

Campbell Collaboration Social Welfare Coordinating Group  
**Title Registration Form**

Please complete this form to begin the process of registering a review with the Campbell Collaboration Social Welfare group. When approved by the editorial board, the title and registration form will be posted in the Campbell Library (<http://www.campbellcollaboration.org/Fralibrary2.html>). Please be explicit about what you will and will not do. Use as much space in the form as you wish. Please return the completed form to [awi@nokc.no](mailto:awi@nokc.no).

**1. Title of review** (Suggested format: [intervention/s] for [outcome/s] in [problem/population] in [location/situation]. Example: behavioural therapy for reducing violence among adolescents in institutions)

Personal assistance for non-demented older adults (65+) with impairments

**2. Background and objective of this review** (Briefly describe the problem and the intervention.)

As is likely to be true in any developed country, the incidence of 'disability' in America is highest among adults between 18 and 65 years, but the rate of impairment among working age adults is much lower than the rate among older adults (17% versus 50%; CDC 2001a). People over 65 are twice as likely as people between 45 and 65 and four times as likely as people between 18 and 44 to have impairments. Overall rates of impairments are strongly influenced by the relative size of the older-adult population.

Proponents of the social model of disability regard activity restrictions as caused by societal and structural barriers and stress the need for their removal. Independence is defined not as doing things alone but as making decisions for oneself and exerting control over how help is provided.

Personal assistance is paid support given to people with impairments in various settings to enable them to participate in mainstream activities. Assistants might help with bathing, dressing, moving around during the day, shopping, etc. Personal assistance is designed for people with permanent impairments and differs from rehabilitative services and from services provided for fixed periods of time in that it is indefinite and ongoing.

Some form of personal assistance is now available (often by statutory right) in all Nordic countries, most Western European countries, Australia, parts of Asia, the U.S. and Canada. The naming and management of personal assistance (including degree of user control) may vary from country to country, which is often related to legislative categories rather than types of interventions.

This review will assess the effectiveness of personal assistance and the impacts of personal assistance on families and carers compared to other interventions.

**3. Define the population** (Who is included and who is excluded?)

Older adults (65+) living in the community who require assistance to perform tasks of daily living (bathing, eating, getting around, etc.) and participate in normal activities due to permanent impairments.

Older adults living outside their own homes (e.g., in nursing homes) will be excluded. Studies in which the majority of participants were demented at baseline will be excluded.

#### **4. Intervention/s** (What is given, by whom, and for how long? What are the comparison conditions?)

In consultation with experts and the reference group, the reviewers sought to determine what minimal amount of assistance could be offered and still follow the personal assistance model for this population.

This review defines personal assistance as individualised support for people living in the community by a paid assistant other than a healthcare professional for at least 20 hours per week, which is provided for an indefinite period of time (i.e., not rehabilitation or respite care).

Comparisons could have included, either singly or in combination, informal care (which might be delivered by partners or other family members), institutionalisation, service housing (cluster housing), on-demand services, night patrols, transportation services, and other alternatives to personal assistance. 'No-treatment' and 'waiting list' groups were eligible even if other services received were not described. Studies examining different forms of personal assistance (e.g., assistance organised by users compared to assistance organised by others) were included. These were treated as separate comparisons.

#### **5. Outcome/s** (What are the intended effects of the intervention? Primary and secondary outcomes should all be mentioned.)

Primary outcomes will include:

- 1) Global quality of life, both (a) generic measures (e.g., the Short-Form Health Survey (Ware 1992) and (b) impairment specific measures. Though well-validated measures for the general population will be considered, a review of global health measures found that 'very few measures have been validated specifically for cognitively impaired respondents' (Riemsma 2001).
- 2) User satisfaction. Direct reports will be preferred, though proxies might be used if users are unable to communicate.
- 3) Participation, including social life, membership in community groups, sexual participation, ability to engage in spontaneous activities, time outside the home, and mobility.

Secondary outcomes will include:

- 1) Unmet needs, particularly the inability to perform activities of daily living.
- 2) Health outcomes, including direct measures of muscle strength, disease, injuries, nutrition, abuse or pain and indirect measures such as hospitalisation, emergency room visits or need for institutionalisation.
- 3) Functional status measured using either generic or impairment-specific tools. Measures might include the FIM Instrument (Heinemann 1993; Linacre 1994) or an index of activities of daily living (Katz 1963; Sheikh 1979).
- 4) Outwardly directed challenging behaviour. Measures might include the Cohen-Mansfield Agitation Inventory (Cohen-Mansfield 1986).
- 5) Psychological outcomes, including dementia, psychological disorders (e.g., anxiety and depression), challenging behaviour, self-harm, suicide and substance abuse. For example, measures might include the Geriatric Depression Scale (Yesavage 1982), the Mini-Mental State questionnaire (Folstein 1975; Tombaugh 1992), or the PAS-ADD (Moss 1998; Prosser 1998).
- 6) Impact on others, including family (spouse and child) employment, satisfaction, and quality of family life. For example, measures might include the Dysfunctional Behaviour Rating Instrument (Molloy 1991), the Short-Form Health Survey (SF-36; Ware 1992) or the GHQ (Goldberg 1979).
- 7) Direct and indirect costs, both immediate and long-term.

**6. Methodology** (What types of studies are included and excluded? Please describe eligible study designs, control/comparison groups, measures, and duration of follow-ups.)

Randomised controlled trials, quasi-randomised controlled trials and nonrandomised controlled studies of personal assistance compared to other forms of support or to 'no-intervention' (which may include unpaid care) in which participants were prospectively assigned to study groups and in which control group outcomes were measured concurrently with intervention group outcomes.  
All relevant measures will be assessed and longterm followup will be sought.

**Reviewer/s**

**Lead reviewer** (Name, address, telephone, fax, e-mail):

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**Other reviewer/s:**

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Jane Dennis

Do you need support in any of these areas: methodology and causal inference, systematic searches, coding, statistics (meta-analysis)?

Once the editorial board approves the registration of your title, you have six months to complete the protocol. If the protocol is not finished after six months, the review area is opened up for others. Queries should be addressed to [awi@nokc.no](mailto:awi@nokc.no)

Revised 22 July 2005