Assessment and Management of Behavioural and Psychological Symptoms of Dementia (BPSD)

Summary based on: Canadian Coalition for Seniors' Mental Health. (2024). Canadian Clinical Practice Guidelines for Assessing and Managing Behavioural and Psychological Symptoms of Dementia (BPSD). Toronto, Canada.

This document provides a summary of the Canadian Clinical Practice Guidelines for Assessing and Managing Behavioural and Psychological Symptoms of Dementia (BPSD), published in 2024 by the Canadian Coalition for Seniors' Mental Health (CCSMH). These guidelines provide evidence-based recommendations for healthcare providers on how to effectively assess and manage BPSDs—various non-cognitive symptoms associated with dementia, such as agitation, psychosis, depression, anxiety, and sexual expressions of potential risk. The comprehensive approach emphasizes individualized, person-centered care that considers biological, psychosocial, and environmental factors, alongside guidance on the appropriate use and deprescribing of pharmacological interventions. The guidelines also highlight the importance of informed consent and integrating patient values and advance wishes into care planning. These guidelines were designed to facilitate shared decision-making among individuals with dementia, caregivers, and healthcare providers, and to guide health leaders, policymakers, and researchers in developing services and interventions to manage and prevent BPSD.

Good Practice Statements

- Educate healthcare providers and caregivers comprehensively on BPSD, focusing on structured methods for assessment and management.
- Ensure informed consent is properly obtained, periodically reassessing the decision-making capacity of the patient with dementia.
- Incorporate the individual's values, preferences, goals of care, and advance care wishes into all BPSD-related decision-making.
- Carefully evaluate the dementia subtype, progression stage, and detailed BPSD symptom profiles (frequency, severity, risk).

- Perform an extensive assessment of biological factors including medical and psychiatric histories, pain, medication effects, and sensory impairments (vision and hearing).
- Evaluate the personhood of the patient, accounting for their gender, cultural background, spiritual beliefs, sexual orientation, and history of trauma or significant life experiences.
- Conduct thorough evaluations of psychosocial and environmental triggers, stressors, and support structures influencing BPSD.
- Adopt person-centered, culturally respectful, and sensitive language when describing behaviours to reduce stigma.
- Always consider psychosocial strategies first, either alone or in combination with carefully monitored pharmacological treatments.
- Tailor interventions specifically to the individual's clinical picture, ensuring they are safe, appropriate, and effective.
- Regularly reassess management strategies, modifying, discontinuing, or substituting interventions as symptoms and circumstances evolve.

Managing Agitation

- Use the International Psychogeriatric Association (IPA) criteria for accurate diagnosis (e.g., excessive motor activity, verbal aggression, or physical aggression causing distress).
- Implement interdisciplinary care involving specialized training, structured assessments, tailored interventions (music therapy, physical exercise, robotic pets, aromatherapy, and massage therapy).
- Pharmacological treatments such as citalopram, risperidone, aripiprazole, brexpiprazole, quetiapine, synthetic cannabinoids, and carbamazepine, among others, should be considered in severe cases or if non-pharmacological interventions fail.
- Avoid seclusion and physical restraints due to potential harm. Pharmacological emergency treatments (short-acting antipsychotics or benzodiazepines) may be used briefly under strict conditions.

Managing Psychosis

- Diagnose using IPA criteria, specifically evaluating the duration and disruption caused by hallucinations and delusions.
- While few studies specifically target psychosis in dementia, evidence and clinical experience indicate that non-pharmacological strategies—such as interdisciplinary care, provider training, communication methods, personalized activities, and music therapy—can effectively reduce psychotic symptoms.
- For pharmacological management, consider citalopram for moderate symptoms, and risperidone or aripiprazole when symptoms are severe or persistent.

Managing Depression

- Diagnose using National Institutes of Mental Health criteria (NIMH), which incorporate dementia-specific considerations like social withdrawal and irritability.
- Adopt structured interdisciplinary approaches including caregiver education, individualized care planning, and cognitive stimulation therapy, reminiscence therapy, physical exercise, and sensory stimulation, among others.
- Use antidepressants cautiously, primarily for moderate-to-severe depression, and ensure regular evaluation for side effects.

Managing Anxiety

- Diagnose anxiety based on DSM-5-TR anxiety disorders criteria.
- Focus primarily on non-pharmacological approaches like caregiver training, cognitive behavioural therapy adapted for dementia, and music therapy.
- Pharmacological intervention with citalopram may be considered for moderate to severe anxiety not responsive to psychosocial approaches.

Managing Sexual Expressions of Potential Risk

- Define clearly as sexual behaviours that are intrusive, non-consensual, or cause distress to others
- Assess using the St. Andrew's Sexual Behaviour Assessment Scale (SASBA), noting triggers and environmental factors.
- Manage primarily through psychosocial interventions—environmental modifications, redirection to suitable activities, and caregiver education. There is insufficient evidence to routinely recommend pharmacological treatments.

Managing Deprescribing Medications

- Evaluate regularly the continued need for antipsychotics, particularly in those without current severe agitation or psychosis.
- Implement gradual dose reductions, monitoring closely for symptom re-emergence. Aim for the lowest effective dose, discontinuing when appropriate.
- Extend periodic medication reviews to include other psychotropics like benzodiazepines and antidepressants, carefully deprescribing unnecessary medications to reduce adverse outcomes.
- Engage in interdisciplinary education, medication reviews involving pharmacists, and targeted physician training to support antipsychotic deprescribing for individuals with dementia in long term care and other residential care settings

Symptom	Assessment Tool	Non-Pharmacological Management	Pharmacological Management
Agitation	IPA Criteria	• Interdisciplinary care • Music therapy, exercise, aromatherapy • Robotic pets, massage therapy	• Citalopram, risperidone • Aripiprazole, brexpiprazole • Quetiapine, synthetic cannabinoids • Carbamazepine (severe cases)
Psychosis	IPA Criteria	• Interdisciplinary care • Staff training, communication • Personalized activities, music therapy	• Citalopram (moderate) • Risperidone, aripiprazole (severe)
Depression	NIMH Criteria	• Caregiver education, cognitive stimulation • Reminiscence therapy, physical exercise • Sensory stimulation	• Antidepressants (moderate-to-severe) • Monitor regularly
Anxiety	DSM-5-TR Criteria	• Caregiver training • Cognitive behavioural therapy • Music therapy	• Citalopram (moderate-to-severe)
Sexual Expressions of Potential Risk	SASBA	• Environmental modifications • Redirection, caregiver education	• No routine pharmacological recommendations
Deprescribing Medications	Regular Review	• Interdisciplinary education • Pharmacist-led reviews • Physician training	• Gradual dose reductions • Target lowest effective dose • Regular monitoring

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This brochure is part of ClarityPath's commitment to supporting caregivers with compassionate, evidence-informed resources.

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References

American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-5-TR (Fifth edition, text revision). (2022). American Psychiatric Association Publishing.

Cummings, J., Sano, M., Auer, S., Bergh, S., Fischer, C. E., Gerritsen, D., Grossberg, G., Ismail, Z., Lanctôt, K., & Lapid, M. I. (2023). Reduction and prevention of agitation in

persons with neurocognitive disorders: an international psychogeriatric association consensus algorithm. International Psychogeriatrics, 1-12. https://doi.org/10.1017/S104161022200103X

Knight, C., Alderman, N., Johnson, C., Green, S., Birkett- Swan, L., & Yorstan, G. (2008). The St Andrew's Sexual Behaviour Assessment (SASBA): development of a standardised recording instrument for the measurement and assessment of challenging sexual behaviour in people with progressive and acquired neurological impairment. Neuropsychological Rehabilitation, 18(2), 129-159. https://doi.org/10.1080/09602010701822381

Olin, J. T., Katz, I. R., Meyers, B. S., Schneider, L. S., & Lebowitz, B. D. (2002). Provisional diagnostic criteria for depression of Alzheimer disease: rationale and background. *The American Journal of Geriatric Psychiatry, 10*(2), 129-141.