The Specialist Dementia Care Programme
Operationalising the 7-Tiered Model of Service Delivery

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Some Things Have Changed......

**VIEWPOINT**

**Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery**

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In 2001, Australia’s population was approximately 19 million, of which an estimated 165 000 people had dementia. Projections are that by 2041 Australia’s population will be 25 million, with an estimated 460 000 people with dementia.

**ABSTRACT**

- People with dementia usually experience behavioural and psychological symptoms of dementia (BPSD) during the...
While Some Things Remain The Same....

The problems

BPSD create problems for the individual, the community and the healthcare system. They are associated with lowered functional abilities and poorer prognosis, an increased burden on caregivers and nursing-home staff, higher costs of care and earlier institutionalisation. Hospitalised patients with BPSD are more difficult to discharge, because of the difficulty of placing them elsewhere.

Currently, in Australia, services for people with BPSD are ad hoc and fragmented. It is unclear who should bear responsibility for this population. Should it be State or federal governments, geriatric or psychogeriatric services, generic mental health services or specialist mental health services for older people, primary or secondary health services? Some States have developed specialised facilities — psychogeriatric nursing homes in Victoria, psychogeriatric extended care units in Western Australia, and CADE (Con-
Seven-tiered model of management of behavioural and psychological symptoms of dementia (BPSD)

Tier 7: Dementia with extreme BPSD (e.g., physical violence)  
Prevalence: Rare  
Management: In intensive specialist care unit

Tier 6: Dementia with very severe BPSD (e.g., physical aggression, severe depression, suicidal tendencies)  
Prevalence: <1%†  
Management: In psychogeriatric or neurobehavioural units

Tier 5: Dementia with severe BPSD (e.g., severe depression, psychosis, screaming, severe agitation)  
Prevalence: 10%‡  
Management: In dementia-specific nursing homes, or by case management under a specialist team

Tier 4: Dementia with moderate BPSD (e.g., major depression, verbal aggression, psychosis, sexual disinhibition, wandering)  
Prevalence: 20%‡  
Management: By specialist consultation in primary care

Tier 3: Dementia with mild BPSD (e.g., night-time disturbance, wandering, mild depression, apathy, repetitive questioning, shadowing)  
Prevalence: 30%‡  
Management: By primary care workers

Tier 2: Dementia with no BPSD  
Prevalence: 40%‡  
Management: By selected prevention, through preventive or delaying interventions (not widely researched)

Tier 1: No dementia  
Management: Universal prevention, although specific strategies to prevent dementia remain unproven

*Prevalence is expressed as estimated percentage of people with dementia who currently fall into this category.  †Estimate based on clinical observations. ‡Estimate based on Lyketsos et al.
and very severe disturbances such as depression, aggression and marked agitation are likely to be in residential facilities. Consultation or primary care management has failed. More intensive care can be provided within a specialist case-management model, in which tailored programs are implemented by a specialist multidisciplinary team. For example, treatment may involve a psychiatrist (or geriatrician) reviewing the cause of the disturbed behaviour, a specialist doctor prescribing medication, a nurse liaising with staff, a psychologist developing a behavioural plan, and a social worker integrating the family into the care plan. RCTs have demonstrated the effectiveness of such teams in the community and in nursing homes.\textsuperscript{29,30}

**Tier 6: Dementia with very severe BPSD**

We estimate that up to 1\% of dementia patients will fit this tier. They come from three groups:

- People with dementia in general hospitals who develop a superimposed delirium. They are best managed in a special medical ward conjointly by geriatricians and old-age psychiatrists, usually for some days, until their acute condition abates.
- People with acute psychiatric problems complicating their dementia. If they did not have dementia their psychiatric condition would warrant psychiatric inpatient care (eg, people who have severe depression with suicidality, whose food or fluid intake is inadequate, or who fail to respond to specialist team case management). Admission to an acute psychogeriatric unit is required, usually for a few weeks. Such hospitalisation has been shown to reduce BPSD.\textsuperscript{31,32}

- People with severe behavioural disturbance complicating their dementia, such as dangerous physical aggression or other behaviours that residential staff or family are unable to cope with despite assistance from other services. These patients require placement in special-care facilities (eg, psychogeriatric or aged-care neurobehavioural units) for some months before returning to mainstream care. These units require secure grounds, more and better trained staff than mainstream nursing homes, and support from multidisciplinary specialist mental health services for older people. They have been shown to reduce problematic behaviours and increase socialisation.\textsuperscript{33}

For the 165 000 Australians currently estimated to have dementia,\textsuperscript{1} up to 1650 tier 6 beds nationally would be needed.

**Tier 7: Dementia with extreme BPSD**

This level of symptom severity is rare, but when it occurs the situation has usually reached a crisis. Patients in this category are generally men under 70 years of age who are very strong
1. 2013: Rudd government funded the *Dementia & Behaviours Supplement* to residential care @ $11.7m p.a.

2. Cost in first year of operations: $110m → ceased 2014

3. Ministerial Dementia Forum 2015 identified key strategies:
   - Increase role cohesiveness and co-ordination of DBMAS
   - Pilot the use of ‘flying squads’
   - Use of ‘special care units’
   ->FUNDED RESPONSE: SEVERE BEHAVIOUR RESPONSE TEAMS
1. DBMAS funded continuously by successive Commonwealth governments since ~2007

1. 8 different service providers across the states and territories = 8 effectively different models of care

2. 2016: Commonwealth called for a single national tender under one service provider

3. Contract awarded to a partnership led by HammondCare Oct 2016 (DSA)
1. July 2016: Health Minister Susan Ley announced funding for an SDCP unit in each of the 31 PHN’s (subsequently increased to 35 units)

2. September 2019: Pilot facility opened by Brightwater (Perth)

3. 2 further units to open late 2019; up to 15 (total) by end FY 19/20

4. SBRT role now includes eligibility assessment for SDCP placement
SDCP Eligibility criteria

1. Presence of a dementia diagnosis (Progressive neurodegenerative disease)
2. Severe to very severe behaviours
3. Behaviours primarily reflect the dementia rather than any comorbidities
4. Behaviours have been refractory to management by a specialist/specialist service

Aims to complement existing state funded services such as PGNH
DBMAS, SBRT and SDCP:
An Integrated Service
1. Develop a clinical pathway for admission to and discharge from proposed SDCUs.

2. Review and update the Brodaty et al. (2003) ‘7 Tiered Model’ of BPSD

3. To develop nationally relevant assessment tools to support clinical decision making for entry and exit criteria

4. To utilise computer modelling to pilot the utility of the proposed pathway.
Progress Thus Far....

1. Literature review undertaken

2. Triage and assessment tools piloted at HammondCare’s Caulfield and Hammondville sites

3. Computer modelling underway

4. DSA staff being trained on Triage tool

5. Assessment tool being field-tested on referrals to the Brightwater unit