Examples of Systematic Reviews on Aging-Related Topics


Many studies have investigated the effectiveness of interventions in promoting advance directives (ADs) but there is uncertainty as to what works best, and in whom. We conducted a systematic review of the evidence in this regard, using both classical meta-analysis approaches and multi-level analyses. Eleven databases were searched for relevant reports published through March 2007. All prospective studies were eligible, whether involving a single group or several and, in the latter case, regardless of the allocation mechanism. Outcomes included formal and informal ADs assessed by chart review or self-report.

Heterogeneous sets of outcomes were pooled under a random-effects model. The search yielded 55 studies, half of which targeted outpatients. Most groups of subjects were educated in a single session led by one healthcare professional. Outcomes were measured within six months of the intervention in 73% of cases. The largest set of single-arm studies yielded an overall AD completion rate of 45.6%. Across randomized trials, the largest pooled odds ratio was 4.0, decreasing to 2.6 when all comparative studies were included.

Multi-variable analyses identified the provision of oral information over multiple sessions as the most successful intervention. This was true regardless of the target population. These findings support the effectiveness of educational interventions in increasing the formulation of ADs and provide practical advice on how best to achieve this goal.


**Background:** Conventional systematic review techniques have limitations when the aim of a review is to construct a critical analysis of a complex body of literature. This article offers a reflexive account of an attempt to conduct an interpretive review of the literature on access to healthcare by vulnerable groups in the UK. **Methods:** This project involved the development and use of the method of Critical Interpretive Synthesis (CIS). This approach is sensitised to the processes of conventional systematic review methodology and draws on recent advances in methods for interpretive synthesis. **Results:** Many analyses of equity of access have rested on measures of utilisation of health services, but these are problematic both methodologically and conceptually. A more useful means of understanding access is offered by the synthetic construct of candidacy. Candidacy describes how people’s eligibility for healthcare is determined between themselves and health services. It is a continually negotiated property of individuals, subject to multiple influences arising both from people and their social contexts and from macro-level influences on allocation of resources and configuration of services. Health services are continually constituting and seeking to define the appropriate objects of medical attention and intervention, while at the same time people are engaged in constituting and defining what they understand to be the
appropriate objects of medical attention and intervention. Access represents a dynamic interplay between these simultaneous, iterative and mutually reinforcing processes. By attending to how vulnerabilities arise in relation to candidacy, the phenomenon of access can be better understood, and more appropriate recommendations made for policy, practice and future research. **Discussion:** By innovating with existing methods for interpretive synthesis, it was possible to produce not only new methods for conducting what we have termed critical interpretive synthesis, but also a new theoretical conceptualisation of access to healthcare. This theoretical account of access is distinct from models already extant in the literature, and is the result of combining diverse constructs and evidence into a coherent whole. Both the method and the model should be evaluated in other contexts.


Self-management education programmes led by lay leaders (rather than health professionals such as doctors or nurses) are becoming common as a way of trying to promote self care for people with chronic conditions. We assessed systematically the effects of these programmes. We included results from seventeen studies which involved a total of 7442 people with chronic conditions including arthritis, diabetes, hypertension and chronic pain. While many of the programmes were similar, they differed in which condition they were for, which measurements researchers reported, and how effective the programmes were. We found that these programmes may lead to modest, short-term improvements in patients' confidence to manage their condition and perceptions of their own health. They also increased how often people took aerobic exercise. Whilst there were small improvements in
pain, disability, fatigue and depression, the improvements were not clinically important. The programmes did not improve quality of life, alter the number of times patients visited their doctor or reduce the amount of time spent in hospital. No adverse events were reported in any of the studies.


“…..a literature review examines articles and papers that study comprehensive models of integrated or coordinated care. The author identified that some models of integrated health and social care can result in improved outcomes, client satisfaction and/or cost savings or cost-effectiveness. MacAdam identifies four frameworks with common interventions that must be structured to support each other.

These key elements are: umbrella organizational structures to guide integration of strategic, managerial and service delivery levels; multidisciplinary case management for effective evaluation and planning of client needs; organized provider networks; and financial incentives to promote prevention, rehabilitation and the downward substitution of services, as well as to enable service integration and efficiency….”


**Objective:** To explore why people from minority ethnic (ME) groups with dementia present later to specialist diagnostic and therapeutic dementia services. We systematically reviewed the literature exploring how and why ME people with dementia present to specialist services.
Method: We included qualitative and quantitative studies that explored pathways to dementia specialist care in ME groups or determinants of whether ME people with dementia accessed specialist services. Included studies were independently evaluated for quality by two authors.

Results: We found 3 quantitative and 10 qualitative papers meeting our inclusion criteria. Barriers to accessing specialist help for dementia included: not conceptualizing dementia as an illness; believing dementia was a normal consequence of ageing; thinking dementia had spiritual, psychological, physical health or social causes; feeling that caring for the person with dementia was a personal or family responsibility; experiences of shame and stigma within the community; believing there was nothing that could be done to help; and negative experiences of healthcare services. Recognition of dementia as an illness and knowledge about dementia facilitated accessing help.

Conclusions: There are significant barriers to help seeking for dementia in ME groups. These may explain why people from ME groups often presented to therapeutic and diagnostic services at a late stage in their illness. Further study is needed to elucidate the role that ethnicity and culture play in the help-seeking pathway for dementia, and to design and test interventions to improve equity of access to healthcare services.


Background: Dementia is an important health and social care problem and is one of the main causes of disability in later life. The number of families affected by dementia will dramatically increase over the next five decades. Despite the implications for health and
social care services in the future, the overwhelming majority of care for people with dementia takes place away from health care settings. Providing informal care for someone with dementia can be psychologically, physically and financially expensive and a range of health service interventions aimed at supporting and providing information to these carers has developed to help carers meet these demands. This review examines whether information and support interventions improve the quality of life of people caring for someone with dementia. **Methods:** A systematic review examining evidence from randomised controlled trials in which technology, individualised or group-based interventions built around the provision of support and/ or information were evaluated. **Results:** Forty-four studies were included in the review. Controlling for the quality of the evidence, we found statistically significant evidence that group-based supportive interventions impact positively on psychological morbidity. However, whilst the improvement was unlikely to be due to chance, the clinical significance of this finding should be interpreted tentatively, due to the difficulties in interpreting the standardised mean difference as a measure of effect and the complex aetiology of depression. No evidence was found for the effectiveness of any other form of intervention on a range of physical and psychological health outcomes. **Conclusion:** There is little evidence that interventions aimed at supporting and/or providing information to carers of people with dementia are uniformly effective. There is a pressing need to ensure that supportive interventions at the development stage are accompanied by good quality randomised evaluations in which outcomes that are important to clinicians and carers are measured.