

problem-based educational input, while eight (53.3%) had provided some type of ward-based educational initiatives. Eleven services (73.3%) reported that they did not have any IT support for recording service activity thereby compromising collation of activity data.

In summary, it appears that all services with a general hospital within their catchment area were endeavoring to provide some type of CL service to that hospital. However, the time and personnel allocated to provision of CL services were inadequate or nonexistent in many instances. Consequently, the services provided were largely reactive and consultative in nature with few educational or proactive initiatives to improve the overall standards of mental healthcare within the hospital. In addition, the services were provided to a restricted group of older adults and service activity was not adequately recorded in many instances. However, the majority of services did indicate a willingness to undertake a more extended role within the hospital assuming that this role was supported by adequate resource provision. Overall, the findings indicate that age-specific CL services for older adults are underdeveloped and, in the context of an aging Irish population, there is now an increasing need to further develop CL services. The increased demand for CL services internationally indicates that this has now become an issue of global significance (Anderson *et al.*, 2011). Ultimately, appropriate resource provision to facilitate a liaison model of care could lead to enhanced standards of care and more effective use of finite healthcare resources.

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A methodology for evaluating change and impact of illness perceptions among patients with memory complaints and their next of kin during the diagnosis process

Memory complaints (MCs) are experienced by a large proportion of middle-aged and older adults and are often a source of distress and worry. Because of the perceived threat of Alzheimer's disease (AD), MCs are known to be associated with depression, anxiety, and poor quality of life (QoL). Generally, these MCs are part of a normal aging process but may also reflect mild cognitive impairment (MCI) or the onset of dementia. Although the literature is unclear about evolution of patients with MCs,

Conflict of interest

None

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there is growing evidence that suggests that MCs are associated with an increased risk of dementia. The potential importance of MCs is furthermore reflected in the new diagnostic criteria proposed for early AD (Dubois *et al.*, 2007).

In the context of clinical assessment of MCs, the process of disclosing a diagnosis is of major importance since it is known to influence disease acceptance of patients and their next of kin. Disease acceptance can affect the way patients and their next of kin cope with changes to social, personal, and professional life in the context of a diagnosis of cognitive impairment. The concept of coping (Lazarus and Folkman, 1984) has been defined as “the overall cognitive and behavioral efforts to master, reduce, or tolerate inside or outside demands which threaten or surpass personal resources.” It is possible that

deterioration of cognitive and emotional abilities can significantly impact on coping strategies and therefore adaptation. The Common Sense Model (CSM) of Leventhal (Leventhal *et al.*, 1984) describes the adaptation to disease as a process involving conscious efforts to modulate cognition, emotions, and behaviors. When an individual experiences a threat to their health, such as memory problems, they formulate a common sense representation or model of the problem. This representation consists of beliefs or perceptions about the health threat based on information from several sources including past experience, lay knowledge, information from friends and family, the media, and the medical profession. Beliefs run along five major themes: the cause of the symptom, the consequences of the symptom, how long the symptom is likely to last, controllability of the symptom, and finally the label applied to the symptom. These beliefs are thought to determine the coping strategies an individual employs to deal with the health threat. Hurt *et al.* (2010) have already proven CSM validity in memory problem perception and have developed the Illness Perception Questionnaire – Memory (IPQ-M). CSM has also been tested on patients who had already received a diagnosis of MCI (Lin and Heidrich, 2012) or AD.

Based on the CSM, this study aims to prospectively examine the memory problem perceptions of patients with MCs and their next of kin during the diagnostic process.

We plan to recruit 125 patients with MCs who come for the first time at the *Research and Resources Memory Center* in Nancy, France. Patients have to express MCs and be free of dementia diagnosis at the first visit. They also need to be accompanied by a next of kin and both have to be fluent in French. This study has been approved by our local Ethics Committee (Committee for the Protection of Persons) and the French Health Security Agency.

After giving their informed consent, patients and next of kin are followed up throughout the diagnostic process with three visits : at their first visit, at one month after the first visit, and at six months after the diagnosis disclosure.

At the first visit, in addition to conventional physical and neuropsychological exams, patients with MCs and their next of kin are evaluated for memory problem perceptions (IPQ-M). Other questionnaires are administered in order to examine how memory problem perceptions impact on anxiety (State-Trait Anxiety Inventory Form Y), depression (Montgomery Asberg Depression Rating Scale), coping strategies (Ways of Coping

Checklist Revised), and QoL (World Health Organization Quality of Life). One month later, patients with MCs and their next of kin come for a second visit at the Memory Center and are invited to complete the same questionnaires in order to assess the evolution of memory problem perceptions. Then, the diagnostic process continues with routine assessment such as blood test and neuroimaging. These complementary exams generally require six months to be conducted. Once the diagnostic process is completed, the diagnosis is disclosed by a specialist (geriatrician, neurologist, or psychiatrist). Patient may receive the diagnosis alone or with his next of kin at his convenience. Six months after the diagnosis has been disclosed, patients and their next of kin are asked to repeat the questionnaires from the first and one-month assessment. Correlations between the diagnosis and memory problem perceptions before and after the disclosure will be explored with variance analyses. Moreover, patients' memory problem perceptions will be compared with those of their respective next of kin. Univariate and multivariate tests will be performed to identify correlations between memory problem perceptions, anxiety, depression, coping strategies, QoL, and cognitive impairment. All analyses will be performed with SPSS 22.0.

We aim to highlight the changes in memory problem perceptions in a longitudinal study through the IPQ-M.

We anticipate that the use of IPQ-M will help gain insight into how patients and next of kin cope with memory problems and the diagnosis of MCI or early dementia. Following on from this study we plan to develop clinical guidelines on how to best adapt the process of disclosing the diagnosis to the individual belief system of the patient and next of kin.

Conflict of interest

None.

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