

Dementia Care for GPs: Behaviour Support, Services and Psychotropics

This webinar will start shortly.

Dementia Care for GPs: Behaviour Support, Services and Psychotropics

Zoom – 20 May 2026, 6:30pm – 8:00 pm

Acknowledgement of traditional owners

We acknowledge the Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we are meeting today. We pay our respects to Elders past and present.

We would also like to acknowledge Aboriginal people who are joining us today.

Learning outcomes

After this session, I will be able to:

- Further develop knowledge of appropriate psychotropic use in dementia care.
- Understand the services available to support people living with dementia who are experiencing behaviour change.
- Understand the services and support available to carers of people living with dementia.

Some housekeeping

- Tonight's webinar is being recorded
- Please use the Zoom Q&A feature to ask questions
- At the end of the webinar your browser will automatically open an evaluation survey. We appreciate you taking the time to complete this to help us improve our events programme
- Scan here to register for your next Primary Health Tasmania event



Presenter



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Head of Clinical Services, Dementia Support Australia

Dementia Support Australia

Funded by the Australian Government
A service led by HammondCare

Dementia Care for GPs: Behaviour support, Services and Psychotropics

A/Prof Steve Macfarlane FRANZCP
Head of Clinical Services
May 2026



An apparently unrelated question!

What is best practice in management of a cough?

- a) Cough suppressant
- b) Antibiotics
- c) Chest physiotherapy
- d) Ventolin inhaler
- e) All of the above
- f) None of the above



Another question...

What is the best practice for management of agitation in dementia?

- a) Diversional therapy
- b) Music therapy
- c) Doll therapy
- d) Aromatherapy
- e) Antipsychotic medication
- f) All of the Above
- g) None of the Above



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Why?



Both 'cough' and 'agitation' are **symptoms**, not diagnoses



Both cough and agitation have **many possible causes**



Identifying and treating the cause will lead to **resolution of the symptom**

Best Practice in Behaviour Management

1. Decrease likelihood of behaviour (before it occurs: prevention is better than cure)
2. Comprehensive assessment of behaviour to determine **cause/s**
3. Use **individualised** non-pharmacological strategies
4. If pharmacological intervention is unavoidable, it complements non-pharmacological strategies
5. Avoid antipsychotic medication if possible, review every 4-12 weeks





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Evaluating the Clinical Impact of National Dementia Behaviour Support Programs on Neuropsychiatric Outcomes in Australia

Stephen Macfarlane^{1,2†‡}, **Mustafa Atee**^{3,4*†‡}, **Thomas Morris**^{1‡}, **Daniel Whiting**^{1‡}, **Madeleine Healy**^{1,5}, **Marie Alford**¹ and **Colm Cunningham**^{1,6‡}

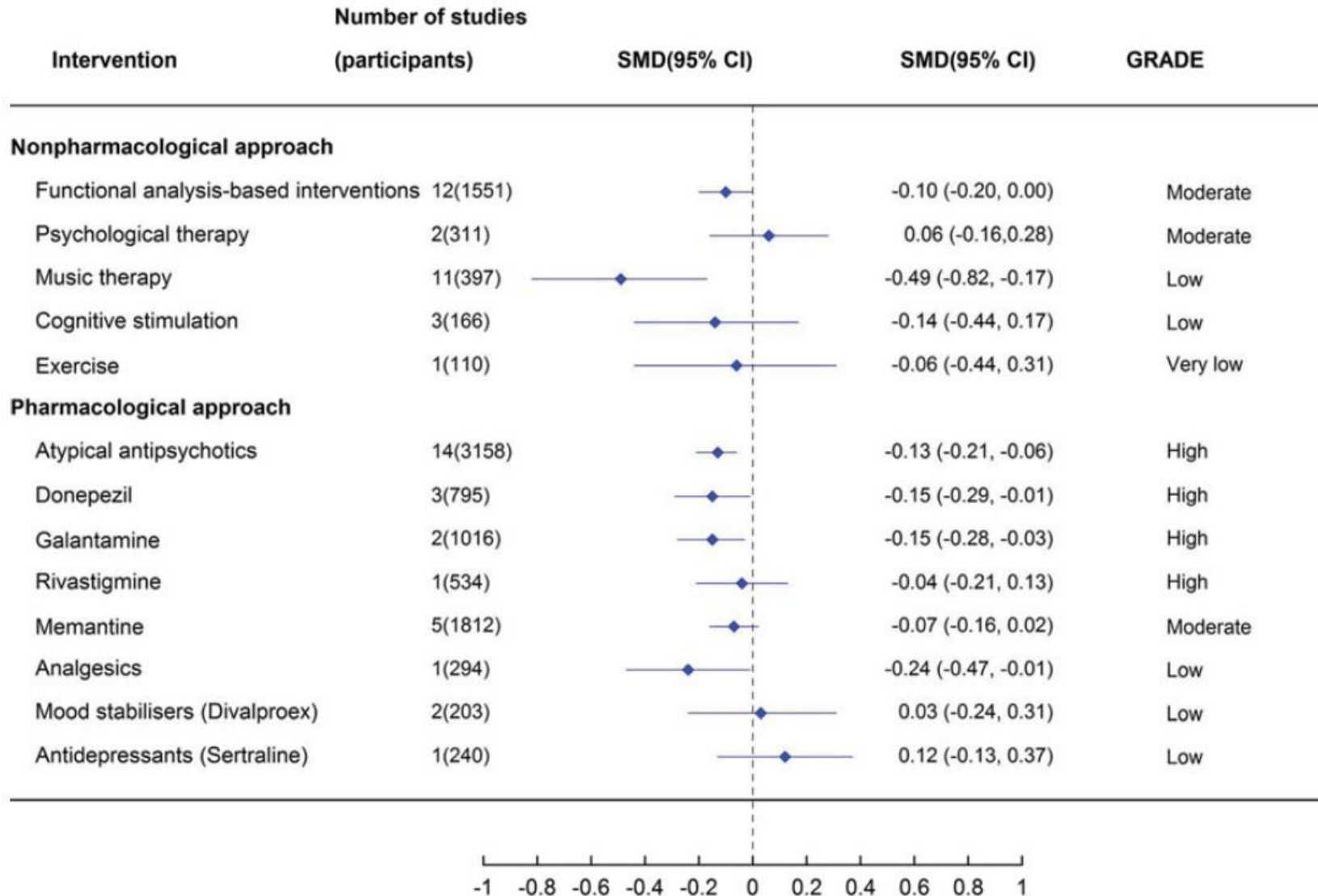
¹ The Dementia Centre, HammondCare, St Leonards, NSW, Australia, ² Faculty of Medicine, Nursing and Health Sciences, Monash University, Clayton, VIC, Australia, ³ The Dementia Centre, HammondCare, Wembley, WA, Australia, ⁴ Curtin Medical School, Faculty of Health Sciences, Curtin University, Bentley, WA, Australia, ⁵ Monash Health, Clayton, VIC, Australia, ⁶ School of Public Health and Community Medicine, University of New South Wales, Sydney, NSW, Australia



Methodology and Results

- 5,914 referrals (55.9% female, age 82.3 ± 8.6 y) from 1,996 RACHs
- The average length in DSA programs was 57.2 ± 26.3 days.
- NPI scores significantly reduced as a result of DSA programs, independent of covariates.
- Reductions in NPI scores:
 - DBMAS (61.4%)
 - SBRT (74.3%)

Compared to Psychotropic Medications?



RACF Accreditation Standards July 2019

Standard 3 - Requirement (3) (a)

Consumers get safe and effectiveclinical care that:

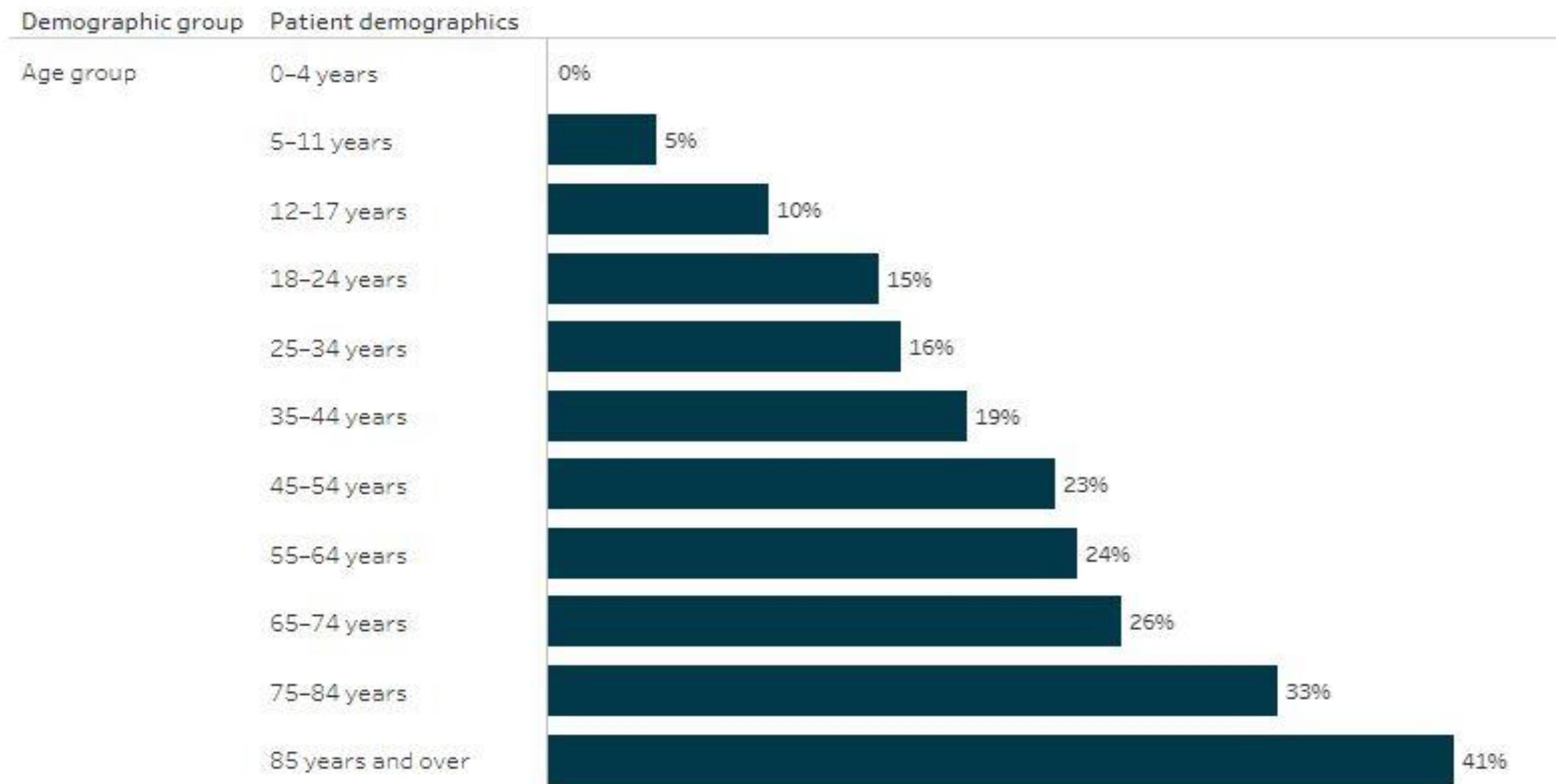
2. *i) is best practice; and
ii) is tailored to their needs; and
iii) optimises their health and well-being*

And yet...

Figure MBS.2. Proportion of population receiving Medicare-subsidised mental health-specific services, by demographic group, 2019-20



Figure PBS.2: People (per cent of the population) dispensed one or more mental health-related medications, by patient demographics, 2021-22



What should the doctor's role be in BPSD: For discussion!

Do we have the training/skills/time to conduct these assessments?

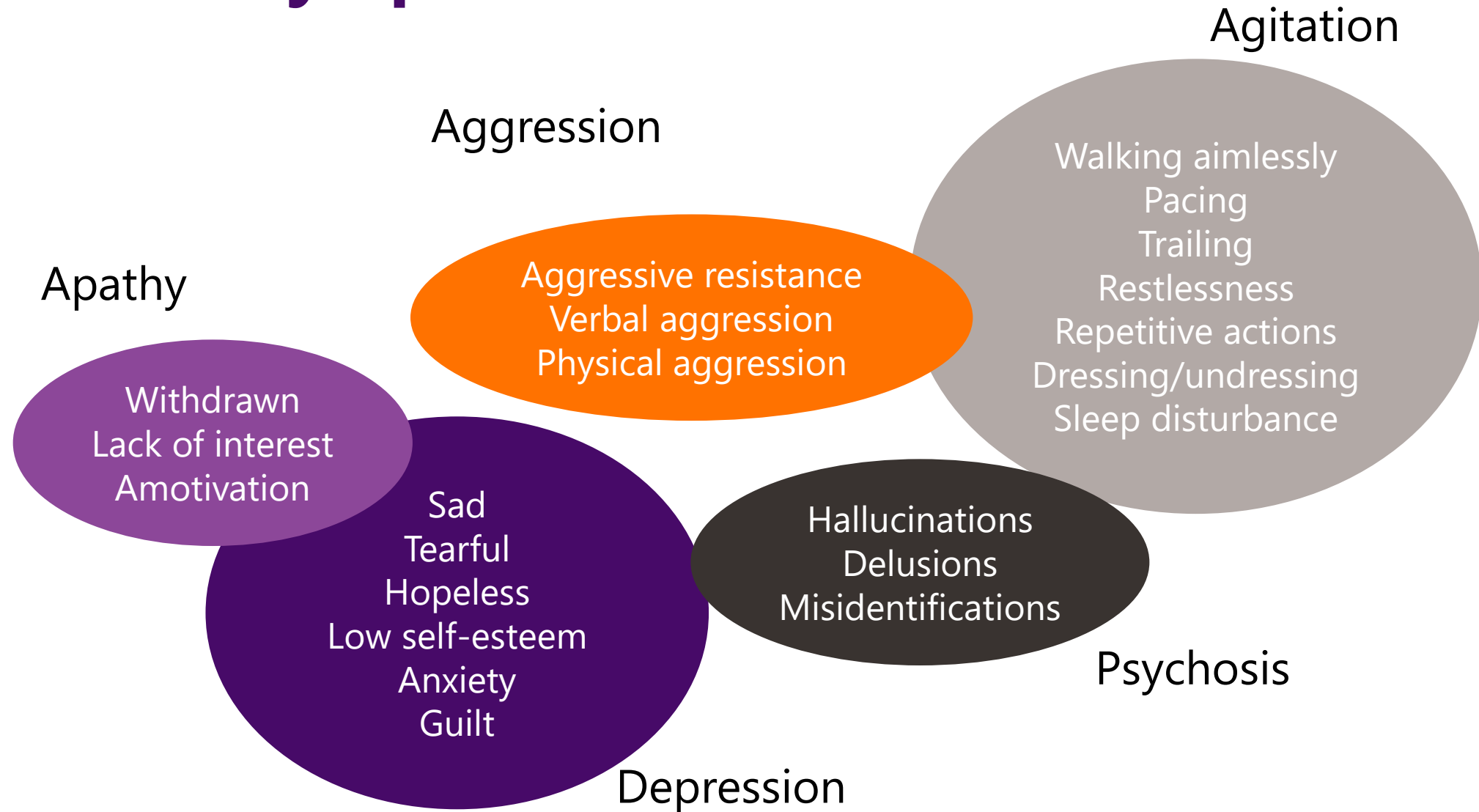
How much did we learn about BPSD in medical school?

How much more did we learn about BPSD during our Fellowship training?

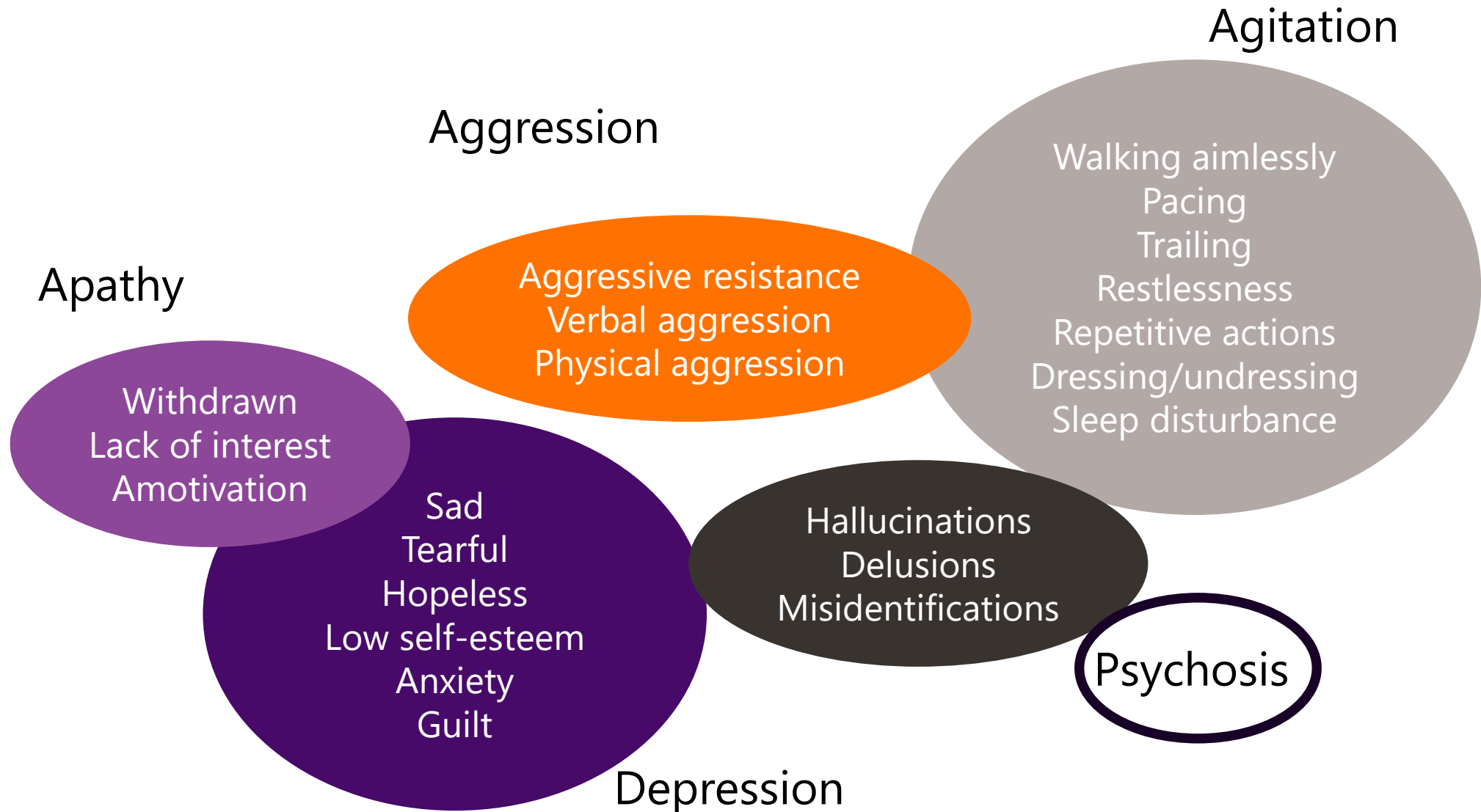
Do we have the skills/time to do anything other than exclude delirium→prescribe in this situation?

If not, what are our options?

Psychiatric Symptoms in Dementia



Psychiatric Symptoms in Dementia



What is psychosis?

Delusions

Fixed, false beliefs that are unshakeable.

Hallucinations

A perception where no stimulus exists

- Hearing things that no-one else can hear
- Seeing things that no-one else can see
- Tasting, smelling, feeling things that others cannot (rare)

Common 'delusions' in dementia



- I have to get home to see my children/parents
- That man is not my husband
- My family never visit me
- Staff are poisoning me
- My wife is having an affair
- My family have put me here to get my house
- Staff are stealing from me
- This is not my home
- There's someone living in the ceiling
- Someone coming into my house and stealing things

These beliefs are incredibly rare (almost never seen) in a person with schizophrenia or bipolar

WHY?

Because.....

Not all 'delusions' are psychotic in origin

From the perspective of someone with memory problems.....?

'I have to get home to see my children/parents'

'That man is not my husband'

'My family never visit me'

'Staff are poisoning me'

'My wife is having an affair'

'My family have put me here to get my house'

'Staff are stealing from me'

'This is not my home'

Antipsychotics in Schizophrenia

The acute efficacy of antipsychotics in schizophrenia: a review of recent meta-analyses. Haddad PM, Correll CU. Therapeutic Advances in Psychopharmacology 2018

Analysis included 167 randomized controlled trials (RCTs) published between 1955 and 2016 ($n = 28,102$ participants)

The effect size for overall symptoms was 0.47 (95% interval = 0.42–0.51)

Drug Trials for Psychosis in Dementia

Maher A., Maglione M., Bagley S., Suttorp M., Hu J., Ewing B., et al. (2011) Efficacy and comparative effectiveness of atypical antipsychotic medications for off-label uses in adults: a systematic review and meta-analysis. *JAMA* 306: 1359–1369.

For the outcome of psychosis, the pooled effect size was:

For risperidone (5 trials) 0.20 (95% CI, –0.02 to 0.42)

For aripiprazole (3 trials) 0.20 (95% CI, –0.02 to 0.42)

For olanzapine (5 trials) –0.07 to 0.17)

For quetiapine (3 trials) –0.03 (95%CI, –0.24 to 0.18)

Why The Difference?

The Neuropsychiatric Inventory - 'Psychosis' Domain

A. DELUSIONS

(NA)

Does the patient have beliefs that you know are not true (for example, insisting that people are trying to harm him/her or steal from him/her)? Has he/she said that family members are not who they say they are or that the house is not their home? I'm not asking about mere suspiciousness; I am interested if the patient is convinced that these things are happening to him/her.

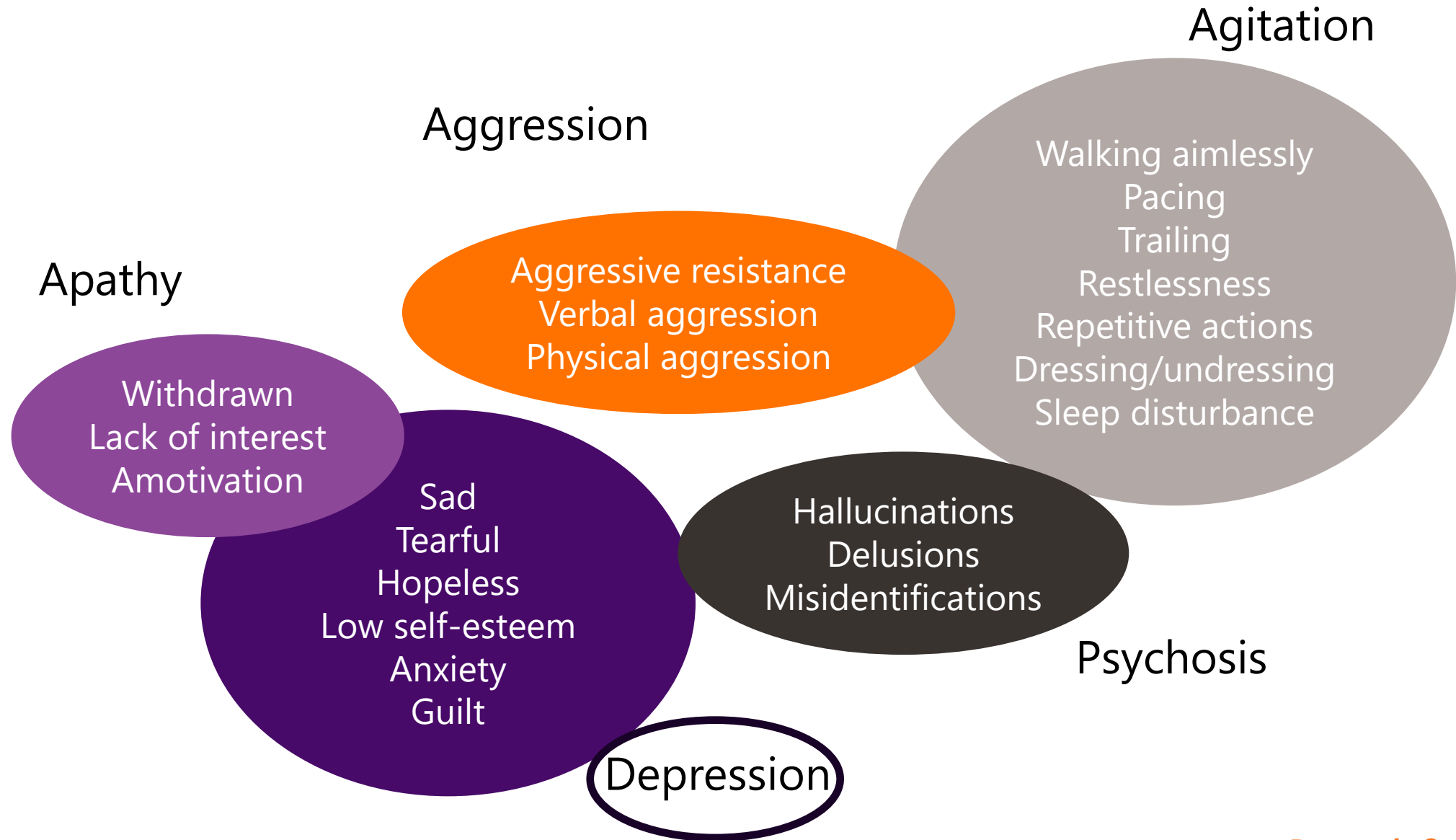
Yes (If yes, please proceed to subquestions)

No (if no, please proceed to next screening question)

N/A

1. Does the patient believe that he/she is in danger - that others are planning to hurt him/her? Yes No
2. Does the patient believe that others are stealing from him/her? Yes No
3. Does the patient believe that his/her spouse is having an affair? Yes No
4. Does the patient believe that unwelcome guests are living in his/her house? Yes No
5. Does the patient believe that his/her spouse or others are not who they claim to be? Yes No
6. Does the patient believe that his/her house is not his/her home? Yes No

Psychiatric Symptoms in Dementia



DSM-5 Major Depressive Disorder

5 or more **symptoms**, present for longer than 2 weeks:

- Depressed Mood
- Loss of interest/pleasure
- Weight loss or gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue
- Feelings of worthlessness, or excessive guilt
- Decreased concentration
- Thoughts of death/suicide



Diagnosing depression in severe dementia

DSM-5 Criteria for depressive disorder:

- Depressed Mood (self-report)
- **Loss of interest/pleasure (observable)**
- **Weight loss or gain (observable)**
- **Insomnia or hypersomnia (observable)**
- **Psychomotor agitation or retardation (observable)**
- Fatigue (self-report)
- Feelings of worthlessness, or excessive guilt (self-report)
- Decreased concentration (self-report)
- Thoughts of death/suicide (self-report)

The Cornell Scale for Depression in Dementia

Screening Tool: Cornell Scale for Depression in Dementia (CSDD)

Scoring System: a = unable to evaluate
0 = absent
1 = mild or intermittent
2 = severe

Ratings should be based on symptoms and signs occurring during the week prior to interview.
No score should be given if symptoms result from physical disability or illness.

A. Mood-Related Signs

1. Anxiety anxious expression, ruminations, worrying	a	0	1	2
2. Sadness sad expression, sad voice, tearfulness	a	0	1	2
3. Lack of reactivity to pleasant events	a	0	1	2
4. Irritability easily annoyed, short-tempered	a	0	1	2

B. Behavioral Disturbance

1. Agitation restlessness, handwringing, hairpulling	a	0	1	2
2. Retardation slow movements, slow speech, slow reactions	a	0	1	2
3. Multiple physical complaints (score 0 if GI symptoms only)	a	0	1	2
4. Loss of interest less involved in usual activities (score only if change occurred acutely, i.e., in less than 1 month)	a	0	1	2

C. Physical Signs

1. Appetite loss eating less than usual	a	0	1	2
2. Weight loss score 2 if greater than 5 lb. in one month	a	0	1	2
3. Lack of energy fatigues easily, unable to sustain activities (score only if change occurred acutely, i.e., in less than 1 month)	a	0	1	2

D. Cyclic Functions

1. Diurnal variation of mood symptoms worse in the morning	a	0	1	2
2. Difficulty falling asleep later than usual for this individual	a	0	1	2
3. Multiple awakenings during sleep	a	0	1	2
4. Early-morning awakening earlier than usual for this individual	a	0	1	2

E. Ideational Disturbance

1. Suicide feels life is not worth living, has suicidal wishes or makes suicide attempt	a	0	1	2
2. Poor self-esteem self-blame, self-deprecation, feelings of failure	a	0	1	2
3. Pessimism anticipation of the worst	a	0	1	2
4. Mood-congruent delusions delusions of poverty, illness or loss	a	0	1	2

Scoring:

A score >10 probably major depressive episode
A score >18 definite major depressive episode

What does the evidence tell us?

Management of behavioral and psychological symptoms in people with Alzheimer's disease: an international Delphi consensus

Helen C. Kales,^{1,2,3} Constantine G. Lyketsos,⁴ Erin M. Miller¹ and Clive Ballard⁵

Table 2. Consensus on current treatments for overall BPSD and agitation

TREATMENT OF OVERALL BPSD WITHIN AND AGITATION [†]	% AGREEMENT ACROSS PANEL +/-1 RANK SCORE	RANK
Thorough assessment and management of underlying causes	100%	1
Caregiver problem -solving/information/education	91%	2
Environmental adaptation/approaches	70%	3
Person-centered care	70%	4
Tailored activity program	70%	5
Citalopram	81%	6
Treat pain - Paracetamol/Analgesia	81%	7
Risperidone	64%	8

[†]Rank order identical for BPSD overall and for agitation.

So, how can we help?

- DSA supports people with dementia, their families and carers when they are experiencing changed behaviours
- DSA operates a 'no wrong door' service
- If we identify the need for mental health support, we will support you in getting in touch with mental health services.

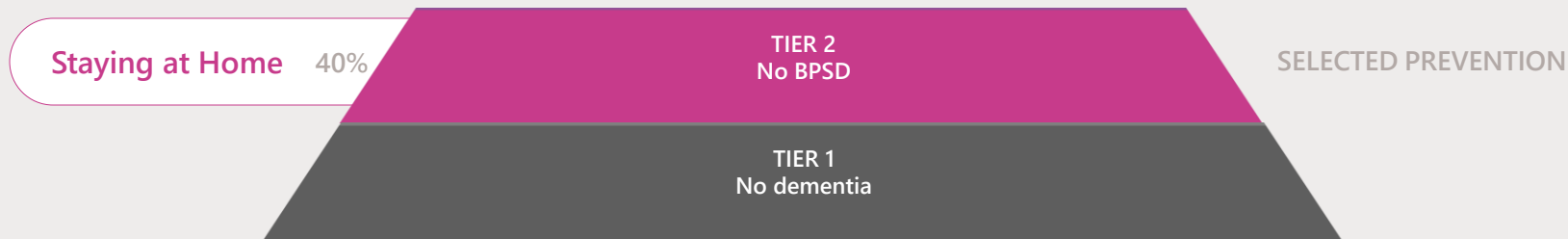


How are our services delivered?

Seven-tier model of service delivery

Eligibility criteria:

- ✓ Dementia diagnosis
- ✓ No BPSD
- ✓ Primary and/or secondary carer



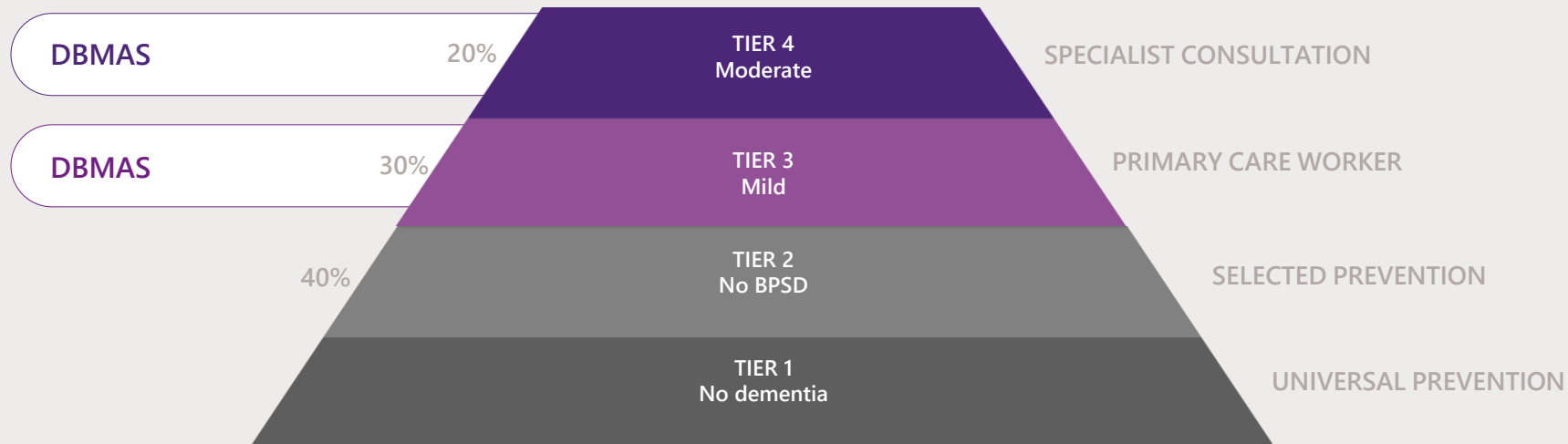
* Adapted from: Brodaty, H., Draper, B. M., & Low, L.-F. (2003). Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery. *The Medical Journal of Australia*, 178(5), 231–234.

How are our services delivered?

Seven-tier model of service delivery

Eligibility criteria:

- ✓ Dementia diagnosis
- ✓ Mild-moderate BPSD
- ✓ Community, acute, residential



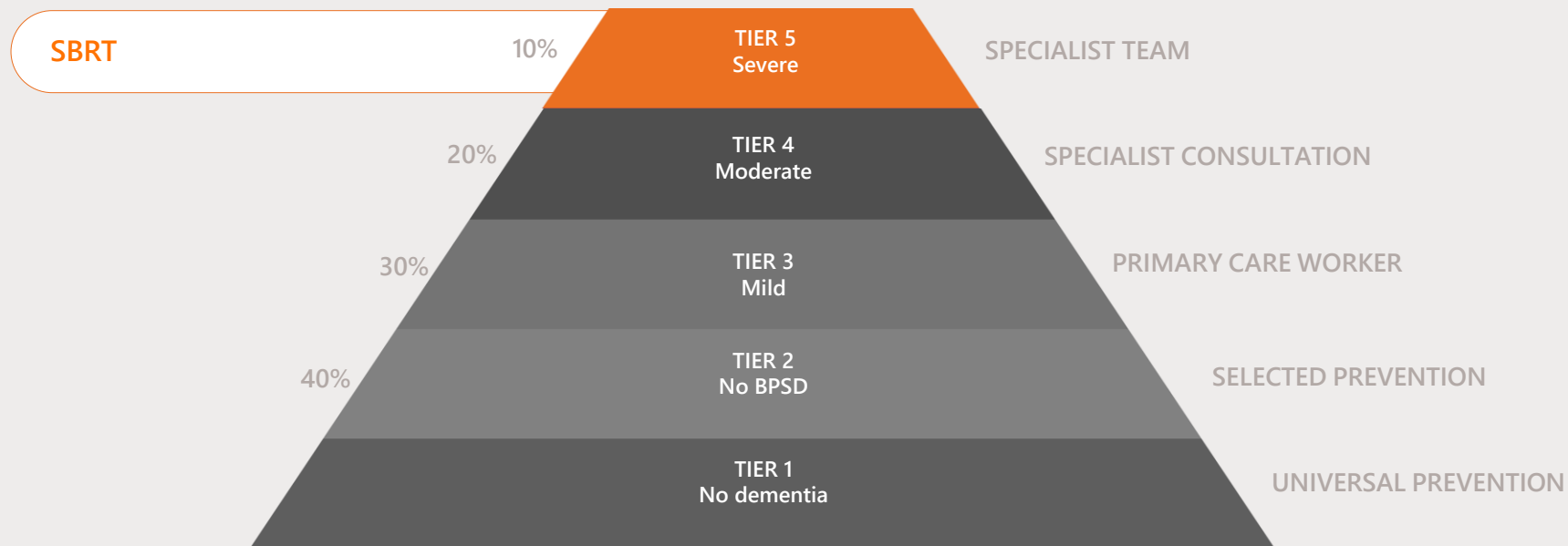
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How are our services delivered?

Seven-tier model of service delivery

Eligibility criteria:

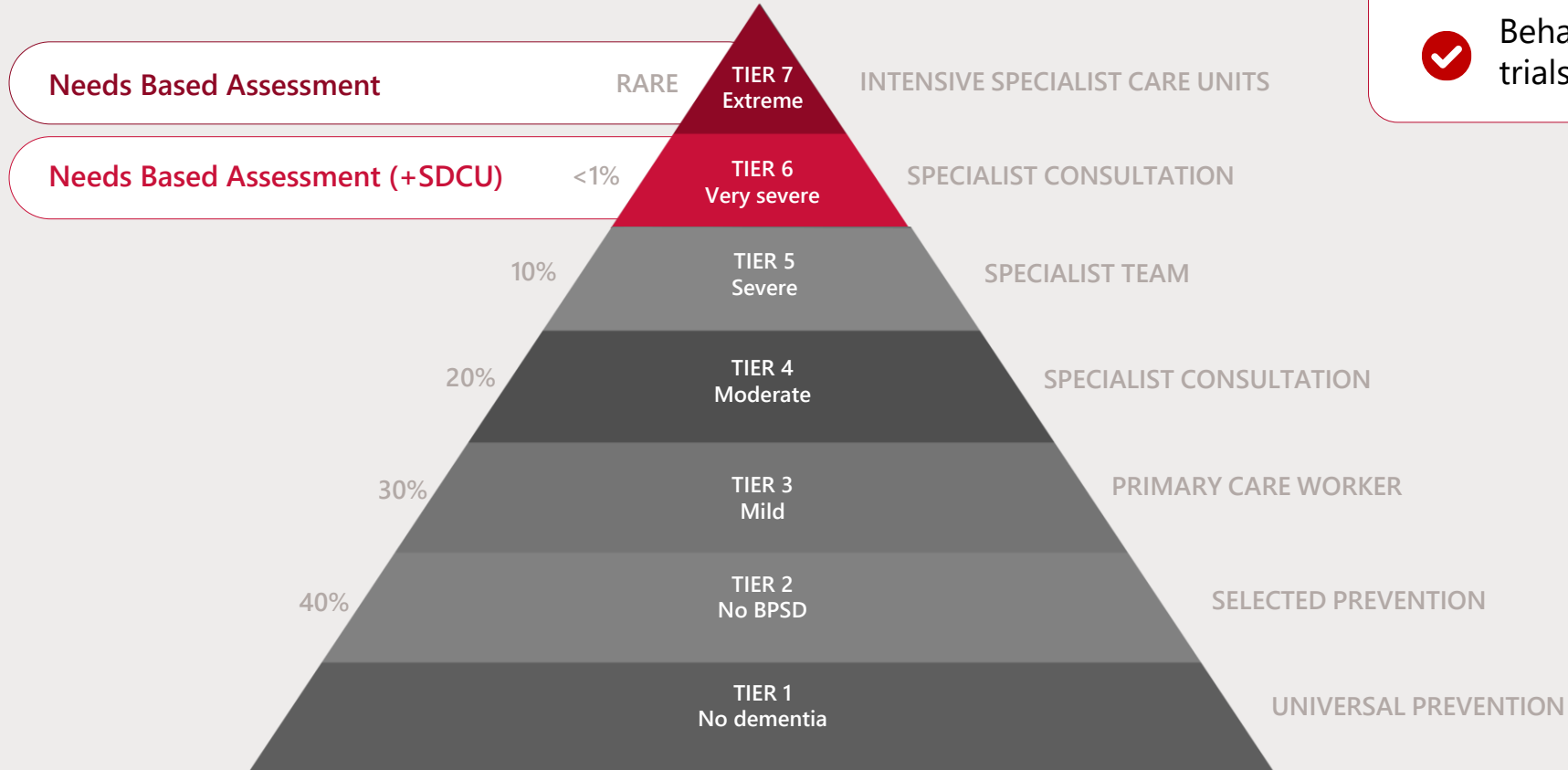
- ✓ Dementia diagnosis
- ✓ Severe BPSD
- ✓ Residential



* Adapted from: Brodaty, H., Draper, B. M., & Low, L.-F. (2003). Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery. *The Medical Journal of Australia*, 178(5), 231–234.

How are our services delivered?

Seven-tier model of service delivery



Eligibility criteria:

- ✓ Behaviours associated with dementia
- ✓ Very severe BPSD
- ✓ Behaviours intractable to adequate trials of management

* Adapted from: Brodaty, H., Draper, B. M., & Low, L.-F. (2003). Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery. *The Medical Journal of Australia*, 178(5), 231–234.

**Dementia Support
Australia**

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Live chat
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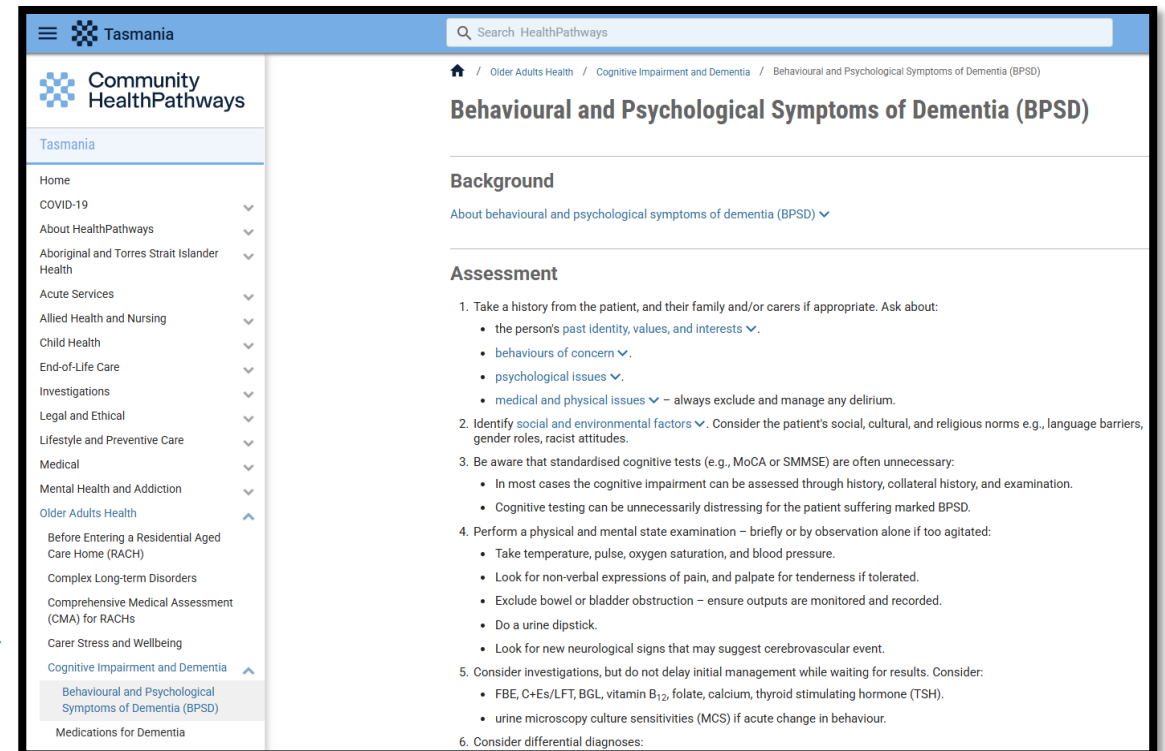
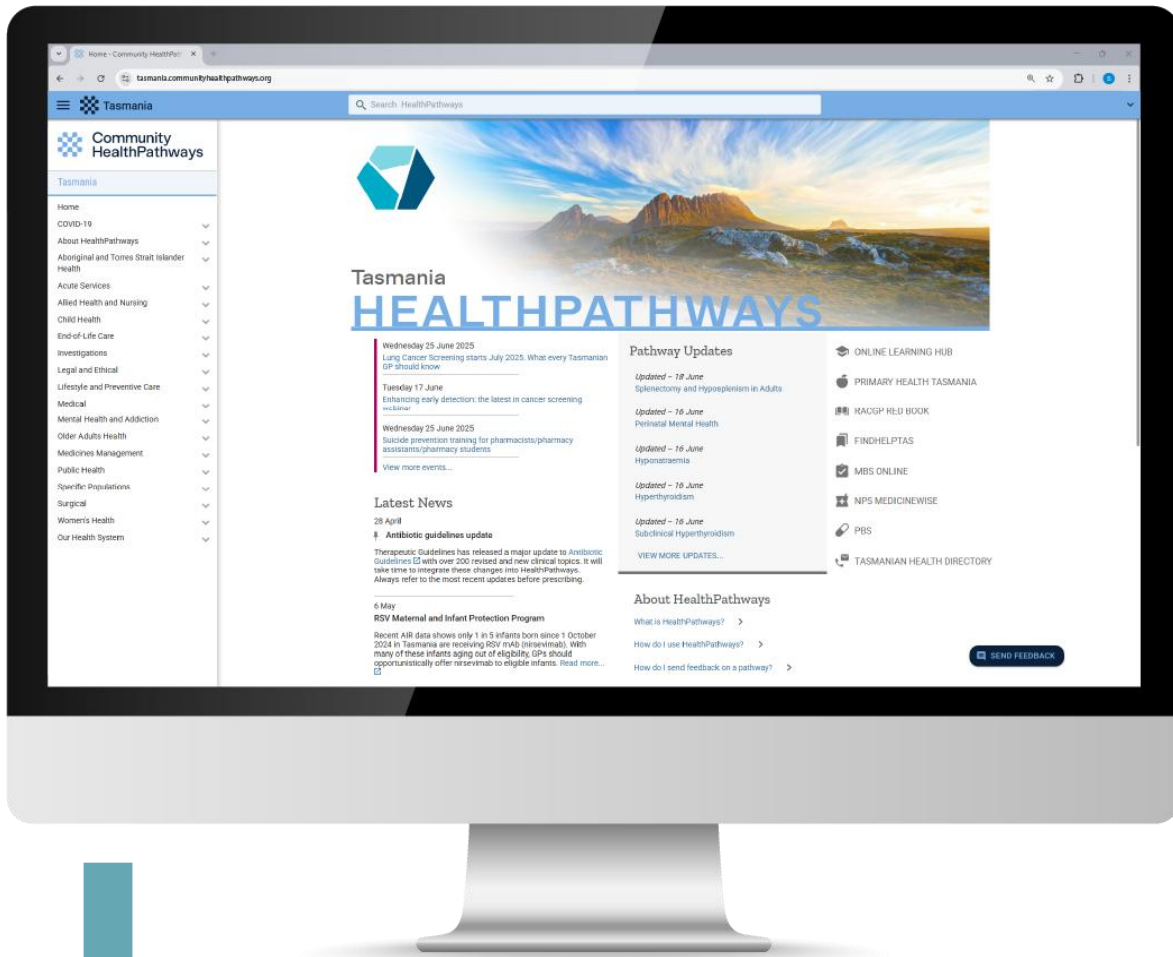
Q&A



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tasmania.communityhealthpathways.org



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Aged care update series

Aged Care Update for GPs: New Strengthened Aged Care Quality Standards

Resource List

Aged Care Reform Update for GPs New Strengthened Aged Care Quality Standards



Aged Care for Tasmanian GPs series - Primary Health Tasmania powerpoint

Online learning - Alis | Aged Care Quality and Safety Commission



Aged Care Update for GPs: Restrictive Practices

Resource List

Aged care reform update - restrictive practices



Aged care reform update - restrictive practices - Primary Health Tasmania powerpoint



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Thank you



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