventions enhancing resilience (Clare *et al.*, 2011; Harris, 2008; Resnick *et al.*, 2011; Windle, 2012), goal-oriented cognitive rehabilitation (Clare *et al.*, 2014; Graff *et al.*, 2007; Logsdon *et al.*, 2008; Potter *et al.*, 2011; Woods *et al.*, 2012, 2006) and assistive technologies, to compensate for disabilities regarding e.g. memory, orientation and action (Boots *et al.*, 2014; Hattink *et al.*, 2016; Lauriks *et al.*, 2007; Meiland *et al.*, 2017; Span *et al.*, 2014). The authors recommend giving more attention to this social health domain, both in practice and research (Droes *et al.*, 2017).

Some years ago, DemenTalent was set up in the Netherlands (www.dementalent.nl). DemenTalent offers people with dementia the opportunity to continue to use their potential and talents by volunteering in societal activities and organizations (e.g. schools, professional education, sports clubs, shops and green maintenance). The aim of this continued contribution to society is to preserve feelings of autonomy, self-esteem, social inclusion and quality of life. Experiences with DemenTalent were positive (www.dementalent.nl/nieuws/efid-award-2014), which generated the idea of linking DemenTalent to existing Meeting Centers for people with dementia and their informal caregivers. These Meeting Centers are socially integrated in the neighborhood and often already have connections with a variety of relevant stakeholders such as schools, sporting clubs, shops, welfare organizations and the community. Moreover, the vision of DemenTalent is fully in line with the vision of the Meeting Centers, i.e. supporting people to adjust to living with dementia in a person-centered way. To this end the centers provide a broad support program (Meeting Centers Support Program; MCSP) for people with mild to moderately severe dementia (a day club offering a range of creative and recreational activities and psychosocial interventions) and caregivers (discussion groups and informative meetings aiming to inform and provide emotional and practical support). There are also social activities for both the person with dementia and their caregiver, to promote contacts and to counteract loneliness. Theoretical starting point of MCSP is the adaptation-coping model: participants are guided with information, practical help and emotional and social support in dealing with the consequences of dementia. Repeated research (Dröes *et al.*, 2011, 2000, 2004) has shown that, compared to participants with dementia in regular day treatment, participants in Meeting Centers have fewer behavioral and mood problems and better self-esteem; their caregivers feel more competent; lonely caregivers have fewer health complaints; finally, nursing home admission is postponed.

Currently more than 160 Meeting Centers are operational across The Netherlands. Adding DemenTalent to these centers would therefore make it available to many more people with dementia. Moreover, the Dutch National Working Group of Meeting Centers saw the individually oriented DemenTalent activity as a valuable addition to the regular group-oriented program offered in Meeting Centers, as it would broaden the target group they would be able to support. National registrations of day-care participation show that only a limited proportion (10-20%, of which 7% indicated day care, CIZ 2013; Alzheimer Nederland, 2014) of people with dementia use group-oriented day care facilities, including Meeting Centers. Reasons include the taboo and stigma surrounding dementia, the expectation that the aid provided does not fit their needs and wishes, and a fear to become dependent or to be admitted to a care institution (this is especially true for traditional day care facilities in the Netherlands, which are organized in nursing homes) (van der Roest *et al.*, 2009).

The individualized Meeting Centers Support Program project (in short: iMCSP) investigated whether a broader"tailor-made" offer, namely adding three new successful individualized interventions for people with dementia and informal caregivers to existing Meeting Centers, would lead to a more varied and larger group of people with dementia and caregivers using the activities and support offered. The new interventions are:

- DemenTalent: People with dementia become active as 'volunteers' in society, based on their talents. Of course with supervision and support.
- Dementelcoach: Caregivers of people with dementia receive 8-10 sessions of telephone coaching.
- STAR e-Learning: informal caregivers follow an internet course on dementia and care, and how to take care of themselves as a caregiver.

In addition, the implementation process of the new interventions was studied and the (cost) effectiveness of the new interventions compared with the current Meeting Center offer for people with dementia and their informal caregivers.

This article only reports on the partial study into the implementation of DemenTalent, more specifically into factors that facilitated or impeded the linking of DemenTalent to Meeting Centers for people with dementia and their informal caregivers. Moreover, we explored possible modifications to successfully link DemenTalent to the Meeting Centers, as well as implementation strategies that were recommended by people involved in the implementation.

Central research questions were:

1) Which factors facilitate or impede the implementation of DemenTalent to Meeting Centers?
2) Which modifications are necessary for successful implementation DemenTalent at the Meeting Centers?
3) Which implementation strategies are recommended by key stakeholders for implementation of DemenTalent at Meeting Centers?

## Methods

### Design

We conducted a qualitative multiple case study. Semi-structured interviews regarding encountered facilitators and barriers were conducted with key figures/stakeholders during the preparation, starting and continuation phases of the implementation of DemenTalent. All stakeholders were interviewed once.

### Setting and participants

Between March 2017 and October 2018, semi-structured interviews were conducted with 22 stakeholders involved in the implementation of DemenTalent in 12 Meeting Centers (see Table 1 for an overview of the interviewed stakeholders). These stakeholders were purposively selected (Barbour, 1999) taking into account their expertise, role in the implementation process, experience with different aspects of the implementation and the different phases of the implementation in which they were involved. A stakeholder was eligible for inclusion if (s)he was a representative (e.g. manager, coordinator, activity coach) of one of the Meeting Centers where DemenTalent was implemented, or of another organization involved in one or more of the implementation phases (preparation, starting, and continuation). Stakeholders varied from representative of a location where DemenTalent volunteer work was done to representative of the local government and the care company that coached the implementation of DemenTalent at the Meeting Centers. Table 1 provides a complete overview of the stakeholders and the role within the project, see Table 2 for the demographic characteristics of the stakeholders. There were no specific exclusion criteria.

### Implementation of DemenTalent

For this implementation study, 12 Meeting Centers were recruited from the National Working Group of Meeting Centers in the Netherlands. All centers received an open invitation email to participate in the project. Centers willing to do so, which had been operational for at least 1.5 years, were eligible for the study.

The implementation was done according to a stepwise plan:

1) In a 3-hour information meeting, the appointed project leaders of DemenTalent and other representative of all participating centers were informed about the research, DemenTalent and the implementation procedure.
2) With each Meeting Center appointments were made about individual coaching of the centers' personnel during the preparation and starting phases of the implementation of DemenTalent by an external coaching company.
3) A series of preparation activities were undertaken by the personnel of each center before actually starting DemenTalent, i.e. before the centers had their first volunteers at work in e.g. a school, shop, sports club or garden:

- recruiting a project leader with dementia as ambassador of the project in the region;
- informing the network of care and welfare referrers;
- recruiting volunteers with dementia, exploring their interests and talents, and matching the volunteers to possible locations for volunteer work;
- recruiting potential locations based on the interests and talents of the persons with dementia;
- informing the personnel on the volunteer locations on how to deal with people with dementia in general and with the individual person appointed for the volunteer task;
- making appointments with the volunteer locations about regular contact with the Meeting Centers to monitor if the person with dementia and the volunteer location were both happy with the work done and with the interaction with the person with dementia and the professionals of the Meeting Center.

This preparation phase varied between 2 to 6 months among centers.

**Table 1.** Overview of interviewed stakeholders and their role in the individualized Meeting Centers Support Program project (iMCSP)

| INTERVIEW | INTERVIEWEE | ROLE IN THE PROJECT |
|---|---|---|
| **Interview 1** | Project leader Meeting Center | Implemented DemenTalent |
| **Interview 2** | Project leader Meeting Center | Implemented DemenTalent |
| **Interview 3** | Duo interview with the two project leaders of one Meeting Center | Implemented DemenTalent, project leader duties were shared |
| **Interview 4** | Duo interview with the projec leader Meeting Center, and employee hired to work on the DemenTalent project | Project leader implemented DemenTalent, employee recruited DemenTalent volunteers and matched them with organizations |
| **Interview 5** | Project leader Meeting Center | Implemented DemenTalent, Dementelcoach, and STAR |
| **Interview 6** | Project leader Meeting Center | Implemented DemenTalent, Dementelcoach, and STAR |
| **Interview 7** | Project leader Meeting Center | Implemented DemenTalent, Dementelcoach, and STAR |
| **Interview 8** | Project leader Meeting Center (external hire) | Implemented DemenTalent |
| **Interview 9** | Duo interview with project leader Meeting Center and manager Meeting Center | Project leader and manager; they worked together in implementing DemenTalent, Dementelcoach, STAR |
| **Interview 10** | Director care organization | The director was involved with implementing DemenTalent in the organization and was part of the project group of iMCSP |
| **Interview 11** | Director external coaching organization | Implementer DemenTalent, part of the project group |
| **Interview 12** | Employee external coaching organization and creator of the DemenTalent intervention | Implementer DemenTalent, part of the project group |
| **Interview 13** | Project leader with dementia | Ambassador for the DemenTalent project in the Meeting Center, additionally this project leader was a volunteer in the DemenTalent project |
| **Interview 14** | Representative volunteers' workplace | Worked with the DemenTalent volunteer in the workplace (swimming pool) |
| **Interview 15** | Duo interview with two representatives of a volunteers' workplace | Worked with the DemenTalent volunteer in the workplace (theatre workshop) |
| **Interview 16** | Representative municipality | This municipality funded the new interventions in several meeting Centres, who kept the representative of the municipality up to date on the progress of the implementation |
| **Interview 17** | Representative Alzheimer Nederland | This representative was part of the project group of iMCSP |
| **Interview 18** | Representative health insurance company | Member of the sounding board of the project |

**Table 2.** Stakeholders' socio-demographic characteristics*

| | FREQUENCY ($N = 22$) | PERCENTAGE OF SAMPLE |
|---|---|---|
| Gender | | |
| - Male | 5 | 22.7% |
| - Female | 17 | 77.3% |
| Age in years | | |
| - 20–29 | 1 | 4.5% |
| - 30–39 | 1 | 4.5% |
| - 40–49 | 4 | 18.2% |
| - 50–59 | 9 | 40.9% |
| - 60–69 | 7 | 31.8% |
| Highest form of education | | |
| - Secondary vocational education (MBO) | 2 | 9.1% |
| - University of Applied Sciences (HBO) | 13 | 59.1% |
| - University | 7 | 31.8% |

*Percentages may not total 100% due to rounding

4) After starting with the volunteer work the Meeting Centers kept in touch with the volunteer organization according to the appointments made and it was monitored if the volunteer work still fulfilled the needs and interests of the person with dementia. If the volunteer work did no longer fulfill the needs of the person, alternatives were discussed with the person. They were also offered to participate in the activities of the Meeting Center's day club, which some of them did.

### Measurements and procedure

A semi-structured interview schedule was composed for this study to identify facilitating and impeding factors during the preparation (3-6 months before the start of the program), starting (0–1 year after the start), and continuation phases (from 1 year after the start) of the implementation.

This schedule was based on the Theoretical framework for tracing facilitators and barriers of adaptive implementation (Meiland *et al.*, 2004), which distinguishes three levels: the *micro* level (primary process/user level), *meso* level (inter-organizational level) and *macro* level (societal level: health care system, legislation, and policy). In addition, it includes (pre)conditions existing before the start of the implementation (features of the intervention, operational conditions, personnel and financial resources, organizational conditions), which can also play a role later on in the implementation process. The composed interview schedule consisted of open-ended questions on all three levels and covered topics potentially related to factors that facilitated or impeded the implementation process in different phases, i.e. the preparation (e.g. recruiting project leaders, training), starting (e.g. personnel, number of participants) and continuation phase (e.g. new collaborations, change in intervention). For a full list of all topics discussed, see appendix A published as supplementary material online attached to the electronic version of this paper at https://www.cambridge.org/core/journals/international-psychogeriatrics. For each key figure/stakeholder specific interview topics matching their expertise and involvement in the different phase(s) of the implementation process were selected.

Two junior (AvR, CP) and two senior researchers (RMD, FM) conducted the interviews between 13 and 32 months after the start of the implementation period of DemenTalent at the Meeting Centers. These lasted between 22 and 118 minutes, with a mean length of 59 minutes. Anonymity was guaranteed.

### Data analysis

All interviews were recorded on tape and transcribed verbatim. A content analysis (Hsieh and Shannon, 2005) of the 24 interviews was carried out using ATLAS.ti. The framework of Meiland *et al.*, (2004) was used as a coding schedule with predefined topics/themes for analyzing the interviews. To ensure reliability, couples of two independent researchers (junior and senior) analyzed 40% of the interviews. The researchers discussed any disagreement on a (predefined topic) code until consensus was reached. New codes were added when factors appeared relevant for the implementation but were not yet included in the coding schedule. Next, the facilitating and impeding factors influencing the implementation were clustered by topic/theme and described. To explain the influencing factors quotations of the interviewed stakeholders were added.

## Results

### Participants

18 interviews were conducted with 22 stakeholders (see Table 1): nine program coordinators/professional DemenTalent project leaders from the Meeting Centers, two managers, two persons appointed specifically for the project from outside the Meeting Center, one project leader with dementia and two persons from an external company who coached the Meeting Center staff on implementing DemenTalent. Additionally, we interviewed three persons who worked at a place where DemenTalent participants did their volunteer work. Finally, we interviewed one representative each of a municipality, the Alzheimer Association in the Netherlands (Alzheimer Nederland) and a health insurance company.

### Facilitators of and barriers to implementation (Research question 1)

In this section, an overview of the mentioned facilitators and barriers of implementing DemenTalent is provided. First facilitators and barriers related to the existing conditions present before, or at the start of the project will be described (see also Table 3). Subsequently, facilitators and barriers in the preparation, starting and continuation phases are described on a micro, meso, and macro level (see also Figure 1).

- Existing conditions

*Characteristics DemenTalent:* Multiple stakeholders mentioned that dementia is still a taboo in their region, and that this impeded the implementation of DemenTalent: People are not open about their dementia diagnosis, or the diagnosis of a family member, and avoid involving people outside their immediate social circle. Some professional project leaders working in these contexts

**Table 3.** Existing conditions facilitating and impeding the implementation of DemenTalent (DT)

| | FACILITATORS | BARRIERS |
|---|---|---|
| **Characteristics project/ interventions** | - Added value of DT<br>- DT fits needs person with dementia and caregiver<br>- Opportunity to learn from other DT projects | - Taboo on dementia<br>- Discussion about the meaning of DT<br>- *Volunteering* may not be the right description of DT |
| **Operational conditions** | - Enough preparation time<br>- Having a project plan | |
| **Human and financial resources** | - Motivated/ capable personnel<br>- Creative project leader, large network.<br>- Project leader enough time for DT<br>- Sharing DT responsibilities | - Limited network<br>- DT is a top-down decision<br>- Rapid turnover of personnel<br>- No extra hours for implementation of DT burdens project leader |
| **Organizational conditions** | - DT fits with vision organization<br>- Meeting Center is located in an active region and part of care network | - No care network in the region<br>- Health care organizations are 'islands'<br>- No support from own organization |

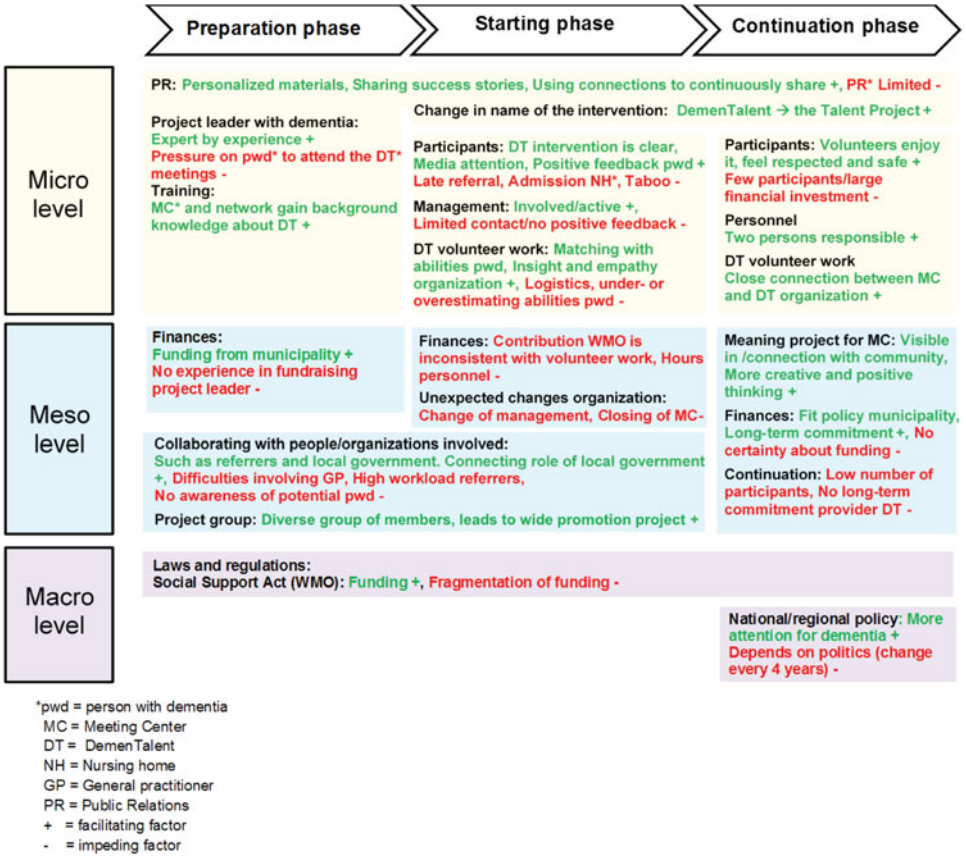


**Figure 1.** Facilitating ( + , written in green) and impeding factors ( − , written in red) in the preparation-, starting- and continuation phase of implementing DemenTalent (DT).

mentioned that information meetings about DemenTalent (or Alzheimer café meetings) attracted very few visitors and they had to invest a lot of time to inform people and get them interested. One of the professional project leaders suggested that an open, accepting and supportive environment may be a precondition to successfully implement DemenTalent:

*"I feel perhaps you should already have a dementia-friendly region before you can start with DemenTalent." – Professional project leader*

*Operational conditions:* In terms of operational conditions, stakeholders mentioned that it is facilitating to have enough preparation time before starting with DemenTalent. This time was used to recruit the project leaders (professional and project leader with dementia), to inform the network, to think about Public Relations strategies, etc. The project leaders who worked with a project plan reported that this was helpful, although the project plan has to be adaptive in order to work.

*Human and financial resources:* These resources are crucial. A motivated and creative professional project leader, preferably with a large network in the region or the social skills to create one, appeared to facilitate the implementation. However, professional project leaders also need enough time to invest in the implementation of DemenTalent. Most project leaders worked as program coordinators in the Meeting Center and therefore had to manage the implementation of DemenTalent on top of their regular duties. Extension of their contract and/or extra personnel to share their tasks facilitated implementation, whereas no extra hours or no extra personnel were mentioned as one of the biggest impeding factors in implementing DemenTalent.

*Organizational conditions:* Support from the own organization was experienced as an important facilitating factor. Sufficient human and financial resources appeared more likely if DemenTalent was compatible with the vision of the organization, and the management supported the project. Conversely, the organization not being supportive impeded the implementation.

*"I noticed with some Meeting Centers, that people were trapped in the rules of the organization. Very hierarchical organizations, with limited freedom, and they gave no room [for developing the DemenTalent project], and yes in that situation you have to stand your ground and say 'Hello, we are participating in this project, and we have to work outside of the box.'"- Founder of DemenTalent and representative external coaching organization*

Finally, the location and network of the Meeting Centers appeared to be important here as well: being located in a region with an active and effective care network facilitated reaching the target group of potential participants for DemenTalent.

- Micro level

*Training:* One of the facilitating factors in the preparation phase was the DemenTalent training: The Meeting Centers were advised to host a few DemenTalent training days organized by an external coaching organization, for their own personnel and other interested healthcare professionals/referrers in their network. During this training they learned about the background of DemenTalent, and did exercises to learn to think creatively ("out of the box") about feasible volunteer work for their clients with dementia. The people who did this training appeared more committed to the project and recruited and referred more participants according to several interviewees.

*Public Relations (PR):* Throughout the whole implementation process, PR proved important. Personalized materials, e.g. flyers and newsletters, were facilitating, but especially *continuously* discussing the intervention with their network appeared to be most effective. As a professional project leader emphasized:

*"They have to read about it over and over. Don't think 'we already promoted it at that occasion', you have to keep reminding them and hope that it will become matter of fact for more and more people. That would be nice, that people know and expect DemenTalent to be there. And keep spreading the word nationwide and on television, regularly." – Professional project leader*

*Project leader with dementia:* What helped with PR was involving the project leader with dementia or other participants as ambassadors, by asking them to talk about their experiences as volunteer workers. The stakeholders agreed that it is most powerful to hear the story from experts by experience.

*"Because we are talking from the sidelines, and he [project leader with dementia] tells the story beautifully and that helps. He is an expert by experience." – Professional project leader*

*Name of the intervention:* Some project leaders felt the name "DemenTalent" impeded recruitment of potential participants in the starting and continuation phases. They suggested that the reference to dementia made it less likely that people would sign up, especially in areas where there is less openness about dementia. For this reason, one of the Meeting Centers changed the name of DemenTalent into the "Talent Project." They reported a positive change thereafter.

*Participants:* Another problem in the starting phase concerned recruiting people with dementia as volunteers. Taboo, referral of people with more advanced stages of dementia, and unexpected decline in cognitive abilities of participants led to fewer volunteers signing up or people dropping out within several months. A few Meeting Centers reported that this caused them to reconsider continuing the DemenTalent program, as they experienced it as a fairly large financial investment for relatively few people. What stimulated the recruitment was media attention and positive feedback reported by participants who signed up: They felt valued, respected and safe at their workplace.

*"We see a lot enjoyment by a large group of people, because you offer something that is tailored especially for them and that gives them so much energy and joy. Additionally, we speak to the caregivers regularly and they told us that they now have someone at home who sees life more positively."*
*– Professional project leader*

*DemenTalent volunteer work:* With regard to the recruitment of volunteers' workplaces, a good match with the abilities of the person with dementia appeared to facilitate successful implementation in the starting phase. The success stories came mostly from workplaces where personnel was informed about dementia and had a lot of empathy. A close connection between the Meeting Center and the workplaces facilitated the continuation of DemenTalent after the research project. On the other hand, logistics (transport, supportive personnel at the workplace) was sometimes experienced as an impeding factor: one of the participants volunteered at a swimming pool, and one situation illustrates the importance of good communication and sufficient support:

*"For example, the first time he came, we didn't exactly discuss what time he would be here. That day he came independently to the swimming pool, changed into his swimsuit and left his clothes God knows where. Three of us spent 15 minutes searching for his clothes." – Employee workplace DemenTalent*

*Management and personnel:* Starting with the implementation of DemenTalent is a huge task, and professional project leaders reported that positive feedback of the management and an involved manager helped them stay motivated, while lack of interest or feedback was seen as an impeding factor.

*"I am an enthusiastic ambassador I think. I am very involved with the project and I would love to continue together. We also want to set up these interventions throughout the whole organization."– Meeting Center manager*

Especially in the continuation phase stakeholders recommend to share the day-to-day duties of DemenTalent with at least two persons, in order to keep the project on track and growing.

- Meso level

*Financial resources:* Finances are a big influencing factor at the meso level, but the reasons are different for each implementation phase. In the preparation phase, the project leader needs to acquire funds to start up the intervention. This is time consuming and not something most project leaders are trained for. They therefore experienced it as impeding. Nevertheless, eventually all Meeting Centers received the funding they needed from the local government, which of course facilitated the implementation. In the starting phase, despite funding, some project leaders did not have enough hours in their contract to fully focus on the project and they felt this impeded successful implementation of DemenTalent. Also, because of municipal funding rules some participants had to pay a contribution to be able to join the project. This contribution depends on the participant's income: higher income means a higher contribution. As DemenTalent is promoted as volunteer work, this message was met with surprise and resistance from potential participants. In the continuation phase, receiving long-term funding commitment from the municipality was named as facilitating. Some stakeholders said that DemenTalent is fully in line with the policy of the municipality, which was seen as facilitating the continuation of DemenTalent in the future. The downside of being funded by the local government is that funding is never certain for more than four years (when policies can change after elections).

*Collaborating with people/organizations*: Good collaboration with professionals of other care and welfare organizations as well as with the municipality appeared also important for successful implementation of DemenTalent in all phases, because they are all potential referrers. However, sometimes it was difficult to get referrers (e.g. general practitioners) involved, due to their high workload. Furthermore, it took time to convince some referrers to look at the potential and talents, instead of the disabilities of people with dementia. A representative from the Alzheimer Nederland emphasized the importance of working together with case-managers, as they are close to the families:

*"Many people with dementia would say 'I don't need anything and I don't have problems yet'. Case-managers can help these families to realize it can be fun and meaningful to be active in [for example] a Meeting Center."- Representative Alzheimer Nederland*

*Project group:* A diverse project group, consisting e.g. of referrers and social organizations, helped to promote DemenTalent.

*Unexpected changes organization:* A few Meeting Centers went through unexpected organizational changes during the starting phase of the project, like a change in management (three Meeting Centers) or in one case the Meeting Center moving to another location. These changes negatively impacted the implementation process.

*Meaning of the project for MC and continuation:* For the continuation phase, a few facilitating and impeding factors were mentioned. What impedes the continuation of DemenTalent is when the number of people participating in it is low, and when there is no or little commitment from the organization to continue DemenTalent. On the other hand, several

Meeting Centers mentioned they had benefitted from the DemenTalent project: awareness of the existence of the Meeting Center increased and, thanks to the volunteers they also integrated more in the community. Another positive outcome is that after starting this project Meeting Center personnel is more creative and more focused on and appreciative of the potential of their visitors, according to the professional project leaders:

> *"It brings a lot of energy when you see a visitor with his head down, like 'I have dementia and can't do anything' changing his attitude into 'I have dementia but I can still contribute'. That gives us a massive amount of energy." – Professional project leader*

- Macro level

*Laws and regulations:* In 2015 the laws and regulations involving elderly care were divided into three new, separate support and care acts. As mentioned, most Meeting Centers received funds from their municipality as part of the Social Support Act (WMO), which proved a facilitating factor for the implementation of DemenTalent. However, if the dementia becomes more advanced and there is a higher need of care, participants may have to reapply for additional aid, the funding of which is based on another Act. Several stakeholders mentioned this fragmentation of funding as impeding the implementation process; they said it makes applying for funds complicated and time consuming.

*National/regional policy:* According to the representative of a municipality, dementia is an important topic on the (local) government agenda and this is positive for the continuation and funding of DemenTalent. The downside is that the government changes every four years, meaning policies for dementia support and care may change as well.

> *"This can only be maintained for four years. After that there are elections again, and the budget will be redistributed. That's why you can only guarantee something for four years." – Representative municipality*

## Recommended modifications (Research question 2)

The only two recommended modifications were suggested by professional project leaders: One recommended changing the name of DemenTalent into Talent project (as proposed by the project leader with dementia), which in their experience proved more effective to recruit new participants.

> *"Yes, it [the Talent project] does sound friendlier than before, something with dementia sounds like the last phase. Although DemenTalent does have a nice ring to it."– Project leader with dementia*

Another professional project leader recommended describing DemenTalent as a "new support program" instead of volunteer work, also because of the required financial contribution for this "volunteer" work. However, they agreed that the advantages of such characterization are context dependent and that conditions for successfully implementing DemenTalent can differ per region and participant.

## Implementation strategies (Research question 3)

The stakeholders were asked if they had any advice on how to successfully implement DemenTalent. The consensus was that it is important to have and use a large network. When asked which persons/organizations from this network they would definitely want to involve, they answered: referrers (case-managers, nurse practitioners) and the local government, specifically people from the Social Support Act department.

> *"We had six Social Support Act consultants present in one of the training days we organized at a Meeting Center. After the training, they would include DemenTalent in the way they worked and in conversations with the families they met. That was an eye-opening moment for us. [.] You want to really implement DemenTalent and therefore it is crucial that people think and act differently, and the one partner or that one case-manager who gets it can make all the difference." – Implementer from external coaching organization*

Additionally, stakeholders recommended involving health care organizations as well as social organizations. A few stakeholders mentioned that collaboration with a volunteer organization could be beneficial; the idea was to link volunteers with and without dementia. Lastly, they suggested collaborating with people with dementia for input and helping inform different types of stakeholders and the public about DemenTalent.

Practical advice was also offered: the organization which coached the Meeting Centers in implementing DemenTalent, suggested that the centers need at least 12 hours per week to implement DemenTalent in their organization. Another recommendation was to be critical when selecting a DementTalent project leader, and to appoint an enthusiastic, creative project leader.

The organizations that hosted DemenTalent volunteers advised other organizations that may want to offer a DemenTalent workplace to provide a safe space for the participant. They also emphasized that the job and the location has to suit a participant, to look at their talents and to provide structure. Lastly, they recommended treating the participant as a person with the same value as everyone else, not as a patient.

"*The nice thing about it is the joy it gives that person [volunteer with dementia] when he notices that he is treated like a normal human being again. I feel like that is my reward for bringing him here.*"– *Employee workplace DemenTalent*

## Discussion

This study provides insight into the facilitating and impeding factors in implementing the DemenTalent intervention in the Meeting Center Support Program. Several influencing factors were found on a *micro* level (e.g. PR, training, management involvement), *meso* level (e.g. finances, collaborating with others) and *macro* level (e.g. laws and regulations, national and regional policy) during the different implementation phases. Factors mentioned by most stakeholders were *human and financial resources*. Implementing DemenTalent is not easy and it requires time from project leaders and personnel. Funds are required to finance this, as is a supportive management. Centers that were most successful in starting the DemenTalent project had enough human and financial resources and support from their organization management. Another important factor appeared to be the culture of the region: Two of the Meeting Centers were located in small villages in parts of the Netherlands where dementia is still taboo and people do not talk about it openly. This impeded recruitment and made setting up DemenTalent more challenging.

Several factors that influenced the implementation of DemenTalent were also reported in previous implementation studies. Meiland *et al.*, (2005) studied the implementation of the Meeting Centers Support Program in the Netherlands, and Mangiaracina *et al.*, (2017) and Van Mierlo *et al.* (2018) compared the implementation process of this program in three different European countries. These studies and our study showed that organizational conditions, funding and collaboration with other care and welfare organizations are crucial for successful implementation. A different up-and-coming innovation in the Netherlands is the concept of green care farms (GCF), where they provide care for people with dementia and focus on agricultural activities. Recently, a Dutch research team has done studies on this topic and some of their findings are comparable with this study. Buist *et al.*, (2018) interviewed professionals from GCF and professionals from traditional long-term care facilities to explore which facilitators and barriers for implementing characteristics of GCF in traditional long-term care facilities they could identify. Similar to our study, they found that characteristics of the personnel (creativity and flexibility) and characteristics of the management (willingness and commitment to implement changes) are key. In another study, De Boer *et al.* (2018) compared the physical environment (and how this is used in activities) of GCF, small-scale living facilities and traditional nursing homes. They found that having a beneficial physical environment is not enough to stimulate people with dementia. In order to use the environment in an optimal way, the nursing home staff proved very important. This emphasizes again the need for motivated personnel in order to activate people with dementia to do meaningful activities. Finally, Van Mierlo *et al.*, (2016) developed an evidence-based model for implementing personalized dementia care interventions, and several of the facilitators and barriers described were indeed found in our study as well. Examples are the need for a qualified and enthusiastic professional project leader, the facilitating effect of collaboration with other organizations, and the impeding effect of the new intervention being seen as competition by other organizations.

### Strengths and limitations

We interviewed a wide variety of stakeholders, ensuring a thorough evaluation of the implementation process. The theoretical framework of Meiland *et al.*, (2004) was used to structure the data collection and analysis. Moreover, the interview scheme, although based on this theoretical framework, was used dynamically: knowledge obtained from the interviews was continuously used to add codes if relevant and adapt the interview scheme for coming interviews. Lastly, reliability was optimized by involving three researchers in the data analysis and by having 40% of the data coded by two sets of researchers independently.

The investigation period of the continuation phase of the implementation of DemenTalent was shorter than the other phases, because of the limited study duration and the delayed start of the implementation in some Meeting Centers. At the end of our study nine of the twelve Meeting Centers had reached the continuation phase. Information collected about this phase is therefore less extensive. Another limitation is that not every Meeting Center had fully implemented DemenTalent at the time of the interview. Therefore, the results of the continuation phase should be interpreted with some caution: a longer period of investigation could reveal more influencing factors in this phase.

### Scientific relevance

This study is the first to provide insight into factors influencing a successful implementation

of DemenTalent, an innovative empowering intervention which aims to promote the social health of people with dementia, linked to existing and successfully operating Meeting Centers for people with dementia and caregivers. This makes it possible to inform the centers on how to serve a broader group of people with dementia and caregivers who are not yet receiving support by the Centers through the individualized DemenTalent intervention. Our study showed that this implementation process is feasible and that positive results were experienced by people with dementia, caregivers and other stakeholders at places where DementTalent was implemented successfully. Future research should focus on the effects of DemenTalent on the functioning and quality of life of participants and their caregivers. Furthermore, it would be useful to investigate which type of formal support (e.g. coaching, telephone support, online community) personnel of the Meeting Centers may need to effectively implement DemenTalent into their Meeting Center and organization.

### Societal relevance

In the Netherlands the majority of people who receive a dementia diagnosis do not utilize the group-oriented day care facilities, such as Meeting Centers or daycare centers in nursing homes. Until now there were few alternatives to be involved in organized meaningful daytime activities. With new diagnostic procedures even more people are expected to get an early diagnosis of dementia in the future. Providing tailored post-diagnostic support is important. DemenTalent has the potential to fill this gap, and may provide many people with a meaningful way to spend their time. There are more than 150 Meeting Centers across the Netherlands and another 20 in Europe and beyond. Linking DemenTalent to the Meeting Centers Support Program would therefore make it available in many regions and a large group of people with dementia. By volunteering in society, people with dementia will become empowered, more active and visible in society, but they will also be given a voice. This is not only beneficial for the volunteers with dementia themselves, but interaction with others will most likely lead to more awareness about dementia among the general public, less prejudice and a more dementia-friendly society. One of the main influencing factors we found was *financial resources*. Most Meeting Centers applied for funding at their municipality and although almost all received the funding needed, it was a very time-consuming process in many cases. With the introduction of the Social Support Act (WMO) and the related transfer of responsibility for funding of day care support to the municipalities, they need all-round knowledge of many care-related topics in order to make informed decisions about the division of funds. More exchange and collaboration between knowledge centers, healthcare and local governments could be helpful to make this process more effective and efficient.

## Conclusion

As far as we know this is the first implementation study into the feasibility of volunteer work for people with dementia in community-based social contexts outside care settings in which a broad group of relevant stakeholders (from people with dementia and informal and professional caregivers to volunteer locations, a care innovation company, the university as research and training institute, health insurance company and local government) were involved. The results show that the implementation was feasible and matched the needs of a subgroup of people with dementia, but that successfulness of the implementation is largely dependent of human resources, the collaboration network in the region and the dementia friendliness of a region.

The insight into facilitating and impeding factors in the implementation of DemenTalent provided by this study will inform and enable other Meeting Centers to adopt a fitting strategy to implement DemenTalent in their own center. This is expected to help disseminate the intervention, giving more people with dementia the chance to fulfill their potential, to find a meaningful and pleasant way of spending their time in an individualized way and to actively participate in society. Although the focus of this article is on linking DemenTalent to Meeting Centers, the insights found in this study can most likely be translated to implementing other innovative interventions to existing community-based care settings. Overall, applying these findings and elaborating on this research topic will contribute to a more inclusive society, less stigmatization and more social health of people with dementia.

## Conflict of interest

No conflict of interest to report.

## Description of authors' roles

All authors contributed substantially to the data collection, analyses and writing of the paper. Annelies van Rijn did most of the data collection. Franka Meiland supervised the data collection and

analyses. Rose-Marie Dröes designed the study and supervised the data collection, analysis and writing.

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## Supplementary material

To view supplementary material for this article, please visit https://doi.org/10.1017/S1041610219001108

## References

**Alzheimer Nederland**. (2014). Handreiking (dag)activiteiten bij dementie. 1st ed. [pdf]. Amersfoort, Nederland. Available at https://www.alzheimer-nederland.nl/sites/default/files/directupload/activiteiten-bij-dementie.pdf.

**Barbour, R.S.** (1999). The case for combining qualitative and quantitative approaches in health services research. *Journal of Health Services Research & Policy*, 4, 39–43.

**Boots, L.M.M., Vugt, M.E., Knippenberg, R.J.M., Kempen, G.I.J.M. and Verhey, F.R.J.** (2014). A systematic review of Internet-based supportive interventions for caregivers of patients with dementia. *International Journal of Geriatric Psychiatry*, 29, 331–344.

**Buist, Y., Verbeek, H., De Boer, B., and De Bruin, S.** (2018). Innovating dementia care; implementing characteristics of green care farms in other long-term care settings. *International Psychogeriatrics*, 30, 1057–1068. doi:10.1017/S1041610217002848.

**Cantley, C. and Bowes, A. (**2004). Dementia and social inclusion: the way forward. In: A. Innes, C. Archibald and C. Murphy (Eds.), *Dementia And Social Inclusion: Marginalized Groups And Marginalized Areas Of Dementia Research, Care And Practice*, 1st ed. London: Jessica Kingsley Publishers, pp. 255–271.

**ciz.nl**. (2013). CIZ Basisrapportage AWBZ. [online] Available at: https://ciz.databank.nl/report/awbz.html.

**Clare, L. *et al.*** (2014). Improving the experience of dementia and enhancing active life–living well with dementia: study protocol for the IDEAL study. *Health and Quality of Life Outcomes*, 12, 164.

**Clare, L.P., Evans, S.M., Parkinson, C.B., Woods, R.M. and Linden, D.D.** (2011). Goal-setting in cognitive rehabilitation for people with early-stage Alzheimer's Disease. *Clinical Gerontologist*, 34, 220–236.

**De Boer, B. *et al.*** (2018). The physical environment of nursing homes for people with dementia: traditional nursing homes, small-scale living facilities, and green care farms. *Healthcare (Basel, Switzerland)*, 6, 137. doi:10.3390/healthcare6040137.

**Dröes, R.M., Breebaart, E., Ettema, T.P., van Tilburg, W. and Mellenbergh, G.J.** (2000). Effect of integrated family support versus day care only on behavior and mood of patients with dementia. *International Psychogeriatrics*, 12, 99–115.

**Droes, R.M., Breebaart, E., Meiland, F.J.M., van Tilburg, W. and Mellenbergh, G.J.** (2004). Effect of Meeting Centres Support Program on feelings of competence of family carers and delay of institutionalization of people with dementia. *Aging & Mental Health*, 8, 201–211.

**Dröes, R.M., Meiland, F.J.M., Schmitz, M. and Van Tilburg, W.** (2011). An evaluation of the Meeting Centers Support Programme among persons with dementia and their carers. *Nonpharmacological Therapies in Dementia*, 2, 19–39.

**Droes, R.M. *et al.*** (2017). Social health and dementia: a European consensus on the operationalization of the concept and directions for research and practice. *Aging and Mental Health*, 21, 4–17.

**Graff, M.J.L., Vernooij-Dassen, M.J.F.J., Thijssen, M., Dekker, J., Hoefnagels, W.H.L. and Olde Rikkert, M.G.M.** (2007). Effects of community occupational therapy on quality of life, mood, and health status in dementia patients and their caregivers: a randomized controlled trial. *Journals of Gerontology Series A-Biological Sciences and Medical Sciences*, 62, 1002–1009.

**Harris, P.B.** (2008). Another wrinkle in the debate about successful aging: the undervalued concept of resilience and the lived experience of dementia. *International Journal of Aging and Human Development*, 67, 43–61.

**Hattink, B.J. *et al.*** (2016). The electronic, personalizable Rosetta system for dementia care: exploring the user-friendliness, usefulness and impact. *Disabil Rehabil Assist Technol*, 11, 61–71.

**Hsieh, H. and Shannon, S.E.** (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15, 1277–1288. doi:10.1177/1049732305276687.

**Huber, M. *et al.*** (2011). How should we define health? *BMJ*, 343, 235–237.

**Lauriks, S., *et al.*** (2007). Review of ICT-based services for identified unmet needs in people with dementia. *Ageing Research Reviews*, 6, 223–246.

**Logsdon, R. G., McCurry, S. M. and Teri, L.** (2008). Evidence-based interventions to improve quality of life for individuals with dementia. *Alzheimers Care Today*, 8, 309–320.

**Mangiaracina, F. *et al.*** (2017). Not re-inventing the wheel: the adaptive implementation of the meeting centres support programme in four European countries. *Aging & Mental Health*, 21, 40–48.

**Meiland, F. *et al.*** (2017). Technologies to support community-dwelling persons with dementia: a position paper on issues regarding development, usability,

effectiveness and cost-effectiveness, deployment, and ethics. *JMIR Rehabilitation and Assistive Technologies*, 4, e1.

**Meiland, F.J., Dröes, R.M., de Lange, J. and Vernooij-Dassen, M.J.** (2005). Facilitators and barriers in the implementation of the meeting centres model for people with dementia and their carers. *Health Policy (Amsterdam, Netherlands)*, 71, 243–53.

**Meiland, F.J.M., Droes, R.M., de Lange, J. and Vernooij-Dassen, M.J.F.J.** (2004). Development of a theoretical model for tracing facilitators and barriers in adaptive implementation of innovative practices in dementia care. *Archives of Gerontology and Geriatrics*, 9(Supp), 279.

**Mensink, D.** (2014). EFID AWARD 2014 'Living well with Dementia in the community'. [online] DemenTalent. Available: https://www.dementalent.nl/nieuws/efid-award-2014.

**Potter, R., Ellard, D., Rees, K. and Thorogood, M.** (2011). A systematic review of the effects of physical activity on physical functioning, quality of life and depression in older people with dementia. *International Journal of Geriatric Psychiatry*, 26, 1000–1011.

**Resnick, B., Gwyther, L.P. and Roberto, K.A.** (2011). *Resilience in Aging: Concepts, Research, and Outcomes*. New York: Springer.

**Span, M. *et al.*** (2014). Towards an interactive web tool that supports shared decision making in dementia: Identifying user requirements. *International Journal on Advances in Life Sciences*, 6, 338–349.

**van der Roest, H.G. *et al.*** (2009). What do community-dwelling people with dementia need? A survey of those who are known to care and welfare services. *International Psychogeriatrics*, 21, 949–65.

**Van Mierlo, L.D. *et al.*** (2018). Facilitators and barriers to adaptive implementation of the Meeting Centers Support Program (MCSP) in three European countries; the process evaluation within the MEETINGDEM study. *International Psychogeriatrics*, 30, 527–537.

**Van Mierlo, L.D., Meiland, F.J., Van Hout, H.P. and Droes, R.M.** (2016). Toward an evidence-based implementation model and checklist for personalized dementia care in the community. *International Psychogeriatrics*, 28, 801–813.

**Windle, G.** (2012). The contribution of resilience to healthy ageing. *Perspect Public Health*, 132, 159–60.

**Woods, B., Aguirre, E., Spector, A.E. and Orrell, M.** (2012). Cognitive stimulation to improve cognitive functioning in people with dementia. *Cochrane Database Systematic Reviews*, Cd005562.

**Woods, B., Thorgrimsen, L., Spector, A., Royan, L. and Orrell, M.** (2006). Improved quality of life and cognitive stimulation therapy in dementia. *Aging and Mental Health*, 10, 219–26.