



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<p><b>Acton (2001) *</b>            Meta-analysis of interventions designed to reduce the burden on persons caring for family members with dementia. Intervention strategies included support group, education, psychoeducation, counseling, respite care, and multicomponent programs.</p>	<p>24 reports testing 27 treatments</p> <p>13 Experimental studies            10 One-group pretest/posttest            4 Quasi-experimental studies</p>	<p>Setting not specified</p> <p>Adults providing care to a family member with dementia</p> <p>Age of individuals with dementia not specified</p>	<p>Caregiver Burden [the Burden Interview and the Burden Scale were the most frequently cited measures]</p>	<p>Only 2 of the 27 treatments had a statistically significant effect on burden; one was a respite intervention and the other a multi-component intervention. The weighted pooled effect size of all interventions showed no significant effect on burden. Of the 6 intervention design types (support group, education, psycho-education, counseling, respite care and multicomponent interventions), only the weighted pooled effect size of multicomponent interventions demonstrated a significant impact on burden (d=0.46, CI=0.14-0.78).</p>
<p><b>Ayalon (2006) *</b>            A systematic review of non-drug interventions designed to manage neuropsychiatric symptoms such as agitation, aggression, delusions, hallucinations, and wandering in people with dementia.</p> <p>Interventions included 1. activities designed to address the unmet need that may be causing the behavior, 2. behavioral interventions involving rewards and redirection, 3. support and education of caregivers and 4. bright light therapy.</p>	<p>3 RCTs and 6 single-case studies</p>	<p>Home, Nursing Home, Adult Day Care</p> <p>Age not specified but aimed towards older adults</p>	<p>Frequency of Behavior Scores on specialized scales such as the Agitated Behavior Rating Scale</p>	<p>The results of all but one caregiver intervention were categorized as clinically significant by the reviews, while statistically significant improvements were reported for: the 1 unmet needs intervention, for 0 of the 4 behavioral interventions, 2 of the 3 caregiving interventions and the 1 bright light therapy study. Authors highlight that out of several hundred studies of these types of interventions, only a few met established criteria for quality, and conclude that faced with limited evidence, “the most promising (although still requiring further evidence) seem to be individually tailored behavioral interventions.</p>

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<p><b>Bates (2004) *</b> A systematic review to determine if psychosocial interventions are effective for people in early stages of dementia or with milder dementing illnesses. Three interventions were identified: reality orientation (2), procedural memory stimulation (1), and counseling (1).</p>	<p>1 randomized study; 3 non-randomized</p>	<p>Milder dementia was defined as by Mini-Mental State Exam (MMSE) scores of 15-23</p> <p>Most studies included individuals &gt;68 years old</p>	<p>Cognitive ability Functional performance Well-being Communication</p>	<p>No positive effects were found for procedural memory stimulation or counseling. Both studies of reality orientation reported positive effects on cognition measured by the MMSE, and these effects were maintained at follow-up. However, all studies had sample sizes under 30 subjects.</p>
<p><b>Brodsky (2003) *</b> Meta-analysis of interventions for caregivers (CGs) of persons with dementia, excluding respite care.</p>	<p>30 studies of 34 interventions</p> <p>19 RCTs 9 non-randomized controlled trials 2 Unspecified design</p>	<p>Home or non-institutional environment</p> <p>2,040 CGs were included in the analysis; CGs were predominantly spouses and aged 55 and older</p> <p>Age of demented persons not specified</p>	<p>Primary measures were psychological morbidity and burden</p> <p>Other outcome measures included coping skills and social support</p>	<p>Weighted average effect sizes (ES) for each outcome measure showed a moderate but statistically significant improvement: CG psychological morbidity, ES 0.31 (95% CI 0.13-0.50; n=26); changes in patient mood, 0.68 (0.30-1.06; n=5); CG knowledge, 0.51 (0.05-0.98; n=8); and overall effect on “any main outcome measure,” 0.22 (0.15-0.48; n=30). The exception was CG burden, which showed no improvement: 0.09 (-0.09-0.26; n=20). There was substantial variability in outcome, partly due to differences in methodology and intervention technique. Interventions involving both patients and CGs improved likeliness of study success. 4 of 7 studies indicated delayed nursing home admission. The authors further conclude that “unsuccessful interventions are short educational programs (beyond enhancement of knowledge); support groups alone, single interviews, and brief interventions or courses that were not supplemented with long-term contact.”</p>

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<p><b>Clare (2003) *</b> Cochrane review to evaluate the effectiveness of cognitive training and cognitive rehabilitation on memory and other aspects of function in people with early Alzheimer’s disease or vascular dementia.</p> <p>Cognitive training is guided practice on a set of tasks that reflect cognitive functions such as memory and attention. The assumption is that practice will generalize beyond the immediate training context. Cognitive rehabilitation focuses on devising strategies to realize patient or caregiver-identified goals with an emphasis on improving function in real world situations.</p>	<p>9 RCTs on cognitive training, none were located on cognitive rehabilitation</p>	<p>Community residents, but actual training occurred in a variety of locations</p> <p>Limited to patients with early Alzheimer’s disease or vascular dementia.</p> <p>There were no exclusions based on age</p>	<p>Person with dementia: memory, performance of various tests/instruments, self-reports of change, depression or anxiety. Also caregiver or clinical observations</p> <p>Caregiver: well-being, depression or anxiety, burden and coping</p> <p>Course of disorder: rate of progression, rate of nursing home admission, impact on costs</p>	<p>No significant positive effects were found for cognitive training; however, no negative effects were identified which is important because there has been speculation it could have a negative effect on mood. The review authors conclude, “Clinical practice requires the ability to distinguish which of a range of possible psychosocial interventions is most likely to be useful for a given individual, and the study designs utilized here do not allow this question to be addressed.”</p> <p>As no studies were identified for cognitive rehabilitation, no results are available.</p>

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<p><b>Cohen-Mansfield (2001)</b> A review of non-drug interventions to reduce inappropriate behaviors by people with dementia.</p> <p>Interventions were categorized as: 1. Sensory including music, massage, white noise (23 studies), 2. social contact (9), 3. behavioral therapy (16), 4. activities (5), 5. environmental interventions (6), 6. medical/nursing care such as pain management (12) and 7. combination therapies (5).</p>	83 articles of various designs, but most were pre-post designs and few included controls (individual study designs not specified)	<p>76% of studies were conducted in nursing homes or special care units. The rest were in hospitals and the community</p> <p>Study subjects had to be over 60 years old for the study to be included</p>	Frequency of Behaviors Scores on specialized scales such as the Agitated Behavior Rating Scale, or the Overt Aggression Scale	53% of studies reported a significant improvement from baseline after treatment in at least one outcome. The diversity of designs and measures made comparisons across treatments impossible. However, 3 studies included direct comparisons and found that actual social contact was more successful than simulated social contact or sensory stimulation; that music therapy had a greater effect than reading aloud on wandering, and that a neuro-developmental sequencing program (multiple sensory activities) produced greater decreases in agitation than traditional activities (adapted bingo, sing along, etc). The review concludes that many interventions show promise and that interventions should be matched to patient's needs and capabilities.
<p><b>Cooke (2001) *</b> Reviewed the content and effectiveness of psychosocial / psycho-educational interventions for the caregivers of persons with dementia. 15 components of interventions were identified: General Education, General Discussion, Support Group, Social Skills Training, Social Support, Social Activities, Cognitive Problem Solving, Cognitive Therapy, Cognitive Skills, Practical Caregiver Skills, Record Keeping, Relaxation, Behavior Therapy,</p>	<p>40 Studies</p> <p>21 used a control group 16 did not use a control group 3 compared two types of interventions without using a control group</p>	<p>Setting not specified</p> <p>Age of demented persons not specified</p>	<p>Five categories of outcomes were selected:</p> <p>Knowledge Psychological well-being Caregiver burden Social outcomes General (includes measures of quality of life)</p>	From abstract: "Approximately two-thirds of the interventions did not show improvements in any outcome measures. Among those studies, which did demonstrate improvements, the inclusion of social components (e.g. social support) or a combination of social and cognitive (e.g. problem solving) components seemed to be relatively effective. It is important to note, however, that these analyses were based on small numbers and the review was limited by a number of methodological issues." With the exception of one large trial, sample sizes were very low.

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Psychotherapy and Counseling, Respite, and Miscellaneous.				
<b>Eggermont (2006) *</b> Systematic review of the literature to evaluate the effect of planned physical activity programs on people with dementia.	27 studies with experimental interventions	Home Care Homes	Mood Sleep Functional Ability Effect on Family Caregiver	Authors conclude that: sustained walking may benefit mood; physical activity has a beneficial impact on sleep; and physical activity has a positive effect on functional ability in care home residents but only when the intervention is long-lasting.
<b>Fox (2000)</b> The Medicare Alzheimer's Disease Demonstration tested a case management model and community care benefit for persons with dementia.	Single RCT 8 study sites	Community  People with Alzheimer's living in the community and their families	Use of community-based services  Regular Medicare service use  Client institutionalization rates	The effect on the use of community-based services was mixed; case managers had a significant impact on treatment group caregivers and access to services, however, there was no difference in the service use volume of the treatment group and control group; in terms of regular Medicare service use, the treatment group had significantly lower and combined expenditures than did persons in the control group; however, the savings were not large enough to compensate for the costs incurred to implement the intervention; provision of case managers and community services was not enough to change the rates of nursing home entry or to delay institutionalization.
<b>Gallagher-Thompson (2007)</b> A review which identified evidence-based psychological treatments (EBTs) for reducing distress and improving well-being of family caregivers.	Psychoeducational programs (14)  Psychotherapy (3)  Multi-component interventions (2)	Community  Family members who provide assistance to impaired older adults 60+	Coping skills Sense of self-efficacy Perceived quality of life (perceived burden, mood, stress)	Programs which target specific components of caregivers' quality of life and include some combination of skill building, education, and support were the most effective interventions. A small average effect size for multi-component interventions may be due to the fact that there were only two studies and both focused upon depression as the primary outcome.

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<p><b>Gitlin (2003) *</b> A meta-analysis of 9 intervention and 6 control conditions of the Resources for Enhancing Alzheimer’s Caregiver Health (REACH) project on caregiver burden and depression at six months. Intervention sites differed in the approach they took. Some implemented a single intervention (i.e. skills training) and some implemented more than one (i.e. coping with care giving class and enhanced support group). Each site developed protocols to minimize deviation from the intervention plan. Additionally, “interventions were responsive to the particular cultural backgrounds of study participants.”</p>	<p>RCT with 9 intervention groups and 6 control groups conducted at 6 sites</p>	<p>Family caregivers of individuals with dementia</p> <p>Persons with dementia were not institutionalized</p> <p>Age of persons with dementia not specified</p>	<p>Upset Behavior Problems Burden</p> <p>Depressive symptoms</p>	<p>The pooled treatment effect for caregiver burden was statistically significant for intervention groups as compared to control groups (<math>p=0.02</math>), however the difference was quite small (0.15 standard deviation units). The pooled effect on depressive symptoms was not significant. A reason for the small overall effect size could be the variation in outcomes among sub-groups. Women and those with high school or less education reported reduced burden as compared to control conditions. Further, caregivers in intervention groups who were Hispanic, those who were non-spouses, and those who had less education reported fewer depressive symptoms than those in the control groups. The authors suggest that these results imply the need for tailored interventions.</p>
<p><b>Hermans (2007) *</b> Cochrane review of non-drug interventions for wandering by people with dementia in domestic (non-institutional) settings. No studies were identified, so no interventions were described.</p>	<p>No trials were identified</p>	<p>Domestic setting (home)</p> <p>Elderly people with any type of dementia assessed and diagnosed by validated criteria in domestic settings</p>	<p>Incidence and frequency of wandering</p>	<p>No results reported as no studies were identified. Authors describe studies conducted in institutional settings and emphasize the need for studies in the community.</p>

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<p><b>Heyn (2004) *</b>            A meta-analysis of the effects of exercise training on older people with cognitive impairment and dementia.</p> <p>Exercise programs included a variety of exercises (endurance, mobility, isotonic, aerobic, resistance) completed at home, to music, or with machines.</p>	<p>30 RCTs</p>	<p>Home            Community locations</p> <p>Subjects had to be 65+ (age was an inclusion criteria)</p>	<p>Cardiovascular Fitness            Strength            Flexibility            BMI            Functional Cognition            Behavior</p>	<p>Improvements with significant and moderate effects sizes (defined as .5 to .8) were found for physical fitness, cognitive function, and behavior. The overall effect size was 0.62 (95% CI, .55-.70).</p>
<p><b>Howard (2001) +</b>            Guideline for the management of agitation in dementia.</p>	<p>Guideline based on literature review and expert panel consensus</p>	<p>Both home and institutional settings are mentioned</p> <p>Age not specified</p>	<p>Guideline recommends:</p> <ol style="list-style-type: none"> <li>1. Full and careful assessment of possible physical, psychological and environmental factors (no evidence provided)</li> <li>2. Optimize quality of care available including safety, stimulation, and treatment (1 citation)</li> <li>3. Non-pharmacological treatment should be tried first and be the mainstay of treatment               <ul style="list-style-type: none"> <li>-assessment will usually identify precipitants</li> <li>-caregivers (formal and informal) need training</li> </ul> </li> </ol> <p>Two types of intervention are a) tailored</p>	<p>No evidence of the effectiveness of this guideline was located.</p>

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			interventions that target precipitants and reinforcers of agitation (1 citation) and b) more general brief intervention techniques (1 citation) 4. Pharmacological management may be indicated when other strategies fail, but not as first line treatment (1 citation) -No evidence to support use of benzodiazepines -antipsychotics frequently cause side effects in the elderly and need to be monitored (2 citations) -atypical antipsychotics have a better side effect profile (3 citations) -polypharmacy should be avoided (no citations) -severe or treatment resistant agitation merits specialist referral (no citations)	
<b>Jorm (1997) *</b> A meta-analysis comparing informant questionnaire to brief	10 studies with comparisons of questionnaires and	Hospital, clinic and community	Sensitivity  Specificity	The most commonly used informant questionnaire, Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

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cognitive tests for screening for dementia.	tests	Mean age was over 70 in all studies		performs as well as the most commonly used test (the Mini-Mental Status Exam). Authors conclude that informant questionnaires are as effective as brief cognitive test and should be used more particularly when tests are problematic due to low literacy; cross-cultural issues or a comparison to earlier life is needed.
<p><b>Kasl-Godley (2000)</b> Literature concerning six types of psychosocial interventions for people with dementia was reviewed in order to evaluate the types of interventions in terms of how they address the different aspects of dementia and the goals of the patients, and to summarize evidence of effectiveness.</p> <p>The interventions reviewed include: 1. psychodynamic approaches (individual or group therapy), 2. reminiscence and life review, 3. support groups, 4. reality orientation, 5. memory training, and 6. cognitive/behavioral approaches.</p>	<p><u>Psychodynamic</u>: 1 pre-post, 1 randomized study <u>Reminiscence</u>: 2 uncontrolled, 1 RCT, 1 cross over, 1 non-random control group. <u>Support Groups</u>: 2 case studies 1 non random comparison study 3 studies based on participant evaluations <u>Reality Orientation</u> 9 evaluations <u>Memory Training</u> 12 studies, designs not all specified <u>Behavioral</u></p>	<p>Outpatient</p> <p>Nursing Home</p> <p>Inpatient</p> <p>Day Hospitals</p> <p>Age not specified</p>	<p>Cognitive Function</p> <p>Qualitative observations of activity</p> <p>Behavioral assessments</p> <p>Depression</p> <p>ADLs</p>	<p><u>Psychodynamic</u>: limited evidence of efficacy <u>Reminiscence</u>: may be most appropriate for people with mild impairment, studies show minor improvement in social and psychological function. <u>Support Groups</u>: evaluations are limited to observation and do not provide strong conclusions. <u>Reality Orientation</u>: has had positive effects on cognition, but little effect on behavior <u>Memory Training</u>: comprehensive cognitive remediation seems better than specific memory techniques. <u>Behavioral</u>: Different behavioral interventions seem appropriate at different stages of dementia, e.g. learning is possible at early stages, reinforcement at moderate stages, while late stages require interventions that do not require the active participation of the patient.</p>

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	Selected reviews cited, literature described as “too extensive to describe”			
<b>Lee (2004) *</b> A review of the effects of respite care for people with dementia and their caregivers. Particular focus is placed on rates of institutionalization.	3 RCTs	Setting not specified but community implied  Mean age of persons with dementia reported in 2 of 3 studies: 72.6 years and 80.2 years	Rate of institutionalization Psychological measures Caregiver attitudes Caregiver physical health Caregiver burden Functional support Health and social service utilization	Study data was not pooled as the interventions and outcomes were too dissimilar. Only two of the three studies provided data that could be re-analyzed. No significant results were found from this re-analysis for any variable. The authors caution that this could be due to the lack of “high quality research” in this area.
<b>Logsdon (2007)</b> A review to identify successful nonpharmacological, evidence-based treatments for behavioral disturbances in older adults with dementia.  Interventions had to be based on psychological theories or models of behavior change and supervised by mental health professionals.	57 RCTs were reviewed; 14 met the inclusion criteria (rigorous methods and intervention had a psychological component that could be separately evaluated). Review provides detail only on the eight with positive findings	1 study of Nursing Home Residents; 7 of community dwelling elderly (information not provided for studies with no positive findings)	Improvement in Behavior  Caregiver burden (secondary)	8 of the 14 studies identified reported statistically significant differences in outcomes between the treatment and control groups. All of the successful programs used a ‘problem-solving’ and ‘behavioral-activation’ focus. They trained staff and family to observe problem behaviors, identify antecedents, and make modifications to decrease occurrence. These approaches were most effective for people with depressive and anxious behaviors. The authors recommend more research to determine what is most effective with severely agitated people.
<b>Lyketsos (2006) +</b> Care principles (guideline) for patients with dementia from	Literature Review and Expert Consensus	Aimed at clinicians in all settings	Guideline states the following should be considered:	No discussion or evidence about the effectiveness of the guideline was located.

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Alzheimer's disease by the American Association for Geriatric Psychiatry.		Age not specified	<p><u>Clinical Actions</u></p> <ol style="list-style-type: none"> <li>1. Medications targeting the pathophysiology of the disease</li> <li>2. Symptomatic therapies for cognitive symptoms (cholinesterase inhibitors)</li> <li>3. Symptomatic therapies for other neuropsychiatric syndromes                             <ul style="list-style-type: none"> <li>-identify which disturbance is present</li> <li>-consider possible contribution causes</li> <li>-address all contributing causes and basic needs</li> </ul> </li> <li>4. Clinicians should be able to implement nonpharmacological interventions or be able to refer to others</li> <li>5. Given no clear standard and the risk, serious consideration should be given to involving a specialist if pharmacologic therapies are needed</li> </ol> <p><u>Supportive Care to Patients</u></p> <ol style="list-style-type: none"> <li>6. Address safety</li> <li>7. Structure day to day</li> </ol>	

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			living to maximize function 8. General medical health should be closely monitored 9. Advance care planning should be done <u>Supportive Care to Caregivers</u> 10. Clinicians should be familiar with or develop checklists of the elements of supportive care for caregivers	
<b>Nair (2007) *</b> A Cochrane review on cognitive rehabilitation for memory deficits following stroke.  Interventions were mnemonic strategies and imagery mnemonic programs and were compared to other memory training approaches.	2 RCTs	Setting not stated  In one study the population was all 3-5 months post stroke, in the other, patients had memory deficits for several reasons, but only those due to stroke were included in this review. Age not specified.	Memory tests Observer-rated measures of memory	No significant effects on list learning, face recognition, recall of stories, or standardized memory test. The one positive effect was identified on route learning (standard mean difference 2.23, 95% CI 0.66 to 3.80).  Authors conclude there is no evidence to support or refute the effectiveness of memory rehabilitation and point out that the study samples were small (n=12 and 6).
<b>Newcomer (1999)</b> Evaluation of the Medicare Alzheimer's Disease Demonstration on caregiver burden and depression. "Applicants to the demonstration	RCT 8 study sites	Community setting  Mean age of the individual with dementia = 78.0 years	Caregiver burden Caregiver depression	"Persons in the treatment group had a high exposure to case management and a greater likelihood of community service use relative to those in the control group. Treatment group membership was associated with statistically significant, but very small reductions in caregiver

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(all voluntary) were randomly assigned into treatment and control groups. Treatment group cases were eligible for case management and up to \$699 per month in community care benefits.”				burden (in 4 of 8 sites) and depression (3 of 8 sites) over a 36-month tracking period. These findings are not sustained with all cases combined...”
<b>Peterson (2001) +</b> A literature review used to develop a guideline on the early detection of dementia. Developed by the Quality Standards Subcommittee of the American Academy of Neurology.	74 articles with evidence classified according to study type (Class I: one or more RCT; Class II: well designed studies with concurrent controls; Class III: expert opinion, case reports)	General or specialty out-patient practices  Elderly patients (age not specified)	Recommendations on screening asymptomatic and at-risk individuals  Recommendations on approaches to screening and assessment	Data was insufficient to allow recommendations on screening asymptomatic individuals. Data does support evaluation and monitoring of people with moderate cognitive impairment for development of dementia. (Class 2 and 3 Evidence). Screening instruments such as the Mini-Mental State Examination are supported by evidence for assessing the degree of impairment (Class I, II, and III) and evidence also supports the use of neuropsychologic batteries (Class II and III). Use of Clock Drawing Test and Informant interviews are listed as options.
<b>Pusey (2001) *</b> A review of Psychosocial Interventions (PSI) for caregivers of persons with dementia. They define PSI as “interpersonal interventions concerned with the provision of information, education, or emotional support together with individual psychological interventions addressing a specific health or social care outcome.”	30 studies: 17 RCTs 12 “Controlled trials without randomization” 1 unknown	The person with dementia resided in the community; institutional care was excluded  No age range was specified for persons with dementia	Psychological health (including depression, guilt, anger, frustration, rage, hostility, stress and anxiety)  Physical health  Quality of life (including the perception of burden)	The authors point out that the sample sizes of the included trials were very small (ranging from 12 to 106, with nearly half having less than 50) and the overall methodological quality was poor. It is thus difficult to draw many conclusions. There is some weak evidence to support group and individual interventions. The authors conclude that the evidence most strongly supports “individualized interventions that utilized problem solving and behavior management.” They note that this approach is “closest to the effective model of psychosocial interventions currently in use with other severe and enduring illnesses.”

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<p><b>Robinson (2007) *</b> A systematic review of non-drug interventions designed to reduce wandering.</p> <p>Interventions include electronic tagging and tracking, caregiver interventions, exercise, music therapy, sensory therapy, and environment design.</p>	<p>11 studies, 8 RCTs for efficacy; 27 studies evaluating acceptability and ethics; 0 studies were located for cost effectiveness</p>	<p>Residential and Institutional Settings are implied but not stated for each study</p> <p>Study populations not specified</p>	<p>Clinical Efficacy Acceptable/Ethical Cost Effectiveness</p>	<p>Authors conclude there is no high quality evidence supporting any interventions, although one study of exercise reported positive results and could be considered some evidence even though the result has not been confirmed. Short term reductions in pacing immediately followed some interventions, but the authors doubt their practical importance. Acceptance was high for walking, exercise, while electronic monitoring raised issues and restraints/lock were viewed as not ethical and dangerous.</p>
<p><b>Smits (2007) *</b> A review of the evidence on effects of combined intervention programs for both the informal caregivers and the persons with dementia.</p>	<p>25 reports of 22 programs. Study design not specified, though authors note that most are not RCTs</p>	<p>Inclusion criteria included: intervention aimed at both caregiver and patient; caregiver and person with dementia living in their own homes; elderly person suffering from dementia</p>	<p><u>Caregiver:</u> Mental health Burden Competence</p> <p><u>Person with dementia:</u> Mental health Cognitive functioning Behavioral problems Physical function Admission to long term care Mortality</p>	<p>Combined programs have a positive affect on caregiver general mental health. The findings for other mental health outcomes, including depressive symptoms, well-being and burden are not conclusive. The combined programs may be promising for caregiver competence, particularly among some subgroups, notably women and minority caregivers.</p> <p>For persons with dementia, a positive influence was found on general mental health and admission to long-term care (delayed admission for program participants vs. controls). Inconclusive results were found for cognitive function, behavioral problems, physical function, and mortality.</p>
<p><b>Sorensen (2002) *</b> Meta-Analysis of interventions for the caregivers of older adults.</p>	<p>78 studies were included; study designs not specified</p>	<p>Setting not specified</p> <p>Inclusion criteria required the care recipient's age to be 60 or greater. Mean</p>	<p>Six outcomes were assessed: Caregiver burden Depression Subjective well-being</p>	<p>All caregiver interventions taken together produced a significant improvement of between 0.14 and 0.41 standard deviation units in the six outcome variables. Psychoeducational interventions and psychotherapy had the most</p>

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## ESTABLISHING A NATIONAL FRAMEWORK FOR GERIATRIC HOMECARE EXCELLENCE

### COGNITIVE FUNCTION

#### ARTICLE DESCRIPTIONS

First Author (Year) and Focus of the Interventions	Study Designs or Methods (# of studies included)	Intervention Settings/Population	Outcomes/Measures	Findings and Conclusions
		age of care recipients across studies was 77.3 years. Of note, the interventions did not target dementia patients specifically, though many interventions for caregivers of dementia patients were included	Perceived caregiver satisfaction Ability/knowledge Care receiver symptoms	consistent results, showing statistical improvement across all categories of outcomes. Multicomponent interventions had significant effects on caregiver burden, well-being, and ability/knowledge. Respite/daycare interventions had a positive impact on caregiver burden, caregiver depression, and caregiver well being. Supportive interventions reduced caregiver burden and increased ability/knowledge but had no effect on the other outcome variables. Training was effective in increasing caregivers' subjective well-being and reducing care receivers symptoms. Interventions were less effective at improving caregiver burden, depression, subjective well-being, and ability/knowledge when all care receivers had dementia than when care receivers did not have dementia or when the sample was mixed.
<b>Spector (2000) *</b> A systematic review and meta-analysis of reality orientation for people with dementia. The reality orientation includes multiple 30 to 60 minute sessions that include the presentation, repetition and use of information about time, place and person.	8 RCTs, 6 included in the meta analysis	Congregate living situation implied but not stated  Subjects were over 55 and diagnosed with dementia, Alzheimer's disease, or organic brain syndrome	Cognitive function Behavior	Cognition was improved in the intervention group (Standardized mean difference -0.56, 95% CI, -0.95 to -0.22). Behavior was also improved (SMD -0.64, 95% CI -1.20 to -0.08) The authors conclude classroom reality training has benefits on cognition and behavior.  Sample sizes ranged from 9 to 47.
<b>Spijker (2008)*</b> A systematic review and meta-analysis of the effectiveness of	Studies of 13 support programs	Studies conducted in the US, UK, Canada, Italy and the Netherlands in a	Odds of institutionalization Time to institutionalization	The analysis found that the programs significantly decreased the odds of institutionalization (OR-0.66, 95% CI 0.43-0.99) and significantly

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nonpharmacological support for caregivers and patients with dementia that were intended to delay institutionalization.	10 RCTs 2 pre/post test with control group  1 quasi experimental design	variety of settings including inpatient, out patient and home care.  Age of person with dementia reported in some studies—all available over 70. Age for caregivers was often reported and the means were predominately over 60.		increased the time to institutionalizations (Standardized Mean Difference =1.44, 95% CI 0.07-2.81, p=.04). When only studies rated highly in terms of methodological quality were included, the results for odds of institutionalization remained the same, while the difference in the time to institutionalization was no longer significant. Characteristics associated with effective interventions included a combination of caregiver involvement and choice among service options.
<b>Verkaik (2005) *</b> A systematic review of psychosocial methods for reducing depression, aggression or apathy in people with dementia. 13 different types of interventions were identified that fell into 4 categories: behavior oriented, emotion oriented, cognition oriented and stimulation oriented.	19 studies, 10 RCTs, 8 Controlled Clinic Trials, 1 Randomized Cross Over study	Home, Nursing Home, Psycho geriatric unit  Study populations not specified	Depression Aggression Apathy	Review found limited evidence that behavior therapy reduced depression in people with probable Alzheimer’s living at home with a caregiver. Some evidence was also found to support the use of multi-sensory therapy in late stage dementia to reduce apathy and psychomotor therapy to reduce aggression in nursing home residents.  Authors conclude the evidence provides stronger support for some types of interventions over others, but that overall it is modest. Excluding studies rated low quality did not change results.
<b>Woods (2005) *</b> A Cochrane review and meta-analysis to assess the effects of reminiscence therapy on older people with dementia and their caregivers.  Reminiscence therapy involves	5 RCTs with controls that were either no treatment or another activity	Home, Nursing Home  Study subjects were older people (mean age > 55) with dementia	Mood Quality of Life Communication and Interaction Cognition- autobiographical memory Caregiver burden	Data from 4 RCTs were available to include in the meta-analysis. At 4 or 6 week follow-up there was improvement in cognition (standardized mean difference 0.5, 95% CI 0.07 to 0.92) and in depression (but this was only measured in one study) and no differences in communication or problem behavior. Authors conclude the review indicates some potential for benefit from this

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discussion of the past, usually with the aid of prompts such as pictures, objects, or music. It can be done in groups or individual sessions.				therapy but given the differences among the interventions the evidence is currently inconclusive about the efficacy of reminiscence for older people with dementia.

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