Journal of
Mind and Medical Sciences

MDPI

Article

Barriers and Facilitators to Implementing Cognitive Stimulation Therapy (CST) in Ireland: A Qualitative Study Exploring Perspectives of Healthcare and Policy Professionals

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Abstract

Background: Cognitive Stimulation Therapy (CST) is one of the most highly recommended non-pharmacological interventions for people living with dementia. In Ireland, over 650 practitioners have been trained to deliver CST; however, the intervention is not routinely available as a post-diagnostic support. The objective of this study was to identify barriers and facilitators to implementation of CST within the healthcare system in Ireland, through interviews with healthcare and policy professionals. **Methods**: Semi-structured interviews were conducted with 10 key stakeholders involved in the provision of dementia services in Ireland, either in a policy role (n = 5) or as a healthcare professional (n = 5). Participants were responsible for the leadership of a dementia service and/or the direct provision of clinical care. Data collection and analysis was guided by the Consolidated Framework for Implementation Research (CFIR). Framework analysis was used to identify themes that illustrated key barriers and facilitators to the implementation of this intervention in an Irish context. **Results**: Findings were organised into five themes: *Familiarity, Understanding, and Evidence; Partnerships and Connections; Policy; Resources;* and *Attitudes and Culture*. These themes illustrated barriers and facilitators to implementation operating at the Innovation, Outer Setting, and Inner Setting CFIR domains. **Conclusion**: Identifying and addressing key barriers and facilitators to the implementation of CST within the Irish healthcare system may help to support successful implementation and sustained use of the intervention in future. The CFIR provides a useful framework for conceptualising pre-implementation barriers and facilitators. The findings of this study can be used to develop specific implementation strategies and/or models to increase the availability of CST in Ireland.

Keywords: cognitive stimulation therapy; Alzheimer's disease; dementia; non-pharmacological interventions; Consolidated Framework for Implementation Research; healthcare professionals; policy professionals; framework analysis

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Academic Editor: Oscar Arias-Carrión

Received: 26 February 2026
Revised: 17 April 2026
Accepted: 29 April 2026
Published: 8 May 2026

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1. Introduction

Cognitive Stimulation Therapy (CST) is a well-known evidence-based intervention [1] that improves cognition, quality of life [2], communication and social interaction [3] for people with mild-to-moderate dementia. There are four different versions of CST [4]. The

intervention was originally developed as a 14-session programme, delivered in-person to groups of approximately 5–8 individuals over 7 weeks (twice per week) [1]. Additional versions were subsequently developed to deliver CST on an individual basis (iCST) [5], virtually (vCST) [6], and to provide maintenance CST through 24 weekly sessions (after completing the original 14-session programme) [7]. The intervention can be delivered by anyone working with people with dementia (e.g., care workers, psychologists, occupational therapists, nurses), who can complete training with an accredited provider and follow manuals for intervention delivery. CST provides an opportunity for those with dementia to engage in structured cognitive activities (e.g., memory games and reminiscence tasks, discussions, puzzles, music, and practical or creative tasks such as baking, gardening, or crafts), in an affordable and cost-effective manner [8]. Qualitative studies provide additional support for CST, with participants with dementia, family members, and care staff citing CST as an enjoyable, positive social activity [9]. National and international best practice guidelines consistently recommend that CST should be offered to people with dementia as a matter of priority [10–12].

In Ireland, CST is gaining increasing interest. An RCT [13], pre-post pilot study [14], and service evaluations across seven sites [15] demonstrated positive outcomes in relation to participant enjoyment, engagement, cognition and quality of life; and positive staff experiences. Research is also ongoing to adapt CST for use with those with intellectual disabilities [16]. Overall, available data indicates that relevant stakeholders are interested in CST implementation [11,15]. Training opportunities to support health and social care professionals to offer CST have also been growing. Engaging Dementia, a dementia training provider, began offering CST training in 2018, and since then have trained over 650 people to deliver CST in Ireland. Despite the evidence base, trained workforce, and support for implementation, CST is yet to be routinely offered in memory or dementia services nationally [17,18]. The specific reasons for this are unclear.

While implementation issues have been identified in low- and middle-income countries like India and Tanzania [19], Irish services are less likely to experience the barriers they identified (e.g., limited healthcare, low dementia awareness, and high levels of stigma). In the UK, research conducted between 2013 and 2016 noted implementation difficulties in community dementia services in the North of England [20]. Identified barriers included a lack of training, supervision experience, and managerial support [20]. These barriers may be more comparable to the Irish context and interestingly map on to feedback obtained during a post-diagnostic service evaluation conducted in Ireland in 2019 [15]. In 2016, the Memory Services National Accreditation Programme (MSNAP) in the UK upgraded CST from a Type 2 to a Type 1 standard; meaning that memory services cannot obtain accreditation unless they offer CST [21]. By 2018, 93 of 97 memory services in the UK were offering CST. This suggests that a change in national standards or policy may lead to a positive change in implementation. While lessons can be learned from our UK colleagues (in England, Scotland, Wales, and Northern Ireland), a detailed evaluation of facilitators and barriers specific to the Irish context is required.

The current research is part of a wider funded project to inform an evidence-based approach to CST implementation nationally. The approach is guided by the CST-International three-phase implementation methodology, which was developed to facilitate the successful implementation of CST in diverse settings, and has been piloted in Brazil, India, and Tanzania [22]. Our research will be the first to utilise this methodology in a high-income country. The current study contributes to phase one of the three-phase methodology, specifically the exploration of facilitators of and barriers to CST implementation in routine care. This phase requires engagement with key stakeholder groups, including those interested in or already delivering CST, healthcare and policy professionals, and people with

dementia and their families. In our first publication from this project [23], we recruited sixty-two practitioners who were trained to deliver CST. We examined their perceptions of the acceptability and efficacy of CST and their opinions on the barriers and facilitators to CST implementation. Overall, we found that although the intervention was deemed acceptable and highly effective, resources and staffing issues commonly hampered implementation [23].

The next step in the project (as guided by [22]), and the aim of the current study, is to investigate the perspectives of healthcare and policy professionals on CST implementation. Our research aims were informed by the Consolidated Framework for Implementation Research (CFIR; [24,25]), and included understanding (1) knowledge and beliefs about CST among key stakeholders that may influence implementation; (2) factors that facilitate or hinder healthcare and policy professionals support for the intervention; (3) the perceived value and/or relative advantages of the intervention compared to other interventions currently available; (4) relevant organisational culture and values related to post-diagnostic supports for people with dementia; (6) policies and funding mechanisms that may support implementation; and (7) the implementation climate. The results from this study will contribute to recommendations and the subsequent development of actionable steps to facilitate increased implementation of CST nationally.

2. Materials and Methods

2.1. Research Design

The current study employed a qualitative research approach using semi-structured interviews and framework analysis [26]. Data collection and analysis were also informed by the CFIR as a guiding framework. We chose the CFIR to guide our approach because it is a comprehensive yet flexible framework for assessing barriers and facilitators to implementation; it has been used in prior CST implementation research [22]; and researchers can choose domains or constructs within the framework that are relevant to their aims, rather than applying the framework as a whole [24,27]. For the current study, the CFIR domains that were deemed applicable for evaluation were: (1) Innovation (CST); (2) Outer Setting (Irish healthcare system); (3) Inner Setting (dementia services provided by the Health Service Executive (HSE) and other organisations) and (4) Individual Characteristics (the characteristics of individuals who could implement CST as part of their role or influence implementation in a policy/leadership capacity). While the CFIR guided our approach, we also ensured that the subjective meaning expressed by participants was retained and captured within our analysis and presentation of our results. The approach to inquiry was pragmatic in nature. Our aim was to gain practical insights into the current context in which CST could be implemented, and factors that may influence increased implementation going forward.

2.2. Researcher Characteristics and Reflexivity

The principal investigator (MK) is an academic with over 15 years' experience working in research related to dementia and is one of two accredited CST trainers in Ireland. MK has collaborated with the research team who developed CST and has trained over 600 practitioners to deliver the intervention in Ireland. The co-investigator CH is also an academic with over 15 years' research experience related to dementia in the Irish context. Both MK and CH have working relationships with some of the key stakeholders who took part in this study. MK and CH were involved in the study design, data collection, and data analysis. EL and CD were the research assistants for this project and supported data analysis and manuscript preparation. EL and CD had no previous relationships with any

of the study participants and were less familiar with the literature on this topic or with dementia services in Ireland.

Some members of the research team (MK, CH) were therefore approaching the study with an in-depth understanding of the intervention and the associated evidence base. In addition, they have a familiarity with the landscape of dementia services in Ireland and hold the perspective that CST should be offered routinely as a post-diagnostic support for people diagnosed with dementia. The researchers themselves have struggled to identify or find clear information about where CST is being offered, despite one of the team having provided training to many certified practitioners to date.

To limit the influence of our prior understanding of the intervention, the current implementation landscape, and any potential bias regarding our own perceptions of the benefits of CST, interview guides were carefully developed to ensure that questions were not leading and were designed to capture key constructs related to implementation science, guided by the CFIR. The team engaged in ongoing reflexive discussions throughout the data collection and analysis processes.

2.3. Sampling Strategy and Study Participants

Purposive sampling techniques were used as we were seeking insight and knowledge from experts working in the field of dementia services in Ireland. We aimed to recruit policy makers/influencers and healthcare professionals. Participants were identified by the project team through existing professional networks and contacts, and by searching online websites and documents to identify relevant groups and individuals who would be eligible to take part (e.g., HSE Model of Care Steering Groups). Sample size was guided by information power [28]; we ceased recruitment when the sample had sufficient variation to address the research questions.

Inclusion criteria for the study were as follows: healthcare professionals were eligible for participation if aged over 18, with a formal qualification in any area of health or social care (including but not limited to geriatrician, psychiatrist, psychologist, speech and language therapist, occupational therapist, advanced nurse practitioner, social worker) and currently working with people with dementia. These criteria were similar to those used to recruit healthcare professionals for our first study [23], although we did not specify that participants in the current study needed to have completed CST training and/or delivered CST. Healthcare professionals were included in the current study to build upon the survey data collected from HCPs in study 1 [23], allowing for a more in-depth exploration of barriers and facilitators to implementation. Policy professionals were eligible if aged over 18 and working in a decision making/policy capacity that may influence the implementation of CST in Ireland (for example, those employed by the HSE or National Dementia Office, advocacy groups/NGOs such as the Alzheimer Society of Ireland, Carers Ireland, the Department of Health, etc.).

Potential participants were contacted by email and provided with a study information sheet. Those who indicated an interest in the study provided informed consent by electronic signature prior to interview and were interviewed using teleconferencing (Microsoft Teams). No incentives or compensation were provided for participation. All study procedures were approved by the Research Ethics Committee at National College of Ireland.

Interviews were conducted with a total sample of 10 key stakeholders, which included five policy professionals and five healthcare professionals. Participant roles are summarised in Table 1. Women made up 60% of the sample.

Table 1. Participant characteristics.

Category	Profession/Role	*n*
Healthcare Professional	Consultant	1
	Social worker	2
Policy Professional	Advanced nurse practitioner	2
	Management level NGO sector	2
	Management level in public healthcare system	2
	Management level in private healthcare	1

2.4. Data Collection

In accordance with published recommendations for use of the CFIR, the research team aimed to pre-identify the CFIR constructs that would be investigated based on their relevance to the study aims [24,25]. For the current study, the following CFIR domains were considered relevant: Innovation Domain; Outer Setting; Inner Setting; and Individual Characteristics. Our intention was to examine where and when barriers or facilitators to implementation may occur, and to discuss possible strategies to compensate for barriers and maximise facilitators. We developed two separate but similar interview guides for each participant group ((1) policy makers/influencers and (2) healthcare professionals) to ensure that the questions were applicable to stakeholders involved. Sample probe and prompt questions were included in interview guides, but interviewers could also ask additional questions based on the responses of the informant.

Interviews were conducted online using Microsoft Teams, between July and November 2023. All interviews were on an individual basis except for one dyadic interview that was conducted to capture the shared experience of two Advanced Nurse Practitioners who worked together in the same service and had delivered CST as part of their roles. Interviews were conducted either by the Principal Investigator (MK) or project co-lead (CH), both of whom have previous experience in qualitative interviewing. Interviews lasted an average of 38 min (range: 30–57 min). Interviews were audio recorded and transcribed verbatim for analysis; automatic transcription within the software was checked against recordings for sense and accuracy by members of the research team. Interview transcripts were deidentified and stored securely in an encrypted shared drive with access limited to the study team; recordings were destroyed once transcription was complete.

2.5. Data Analysis

The data were analysed using Framework Analysis, following a seven-step process as described by [26]: (1) transcription; (2) familiarization; (3) coding; (4) developing a working analytical framework; (5) applying the analytical framework; (6) charting data into the framework matrix; and (7) interpreting the data and finalising themes. The analysis was an ongoing iterative process, during which members of the research team independently coded transcripts and met regularly to discuss and develop consensus on codes, the overall analytic framework, and the final set of themes.

Data analysis was conducted using MAX-QDA (Version 22 and 24). Once transcription (step 1) was complete, the research assistant worked with the lead and co-investigators to read and re-read each transcript, to familiarise (Step 2) themselves with the data, and to record initial analytical notes and impressions. Once the familiarization process was complete, transcripts were coded line-by-line using a combination of deductive and inductive open coding (Step 3). Deductive codes were defined using CFIR domains and constructs that the research team had pre-identified as relevant to the current study. Inductive open

coding was used to capture additional codes that reflected the language and experience of the participants but did not clearly link with a pre-defined CFIR construct. Two members of the research team independently coded the first two transcripts. Once independent coding of the first two transcripts was complete, the research team met to compare the labels applied to these transcripts, and to agree on the working analytical framework (Step 4), i.e., the set of codes which was then applied to all subsequent transcripts (Step 5). Codes were grouped into categories defined by each relevant CFIR domain, with an additional category for "Other" codes to capture content that had been coded inductively and did not clearly sit within a CFIR domain. Regular meetings of the study team during the analysis process were used to review the analytic framework, resolve any discrepancies through reflexive discussion, and review codes identified in the 'other' category to agree their placement in the framework or removal from the analysis. Codes and categories were annotated with memos within the qualitative analysis software, which were then used to generate the framework matrix (Step 6), which summarised the data for each transcript by category and code and facilitated reference to relevant quotations to illustrate these summaries. Once all transcripts had been coded, indexed, and charted, the framework matrix of charted data was reviewed by members of the project team to identify the key themes (Step 7), and to link themes to relevant CFIR domains and constructs where applicable.

Strategies to enhance the reliability of the data and analysis and reduce bias, included using multiple coders, regular meetings of the full analytic team to review the analytic framework and resolve any discrepancies or disagreements, and keeping an audit trail of steps taken in the analyses.

3. Results

We identified five key themes within the data: *(1) Familiarity, Understanding, and Evidence; (2) Partnerships and Connections; (3) Policy; (4) Resources; (5) Attitudes and Culture*. Themes were identified through a combination of inductive and deductive processes; where relevant, codes were mapped to relevant CFIR constructs, and similar constructs were then grouped into themes. However, some codes identified inductively led to the development of themes or sub-themes that did not clearly map to a CFIR construct. The themes and associated sub-themes are listed in Table 2, along with a summary of associated barriers and/or facilitators, and mapping to CFIR domains and constructs where relevant.

3.1. Familiarity, Understanding and Evidence Base

3.1.1. Familiarity with the Intervention

There were varying levels of familiarity with CST among the participants—some were very familiar with the intervention, either having delivered the programme, or being familiar with relevant literature. Others reported having little, if any, familiarity with CST. This variation was likely attributable to the diverse roles of the participants (e.g., policy professional, advanced nurse practitioner, geriatrician, healthcare manager, etc.). Some noted that CST was not something that would be directly relevant to their day-to-day work (*"not on my radar"* (P1)).

Table 2. Key healthcare and policy stakeholder identified barriers and facilitators to implementation of CST, by CFIR domain and construct (where relevant).

Theme/*Subtheme(s)*	CFIR Domains(s) -> Construct(s)	Barriers	Facilitators
Familiarity, Understanding, and Evidence		Lack of awareness: many stakeholders do not know about CST.	
Familiarity with the intervention	Outer setting -> Societal Pressure		Raising awareness of the intervention could drive public demand and advocacy for CST to be provided.
	Innovation -> Innovation Design	Lack of available or easily accessible information about CST, e.g., online	
Understanding of CST	Innovation -> Innovation Design	Intervention could be more clearly defined and described—even the name may be confusing. Lack of clear, easily accessible information about what exactly the intervention entails.	
Evidence Base	Innovation -> Innovation Evidence Base	Scepticism about strength of evidence; need for further evidence related to longer term benefits.	Intervention is supported by a strong evidence base. Scientific evidence is important to drive support for implementation from policy makers.
Partnerships and Connections	Outer Setting -> Partnerships and Connections	Challenges for healthcare professionals engaging with external partners—e.g., sustainability of funding, communication.	Existing relationships between healthcare service and community groups, NGOs, etc. can be leveraged to facilitate implementation. Intervention is currently being delivered in partnership with community partners—with referrals from healthcare service—in some areas.
Policy	Outer Setting -> Policies and Laws	There may be challenges recruiting staff for full implementation of Model of Care, and this may be a barrier to implementation of post-diagnostic supports like CST.	CST is listed as a recommended post-diagnostic support in new Model of Care for Dementia policy document. Additional resources available as part of Model of care, particularly MASS and RSMC structures, and additional staffing, could support implementation. New roles introduced under the Model of Care provide an opportunity to define CST delivery as part of these roles.

Table 2. *Cont.*

Theme/*Subtheme(s)*	CFIR Domains(s) -> Construct(s)	Barriers	Facilitators
Resources	Inner Setting -> Tension for Change	Currently there are not enough resources to provide adequate service provision. Availability of services is not consistent—there is a "postcode lottery" with greater access to services in some regions.	
	Outer Setting -> Financing	Lack of funding and resources can be a barrier to service provision generally.	Additional funding available linked to new Model of Care, e.g., for new staff.
	Innovation -> Innovation Cost		CST is cost effective; the costs associated with implementation are low.
	Inner Setting -> Funding	It can be difficult to obtain small amounts of funding for intervention materials, refreshments, etc., there is a lot of paperwork and bureaucracy associated with this.	
Staffing	Inner Setting -> Available Resources	Lack of staff available to deliver CST. Lack of staff with a specific role or remit to deliver CST—when it is implemented, staff are trying to fit this in on top of their existing workload which can be challenging.	
Time	Inner Setting -> Work Infrastructure	It is difficult for staff to make time to deliver CST—they need to be allocated specific time within their workload for CST delivery.	
Attitudes and Culture *Leadership and Organisational Culture*	Inner Setting -> Culture	Sometimes challenging to get support from management for staff to be given time/resources to deliver CST. In some settings a fatalistic attitude to dementia may pose a barrier to implementation of post-diagnostic services and supports.	"Buy-in" from management can facilitate implementation.

Table 2. *Cont.*

Theme/*Subtheme(s)*	CFIR Domains(s) -> Construct(s)	Barriers	Facilitators
	Inner Setting -> Relational Connections		A holistic, multidisciplinary culture within dementia services with high-quality teams can support implementation—this is a facilitator in some settings where this culture is present (but was not reported consistently across all participants).
Individual Attitudes and Motivations	Inner Setting -> Culture -> Recipient Centredness		Healthcare professionals are motivated to provide the best quality care—their recipient centred approach is an important facilitator as they are motivated to provide supports to their patients. Healthcare professionals perception that the intervention can have a positive impact for their patients will motivate them to deliver CST. Healthcare professionals reported a positive attitude to CST and recognised the value of the intervention.
Relative Priorities	Inner Setting -> Relative Priorities	Limited resources may lead to other services that are perceived as more critical/urgent being prioritised over CST. Challenges in balancing resources between assessment/diagnosis and post-diagnostic services may lead to CST not being prioritised. Pharmacological interventions are sometimes prioritised over non-pharmacological interventions.	Participants considered CST to be an important priority.

The variation in participants' level of familiarity about the intervention is likely reflective of the widespread variation in knowledge of CST across the healthcare and policy landscape more generally, as well as among the public. A lack of knowledge about the intervention among key stakeholders was noted by several participants, *"unfortunately, it's just not well known"* (P2). Participants highlighted that a key barrier to implementation was people simply not knowing about the intervention:

> *"I would say most people probably don't know what cognitive stimulation therapy is."* (P3)

> *"I think the awareness around it can be questionable, not from the people who have done the training obviously. But I think that across the healthcare service of people who haven't done the training or someone who hasn't done it, like even plenty of OTs* [occupational therapists] *probably wouldn't know much about it unless you've done it locally."* (P5)

Some participants discussed the idea of "*pockets*" (P1, P6) of knowledge or good practice, both specifically about CST but also in relation to post-diagnostic supports for people with dementia more generally. These pockets of knowledge were typically driven by individuals rather than by a unified, system-wide, or coordinated approach. *"There's pockets of good things, but they are human being dependent"* (P1).

Participants suggested that there was a need to raise awareness and understanding of CST. It was noted that information was not readily accessible online:

> *"Like when you Google it, like if somebody was looking for a local service and they Google it, there's no one organization who's leading on it. So, you have bits and pieces. . .nobody's taking responsibility to be a provider in that space."* (P7)

The data suggests that lack of awareness of the intervention is currently a barrier to implementation; however, participants also reflected on the potential for awareness raising activities to be a facilitator for increased implementation in future. In this context, participants discussed the importance of healthcare professionals across a range of settings being familiar with CST, so that they could provide information and referrals to their patients:

> *"I think what I find from speaking to people with dementia and family carers is they get their information from so many different places and then part of it is, you know, empowering, say people who work on helplines or people who work in services or dementia advisors—who I know are very well versed in CST—but making sure that everyone, all the professionals know the information. Because I think, there's a huge part of that online piece, but if you're already in touch with dementia services, you will ask the people who work in those services what to do next."* (P3)

The need for awareness raising was also linked to the CFIR construct of societal pressure; that advocacy, lobbying of political figures, and demand for services from the public are important facilitators for driving investment to support implementation of services and interventions like CST.

> *"You also need people on the ground to be asking for it. That's really powerful in terms of advocacy, so it's even just raising awareness of it more generally, you know."* (P3)

> *"When you don't have a high knowledge base from the public about it, they're not calling for it. So if you think of how day centres started or carer support started or respite started initially, it would have been driven by local people saying we need this service. And if you don't know about it and how important it is, you're not going to be campaigning to have it in your local area."* (P7)

Participants also acknowledged that while there is a "*huge need*" (P4) for increased dementia services, and demand for these services from patients and their families, this was unlikely to be a specific request for CST due to a lack of awareness about it *". . .people aren't*

knocking down the door looking for CST, so you have to kind of establish that there is a need for it. So, there's a little bit in that as well. It's not like people are saying we want a CST group" (P4).

3.1.2. Understanding

This sub-theme relates to the CFIR construct of 'Innovation Design' (how the intervention is designed and presented). Several participants highlighted aspects of how the intervention is described, and even named, which may serve as a barrier to implementation.

> *"Even the name cognitive stimulation therapy, I don't think. . .you know. . .also to understand what that means. I think to the normal person on the street or a typical person* [with] *dementia, kind of sounds a bit scary nearly in a way."* (P3)

The potential for confusion and lack of clarity around terminology was evident in discussions with some participants, *"that's even it, I'm juxtaposing cognitive stimulation and cognitive training, you can see my confusion"* (P8) and in some cases participants reported confusion between CST and Cognitive Behavioural Therapy.

> *"I suppose CST, like people say, what is that? Is it cognitive behavioural therapy—CBT. Or you know, these acronyms. Sometimes I think they do us more harm than good because it doesn't, it doesn't actually describe anything."* (P6)

Some participants felt that there was a lack of clear information available about what exactly the intervention entailed, and that there was potential for it to be confused with engaging in any kind of general cognitive stimulation or activity (e.g., doing a crossword, etc.) rather than being understood as a specific, evidence-based programme that runs in accordance with a specified protocol.

> *"I think maybe a lot of people could see and be like, oh yeah, I'll buy a crossword book, or we can, you know, do a quiz, when actually cognitive stimulation therapy is actually as you said, a therapeutic intervention with a big evidence base behind it. And maybe if we spoke about CST in the way we speak about other interventions, and you know even the way we speak about drugs and we talk about there's research here and research there. I think even the way that healthcare professional would speak about CST is different to the way we'd speak about other things. And maybe that's why it is maybe not valued or considered you know as impactful as maybe it really is."* (P3)

3.1.3. Evidence Base

The available scientific evidence related to CST was discussed by several participants, but there were conflicting viewpoints about the strength, quality, and availability of this evidence.

> *". . .there's very, very few evidence-based interventions there, you know, anywhere near as successful as CST is."* (P9)

> *"I mean the evidence-based stuff, is basic, you know, it's at least as good as any of the medications on the market today. . .we have something already that's got a proven track record, you know with an evidence base, so for me it's an absolute no brainer."* (P9)

> *"I think even on my own limited understanding of all the literature on it, when I've gone looking around it, it's hard to find a consistent evidence base that says it works. . .so I'm kind of on the fence."* (P8)

Several participants specifically noted the available scientific evidence as a strength of the intervention, particularly in the context of an overall treatment landscape where limited evidence-based interventions are available. This was considered an important facilitator in terms of encouraging healthcare professionals and policy makers to implement CST:

> *"The policymakers will listen to evidence. Definitely. So that's really important, research and evidence."* (P5)

> *"I think any time I've tried to explain CST to people, I'll always refer to the evidence base. It seems like there's people who think it's just you see a cobbled together, or some kind of distraction therapy or some sort of—'just keep them busy' therapy. It's actually, you know, it's researched. It has an evidence base behind it. We're not just here providing it for the sake of it. . .I refer to it all the time, I think it's essential. And because if you need to stand up and say, explain your rationale for doing the course and doing everything and following up on implementing it in our service, you just have to have that, I mean without it, you're sort of like, I feel people wouldn't take it as seriously. They wouldn't see it as a legitimate intervention."* (P4)

> *"How it is prioritized at the top of all the different things that are going on probably comes down to, awareness, evidence, and I suppose people's understanding of what the benefits will be. I think that will be, that's really important. That's ultimately what will impact on people delivering this and they want to make sure it's, it is offering something to the person."* (P5)

It is important to acknowledge, however, that while participants agreed that a strong evidence base was an important facilitator for implementation, some participants were more sceptical about the evidence that is currently available to support CST:

> *"I've to see evidence of large numbers and I've to see evidence of something beyond a couple of weeks or a couple of months follow-up. And you know, I think there is a lot of inconsistent, and I know the studies you are talking about, I mean there's been meta-analyses and systematic reviews as well, so I don't think it's just my own impression. I think the bias, then bias of people reporting has ultimately led to whether it looks positive or it looks—and that leaves people like myself who are trying to wade through it, it makes it a very difficult evidence base to kind of navigate towards a meaningful answer."* (P8)

Participants also discussed the type of evidence they felt would be most important or beneficial to drive implementation of the intervention. Some emphasized published, peer-reviewed trials, etc. but others expressed a desire to see more practical or context-specific information:

> *"People need case studies, they need, you know, the lived experience stuff, because you can know the data until the cows come home but that doesn't help you care for someone."* (P10)

3.2. Parnterships and Connections

Participants stressed the importance of leveraging existing partnerships and relationships between the healthcare system and community-based organisations, advocacy groups, etc. as a potential facilitator for raising awareness of CST and driving implementation of the intervention.

Participants discussed the need for a "*multi-agency approach*" (P1) to delivering post-diagnostic supports, and a desire to develop an "*ecosystem or infrastructure of support*" (P8) around the person with dementia. Existing community groups or services such as Alzheimer Cafes, Men's Sheds, day centres, etc. were considered as a location where CST could be integrated:

> *"I did wonder as well if CST could be embedded in settings that already get people together. I think it would be easier to deliver it because. . .well you need to find a place to do it. And finding the patients, I suppose could be an issue. . .and then having that place, I suppose for you and the given dates and times."* (P6)

One participant who had experience delivering CST gave a specific example of partnering with an existing community service—a local memory café—to access space and resources for the delivery of a CST group. Another clinician discussed referring patients from their clinic to a local community-based organisation who were providing CST. One participant noted that these partnerships are not without challenges, for example, related to communication between different organisations, lack of direct referral pathways, or issues related to sustainability or consistency of services due to funding.

Related to the earlier theme of Familiarity, Understanding, and Evidence, one participant (P7) also highlighted specific organisations and partnerships that could be leveraged to raise awareness of CST. For example, the Understand Together campaign—a national public awareness and support campaign for dementia in Ireland—was identified as a potential vehicle for providing centralised information about where the intervention is available and how it works.

3.3. Policy

A key theme identified in these interviews related to recent developments in national policy, specifically the new HSE Model of Dementia Care which was published in 2023. Many participants discussed this as a key policy development with the potential to considerably change the landscape of service provision for people with dementia. This policy was therefore recognised an important facilitator to increase implementation of CST going forward. Indeed, CST is specifically listed within this document as a recommended intervention in the post-diagnostic support pathway— *"the fact that it is mentioned in the model of care is huge"* (P3).

This new policy was described as an important "*advocacy tool*" (P7). Participants noted that advocacy groups and other organisations could leverage this new Model of Care document to lobby for funding to implement CST. This lobbying activity could take place through pre-budget submissions or direct contact with relevant government Ministers and could potentially facilitate investment in the intervention. However, the data from this study did not suggest that there is currently any direct investment in CST delivery stemming from this policy document. The Minister of State for Older Persons was identified as an important figure to target with such lobbying efforts. Similarly, the National Dementia Office were discussed as a key stakeholder to target with a formal, costed proposal for the implementation of CST within a service.

While the introduction of the new Model of Care was seen as a positive development and an important facilitator for future implementation, it is important to also note that there was a distinction in the data between content that reflected what *could* be implemented as part of this new Model, as opposed to the services and structures that are *currently* in place on the ground. Therefore, some of the content related to how CST fits within the healthcare system (where it should be delivered, by whom, how it would be funded, etc.) could be considered aspirational and evolving. This was recognised by participants, and was summed up by one who stated:

> *"I know in the model that was launched. . .it spoke about post-diagnostic support and CST being one of them. So, like I know all these models and all these things look fabulous. But if they're not actually you know, if they're not actually delivered or you know put into practice, then how can we take them seriously."* (P2)

For example, participants discussed new Memory Assessment and Support Services (MASS) and Regional Specialist Memory Clinic (RSMC) structures being established nationwide (as part of the new Model). Identifying these as structures through which CST could be delivered.

> *"The MASS and regional assessment units are the beginning. They are at the beginning of. . .of follow-up I suppose because so many people historically have been diagnosed and left off then. So, these will provide a service and knit the person into the service, ehm, and it will not just be about 'here's your dementia and there you go', it will be 'what can we do to support you and your carers'. And so there's different pathways and I have to say the Dementia Office is doing some superb work on that and getting funding to get the bodies in post is phenomenal. They've done an awful lot of work in the last two years that has really made a difference."* (P1)

> *"And what I felt was really important was that the MASS is not just diagnostics, they're post-diagnostic support. So there's a pathway of care for people, which is really important. . .depending on the person it's individualised, tailored care plan for them. That includes a suite, a range of services and supports to help them adapt and live with their dementia. . .I would see CST and CRT [*Cognitive Rehabilitation Therapy*] as being really fundamental to that. . ."* (P7)

3.4. Resources

The availability of resources (or lack thereof) was considered a key determinant of implementation of interventions like CST: *"It's like any therapy or intervention, there needs to be the place to do it, there needs to be the people who can do it, deliver it, and then they need to be able to evaluate the impact of it. So, they need to have those systems, it needs to be a systems approach to it"* (P1).

There was widespread recognition among participants that resources are scarce, and that there is a need to *"improve access to memory services nationally"* (P5) for people with dementia: *"there's still a huge amount to do in relation to service provision"* (P3). Participants referred to *"just trying to keep pace with"* (P3) the current demand, in the context of growing numbers of people living with dementia. This was reflective of the CFIR construct Tension for Change—participants voiced a dissatisfaction with the current situation, and a need for improvement. In this context, one particular challenge that was noted was the idea of a *"postcode lottery"* where services are not consistently provided and are location dependent. The provision of services locally, rather than requiring patients to travel long distances to regional clinics, was also highlighted as an area that required further resourcing (P5, P8, P7).

> *"You can't have the situation either with it, even with the diagnostic piece or the post-diagnostic piece, the post-code lottery, they can't—it can't go on like that. And we need to have some replication across the country."* (P9)

> *"It should take a population-based approach. . .if they set up a memory assessment support service, that has to serve a population of people, so then you don't have this inequity of some areas have a good service and others don't. But to be honest, I think we're a ways off of that."* (P7)

The availability of funding and resources to services was considered a key factor that influences implementation of interventions like CST—*"I think fundings always an issue, isn't it?"* (P9). Participants recognised increased investment in dementia care by the State in recent years, while also acknowledging a need for much more funding to meet the demand for services and supports—*"things have improved hugely in recent years, but that's not to say we're in a space where we have enough services and supports. Currently there is no county in Ireland that has the full number of required services and support for people affected by dementia"* (P3).

The Model of Care was recognised as driving investment and participants reported that this was already translating into increased resources and staffing on the ground:

"...there's a kind of boom in memory assessment services going on. And so, there's big staff uplift. So, areas where there weren't memory clinics before are getting them and are getting full staff complements alongside that. So, you saw the staff complements in the model of care so. Um, so there's big staff uplifts." (P9)

"It's' the resources that haven't been there and they are now getting established because they've had a budget to establish those MASSs." (P1)

"So, the memory assessment services and the regional specialist memory clinics, they've been heavily funded and supported by the Department of Health and the HSE, which is fantastic. So, you know all of these clinics and services will have consultants and registrars, nurses, advanced nurse practitioners, clinical nurse specialists, OTs, social workers, dieticians, speech and language therapists, and admin. So each of those clinics and services will have access to those and it would be hoped that the brain health piece in particular and the post diagnostic support piece, that will start off in the memory clinics." (P5)

Participants did discuss some specific resources that are available within the system, and could be leveraged to facilitate implementation of CST, including Memory Technology Resource Rooms, Dementia Advisors, multidisciplinary teams within the new MASS and RSMC structures. CST was recognised as cost-effective, and participants felt that the costs associated with running the intervention were minimal. However, some reported difficulty obtaining funding for materials or other resources needed to run the groups:

"We just went off and got our own materials, we brought things from home. We cobbled it together, you know, and it worked well...but you know, I would see if you were to go more long term with it, that probably the sensible thing would be to do is you know get materials, get different things that you might need for it. So that's another barrier. So probably the paperwork in the kind of applying for different things that it's easier to just bring them yourself and make it as easy as possible." (P4)

3.4.1. Staffing

Lack of available staff was identified as an important barrier to implementation:

"You know, actually, the neuropsychologist, psychologists, occupational therapists and things like that are, it's a rare commodity at the moment. So you can't scale anything on the degree, no more than disease modifying therapies, we don't have people to actually do this stuff." (P8)

"...there's a huge supply issue of qualified staff across the healthcare sector...so while there is money there, it's difficult to find qualified people to fill the roles." (P7)

Several participants expressed optimism about increased staffing resources becoming available as the new Model of Care is rolled out nationally, while others noted that challenges were already evident in this regard. It was noted that MASS and RSMC structures were still not fully operational because recruitment of the required personnel was an ongoing process (P5). While challenges were identified, there were also opportunities—as one participant noted, the fact that these services are at an early stage of development means that there is scope to ensure CST is built into staff roles from the outset:

"When you get a new job and it's a new service and you, you are developing it, this is the time when you need to think 'Ok, how am I going to configure it?'. And that's when you can carve the time." (P6)

Some participants (P9, P8) discussed different examples that illustrated the sometimes precarious nature of funding for specific roles or services—for example, one healthcare

professional reflected on "*scraping together*" (P9) funding from different budgets to support a short-term 0.5 FTE role, to pilot implementation of an occupational-therapy based intervention within their clinic. There was a recognition of a need for more sustainable funding models to facilitate implementation of interventions like CST. One participant felt that embedding delivery within the HSE was important to ensure continuity of funding.

> *"...it comes back to the same worry I have even about those* [dementia advisor] *roles. Is that's dependent on a funding envelope that isn't, that isn't effective long term, you know. So I've always kind of backed trying to do stuff that falls within the funding structure and it could be through memory services. I mean the ideal is nearly through memory services with, you know, a defined purpose, and that you have therapy assistants attached to occupational therapists."* (P8)

In addition to the general availability of staff, ensuring that there are staff with specific role/remit to deliver interventions like CST was identified as an important requirement. There was a perception that, at present, when CST is being implemented, it is something that healthcare professionals are trying to fit into or on top of their existing workload, serving as a barrier to implementation:

> *"You look to see people being hired to do CST, amongst other things...and at the minute I don't think it's happening. It's current professionals taking time away to do CST."* (P6)

> *"I think when it becomes an add-on to an already really busy role and the person is overworked, then it becomes really difficult."* (P3)

> *"I suppose that would be one of the barriers. It's just trying to manage your time and make sure that you're fulfilling all aspects of your role as well as everything else."* (P4)

3.4.2. Time

Participants noted the importance of staff being allocated specific time within their workload model to deliver CST or other post-diagnostic supports. One participant also specifically highlighted the need for administrative personnel and support as a crucial resource to facilitate implementation *"admin is a big thing, trying to make sure people know where to go, when to go, for how long they've to go for, you know is very, very important as well"* (P8).

Several participants discussed difficulties related to finding or making time to deliver CST, particularly since the intervention requires staff to have specific time available over a period of consecutive weeks. One advanced nurse practitioner (P2) had hoped to deliver CST as part of her role after completing the training, but instead *"had no other option"* but to deliver the intervention on a voluntary basis, in partnership with a local community group. This is reflective of the recipient-centred attitude and motivation further discussed in a theme below, but also highlights the difficulties encountered in allocating staff time to deliver the intervention and incorporating the intervention into existing workflows.

3.4.3. Patients' Individual Resources

In addition to resources needed within the healthcare service to provide CST, participants also discussed the resources that individual patients need to be able to access to attend the intervention—particularly in relation to transport, and often a reliance on family members or carers to provide that transport.

3.5. Attitudes and Culture

3.5.1. Leadership—Organisational Culture

Organisational culture and attitudes among leaders within the healthcare system were identified as an important determinant for whether non-pharmacological post-diagnostic

services like CST are implemented in practice. The need for *"buy in"* and support (P2) from management was considered an important facilitator: *"it has to be coming from the top"* (P3). Two participants with experience delivering CST noted that support from management needed to go beyond a simple agreement for the intervention to be offered, but needed to include consideration of the resources, space, and time that would be required for staff to deliver CST *"you need a little bit more than a go ahead"* (P2).

> *"We are still very much led by a consultant led model. So you're really dependent on the consultants having an awareness of these type of post-diagnostic supports and being very supportive and willing to support the broader team and putting an emphasis on that."* (P10)

> *"There's a lot of people would say, do the CST training, think it's amazing, they're like 'I'm gonna go and implement it' but then all of a sudden their workload grows too much, whereas what they really need is their manager to say no, we need to prioritise this, let's take off some of that workload so you could prioritise CST."* (P3)

Participants reported quite mixed experiences in terms of whether this supportive culture and 'buy in' is currently in existence in the healthcare system—this seems to vary widely across different settings and locations. Some reported difficulties in getting agreement or support from management to provide non-pharmacological interventions like CST (*"They just didn't understand it"* (P4)). Some felt that there was an overall culture/attitude towards dementia that was "*fatalistic*" (P6) or overly medicalised (P10, P7) ("*still based in a kind of hospital model, a sickness led by psychiatry*" (P10)). This was considered a potential barrier in terms of motivation or willingness to drive implementation of non-pharmacological approaches. However, it should be noted that other participants reported more positive experiences in terms of a holistic and multidisciplinary culture:

> *"I've been absolutely blessed with the leaders that we have within our service across different disciplines. . .and also that there's a very consistent culture. Like I mean that holistic—you know we all know what we're meant to be doing you know as hard-nosed brass tack doctors [laughter] but actually it's very, there's a very easy culture whereby we fold it in to actually the more important holistic stuff."* (P8)

3.5.2. Individual Attitudes and Motivations

Among the healthcare and policy professionals who were interviewed for this study, there was clear evidence of a recipient-centred approach to care for people with dementia. There was evidence of healthcare professionals making personal effort, in their own time or using their own resources, to provide additional support to their patients. Participants were motivated by a desire to provide the best possible care and to improve the overall quality of life of patients and their families.

> *"The sense of having something to offer is huge because when you feel like there is nothing to offer your patients, it's soul destroying, it's heartbreaking. So to be able to offer someone a sense of hope, I think is really important as well."* (P1)

> *"I think as well it's about like the values, the principles and the model of care were really about, one that was really important to me was that personal outcome focused approach, which is really about the person in front of you—and each person you see is going to be different. So it's tailoring any care plan or support to that individual where they're at."* (P7)

This attitude was reflected in a holistic approach to treatment; participants recognised the importance and value of non-pharmacological interventions and post-diagnostic supports in general, and of CST specifically:

> *"I think it's imperative if it's evidence based to improve cognition and reduce deterioration. . . there's loads of reasons why. First of all, for the person and for their quality of life and for their sense of. . .it can be quite fatalistic, can't it, being diagnosed with dementia? And if you know there's any hope at all, and then for their carers and their family, for the burden."* (P1)

> *"People come and they say, well how do you set up a memory service? And I will absolutely tell you, I say you start from post-diagnostics backwards, because that's what people need. I mean, there is no, there is no point—it's an academic exercise in, you know, the diagnosis if you do not have a post-diagnostic paradigm."* (P8)

When discussing the benefits of CST, the holistic approach of participants was reflected in their consideration of the broader impact, beyond the effects on cognition. For example, participants discussed the positive impact on confidence, social connection, and mood. It was recognised that while these outcomes might not be direct intervention targets, they are also important reasons to deliver CST:

> *"And I think at the very least it combats isolation and you know a lot of people certainly post-diagnostically, I think retreat into themselves and find to come out again and I think CST, maybe that's not part of the evidence but I, you know, it's those kind of as I said those human touch interventions. I think they're just hugely valuable."* (P9)

> *"What really struck me from that evidence-based piece you did. . .was how it gave people confidence. And that is one of the things that is stripped from people when they ger a diagnosis is their confidence just goes and it limits their life. Their life shrinks because of that. So I think it's so important and the connections that people make and not feel alone and to be with there with people like the benefits are, there's so many. . .I think it's really important."* (P7)

Participants who had experience of delivering CST also reported gaining personal enjoyment from delivering the intervention, alongside the benefits they felt were present for the intervention recipients.

3.5.3. Relative Priorities

As discussed in the earlier 'Resources' theme, barriers related to limited resources, such as lack of funding, space, or staff, were highlighted by most participants. Several participants discussed the need to prioritise where these limited resources were directed and considered this a potential barrier to implementation of CST—other services that are perceived as more critical may be prioritised instead. One participant described how CST might be considered a 'luxury' compared to crisis support services such as respite care:

> *"Not in my opinion, but I think that's the opinion of others is that things like CST or Alzheimer cafes, they're luxury because you know there's this huge number of people who are effectively in crisis. And the way that that's dealt with is through home care, day care, respite care. But then you have this other level of services that I don't think people realise how impactful or useful or how much support they can actually provide a person because we're just trying to keep people, you know, keep their heads above water at the moment."* (P3)

The idea of prioritisation of services was also discussed in the context of balancing resources between assessment and diagnosis versus post-diagnostic supports, with differing perspectives on which should be prioritised:

> *"The main challenge we have is this competing interest around us having to up our game and up our skill at making better, more accurate diagnoses and at the same time continue to deliver and focus on what it is people need after those diagnoses. And it's probably the*

easier thing for doctors and even to be honest with other practitioners in a clinic to do, other clinicians in a clinic to do, is to focus on what we're good at, which is measuring stuff, as opposed to some of this is which is much, much harder and takes much longer to become skilled at. . .the complexity that's coming into the system, the complexity around diagnosis now is distracting people to a certain extent. So there's a desperate upskill. . .a lot of the time they become a little bit overwhelmed or almost overawed at the imaging, the blood, CSF biomarkers and all that kind of stuff when actually the reality of it is that the more complex stuff is that post-diagnostic support." (P8)

"I guess you have to get assessment and diagnosis right nearly before you can start looking at the post-diagnostic pathways and it's hard to say but I think if you were to ask just a regular person on the stress what they would prefer, it would probably be better assessment to diagnosis. . .so it's a tricky one. . .they do really need to focus on both of them at the same time. But I'd say if they were to prioritise, probably have to be assessment and diagnosis first." (P3)

Some participants also discussed challenges related to relative priorities in the context of pharmacological versus non-pharmacological interventions:

"And I think sometimes people might not necessarily value psychosocial interventions in the same way that they might value drug interventions." (P3)

"There's very, very few evidence-based interventions there, you know anywhere near as successful as CST is. You know, they have to be weighed up against the medications. That's the problem, you know. . .you're not comparing like with like half the time. So, but I, you know from a personal point of view, if I find myself in that boat, I'd definitely, I mean I'd be taking the medication but I'd definitely want to do CST as well." (P9)

"There is danger, I think now that we are seeing the breakthroughs, thankfully in relation to medical interventions for Alzheimer's disease. . .that the primary focus will go towards the kind of pharmacological interventions—we have to have a balance as well around the non-pharmacological interventions. . .both are like. . .obviously it's hugely important, the pharmacological, but we can't neglect the non-pharmacological." (P7)

While participants recognised issues that might lead to CST not being considered a priority, this did not necessarily reflect their own view of the intervention, or their own relative priorities:

"I absolutely think that we do need to prioritise CST. I do feel really strongly about it. Psychosocial interventions go under the radar way too much when actually they can be just as powerful as pharmacological interventions." (P3)

"I would think it's fundamental. . .I think it's really important." (P7)

"When there's competing demands it has to, we have to influence people's thinking and order of priority. How is it prioritised at the top of all the different things that are going on and it probably comes down to awareness, evidence, and I suppose people's understanding of what the benefits will be." (P5)

4. Discussion

The aim of this qualitative analysis was to identify barriers and facilitators to the implementation of CST in Ireland. We wanted to understand why CST is not widely available despite many healthcare professionals and dementia specialists being trained to deliver this intervention. We also aimed to identify actionable suggestions and recommendations to increase the availability of CST in future.

The study identified several barriers to intervention implementation, including lack of knowledge about the intervention, a lack of readily accessible information about CST

(including effectiveness and where/how to access the intervention), and a lack of available resources within the healthcare system and associated partner organisations. Participants also identified factors that currently facilitate, or could facilitate, the provision of CST; these included the available scientific evidence for effectiveness of CST, the introduction of new polices related to dementia care in Ireland and associated increases in resourcing, the cost-effectiveness of CST, and the potential to harness the motivations, positive attitudes, and existing partnerships among those working in dementia services.

A lack of familiarity with, or understanding of, CST among stakeholders is a key barrier to implementation [22,29]. The study demonstrated that healthcare and policy professionals have mixed levels of knowledge and understanding of CST and the supporting evidence base, despite the intervention being recommended by health and social care guidelines [12], including national policy for dementia care [11]. There is a need for clear, accessible information about the intervention and awareness-raising activities to encourage implementation. Strategies to raise awareness of the intervention among key stakeholders and the public more generally were identified as important facilitators for driving increased implementation—for example, through increased referrals for CST by healthcare professionals and through advocacy or public pressure for increased access to the intervention. A cohesive strategy for raising awareness and understanding of CST, and for supporting practitioners engaged in delivery across the country, could be effective in addressing some of the barriers identified in this study.

The provision of additional resources is crucial if CST is to be made widely available within memory services in Ireland—participants noted challenges related to staff availability, time, space, administrative support, and funding. Similar barriers have been noted in other countries [22,30], particularly related to staff availability and time, and funding for materials and other resources. While additional resources are required, the relatively low cost-cost of these resources, and the overall cost-effectiveness of CST, has been noted as a facilitator in the current research and previous studies [13].

National policy related to dementia care, particularly the Model of Care for Dementia in Ireland, (which was published in the year these interviews were conducted) was considered an important facilitator for implementation of interventions like CST. The introduction of this new policy document and increased resources associated with policy implementation, was broadly seen as a positive development. Participants discussed the importance of CST being listed as a post-diagnostic support within this policy, and highlighted the potential for new care pathways, clinics/services, and additional staffing to increase implementation of the intervention going forward. However, since this policy was at an early stage of roll-out at the time of this study, concrete evidence of this facilitator increasing CST implementation was not yet available. The available evidence from other countries highlights the potential for such policy requirements to facilitate increased implementation. For example, in the UK, the inclusion of CST in the NICE guidelines [12] and as an accreditation requirement for the Memory Services National Accreditation Programme (MSNAP), ref. [31] has led to increased availability, with the majority of NHS memory clinics routinely offering CST as a post-diagnostic intervention [32]. While the new Model of Care in Ireland does not currently include a specific accreditation model equivalent to MSNAP in the UK, such processes could be considered in future to support policy implementation. It has previously been suggested that accreditation and associated audit processes such as MSNAP, while laborious and requiring financial investment, could provide useful scaffolding to maintain and improve standards in Irish memory clinics [33].

Healthcare and policy professionals are gatekeepers for interventions and supports, and their buy-in determines the extent to which those supports are recommended or facilitated for people with dementia [34]. The importance of organisational culture and

leadership in supporting the implementation of CST was evident throughout the interviews. The current study suggests that healthcare and policy professionals display a high degree of willingness and motivation to engage in evidence-based best practice to support people living with dementia. These individual characteristics and motivations can be leveraged as an important facilitator for implementing CST but need to be supported with 'buy-in' among those in leadership positions. A lack of managerial support has been identified as a barrier to implementation in previous research [20] and was also experienced as a barrier by some participants in the current study. Practical actions to increase managerial support could include activities linked to awareness raising and information provision discussed earlier in this section—more accessible information related to the evidence-base for CST, as well as practical guidance for implementation, may be useful for those in leadership roles.

A key strength of this paper is its potential use for guiding future implementation of CST within the Irish healthcare system. Participants were directly involved at senior levels in healthcare and policy provision for dementia in Ireland and were therefore well-placed to provide valuable insights and actionable suggestions for future implementation. While purposive sampling of key stakeholders was considered appropriate for the pragmatic nature of this study, it should be acknowledged that those with more positive attitudes to CST may have been more likely to take part, and this potential for bias should be acknowledged as a limitation.

This study applied the first phase of a three-stage methodology for CST implementation, that was previously validated in three countries [22,30] by identifying barriers and facilitators to implementation in Ireland. The identification of barriers and facilitators to implementation is an important first step to increasing the availability of non-pharmacological interventions like CST, and ultimately improving outcomes for those diagnosed with dementia. The study can inform future research aiming to complete stages two and three of this process, by developing, evaluating and disseminating an implementation plan for CST in Ireland. The findings of this study provide actionable suggestions for enhancing the implementation of non-pharmacological interventions like CST. Future research to evaluate implementation should include implementation strategies designed to reduce barriers and leverage facilitators identified in the current research, and associated findings from people living with dementia and their caregivers from the wider project.

5. Conclusions

This study identified key determinants impacting the implementation of CST from the perspective of healthcare and policy professionals. The findings suggest that healthcare and policy professionals report generally positive attitudes to CST and want to provide the intervention to people living with dementia. However, they describe challenges in achieving implementation of CST in Ireland due to barriers identified in this study, particularly related to a lack of resources, and a need for more accessible information to increase awareness and understanding of the intervention and its benefits.

The findings of this study support several practical implications and recommendations. There is a need for a coordinated approach to providing clear, consistent, and accessible information about CST for key stakeholders, including where the intervention is available. National organisations such as Understand Together or Engaging Dementia are an important resource that could be leveraged to coordinate awareness raising, for example, through a dedicated, regularly updated space on their website providing information and materials, and signposting to services providing CST. Recent policy developments, most importantly the introduction of the Model of Care for dementia in 2023, are an important facilitator for increasing provision of CST and other post-diagnostic interventions. The policy provides a framework through which increased resources can be made available to

support intervention delivery. To address barriers related to staffing and time, organisations providing CST should be supported to recruit staff with a designated role to provide the intervention or ensure that intervention delivery is a recognised part of existing staff workload, with sufficient time allocated. The new RSMC and MASS structures, introduced through the Model of Care, provide an opportunity to address these resource requirements; however, appropriate investment is essential. A significant challenge to staffing RSMCs and MASSs arose in 2023, when the HSE implemented a year-long recruitment embargo [35] which among other issues, is having a lasting impact on healthcare resourcing countrywide [36,37]. In the context of funding challenges, specific policy levers to mandate CST provision, similar to the MSNAP accreditation requirements in the UK, may be useful to guide prioritisation of resources in memory services.

This research is timely given the introduction of the new Model of Care in the year that the interviews were conducted, and the associated increase in resources and available services through which CST can be provided. Future studies using an implementation science approach can support the development of implementation models, and evaluate the effectiveness of these models, to increase the availability in CST within the evolving landscape of dementia service provision in Ireland.

Author Contributions: Conceptualization, M.E.K. and C.H.; methodology, M.E.K. and C.H., data collection, M.E.K., C.H., E.L. and C.D., formal analysis, M.E.K., C.H., E.L. and C.D.; writing—original draft preparation, M.E.K. and C.H.; writing—review and editing, M.E.K., C.H., E.L. and C.D.; project administration, M.E.K. and C.H.; funding acquisition, M.E.K. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by the Irish Research Council under the New Foundations Scheme, grant number NF/2022/38563641.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Research Ethics Committee at National College of Ireland (Approval Number 1002202303, date of approval 10 February 2023).

Informed Consent Statement: Informed consent (documented via electronically signed consent form) was obtained from all participants involved in the study.

Data Availability Statement: The qualitative data generated and analysed in this study are not publicly available due to ethical and confidentiality considerations. The contextual specificity of the national setting and the professional status of participants mean that disclosure of the data could lead to identification of individual stakeholders.

Acknowledgments: Sincere thanks to our civic society partner for this project, the Alzheimer's Society of Ireland. Thanks also to our project collaborators and expert advisors, including Kim Tully, Matthew Gibb, Aimee Spector and Brian Lawlor. To all the participants who took the time to contribute to this study, thank you for making this research possible.

Conflicts of Interest: The senior author (MK) is an accredited CST trainer with the International CST centre. All other authors declare no conflicts of interest. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

Abbreviations

The following abbreviations are used in this manuscript:

CST	Cognitive Stimulation Therapy
CFIR	Consolidated Framework for Implementation Research
RCT	Randomised Controlled Trial
MSNAP	Memory Services National Accreditation Programme

HSE	Health Service Executive
NGO	Non-Governmental Organisation
NICE	National Institutes for Clinical Excellence
CBT	Cognitive Behavioural Therapy
OT	Occupational Therapy
MASS	Memory Assessment and Support Services
RSMC	Regional Specialist Memory Clinic

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