

# Best Evidence Summaries of Topics in Mental Healthcare

**BEST** *in* **MH** *clinical question-answering service*

## Question

“In adults with dementia, how effective are group exercise interventions, compared to any other intervention, in improving patient outcomes?”

## Clarification of question using PICO structure

*Patients:* Adults with dementia

*Intervention:* Group exercise interventions

*Comparator:* Any other intervention

*Outcome:* Improving patient outcomes

## **Clinical and research implications**

There is some weak evidence, from one systematic review and one additional randomised controlled trial (RCT), that exercise interventions may have a small beneficial effect on cognition and ability to perform activities of daily living in people with dementia. The results of a second RCT indicated that exercise may significantly slow decline in physical function, but only where an intensive, tailored home-based exercise intervention was used. Studies included in the systematic review, and additional RCTs, were conducted in populations with differing severities of dementia, evaluated exercise programs with differing content, intensity and duration, and used different measurement scales to assess outcomes. Further research is needed on the effectiveness of exercise programs for patients with dementia; future studies should aim to standardise key intervention characteristics and should investigate possible variation in effectiveness according to severity of disease.

## **What does the evidence say?**

### *Number of included studies/reviews (number of participants)*

We identified one systematic review,<sup>1</sup> and two additional randomised controlled trials (RCTs),<sup>2,3</sup> which reported data relevant to this evidence summary. The systematic review included RCTs that compared exercise programs (any combination of aerobic, balance, and strength training) of any duration to usual care or a social contact intervention, in people with any type and severity of dementia.<sup>1</sup> Both additional RCTs were three arm trials.<sup>2,3</sup> One compared an exercise intervention (tai chi) to a cognitive intervention (mahjong) or a control (simple handicrafts); most (84%) of participants in this trial had very mild or mild dementia.<sup>2</sup> The second RCT compared a group exercise intervention to a tailored home-based exercise intervention or a control (usual community care); the majority (67%) of participants in this study had moderate or severe Alzheimer's disease (AD).<sup>3</sup>

### *Main Findings*

The systematic review found evidence of a borderline significant treatment effect, in favour of the exercise intervention, for measures of cognition (standard mean difference (SMD) 0.55 (95% CI: 0.02 to 1.09)) and measures of activities of daily living (ADL) (SMD 0.68 (95% CI: 0.08 to 1.27)), but no significant effect on measures of depression or challenging behaviour.<sup>1</sup> However, studies used to generate these summary estimates were conducted in populations with differing severities of dementia, evaluated exercise programs with differing content, intensity and duration, and used different measurement scales to assess outcomes.<sup>1</sup> The RCT that compared mahjong, tai chi and a control handicraft activity found significant differences in MMSE score between the mahjong and control groups and between the tai chi and control groups, at 6 and 9 months.<sup>2</sup> Over the 9-month period of the study, the control group dropped 2.9 points (95% CI: -4.2 to -1.7) on the MMSE, whereas the mahjong and tai chi groups gained 1.5 (95% CI: 0.0 to 3.0) and 1.3 (95% CI: 0.0 to 2.5) points, respectively.<sup>2</sup> The RCT that compared group exercise, tailored home-based exercise and a usual care control found that physical functioning on the Functional Independence Measure (FIM) declined less, over 12 months, in the exercise groups than in the control group.<sup>3</sup> However, the difference at 12 months was only significant for the tailored home-based exercise intervention.<sup>3</sup> Neither intervention showed a significant effect on Short Physical Performance Battery (SPPB) scores.<sup>3</sup>

### *Authors Conclusions*

On systematic review concluded that there is promising evidence that exercise programs can have a significant impact in improving ability to perform ADLs and possibly in improving cognition in people with dementia, although some caution is advised in interpreting these findings. The review also concluded that there was no evidence of a significant effect on challenging behaviours or depression and a lack of data for other outcomes of interest. One additional RCT concluded that mahjong and tai chi can preserve functioning or delay decline in some cognitive domains. A second RCT concluded that an intensive and long-term exercise program had beneficial effects on the physical functioning of patients with AD.

### *Reliability of conclusions/Strength of evidence*

One high quality Cochrane systematic review concluded that there was promising evidence that exercise programs can improve ability to perform ADLs and cognition in people with dementia.<sup>1</sup> However, it should be noted that the summary estimates supporting these conclusions were of borderline statistical significance and were derived from studies conducted in populations with differing severities of dementia, which evaluated exercise programs with differing content, intensity and duration, and used different measurement scales to assess outcomes.<sup>1</sup> One additional RCT, which compared a cognitive intervention (mahjong) to an exercise intervention (tai chi), or a control, found that both interventions were associated with a borderline significant improvement in Mini Mental State Examination (MMSE) score over 9 months, compared to control.<sup>2</sup> It should be noted that this study included mainly people with very mild or mild dementia, was poorly reported with respect to randomisation and allocation procedures, and used un-blinded outcome assessment procedures ( a potential source of bias).<sup>2</sup> The remaining RCT compared a group exercise program, a tailored home-based exercise program and a usual care control and concluded that long-term intensive exercise has beneficial effects on physical functioning in people with AD and had some methodological quality limitations.<sup>3</sup> Treatment effects were only observed for one of the two measures of physical function assessed and the difference between treatment and control, was only statistically significant for the tailored home-based exercise program.<sup>3</sup>

### **What do guidelines say?**

SIGN guidelines for the management of people with dementia (CG86, 2006) make the following recommendations regarding group exercise;

“The suggested benefits of exercise programmes for people with dementia include improvements in ambulatory status, walking endurance and urinary continence, but there is a lack of good quality evidence to support this.”

“Evidence from patients in residential care suggests that a combination of conversation and exercise on a structured basis may reduce deterioration in mobility in people with dementia but there is no evidence to support the use of either intervention in isolation.”

“Overall the clinical impact of physical activities on core or associated symptoms of dementia is minimal.”

“For people with dementia, a combination of structured exercise and conversation may

help maintain mobility.”

“For people with dementia, a combination of structured exercise and conversation may help maintain mobility.”

(pp.11)

“Individualised activities adapted to maximise the person’s remaining abilities and based on previous interests may be more beneficial to people with dementia than generic activities.” (pp.12)

NICE guidelines (CG42,2006)make the following recommendations regarding exercise but do not specifically comment on ‘group’ exercise;

“Health and social care staff should aim to promote and maintain the independence, including mobility, of people with dementia. Care plans should address activities of daily living (ADLs) that maximise independent activity, enhance function, adapt and develop skills, and minimise the need for support. When writing care plans, the varying needs of people with different types of dementia should be addressed. Care plans should always include:

...

physical exercise, with assessment and advice from a physiotherapist when needed.”

(pp.25)

“A range of tailored interventions, such as reminiscence therapy, multisensory stimulation, animal-assisted therapy and exercise, should be available for people with dementia who have depression and/or anxiety.”

(pp.36)

The evidence included in this summary is consistent with current guidelines.

**Date question received:** 13/02/2014

**Date searches conducted:** 17/02/2014

**Date answer completed:** 10/03/2014

## References

### SRs

1. Forbes, D., Thiessen, E.J., Blake, C.M., Forbes, S.C. and Forbes, S. (2013) Exercise programs for people with dementia. *Cochrane Database of Systematic Reviews*, Issue 12

### RCTs

2. Cheng S-T., Chow P.K., Song Y-Q., Yu E., Chan A.C.M., Lee T.M.C, and Lam J.H.M. (2014) Mental and Physical Activities Delay Cognitive Decline in Older Persons with Dementia. *Am. J. Geriatr. Psychiatry*;22(1):63-74.
3. Pitkala K.H., Poysti M.M., Laakkonen M-L., Tilvis R.S., Savikko N., Kautiainen H. and Strandberg T.E. (2013) Effects of the Finnish Alzheimer Disease Exercise Trial (FINALEX). *JAMA Internal Med*;173(10):894-901.

**Guidelines**

National Institute for Health and Care Excellence (2006) Dementia. Supporting people with dementia and their carers in health and social care. CG42. London: National Institute for Health and Care Excellence.

<http://www.nice.org.uk/nicemedia/live/10998/30318/30318.pdf>

Scottish Intercollegiate Guidelines Network (2006) Management of patients with dementia. A national clinical guideline. CG86. Edinburgh. Scottish Intercollegiate Guidelines Network.

<http://www.sign.ac.uk/pdf/sign86.pdf>

## Results

### Systematic Reviews

Author (year)	Search Date	Inclusion criteria	Number of included studies	Summary of results	Risk of bias
Forbes et al. (2013)	09/2011, 08/2012 and 10/2013	<p><i>Participants:</i> The majority of participants in trials had to be adults over 65 years diagnosed as having dementia using accepted criteria such as DSM-III-R/DSM-IV, ICD-10 or CERAD-K.</p> <p><i>Intervention:</i> Any exercise program with any combination of aerobic-, strength- or balance-training (any duration).</p> <p><i>Comparator:</i> Usual care or social contact/activities</p> <p><i>Outcomes:</i> Primary outcomes; cognition, activities of daily living (ADL), challenging behaviour, depression and mortality of people with dementia. Secondary outcomes; caregiver burden, quality of life and mortality. Use of healthcare services by people with dementia and their family caregivers.</p> <p><i>Study design:</i> Randomised controlled trails (RCTs), (parallel group or cross-over).</p>	17 data sets, from 16 studies were included in the review.	<p>This systematic review aimed to assess the effects of exercise programs for older people with dementia on cognition, activities of daily living (ADLs), challenging behaviour, depression, healthcare service use and mortality. It also aimed to assess effects on family caregivers' burden, quality of life, and mortality.</p> <p>Included studies were conducted in people with varying disease severity, from studies which included only people with mild dementia, to studies which included only people with severe Alzheimer's disease (AD); sample size ranged from 12 to 191. In all cases, the majority of study participants were female, and ten studies reported a mean age for participants of &gt;80 years. The content, intensity and duration of exercise programs varied. Content was classified as aerobic and/or strength and/or balance. The duration of the intervention ranged from 2</p>	<p>Clear research objectives were defined and inclusion criteria were reported.</p> <p>Searches used ALOIS, the Cochrane Dementia and Cognitive Improvement Group's Specialised Register, which is up-dated monthly from a number of bibliographic databases. The search strategy also included grey literature sources. There were no language</p>

			<p>weeks to 1 year, and intensity ranged from 20 minutes 3x/week to 30 minutes daily. For most included studies, the comparator was either a social contact intervention or usual care. The main potential source of bias in included studies was in relation to non-blinding of study participants and personnel (a consequence of the nature of the intervention).</p> <p><b>Cognition:</b> Where all studies (n=8) were included in the analysis, there was a borderline positive effect in favour of exercise; SMD 0.55 (95% CI: 0.02 to 1.09). When studies conducted in people with moderate to severe dementia were excluded, there was no statistically significant difference between the exercise and control groups.</p> <p><b>ADL:</b> Based on data from six studies, there was a borderline positive effect in favour of exercise SMD 0.68 (95% CI: 0.08 to 1.27). Severity of dementia varied across the six studies, from a study that included only people with mild AD to a study that included only people with severe AD; no subgroup analyses were presented.</p>	<p>restrictions.</p> <p>The review process included measures to minimise error and/or bias (involvement of at least two reviewers throughout).</p> <p>The methodological quality of included studies was assessed using the Cochrane risk of bias tool.</p> <p>Summary estimates were calculated where studies used the same outcome measure (cognition, ADL, or depression, not necessarily using the same scale). A fixed effect model was used where the <math>I^2</math> statistic</p>
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				<p><b>Depression:</b> Based on data from five studies, there was no statistically significant difference between the exercise and control groups. Studies included people with mild-moderate, mild-severe, or moderate-severe dementia; no subgroup analyses were presented.</p> <p><b>Challenging behaviour:</b> The only study to report data on challenging behaviours was conducted in people with mild to moderate AD (n=110) and reported no significant difference between the exercise and control groups.</p>	<p>(measure of between study heterogeneity) was &lt;30%; otherwise a random effects model was use. Where available, intention-to-treat (ITT) data were used in meta-analyses. Analytical methods were broadly appropriate, but summary estimates should be interpreted cautiously due to the variety of content, intensity and duration of the exercise programs evaluated by included studies, as well as variation in the comparator condition. One sensitivity analysis was conducted to</p>
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					explore the effect of excluding trials in people with moderate- severe dementia.
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### RCTs

Author (year)	Inclusion criteria	Number of participants	Summary of results	Risk of bias
Cheng et al. (2014)	<p><i>Participants:</i> Participants were recruited from 9 nursing homes in Hong Kong. Inclusion criteria; MMSE score of 10-24, suffering from at least very mild dementia. Exclusion criteria; being bedbound, audio/visual impairment, regular activity participation before study or contradictions for physical or group activities.</p> <p><i>Intervention:</i> Tai-Chi, a seated 12-form Yang style tailor made for frail individuals. 1 hour, 3 times a week for 12 consecutive weeks.</p> <p><i>Comparator:</i> Mahjong (136 tiles version) or simple handicrafts which involved connecting beads to create different shapes. All 1 hour, 3 times a week for 12 consecutive weeks.</p>	n=110 (Tai Chi n=39, Mahjong n=36, simple handicraft n=35)	<p>This study aimed to assess the effects of cognitive stimulation (mahjong) and physical exercise (tai chi) on cognitive performance in people with dementia, compared with a control condition of simple handicrafts activities.</p> <p>The mean age of study participants was approximately 81 years and the majority were female. With the exception of diastolic blood pressure, there were no significant baseline differences between the three groups with respect to demographic characteristics, measures of general health, depression, or cognition. Most study participants had a Clinical Dementia Rating (CDR) indicative of very mild dementia (46%) or mild dementia (38%); the remaining 16% had moderate dementia.</p> <p>MMSE: The effects of mahjong and tai chi, compared to control, varied by time. Significant differences between the groups occurred at 6 and 9 months only. The difference in MMSE</p>	<p>The study was described as a cluster randomised trial, with no further details reported.</p> <p>Due to the nature of the intervention and the difficulty in preventing participants from talking about the intervention to interviewers,</p>













	<p><i>Outcomes:</i> Primary outcome; MMSE score. Secondary outcomes; immediate/delayed recall, categorical fluency and digit span.</p>		<p>between tai chi and control was 2.3 (95% CI: 0.4 to 4.2) and 3.7 (95% CI: 1.4 to 6.0) points, at 6 and 9 months respectively. The difference in MMSE between mahjong and control was 3.0 (95% CI: 0.9 to 5.0) and 4.5 (95% CI: 2.0 to 6.9) points, at 6 and 9 months respectively. Over the 9-month period of the study, the control group dropped 2.9 points (95% CI: -4.2 to -1.7) on the MMSE, whereas the mahjong and tai chi groups gained 1.5 (95% CI: 0.0 to 3.0) and 1.3 (95% CI: 0.0 to 2.5) points, respectively.</p> <p>Secondary outcomes: Despite an overall significant interaction with time, the individual means for the mahjong and tai chi groups, on any secondary outcome measure, were not significantly different from those of the control group at all time points.</p>	<p>participants, study personnel and outcome assessors were all un-blinded.</p> <p>ITT analyses were reported.</p> <p>Results were reported for all specified outcomes.</p>
Pitkala et al. (2013)	<p><i>Participants:</i> Patients on the AD drug reimbursement register of the Social Insurance Institution of Finland who were living at the same address as their spouse. Inclusion criteria: fulfilled the criteria for diagnosis of probable AD according to NINCDS-ADRDA; aged 65 years or older; able to walk with or without a mobility aid; no other terminal disease; at least 1 of fall during the past year, decreased walking speed, or unintentional weight loss.</p> <p><i>Intervention:</i> Group based exercise, 4-hour sessions</p>	<p>n=210, (group exercise program n=61, home based exercise program n=68, control n=65).</p>	<p>This study aimed to assess the effects of intense and long-term exercise on the physical functioning and mobility of home-dwelling patients with AD.</p> <p>The mean age of study participants was approximately 78 years and the majority were female. 67.1% suffered from moderate or severe AD according to the CDR and 96% were receiving AD medication. There were no apparent baseline differences between the groups with respect to demographic characteristics, number of medications, or measures of function and cognition.</p> <p>FIM: Functioning deteriorated over time in all groups, but</p>	<p>The randomisation Used a computer-generated sequence; numbers received by telephone from a randomisation centre. Randomisation centre did not</p>


	<p>with approximately 1-hour training, twice a week for 1 year. Classes followed a predetermined exercise program consisting of endurance, balance, strength training and exercised for improving executive functioning.</p> <p><i>Comparator:</i> Tailored home-based exercise, 1-hour training twice a week for 1 year or control group receiving usual community care.</p> <p><i>Outcomes:</i> Physical functioning (Functional Independence Measure (FIM)) and mobility (Short Physical Performance Battery (SPPB)) and information on the use and costs of social and health care services.</p>		<p>deterioration was less in the exercise groups than in the control group. Over the 12 month period of the study, the FIM change was -7.1 (95% CI: -3.7 to -10.5) in the home exercise group, -10.3 (95% CI: -6.7 to -13.9) in the group exercise group, and -14.4 (95% CI: -10.9 to -18.0] in the control group. The difference between the home exercise group and the control group was significant at 6 (<math>P = .001</math>) and 12 (<math>P = .004</math>) months, but there was no significant difference between the group exercise and control groups at either time point. The changes in the FIM motor function scores differed significantly between the groups, but no differences in the FIM cognitive scores were observed (no data reported).</p> <p>SPPB: There were no significant differences in SPPB scores between the groups.</p>	<p>know the identities of the potential participants.</p> <p>The nature of the intervention precluded blinding of participants and study personnel, however, outcome assessors were blind to treatment group.</p> <p>ITT analyses were reported.</p> <p>Full results were not reported for SPPB.</p>
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### Risk of Bias: SRs


Author (year)	Risk of Bias				
	Inclusion criteria	Searches	Review Process	Quality assessment	Synthesis
Forbes et al. (2013)					

### RCTs

Study	RISK OF BIAS					
	Random allocation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective Reporting
Cheng et al. (2014)						
Pitkala et al. (2013)						

 Low Risk

 High Risk

 Unclear Risk

## Search Details

Source	Search Strategy	Number of hits	Relevant evidence identified
<b><i>SRs and Guidelines</i></b>			
NICE	Dementia AND exercise	106	2
DARE	1 (group*) 2 MeSH DESCRIPTOR Group Processes EXPLODE ALL TREES 3 (exercis*) 4 (physical adj3 activit*) 5 (fitness) 6 (sport) 7 (physical adj2 (intervention* OR therap* OR activit*)) 8 MeSH DESCRIPTOR Exercise EXPLODE ALL TREES 9 MeSH DESCRIPTOR Sports EXPLODE ALL TREES 10 MeSH DESCRIPTOR Physical Fitness EXPLODE ALL TREES 11 (dement*) 12 MeSH DESCRIPTOR Alzheimer Disease EXPLODE ALL TREES 13 MeSH DESCRIPTOR Dementia EXPLODE ALL TREES 14 MeSH DESCRIPTOR Lewy Body Disease EXPLODE ALL TREES 15 (alzheimer*) 16 #1 OR #2 17 #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 18 #11 OR #12 OR #13 OR #14 OR #15 19 #16 AND #17 20 #18 AND #19	95	
<b><i>Primary studies</i></b>			
CENTRAL	#1 Dementia:ti,ab,kw 4727	131	

	#2 Alzheimer*Alzheimer* 5228 #3 MeSH descriptor: [Dementia] explode all trees 3568 #4 #1 or #2 or #3#1 or #2 or #3 8268 #5 "physical activity""physical activity" 7178 #6 exercise 43454 #7 MeSH descriptor: [Exercise] explode all trees 12693 #8 #5 or #6 or #7 47661 #9 group or groups or classes 342157 #10 #4 and #8 and #9 = 131		
Embase	1. EMBASE; *DEMENTIA/; 40027 results. 2. EMBASE; dementia.ti,ab; 88194 results. 3. EMBASE; alzheimer*.ti,ab; 116149 results. 4. EMBASE; 1 OR 2 OR 3; 178521 results. 6. EMBASE; "physical activity".ti,ab; 71302 results. 7. EMBASE; exercise.ti,ab; 215201 results. 8. EMBASE; exp EXERCISE/; 204600 results. 9. EMBASE; exp PHYSICAL ACTIVITY/; 225698 results. 12. EMBASE; group-activit*.ti,ab; 1184 results. 13. EMBASE; group-intervention*.ti,ab; 3089 results. 14. EMBASE; group-based.ti,ab; 4442 results. 15. EMBASE; 12 OR 13 OR 14; 8641 results. 16. EMBASE; 6 OR 7 OR 8 OR 9; 492854 results. 17. EMBASE; 15 AND 16; 1074 results. 18. EMBASE; group-exercis*.ti,ab; 1117 results. 19. EMBASE; group-physical.ti,ab; 286 results. 20. EMBASE; exercise-class*.ti,ab; 490 results. 21. EMBASE; 18 OR 19 OR 20; 1831 results. 22. EMBASE; 17 OR 21; 2846results. 23. EMBASE; 4 AND 22; 53 results.	53	
Medline	33. MEDLINE; *DEMENTIA/; 27364 results.	12	

	<p>34. MEDLINE; dementia.ti,ab; 63620 results.</p> <p>35. MEDLINE; alzheimer*.ti,ab; 87340 results.</p> <p>36. MEDLINE; 33 OR 34 OR 35; 132460 results.</p> <p>37. MEDLINE; "physical activity".ti,ab; 53200 results.</p> <p>38. MEDLINE; exercise.ti,ab; 170618 results.</p> <p>39. MEDLINE; exp EXERCISE/; 114492 results.</p> <p>40. MEDLINE; exp PHYSICAL ACTIVITY/; 188093 results.</p> <p>41. MEDLINE; 37 OR 38 OR 39 OR 40; 325072 results.</p> <p>43. MEDLINE; group-activit*.ti,ab; 934 results.</p> <p>44. MEDLINE; group-intervention*.ti,ab; 1641 results.</p> <p>45. MEDLINE; group-based.ti,ab; 3242 results.</p> <p>46. MEDLINE; 43 OR 44 OR 45; 5771 results.</p> <p>47. MEDLINE; 41 AND 46; 596 results.</p> <p>48. MEDLINE; group-exercis*.ti,ab; 791 results.</p> <p>49. MEDLINE; group-physical.ti,ab; 214 results.</p> <p>50. MEDLINE; exercise-class*.ti,ab; 311 results.</p> <p>51. MEDLINE; 47 OR 50; 899 results.</p> <p>52. MEDLINE; 36 AND 51; 12 results.</p>		
PsycINFO	<p>58. PsycINFO; *DEMENTIA/; 20146 results.</p> <p>59. PsycINFO; dementia.ti,ab; 41445 results.</p> <p>60. PsycINFO; alzheimer*.ti,ab; 38456 results.</p> <p>61. PsycINFO; 58 OR 59 OR 60; 64227 results.</p> <p>62. PsycINFO; "physical activity".ti,ab; 16727 results.</p> <p>63. PsycINFO; exercise.ti,ab; 31639 results.</p> <p>64. PsycINFO; exp EXERCISE/; 16200 results.</p> <p>65. PsycINFO; exp PHYSICAL ACTIVITY/; 22805 results.</p> <p>66. PsycINFO; 62 OR 63 OR 64 OR 65; 47772 results.</p> <p>67. PsycINFO; group-activit*.ti,ab; 1687 results.</p> <p>68. PsycINFO; group-intervention*.ti,ab; 2704 results.</p> <p>69. PsycINFO; group-based.ti,ab; 2423 results.</p> <p>70. PsycINFO; 67 OR 68 OR 69; 6736 results.</p> <p>71. PsycINFO; 66 AND 70; 316 results.</p>	18	

	72. PsycINFO; group-exercis*.ti,ab; 364 results. 73. PsycINFO; group-physical.ti,ab; 90 results. 74. PsycINFO; exercise-class*.ti,ab; 197 results. 75. PsycINFO; 72 OR 73 OR 74; 628 results. 76. PsycINFO; 71 OR 75; 922 results. 77. PsycINFO; 61 AND 76; 18 results.		
<b>Summary</b>	<b>NA</b>	<b>NA</b>	

### Disclaimer

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