**Supplementary File 3. Table 2. Non-pharmacological clinical interventions that were implemented**

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| **Implementation****Study** | **Description of the clinical interventions (tested in a randomised controlled trials), that are the focus of included implementation studies.**  | **Improvements in behaviour changes or psychological symptoms for people with dementia demonstrated in original RCTs.**  |
| **a Döpp *et al.,*(2011)**Döpp *et al.,*(2013a)Döpp *et al.,*(2013b)Döpp *et al.,*(2015)Van’t Leven *et al* ., (2012) | *Community Occupational Therapy in Dementia Individually (COTiD)*(Graff *et al.,* 2006; Graff *et al.,* 2007)Intervention: Tailored occupational therapy delivered to people with dementia and their carers at home. Focus was on meaningful activities carer wanted to improve. Intervention elements included assessment, training of carer modification of activities and environment. Caregivers were taught effective supervision, problem-solving and coping strategies taught. Dose: 10 x 1-hour session over 5 weeks | Statistically significant reduction in depression and in negative affect of the person with dementiaGraff *et al.,* (2007) |
| **Gitlin *et al*., (2010)** | Environmental Skill Building Program (ESP) (Also known as Skills2 Care) (Gitlin *et al.,* 2003; Gitlin *et al*., 2005)Intervention: Occupational therapist works with person with dementia and carer in their home to carry out an assessment and help carers prioritise main concerns. Therapists tailor dementia education and provides instruction in problem solving and implementing the following strategies: environmental simplification, communication, activity simplification, engaging people in activities and stress reduction. Dose: 6-month active phase: 5 x 90 min sessions + 1 x 30-min phone calls. Plus 6-month maintenance phase: 1 x home visit + 3 phone calls  | Statistically significant reduction in the number of behaviours in the maintenance phase (Gitlin *et al.,* 2005) |
| **a McCurry *et al.,* (2017);**Teri *et al*., (2012) | STAR-Community Consultants (STAR-C) (Teri *et al*., 2005)A behavioral intervention delivered in the home to caregivers Intervention: Caregivers taught about the Alzheimer’s disease, practice using the Antecedent-Behavior-Consequence model to reduce behaviour problems in dementia, effective communication strategies, and implementing pleasant events. Also learn to improve own well-being. Dose: 1/week x 8 weeks + 4 monthly phone calls | Significant reduction in the severity and frequency of behaviors.(Teri *et al*., 2005) |
| **Samia *et al*.,(2014)** | *Savvy Caregiver Program* (Hepburn *et al.,* 2007).Group workshops are provided to family caregivers and includes content to train family caregivers in the basic knowledge, skills, and attitudes needed for caring for person with dementia and how to be an effective caregiver Dose: Weekly 2-hour workshop sessions over 6 weeks. | Statistically significant reduction in apathy (Sepe-Monte *et al.,* 2016) |
| **a Sherman and Steiner (2018)** Steiner and Sherman (2017) | *Savvy Caregiver Program* (Hepburn *et al.,* 2007).As above Renamed as Creating Confident Caregivers® | As above |
| Menne *et al.,* (2014);Primetica *et al.,*(2015);Teri *et al*., (2012)**a Menne *et al*., (2017)** | *Reducing Disability in Alzheimer’s Disease (RDAD)* (Teri *et al.,* 2003)Intervention: Training in the home with both the person with dementia and the carer. The person with dementia is guided through a series of exercises while the caregiver observes. Education about dementia and instruction in behaviour management using problem-solving (using the Antecedent-Behavior-Consequence model) provided to the carer.Dose: 12 x 1-hour sessions for 3 months; monthly follow-up sessions for 3 months. | Decreased depressive symptoms(Teri *et al.,* 2003) |
| *Studies implementing REACH II*  |
| **Burgio *et al.,*(2009)** | *Resources for Enhancing Alzheimer’s Caregiver Health (REACH II)* (Belle *et al.,* 2006).Caregiver training and counselling in the person’s home, training in the use of pleasant events or relaxation techniques, improving safety of the home environment, caregiver self-care, skills for accessing social support and ‘prescriptions’ for managing ADL, IADL and behaviours. A risk appraisal is used to determine the areas that need the most attention.Dose: 9 x 1.5-hour sessions at home over a 6-month period + 3 x 30 min telephone calls (Total 15 hrs), and 5 x telephone support group sessions. | Improvement in ‘problem behaviours’ in Hispanic or Latino participants (Belle *et al.,* 2006) |
| **Cheung *et al.,* (2015)** | REACH II (as above) | (as above) |
| **Czaj *et al.,*(2018)** | REACH II (as above) | (as above) |
| **Nichols *et al.,* (2011)** | REACH II (as above) | (as above) |
| **Nichols *et al.,* (2014)** | REACH II (as above) | (as above) |
| **Stevens *et al.,* (2012)** | REACH II (as above) | (as above) |

**a** Some studies were reported across multiple papers. Only the paper with the author in **bold** is reported in the review for succinctness.