

The Availability And Uptake Of Non-pharmacological Dementia Interventions In The UK And Barriers To Access

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Introduction – NICE Guidelines

Non-pharmacological interventions are recommended for the treatment of dementia within the UK National Health Service (NHS). However, the extent to which a non-pharmacological options are available across the UK remains unclear. Questions persist regarding what interventions are offered, how accessible they are, their uptake, and the factors that influence patient engagement with those interventions.

The National Institute for Health and Care Excellence (NICE) guidelines¹ encompass both well-established and evidenced therapeutic approaches as well as a non-specific recommendations for wellbeing support activities.

- Offer group **cognitive stimulation therapy** to people living with mild to moderate dementia.
- Consider group **reminiscence therapy** for people living with mild to moderate dementia.
- Consider **cognitive rehabilitation** or **occupational therapy** to support functional ability in people living with mild to moderate dementia.
- **Offer** a range of activities to promote wellbeing that are tailored to the person's preferences".

Literature review



A systematic literature review was undertaken including studies evaluating four NICE specified interventions (cognitive stimulation therapy - CST, cognitive rehabilitation, occupational therapy and reminiscence therapy). Exercise therapy and music therapy were also included as “activities to promote wellbeing”.

Searches of MEDLINE, Embase, PsycINFO and CINAHL were undertaken on the 9th July 2025 and combined with grey literature searches. Eligible studies were screened by two reviewers, with findings synthesised narratively due to heterogeneity.

Population – people with dementia and/or their carers.

Interventions – Cognitive rehabilitation, cognitive stimulation therapy, occupational therapy, and reminiscence therapy, exercise therapy and music therapy

Outcomes – uptake and access of treatments, barriers and facilitators, system issues.

Study type - observational data, service audits survey and interviews.

32 relevant papers found

References:
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1. Intervention availability

The proportions of patients offered NICE-specified non-pharmacological interventions are low

- The 2021 memory assessment service (MAS)² audit found that
 - **70.9%** people going through MAS are offered a “post-diagnostic intervention for dementia”
 - **50.6%** people are offered an intervention other than signposting
 - **22** different innervations were measured
 - **46.7%** offered Signposting, **20.4%** ‘Specialist information” **18.5%** “Other”
 - **17.1%** of attendees are offered a NICE specified intervention



The broad nature of the NICE recommendations means that a wide array of different types of non-pharmacological interventions are offered across the UK. This may affect the proportion of patients who are able to access those non-pharmacological interventions with a stronger evidence base.

2. Focus on CST

Offering CST – patient view

The 2021 MAS audit² compared the rates of offering different non-pharmacological interventions for dementia. Those included in the review are added here:

Intervention	% MAS attendees offered therapies
Cognitive stimulation therapy*	10.9%
Cognitive rehabilitation*	0.5%
Occupational therapy*	5.0%
Reminiscence therapy*	0.7%
Music therapy	0.3%

Whilst CST is the most commonly offered of the NICE recommended interventions, across three MAS audits ²⁻⁴ it is **offered to less than half** of patients.

There are many reasons that people decline CST. Those may include sensory impairment, advanced dementia, travel barriers and digital exclusion (for virtual CST), attitudes towards therapies over medication and lack of understanding of CST.^{2,4,6}

Low acceptance rates and the **variability in services** being able to offer CST mean a substantial number of people not accessing an evidence-based treatment that may help them.

Offering CST – service view

More than 75% of services reported that they were able to offer CST.²

However, CST was recorded as **not available to 41-43.2%**^{4,2} patients.

This was not reflected in the proportion of people who were offered CST, which varied widely at a service level.

11 services who said they could offer CST had not offered it to any patients audited.⁴

Other types of CST, such as virtual⁵, individual^{6,7} and maintenance^{8,9} CST have been studied. Despite strong supporting evidence maintenance CST is rarely commissioned.⁹

Acceptance of CST

Of those offered CST, **about half of patients** decline it – this is regardless of whether it is offered virtually or face-to-face. However, decline rates are higher for face-to-face CST.

3. Personal barriers and facilitators

Access is about whether people *can* reach or obtain an intervention. It focuses on **opportunity**, not behaviour.

Across all included non-pharmacological interventions, access is limited by¹¹⁻²⁸:



Uptake is about whether people start the intervention once they have access to it. It focuses on **engagement, acceptance, and use**.

Across all included non-pharmacological interventions, barriers to uptake include¹¹⁻²⁸:



4. System issues

As well as personal barriers, access to non-pharmacological treatments is also affected by systemic issues around workforce, funding and service provision.¹⁰⁻²⁸

- **Workforce shortages** – not enough staff are trained to deliver non-pharmacological interventions to people living with dementia (such as occupational therapists). This can reduce session frequency and limit the ability to sustain programmes.
- **Lack of funding** - means that there are insufficient resources to offer effective interventions, and to train staff to provide them. Local budget constraints and prioritisation of diagnosis over post-diagnostic support further restrict capacity.
- **Service Fragmentation** - means there is poor communication between services, which can be reliant on carers and GPs for coordination and IT systems can be incompatible.
- **Medical model dominance** - leads to medications being prioritised over non-pharmacological interventions. Services also prioritise responding to crises over preventative measures.
- **Commissioning issues** - System leaders lack knowledge of interventions and practitioners have little influence over commissioning decisions. Resource allocations tend to prioritise diagnosis and non-pharmacological interventions are often under-funded. There is also organisational pessimism about dementia.

Limitations and conclusion

Effective non-pharmacological interventions are used in the UK, but not as consistently as with pharmacological treatments. This may be partly due to a bias towards pharmacological treatment, as well as broad recommendations diluting access to interventions with the strongest evidence base such as CST. Whilst qualitative research was readily available across all included interventions, there was very little quantitative information about most non-pharmacological interventions. This highlights a large evidence gap in understanding who is being offered these interventions on a national and regional level.