

Assessment and Management of Behaviours and Psychological Symptoms associated with Dementia (BPSD):

**A Summary Handbook
for NSW Health Clinicians providing
services for people experiencing BPSD**

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Overview

Persons living with dementia can experience a good quality of life for long periods. They may also experience behaviours and psychological symptoms associated with dementia (BPSD). BPSD refers to the non-cognitive presentations of dementia, such as agitation, aggression, anxiety, apathy, depression, disinhibition, psychosis and nocturnal disruption.

When BPSD are present, people require care across multiple settings and NSW Health teams. BPSD may be the focus of care or a co-morbid issue requiring management. In each situation, the person experiencing BPSD and carers should receive high-quality care with a consistent approach to BPSD.

Clinical terms such as BPSD exist to guide clinical care and should never be used to objectify, demean or disempower people. People living with dementia and their carers report that clinical terminology often do not reflect their lived experience. People living with dementia, their carers and healthcare professionals in other settings may prefer to use the terms 'responsive behaviours' and 'changed behaviours' to describe this aspect of the person's lived experience.

Key principles

A person who is experiencing BPSD is firstly a person who may be unwell and requires care. The key principles for providing care are:

1. **Person-centred care:**

This emphasises understanding the person and providing care to meet their needs rather than focusing on the behaviour or disease to be "managed". Person-centred care requires care delivered through mutual trust. Clinicians strive for empathy, respect and understanding and focus on development of rapport. Good verbal and non-verbal communication and active listening are crucial. Person-centred care incorporates *trauma-informed care* and recognises the possible effects of past/ongoing trauma on health and behaviour and avoids re-traumatisation. The person, their carer(s) and clinicians work together to develop

a behaviour management plan with shared goals based on the person's values and experiences. Physical, psychological and social goals are considered and prioritised.

2. **Multi-team approach:**

Caring for people with dementia and BPSD is a complex clinical challenge and requires expertise from different health professions. Many clinical scenarios will require a rapid response, which should not be delayed by awaiting a particular professional. Management occurs across multiple settings. Clinicians work with the person's carer(s) and other teams to ensure the person's needs are met, with minimal disruption during transfers of care and at discharge. Each clinician should respect the expertise of other disciplines, teams and carers as of equal value in the care of the person with BPSD.

3. Legal and ethical responsibilities:

Consent is a cornerstone of care. Clinicians have a responsibility to obtain consent to treatment. The person providing consent should be able to understand their condition and recommended treatment, balance potential benefits and risks of treatment, consider alternatives, and arrive at a rational choice. Clinicians should not assume that all people with dementia lack capacity. A person may be capable of making simple, but not more complex treatment decisions. Capacity may be regained, for instance, after a period of delirium.

A person may have an Advanced Care Directive or appointed a substitute consent provider such as an Enduring Guardian. When this has not occurred and the person lacks capacity, the 'Person Responsible', as defined by the Guardianship Act or the NSW Civil and Administrative Tribunal (NCAT), should be consulted to help guide decisions.

In certain situations of clinical urgency, treatment may proceed without consent, for the period of the emergency only. This decision and reasons must be documented. Thereafter, the Person Responsible or NCAT should be consulted. See appropriate NSW legislation for specific legal and ethical obligations for healthcare professionals.

Care Priorities

Priority	Examples
1. Management of physical care needs	<p>Particular attention must be paid to the assessment of potential delirium, which is a medical emergency requiring immediate treatment.</p> <p>Is there drug interaction? Could the person be in pain, be hypoglycaemic, need to go to the toilet or have other basic unmet needs such as thirst or hunger?</p> <p>Consult the carer for their expert advice on potential strategies to meet the needs of the person with dementia (HB).</p>
2. Behaviour management plan – behavioural and environmental management strategies	<p>Creation of a behaviour management plan in the prescribed format is required.</p> <p>Optimal communication, Antecedent Behaviour Consequence (ABC) approach to behaviour modification, noise reduction, distraction minimisation, preferred music, sleep hygiene and/or other psychosocial strategies should be provided, based on an understanding of the person, their needs and capacities.</p> <p>Residential Aged Care Facilities (RACF) are required to have a Behavioural Support Plan (BSP) in place for any resident who is receiving care and experiencing BPSD. People with younger onset dementia who receive NDIS funding may have a BSP. People with younger onset dementia who receive NDIS funding <u>and are experiencing BPSD</u> must have a BSP developed by an approved NDIS Behaviour Support Practitioner.</p> <p>Information on BSP and toolkits to assist aged care providers are available through Dementia Support Australia. Information on NDIS and BSP is available through Dementia Australia – NDIS Support – Younger Onset Dementia Hub.</p> <p>Information from the NDIS Quality and Safeguards Commission regarding behavior support for NDIS Participants can be found at: https://www.ndiscommission.gov.au/participants/incidents-and-behaviour-support/understanding-behaviour-support-and-restrictive-0</p>
3. Psychological engagement	<p>Is the person distressed and anxious because of separation from loved ones, social isolation, bereavement or frustration?</p> <p>Psychological engagement enables the clinician to assess the presenting behaviour or symptom in the context of the person's psychosocial and cultural background.</p> <p>In addition, it is important to distinguish BPSD from delirium and comorbid psychiatric disorders such as depressive disorder, mania and schizophrenia, and vice versa.</p>

Priority	Examples
<p>4. Cautious use of psychotropic medications</p>	<p>Important but limited roles, used with caution and appropriate consent. Antipsychotics should be limited in use for up to 12 weeks.</p> <p>Prescription of psychotropic drugs should be considered only after psychosocial approaches have been unsuccessful, unless in an emergency. Psychotropics should be prescribed carefully with regard to potential benefits, which can be limited, and adverse effects, which can be substantial. The principles of prescribing are:</p> <ul style="list-style-type: none"> • clearly identify the target symptoms or behaviours • start with low doses • increase doses slowly • regularly review medication effects and side effects • avoid polypharmacy • limit the duration of medication use • notify the GP of need for review and discontinuation plan in discharge summary from hospital or community care • provide indications for use of psychotropic medication in discharge summary
<p>5. Care with and for the carer</p>	<p>Engage with and be mindful of the needs of the carer and family. Carers are partners in care. They understand the person’s background and triggers for behaviours and can assist in management. It is essential to provide carers and family with support, education about appropriate techniques for managing behaviours and information on community resources.</p>

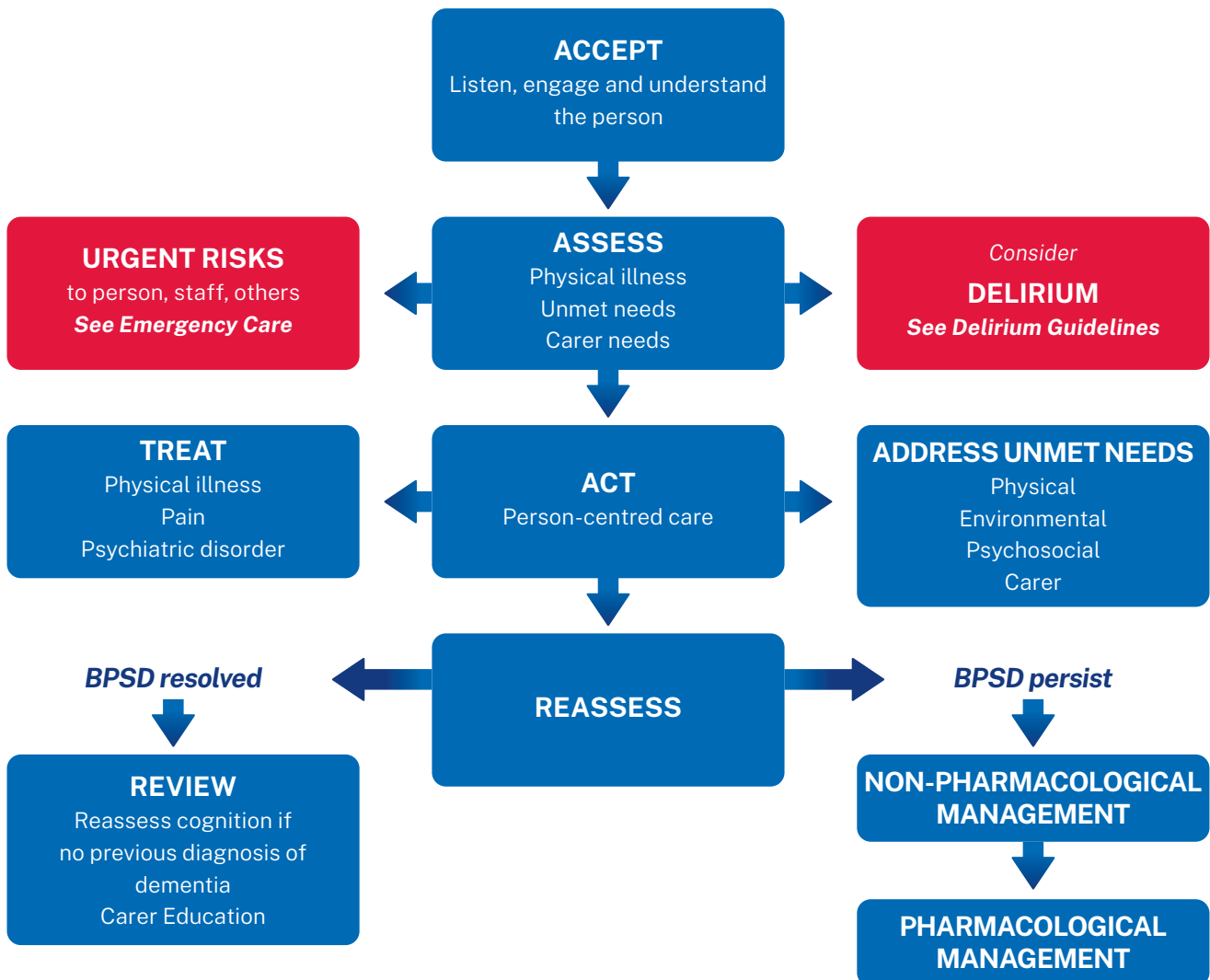
The Cycle of Care

In addition to managing the primary reason for admission, NSW Health staff need to incorporate the four-stage Cycle of Care for BPSD into the treatment plan:

ACCEPT, ASSESS, ACT
and **(RE)ASSESS.**



Prioritisation of actions with the person with BPSD



Summary:

- Behaviours and psychological symptoms associated with dementia (BPSD) refers to the non-cognitive presentations of dementia: aggression, agitation, anxiety, apathy, depression, disinhibition, nocturnal disruption, psychosis, vocally disruptive behaviour, wandering/exiting
- A person with behavioural disturbance is a person who is trying to communicate and/or is unwell and requires help
- Key principles to remember:
 - Person-centred care incorporating trauma-informed care
 - Multi-team and multi-disciplinary approach
 - Legal and ethical responsibilities
- Priorities in care:
 - Understand factors (often multiple) that may affect the person's behaviour/symptoms
 - Management of physical care needs
 - Behavioural and environmental management strategies including creation of a Behaviour Management Plan
 - Psychological engagement
 - Cautious use of psychotropic medication
 - Engage with and care for the carer

Acceptance of the person requires an understanding of the impact of dementia and BPSD upon the person and their carer(s) and family.

Dementia is a syndrome characterised by decline in one or more cognitive domains and in function, specifically:

- memory disturbance (amnesia)
- loss of receptive or expressive language skills (aphasia)
- impaired ability to carry out motor functions (apraxia)
- failure to recognise objects (agnosia) or a familiar face (prosopagnosia)
- disturbances in executive functions such as planning, organising and sequencing tasks and abstract thinking
- decline in activities of daily living and in social functioning
- behavioural changes and psychological symptoms, personality changes, emotional changes, impaired judgement, loss of empathy and inhibition

Most (but not all) dementias are progressive. While most dementias are not yet curable, there are many strategies to maintain good quality of life. Investigations for reversible causes should always be undertaken.

For people living with dementia:

- cognitive impairment is only one feature
- behaviours such as agitation and aggression occurs in 60-90%
- psychological symptoms such as psychosis and depression occur in up to 25%
- apathy occurs in 55-90%

Dementia often presents at a younger age in Aboriginal and Torres Strait Islander peoples than it does in the non-indigenous population.

Agitation and Aggression

Agitation can be non-aggressive or aggressive verbal or motor behaviours that appear inappropriate. One example is a “catastrophic reaction”. A person suddenly becomes tearful, angry and abusive. In the same situation, a non-aggressive response might present as repetitious movement or moaning.

These types of episodes may occur for many reasons such as delirium, drug interaction, pain, physical illness, depression, disorientation, separation from family or other unmet needs.

Anxiety

Anxiety can be debilitating, intrusive and may be mistaken for agitation and aggression. When people are anxious or fearful they may feel a need to protect themselves (fight), leave the situation (flight) or to withdraw (freeze).

Common anxieties are a fear of being left alone, concerns about the future (e.g. finances, health, family), and worries about previously non-stressful events and activities.

Apathy

Apathy presents as low initiative and low emotional response. People who are apathetic are not sad or suicidal. They may lack motivation or interest. For example, an apathetic person may watch TV but not “care” what the program is or may not prepare food but will eat what is provided.

Depression

Depression is more common in vascular dementia and Parkinson’s dementia. Symptoms may include agitation, apathy, appetite and weight loss, and sleep disturbance. Consider depression if the person is tearful, pessimistic, says they want to die, or has acute decline in cognition is apathetic.

Nocturnal Disruption

People with dementia can have disrupted sleep-wake cycles. Disruptive effects of illness, hospitalisation and/or changes to their environment may be superimposed on this underlying pattern of disrupted cycles.

Worsening cognition, mood and behaviour can exacerbate sleep difficulties, and sleep difficulties can affect cognition, mood and behaviour.

Psychosis

Psychosis involves delusions, hallucinations and misidentifications. Delusions are fixed, false beliefs. In people with dementia, false beliefs tend to reflect memory loss or perceptual changes. Hallucinations may be visual or auditory. In people with dementia, hallucinations are often misinterpretations of cues in their environment. They may also be a side-effect of medications. Misidentifications occur when the person mistakes people or objects for something else, due to perceptual disturbances. Believing that someone is stealing food may be a delusion; talking aloud with a deceased relative may be a hallucination; and thinking that reflective decorations are moving insects may be an illusion.

Inappropriate sexual behaviour (ISB)

ISB is verbal or physical sexual actions displayed in an inappropriate social context, self-directed or directed at others.

Influencing factors include disinhibition, lack of privacy, boredom, previous behaviour, absence of partner(s), medication, alcohol, mood disorder, delusions, hallucinations and misinterpretations.

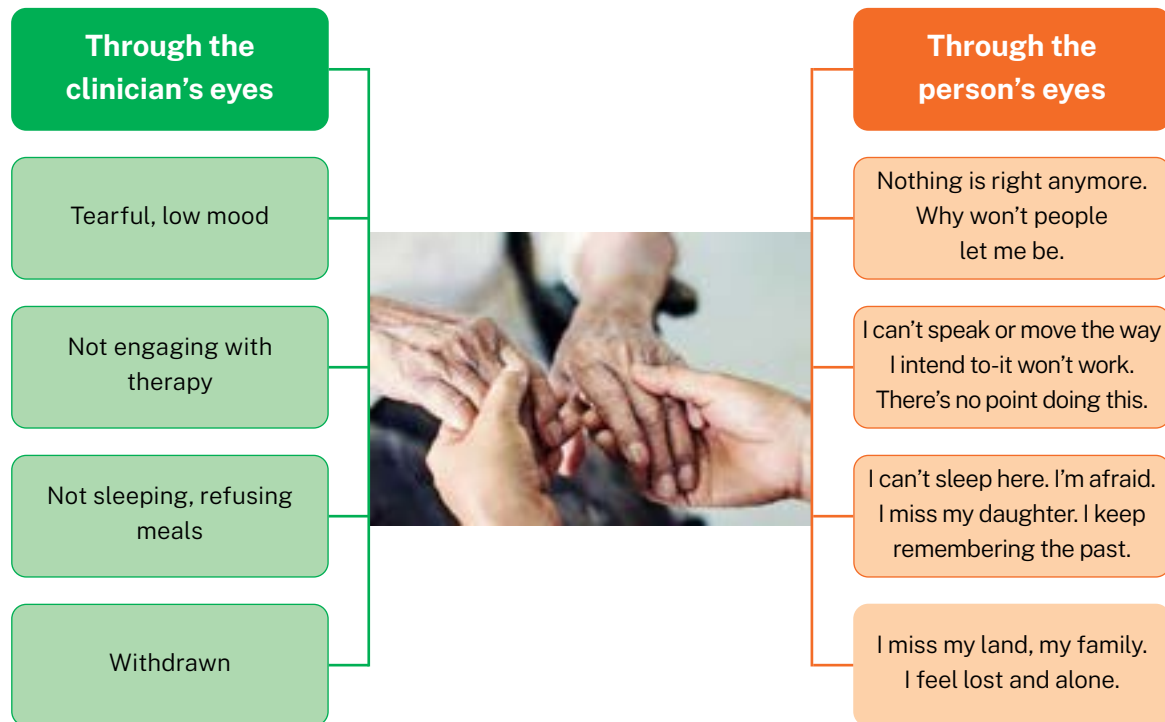
Person-centred care

- uses principles that apply to all people with dementia
- may reduce the emergence of BPSD
- includes care beyond the physical needs of the person, or medication alone
- focuses on understanding and helping the person
- stresses the importance of the person feeling valued and recognised as a unique individual
- respects and values the person's strengths and vulnerabilities, life experiences, cultural background, coping resources and social, family and community networks
- adapts services to the person's unique context, history, socio-cultural background, needs and preferences
- maximises residual strengths in the person
- utilises development of rapport and partnerships between the person, carer and clinicians
- implies recognition, respect, empathy and trust in forming such relationships
- recognises that behaviour is an attempt to communicate and/or to meet a need
- recognises that how people experience and present with BPSD may be influenced by the effects of past or ongoing traumatic experiences
- emphasises the clinician's responsibility to identify and respond appropriately to messages being conveyed by the person
- is supported by good communication

Key communication points

Body language and the tone of your voice provide most communication. The actual words used are less important. A warm smile, laughter or touch, where appropriate, may be more effective than conversation. Using multiple sensory cues (e.g. contextual cueing) during care provision—visual, auditory, touch—may help the person better understand context and meaning.

Non-verbal actions	Verbal actions
Minimise background noise	Talk in a gentle tone
Stay calm and still while talking, in the person's line of sight	Use short sentences and simple words
Ensure hearing aids are functioning and turned on Use a portable hearing amplifier if no hearing aids available	Explain all procedures and activities slowly in simple terms
Check that prescription glasses are available and worn	Allow time for what you say to be understood
Break down tasks into smaller steps	Clarify what they have said - repeat or reword
Communicate at eye level Use simple, calm hand gestures and facial expressions	Use personal references where available, e.g. "your son Yìchén", "your pink jumper", "this photograph of your granddaughter", etc.
Allow plenty of time for the person to reply	



It is important to apply respectful, culturally appropriate ways of approaching and communicating with people and their carers to support effective therapeutic relationships and enable the best possible outcomes.

Person-centred care with Aboriginal and Torres Strait Islander peoples

Person-centred care for an Aboriginal and/or Torres Strait Islander person with dementia should be 'family-centred' and 'community-centred'. Culturally safe, appropriate, objective and reliable assessment and identification of cognitive impairment and dementia is required. Recognition of the unique cultural and historical background of Aboriginal and Torres Strait Islander communities is essential to understanding factors that contribute to BPSD.

Aboriginal and Torres Strait Islander health workers are primary contacts for health-related issues. More information may be found in the [Aboriginal Older People's Mental Health - Resources for Local Health District SMHSOP](#) and [Communicating Positively: A Guide to Appropriate Aboriginal Terminology \(GL2019_008\)](#),

Health workers supporting people with dementia in Aboriginal communities in remote areas can access [culturally appropriate posters](#) developed in

collaboration with the DBMAS Northern Territory (DBMAS NT) and other expert clinicians. Additional resources are available through [Dementia Australia](#).

Person-centred care with people from culturally and linguistically diverse (CALD) backgrounds

Person-centred care for people with dementia and carers from CALD backgrounds is complex and requires understanding of individual experiences, unique cultural differences, varied perspectives of what dementia is and/or stigma around dementia.

People from CALD backgrounds and their families should receive support from bilingual staff and/or professional interpreters. Resources for aged care providers are available at Australian Government Department of Health: [Partners in Culturally Appropriate Care \(PICAC\)](#).

Resources in various languages for people and their carers may be found at the [Dementia Australia](#) and [Dementia Training Australia](#).

Work with the family/carer.

Maximise residual strengths in the person.

Successful interventions will build on a person's strengths.

The person and/or their family/carer may be able to provide knowledge of the person's history and values. The 'Sunflower Tool', the 'TOP 5' toolkits, or similar tools are helpful resources to collect, display, and communicate information about the person easily and consistently.

The person experiencing BPSD, their family/carer and clinicians must also work together to identify what matters to the person in developing a care plan, including a **behaviour management plan**.

Holistic goals (physical, psychological and social) should be considered.

Factors that should guide assessment and care planning include:

- the person's response to past/current healthcare environments
- their personal history, cultural and religious background
- personal strengths and vulnerabilities
- personal values, likes and dislikes, usual routines and preferred care approaches
- interpretation of causes/triggers for behaviours arising from unmet needs and/or the psychosocial environment
- family/carer advice on how to reduce unhelpful triggers in the healthcare context.

After identifying strengths, strategies to maximise function/reduce BPSD may include:

- task modification
- aligning daily routines to the person's preferences
- facilitating community integration
- equipment prescription and home modification
- risk reduction such as falls prevention.

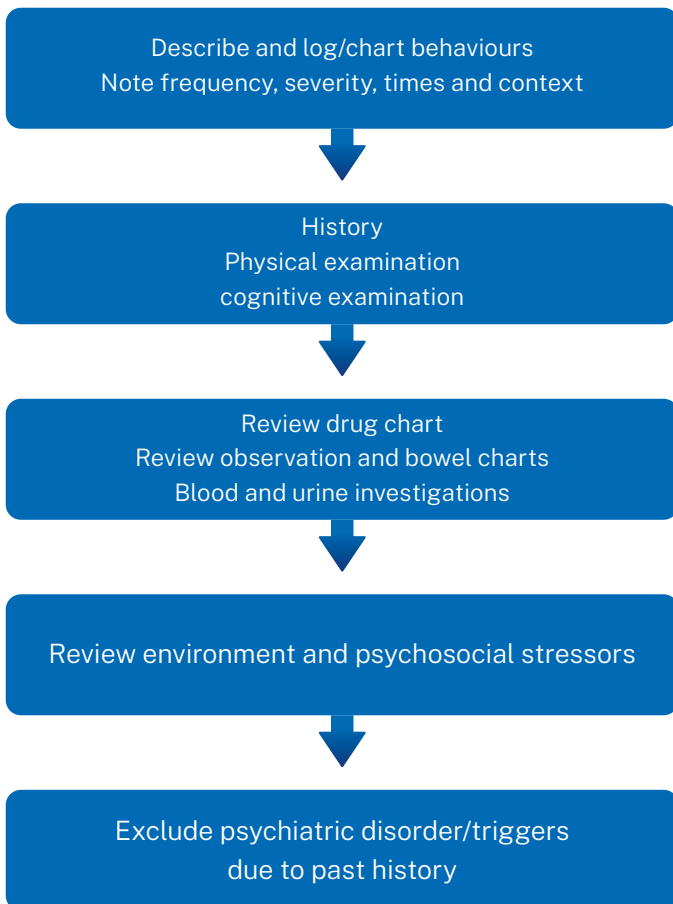
Person-centred care with people experiencing BPSD in healthcare settings

Communicate with the person	Use a gentle manner and clear and calm communication; reintroduce yourself, actively listen, remind/reorient the person who/where/why but don't argue with them, reassure the person.
Communicate with other staff	Use simple, clear, reliable systems across staff/wards/shifts for identifying when someone has dementia with or without BPSD.
Work with and support carers/family	Communicate regularly with family and carers, listen to and document their knowledge, apply the knowledge they share with you, support family/carers and assist them throughout their care experience—it will help the person, it will help the family, it will help you.
Ask about, assess and identify needs	Ask, assess and identify, don't assume: each person with dementia will have different needs and abilities in activities of daily living; some people will need more assistance, others will be more independent.
Investigate, do not overwhelm	Where there are communication difficulties, proactively assess for needs including thirst, hunger, pain, toilet use and soiled clothes/bedding, and explain what you are doing; asking questions is good practice but repeatedly asking people what they need may not be an effective strategy.
Consistency is key	Aim for familiarity, keep staffing and rooms consistent; avoid moving people where possible, avoid moving staff where possible, avoid surrounding the person with too many staff.
Calm environment	Try to reduce overstimulation in their environment, e.g. noise and glare.
Document, document, document...	Document psychological well-being and/or distress, and wherever possible document antecedents/triggers.
Get to know the person	Invest time getting to know the person in the near term to save time in the long term; the person's needs and responses will be related in part to their personal history, beliefs, culture, and social relationships.
Ensure that everyone gets to know the person	Use a simple, clear reliable system (e.g. 'Sunflower Tool') to document and remind staff of the person's preferred name, family, likes, dislikes, etc.
Tailor and target activities to the person	Tailor activities to the person and provide access to activity resources (e.g. easily replaceable, age-appropriate items such as playing cards, magazines, newspapers).
Personalise the environment	Encourage family/carers to personalise the person's environment where appropriate and possible (e.g. photos, favourite blanket).
Involve family in care	Consider extending visiting hours for family and carers of people with dementia, invite interested family to assist with daily care practices such as meals, drinks, grooming.
Mealtimes are important - give people time and space to eat	Create protected mealtimes so that people and family/carers can focus on nutrition and hydration without interruption.
Help people to eat when and what they want	Provide 24-hour access to a range of beverages and foods including cutlery-free meals, finger foods and snacks that meet the person's individual needs.
Help people who need help	Help people to eat in a timely manner; use a simple, clear, reliable system to identify who needs help and who will provide the help.

Assessment of the person with BPSD

Conduct assessment of the person in a way that maintains the dignity and privacy of the person while ensuring their safety and minimising distress. Identifying the person's residual strengths and identifying the BPSD that they may be experiencing are equally important.

Assessment



Possible causes of BPSD



Assess and treat physical illness

<p>First Priority Screen for and treat Delirium</p> <p>Causes: Physical illness</p> <ul style="list-style-type: none"> • Infection • Metabolic • Haematological <ul style="list-style-type: none"> • Cerebral • Cardiac • Endocrine • Drugs including withdrawals; and alcohol viz DTs. 	<p>Toxicity</p> <p>From:</p> <ul style="list-style-type: none"> • Medications • Polypharmacy • Alcohol/other drugs (Intoxication or withdrawal) • Anaesthesia 	<p>Pain</p> <p>From:</p> <ul style="list-style-type: none"> • Constipation • Wounds, fractures • Surgery • Comorbidities, e.g. arthritis, stroke 	<p>Sensory impairment</p> <p>Including:</p> <ul style="list-style-type: none"> • Hearing • Vision
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Delirium

Consider delirium in any older person with new/worsening confusion and/or behaviour change. Indications of delirium are:

- **sudden, acute onset** (hours or days)
- **altered consciousness or awareness** disorientation
- **fluctuating presentation**
- **inattention:** unable to focus on conversations, with disorganised thoughts.

The Confusion Assessment Method (CAM) takes 5 minutes and can assist in identifying and rating these issues.

The 4 'As' test (4AT) takes <2 minutes and can be used for people with sensory impairment.

Information on these and other delirium assessment tools see the [Dementia Outcomes Measurements \(DOMS\) Suite](#) and [NSW Health - Agency for Clinical Innovation: Screening and assessment tools for older people](#) resources.

Safety

Assess safety and develop a behaviour management plan. Clinicians should:

- Consider risks within local policies and protocols for the assessment and management of risk and patient safety
- Seek advice from more senior clinicians if unsure of appropriate action
- Discuss their assessment and plan, in appropriate language and detail, with the person and the carer
- Balance identified risks with the risks of interventions, informed by the values of the person and carer
- Request pharmacy review if concerned about medications or interactions
- Check policies on restrictive practices, e.g.:
 - [Safe Assessment Rooms](#)
 - [Aggression, Seclusion & Restraint in Mental Health Facilities – Guideline Focused Upon Older People](#)
 - [Seclusion and Restraint in NSW Health Settings](#)
 - [Managing Acute Severe Behavioural Disturbance \(ASBD\) during COVID-19](#)

Assess and treat psychiatric comorbidities

NB. Assess and treat once physical issues adequately addressed, and/or if pre-existing psychiatric illness.

Schizophrenia/ Delusional disorder

- More extreme delusions
- Auditory hallucinations
- Past history
- Family history

Mania

- Persistent physical overactivity
- Rapid speech
- Difficult to interrupt
- Grandiose ideas
- Irritability/disinhibition

Depressive disorder

- Persistent depressed mood
- Morbid/suicidal thoughts
- Feeling of hopelessness/
worthlessness/guilt

Summary:

The following factors require assessment:

1. The person (for delirium, pain, unmet needs or other physical problems)
2. Safety
3. Communication
4. Environment
5. Psychological symptoms
6. Behaviours

The person may have:

- communication problems and so they express unmet needs through behaviour, rather than through specific complaints
- personality and cultural factors and past experiences that influence why/when/what/how BPSD present

If dementia has not been diagnosed previously, determine if a diagnosis of BPSD is appropriate after acute physical and psychiatric problems have resolved.

Act 1: Non-pharmacological and psychosocial management

Behaviour assessment and management

The ABC approach to characterising precipitating events and resultant behaviours:

A: the antecedent event(s) that prompt behaviour(s)

B: the specific behaviour(s) observed

C: the consequences of the behaviour(s) on the person, staff, other people and the environment.

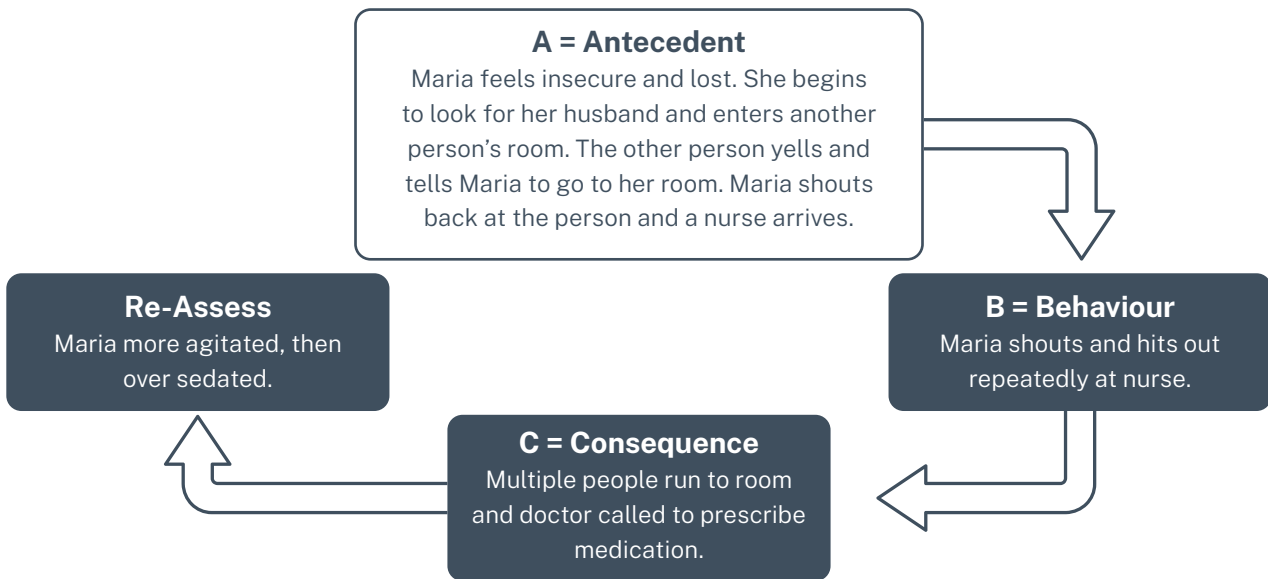
It is important to:

- document all incidents, keep a chart of frequency, severity and other details
- understand the context and contributing factors
- **discuss** with all staff, family, other carers
- determine the risks

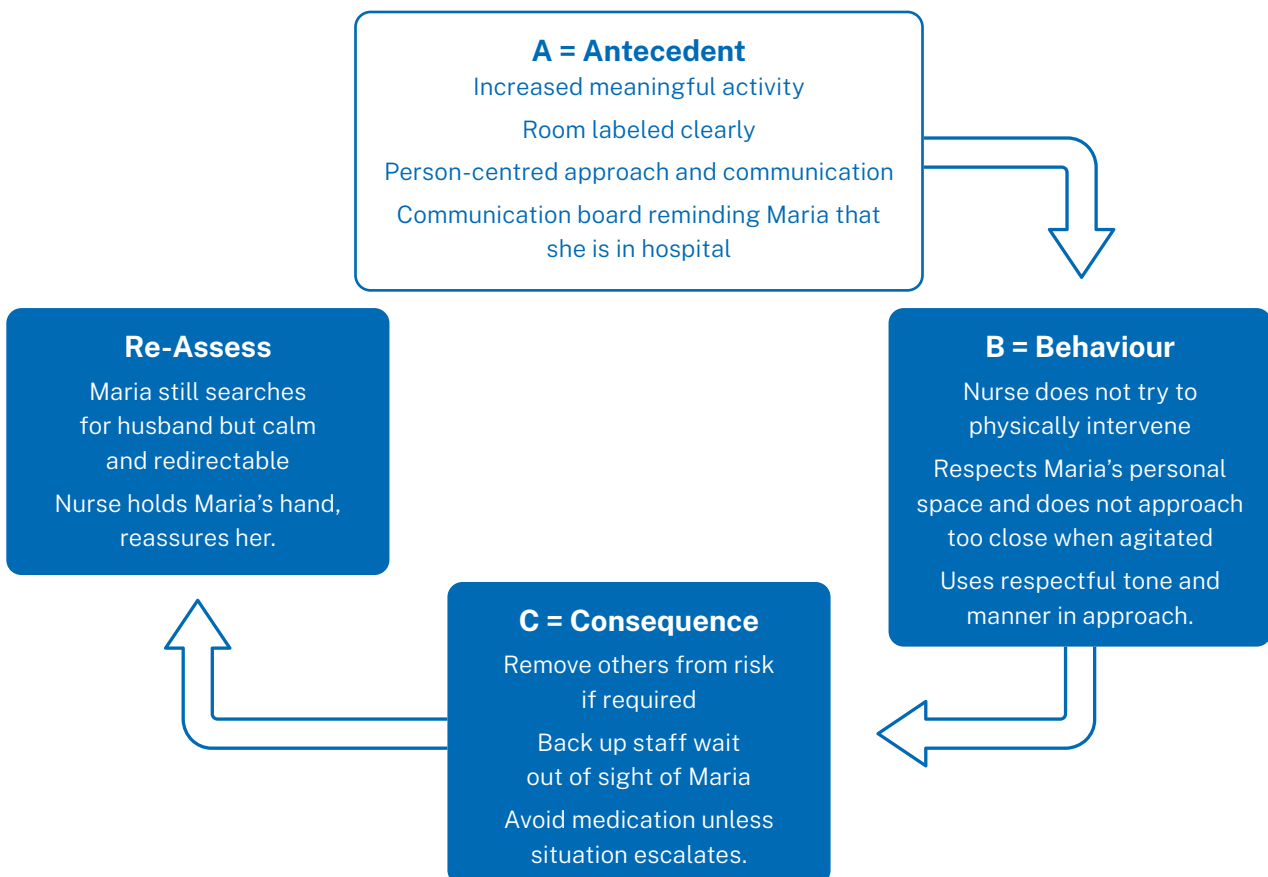
- determine whether behaviours relate to the person's background
- consider the multiple factors contributing to the behaviours and prioritised solutions when devising a behaviour care plan.

The following figure adapted from Dementia Support Australia (DSA) online Behaviour Support Plan (BSP) Resources illustrates application of the ABC approach to "Maria's vignette". For more information on this and other clinical vignettes that illustrate the application of the BPSD framework, see the full text version of [Assessment and Management of Behaviours and Psychological Symptoms associated with Dementia \(BPSD\): A Handbook for NSW Health Clinicians providing services for people experiencing BPSD.](#)

ABC assessment: Behavioural assessment and intervention using a person-centred care approach



Maria is 89 and experiences behaviours and psychological symptoms associated with dementia. She enters other people's rooms while searching for her husband. She becomes upset when confronted and defends herself by hitting if others try to guide her back to her room.



Interventions for general BPSD and for specific behaviours and symptoms

Behaviour/symptom	Possible factors	Interventions that may help based on current evidence. (see act 2 for pharmacological management)
General BPSD	One or more of the factors listed below for individual BPSD	<ul style="list-style-type: none"> • Exercise program tailored for the person • Psychoeducational interventions for the carer(s) to develop problem/goal-focused coping strategies • Antecedent-Behaviour-Consequence-Description (ABCD) approach/analysis or similar • Music therapy • Reminiscence therapy • Analgesic pain management using a stepped protocol
Aggression	delirium, pain, physical restraints, loss of functional abilities, direct care	<ul style="list-style-type: none"> • Outdoor activities/gardening, • Massage and touch therapy <p>Note: evidence for long-term care and community only</p>
Agitation	hospitalisation, seclusion/ isolation, delirium, pain, benzodiazepines, younger age, younger-onset dementia, poor formal caregiver communication, Alzheimer's dementia (AD), COVID-19	<ul style="list-style-type: none"> • Responding to unmet needs (e.g. pain, boredom), balanced sensory stimulation, appropriate music and improving formal caregiver communication • Exercise combined with modification of any activity of daily living
Anxiety	hospitalisation, pain, discomfort, loneliness	<ul style="list-style-type: none"> • Individualised music therapy
Apathy	Behaviour variant Fronto-temporal Dementia (bvFTD), younger-onset AD, other BPSD present	<ul style="list-style-type: none"> • Cognitive stimulation • Therapeutic conversation • Individually tailored activities
Depression	vascular dementia, AD, younger onset AD, some cardiovascular comorbidities, medication withdrawal, functional impairment, Culturally and Linguistically Diverse (CALD) background, disengagement from exercise and activities	<ul style="list-style-type: none"> • Music therapy (passive/active) tailored for the person • Massage and touch therapy • Electroconvulsive therapy (ECT) only in exceptional circumstances for non-responsive severe symptoms <p>Interventions in community settings:</p> <ul style="list-style-type: none"> • Animal therapy (e.g. activity, time spent with animals) • Cognitive stimulation (e.g. structured games/art therapy) • Exercise (aerobic, resistance, or balance training) • Massage and touch therapy • Reminiscence therapy • Multidisciplinary care • Occupational therapy • Cognitive stimulation and a cholinesterase inhibitor • Exercise combined with social interaction and cognitive stimulation • Psychotherapy (e.g. cognitive behavioural therapy, counselling, validation therapy, problem adaptation therapy, supportive therapy, or psychodynamic interpersonal therapy) combined with reminiscence therapy and environmental modification

Behaviour/symptom	Possible factors	Interventions that may help based on current evidence. (see act 2 for pharmacological management)
Disinhibited behaviours	bvFTD and young-onset AD, other BPSD present	No non-pharmacological method recommended in recent literature
Nocturnal disruption	pain, discomfort, anxiety, depression, medication side-effect	No treatment shows definitive effectiveness, some benefit from nonpharmacological interventions
Psychotic symptoms (e.g. delusions, hallucinations)	delirium, pain, AD, bvFTD, greater impairment	<ul style="list-style-type: none"> • Reorientation • Human presence
Vocally disruptive behaviours	delirium, pain, discomfort, emotional distress, loneliness	<ul style="list-style-type: none"> • Individualised music listening No pharmacological method shows definitive effectiveness
Wandering/exiting	pain, boredom, fear, social isolation, loneliness, wanting to leave/go home	<ul style="list-style-type: none"> • Environmental modification: i.e. replace poor lighting, reduce glare/reflections/shadows, increase exposure to natural light, create clearer signage and visual cues, personalise décor, add communal waiting/living areas and amenities

Summary:

The care of a person with dementia and BPSD should be managed within a model of person-centred care

- Display key personal information
- Identify residual strengths for use in management
- Actions include:
 1. Maintain safety
 2. Modify communication
 3. Modify environment
 4. Meaningful activities
- Consider the following specific non-pharmacological therapies:
 - behaviour management
 - aromatherapy
 - music
 - validation and reminiscence therapy
 - sleep hygiene
- In general, the person should be cared for in an environment free of restraints
- Care for and with the carer

ACT 2: Pharmacological management

Essentials of prescribing psychotropic medication to the person experiencing BPSD

- Check for and treat reversible causes
 - Ensure there is baseline assessment of frequency and severity of behaviour
 - Ensure that appropriate non-pharmacological strategies have been trialled first
 - Ensure consent is present (see Chapter 8 of the complete handbook)
 - Continue cognitive enhancing drugs unless there is clear evidence that their introduction may have caused the BPSD
 - Consider whether any psychotropics previously prescribed for BPSD can be discontinued
 - Continue psychotropics prescribed for another clinical indication (e.g. schizophrenia) unless the BPSD is considered to be an adverse effect of the psychotropic
- Use the 3t approach to prescription, namely:
 1. Target behaviours or symptoms that potentially respond to psychotropics
 2. Titrate carefully; start at a low dose and increase slowly
 3. Time limit the use of psychotropics
 - Stop if there has been no response within 4 weeks or significant adverse effects
 - Avoid using multiple psychotropics as far as possible
 - Review the ongoing use and dose of each psychotropic at least every 12 weeks
 - Planned review of antipsychotics with view to withdrawal should occur within 12 weeks
 - Depot antipsychotics should not be used (unless prescribed for a co-occurring chronic psychotic disorder)

If medications are indicated, the following hierarchy is recommended:

1. **Analgesics** – for agitation. Most commonly paracetamol 500gm ii tds for agitation; (may use buprenorphine transdermal patch if already on paracetamol)
2. **Antidepressants** – for depression, sometimes for psychosis; short acting SSRI; best evidence is for citalopram (and by inference escitalopram): if potential for QT prolongation is risky may choose sertraline,
3. **Antipsychotics** for aggression, agitation, psychosis – only risperidone is PBS approved
4. **Cholinesterase inhibitors** – limited evidence for benefit except for Lewy body dementia
5. **Memantine** – limited evidence for benefit
6. **Benzodiazepines** – short term benefit for anxiety and agitation
7. **Anticonvulsants** – poor evidence, for agitation, specialist consultation required

Drug classes used to treat BPSD

Type of medication	Name of drug class	Example agents (total daily dose)	BPSD indication	Selected adverse effects
Analgesic		Paracetamol, up to 3g	Pain-related agitation	Sedation, hepatic dysfunction
Antidepressant	SSRI	Citalopram 10–20mg Sertraline 25-100mg Escitalopram 5-10mg	Non-urgent treatment of agitation, aggression or psychosis Severe depression	QTc prolongation monitor ECG (citalopram) Hyponatraemia, falls, sleep disturbance
Cognitive enhancing	Cholinesterase inhibitor (ChEI)	Rivastigmine (Exelon Patch) 4.6– 9.5mg Donepezil 5-10mg Galantamine 8-16mg	Agitation, psychosis in DLB	Exclude bradyarrhythmias – need ECG gastrointestinal AEs, urinary symptoms
Antipsychotic	Atypical	Risperidone 0.25– 2mg Aripiprazole 2.5mg – 15mg	Psychosis and aggression in Alzheimer’s disease (PBS indication); psychosis, aggression, agitation in dementias other than DLB Second line for psychosis, aggression, agitation in dementias other than DLB	Falls, confusion, hypotension, extrapyramidal side effects, QTc prolongation, monitor ECG
Sedative/hypnotic	Benzodiazepine	Lorazepam 0.5–1mg Oxazepam 15-30mg	Very short term only, Agitation, severe anxiety Nocturnal sedation	Falls, confusion, rebound insomnia
Anticonvulsant		Carbamazepine 100–300mg	Agitation Possibly 3rd or 4th line treatment, only with specialist consultation	Falls, disturbed gait, confusion, hepatic dysfunction, blood dyscrasias

Emergency care

- Any situation in which the physical safety of the person, carers and other patients is potentially seriously compromised is considered an emergency
- It is still essential to consider cause(s) of the behaviour – such as delirium or unmet needs
- Use non-pharmacological actions to prevent the behaviour escalating
- Ensure that all staff are aware of local policies and procedures for responding to behavioural emergencies
- Acute sedation may be considered only if essential to immediately reduce risks to the person, other patients and/or staff in the immediate environment

Early intervention and de-escalation: These actions may suffice to quell the emergency

Recognise warning signs before escalation. Attend to such persons as a priority – do not delay. Protect the person and others from coming to harm by engaging the person, using a calm, friendly, engaging, respectful approach and:

- Do not chastise for ‘bad behaviour’, actively listen to their perceived cause of distress
- Do not argue or raise your voice
- Be aware of body language – adopt a non-threatening stance, arms by your sides, open palms
- Manoeuvre the person away from open windows, balconies and doors
- Remove objects that can harm others (such as cutlery) or the person (such as electric cords)
- Remove from the immediate environment others

who may be at risk

- Summon the assistance of other staff, consider using staff who have rapport with the person
- Give the person space and time to settle, do not rush them
- Move the person to a quiet room to enable continuous direct observation, or to a safe assessment room
- Involve the carer(s) and close family to find out what usually calms the person
- Try distraction with food/drink, music, TV, etc.

Consent

- According to the Guardianship Act, urgent treatment that is considered necessary to save the patient’s life, to prevent serious damage to the patient’s health or to alleviate significant pain/distress does not require substitute consent. However, ongoing use of medication requires substitute consent.

Medication for use in in-patient behavioural emergencies

Route	Medications	Initial Dose	Maximum Dose in 24 Hours	Caution	
ORAL	BENZODIAZEPINE (preferred)	Lorazepam	0.5 - 1mg	Max dose 5 mg	Respiratory depression, confusion, ataxia
	And/or	Olanzapine wafer OR	5mg-10mg	Max dose 10 mg	Confusion, hypotension, bradycardia, ataxia
	ANTIPSYCHOTIC	Risperidone	0.5 - 1 mg	Max dose 2 mg	Hypotension, sedation, ataxia
IM	ANTIPSYCHOTIC	Olanzapine ¹	2.5 mg	2.5 mg increments 2-4 hours apart to max dose of 7.5mg DO NOT use if delirious; seek specialist advice	Confusion, hypotension, bradycardia, ataxia

Precautions: ¹ Do not use Olanzapine IM within 2 hours of parenteral benzodiazepines due to risk of respiratory depression.

Seclusion and restraint

The restraint of a patient in a clinical care area is the responsibility of the clinical team. Clinicians MUST review and adhere to local policy and procedures if they need to use seclusion and restraints. [Seclusion and Restraint in NSW Health Settings \[PD2020_004\]](#) sets out the requirements for ratification, clinical

monitoring and subsequent clinical reviews.

NSW Health is committed to minimising and, where safe and possible, eliminating the use of seclusion and restraint. There may be rare instances in which seclusion or restraint is required in **NSW Health settings. NSW Health staff must only use seclusion and restraint as set out in [Seclusion and Restraint in NSW Health Settings \[PD2020_004\]](#).**

Staff should avoid:

- using prone restraints;
- restraining in ways that interfere with the person's airways, breathing, or circulation; and
- bending the person's head or trunk towards the knees if seated.

Where legally permitted and after considering privacy requirements, NSW Health staff must make every effort to notify the following persons (as applicable to the person and legal status) about the use of seclusion or restraint and the reasons for use – carer, guardian, and others as appropriate and determined by local protocols.

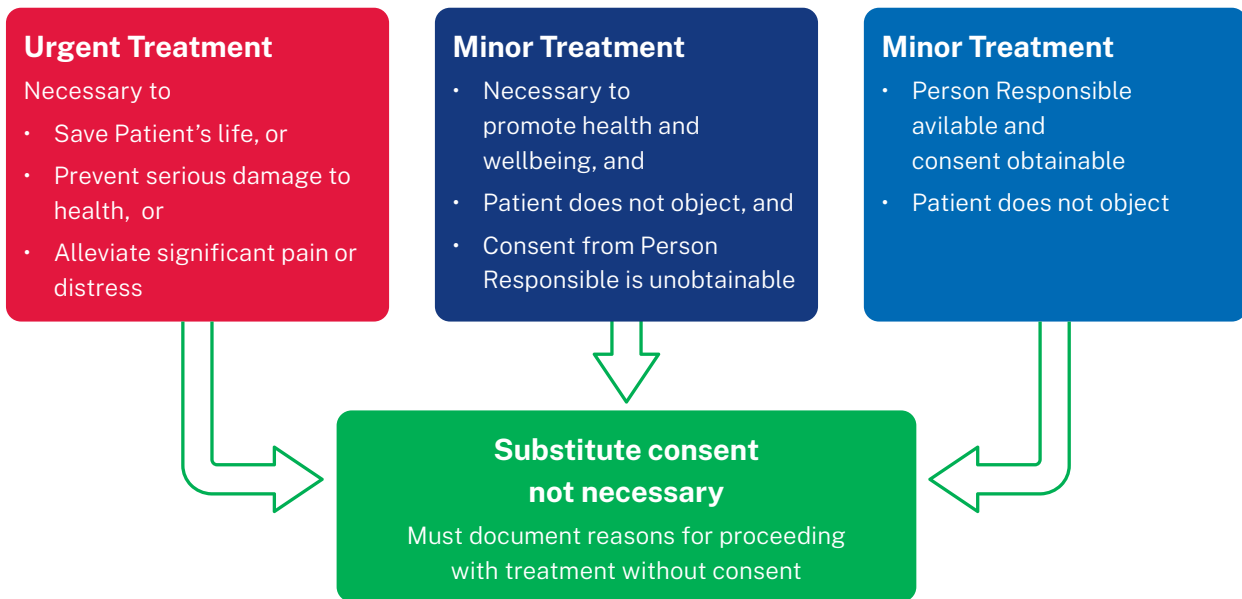
NSW Health staff should not authorise nor condone any restrictive practices described for patients being managed in the community, whether these are applied by formal aged care services or by family and other carers. Restrictive practices used by family and other carers might be a form of elder abuse.

NSW Health clinicians need to be aware that there are [Commonwealth](#) and [State of New South Wales](#) regulations regarding restrictive practices in residential aged care facilities (which include multipurpose services and State Government residential aged care facilities).

Legal and ethical considerations

- Consent must be obtained appropriately for treatment
- The clinician must assess the person's ability to consent
- It should not be assumed that all people with dementia lack capacity
- A person with dementia may be capable of making simple decisions but not more complex decisions
- A person with delirium may recover their ability to make decisions once the delirium has resolved
- In situations in which consent cannot be obtained
 - No consent is required in a clinical emergency
 - Otherwise, written substitute consent must be obtained from the 'Person Responsible' or the NSW Civil and Administrative Tribunal (NCAT) for 'Major Treatment'
 - 'Minor treatment' necessary to promote the patient's health and wellbeing can proceed without consent if the patient is not objecting and there is no Person Responsible or the Person Responsible is not available or unwilling to provide consent. The clinician must document this appropriately in the patient's Health Record.
- Document consent and treatment decisions in the patient's Health Record

Obtaining substitute consent when the patient lacks capacity



Team approach to coordinating care

The complexity of dementia requires a team approach to integrate a wide range of health services delivered across the public and private sectors. In addition, many services are provided by community and voluntary workers. To deliver high standards of care, health practitioners need to know and accept their own role and those of their team members in partnership with the person with dementia and their support network.

In summary, the key clinical teams relevant to the management of people with BPSD in the NSW public health services are:

- the emergency department team
- specialist aged care services including geriatric medical teams

- Aged Care Assessment Teams (ACAT) a key role in assessing the level of residential and community care services the person needs
- general adult psychiatric teams, especially consultation-liaison services
- Older People's Mental Health Services (OPMHS) including acute and non-acute inpatient units/services, consultation-liaison and multidisciplinary community services, community OPMH partnership services including residential aged care services and programs
- general community nursing team
- ward teams including surgical, medical and other specialty wards.

