

Kliiniline küsimus nr 7

Kas Alzheimeri tõvega patsientide ravi ja hoolduse korraldamisel kasutada patsientide kognitsiooni ja igapäevategevustega toimetuleku säilitamiseks/parandamiseks ning ohutuse tagamiseks all-
loetletud mittefarmakoloogilisi sekkumisi vs. mitte?

- Kognitiivne treening/rehabilitatsioon;
- Tegevusteraapia (igapäevatoimingute treening);
- Multikomponentne sekkumine (multicomponent intervention);
- loovteraapia;
- muusikateraapia;
- validatsioonimeetod;
- psühhosotsiaalsed sekkumised;
- füüsilise keskkonna kohandamine;
- tegevus- ja liikumisvabaduse piiramine patsiendi turvalisuse huvides

Kriitilised tulemusnäitajad: patsiendi kognitsiooni paranemine ja/või säilitamine, patsiendi käitumis- ja psüühikahäirete vähenemine, patsiendi toimetulek igapäevategevustega, patsiendi elukvaliteet, patsiendi ohutuse tagamine, lähedase/omastehooldaja/hooldaja koormatus, meetodi kulutõhusus.

Süsteemaatilised ülevaated

Kokkuvõte: Leiti 9 süstemaatilist ülevaadet või meta-analüüsi, mis käsitlesid mittefarmakoloogilisi ravimeetodeid. Mittefarmakoloogilistel ravivõtetel (kognitsiooniteraapia, multikomponentne sekkumine, kognitiivne stimulatsioon ja rehabilitatsioon) võib olla efekt kognitsiooni parandamiseks (1, 3, 4, 5, 8). Kusjuures individuaalse lähenemise efekt on suurem, kui grupiteraapial (3). Tuuakse välja, et sekkumised toimivad vaid kerge kuni mõõduka dementsusega patsientidel, raske dementsusega patsientidel rakendamine ei ole efektiivne (4, 8). Kognitiivsel stimulatsioonil on kõige enam tõenduspõhiseid andmeid, kuid edasised uuringud on vajalikud kuluefektiivsuse hindamiseks (5, 8).

Ühes ülevaates oli positiivne efekt vaid kognitiivsel rehabilitatsioonil, kuigi soovitus põhineb vaid ühel RCT-l (metaanalüüsi teha ei saanud) (2). Kognitiivsel treeningul positiivne efekt puudus. Toodi ära ka, et võib olla isegi negatiivne efekt patsiendi tuju alanemise tõttu, eriti raskema dementsusega patsientidel (2).

Ei ole efekti validatsioonimeetodil (1, 7). Muusikateraapial on lühiajaline efekti tujule ja käitumisele, kuid pikaajalist kasu ei leitud (6). Muusikateraapial puudub efekt kognitsiooni paranemisele (1).

Füüsilise keskkonna kohaldamist ja tegevus- ning liikumisvabaduse piiramist käsitletakse rohkem psüühika- ja käitumishäirete kontekstis. Ei leitud piisavalt tõendeid, et soovitada füüsilise keskkonna kohaldamist käitumishäirete parandamiseks (7).

Ühes süstemaatilises ülevaates tuuakse välja, et füüsilised harjutused (*exercise programs*) võivad parandada igapäevategevustega (ADL) toimetulekut, efekt kognitsioonile ja neuropsühhiaatrilistele sümptomitele puudub (9).

Piirangud: enamus uuringuid on tehtud väikses uuringurühmas; mittefarmakoloogiste ravimeetodite kontrollrühmas on enamasti "tavapärase" (farmakoloogilise) ravi grupp, mis teeb efekti hindamise keeruliseks. Tihti vaadeldakse mitut sekkumist korraga, mistõttu on keeruline selgitada ühe konkreetse sekkumise efekti. Kaasatud on vaid kerge kuni mõõduka dementsusega patsiendid. Mõnes ülevaates on hõlmatud erinevate diagnoosidega dementsed patsiendid.

Vaadeldud uuringute põhjal saab soovitada kognitiivsele stimulatsioonile ja multikomponentssele sekkumisele suunatud meetodeid, mille võib olla efekt kognitsiooni paranemisele kerge kuni mõõduka dementsusega AT haigetel. Muudel sekkumistel oluline efekt puudub või on lühiajaline.

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1.Olazarin, J., et al. Nonpharmacological Therapies in Alzheimer's Disease: A Systematic Review of Efficacy. Dement Geriatr Cogn Disord 2010;30:161–178

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Interventsioonid, mida vaadeldi: Cognitive training, Behavioral interventions, Cognitive stimulation, Transcutaneous electrical stimulation, Physical exercise, Use of music, Reminiscence, ADL training, Massage and touch, Recreation therapy, Use of light, Multisensory stimulation, Support and psychotherapy, Validation, Acupuncture, Transcranial magnetic stimulation, Muscle relaxation, Multicomponent interventions.

Kognitsioonitreening, kognitiivne stimulatsioon (Grade B):

Treening individuaalselt ja grupis viis kognitsioonivõime paranemisele (tähelepanu, mälu, orienteerumisvõime, verbaalne, visuaalne ja üldine kognitsioon). Kusjuures kombinatsioonravi (donepezil + kognitsioonitreening) efektiivsem, kui farmakoteraapia üksinda.

Igapäevaelu tegevused (ADL)(Grade B):

Positiivne efekt kõigis vaadeldud uuringutes. Uuring hooldekodu haigetel, interventsioonid: päevakava loomine, individuaalse autonoomia parandamine, söömise iseseisvus, orienteerumine majas.

Multikomponentne sekkumine (Grade B):

Kognitiivne stimulatsioon, reminiscence ja relaksatsioon parandasid orienteerumist peale 3 kuud võrreldes kontrollgrupiga. Kognitiivne stimulatsioon ja psühhomotoorne treening - instrumentaalsete ADL väiksem langustendents. Käitumishäired, tuju ja elukvaliteet paraneb samuti multikomponentsel treeningul.

NPTs lacking any recommendation were: transcutaneous electrical stimulation, physical exercise, use of music, reminiscence, massage and touch, recreation therapy, use of light, multisensory stimulation, support and psychotherapy, validation, case management and respite care.

Kokkuvõtte: Palju low quality uuringuid, uuringugrupid väikesed, enamus kaasatud uuringuid käsitleb multikomponentset sekkumist, mistõttu raske selgelt välja tuua, millel efekt.

2.Bahar-Fuchs A, Clare L, Woods B. Cognitive training and cognitive rehabilitation for mild to moderate Alzheimer's disease and vascular dementia. 2013 The Cochrane Collaboration. Published by JohnWiley & Sons, Ltd.

AMSTAR skoor: 11/11 - kõige põhjalikumalt tehtud meta-analüüs.

Süsteemaatiline ülevaade, mis kirjeldab ainult kognitiivse treeningu ja rehabilitatsiooni efekti. Leiti, et kognitiivsel treeningul ei ole positiivset efekti ega ka kõrvaltoimeid. Ühest uuringust (Small, 1997) tuli välja, et võib olla isegi negatiivne efekt, kuna mõjub halvasti patsiendi tujule ja seeläbi põhjustada frustratsiooni ja depressiooni nii patsiendis, kui ka omastehooldajates. Kognitiivse rehabilitatsiooni kohta ei saanud teha metaanalüüsi, kuna oli ainult 1 uuring. Kuid uuringu(Clare, 2010) tulemus oli positiivne.

Inglise keelne kokkuvõtte: No positive or adverse effects of cognitive training were detected in the meta-analysis. The finding of no adverse effects of cognitive training is relevant in light of proposals from previous commentators (e.g. Small 1997) that cognitive training may have a negative impact, particularly on mood. Only one RCT of individualised cognitive rehabilitation was identified (Clare 2010). Hence, no meta-analysis could be conducted. However, the results of this single, high-quality trial are positive, indicating that cognitive rehabilitation is likely to provide some benefit for patients in the short term and in the medium term related to self-rated competence and satisfaction in performing meaningful personal goals, memory capacity and general quality of life.

Kirjutab ka eelnevalt käsitletud ülevaatest põhjendamaks tulemuste erinevust: Specifically, Olazarin 2010 included in their review participants with any kind of dementia, and in fact allowed for inclusion of a small proportion of participants with cognitive decline but without confirmed dementia. In addition, like Sitzer 2006, Olazarin 2010 used less strict inclusion criteria, leading to inclusion of several low-quality studies. Finally, rather than examining different cognitive domains separately, Olazarin 2010 analysed cognition broadly, and studies contributed diverse measures of cognition to the evaluation of this outcome, whereas cognitive outcomes in the current study were evaluated separately against widely agreed cognitive domains. These methodological differences are most likely to account for the differences between the current review and the review by Olazarin 2010.

3.D. I. Sitzer, E. W. Twamley, D. V. Jeste. Review Article Cognitive training in Alzheimer's disease: a meta-analysis of the literature. Acta Psychiatr Scand 2006: 114: 75–90

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Kognitiivne teraapia parandab patsientide kognitsiooni ja funktsionaalseid võimeid ning aeglustab allakäigu kiirust. Individuaalne teraapia on efektiivsem kui grupiteraapia. Patients with Alzheimer's disease may derive some cognitive and functional benefits from cognitive training. Restorative cognitive training strategies demonstrated larger effect sizes than compensatory strategies. The largest effect sizes were seen in the domains of learning, memory,

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executive functioning, activities of daily living, general cognition, depression, and general functioning.

Studies reviewed frequently reported small sample sizes, which we accounted for by weighting the results of each study by sample size. Few studies used performance-based measures of daily functioning. Most studies combined multiple treatment strategies, making it difficult to evaluate the efficacy of individual strategies.

The most efficacious CT interventions were those that used restorative strategies, such as general cognitive stimulation (e.g. prompting recall of remote memories, practicing conversation skills, problemsolving, reading, and engaging in creative activities), computerized visuospatial drills, and memory drills emphasizing repetition.

Compensatory techniques (e.g. visualization, procedural memory training, and external devices) appeared to be less effective than restorative strategies at improving cognitive and functional abilities.

Greater effect sizes were observed for studies using individual treatment modalities over group modalities. It is unclear whether these individual modalities were better tailored to the specific needs of each individual, or if the benefit over group modalities was due to more individualized attention

CT may show promise for improving learning, but not memory. The rate of decline may be slower in patients receiving CT.

4. Elisa Aguirre, et.al. Cognitive stimulation for dementia: A systematic review of the evidence of effectiveness from randomised controlled trials. Ageing Research Reviews 12 (2013) 253–262

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Kognitiivne stimulatsioon on efektiivne eraldi ja koos ACHEI raviga. Kognitiivse stimulatsiooni meetodud: sõnamängud, pusled, mineviku ja olevikusündmuste arutelu, muusikateraapia, küpsetamine, aiandus. Leiti kognitsiooni, elukvaliteedi, sotsiaalsete interaktsioonide paranemist. Uuringugrupis olid vaid kerge ja mõõduka dementsusega patsiendid, tuuakse välja, et raske dementsusega patsientidele meetodid ei sobi.

Mõisted:

- (a) 'Cognitive stimulation' as engagement in a range of activities and discussions (usually in a group) aimed at general enhancement of cognitive and social functioning;
- (b) 'cognitive training' as guided practice on a set of standard tasks designed to reflect particular cognitive functions with a range of difficulty levels to suit the individual's level of ability;
- (c) 'cognitive rehabilitation' as an individualised approach where personally relevant goals are identified, and the therapist works with the person and his/her family to devise strategies to address these. The emphasis is on improving performance in everyday life, rather than on cognitive tests, building on the person's strengths and developing ways of compensating for impairment.

Cognitive stimulation is effective irrespective of whether ACHEIs are prescribed, and any effects are in addition to those associated with the medication. Not only benefits cognition but also self reported well being and quality of life as well as communication and social interaction. The trials included people in the mild to moderate stages of dementia and the intervention does not appear to be appropriate for people with severe dementia.

Activities: discussion of past and present events and topics of interest, word games, puzzles, music and practical activities such as baking or indoor gardening.

Samas: Forest plot-graafikutel 95% CI lõikub 1 joonega.

5. Clive Ballard, et al. Nonpharmacological Treatment of Alzheimer Disease. The Canadian Journal of Psychiatry, Vol 56, No 10, October 2011.

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Süsteemiline ülevaade, mis uurib kognitiivse treeningu ja stimulatsiooni, rehabilitatsiooni efektiivsust. Leiti, et esineb tagasihoidlik, kuid oluline efekt parandamaks kognitsiooni, neil on additiivne efekt kombinatsioonis ACHEI-raviga. Kusjuures kognitiivne stimulatsioon on kõige enam tõendus põhine, kuid nõuab edasisi uuringuid kuluefektiivsuse osas.

Limitations: Most RCTs evaluating nonpharmacological treatments in people with AD are modest in size. Many of the studies use usual treatment as the control.

6. Orla McDermott, et al. Music therapy in dementia: a narrative synthesis systematic review. Int J Geriatr Psychiatry 2013; 28: 781–794

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Ülevaade, mis hindab muusikateraapia efektiivsust kognitsioonile. Leiti vähene lühiajaline efekt elukvaliteedile, kuid pikaajaline efekt puudus.

Music therapy involves building a therapeutic relationship through listening and responding to a sound. Clinicians often report clients' preserved memory of familiar songs. This suggests that music

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is an accessible medium for people with dementia. Both active and receptive music therapies either in individual or group format were considered. Active music therapy applies to a model where both clients and therapists participate in music making. Receptive music therapy implies clients listening to recorded or live music that are selected to meet individual clinical needs.

Perhaps changes cannot be sustained as the dementia becomes more severe. The intervention might still be deemed worthwhile if it improved the person's quality of life, even temporarily.

There was little evidence for longer-term benefits and no longitudinal studies investigating how and why music therapy might work.

7. Gill Livingston, et al. Systematic Review of Psychological Approaches to the Management of Neuropsychiatric Symptoms of Dementia. Am J Psychiatry 2005; 162:1996–2021.

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Ülevaade, mis uuris muuhulgas füüsilise keskkonna kohaldamist käitumishäirete vähendamiseks - ei leitud olulist efekti. Visuaalse keskkonna muutmine (uste varjamine väljapääsu takistamiseks) vähendas agitatsiooni, kuid ei olnud statistilised oluline (Grade C). Peeglite eemaldamine vähendas ärevust, samas peeglite asetamine ustele vähendas osakonnast lahkumist (Grade D). Reaalsuse orientatsioon (*signposting* – sildid ustel, jne) vähendas neuropsühhiaatrilisi sümptomeid (Grade D). Elamine grupis (hooldusasutuses) soosimaks kodulaadset atmosfääri- efekt puudus (Grade D). Uste lukust lahti jätmine - vähem uitamist ja neuropsühhiaatrilisi sümptomeid (Grade D).

Enhancement of the visual environment in a selected area of a residential home was associated with a decrease in agitated behaviors, although the finding was not statistically significant.

Consistent evidence from level-4 studies for changing the environment to obscure the exit indicates a grade of recommendation of C.

In a study with a single case design, one of two patients was less agitated after removal of mirrors from the ward environment (146). Placing a full-length mirror over a doorway led to a significant decrease in exiting during the intervention for nine patients. The grade of recommendation for use of mirrors is D.

Two single case studies found that signposting alone was ineffective, but signposting in combination with reality orientation therapy led to improvements in ward orientation in two of four and five of five patients, respectively (141, 149). In the third study, signposts were placed alongside prompts that served to draw attention to the signs; this arrangement led to a reduction in neuropsychiatric symptoms in all five study participants (143). The grade of recommendation for signposting is D.

Group living is the name given to specially designed nursing homes that encourage a homelike atmosphere. In summary, group living may have beneficial or deleterious effects—or no effect—on neuropsychiatric symptoms. The grade of recommendation for group living is D.

Unlocking doors. One small uncontrolled study examined the effect of unlocking ward doors for 3-hour periods (154) (Table 11). Patients showed fewer neuropsychiatric symptoms and decreased wandering when the door was open. The grade of recommendation for unlocking doors is D.

8. Bob Woods, et al. Cognitive stimulation to improve cognitive functioning in people with dementia. Cochrane Database of Systematic Reviews 2012 , Issue 4

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Süsteemaatiline ülevaade, mille kohaselt kognitiivne stimulatsioon on efektiivne parandamaks dementsete patsientide mälu ja elukvaliteeti. Tuju ega käitumise paranemise osas efekti ei leitud. Kaasatud uuringutes olid patsiendid kerge kuni mõõduka dementsusega.

People with dementia and their caregivers are often advised that 'mental exercise' may be helpful in slowing down the decline in memory and thinking experienced by many people with dementia.

This review examined the evidence for one form of mental exercise, described as cognitive stimulation. This involves a wide range of activities that aim to stimulate thinking and memory generally, including discussion of past and present events and topics of interest, word games, puzzles, music and practical activities such as baking or indoor gardening. Typically this is carried out by trained staff with a small group of four or five people with dementia for around 45 minutes at least twice a week. Family caregivers have also been trained to provide cognitive stimulation to their relative on a one-to-one basis.

This review included 15 trials with a total of 718 participants. The findings suggested that cognitive stimulation has a beneficial effect on the memory and thinking test scores of people with dementia.

Although based on a smaller number of studies, there was evidence that the people with dementia who took part reported improved quality of life. They were reported to communicate and interact better than previously. No evidence was found of improvements in the mood of participants or their ability to care for themselves or function independently, and there was no reduction in behaviour found difficult by staff or caregivers. Family caregivers, including those who were trained to deliver the intervention, did not report increased levels of strain or burden.

The trials included people in the mild to moderate stages of dementia and the intervention does not appear to be appropriate for people with severe dementia. More research is needed to find out how

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long the effects of cognitive stimulation last and for how long it is beneficial to continue the stimulation. Involving family caregivers in the delivery of cognitive stimulation is an interesting development and merits further evaluation.

9. Forbes D, et.al. Exercise programs for people with dementia. Cochrane Database Syst Rev. 2015 Apr;4.

AMSTAR; ei ole võimalik hinnata, kuna tasuta kättesaadav vaid *abstract*.

Ülevaade, mis hindab füüsiliste harjutuste efekti dementsete patsientide kognitsioonile, ADL, neuropsühhiaatrilistele sümptomitele, suremusele. Teisesed tulemusnäitajad oli omastehooldajate koormatus, pöördumine tervise teenuse osutajate juurde. Leiti, et füüsilised harjutused võivad parandada patsientide igapäevategevustega toimetuleku (ADL), ei olnud efekti kognitsioonile ega käitumisele. Teiste tulemusnäitajate osas ei saanud järeldusi teha.

Primary objective: Do exercise programs for older people with dementia improve their cognition, activities of daily living (ADLs), neuropsychiatric symptoms, depression, and mortality?

Secondary objectives: Do exercise programs for older people with dementia have an indirect impact on family caregivers' burden, quality of life, and mortality? Do exercise programs for older people with dementia reduce the use of healthcare services (e.g. visits to the emergency department) by participants and their family caregivers?

Viited

Kokkuvõte (abstract või kokkuvõtlikum info)	Viide kirjandusallikale
1. Süstemaatiline ülevaade, mis hindab mittefarmakoloogiliste võtete efektiivsust Alzheimeri tõve haigetel ja AT-ga seotud haigustega (ADRD) patsientidel nii patsiendi (<i>patient with disease</i>, PWD) kui ka hooldaja (<i>caregiver</i>, CG) aspektist. -Otsiti andmebaase (Medline, PsycINFO, CINAHL, Embase, Lilacs and the Cochrane Dementia and Cognitive Improvement Group Specialized Register), leiti 1313 RCT, millest valiti välja 179 uuringut (hõlmasid 26 interventsiooni) -Results: <u>Grade A</u> treatment recommendation was achieved for institutionalization delay (multicomponent interventions for the caregiver, CG). <u>Grade B</u> recommendation was reached for the person with dementia (PWD) for: improvement in cognition (cognitive training, cognitive stimulation, multicomponent interventions for the PWD); activities of daily living (ADL) (ADL training, multicomponent interventions for the PWD); behavior (cognitive stimulation, multicomponent interventions for the PWD, behavioral interventions, professional CG training); mood (multicomponent interventions for the PWD); QoL (multicomponent interventions for PWD and CG) and restraint prevention (professional CG training). Conclusion: <u>NPTs emerge as a useful, versatile and potentially cost-effective approach to improve outcomes and QoL in ADRD for both the PWD and CG.</u>	1. Olazarin, J., et al. Nonpharmacological Therapies in Alzheimer's Disease: A Systematic Review of Efficacy. <i>Dement Geriatr Cogn Disord</i> 2010;30:161–178
2. Süstemaatiline ülevaade, mis hõlmab 11 RCT-d, mis käsitlevad kognitsioonitreeninguid ja 1 RCT, mis uuris kognitsiooni rehabilitatsiooni. -Otsiti andmebaase: MEDLINE, EMBASE, CINAHL, PsycINFO, LILACS -Main results: Cognitive training <u>was not associated with positive or negative effects in relation to any reported outcomes</u>. The overall quality of the trials was low to moderate. The single RCT of cognitive rehabilitation found promising results in relation to a number of participant and caregiver outcomes, and was generally of high quality -Conclusions: Available evidence regarding cognitive training remains limited, and the quality of the evidence needs to improve. However, there is still <u>no indication of any significant benefit derived from cognitive training</u>. Trial reports indicate that some gains resulting from intervention may not be captured adequately by available standardised outcome	2. Bahar-Fuchs A, Clare L, Woods B. Cognitive training and cognitive rehabilitation for mild to moderate Alzheimer's disease and vascular dementia. 2013 The Cochrane Collaboration. Published by JohnWiley & Sons, Ltd.

measures. The results of the single RCT of cognitive rehabilitation show promise but are preliminary in nature. Further, well-designed studies of cognitive training and cognitive rehabilitation are required to obtain more definitive evidence. NB! GRADE tabelid kaasas!	
3. Süstemaatilise ülevaade, mis uurib Alzheimeri tõve haigetel kognitiivse treeningu efektiivsust. -kaasati 17 RCT, andmebaasid: MEDLINE, PsycINFO Results: An overall effect size of 0.47 was observed for all CT strategies across all measured outcomes. Mean effect sizes were higher for restorative (0.54) than for compensatory (0.36) strategies. Domainspecific effect sizes ranged from 2.16 (verbal and visual learning) to)0.38 (visuospatial functioning). Data are also presented on the relative impact of restorative and compensatory strategies for each domain of functioning. Conclusion: <u>CT evidenced promise in the treatment of AD, with primarily medium effect sizes for learning, memory, executive functioning, activities of daily living, general cognitive problems, depression, and self-rated general functioning.</u> Restorative strategies demonstrated the greatest overall effect on functioning. Several limitations of the published literature are discussed	3. D. I. Sitzer, E. W. Twamley, D. V. Jeste. Review Article Cognitive training in Alzheimer's disease: a meta-analysis of the literature. Acta Psychiatr Scand 2006: 114: 75–90
4. Metaanalüüs, mis hindab kognitiivse stimulatsiooni efekti dementsetel patsientidel. -kaasab 15 RCT (kokku 718 pts), andmebaasid: Medline, Embase, Cinahl, Psycinfo and Lilacs Results: A consistent <u>significant benefit to cognitive function was identified following treatment and the benefits appeared to be over and above any medication effects.</u> This remained evident at follow-up up to three months after the end of treatment. In secondary analyses, with smaller total sample sizes, significant benefits were also noted for quality of life and well-being, and on staff ratings of communication and social interaction. No differences in relation to mood, activities of daily living or challenging behaviour were noted. There is consistent evidence that cognitive stimulation interventions benefit cognitive function and aspects of well-being. Cognitive stimulation should be made more widely available in dementia care.	4. Elisa Aguirre, et.al. Cognitive stimulation for dementia: A systematic review of the evidence of effectiveness from randomised controlled trials. Ageing Research Reviews 12 (2013) 253–262
5. Ülevaade, mis hõlmas 9 RCT uuringut, andmebaaside kohta info puudub. Results: There is evidence from a modest number of well-conducted randomized controlled trials (RCTs) that various nonpharmacological approaches, including cognitive training, cognitive rehabilitation, and cognitive stimulation therapy (CST), confer modest but significant benefits in the treatment of cognitive symptoms in people with AD, and that <u>there may be additive benefits in combination with cholinesterase inhibitor therapy.</u> Cognitive rehabilitation also appears to result in functional benefits in AD. The modest number of RCTs focusing on cognitive training in AD is consistent with the results of larger cognitive training trials in healthy older people. However, there is no convincing evidence of any benefits associated with brain training games. Conclusion: An emerging evidence base indicates that different approaches to <u>cognitive training and cognitive stimulation in people with AD confer modest but significant benefits.</u> The best evidence base is for CST, although this approach is labour-intensive, and requires further evaluation of cost-effectiveness. There is currently no evidence that brain training games provide any significant benefit to people with AD.	5. Clive Ballard, et al. Nonpharmacological Treatment of Alzheimer Disease. The Canadian Journal of Psychiatry, Vol 56, No 10, October 2011.

6.Süstemaatiline ülevaade, mis hõlmab 18 RCT. Andmebaasid: MEDLINE, EMBASE, PsycINFO, CINAHL, Cochrane Library, Web of Science, Journal of Music Therapy, and Nordic Journal of Music Therapy. Recent reviews on music therapy for people with dementia have been limited to attempting to evaluate whether it is effective, but there is a need for a critical assessment of the literature to provide insight into the possible mechanisms of actions of music therapy. This systematic review uses a narrative synthesis format to determine evidence for effectiveness and provide insight into a model of action. Conclusion: <u>Evidence for short-term improvement in mood and reduction in behavioural disturbance was consistent, but there were no high-quality longitudinal studies that demonstrated long-term benefits of music therapy.</u> Future music therapy studies need to define a theoretical model, include better-focused outcome measures, and discuss how the findings may improve the well-being of people with dementia.	6.Orii McDermott, et al. Music therapy in dementia: a narrative synthesis systematic review. Int J Geriatr Psychiatry 2013; 28: 781–794
7.Süstemaatiline ülevaade, mis uurib muuhulgas keskkonna kohaldamist, kuid psüühikahäirete kontekstis. Hõlmab 162 RCT, otsitud Cochrane Library jt andmebaasid. Conclusion: interventions that changed the visual environment looked promising, but more research is needed.	7.Gill Livingston, et al. Systematic Review of Psychological Approaches to the Management of Neuropsychiatric Symptoms of Dementia. Am J Psychiatry 2005; 162:1996–2021.
8. Süstemaatiline ülevaade, mis hõlmab 15 RCT (718 patsienti) kognitiivse stimulatsiooni efektiivsuse hindamist kognitsiooni parandamiseks dementsetel patsientidel. Andmebaasid: Cochrane Dementia and Cognitive Improvement Group Specialized Register, called ALOIS. Results: A clear, consistent benefit on cognitive function was associated with cognitive stimulation (standardised mean difference (SMD) 0.41, 95% CI 0.25 to 0.57). This remained evident at follow-up one to three months after the end of treatment. In secondary analyses with smaller total sample sizes, benefits were also noted on self-reported quality of life and well-being (standardised mean difference: 0.38 [95% CI: 0.11, 0.65]); and on staff ratings of communication and social interaction (SMD 0.44, 95% CI 0.17 to 0.71). No differences in relation to mood (self-report or staff-rated), activities of daily living, general behavioural function or problem behaviour were noted. In the few studies reporting family caregiver outcomes, no differences were noted. Importantly, there was no indication of increased strain on family caregivers in the one study where they were trained to deliver the intervention. Conclusions: There was consistent evidence from multiple trials that <u>cognitive stimulation programmes benefit cognition in people with mild to moderate dementia over and above any medication effects.</u> However, the trials were of variable quality with small sample sizes and only limited details of the randomisation method were apparent in a number of the trials. Other outcomes need more exploration but improvements in self-reported quality of life and well-being were promising. Further research should look into the potential benefits of longer term cognitive stimulation programmes and their clinical significance.	8. Bob Woods, et al. Cognitive stimulation to improve cognitive functioning in people with dementia. Cochrane Database of Systematic Reviews 2012, Issue 4
Süstemaatiline ülevaade, mis hindab füüsiliste harjutuste programmide efektiivsust dementsetel patsientidel. Kaasati 17 RCT (1067 patsienti). Andmebaasid: ALOIS, the Cochrane Dementia and Cognitive Improvement Group's Specialised Register.	9.Forbes D, et.al. Exercise programs for people with dementia. Cochrane Database Syst Rev. 2015 Apr;4.

Conclusion: There is promising evidence that exercise programs may improve the ability to perform ADLs in people with dementia, although some caution is advised in interpreting these findings. The review revealed no evidence of benefit from exercise on cognition, neuropsychiatric symptoms, or depression. There was little or no evidence regarding the remaining outcomes of interest (i.e., mortality, caregiver burden, caregiver quality of life, caregiver mortality, and use of healthcare services).

Tasuta kättesaadav vaid abstract!

Ravijuhendid

Kokkuvõte: Mittefarmakoloogilist ravi käsitletakse 4 Alzheimeri tõve (AT) ravijuhendis (1-4) ja 2 dementsuse ravijuhendis (5, 6). Ravijuhendites on infot enamuse kliinilises küsimuses ära toodud mittefarmakoloogiliste sekkumiste kohta: kognitiivne treening/rehabilitatsioon, tegevusteraapia, igapäevatoimingute treening, loovteraapia, muusikateraapia, validatsioonimeetod, psühhosotsiaalsed sekkumised ja füüsilise keskkonna kohaldamine. Ei leidunud infot multikomponentse sekkumise ja patsiendi turvalisuse huvides tegevus- ja liikumisvabaduse piiramise kohta.

Ameerika Psühhiaatriate Assotsiatsiooni 2014. aasta AT ravijuhend on mittefarmakoloogise ravi osas kõige põhjalikum. Ravijuhendi järgi jaotatakse mittefarmakoloogiline ravi (psühhosotsiaalsed sekkumised) neljaks: käitumisele, emotsioonile, kognitsioonile ja stimulatsioonile orienteeritud. Ravijuhend soovib käitumusel, emotsioonil ja stimulatsioonil põhinevaid sekkumisi mõõduka kindlusega (*moderate confidence*), kognitsioonile suunitletud sekkumisi vähema kindlusega (4). Kognitsioonile suunatud sekkumised (reaalsusele orientatsioon, oskuste treening ja rehabilitatsioon) - leiti mõningane ja ajutine positiivne efekt, kuid kokkuvõttes ei tasu ravi kulukus ja võimalik kõrvaltoimete risk (tõusnud frustratsioon, viha, depressioon) end ära (III) (4). Samale järeldusele jõuab ka Canadian Medical Association dementsuse ravijuhend: ei ole piisavalt tõendeid, et kognitiivne treening, rehabilitatsioon omaks efekti kognitsiooni parandamises ja säilitamises kerge kuni mõõduka dementsuse korral (5). Kognitsiooni treeningu efektiivsus pole piisavalt tõestatud võib põhjustada patsientidel pigem frustratsiooni (II)(3). Igapäevatoimingute treening ja füüsilise keskkonna kohaldamine (*occupational therapy*) parandab patsientide funktsionaalset võimekust (II) (1). Canadian Medical Association dementsuse ravijuhendis leiti positiivset efekti ADL treeningul, kuid soovitude tegemiseks puudub piisav informatsioon (5).

Emotsioonile suunatud sekkumised (Reminiscence, valitatsioonimeetod, toetav psühhoteraapia, sensoorne integratsioon, *simulated presence therapy*) ei omanud kliiniliselt olulist efekti kognitsiooni, meeleolu ega käitumise osas (III) (4). Validatsioonimeetodi ja reminiscence efektiivsuse kohta on vastakaid andmeid ja ei saa kindlalt soovitada (3). Algstaadiumis patsientidele võib psühhoteraapia grupis (oma kogemuste jagamine) vähendada depressiooni. Harimine, psühhosotsiaalne tugi nii patsiendile kui ka omastele omab positiivset efekti kognitsioonile, meeleolule, tervisele, enesehinnangule ja stressile (2).

Käitumisele suunatud sekkumised võivad olla efektiivsed meeleolu ja käitumishäirete (agressiivne käitumine) korral. Samas näidati, et efekt püsib vaid nii kaua, kuni kestab interventsioon. Käitumishäirete ravis soovitatakse esmalt proovida mittefarmakoloogilisi sekkumisi (II) (4). Lähemalt tuleb käsitlemisele kliinilise küsimuse nr. 12 all.

Stimulatsioonile suunatud sekkumised (mängud, lemmikloomad, muusikateraapia, kunst, füüsilised harjutused, multisensoorne stimulatsioon, aroomiteraapia, *simulated presence therapy*) vähendavad käitumishäireid (agitatsioon) ja parandavad meeleolu. Tõenduspõhisus on vähene, kuid *common sense* soovib kaasata dementsuse patsiendi ravis (II) (4). Individualiseeritud treeningprogrammid (*exercise programs*) parandavad kerge kuni keskmise raskusega dementsusel funktsionaalset sooritust. Füüsilised harjutused parandavad kognitsiooni, meeleolu, und ja funktsionaalset võimekust, vähendavad käitumishäireid (2, 5). Muusikateraapia ja reminiscence võivad parandada sotsiaalseid suhteid, emotsionaalseid oskuseid ja vähendada käitumishäireid (2). NICE 2014. aastal uuendatud ravijuhendis öeldakse, et kognitiivsel stimulatsioonil võib olla efekt kognitsiooni säilitamisel ja tuleks soovitada kerge kuni mõõduka dementsusega haigetele, sõltumata põhjusest (6). EFNS ravijuhendis tuuakse välja, et kognitiivne stimulatsioon võib omada efekti kerge kuni mõõduka raskusega AT patsiendi mittefarmakoloogilises ravis – hea praktika tava soovitus (1). California workgroupi ravijuhendis leiti, et kognitiivne stimulatsioon koos farmakoloogilise raviga on efektiivsem kui farmakoteraapia üksinda (2).

Kokkuvõtlikult võib öelda, et ravijuhendite soovitudele aluseks olnud RCT koosnesid väikestest uuringugruppidest ning tihti rakendati uuritavatel mitmeid mittefarmakoloogilisi interventsioone

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koos, mistõttu efekti hindamine osutus keerukaks. Leidus mõõdukat tõendus põhjust soovitamaks kognitiivset stimulatsiooni, efektiivsemaks osutusid muusikateraapia ja füüsilised harjutused. Kognitiivne treening ja rehabilitatsioon ei omanud soovitud efekti ning pigem mõjus ebasoodsalt (patsiendi frustratsioon). Emotsioonile suunatud sekkumised (validatsioonimeetod, psühhoteeraapia, jne) ei omanud kliiniliselt olulist efekti.

Soovituste tasemed:

[I] Recommended with substantial clinical confidence

[II] Recommended with moderate clinical confidence

[III] May be recommended on the basis of individual circumstance

Allpool on toodud lühikokkuvõtted (eesti ja inglise keeles) mittefarmakoloogilise ravi soovitustest ravijuhendite kaupa:

1.EFNS guidelines for the diagnosis and management of Alzheimers disease

Ravijuhend, mis käsitleb Alzheimeri tõve diagnostika ja ravi aspekte. Tuuakse välja, et mittefarmakoloogiline ravi on oluline nii kognitsiooni kui ka psüühikasümptomite käsitluses. Kuna leidub vähe tõendus põhjust informatsiooni, siis mainitakse, et kognitiivne stimulatsioon ja rehabilitatsioon kerge kuni mõõduka raskusega AT korral võib olla kasulik (hea praktika tava). Tuuakse välja, et psüühikahäireid tuleks esmalt püüda ravida mittefarmakoloogiliste võtetega.

Occupational therapy - võiks eestikeeles tõlkida kui igapäevatoimingutega toimetuleku parandamine (füüsilise keskkonna kohaldamine muuhulgas), ADL õpe ja kohaldamine, omaste õpetus, jne. Leiti, et parandab patsientide funktsioneerimist (soovituse tase - B). There is much interest in the use of cognitive therapies in AD. Preliminary studies seem to suggest a beneficial effect of cognitive stimulation, also known as Reality Orientation. More studies are needed before it can be classified as class I evidence, but in individual cases the clinician may decide to try this form of therapy (good practice point). Cognitive stimulation or rehabilitation may be considered in patients with mild to moderate AD (good practice point). Occupational therapy can improve patients functioning and reduce need for informal care (Level B).

2. California Workgroup on Guidelines for Alzheimer's Disease Management

Ravijuhend käsitleb Alzheimeri tõve patsiendi ravi. Keskendub ka omastehoolajate toetamisele. Toodi välja, et harimine, psühhosotsiaalne tugi nii patsiendile kui ka omastele omab positiivset efekti kognitsioonile, meeleolule, tervisele, enesehinnangule ja stressile.

Muusikateraapia ja reminiscence võivad parandada sotsiaalseid suhteid, emotsionaalseid oskuseid ja vähendada käitumishäireid. Füüsilised harjutused parandavad kognitsiooni, meeleolu, und ja funktsionaalset võimekust, vähendavad käitumishäireid. Kognitiivne stimulatsioon koos farmakoloogilise raviga on efektiivsem kui farmakoteeraapia üksinda. Algstaadiumis patsientidele võib psühhoteeraapia grupis (oma kogemuste jagamine) vähendada depressiooni.

Patients in the early stages of Alzheimer's Disease may derive significant benefits from use of community-based services focusing on their needs. In a study carried out at an interdisciplinary center for older adults in Florida that offered education, therapy, and psychosocial support for both individuals with memory loss and their family members, researchers found positive effects on cognition, affect, health, self-esteem, and stress (Buettner, 2006; Buettner & Fitzsimmons, 2006). In the adult day services setting, Alzheimer's Disease patients have access to activities which have been shown to benefit these individuals. Such activities include music therapy, which can improve social and emotional skills, decrease behavioral symptoms, and aid recall (Ziv, Granot, Hai, Dassa, & Haimov, 2007); reminiscence, which can promote interpersonal connections (Kasl-Godley & Gatz, Guideline for Alzheimer's Disease Management 23 California Version © April 2008 2000); and walking and other forms of physical exercise, which can improve cognition, mood, sleep, and functional ability (Eggermont, van Heuvelen, van Keeken, Hollander, & Scherder, 2006; Williams & Tappen, 2007).

Recommendations: Develop and implement an ongoing treatment plan with defined goals. Discuss with patient and family referrals to early-stage groups or adult day services for appropriate structured activities, such as physical exercise and recreation.

Cognitive stimulation, such as activities provided in adult day services programs, has been shown to benefit persons with Alzheimer's Disease more than drug therapy alone (Femia, Zarit, Stephens, & Greene, 2007). In one study, adult day services participants with mild Alzheimer's Disease receiving cognitive stimulation and donepezil over a one-year period improved their scores by 1.5 points on the Mini-Mental State Exam (from an average of 22.95 to 24.45), while those receiving medication only saw their scores decline (from an average of 21.17 to 17.8) (Requena et al., 2004).

Physical exercise has multiple health benefits for the person with early Alzheimer's Disease, as demonstrated in studies examining both aerobic and non-aerobic forms (e.g., strength training, endurance, balance) of exercise (Logsdon, McCurry, & Teri, 2005). As reported in a meta-analysis

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of studies of exercise programs for Alzheimer's Disease patients (Heyn, Abreu, & Ottenbacher, 2004), exercise has been shown to benefit cognitive performance, strength, physical fitness, functional performance, flexibility, and cardiovascular measures. Although studies are limited, cognitive benefits have been associated with aerobic exercises such as walking and using an exercise bicycle (Palleschi et al., 1996; Rolland et al., 2000). Additionally, engaging in physical exercise has been associated with reductions in depression and improvement in mood and behavioral problems (Regan, Katona, Walker, & Livingston, 2005; Teri et al., 2003; Williams & Tappen, 2007).

Reported benefits of early-stage support groups include the opportunity to share experiences and increased social support (Zarit et al., 2004). Although individual or group psychotherapy with a trained professional can help early-stage individuals make sense of their experiences and reduce depression (Cheston, Jones, & Gilliard, 2003), few professionals have developed the specialized skills needed, and early-stage support groups are not readily available. Most that do exist, however, use a model that includes some combination of education and supportive peer discussions, involving either early-stage individuals only or both those affected and their care partners in parallel groups (Yale, 1995; Alzheimer's Association, 2007).

Recommendation: Pay particular attention to the special needs of early-stage patients, involving them in care planning, heeding their opinions and wishes, and referring them to community resources, including the Alzheimer's Association.

3. Optimal management of Alzheimer's disease patients: Clinical guidelines and family advice

Ravijuhend, mis võtab kokku 4 tunnustatud ravijuhendi soovitused (NICE, EFNS, APA ja AAN) omaste nõustamise ja mittefarmakoloogilise ravi osas. Kokkuvõtlikult toodi välja, et on piiratud tõendusmaterjal psühhosotsiaalsete sekkumiste efektiivsuse kohta.

Käitumuslikud lähenemised ja kognitsiooni stimulatsioon on ära toodud level 2 soovitusena. Samas kognitiivne treening ei ole soovitatud, kuna ei too tõenäoliselt efekti ning võib põhjustada patsientides frustratsiooni.

All of the reviewed guidelines concluded that there is limited evidence (from randomized controlled trials) regarding the specific effects of psychosocial interventions on dementia patients. Behavioral approaches, and stimulation-oriented treatments (eg, recreational activity, art therapy, music therapy, and pet therapy) are recommended with level 2 evidence. Furthermore, supportive psychotherapy is recommended to address issues of loss in the early stages (level 2 evidence). Cognition-oriented treatments, such as reality orientation, cognitive retraining, and skills training focused on specific cognitive deficits, are not recommended since they are unlikely to have a persistent benefit and have been associated with frustration in some patients. The levels of evidence for reminiscence and validation therapy are not consistently classified in the guidelines (NICE-SCIE: level 2 evidence; APA: level 3 evidence).

Table 4 Levels of evidence for interventions that include family advice

Intervention	APA	NICE	EFNS	AAN
Education	Level [I]	Recommended; no access to evidence rating	[Level B rating]	Level [Guideline]
Counseling	Level [II]	Recommended; no access to evidence rating	[Level B rating]	Level [Guideline]
Assessment of caregiver distress and Needs	Recommended; no access to evidence rating	Recommended; no access to evidence rating	[Level C rating]	No recommendation; Call for research
Practical support and services	Recommended; no access to evidence rating	Recommended; no access to evidence rating		Level [Practice options]
Psychosocial interventions for dementia patients				
• Behavioral approaches	Level [II]	Recommended; no access to evidence rating		Level [Guideline]
• Stimulation-oriented treatments	Level [II]	Evidence grade [Moderate]		Level [Guideline]
• Reminiscence and validation therapy	Level [III]	Evidence grade [Moderate]		No Recommendation

4. PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH ALZHEIMER'S DISEASE AND OTHER DEMENTIAS. October 2014

Ravijuhend, mis käsitleb Alzheimeri tõve haigete ravi. Mittefarmakoloogilise ravi aspektist psühhosotsiaalsed interventsioonid võivad parandada või säilitada patsiendi kognitsiooni, funktsioneerimist, käitumist ja elukvaliteeti. Ei ole selge, millised

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interventsioonid toimivad kõige paremini ja pikaajaline efekt on küsitav. Samas leitakse, et kuna need on ohutud patsiendile (peale võimaliku frustratsiooni tekke), toetatakse interventsioonide kasutamist.

Mittefarmakoloogiline ravi (psühhosotsiaalsed sekkumised) jaotatakse neljaks: käitumisele, emotsioonile, kognitsioonile ja stimulatsioonile orienteeritud. Ravijuhend soovib käitumuslikke, emotsioonile ja stimulatsioonile põhinevaid sekkumisi mõõduka kindlusega (moderate confidence), kognitsioonile suunitletud sekkumisi vähema kindlusega.

Kognitsioonile suunatud sekkumised (reaalsusele orientatsioon, kognitiivne stimulatsioon, oskuste treening ja rehabilitatsioon) - leiti mõningane ja ajutine positiivne efekt, kuid kokkuvõttes ei tasu ravi kulukus ja võimalik kõrvaltoimete risk (tõusnud frustratsioon, viha, depressioon) end ära (III).

Emotsioonile suunatud sekkumised (Reminiscence, valitatsioonimeetod, toetav psühhoteraapia, sensoorne integratsioon, simulated presence therapy) ei omanud kliiniliselt olulist efekti kognitsiooni, meeleolu ega käitumise osas (III).

Käitumisele suunatud sekkumised võivad olla efektiivsed meeleolu ja käitumishäirete (agressiivne käitumine) korral. Samas näidati, et efekt püsib vaid nii kaua, kuni kestab interventsioon. Käitumishäirete ravis soovitatakse esmalt proovida mittefarmakoloogilisi sekkumisi (II).

Stimulatsioonile suunatud sekkumised (mängud, lemmikloomad, muusikateraapia, kunst, füüsilised harjutused, multisensoorne stimulatsioon, aroomiteraapia, *simulated presence*) vähendavad käitumishäireid (agitatsioon) ja parandavad meeleolu.

Tõenduspõhisus on vähene, kuid *common sense* soovib kaasata dementse patsiendi ravis (II).

[I] Recommended with substantial clinical confidence

[II] Recommended with moderate clinical confidence

[III] May be recommended on the basis of individual circumstance

Psychosocial interventions improve or maintain cognition, function, adaptive behavior, and quality of life. Available research does not conclusively show which psychosocial intervention works best for which service setting, specific behavior, disease stage, or caregiver and patient profile. With the exception of possible frustration in patients who receive cognition-oriented therapies, there are no plausible harms associated with these interventions. Thus, despite limitations in supporting research, common sense continues to support their use in the care of all persons with dementia.

There's uncertainty about longterm benefits (benefits do not persist beyond the duration of interventions). The guideline recommends behavior-, emotion-, and stimulation-oriented approaches with moderate confidence and cognition-oriented approaches with less confidence.

Support programs for caregivers and patients with dementia significantly decreased the odds of institutionalization and improved caregiver well-being.

Cognition-oriented treatments include reality orientation and cognitive stimulation, training, and rehabilitation. The 2007 guideline described modest improvements with some of these cognition-oriented treatments but concluded that transient benefits may not justify the cost of treatment or the risk of adverse effects, such as increased frustration in some patients. New evidence remains consistent with that recommendation.

In a single communitybased randomized controlled trial, Clare et al. (2010) compared the efficacy of cognitive rehabilitation with relaxation therapy or no treatment in 69 persons with early-stage Alzheimer's disease. The eight weekly cognitive rehabilitation sessions consisted of personalized interventions to achieve participants' goals using practical aids and strategies, techniques for learning new information, practice in maintaining attention and concentration, and techniques for stress management. Cognitive rehabilitation produced improvement in goal performance and satisfaction, whereas the control treatments were not associated with any gains.

In a nursing home-based randomized controlled trial, Graessel et al. (2011) tested the efficacy of a group intervention comprising motor stimulation, practice in activities of daily living, and cognitive stimulation on cognition and function. At 12 months, compared with usual-care, the 98 intervention participants remained stable in cognitive and functional capacities, whereas controls declined. A literature review and meta-analysis of cognitive stimulation therapy for individuals with mild to moderate dementia found only a trend toward delayed cognitive decline (Yuill and Hollis 2011). Stimulation-oriented treatments (e.g., physical activity, music therapy, and multisensory stimulation) create opportunities for socialization; improve cognition and function; and aim to reduce behavior disorders, anxiety, and apathy. A meta-analysis of studies identified in the Cochrane database (Forbes et al. 2008) found insufficient evidence of effectiveness for physical activity to improve cognition, function, behavior, or depression.

A more recent systematic review with meta-analysis (Potter et al. 2011) found that physical activity improved physical function (e.g., walking, timed get-up-and-go) but had uncertain effects on mood and quality of life. Some, but not all, clinical trials of music therapy (Cooke et al. 2010;

Raglio et al. 2008; Sung et al. 2006) report positive outcomes (e.g., reduced agitation), but small samples, uncertain adherence to treatment protocols, and other limitations in research methods preclude strong recommendations. On the other hand, the lack of adverse effects supports their use.

5. David B. Hogan MD, et al. Diagnosis and treatment of dementia: 5. Nonpharmacologic and pharmacologic therapy for mild to moderate dementia. CMAJ 2008;179(10):1019

Ravijuhend, mis käsitleb dementsuse diagnoosi ja ravi aspekte. Mittefarmakoloogilise ravi soovitusel on ära toodud allpool (box 1). Kokkuvõtlikult ei ole piisavalt tõendeid, et kognitiivne treening, rehabilitatsioon omaks efekti kognitsiooni parandamises ja säilitamises kerge kuni mõõduka dementsuse korral. Leiti positiivset efekti ADL treeningul, kuid soovitude tegemiseks puudub piisav informatsioon. On infot, et individualiseeritud treeningprogrammid (*exercise programs*) parandavad kerge kuni keskmise raskusega dementsusel funktsionaalset sooritust.

Exercise programs: Benefits include increased strength, fitness, and improvements in cognitive and functional performance. A randomized controlled trial published after the consensus conference reported that a simple exercise program (1 hour twice a week), compared with routine medical care, was associated with a significantly slower rate of functional decline in nursing home residents with Alzheimer disease.

Box 1: Recommendations for nonpharmacologic interventions for the management of cognitive and functional limitations arising from mild to moderate dementia

- There is insufficient evidence to draw any firm conclusions about the effectiveness of cognitive training or cognitive rehabilitation in improving or maintaining cognitive and functional performance in people with mild to moderate dementia
- Further research is required to be able to conclude that cognitive training or cognitive rehabilitation is effective in improving cognitive and functional performance in people with mild to moderate dementia
- Although there is some indication of a beneficial impact on activities of daily living, there is insufficient evidence to draw firm conclusions about the effectiveness of environmental interventions in promoting functional performance in people with mild to moderate dementia
- There is good evidence to indicate that individualized exercise programs have an impact on functional performance in people with mild to moderate dementia
- For other nonpharmacologic interventions, there is insufficient evidence to draw any conclusions about their efficacy in improving or maintaining functional performance in people with mild to moderate dementia

6. Dementia: supporting people with dementia and their carers in health and social care. NICE 2006.

Ravijuhend, mida uuendati 2014. aastal, vaatleb dementsuse käsitlust (muuhulgas Alzheimeri tõve käsitlust). Tuuakse välja, et vaid kognitiivsel stimulatsioonil võib olla efekt kognitsiooni säilitamisel ja tuleks soovitada kerge kuni mõõduka dementsusega haigetele, sõltumata põhjusest.

1.6.1 Non-pharmacological interventions for cognitive symptoms and maintaining function

1.6.1.1 People with mild-to-moderate dementia of all types should be given the opportunity to participate in a structured group cognitive stimulation programme. This should be commissioned and provided by a range of health and social care staff with appropriate training and supervision, and offered irrespective of any drug prescribed for the treatment of cognitive symptoms of dementia.

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