Royal College of Occupational Therapists

Occupational therapy practice guideline for dementia: supporting prevention, participation and living well

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Royal College of Occupational Therapists

Table of contents

1. Introduction

1.1 Purpose of the guideline

The purpose of this guideline is to provide evidence-based recommendations for occupational therapists working with people living with dementia, regardless of setting. The recommendations are based on high-quality contemporary research evidence and are intended to support informed, person-centred occupational therapy practice.

The guideline is relevant to the whole of the occupational therapy workforce, recognising the breadth of the profession and that occupational therapists across all roles and settings may work with people living with dementia and their families, carers and supporters. The guideline aims to help ensure that people living with dementia are offered a consistent, evidence-based occupational therapy approach, irrespective of service context or professional specialism.

1.2 Scope of the guideline

The guideline seeks to answer the following questions:

What is best practice for occupational therapists when:

a. working with people to modify their lifestyle with the goal of reducing the risks associated with the development of dementia?
b. working with people diagnosed with dementia and their families, carers and supporters by enabling engagement in occupations with the goal of maximising personal outcomes from diagnosis to end of life?

The guideline recommendations are based on systematic review evidence relevant to occupational therapy regarding:

- strategies and interventions to reduce the risk of developing dementia
- assessments, interventions and outcomes involving and concerning people diagnosed with all dementia (all forms and stages)
- families, carers and supporters of people diagnosed with dementia.

1.3 Target audience

This guideline is primarily targeted at the 47,000-plus UK occupational therapy workforce, including learners and support workers, working in all setting such as the NHS, primary care, acute care, social care, prisons and in the community. However, we anticipate it will be useful for managers and occupational therapists to share these recommendations with commissioners and leaders responsible for occupational therapy service provision. We also recognise that people living with dementia and their families, carers and supporters may use the guideline to understand what they can expect from occupational therapists and the benefits of engaging with occupational therapy. Finally, this guideline is a basis for promoting the value of occupational therapy to policymakers and policy implementers.

1.4 Guiding principles and values

This guideline reflects the holistic practice of occupational therapy: that wellbeing can be experienced through the dynamic interaction between person, environment, and occupation. Our recommendations identify the value of prioritising person-centred care, choice, autonomy and meaningful participation. They also aim to reduce stigma, and address dementia risk reduction. We support a rehabilitative approach that recognises independence may be redefined over time, with

success measured by the person's ability to engage meaningfully in chosen occupations with appropriate support over time.

People living with dementia and their families, carers and supporters have been involved in the development of this guideline. Their lived experience has been used to inform both the scope and the subsequent recommendations. Through our discussions, we heard that:

- we should include the term 'supporters' in this document to acknowledge that many people may live alone without family members or carers
- effective occupational therapy depends upon therapists taking time to genuinely know the person and understand their current needs, preferences and circumstances, which may change over time
- person-centred care means listening carefully, asking 'What matters to you today?' and recognising that if a person declines one offer this does not mean rejecting support
- clear communication about what occupational therapy can and cannot do and maintaining connections even when people are waiting for or initially declining services is important.
- occupational therapists must ensure that they are aware of the wider support available to people in their local community and assist them to access this.

1.5 Equity and social determinants of health

Social determinants of health such as income, housing, social support, access to services, and cultural context, significantly affect people's experience of dementia and their ability to access timely support. Occupational therapists implementing these recommendations should:

- tailor interventions to each person's unique background, preferences and circumstances
- recognise and address barriers to accessing services (e.g. transport, digital literacy, language, financial constraints, geographic isolation)
- acknowledge cultural and ethnic diversity in beliefs and practices around dementia and caregiving
- consider how economic and social resources shape health outcomes
- advocate for local and national policy changes that address broader social determinants affecting people with dementia and their supporters

1.6 Using the guideline

This guideline should be used in conjunction with the current versions of the following professional practice documents (knowledge of and adherence to these standards is assumed):

- *Standards of conduct, performance and ethics* (Health and Care Professions Council [HCPC] 2024).
- *Standards of proficiency – occupational therapists* (HCPC 2023).
- *Professional standards of practice, conduct and ethics for occupational therapy* (RCOT in press).

Dependent on the location of their practice, occupational therapists should also be familiar with their relevant dementia strategies and the following:

- *Dementia: assessment, management and support for people living with dementia and their carers* (National Institute for Health and Care Excellence [NICE] 2018, reviewed 2025)
- *Assessment, diagnosis, care and support for people with dementia and their carers* (Scottish Intercollegiate Guidelines Network [SIGN] 2023).

This guideline should be used alongside the therapist’s clinical reasoning and professional expertise and a person-centred understanding of the needs of the person living with dementia and their

families, carers and supporters. Therapists are responsible for interpreting and applying the recommendations within their specific service context, recognising that local resources, roles and services and pathways will vary.

2. Background

2.1 Why this guideline is needed

Until now there has been no UK-wide, profession-specific, evidence-based guidance for occupational therapists working with people diagnosed with dementia and their families, carers and supporters in the UK. This guideline is a priority for several reasons:

- Evidence suggests that up to 45% of dementia could be prevented or delayed by addressing modifiable risk factors (Livingston et al 2024), many of which can be addressed through occupational therapy interventions. There is emerging evidence to support occupation-based health promotion across the lifespan to reduce the risk of dementia. This links directly to RCOT's commitment to public health (RCOT 2024a).

- Occupational therapists in the UK working across different practice settings are highly likely to encounter people diagnosed with dementia and their families, carers and supporters. There are an estimated 885,000 people with dementia living in the UK, and this is projected to rise to around 1.6 million people by 2040 (Wittenberg et al 2019). Whilst dementia primarily affects those aged 85 and over, it can develop at any age including childhood (Alzheimer Scotland 2025). Dementia prevalence is also linked to deprivation and health inequalities (Carnell Farrar 2024). Finally, people living with dementia are more likely to have several other health conditions, meaning their care needs are often complex (Public Health England 2019).

- Dementia has a significant impact on the person's ability to do the things they want and need to do. It also has a significant impact upon the people that support them. Addressing these aspects is a core focus for occupational therapists and there is emerging evidence of the benefits of occupational therapy for people diagnosed with dementia and their families, carers and supporters. Occupational therapists therefore need to be confident in their practice and assured that they are aware of and compliant with evidence-based practice recommendations.

- The landscape of dementia diagnosis and treatment is evolving because of scientific and research advances. Increasing emphasis on 'precision' diagnosis and care (Alzheimer's Disease International 2025) is enabling dementia to be identified earlier and with greater reliability. This creates greater opportunities for occupational therapists to work with people in the earlier stages of dementia, supporting the timely delivery of person-centred, evidence-based rehabilitation and self-management interventions that help people to remain independent at home for as long as they choose.

- People with lived experience of dementia are best placed to advocate for what matters to them and what they need; it is essential that occupational therapists listen and respond accordingly. It is our professional responsibility to promote inclusion, rights and opportunities for people living with dementia to engage in their chosen occupations (WFOT 2022; Maclean et al 2023).

2.2 Inequalities and dementia

People affected by dementia do not all experience equal access to diagnosis and care. Inequalities can arise due to factors including age, sex, ethnicity, socioeconomic circumstances, type of dementia, disability, sexuality, and religion. For example, young onset and rarer forms of dementia

often take longer to diagnose, women are more likely to both develop dementia and take on caring responsibilities, and people from minority ethnic groups may receive diagnoses later and at a more advanced stage due to cultural, linguistic, and service barriers. People living in deprived or rural areas are also more likely to experience delayed or less accurate diagnoses. Individuals with intellectual disabilities, particularly those with Down's syndrome, are at a much higher risk of developing dementia, yet diagnosis can be more complex because symptoms may present differently and communication difficulties can make changes harder to identify. In addition, people from LGBTQ+ communities, different religious backgrounds, and those with disabilities are often underrepresented in research, meaning their specific needs may not be fully understood or supported. These disparities can affect dementia prevention, diagnosis, post-diagnostic support, access to treatments, and participation in research (Giebel 2024; Hodgson et al. 2024; Mukadam 2025). Occupational therapists contribute to reducing these inequalities through providing culturally sensitive individualised and accessible support.

2.3 Context

Existing evidence-based guidelines and dementia pathway frameworks across the four nations of the UK identify recommendations for all services and relevant stakeholders, including occupational therapists. These all recommend that people living with dementia should be provided with support and enabling approaches to live as well as possible. The focus should be on empowering people with dementia and their families, carers and supporters by providing stage-appropriate, personalised interventions that support functioning and independence, for as long as possible, wellbeing and meaningful relationships (NHS England 2016; NICE 2018; Northern Ireland Department of Health and Social Care 2018; SIGN 2023; Scottish Government 2023 and 2024; UK Government 2025; Welsh Government 2025).

Nevertheless, diagnosis and treatment for dementia vary regionally within and across the UK. There is clear scope to improve practice and reduce inconsistencies, particularly in service access and provision of non-pharmacological approaches, including those provided by occupational therapists. Current healthcare often remains medication-focused, with less consistent access to, and awareness of, interventions that support social health, memory and occupational functioning (SIGN 2023). Treatment should be recognised as extending beyond pharmacological therapies to include other interventions that promote quality of life, an approach supported by the development of Scottish and Welsh frameworks for Allied Health Professional practice in dementia (Welsh Government 2022; Alzheimer Scotland 2024). However, there remains scope to extend and embed this across the UK to unify practice, increase visibility and address challenges of resource capacity, systems and the competing demands and focus currently experienced by occupational therapists.

This guideline aims to support all occupational therapists in the UK to provide quality occupational therapy interventions when working with people living with dementia and their families, carers and supporters, regardless of setting. The evidence base highlights that occupational therapists have a significant and valuable contribution to make at specialist, targeted and universal levels to the lives of people living with dementia and their families, carers and supporters, and to implement what people with lived experience tell us is important to them.

3. Recommendations

The following recommendations are underpinned by the systematic review research evidence available which supports the delivery of occupational therapy for people living with dementia and their families, carers and supporters and for dementia risk reduction.

Recommendations are graded A or B based on the quality of the supporting research evidence:
Grade A (High evidence): Occupational therapists should implement this recommendation.
Grade B (Moderate evidence): Occupational therapists should consider implementing this recommendation based on individual needs or circumstances of the person or group they are working with.

Recommendations with low-level evidence (Grade C) are not included in this guideline.

Information about the individual systematic reviews (for example, research aim, methodological limitations and findings) can be accessed in the evidence tables (Appendix 2).

The absence of a recommendation on a particular topic does not imply that occupational therapists should not address it in their practice. This guideline is based on systematic review evidence; therefore, other aspects of occupational therapy practice with people living with dementia may be informed by other evidence sources, clinical expertise and professional judgement and the needs and preferences of individuals. Areas where evidence is limited have been identified to inform recommendations for future research.

3.1 Foundational principles

	Recommendation	Recommendation strength
1.	Consider undertaking observation-based assessments within familiar settings where people undertake their occupations, being aware of the impact of the environment. Involve people in decision-making about their care based on their goals and aspirations. (Anselmo et al 2025 [B]; Innes at al 2025 [B])	B
2.	Ensure that all assessments and interventions take into account cultural traditions, beliefs and customs, particularly for people from migrant communities and ethnic minority groups. (Stenberg & Hjelm 2023 [A])	A
3.	Create environments and opportunities where people living with dementia can contribute to and engage in occupations that have meaning to the person, are culturally appropriate and maintain links with others from across their life stages. (Woodbridge et al 2018 [A])	A
4.	Use occupation to assist the person living with dementia to maintain optimum physical and psychological health, tailoring the occupation to	A

	Recommendation	Recommendation strength
	the person's hobbies, interests and their changing needs as the dementia progresses. (Strick et al 2021 [A])	
5.	Use a cognitive approach as part of a multimodal non-pharmacological approach when working with people living with dementia to maintain and improve cognitive function. (Ham et al 2021 [A]; Xiang and Zhang 2024 [A]; Tulliani et al 2022 [A]; Sung et al 2023 [A]; Smallfield and Heckenlaible 2017 [B])	A
6.	Consider early intervention tailoring approaches according to dementia subtype and working collaboratively within multidisciplinary teams and with families, carers and supporters to improve self-identity, mood and sense of purpose for the person living with dementia. (Vlotinou et al 2023 [B])	B
7.	Consider, if appropriate to the needs of the person living with dementia, addressing sexuality in occupational therapy assessments and interventions. (Kong et al 2025 [B])	B

3.2 Modifiable risk factors for dementia

	Recommendation	Recommendation strength
8.	Offer occupation-based health promotion advice and interventions across the life course to support reducing the risk of developing dementia. This could include advising on the benefits of learning new things and participating in leisure activities that involve cognitive engagement and social activities. (Da Silva et al 2025 [A]; Fallahpour 2016 [A]; Su et al 2022 [B])	A

3.3 Occupation

	Recommendation	Recommendation strength
9.	Provide and support individualised occupation-based interventions for people living with dementia to enhance engagement and social participation, promote identity, self-worth, sense of purpose and support psychological wellbeing and quality of life. This should be available for people with young onset dementia and across all life stages and in all settings. (Ruíz-Hernández et al 2023 [A]; Scott et al 2022 [A]; Houghton et al 2022 [A]; Zhang et al 2025 [A]; Laver et al 2016 [A]; Lewis et al 2017 [A]; Batubara et at 2022 [A]; Dorris et al 2021[B]; Smallfield and Heckenlaible 2017 [B])	A

	Recommendation	Recommendation strength
10.	Recommend animal-assisted interventions for people living with dementia to reduce depression levels, noting no significant effects on cognitive function, neuropsychiatric syndrome or independence in activities of daily living. (Batubara et al 2022 [A])	A

3.4 Environment

	Recommendation	Recommendation strength
11.	Consider environmental interventions for managing distressed behaviour symptoms and falls prevention in people living with dementia. These might include music, multisensory interventions, person-centred tailored design and environmental modification as part of a multifaceted approach. (Jensen and Padilla 2017 [B])	B

3.5 Technologies

	Recommendation	Recommendation strength
12.	Use digital technologies to support people living with dementia and their families, carers and supporters, selecting technology based on individual need and personal goals, and ensuring technologies are accessible and easy to interact with. (Sweeney et al 2021 [A]; Goodall et al 2021 [A])	A
13.	Adapt and customise assistive technology to the individual needs of both the person living with dementia and their families, carers and supporters, including consideration of carers' skills and comfort with technology, to prevent abandonment of devices. (Sriram et al 2019 [A])	A
14.	Provide person-centred and family-centred information about specific uses and benefits of different categories of assistive technologies to people living with dementia and their families, carers and supporters, recognising that perceived usefulness may not always correlate with measurable outcomes. (Sriram et al 2019 [A])	A
15.	Use everyday technologies (such as smartphones, tablets and computers) for people living with dementia to maintain sense of identity through achievement, enable current interests, engage in reminiscence and storytelling, and enhance carer-person relationships, providing	A

	Recommendation	Recommendation strength
	social scaffolding matched to individual needs and abilities as a normalised part of learning. Sweeney et al 2021 [A])	

3.6 Home-based interventions in community settings

	Recommendation	Recommendation strength
16.	Provide multicomponent home-based interventions for people living with dementia that are tailored to the individual's needs, incorporating occupation-focused interventions and environmental adaptations/modifications. (Clarkson et al 2017 [A]; Rahja et al 2018 [A]; Bennett et al 2019 [A]; Tan et al 2022 [A]; Scott et al 2019 [A]; Raj et al 2021 [A]; Chester et al 2024 [A])	A
17.	Provide home-based interventions that include both the person living with dementia and where appropriate their families, carers or supporters, providing psychoeducation and skills training for caregivers in communication, task simplification and compensatory intervention strategies embedded within daily routines. (Clarkson et al 2017 [A]; Rahja et al 2018 [A]; Bennett et al 2019 [A]; Tan et al 2022 [A]; Scott et al 2019 [A]; Raj et al 2021 [A]; Chester et al 2024 [A])	A
18.	Provide occupational therapy in community settings for people living with dementia using physical activity and rehabilitation, cognitive stimulation and therapeutic use of music, animals and art, either combined or applied in isolation and maintained over time, to delay cognitive decline, maintain participation in daily activities, slow disease progression and support independent living at home, particularly in the early phase of dementia. (Ruíz-Hernández et al 2023 [A])	A

3.7 Occupation to support transitions of care

	Recommendation	Recommendation strength
19.	Assess and address the occupational needs of the person living with dementia during all transitions of care, applying a person-led approach, a comprehensive assessment, ensuring the therapeutic activities and occupational interventions match the individual interests, abilities, preferences, and needs. (Groenendaal et al 2022 [A])	A

	Recommendation	Recommendation strength
20.	Advocate for interdisciplinary collaboration between health and social care professionals across health and care settings during all phases of transitions. Ensure the person living with dementia remains central to all decisions, and that families, carers and supporters are actively involved throughout the process. (Groenendaal et al 2022 [A])	A

3.8 Occupation to support quality of life in care settings

	Recommendation	Recommendation strength
21.	Provide and/or support the delivery of personalised, occupation-focused interventions focused on activities and occupations for people living with dementia in care settings. Activities provided should follow recommendations 22-24 to enhance quality of life, reduce any stress and distress and improve mood and psychological wellbeing. (Uceda-Portillo et al 2024 [A]; Du Toit et al 2019 [A]; Travers et al 2016 [A]; Saragih et al 2022 [A]; van der Valde-van Buuringen et al 2023 [A])	A
22.	Support the use of multisensory environments to improve the occupational engagement of people in the later stages of dementia, using all sensory modalities in a person-led, individualised approach with the goal of improving the person's mood, decreasing any signs of stress and reducing distress. (Cusic et al 2022 [A])	A
23.	Offer reminiscence therapy for people with dementia living in care settings to increase cognitive function and quality of life and reduce depressive and neuropsychiatric symptoms, noting that it does not significantly reduce dependency in activities of daily living. (Saragih et al 2022 [A])	A
24.	Provide person-centred garden activities for people with dementia in care settings including sitting, walking, socialising, having refreshments or meals outdoors, gardening and outdoor therapy, to improve quality of life and reduce behavioural and psychological symptoms of dementia. (van der Velde-van Buuringen et al 2023 [A])	A

3.9 Families, carers and supporters

	Recommendation	Recommendation strength
25.	**Original wording**: Provide tailored multicomponent psychoeducation and skills training to families, carers and supporters, including information about dementia, education, skills practice, environmental modifications, communication skills and problem-solving, to enhance confidence and competence in supporting the person living with dementia. (Ghosh et al 2023 [A]; Huis in het Veld et al 2015 [A]; Vandepitte et al 2016 [B]; Cheng and Zhang 2020 [B]; Abrahams et al 2018 [B]; Verrier Piersol et al 2017 [B])	A
26.	Support families, carers and supporters to maintain their own health and wellbeing, offering advice and interventions addressing sleep, social support, leisure activities, shared meaningful experiences with the person living with dementia (such as hobbies, walking, spiritual practices and music) and access to respite. (Waligora et al 2019 [A]; Stenberg and Hjelm 2023 [A]; Wiegelmann et al 2021 [B]; Cheng and Zhang 2020 [B])	A
27.	Recommend assistive technology to support families, carers and supporters assisting a person living with dementia at home, including technology that supports safety and security, memory and orientation and social and leisure activities. (Sriram et al 2019 [A])	A

3.10 Intellectual disabilities

	Recommendation	Recommendation strength
28.	Consider structured, personalised psychosocial interventions for people with intellectual disabilities and dementia to improve mood, communication, engagement, cognition, daily functioning and quality of life, achieving individual goals related to mood, engagement, safety and independence. (Muralidhar et al 2024 B])	B

4. How the evidence informed the recommendations

This section summarises how the available evidence was interpreted to inform the recommendations, including consideration of the strength, consistency and applicability of the evidence and, where applicable, the professional judgement of the Guideline development group.

4.1 Foundational principles

Evidence from multiple systematic reviews consistently suggests that person-centred, occupation-focused approaches underpin effective occupational therapy for people living with dementia. Assessment conducted within familiar environments supports more accurate identification of preserved abilities and functional performance, as standardised or proxy measures may underestimate ability, particularly in non-institutional settings (Anselmo et al 2025). However, variability in assessment approaches and tools limits certainty regarding optimal methods.

Qualitative and mixed-method evidence consistently highlights the role of meaningful occupation in supporting identity, self-worth, and psychological wellbeing (Strick et al 2021). Involving people in decision-making and tailoring interventions to their goals and preferences is also associated with improved engagement and dementia-friendly outcomes (Innes et al 2021). These findings are derived across a range of settings and cultural contexts, although generalisability may vary.

Evidence from multiple reviews suggests that cognitive approaches, particularly when incorporated within multimodal interventions, can improve cognitive outcomes (Ham et al 2021; Xiang and Zhang 2024; Tulliani et al 2022; Sung et al 2023). However, effects on activities of daily living are inconsistent, and intervention heterogeneity limits certainty.

Evidence supporting early, subtype-specific intervention and consideration of sexuality is limited and largely descriptive (Kong et al 2025). Although the available evidence related to sexuality in dementia is limited (Kong et al 2025), the Guideline development group considered it important to include this recommendation given its relevance to person-centred care and the recognition that this area is frequently overlooked in practice. This supports recommendations that emphasise person-centred assessment, cultural sensitivity, and professional judgement in tailoring interventions.

4.2 Modifiable risk factors for dementia

Evidence consistently suggests that engagement in cognitive, physical, and social activities is associated with reduced risk of developing dementia (Su et al 2022; Fallahpour et al 2016). Additional evidence indicates that lifelong participation in cognitively stimulating occupations may contribute to cognitive reserve and delay onset (Da Silva et al 2025).

However, variation in how leisure activities are defined and measured, along with potential confounding factors such as education and baseline health status, limits certainty. Most evidence is derived from general population studies, rather than intervention trials, which may limit direct applicability to clinical practice.

Despite these limitations, the consistency of findings supports offering occupation-based health promotion advice across the life course, with flexibility to tailor recommendations to individual preferences, contexts, and capabilities.

4.3 Occupation

Evidence from multiple systematic reviews consistently suggests that individualised, occupation-

based interventions improve engagement, social participation, wellbeing, and quality of life for people living with dementia (Ruíz Hernández et al 2023; Scott et al 2022; Houghton et al 2022; Laver et al 2026; Smallfield and Heckenlaible 2017). These findings are reported across community and care settings, although intervention designs and outcomes are heterogeneous, which limits certainty regarding specific modalities.

A consistent finding is that interventions are more effective when tailored to individual preferences, abilities, and life history. Evidence suggests that individualised and therapist-supported approaches are more effective than standardised or group-based interventions (Scott et al 2019). Interventions such as intergenerational programmes and horticultural activities appear to support engagement and wellbeing, but show mixed or limited effects on cognitive and functional outcomes (Houghton et al 2022; Scott et al 2022).

Evidence indicates that specific interventions may affect particular outcomes. For example, animal-assisted interventions are associated with reduced depression but show no significant effect on cognition or activities of daily living (Batubara et al 2022).

Overall, while the direction of evidence is consistent, variability in study design, delivery, and outcomes limits precision. This supports recommending individualised occupation-based interventions, with flexibility to select and adapt approaches based on intended outcomes and individual need.

4.4 Environment

Evidence suggests that the physical and sensory environment significantly influences occupational performance and behaviour in people living with dementia (Woodbridge et al 2018). This finding is consistent across home, community, and care settings, although the relative contribution of specific environmental components is unclear.

There is stronger evidence supporting the use of music and multisensory interventions to reduce behavioural and psychological symptoms, alongside moderate evidence for environmental modifications such as noise reduction and home-like settings (Jensen and Padilla 2017). However, evidence for other environmental interventions, including aromatherapy, functional task availability and light manipulation, is less consistent, and studies vary in design, delivery and outcomes.

The evidence indicates that environmental interventions are most effective when implemented as part of a broader, person-centred and multifactorial approach.

Given variability in findings and methodological limitations, this supports recommendations to consider environmental interventions, with professional judgement required to tailor strategies to individual needs, preferences, and contexts.

4.5 Technologies

Evidence suggests that both assistive and everyday technologies can support engagement, identity, relationships, and wellbeing for people living with dementia (Goodall et al 2021; Sweeney et al 2021). Findings are consistent across community and care settings, although intervention types and technologies vary widely.

Evidence indicates that technologies can improve behaviour, mood, and social engagement, and help maintain a sense of identity. However, effects on cognitive outcomes are mixed, and some

studies report negative or no effects (Goodall et al 2021). Usability and accessibility are key factors influencing outcomes in practice, with many individuals experiencing difficulties interacting with technology. The Guideline development group noted that these practical challenges are highly relevant in real-world settings and therefore emphasised the importance of accessibility, usability, and ongoing support when making recommendations. It is also important to note that technology – including artificial intelligence – is developing at a rapid pace.

Evidence from caregiver-focused studies suggests that assistive technologies are valued, particularly for safety and orientation. However, perceived usefulness does not consistently translate into measurable improvements in caregiver outcomes such as burden or wellbeing (Sriram et al 2019). A consistent finding is that lack of personalisation and support leads to abandonment of devices.

Overall, heterogeneity in design, delivery, and outcomes limits certainty. This supports recommending the use of technology where appropriate, with careful selection, adaptation, and support to match individual needs and capabilities.

4.6 Home-based interventions in community settings

Evidence from multiple systematic reviews consistently suggests that multicomponent home-based occupational therapy interventions improve activities of daily living, behavioural symptoms, and quality of life for people living with dementia, and reduce caregiver burden (Bennett et al 2019; Raj et al 2021; Rahja et al 2018). These effects are most evident in home and community settings.

Evidence indicates that interventions are more effective when they are individualised, delivered over multiple sessions, and involve both the person living with dementia and their caregiver (Tan et al 2022; Scott et al 2019). Interventions that combine occupation-focused strategies, environmental adaptations, and caregiver education and skills training show the most consistent benefits.

Evidence also suggests that these interventions can be cost-effective, particularly where environmental and behavioural components are included (Clarkson et al 2017; Rahja et al 2018).

However, findings for cognition, mood, and some functional outcomes are mixed, and evidence quality ranges from low to moderate in some reviews (Bennett et al 2019; Tan et al 2022). Intervention heterogeneity and variation in outcome measures limit certainty.

This supports recommending tailored, multicomponent home-based interventions, involving caregivers where appropriate, with flexibility to adapt components to individual needs and contexts.

4.7 Occupation to support transitions of care

Evidence suggests that maintaining meaningful occupation during transitions of care supports identity, engagement, and quality of life, and may reduce behavioural symptoms (Groenendaal et al 2022). These findings are consistent across different transition contexts, although the evidence base is small.

Evidence identifies key facilitators including person-centred assessment, continuity of care, involvement of caregivers, and matching activities to individual preferences and abilities. Barriers include environmental change, lack of knowledge about the person, and poor coordination between services.

Most evidence is descriptive and derived from small numbers of studies, which limits certainty and generalisability. There is limited evidence on the effectiveness of specific intervention models. Given the limited evidence base, the Guideline development group applied professional judgement to prioritise continuity of personalised occupation as a key principle during transitions.

This supports recommendations to prioritise person-centred assessment, continuity, and interdisciplinary collaboration during transitions, with professional judgement required to tailor approaches to individual circumstances.

4.8 Occupation to support quality of life in care settings

Evidence from systematic reviews consistently suggests that personalised, occupation-focused interventions in care settings improve quality of life, mood, and behavioural outcomes (Uceda-Portillo et al 2024; Travers et al 2016). Benefits are observed across residential and nursing home settings, although intervention approaches vary.

Evidence indicates that individualised activities aligned with personal preferences are most effective for reducing agitation, depression, and anxiety. Reminiscence therapy shows consistent benefits for cognition, mood, and quality of life, but does not significantly improve independence in activities of daily living (Saragih et al 2022).

Multisensory environments are associated with improvements in mood and reductions in distress, particularly in later stages of dementia (Cusic et al 2022). Garden-based and outdoor activities also show positive effects on quality of life and behavioural symptoms (Van der Velde-van Buuringen et al 2023).

However, heterogeneity in study design, intervention delivery, and outcome measures limits certainty. Some studies lack sufficient detail to replicate interventions.

Overall, this supports recommending personalised, occupation-focused interventions in care settings, with emphasis on tailoring to individual preferences and needs rather than standardised group approaches.

4.9 Families, carers and supporters

Evidence from multiple systematic reviews suggests that multicomponent psychoeducational and skills-based interventions can reduce caregiver depression and burden and improve competence and confidence (Ghosh et al 2023; Verrier Piersol et al 2017; Abrahams et al 2018). Interventions are most effective when tailored, practical, and embedded within daily routines.

However, findings are mixed for outcomes such as quality of life, anxiety, and social support, reflecting heterogeneity in intervention content, duration, and measurement (Cheng and Zhang 2020; Ghosh et al 2023). In interpreting this variability, the Guideline development group placed greater weight on the important occupational therapy role of working with families, carers and supporters to support their health and wellbeing.

There is also evidence that individualised interventions may be more effective than group-based approaches in some cases (Vandepitte et al 2016).

Evidence suggests that supporting caregivers' own health and wellbeing, including sleep, social participation, and access to respite, is important, although intervention effects are variable (Waligora

et al 2019; Wiegelmann et al 2021). Cultural factors may influence engagement with services and should be considered (Stenberg & Hjelm 2023).

Assistive technology is generally acceptable to caregivers, particularly for safety and orientation, although its impact on measurable outcomes is inconsistent (Sriram et al 2019).

Overall, this supports recommending tailored, multicomponent interventions for caregivers, with emphasis on individualisation, practical skills, and consideration of cultural and contextual factors.

4.10 Intellectual disabilities

Evidence relating to people with intellectual disabilities and dementia is limited and less robust. Available evidence suggests that structured, personalised psychosocial interventions may improve engagement, communication, mood, cognition, and quality of life (Muralidhar et al 2024). However, this evidence is characterised by small sample sizes and a lack of large-scale randomised controlled trials.

Despite these limitations, there is consistent indication that personalised, goal-oriented approaches are beneficial. The Guideline development group considered it important to include this recommendation to address a recognised gap in practice and to support equitable care for this population.

This supports recommendations to consider structured, individualised interventions, with cautious interpretation of the evidence and reliance on professional judgement to adapt approaches to this population.

5. Implementation of the guideline

5.1 Implementation resources

Three core implementation resources are available to support this evidence- based guideline for the occupational therapy workforce, including learners and support workers.

Quick reference and implementation guide

The quick reference and implementation guide is intended to be used by practitioners as an easily accessible reminder of the recommendations and suggestions for implementation. It should ideally be used once the practitioner has read the guideline in full to ensure an understanding of the context and development of the recommendations.

Audit tool

It is recommended that occupational therapists use the RCOT audit tool that supports this guideline.

The audit tool provides a template for individual occupational therapists or services to audit and review their current service provision against the recommendations. The aim is to encourage reflection upon current practice and to consider, where practice does not follow the recommendations, the professional reasoning in place to support decisions.

A baseline assessment conducted using the audit tool can then be repeated to enable review of progress on identified actions. It is recommended that an audit is conducted every one or two years to monitor ongoing change. The audit tool, while initially providing a tool for use within an individual/service context, also offers the potential for future benchmarking and wider comparative analysis across different services.

Recommendations that involve shared responsibility across professional roles may be usefully audited jointly with other members of the multidisciplinary team, recognising that implementation may be shared across services and roles.

Continuing professional development/knowledge transfer resource

The continuing professional development resource is interactive and can be tailored for local use. The session can be used for group or self-directed learning, or for raising awareness of the guideline at multidisciplinary meetings, study days or events.

Accessing the implementation resources

The quick reference guide, audit tool and continuing professional development session resources are available as separate documents.

These can be downloaded, together with the full guideline document, from RCOT's website: *https://www.rcot.co.uk.*

5.2 Enablers to implementation in practice

New research evidence can take time to embed into practice, and occupational therapists may experience challenges with in implementing the recommendations. These may include time and resource limitations, existing patterns of service delivery and established professional and service cultures. However, the recommendations set out in this guideline demonstrate the positive impact that occupational therapy can have in people's lives within dementia care, health promotion and

dementia prevention.

Consideration and discussion, at a local level, of how these recommendations might be implemented is essential. This approach is intended to support meaningful change over time, with the ultimate aim of improving outcomes for people with lived experience.

Familiarity with the guideline

Familiarity with the guideline is an important enabler to implementation. Occupational therapists are strongly encouraged to be aware of the recommendations, to discuss them with their teams and colleagues and to consider how they align with professional codes of practice, standards and policies.

Engaging with the recommendations will enhances occupational therapy practice. It also supports the identification of areas for further learning and development in dementia care and rehabilitation. RCOT will support awareness of the guideline following publication through communication activity, including promotion during dementia awareness initiatives.

Spreading the messages

Occupational therapists are encouraged to discuss the recommendations with a range of key stakeholder such as multiprofessional colleagues from other professional groups, managers, third-sector partners, allied health professional strategic leaders and service commissioners. Consideration should be given to where the service's culture or structures could evolve, and where there may be gaps in service provision that will impact delivery of the recommendations.

Engagement with people living with dementia and their families, carers and supporters in local communities is vital. Sharing the recommendations and having conversations about what matters to people in relation to occupational therapy can support meaningful and locally relevant implementation. RCOT will develop resources to support the sharing of key messages, which can be adapted to reflect local context.

Planning for local implementation

Implementation of the recommendations will vary depending upon the local context. Occupational therapists are encouraged to consider resources available within their setting, to identify areas of current good practice and to recognise where change may require phased implementation rather than immediate adoption.

Awareness of local dementia prevalence will support review of how occupational therapy is currently provided across a framework of universal, targeted and specialist provision and whether this requires enhancement, adaptation or change. Tools that support teams to explore both enablers and challenges to implementation, such as structured reflection or force-field analysis, may be helpful in supporting local discussion, planning and action.

Cultural responsiveness

People with lived experience have emphasised, and the evidence supports, the importance of person-centred interventions in health and social care. Occupational therapists are encouraged to tailor the application of recommendations to the diverse backgrounds and worldviews of the people who use their services, including understanding what is important to individuals and cultural groups accessing occupational therapy services.

Engagement with individuals, families and community groups may improve understanding of the different cultural perspectives on dementia and caregiving, increase cultural awareness and support implementation of the recommendations in ways that are relevant and respectful.

Equity and access

Occupational therapists are encouraged to recognise the influence of social determinants of health upon people's experiences of dementia and their ability to access and benefit from occupational therapy interventions. Access to resources, services and support varies, and these factors may affect implementation in practice.

Some groups may be under-represented in dementia services or face additional barriers to accessing occupational therapy, including people from ethnic minority communities, people living in areas of socioeconomic disadvantage, people with learning disabilities, LGBTQ+ people, and those living alone or without informal support. Differences in access to diagnosis, referral pathways, culturally appropriate services and community resources may contribute to inequitable outcomes.

Where inequities are identified, occupational therapists may play a role in advocating for change, adapting approaches to reduce barriers to participation, and working collaboratively with others to promote equitable access to occupational therapy support. This may include working with community organisations, using inclusive and accessible communication, and considering how services can be better aligned with the needs and priorities of under-represented groups.

6. Recommendations for future research

During the process of drafting the recommendations, guideline development members identified areas where further research is needed. It is important to note that the guideline's scope meant that recommendations were based on systematic reviews.

These recommendations for future research should be considered in context with other occupational therapy research priorities, such as the top ten research priorities for occupational therapy in the UK (RCOT 2021).

Underpinning these recommendations is the belief that people living with dementia and their families, carers and supporters can be involved in all stages of research as advisors, participants and as co-researchers and implementors. Incorporating their voices into research questions, methods and outcomes of dementia and occupational therapy research is essential for good quality, relevant research.

Priority areas for research:

- Understanding the views of people living with dementia and their families, carers and supporters across all aspects of dementia and occupational therapy delivery.
- Examining how tailored occupational therapy-led health promotion programmes might support those at risk of developing dementia to make and maintain lifestyle changes.
- Examining how tailored occupational therapy-led health promotion programmes might assist people diagnosed with dementia to maintain independence and wellbeing, including those living alone and those with significant co-morbidities, with consideration of how ethnicity, gender and socioeconomic resources interact with these programmes.
- Identification of a common set of outcome measures for occupational therapists to apply during practice initiatives to examine practice at a local level.
- Coordinating, aggregating and reporting on data collected through practice initiatives to inform professional practice.
- Systematic reviews on the evidence for occupational therapists' support for assessing the driving skills and transition to stop driving of people living with dementia and staying in work while living with dementia.
- Examine how occupational therapy can support people living with dementia to remain in employment or career transition.
- Systematic reviews examining how tailored occupational therapy rehabilitation can support the goals of people living with dementia and their families, carers and supporters.
- Examining how occupational therapy practice should respond to emerging technologies such as AI, virtual reality and other intelligent solutions, including identification of advantages and disadvantages.
- Participation by occupational therapists in design projects where people living with dementia and, where appropriate, their families, carers and supporters are the identified beneficiaries.

- Exploring the relationships between health promotion, rehabilitation, self-management and occupational therapy, and how such models might translate into new forms of practice.

- Collating best practice examples of people living with dementia and their families, carers and supporters being involved in occupational therapy practice and research as consumers, advisors and leaders.

- Understand the return on investment of interventions and how challenges to delivering interventions with the highest return on investment are overcome.

7. Guideline development process

Information on the following steps in the guideline development process can be found in the *Evidence-based guideline development manual* 5th edition (RCOT 2024b).

7.1 Declaration of funding for the guideline development

As a membership organisation, RCOT's major source of funding is through membership fees. Other sources of income are primarily through rental income and advertising.

RCOT funds the development and publication guidelines and provided specific resources to cover the meeting software, literature searches and editorial, publication and promotional support.

There were no external sources of funding.

7.2 Guideline development group

The Guideline development group was comprised of fourteen occupational therapists with expertise in dementia, three people with experience of dementia, either as a person diagnosed with dementia or as a carer of someone with dementia (Appendix 3). RCOT officers supported the group.

The occupational therapist group members were all practising therapists, educators, or researchers. All group members conducted the guideline development work in their own time, with some support from their employers (for example to attend meetings).

7.3 Conflicts of interest

All Guideline development group members were required to declare any pecuniary or non-pecuniary conflicts of interest, in line with the guideline development procedures (RCOT 2024b).

The nature of the potential or actual conflicts made in the declarations (Appendix 4) was not determined as being a risk to the transparency or impartiality of the guideline development.

7.4 Stakeholder involvement

Stakeholders expected to have an interest in the guideline topic were identified by the Guideline development group members at the first guideline meeting. Specific attention was paid to identifying professional bodies that represent those who work with people diagnosed with dementia and their families, carers and supporters, and national charitable or voluntary organisations that may represent people who access services.

Consultation on guideline scope with stakeholders

The following stakeholders were invited to comment on a draft of the scope document:

- Age Scotland
- Age UK
- Allied Health Professional Consultant Wales
- Alzheimer's Disease International
- Alzheimer Europe
- Alzheimer Scotland

- Alzheimer's Research UK
- Alzheimer’s Society
- Association of Clinical Psychologists UK
- British Association of Social Workers
- British Dietetic Association
- British Geriatrics Society
- British Heart Foundation
- British Institute of Learning Disabilities Growing Older with Learning Disabilities Network
- British Psychological Society
- Care Inspectorate Scotland
- Care Inspectorate Wales
- Care Quality Commission
- Carers Northern Ireland
- Carers UK
- Chartered Institute for Housing
- Chartered Society of Physiotherapists
- Chief Allied Health Professions Officer for each nation
- COTED, to reach programme leads of higher education institutions
- Commissioner for Older People (Northern Ireland)
- Community Rehab Alliance (England)
- Contented Dementia Trust
- DEEP
- Dementia Action Alliance
- Dementia UK
- Dementia Carers Count Dementia Community/Journal of Dementia Care
- Health Education and Improvement Wales
- Health Improvement Scotland
- Healthcare Inspectorate Wales
- Homecare Association
- Hospice UK
- Housing Learning and Improvement Network
- Innovations in Dementia
- Lleisiau Dementia
- Macmillan
- Marie Curie
- Marie Curie Scotland
- Meeting Centres (healthcare policy)
- Mencap
- NHS Education Scotland
- NHS England’s Workforce, Training and Education Directorate
- National Care Association
- National Care Forum
- Neurological Alliance
- North East Wales Carers Information Service
- Northern Ireland Dementia Regional Group
- NI Assembly All Party Group on Dementia

- Older Persons Commissioner (Wales)
- Parkinson's UK
- Rare Dementia Support
- Regulation, Quality Improvement Authority for Northern Ireland
- Right to Rehab (Scotland)
- Right to Rehab (Wales)
- Right to Rehabilitation Coalition
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Paramedics
- Royal College of Podiatry
- Royal College of Psychiatrists
- Royal College of Radiologists
- Royal College of Speech and Language Therapists
- Royal Pharmaceutical Society
- Scottish Government Dementia Policy team
- Society and College of Radiographers
- Sue Ryder
- The Alliance Scotland
- The Carers Trust
- The Lewy Body Society
- TSA, the voice of tech enabled care
- UK Dementia Research Institute
- Young Dementia Network

Consultation on draft guideline with stakeholders

The draft guideline was sent to each of the stakeholders who had been contacted as part of the scope consultation for their review and comment. The consultation took place from 27 May – 29 July 2026.

7.5 Involvement of people with experience of dementia

In addition to three people with experience of dementia (either through living with dementia themselves or caring for someone living with dementia) participating as members of the Guideline development group, a wider group of people with experience of dementia were consulted on the scope and guideline draft.

Consultation on the guideline scope with people living with dementia and their family, carers and supporters

People living with dementia and their families, carers and supporters were invited to take part in the consultation. We asked representative organisations to distribute the MS Forms consultation questionnaire via their networks. Additionally, we spoke to people with lived experience through three focus groups:

- Alzheimer's Society (held 24.04.25)
- East Kent Forget-me-nots (held 09.05.25)
- Experts by Experience, Centre for Applied Dementia Studies, University of Bradford (held

16.05.25).

We asked people what they thought the guideline needs to be about, what it should include and what is important to them. See Appendix 6 for the focus group discussion guide.

Consultation on draft guideline with people living with dementia and their families, carers and supporters

To be updated post-consultation

7.6 Involvement of occupational therapists not on the Guideline development group

Scope consultation with occupational therapists

RCOT members were invited to participate in the scope consultation via advertisement on, social media channels, RCOT's website and Highlight. Members could access the scope via RCOT's website along with the Microsoft Forms consultation questionnaire.

Consultation on guideline draft with occupational therapists

To be updated post-consultation

7.7 Consultation responses from stakeholders, people with experience of dementia and occupational therapists

All comments received from stakeholders, people with experience of dementia and occupational therapists on the draft scope and draft guideline document were reviewed by the Guideline development group. Where appropriate, revisions were incorporated into the scope form or guideline document. Conflict of interest declarations were noted and reviewed for any necessary action.

Details of the comments obtained as part of the consultation activities are available on request from RCOT.

7.8 External peer review

Two independent peer reviewers were invited by the Guideline development group to critically appraise a draft of the full guideline. Reviewers were selected for their known clinical and research expertise in the field. The peer reviewer form asked for comment on both the presentation and content of the draft guideline, and the robustness of the method to develop the recommendations and guideline.

7.9 Quality assurance and approval process

The guideline scope and final document were reviewed by the RCOT Guidelines Governance Group and approved by RCOT Head of Research and Innovation and Director of Practice and Innovation, in line with the requirements of the *Evidence-based guideline development manual* 5th edition (RCOT 2024b).

The scope was approved by RCOT in August 2025 and the final version of the guideline was approved by RCOT in TBC.

7.10 Guideline questions

What is best practice for occupational therapists when:

a. working with people to modify their lifestyle with the goal of reducing the risks associated

with the development of dementia

b. working with people diagnosed with dementia and their families, carers and supporters by enabling engagement in occupations with the goal of maximising personal outcomes from diagnosis to end of life?

7.11 Literature search strategy and outcomes

The literature search was carried out by RCOT's Health Information Specialist, using a search strategy defined following discussion and agreement with the Guideline development group. All searches were conducted in August 2025.

Key terms

The overall search strategy involved combining concept groups of key words. Six key categories or concepts and their related terms were identified (see Appendix 5 for more detail):

- types of dementia terms and conditions
- dementia risk reduction/prevention terms
- health promotion interventions/brain health
- occupation terms
- activity terms
- occupational therapy terms
- systematic review terms.

The combination of these categories, or strings, searched aimed to identify the most relevant search yields to meet the requirements of the guideline scope.

The databases searched reflected the most likely sources of published peer-reviewed occupational therapy evidence. Nine databases were searched for articles published from 1 January 2015 to the dates the individual searches were carried out. Hand-searching was not conducted.

Details of the date of each database search, search fields and search yields are in Appendix 5, Tables A4.2 – A4.3. Full search histories are available on request from RCOT.

Literature search yields and screening

The literature search identified a total of 3,632 articles. These were scrutinised for duplicates, both within-database searches and cross-database search returns, by RCOT's Research and Development Officer, along with results that were not in scope because of research methodology. A total of 2,833 articles were removed.

The Guideline development group then screened the abstracts of the resulting 799 articles. Two members of the Guideline development group independently double screened ten per cent of the results (n=80). The rest (n=719) were screened by one member.

Criteria for inclusion and exclusion of evidence

The Guideline development group screened the abstracts against the following inclusion and exclusion criteria:

Inclusion criteria:

- research on assessments, interventions and outcomes involving and concerning people diagnosed with all forms and at all stages of dementia

- research involving and concerning families, carers and supporters of people diagnosed with dementia
- research involving and concerning interventions for occupation-based health promotion to reduce the risk of developing dementia
- research on assessments, interventions and outcomes relevant to occupational therapy t by being occupation-based.
- research published from 2015 onwards (to manage the volume of research)
- research utilising a systematic review methodology. By systematic review, we mean the following: 'A review that summarises the evidence on a clearly formulated review question according to a predefined protocol, using systematic and explicit methods to identify, select and appraise relevant studies, and to extract, analyse, collate and report their findings. It may or may not use statistical techniques, such as meta-analysis.' (National Institute for Health and Care Excellence Glossary https://www.nice.org.uk/Glossary?letter=S).
- research published in peer-reviewed journals.

Exclusion criteria:

- research not involving or concerning dementia or dementia risk reduction through occupation-based health promotion,
- research on assessments, interventions and outcomes not relevant to occupational therapy and not occupation-based
- research that cannot be feasibly translated into English
- research published before 2015
- research methodologies that are not systematic reviews, as defined above
- grey literature.

The allocation process ensured that articles were not screened for inclusion by authors or co-authors. Where the screeners differed as to whether an article should be included or excluded for appraisal, the screeners discussed to reach a consensus decision.

Through this process, articles potentially relevant to the guideline and to include for critical appraisal were identified.

Critical appraisal of original literature results

Following screening of the abstract, 666 articles were further excluded, resulting in a total of 133 items identified for full paper review and critical appraisal.

During the critical appraisal process, 47 articles were identified as being out of scope and the librarian was unable to acquire six, resulting in 80 articles, the full papers of which were accessed and which were critically appraised. Forty-nine articles were subsequently used in developing the recommendations.

An overview of the literature search outcomes is provided in Figure 6.1.

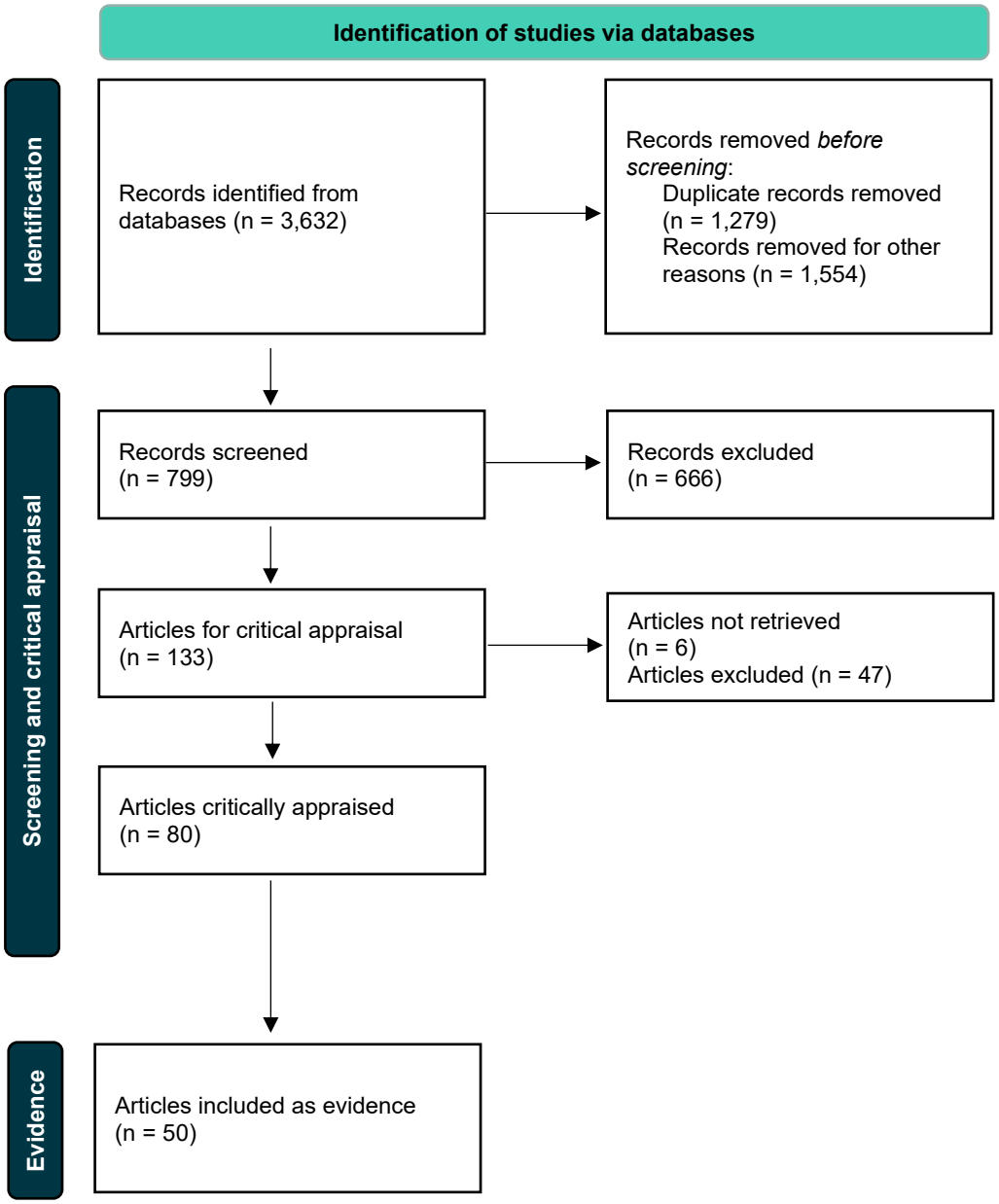

Figure 6.1 Literature search results

7.12 Strengths and limitations of body of evidence

Just over 25% (n=35) of the articles identified in the search as potential evidence were critically appraised by two independent reviewers, while the rest (n=98) were appraised by one reviewer. Appraisals were undertaken by members of the Guideline development group, though one person with lived experience opted not to appraise. The allocation process ensured that reviewers did not appraise any evidence that they had authored or co-authored. Any discrepancy in grading was discussed and the final grading agreed and confirmed via consensus.

The quality of the evidence was initially assessed and recorded using forms based on the JBI Checklist for systematic reviews and research syntheses (Aromataris et al 2015). This appraisal included factors such as the appropriateness of the inclusion/exclusion criteria and search strategy, procedural rigour in the review's quality appraisal, data extraction, synthesis and assessing potential biases.

A quality of evidence grade was assigned to each individual article using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach, as defined within the *Practice guideline development manual* 5th edition (RCOT 2024b). The grading takes account of the research design and the confidence in the research findings.

Different methodologies start at different grades. The initial grading of systematic reviews is A, which means they cannot be upgraded. However, limitations in the design of a study or its implementation may bias the estimates of the treatment effect. If there were serious limitations, then downgrading of the quality of the evidence was considered. Appraisers downgraded a systematic review if there was:

- serious or very serious limitation to study quality
- important inconsistencies in results
- some or major uncertainty about whether the included studies match the reviews' scope
- imprecise or sparse data (relatively few participants and/or events)
- high probability of reporting bias.

The presence of each of the above can reduce the quality rating of a systematic review by one or, if very serious, by two levels.

Decisions made by appraisers to increase or decrease the initial grade of the evidence were recorded and justified on the critical appraisal forms. If the appraiser found no reason to downgrade the evidence, then the original grading remained.

All of the evidence used to develop the recommendations was from high or moderate quality studies, summarised below:

Grade A= 70% (n=35)

Grade B =30% (n=15)

The Guideline development group downgraded 15 of the identified reviews, initially graded A, due to limitations identified from the critical appraisal and a resultant lack of confidence in the findings. These decisions are described in the evidence tables (see Appendix 2).

Even where studies were not downgraded, limitations were identified in some. These included the heterogeneity of included studies, poor methodological quality of included studies and

evidence reviews that did not meet the rigour of systematic reviews.

The evidence used to develop the recommendations is provided in Table 6.1. A summary of each piece of evidence can be found in Appendix 2.

Table 6.1: Summary of evidence used to develop the recommendations and best practice suggestion

Topic area	Author	Year	Evidence quality
Foundational	Ham et al	2021	A
	Stenberg and Hjelm	2023	A
	Strick et al	2021	A
	Sung et al	2023	A
	Tulliani et al	2022	A
	Woodbridge et al	2018	A
	Xiang and Zhang	2024	A
	Anselmo et al	2025	B
	Innes et al	2023	B
	Kong et al	2025	B
	Smallfield and Heckenlaible	2017	B
	Vlotinou	2023	B
Modifiable risk factors for dementia	da Silva et al	2025	A
	Fallahpour et al	2016	A
	Su et al	2022	B
Occupation	Batubara et al	2022	A
	Houghton et al	2022	A
	Laver et al	2016	A
	Ruíz-Hernández et al	2023	A
	Scott et al	2022	A
	Zhang et al	2025	A
	Dorris et al	2021	B
	Lewis et al	2017	B
	Smallfield and Heckenlaible	2017	B
Environment	Jensen and Padilla	2017	B
Technologies	Goodall et al	2021	A

Topic area	Author	Year	Evidence quality
	Sriram et al	2019	A
	Sweeney et al	2021	A
Home-based interventions in any community setting	Bennett et al	2019	A
	Chester et al	2024	A
	Clarkson et al	2017	A
	Rahja et al	2018	A
	Raj et al	2021	A
	Ruíz-Hernández et al	2023	A
	Scott et al	2019	A
	Tan et al	2022	A
Occupation to support transitions of care	Groenendaal et al	2022	A
Occupation to support quality of life in care settings	Cusic et al	2022	A
	Du Toit et al	2019	A
	Saragih et al	2022	A
	Travers et al	2016	A
	Ucedo-Portillo et al	2024	A
	van der Velde-van Buuringen et al	2023	A
Families, carers and supporters	Sriram et al	2019	A
	Stenberg and Hjelm	2023	A
	Waligora et al	2019	A
	Cheng and Zhang	2020	B
	Wiegelmann et al	2021	B
Intellectual disabilities	Muralidhar et al	2024	B

7.13 Method used to arrive at recommendations

Evidence tables summarising the appraised articles were created. The evidence tables, along with reference to the article where appropriate, were used to judge the potential contribution of each paper and used as the basis for developing the recommendations. Once a recommendation had been developed, the overall quality of the evidence rating for that recommendation was determined. The strength of the recommendations is identified via an A (all occupational therapists should do this) or B (all occupational therapists should consider doing this) based on the quality of the supporting evidence. If a recommendation has high level evidence (graded A), it received an ‘A’ rating. If it only has moderate level evidence (graded B), it

received a ‘B’ rating.

The development of the recommendations involved consensus decisions obtained via Guideline development group meetings, email correspondence, and a formal vote via Microsoft Forms.

Fifty systematic reviews were used to develop the recommendations.

7.14 Generalisability, limitations and any potential biases of the guideline

Due to the broad scope of the guideline question, the systematic reviews included in the evidence review were heterogeneous. There were variations in sample populations, in the type, amount and frequency of specific interventions, and in the availability of occupational therapy services within the service model.

Evidence included in the development of the guideline recommendations only included systematic reviews. It is acknowledged that this means that more recently published high-quality research that would not have been included in systematic reviews may have been missed. Additionally, the evidence mostly comes from countries in the Global North, and particularly countries where English is a common language.

RCOT developed, authored, and funded this guideline. The potential for any bias in development and authoring was, however, minimised through the rigorous nature of the guideline development process. This was achieved through the systematic methodology adopted, the contributions of stakeholders and people who access services, the opinions of the external peer reviewers and occupational therapists, and the judicious management of any potential or actual conflicts of interest.

8. Updating the guideline

RCOT is responsible for the review of this guideline, with a full review beginning four years after publication. The review may happen earlier, however, if there is significant new evidence that impacts on practice or the recommendations. Monitoring significant new evidence will be conducted annually via literature searches that are subsequently screened by RCOT members who have knowledge of the guideline and the clinical area.

All RCOT evidence-based guidelines are automatically retired 10 years after the original publication date and the document is archived in our library.

Appendix 1: Glossary and abbreviations

Term	Definition
Affect	The outward, observable expression of a person's internal emotional state. This could include inferences about a person's mood or emotional wellbeing based on facial expressions, tone of voice and body language.
Assessment	The process of collecting, analysing and synthesising information about a person's physical, cognitive, emotional and functional abilities. This informs action plans, intervention plans, problem solving and recommendations. Assessments can be standardised or non-standardised, and may be observational, interview-based or task based. The occupational therapist and the person they are working with should focus on the strengths that individual has as well as their needs in the context of their environment and living situation.
Cognitive approach	'A therapeutic approach designed to help people improve or compensate for problems with thinking skills such as memory, attention, problem-solving, or planning, often after brain injury, stroke, or a diagnosis of dementia.' *Alzheimer's Disease International 2025, p7*
Confidence interval (CI)	'A way of expressing how certain we are about the findings from a study, using statistics. It gives a range of results that is likely to include the 'true' value for the population. A wide confidence interval (CI) indicates a lack of certainty about the true effect of the test or treatment - often because a small group of patients has been studied. A narrow CI indicates a more precise estimate (for example, if a large number of patients have been studied). The confidence interval is usually stated as '95% CI', which means that the range of values has a 95 in a 100 chance of including the 'true' value. For example, a study may state that 'based on our sample findings, we are 95% certain that the 'true' population blood pressure is not higher than 150 and not lower than 110'. In such a case the 95% CI would be 110 to 150.' *http://www.nice.org.uk/website/glossary/glossary.jsp*
Families, carers and supporters	People who support the person with a diagnosis of dementia, which could include family members, friends and/or neighbours. We recognise that a dementia diagnosis can impact entire support networks. This does not include professionally paid health and social care providers.
GRADE	**Grading of Recommendations Assessment, Development and Evaluation** GRADE is a systematic and explicit methodology to assist in the judgement of the quality and strength of guideline recommendations. In the guideline, we've used GRADE to signify the quality of the systematic reviews included to support recommendations. These judgements then informed the quality rating of the recommendation.

	http://www.gradeworkinggroup.org
Health promotion	'Health promotion enables people to increase control over their own health. It covers a wide range of social and environmental interventions that are designed to benefit and protect individual people's health and quality of life by addressing and preventing the root causes of ill health, not just focusing on treatment and cure.' *https://www.who.int/news-room/questions-and-answers/item/health-promotion#:~:text=Health%20promotion%20enables%20people%20to%20increase%20control,not%20just%20focusing%20on%20treatment%20and%20cure*
Intervention	The work occupational therapists do for and with individuals/groups, which might include providing services such as rehabilitation, support, information, recommendations or advice, direction, supervision and education.
Intellectual disability	'Intellectual disability is a term used when there are limits to a person's ability to learn at an expected level and function in daily life.' Also referred to as 'learning disability'. *https://www.cdc.gov/ncbddd/developmentaldisabilities/facts-about-intellectual-disability.html#:~:text=Intellectual%20disability%20is%20a%20term,disability%20vary%20greatly%20in%20children*
Lived experience	The individual knowledge, insight and perspectives gained through direct involvement in and/or personally experiencing given characteristics or circumstances. In this guideline it primarily refers to people living with dementia and their families, carers and supporters.
Multicomponent	A combination of at least two interventions, such as education, modifications and rehabilitation.
Multimodal	The use of multiple types of interventions to address one condition or situation.
Multisensory	Use of sensory input across multiple sensory systems, for example touch, sound and smell.
NHS	The publicly-funded healthcare systems in the UK.
NICE	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. *http://www.nice.org.uk*
Non-pharmacological	Interventions that do not involve medication, including occupation-based, psychosocial, cognitive, environmental and lifestyle approaches.
Occupation-focused	Practice where information about the person, environment and occupation relates closely with occupational performance.
Occupational performance	A person's ability to carry out the activities and roles that they need, want or are expected to do in their daily life.
Occupations	Any activity that we need, want or like to do to live and to look after our physical and mental health, and our emotional and spiritual wellbeing. Occupations give our lives meaning, purpose and structure. They help shape

	who we are, connect us with others and help create our identity and sense of belonging. Through occupation we are all able to enhance our health and quality of life.
Occupational therapy workforce	For the purposes of this document, this is a collective term that includes occupational therapists, support workers and occupational therapy learners, including students and apprentices. It includes practitioners in all roles, including those who are in health and social care settings, management and leadership, education, research, consultancy and advisory roles and working in industry.
Outcome	The measured changes that can be attributed to an intervention. Outcomes relevant to occupational therapy practice should focus on what matters to the person, their family, carers and supporters, and could include occupational performance, quality of life, behaviour, mood, physical or cognitive ability.
Outcome measures	Tools, including standardised assessments, used by therapists to establish the efficacy of interventions, for example whether the desired outcomes have been achieved and to what extent.
p value	The p value is a statistical measure that indicates whether or not an effect is statistically significant. For example, if a study comparing two treatments found that one seems to be more effective than the other, the p value is the probability of obtaining these results by chance. By convention, if the p value is below 0.05 (that is, there is less than a 5% probability that the results occurred by chance), it is considered that there probably is a statistically significant difference between treatments. If the p value is 0.001 or less (less than a 0.1% probability that the results occurred by chance), the result is seen as highly significant. *http://www.nice.org.uk/website/glossary/glossary.jsp*
People living with dementia	Those who have a diagnosis of dementia, at all stages of the disease.
People who access services	People who have received health and social care assessments/interventions. The term may refer to an individual, families and carers, a group or a community.
Personalised	A personalised approach to health and care emphasises that people are in control of and are given choices in the ways that their needs are heard, addressed, planned and delivered. This approach is based on people's strengths and what matters to them. It aims to ensures that people are active participants, not just passive recipients, of the treatment, care and support that they receive.
Psychological wellbeing	A sense of purpose, self-worth, and satisfaction with life and mental and emotional health.
Psychosocial intervention	Cognitive or social activities that may maintain or improve functioning, interpersonal relationships and wellbeing in people living with dementia. Psychosocial interventions do not involve the use of medication, although they can be used in conjunction with medication.

Quality of life	'An individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.' *https://www.who.int/tools/whoqol*
Rehabilitation	'Addresses the impact of a health condition on a person's everyday life by optimizing their functioning and reducing their experience of disability.'
Royal College of Occupational Therapists (RCOT)	We've championed the profession and the people behind it for over 90 years, and today, we are thriving with over 36,000 members. Then and now, we're here to help achieve life-changing breakthroughs. For our members, for the people they support, and for society as a whole.
Self-management	Centralises the knowledge that a person has about their health condition or situation (De longh et al 2015). It involves assisting the person to identify and implement strategies and solutions to maintain or improve their health, supported by, rather than led by professionals. This means creating a partnership with and supporting individuals to manage challenges and achieve positive changes to their lives. Aspects that assist people to self-manage include providing information and working with them to identify and achieve individual goals.
SIGN	The Scottish Intercollegiate Guidelines Network (SIGN) collaborates with health and social care professionals, patient organisations and individuals to produce evidence-based guidelines for the people of Scotland. *https://www.sign.ac.uk/about/*
Systematic review	'A review that summarises the evidence on a clearly formulated review question according to a predefined protocol, using systematic and explicit methods to identify, select and appraise relevant studies, and to extract, analyse, collate and report their findings. It may or may not use statistical techniques, such as meta-analysis.' *http://www.nice.org.uk/website/glossary/glossary.jsp*
Universal, targeted, specialist	A framework for delivery of services. **Universal:** everyone who interacts with people concerned about their memory or needing support with cognition **Targeted**: collaborative approach offering supported self-management, tailored consultations and education **Specialist**: direct referral to occupational therapy rehabilitation delivered in a one-to-one or group setting and may involve a period of direct intervention to address a particular need

Appendix 2: Evidence tables

Each item of evidence used to support the recommendations has an associated evidence table.

The evidence tables are detailed in a separate document, *Evidence-based guideline supplement: Evidence tables*, which can be downloaded from the RCOT website at: https://www.rcot.co.uk/explore-resources/standards-guidelines/rcot-practice-guidelines

Appendix 3: Guideline development group

Professor Elaine Hunter (Lead)

- National Allied Health Professions Consultant, Alzheimer Scotland
- Visiting Professor, School of Health and Social Care, Edinburgh Napier University
- Member of: RCOT, lead for the Scottish National AHP Dementia Forum and implementation of the national AHP dementia framework, Connecting People, Connecting Support
- Fellow of RCOT

Professor Gail Mountain (Co-lead)

- Professor Emeritus, University of Bradford
- Honorary Professor of Health Services Research, University of Sheffield
- Member of: RCOT
- Fellow of RCOT

Dr Catherine Brewin

- Advanced Practitioner Occupational Therapist, Nottingham City Hospital
- Member of: RCOT

Dr Pat Chung

- Senior Lecturer, Canterbury Christ Church University
- Adjunct Associate Professor, Tung Wah College School of Medicine, Hong Kong
- Member of: RCOT

Professor Claire Craig

- Professor of Inclusive Design, Royal College of Art
- Co-Chair, Helen Hamlyn Centre for Design
- Member of: RCOT
- Fellow of RCOT

Suzannah Evans

- Senior Lecturer in Occupational Therapy, Wrexham University
- Member of: RCOT

Dr Aisling Flynn

- Lecturer in Occupational Therapy, Bournemouth University
- Member of: RCOT, INTERDEM Academy

Dr Emma Hooper

- Research Fellow, Centre for Dementia Research, Leeds Beckett University
- Member of: RCOT

Ike Junior

- Person with experience of caring for a person living with dementia

Mary McGrath

- Occupational Therapist, Advanced Practitioner Level 2, Memory Clinic, Belfast Health and Social Care Trust
- Member of: RCOT, Association of Occupational Therapists of Ireland

Jessica Moss

- Older Adult Mental Health Head Occupational Therapist for Aneurin Bevan University Health Board
- Member of: RCOT

Karen Shearsmith-Farthing

- Advanced Practice Occupational Therapist, Dementia Lead, Hywel Dda University Health Board
- Member of: RCOT

Myra Wilson

- Person living with dementia

Dr Sandie Woods

- Sessional Lecturer/hourly paid lecturer, London South Bank University, University of East London, University of Roehampton and University of West London,
- Member of: RCOT, PAN London OT Dementia Group, Healthcare Quality Improvement Partnership, Higher Education Dementia Network (HEDN)

Zoe Williams

- Occupational Therapy Lecturer and Practice Education Lead, University of South Wales
- Member of: RCOT

One person with experience of caring for a person living with dementia chose not to be named in the guideline.

Appendix 4: Conflicts of interest declaration

Conflicts of interest declarations were made as follows:

- Occupational therapist Guideline development group members reported membership of RCOT, and other professional bodies (such as the Higher Education Dementia Network, or the Association of Occupational Therapists of Ireland). One person with lived experience is part of the Alzheimer's Society Research Network Volunteers and a joint research project between Marie Curie and Alzheimer's Society.
- Some Guideline development group members have published research papers, and/or contributed to research or other guides for occupational therapy practice (such as competencies or standards).
- The editorial lead was an RCOT employee.

The nature of declarations made by all those involved in the guideline development was related to professional interests and expertise in clinical practice, education or research. Where research included in the guideline literature search was authored by a guideline group member, it was not screened and appraised by the author.

No commercial or financial interests were declared.

The adherence to our conflicts of interest policy, the nature and management of the above declarations, together with the robust guideline development methodology, mean that the potential for any bias has been considered and mitigated.

Appendix 5: Literature search strategy

Table A4.1: Original search terms

1: Dementia terms and conditions	2: Risk reduction/prevention terms	3: Health promotion interventions/Brain health	4: Occupation terms	5: Activity terms	6: Occupational Therapy terms	7: Systematic review terms
alzheimer* OR dement* OR frontotemporal lobar degeneration OR lewy bod* OR posterior cortical atrophy OR primary progressive aphasia	prevent* OR (delay* or reduc* or decreas* or minimis* or minimiz*) N4 risk*	(health or wellbeing or well-being or well being) N4 promot* OR (health behavior* or health behaviour* or health education or health prevention or patient education) OR lifestyle* N4 (chang* or health* or intervention* or modif* or redesign*) OR (ageing or aging) N4 (healthy or success* or well) OR self-efficacy or self efficacy or self-	occupation OR occupations OR occupation-	activit* OR ADL* OR IADL*	occupational therap*	systematic* N3 (overview* or review*)

1: Dementia terms and conditions	2: Risk reduction/prevention terms	3: Health promotion interventions/Brain health	4: Occupation terms	5: Activity terms	6: Occupational Therapy terms	7: Systematic review terms
		management or self management OR resilien* OR brain N4 (health or healthy or integrity or reserve) OR cognition OR cognitive N4 (ageing or aging or decline or function* or health or performance or reserve)				

Core databases or platforms

The tables below show the literature search results by string combinations searched.

Table A4.2: Core databases or platforms: EBSCO and Ovid

Database or platform and search date	EBSCO	Ovid
	18.08.25	19.08.25
Search term strings (below) and fields searched (right)	Title, abstract, subject	Title, abstract, descriptor, subject word heading, article identifier, MeSH subject headings
Strings: 1 AND 2 AND (3 OR 4) AND 7	1,359	265
Strings: 1 AND (4 OR 5) AND 7	2,134	715
Strings: 1 AND 6 AND 7	182	87
Total results	3,675	940
Removed via platform de-duping and/or filter options (date/language)	994	243
Total for cleansing	**2,681**	**697**

Medline, CINAHL – accessed via EBSCOHOST platform

AMED, HMIC, APA PsycINFO, Social Policy and Practice – accessed via Ovid platform

Table A4.3: Specialist databases or platforms

Database or platform	Fields	Terms	Number retrieved	Date of search
Global Index Medicus (WHO)	Title, abstract and subject	(Alzheimer*) AND (prevent* OR risk*) AND (systematic review)	44	21.08.25
		(Alzheimer*) AND (activit* OR occupation*) AND (systematic review)	30	
		(Dementia) AND (prevent* OR risk*) AND (systematic review)	92	
		(Dementia) AND (activit* OR occupation*) AND (systematic review)	44	
		(Frontotemporal lobar degeneration) AND (prevent* OR risk*) AND (systematic review)	0	

Database or platform	Fields	Terms	Number retrieved	Date of search
		(Frontotemporal lobar degeneration) AND (activit* OR occupation*) AND (systematic review)	0	
		(Lewy bod*) AND (prevent* OR risk*) AND (systematic review)	2	
		(Lewy bod*) AND (activit* OR occupation*) AND (systematic review)	0	
		(Posterior cortical atrophy) AND (prevent* OR risk*) AND (systematic review)	0	
		Posterior cortical atrophy) AND (activit* OR occupation*) AND (systematic review)	0	
		(Primary progressive aphasia) AND (prevent* OR risk*) AND (systematic review)	0	
		(Primary progressive aphasia) AND (activit* OR occupation*) AND (systematic review)	0	
		Total	**212**	
SciELO	Title and abstract	[(ti:(Alzheimer*)) OR (ti:(Dementia)) OR (ti:(Frontotemporal lobar degeneration)) OR (ti:(Lewy bod*)) OR (ti:(Posterior cortical atrophy)) OR (ti:(Primary progressive aphasia))] AND (ti:(systematic review)) AND [(ti:(prevent*)) OR (ti:(risk*))]	0	21.08.25
		[(ab:(Alzheimer*)) OR (ab:(Dementia*)) OR (ab:(Frontotemporal lobar degeneration)) OR (ab:(Lewy bod*)) OR (ab:(Posterior cortical atrophy)) OR (Primary progressive aphasia))] AND (ab:(systematic review)) AND [(ab:(prevent*)) OR (ab:(risk*))]	43	
		(ti:(Alzheimer*)) OR (ti:(Dementia)) OR (ti:(Frontotemporal lobar degeneration)) OR (ti:(Lewy bod*))	3	

Database or platform	Fields	Terms	Number retrieved	Date of search
		OR (ti:(Posterior cortical atrophy)) OR (ti:(Primary progressive aphasia)) AND (ti:(systematic review)) AND [(ti:(activit*)) OR (ti:(occupation*))] [(ab:(Alzheimer*)) OR (ab:(Dementia*)) OR (ab:(Frontotemporal lobar degeneration)) OR (ab:(Lewy bod*)) OR (ab:(Posterior cortical atrophy)) OR (Primary progressive aphasia))] AND (ab:(systematic review)) AND [(ab:(activit*)) OR (ab:(occupation*))] **Total**	28 **74**	
OTDBASE	Topic and title	[Topic] Aged [subtopic] Alzheimer's and RD [Topic] Aged [subtopic] Dementia [Topic] MH [subtopic] Alzheimer's and RD [Topic] MH [subtopic] Dementia [Title] Alzheimer [Title] Dementia [Title] Frontotemporal lobar degeneration [Title] Lewy body [Title] Lewy bodies [Title] Posterior cortical atrophy [Title] Primary progressive aphasia **Total**	5 7 97 18 20 20 0 0 0 0 0 **167**	20.08.25

Appendix 6: Scope consultation focus group discussion guide

Introduction

Occupational therapists work with people who have experienced illness and/or disabilities to identify how they can make positive changes to daily living and lifestyle and continue to do the things of importance to them.

Occupational therapists work in health and social care. You may have received support from an occupational therapist in the community or hospital. If you are diagnosed with dementia this might have involved assisting you to make changes so that everyday life is safer and you can undertake activities you need to do and also would like to do.

The Royal College of Occupational Therapists is the professional organisation representing occupational therapists. They are creating a guideline for occupational therapists so that they can work in the best possible ways with people with dementia and their supporters. As a person with dementia or a supporter of someone with dementia we would love to hear what you think should be included in the guideline.

Anything you tell us will be anonymous and will be saved on the Royal College of Occupational Therapists secure computer systems.

We will let you know how your comments made a difference to the final scope.

What we would like you to do

Please try to answer the questions below.
There are no right or wrong answers – we are interested in everything that you can tell us.
Don't worry If you can't answer all of the questions.

This is what we think that the guideline should be about:
How can occupational therapists help people diagnosed with dementia to be independent and live as good a life as possible?

Questions for you
Do you understand what the guideline will be about?
Is this important for you or not?
Are we missing anything?

We think that we will need to include the following in the guidelines:

1. How to encourage people diagnosed with dementia to talk about what matters to them
2. How to support people to continue to do the things of importance to them such as everyday activities, hobbies and interests
3. How to help people to manage any concerns that they might have; for example how to manage memory difficulties.
4. How to encourage people to maintain their overall health and wellbeing.

Questions for you
Do you understand all the above points?
If not what don't you understand?
Do you agree with all the points?

If not which don't you agree with?
Are we missing anything?

We also think that we will need to include:

1. How to assist supporters of people with dementia to obtain help so that they can look after their own needs.
2. Examples of how someone supporting a person with dementia can be independent for as long as possible.
3. Details of training and education that occupational therapists might provide to guide supporters, or people whose work involves helping supporters.

Questions for you
Do you understand all the above points?
If not what don't you understand?
Do you agree with all the points?
If not which don't you agree with?
Are we missing anything?

Finally we will need to include guidance for occupational therapists:

1. Ways to improve their skills, knowledge and confidence.
2. How to improve team working with other professionals.
3. How they can use new ways of working and technologies so that people diagnosed with dementia and supporters are able to benefit.

Questions for you
Do you understand all the above points?
If not what don't you understand?
Do you agree with all the points?
If not which don't you agree with?
Are we missing anything?

Finally is there anything else we that have not raised that you would like to mention?

Thank you for your time and thoughts! We will be back in touch to let you know how your comments have influenced the content of the guideline and to show you the final content. We'll also acknowledge the group/network in our guideline.

Appendix 7: Guideline consultation focus group discussion guide

To be updated post-consultation

Appendix 8: Acknowledgements

The Guideline development group would like to thank all those who have contributed to the development of this evidence-based guideline.

A8.1 People with experience of dementia

We are grateful to people living with dementia and their families, carers and supporters who participated in our consultations on the guideline scope and draft guideline document, including the following groups who so generously gave their time:

- Alzheimer's Society
- East Kent Forget-me-nots
- Experts by Experience, Centre for Applied Dementia Studies, University of Bradford.

The following people with experience of dementia commented on the guideline scope and wished to be acknowledged:

- Ann Booth
- Alison Honour
- Kerry Lovell.

A8.2 Stakeholders

Six organisations or healthcare professionals commented on the guideline scope and the following wished to be acknowledged:

- Association of Clinical Psychologists – UK
- British Geriatrics Society
- Commissioner for Older People for Northern Ireland
- Special Interest Group on Social Work and Ageing, British Association of Social Workers.
- Dr Aida Suarez Gonzalez, Consultant Clinical Psychologist (Neuropsychologist) and Principal Research Fellow, Institute of Neurology at Queen Square, University College London

A8.3 Occupational therapists

Fifty occupational therapists commented on the draft guideline scope. The following wished to be acknowledged:

- Katie Bastick, Clinical Operational Lead, Krysalis Consultancy
- Dany Brookes, Occupational Therapist, Cornwall Partnership NHS Foundation Trust
- Meg Brownings, Principal Occupational Therapist, West Sussex County Council
- Jade Clark, Frailty Specialist Practitioner & Occupational Therapist, EKHUFT
- Shelley Crossland, Leicestershire Partnership NHS Trust
- Faye de Waal, Occupational Therapist, Dementia Assessment Service, Sussex Partnership NHS Foundation Trust
- Ailsa Dow, Occupational Therapy Team Manager, Fife Health and Social Care Partnership
- Carol Duff, Consultant Occupational Therapist, Lincolnshire Partnership NHS Foundation Trust
- Aimee Greene, Senior Occupational Therapist - Older People's Service (Inpatient Dementia Assessment Unit), Leeds and York NHS Partnership Foundation Trust
- Susan Haynes, Specialist Occupational Therapist, NHS Lanarkshire.

- S Heritage, Band 7 Occupational Therapist, Manchester Foundation Trust
- Carrie Hill, OT Professional Lead - Mental Health, NHS Highland (Argyll & Bute HSCP)
- Sarah Howe, Dementia Specialist Occupational Therapist, NHS and Private Consultation as 'Remember Mercy'
- Kathleen James, Clinical Specialist Occupational Therapist, University Hospitals Bristol and Weston NHS Trust
- Julian Jeyasingh Jacob, Occupational therapy research fellow, UKDRI Care research & technology centre, Imperial College London
- Helen Justice
- Molly Kennedy, Occupational Therapist, City of Edinburgh Council
- Richard Leverington Lead Occupational Therapist for Later Life Manchester Division - Greater Manchester Mental Health NHS Foundation Trust
- Gemma Lewis, Occupational Therapist, Dorset Health Care University Foundation Trust
- Dr Fiona Maclean, Head of Subject of Allied Health & Social Care Science and Associate Professor of Occupational Therapy, Edinburgh Napier University
- MHSOP OT Tees Team, Tees Esk and Wear Valleys NHS Foundation Trust
- Ellen Martinez, Parkinson's Specialist Occupational Therapist, Manchester Foundation Trust
- Emma McDonald, Team Lead Occupational Therapist, Ayrshire & Arran NHS
- Laura Mumford, Occupational Therapist, NHS GGC
- Occupational Therapy, Older Adults Community Team, CNTW, NHS Foundation Trust
- Rachel Parr, Dementia Specialist Practitioner, Lancashire Teaching Hospitals NHS Trust
- Chloe Pearce
- Kelly Peare, Lead Occupational Therapist, Tees Esk & Wear Valleys NHS Foundation Trust
- Nina Price, Lead Occupational Therapist, CNWL NHS Foundation Trust
- Carol Robson, Memory Specialist Occupational Therapist, Oxleas NHS
- Abbie Salmon, Occupational Therapist, Somerset NHS Foundation Trust
- Claire Shanahan Highly Specialist Occupational Therapist (Special Interest Dementia) Bradford District Care NHS Foundation Trust
- Karen Sharrock, Professional Lead OT, Hywel Dda University Health Board
- Alexander Smith, Senior Lecturer in Occupational Therapy, Swansea University
- Sherisse Smith, Specialist Occupational Therapist, The ExtraCare Charitable Trust
- Gabrielle Stewart, Deputy Head of Division or Occupational and Arts Therapies, Queen Margaret University
- Charlotte Sutcliffe, Occupational Therapist - Frailty Team, Township 1 Primary Care Network, Sheffield
- Nicky Tann, Occupational Therapist, NELFT on behalf of the Pan London Memory Service OT Network
- Lindsay Truran, Senior Lecturer, University of Hertfordshire
- Melanie Vale, Professional Head OT for Learning Disabilities, Aneurin Bevan University Health Board
- Karen Walls, Principal Occupational Therapist, Northern Trust
- Clare Whitaker, Consultant Occupational Therapist, Birmingham and Solihull Mental Health Trust

A8.4 External peer reviewers

Two independent reviewers appraised the draft guideline:

- To be updated post-consultation

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