Australian Government
Department of Health, Disability and Ageing

# Specialist Dementia Care Program (SDCP) Program Framework

September 2026

# Contents

# 1. Purpose

This document sets out the framework for implementation of the Specialist Dementia Care Program (SDCP) including scope, eligibility requirements, the model of care, administrative arrangements, and respective roles and responsibilities of program stakeholders in the delivery of the program.

This framework may be updated as the SDCP is implemented, and engagement is conducted with program stakeholders.

# 2. Background and context

The SDCP is an ongoing program with the first SDCP unit commencing operation in late 2019. The intention is that 55 SDCP units will be established nationally.

Since the measure was announced and implementation commenced, the Department of Health, Disability and Ageing (the department) has undertaken detailed policy development, consultation and evaluation of the program.

The department has used a range of information sources including commissioned research, expert advice, and stakeholder feedback to inform the design and continuous improvement of the program and this framework.

# 3. Program intent

The SDCP funds registered residential care providers to establish and deliver SDCP units. The SDCP is designed to provide transitional support and care for individuals experiencing very severe behavioural and psychological symptoms of dementia (BPSD) [1] (which may also be described as responsive behaviours associated with dementia).

It is estimated that fewer than one per cent of all people living with dementia experience very severe BPSD which places themselves or others at risk of harm and means they are unable to be appropriately cared for in mainstream residential care homes.

The key features of the SDCP are:

- transitional support for those experiencing very severe BPSD, where a dementia diagnosis is the primary source of behaviours
- a living environment that is a small unit (typically 9 beds), cottage-like and dementia-friendly that meets the dementia enabling design principles and is guided by the National Aged Care Design Principles and Guidelines
- care delivered by a team of highly trained dementia support staff, with oversight and regular visits by a specialist clinical in-reach team
- person-centred and goal-oriented care that builds on the strengths, capabilities and life story of each resident and is tailored to the unique circumstances, background, cultural sensitivities and preferences of the resident, their family and carers
- support for residents to transition to less intensive mainstream aged care settings once their symptoms have stabilised.

[1] Using the Brodaty, Draper and Low (Brodaty et. al.) seven-tiered model of management of behavioural and psychological symptoms of dementia, this includes people who would be classified as Tier 6 or equivalent. Brodaty H, Draper BM, Low, L. 'Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery.' *The Medical Journal of Australia* 2003; 178(5): 231-234.

## 3.1 SDCP Objectives and Intended Outcomes

The SDCP objectives, which are also set out in the Grant Opportunity Guidelines for the program, are to:

- provide care for people exhibiting very severe BPSD who are unable to be effectively cared for by mainstream residential care homes
- enable registered providers to deliver care in a dedicated dementia friendly environment that meets the dementia enabling design principles and is guided by the National Aged Care Design Principles and Guidelines (generally a dedicated unit within a broader residential care home)
- provide intensive, specialised residential care with a focus on stabilising and reducing the person's symptoms over time with the aim of enabling transition to a less intensive care setting
- complement existing Australian Government-funded dementia behaviour support programs including the Dementia Behaviour Management Advisory Service (DBMAS) and Severe Behaviour Response Teams (SBRT)
- enhance the existing health and aged care service systems for people with very severe BPSD, including complementing state and territory government services and supports
- generate evidence on best practice care for people exhibiting very severe BPSD, that can be adapted for use in mainstream settings to benefit all people living with dementia.

The intended outcomes of the SDCP are:

- improved wellbeing for residents and their carers
- stabilisation or reduction of behavioural symptoms enabling residents to successfully transition to less intensive care settings
- minimisation of adverse events, hospital admissions and psychotropic drug use for residents
- minimise the use of restrictive practice through the use of behavioural approaches
- enhanced capability of SDCP providers to deliver specialised care for the target group
- dissemination of learnings about best practice care for the target group, to benefit the broader aged care and health systems
- new or improved partnerships between residential care homes and local health services.

## 3.2 SDCP Service Delivery Principles

The SDCP:

1. adopts an inclusive, person-centered and goal-oriented philosophy and approach to care that builds on the strengths and capacity of individuals.
2. aims to optimise functioning, stabilise behavioural symptoms, improve wellbeing and quality of life through optimal care, with a strong focus on ongoing care assessment, care planning and access to therapeutic and meaningful activities.
3. delivers services tailored to the unique circumstances, background, cultural sensitivities and preferences of each resident, their family and carers. This includes using supported decision-making rather than substitute decision-making wherever possible and by consulting, valuing and supporting the caring relationship.
4. uses a multidisciplinary approach with formalised arrangements for access to specialist services; including clinical services and allied health; to support the provision of optimal care and clinical governance. Care and services provided by or on behalf of the provider

reflect the Australian Clinical Practice Guidelines and Principles of Care for People with Dementia.

5. delivers care in a safe, stable and enabling environment that reflects dementia friendly / dementia enabling design principles and is guided by the National Aged Care Design Principles and Guidelines.
6. employs adequate numbers of appropriately skilled and trained staff with the capability, commitment and confidence to work with people exhibiting very severe BPSD.
7. provides care using the least restrictive practices that promote human rights. Support and planning for the transition of people to the lowest tier of care appropriate to their needs begins at time of placement.
8. builds and maintains collaborative partnerships with local hospital networks, acute and subacute services, mainstream residential care providers, primary care professionals and community-based services at the regional level to facilitate access and smooth transitions to appropriate services for the target group.
9. actively participates in monitoring, evaluation, continuous improvement, and sharing of information to inform best practice and new models of care for people exhibiting very severe BPSD.
10. is underpinned by collaboration between the Australian Government and state and territory governments that enhances access to services and facilitates smooth transitions between service systems for the target group.

# 4. Program components

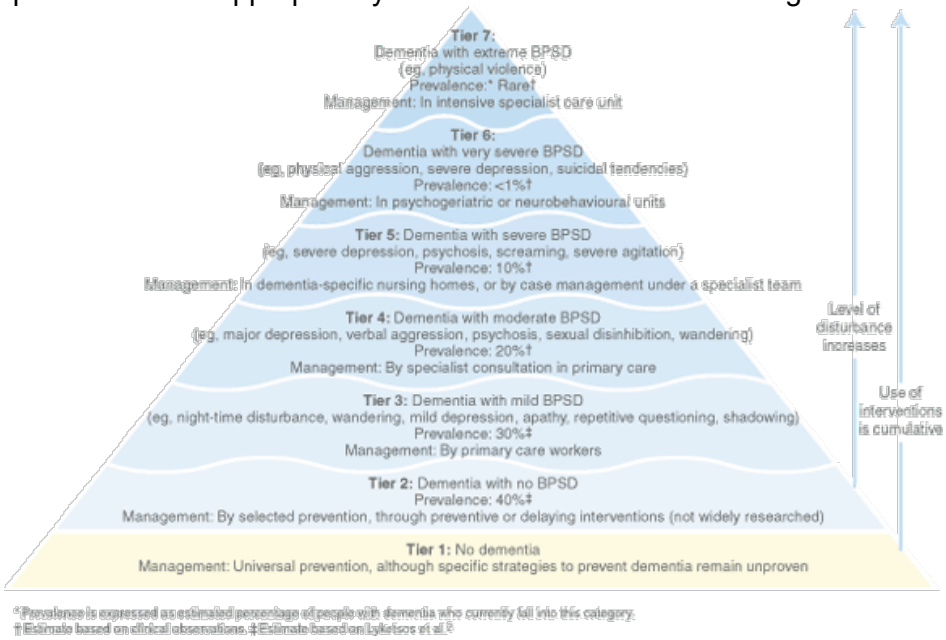
The following sections set out the key components of implementation and delivery of the SDCP.

An individual's journey from referral, to assessment, to placement and through to transition out of the program is described below and illustrated in the diagrams at **Appendix A**.

## 4.1 Target group

Individuals with very severe BPSD, where dementia is the primary diagnosis and driver of symptoms (generally behaviours classified as, or equivalent to, Tier 6 in the Brodaty et al. model), who:

- are unable to be appropriately cared for by mainstream residential care homes, and
- do not require care more appropriately delivered in other health settings.



## 4.2 Access to the program

### 4.2.1 Who can access the program

Individuals accessing the SDCP must be approved to receive residential care under the *Aged Care Act 2024* and deemed eligible for the program by Dementia Support Australia (DSA) through the Needs Based Assessment process because the individual's BPSD:

- is very severe;
- is primarily a result of dementia; and
- has not responded to trials of other specialist services.

Further detailed information on the Needs Based Assessment process is outlined in the sub-section below.

Under the *Aged Care Act 2024* individuals who are aged 65 or over (or aged 50 or over and an Aboriginal or Torres Strait Islander person or homeless or at risk of homelessness) may be eligible for funded aged care services. This includes individuals accessing the SDCP.

If an individual aged under 65 was already receiving funded aged care services or was on a waitlist for placement for SDCP before 1 November 2025, they can be considered for access to the SDCP.

### 4.2.2 Referral Pathways

Anyone can make a referral to the SDCP. This may include medical specialists, general practitioners, SBRT, an approved needs assessor, residential care home managers, families, carers and/or appointed substitute decision makers. Referrals must include supporting documentation from treating clinicians.

The SDCP is a borderless program, meaning that eligible participants are able to be considered for placement in any SDCP unit, and referrals to the program may come from anywhere around Australia.

***Consent for Referral and Assessment***

Appropriate consent must be obtained before any assessment of a referral can be undertaken. This includes appropriate consent from the individual being referred or their appointed substitute decision maker responsible for the individual's care.

Consent in the first instance can be obtained verbally for a referral, but written consent will be sought by the Dementia Support Australia (DSA) assessor during the assessment process. The assessment process cannot proceed without this consent.

More detailed information on the referral and assessment process, including the referral form to the SDCP, is available on the DSA website Assessing Eligibility | Specialist Dementia Care Program (SDCP).

### 4.2.3 Assessment of Referrals

The assessment of referrals has two steps:

1. A Needs Based Assessment – an assessment by DSA for eligibility for the program.
2. Suitability for Placement Assessment - an assessment by the SDCP provider for suitability for placement within a unit.

The assessment process and eligibility requirements are outlined below and illustrated in the diagrams at **Appendix A**.

***Step 1 - Needs Based Assessment***

The Needs Based Assessment is an assessment for eligibility for the program which uses a nationally consistent assessment methodology. The Needs Based Assessment includes three phases and is undertaken by DSA.

***Eligibility confirmation,*** to check that:

- the person has had an aged care assessment (such that the individual is approved to receive residential care under the *Aged Care Act 2024*)
- there is a dementia diagnosis
- the person would not be under a state or territory mental health detention order when entering a SDCP unit
- there is appropriate consent, either from the individual being referred or their appointed substitute decision maker.

***Triage of referral*****,** to understand:

- current circumstances – pattern(s) of behaviour, what's happened, what's changed, pattern(s) of incidents, and timeframes
- clinical history, including whether the person's dementia is the major cause of their behaviours (or whether they may be related to another medical condition, co-morbidity, or disability)
- whether the person is medically stable and is not requiring treatment that would be more appropriately delivered in an acute care or other health care setting (for example treatment for delirium or terminal agitation)
- severity of BPSD
- initial risk assessment – to determine the risk that the person presents to themselves and others within their current environment
- the extent to which prior behaviour management strategies (recommended by DBMAS and/or SBRT or other dementia support services) have been implemented within their current care setting, and corresponding outcomes
- likelihood that the person would benefit from care in a SDCP unit and be able to transition back to a less intensive care setting within 12 months
- prior dementia behaviour support interventions and/or aged care assessment(s).

***Comprehensive face-to-face assessment,*** to validate and build on triage information and assess the person and their current care environment in more detail, using agreed tools and frameworks.

The outcome of the Needs Based Assessment will be either:

- a recommendation from DSA that the individual should be considered for care under the SDCP. In this case, with the individual and their appointed substitute decision maker's consent, the individual 's information will be provided to the SDCP provider for the final suitability for placement assessment; or
- a decision by DSA that the individual should not be considered for care under the SDCP at this time. In this case, the individual, appointed substitute decision maker and referring body (and any other parties nominated by the individual) will be notified of the decision. Advice will also be provided on alternative care options. These may include being assisted in finding an alternate mainstream aged care provider, referral to an acute service, or remaining within their existing care environment but with additional advice or support from DSA through relevant funded programs.

DSA will undertake the above assessment process for all SDCP referrals and will ensure that all less intensive support strategies where available have been exhausted before placement in a SDCP unit is recommended.

The Needs Based Assessment process generally takes between 4-6 weeks if consent and the relevant clinical information have been provided for the referral so that an assessment can be undertaken.

***Review of a Needs Based Assessment***

DSA have established processes to enable people to seek review of the Needs Based Assessment outcome and will provide information on the review process upon request.

***Step 2 - Suitability for Placement Assessment***

Once DSA determines a person is eligible for the program, the next step is for the SDCP provider to undertake a Suitability for Placement Assessment.

All SDCP providers have their own Clinical Advisory Committee (see sub-section 4.3.6 below). One of the functions of the Clinical Advisory Committee is to undertake the Suitability for Placement Assessment.

The Suitability for Placement Assessment will consider factors such as whether:

- the SDCP unit is a 'good fit' for the person's particular needs and behaviour triggers based on the current mix of residents and staffing profile
- the person presents particular safety risks to staff or other residents
- there are complexities in the family and carer dynamics that need to be understood
- there are other relevant external factors that might affect the placement.

There should be no preference given to taking individuals from certain settings over others (for example, an acute setting over a residential care home) as part of the Suitability for Placement Assessment.

A Suitability for Placement Assessment by the Clinical Advisory Committee **must** be undertaken within 2 weeks of a SDCP provider receiving a referral from DSA. This is to allow for a placement outcome to be determined, including timeframes for placement and consideration of other placement and care options if the individual is determined to not be suitable for placement.

The Suitability for Placement Assessment is not a second determination of program eligibility. If the Clinical Advisory Committee has any concerns about the Needs Based Assessment, a request to review the eligibility assessment can be made to DSA at any time.

The SDCP provider is the final decision maker on accepting a person into the unit, having regard to the advice of its Clinical Advisory Committee. It is expected that the majority of eligible referrals be accepted into the unit following the Suitability for Placement Assessment, provided that a place is available. It is expected that once units are established and have reached full occupancy, full occupancy levels are maintained to support the management of waitlists and ensure the impact of the unit is maximised.

Once it is agreed that an individual will be placed in the SDCP unit, the individual will be required to enter the unit within three months, or the approval will lapse and a new Needs Based Assessment will be required.

***When an individual is not accepted for placement***

Where a SDCP unit does not accept an individual following a Suitability for Placement Assessment, the SDCP provider is responsible for informing the individual, the appointed substitute decision maker and the referrer of the outcome.

The individual will be placed on a waitlist for placement and will be re-presented to their preferred SDCP unit/s should a vacancy become available. DSA can also be contacted to assist with identifying alternative support options for the individual whilst awaiting placement. An individual on the waitlist for a period of 3 months or more will undergo reassessment by DSA to continue to confirm their eligibility for the program.

### 4.2.4 Transition into the unit

The SDCP provider will contact the referrer and the individual who has been referred will be notified and assisted to transition into the SDCP unit. Transport to the SDCP unit is primarily the responsibility of the family, carer or appointed decision maker. Dependent upon the location of the individual prior to admission, the individual may be supported with transport through the respective health service.

The key enablers to ensure successful transitions into a SDCP unit include:

- early communication and expectation-setting with families, carers and/or appointed substitute decision maker
- understanding the individual's unique needs and preferences with unit staff prior to admission
- flexible resourcing to support admissions. New residents typically require more supervision as they adapt to the new environment
- support from specialist in-reach clinicians to facilitate the transition in process, particularly when the transition is from an inpatient facility.

### 4.2.5 Transitions between units

As the SDCP is a transitional program, transfers of residents between SDCP units is generally not supported. However, if there are exceptional circumstances where it is potentially in the best interest of the resident to transfer to another SDCP unit, these cases may be considered by the department.

## 4.3 The delivery of care

### 4.3.1 Philosophy of care and care approach

The SDCP uses a psychosocial, person-centred and goal-oriented philosophy and approach to care that builds on or maintains the strengths and capacity of individuals, based on the service delivery principles. There is a focus on understanding the resident, their life story and how this may contribute to their behavioural expressions.

A restraint-free way of thinking underpins service-level policies and procedures and provision of care. Consistent with standard residential aged care practice, use of restrictive practices are used only as a last resort to prevent harm, in the least restrictive form and only to the extent necessary after considering the likely impact to the resident

SDCP providers must comply with the *Aged Care Act 2024,* including meeting the requirements of the Aged Care Quality Standards.

### 4.3.2 Specific SDCP provider requirements

In recognition of the particular needs of the resident group, specific additional requirements apply to SDCP unit providers, and include:

- at least one registered nurse onsite and on duty at all times,
- higher staffing levels across all shifts with staff that have specific expertise in dementia and behaviour management. It is expected that there is a staff to resident ratio of 1:3 during daytime (both morning and afternoon shifts) and consideration of the same ratio during evening shifts
- care workers must hold a minimum of Certificate III in Individual Support (Ageing) with additional dementia specific training and experience
- establishment and operation of SDCP governance arrangements including the Clinical Advisory Committee and Clinical Review Team (as discussed at sub-section 4.3.6)

- development of relevant policy, protocols and clinical governance processes in conjunction with the Clinical Advisory Committee and Clinical Review Team to support the safe and efficient operation of the SDCP unit and continuous improvement through reflective practice
- establishment of a Memorandum of Understanding (or similar) with the local health service and any other relevant parties for the provision of clinical in-reach support
- clear expectation-setting on commencement with families, carers and/or appointed substitute decision maker regarding the transitional nature of the program
- provision of transition out support to the individual and/or appointed substitute decision-maker
- management of Security of Tenure requirements for residents admitted to and transitioned out of the SDCP unit (for further information on SDCP specific requirements see Section 5)
- ongoing promotion of the program across relevant networks to ensure stakeholders understand the program, eligibility requirements and transition in and out arrangements.

***Funding to support the additional requirements***

In addition to requirements under the Aged Care Quality Standards, SDCP providers are supported to deliver the SDCP program requirements through grant funding which includes:

- daily payments per place to support the delivery of person-centered care in accordance with the service delivery principles (e.g. to meet fixed costs, maintain a higher level of staffing, have a skilled workforce and a capacity to accept residents at short notice).
- transitional payments to support
    - costs directly related to accepting and settling residents into the SDCP unit, including tailored modifications to the physical environment to meet the needs of the transitioning residents
    - costs directly related to transitioning residents out of the SDCP unit and into mainstream residential care homes. This may include assessment of the receiving home and providing advice and training to the receiving home.

Funding is subject to indexation.

This grant funding is payable on top of the residential care subsidies and supplements and an individual's fees, payments and contributions normally payable for residential care.

### 4.3.3 Care planning

The program requires a holistic approach to care which includes:

- involvement of the resident, families, carers and/or appointed substitute decision makers in care planning and goal setting discussions
- establishing, monitoring and reviewing the care plan with the resident, family, carers and/or appointed substitute decision maker and other identified health and care staff, to ensure that families, carers and/or appointed substitute decision makers become embedded in the care journey
- providing support to each resident in line with the needs identified in their care plan and / or other relevant clinical and behaviour support plans
- ongoing planning and communication with families, carers and/or appointed substitute decision maker about transition out arrangements beginning when the resident is placed in the unit (as discussed in section 4.4)
- explicit consideration of culturally appropriate care

- a strong program of therapeutic and meaningful engagement and enrichment activities that reflect individual interests and strengths
- maximisation of opportunities for independent performance of activities of daily living
- care planning that is consistent with the legislative requirements regarding restrictive practices and behaviour support plans.

The same care and services that must be provided to any individual receiving residential care are required to be provided to residents in SDCP units, including ensuring personalised care planning and access to necessary specialist services.

Specified care and services must be delivered in a way that meets requirements under the *Aged Care Act 2024*, including the Statement of Rights, the Aged Care Code of Conduct and the Aged Care Quality Standards.

### 4.3.4 Care setting

The care setting for the SDCP is a dedicated dementia friendly environment, operating as a unit, usually within a larger residential care home, and as such operates under the *Aged Care Act 2024*. Each SDCP unit will generally comprise of 8 beds plus an additional 'bounce back' bed, to accommodate people who may need to be readmitted if their transition out of the program is not successful.

SDCP providers are required to deliver care in physical environments that reflect dementia friendly / dementia enabling design principles, including the 10 Dementia Enabling Environment Principles.[2] Further information can be found at this link Dementia Enabling Environment.

SDCP providers may also be guided by the Accommodation and Design Principles. National Aged Care Design Principles and Guidelines | Australian Government Department of Health, Disability and Ageing.

### 4.3.5 Access to specialist clinical in-reach and allied health services

Access to medical specialists is critical to ensure appropriate clinical oversight and care for the resident group and includes the provision of education and capability building of care staff within the unit.

The Commonwealth provides funding directly to state and territory governments through a Schedule to the Federation Funding Agreement – Health for clinician and coordination staff hours to support the SDCP model of care.

The intent is that all SDCP providers will be able to access clinical support under this arrangement free of charge. States and territories deliver the following activities:

- clinical advice and support (by a psychogeriatrician/geriatrician or suitable alternative and Clinical Nurse Consultant or equivalent) for residents through participation in the Clinical Review Team of each SDCP unit in the state or territory
- participation by the clinicians in the Clinical Advisory Committee for each SDCP unit in the state or territory
- supportive education, modelling and mentoring for SDCP unit staff
- establishing communication channels and facilitating relationships between the local health service and the SDCP provider
- establishing and maintaining networks and partnerships with SDCP providers and DSA
- facilitating pathways for eligibility assessments to be undertaken by DSA within state or territory hospitals or mental health facilities

[2] Burton J, Fleming R (2018). Dementia Enabling Environment. *Dementia Enabling Environments website.*

- work with SDCP providers in the state or territory to establish memorandums of understanding to support the partnership
- manage a risk or issue identified by the clinicians consistent with the memorandum of understanding and where appropriate, escalate a risk or issue to Commonwealth officials where the risk or issue cannot be resolved between the State Health Service or the SDCP provider
- participate in relevant SDCP forums and governance groups
- participate in and contribute to evaluation of the SDCP's activities to inform future program delivery.

A Memorandum of Understanding (MoU) is agreed between the SDCP provider and the local health service, and in some cases includes the state or territory government. This memorandum (extracted at **Appendix B)** sets out the respective roles and responsibilities in the delivery of support for the unit. The MoU should be reviewed at least every 12 months.

Unless otherwise agreed between the Commonwealth, SDCP provider and the local health service, SDCP providers are responsible for directly sourcing and funding allied health services such as psychologists, physiotherapists, occupational therapists, dieticians, dentists, oral hygienists, speech pathologists and any other necessary health professionals as required and for funding these services.

### 4.3.6 Clinical governance

The SDCP model of care is supported by the following governance arrangements:

- Clinical Review Team (or similar), and
- Clinical Advisory Committee.

The respective roles of these groups are outlined below.

***Clinical Review Team***

Initial and ongoing care planning is overseen by the Clinical Review Team. The Clinical Review Team is comprised of members of the multidisciplinary care team including clinicians (psychogeriatrician or geriatrician and Clinical Nurse Consultant or equivalent) and care staff, and meet weekly to oversee the routine care of individuals within the SDCP unit. The team's role includes:

- reviewing and updating behaviour support and care plans
- regular team debriefing, including following incidents at the unit to enable care staff to learn through reflective practice and real-life case-based discussions
- identifying individuals whose behaviours have settled and are ready for transition out of the SDCP unit
- advising the Clinical Advisory Committee of those individuals ready to transition out.

The Clinical review Teams plays an important role in capability building for care staff and provides clinicians with greater insight into the daily behaviours and triggers of each resident.

***Clinical Advisory Committee***

Each SDCP service will establish a Clinical Advisory Committee which is expected:

- to meet within two weeks of a place becoming available in the unit
- to meet monthly for all other activities listed below.

This process and timing are to allow alternative support options to be considered for the individual if no place is available.

The committee is generally comprised of the residential care home manager, program manager, clinicians (psychogeriatrician or geriatrician and Clinical Nurse Consultant or equivalent), DSA and other members as relevant.

The role of the committee includes:

- advising on the suitability for placement assessments and placement of people in the SDCP unit
- providing advice, planning and support for resident transitions out of the SDCP unit following stabilisation
- monitoring and advice on clinical practices and activities of the SDCP unit
- providing input to independent program evaluation
- enabling liaison between SDCP unit staff and the broader residential care home, the local health network, DSA and other relevant parties
- ensuring SDCP providers are able to access clinicians to serve on the Clinical Advisory Committee through the agreement between the Commonwealth and relevant state or territory government
- on-the-ground partnerships between SDCP providers and identified specialists employed within local hospital networks should assist in minimising avoidable hospital admissions and streamlining admission arrangements when an acute admission is necessary.

SDCP providers are responsible for maintaining effective relationships and partnership arrangements in their area to ensure the model is locally supported.

DSA presents eligible referrals to the Clinical Advisory Committee and any further information to support the Suitability for Placement Assessment.

## 4.4 Transition-out

### 4.4.1 Duration of stay

The focus of the SDCP is to stabilise and reduce a person's symptoms with the aim of enabling them to transition out of the unit to a less intensive care setting. It is expected that the usual length of stay in a SDCP unit will be approximately 12 months. This may be extended in specific circumstances following a review of the resident by the Clinical Advisory Committee. In these circumstances the SDCP provider will be expected to justify the need for ongoing care and demonstrate efforts to enable supported transition out to mainstream accommodation.

Transport arrangements to a mainstream residential care home if required, will be the responsibility of the family, carers and/or appointed substitute decision maker. If appropriate, transition out funds may be used to facilitate the transfer of the resident to a mainstream residential care home.

Where a resident is entering end of life care, as identified by a GP or clinical representative, the resident may remain in the SDCP unit. Transition out funds may be used to support end of life care for that resident in recognition of the additional staffing and care required.

### 4.4.2 Communicating and planning for transition out

As a condition of entering a SDCP unit, the resident or their appointed substitute decision maker must consent to accept a suitable mainstream residential care place when the Clinical Advisory Committee recommends that the resident is ready to transition out, noting that a stay in a SDCP unit is transitional.

Planning for transition out is a key element of the program and is required to commence from placement within the SDCP unit. The SDCP provider is responsible for coordinating the transition out process with involvement from specialist in-reach clinicians, the resident or their appointed substitute decision maker. Parties should identify at placement if the resident's or their appointed substitute decision maker's preference on discharge is to:

- ‘step down’ to a mainstream place within the SDCP provider’s broader residential care home
- return to a previous residential care home
- move to a new residential care home.

As part of the transition out process, the SDCP provider is responsible for assisting the resident, family or appointed substitute decision maker to find a suitable place, ensuring it is appropriate for the resident, and for coordinating the resident’s transition to the new residential care setting.

When the Clinical Advisory Committee considers that a resident no longer requires SDCP level care or reaches a 12 month stay within the unit and demonstrates readiness to transition, the SDCP provider must actively manage the transition out process to ensure the most efficient flow of residents through units and the most effective use of SDCP placements for those who need this level of care.

The planning must include arrangements between the SDCP provider and receiving mainstream residential care home, pharmacist and general practitioner, and formalised through a 3-month transition plan developed by the provider and the clinical in-reach team. DSA are also available to assist with transitions out of the unit where the transition is to a place other than the SDCP provider’s mainstream facility.

Post-discharge transition out support is critical to the success of the program and ensuring that outcomes achieved during the resident’s time in the program are sustained.

The transition support includes:

- a focus on information sharing and providing in-reach support to prepare the care environment ahead of time (for example by upskilling staff onsite to understand behaviour triggers, effective behavioural management strategies, and tailoring personalised care plans for the new environment)
- partnering with families, carers and/or appointed substitute decision makers, the receiving residential care home and the local health service, as appropriate, to coordinate transport of the resident
- providing outreach support to the receiving residential care home for up to 3 months post discharge of the resident to answer any questions about the resident and behaviour triggers, and to monitor the progress of the resident to identify any bounce back risk.

Comprehensive documentation about the resident, including behaviour support strategies and transition support arrangements, must be provided to staff at the receiving residential care home, regardless of whether the resident is transferring within the broader facility or to an external residential aged care home.

#### 4.4.3 Readmission

There is no restriction on a person’s readmission to a SDCP unit if assessment indicates this is necessary.  One bed in each unit must be kept available as a bounce back bed to accommodate people whose transition out is not successful. Within the first 12 weeks after discharge from the unit, SDCP providers are expected to readmit individuals if needed, without the need for a formal reassessment. There are no restrictions on the number of placements per resident, provided they meet all assessment criteria.

# 5. Security of tenure

## 5.1 Security of tenure

Security of tenure is established through the *Aged Care Act 2024*.

SDCP providers and residents, families, and/or appointed substitute decision makers will work together to ensure a smooth transition following a period of care in a SDCP unit. However, where

agreement cannot be reached, security of tenure requirements will protect the rights of both parties by establishing the circumstances in which a SDCP provider can ask a resident to leave the SDCP unit.

These circumstances are outlined in the *Aged Care Rules 2025*, in particular rule 149. Reasons for asking a person to leave a SDCP unit must be made clear in the resident service agreement. Specifically, for the SDCP this is based on a documented decision made by the Clinical Advisory Committee which has determined that the resident is no longer requires the level of care provided under the SDCP.

In accordance with rule 149 under the *Aged Care Rules 2025*, SDCP providers must ensure suitable alternative accommodation is available with an alternative registered provider that meets the resident's needs and is affordable by the resident; or in a place more suited to the resident's long-term needs.

## 5.2 Security of tenure to vacated place

As the care period in the SDCP unit is expected to be approximately 12 months, there will be no security of tenure to the vacated place (i.e. to the residential care home that the individual was living in before they entered the SDCP unit) as the person will be entering a new residential care home (i.e. the SDCP unit). This must be made clear to potential residents, families, and/or appointed substitute decision makers considering a SDCP placement.

SDCP units are transitional units and security of tenure arrangements, as it relates to SDCP, must be discussed with the resident, their family and/or appointed substitute decision maker and included in all documentation. In line with the Security of tenure provisions, SDCP providers need to strongly emphasise that residents will be assisted and supported to find alternative suitable accommodation and will not be discharged without a suitable place being made available.

## 5.3 Leave from care

A person's leave from a SDCP unit is in line with standard residential care provisions, including in relation to access to emergency, social, hospital, hospital transition and extended hospital leave.

# 6. Individual Fees and contributions

## 6.1 Resident accommodation payments and contributions

Fees and contributions may be payable by an individual accessing residential care, as outlined in Chapter 4 of the *Aged Care Act 2024*.

These arrangements apply to SDCP residents.

Residents entering a SDCP unit may be liable to pay an accommodation payment or contribution in accordance with arrangements applying to residential care under the *Aged Care Act 2024*.

If an individual has been receiving mainstream residential care before transitioning to a SDCP unit, this means that the individual will have to exit their existing residential care home. Any refundable deposits paid to the first home must be refunded to the care recipient in accordance with the law.

If payable, an accommodation payment or contribution is then paid to the SDCP provider. In some circumstances, the result of moving to a SDCP unit may mean that an individual could be asked to pay more or less towards their accommodation compared to what they were previously paying. This should be clearly explained to the individual, their family or appointed substitute decision maker.

## 6.2 Financial Hardship

If a prospective or current SDCP resident cannot afford the fees and contributions they are liable for, they can apply for hardship assistance under the arrangements in the *Aged Care Act 2024*. For further information contact My Aged Care Financial hardship assistance | My Aged Care.

## 6.3 Higher Everyday Living Fee

SDCP providers should carefully consider whether Higher Everyday Living Fees (HELF) are appropriate for this cohort. It is an expectation that HELF would not be charged for enhanced or supplementary residential clinical care provided through the SDCP unit. Providers should refer to the following guidance Higher everyday living, additional and extra service fees | Australian Government Department of Health, Disability and Ageing

# 7. Obligations of SDCP providers

## 7.1 Obligations of registered aged providers

SDCP providers are registered providers of residential care under the *Aged Care Act 2024*.

It is a condition of registration that a registered provider of residential care must comply with the requirements of the *Aged Care Act 2024*, including the delivery of safe and quality services in line with the Statement of Rights. As specialist dementia care is delivered in a residential care home, compliance with all the Aged Care Quality Standards apply.

SDCP providers are also required to deliver SDCP in accordance with their grant agreement.

## 7.2 Aged Care Complaints

SDCP residents, their families, carers and/or appointed substitute decision makers, have access to the complaints handling arrangements under the *Aged Care Act 2024* in the same way as all other individuals accessing funded aged care services.

A complaint about the care being received in the SDCP can be lodged with the Aged Care Quality and Safety Commission How to raise a concern | Aged Care Quality and Safety Commission or by phoning 1800 951 822. Complaints about clinical in-reach services should be lodged with the Australian Health Practitioner Regulation Agency - www.ahpra.gov.au

## 7.3 Serious Incident Response Scheme

The Serious Incident Response Scheme (SIRS) aims to reduce the incidence of abuse and neglect in residential, home care and flexible aged care service settings. As a registered provider, providers delivering services under SDCP must manage and report a serious event that has happened or is suspected to have happened to the Aged Care Quality and Safety Commission.

For more information about SIRS go to: The Serious Incident Response Scheme | Aged Care Quality and Safety Commission.

Critical incidents involving SDCP residents must also be reported to your grant agreement manager for provision to the department. This will assist the department to consider trends within SDCP and assist with ongoing program management.

# 8. Program Training, Governance and Promotion

## 8.1 SDCP Training Support

Residents within SDCP units require highly specialised, person-centred care. Supporting staff with appropriate training is a fundamental part of delivering the SDCP. Staff who work in SDCP

units are required to have specific expertise and knowledge in dementia and behaviour management.

A guide as to the relevant knowledge, experience and training for staff working in SDCP units has been developed and can be found in the SDCP Guidelines for Skills and Training (the guidelines): https://dta.com.au/app/uploads/downloads/Skills-and-Training-Guidelines-SDCP-May2024.pdf

The guidelines should be used alongside the SDCP provider's own staff development and training programs, including education and mentoring provided by the specialist clinical in-reach team.

SDCP providers can access training and education provided by Dementia Training Australia by contacting them directly at dta.com.au or by calling 1800 100 500.

## 8.2 Program Governance

There are forums convened by the department to support the ongoing implementation of the SDCP which includes:

- A Community of Practice for all SDCP providers either establishing or operating a unit to collectively share experiences, discuss issues and successes and contribute to improved processes and outcomes; to more effectively provide best practice care for people within their units; and to enhance the provision of quality dementia specific care across the aged care sector.
- A Clinicians Community of Practice for all clinicians that are involved in the program to collaborate on clinical services to SDCP units, identify challenges, issues and strategies in program implementation for clinical services, share evidence-based practice and education initiatives/strategies; and contribute towards the provision of best practice and quality care for people living with dementia.

The department also meets regularly with each state and territory government to discuss specialist clinical in-reach arrangements across the jurisdiction and to address any issues related to program implementation and management.

## 8.3 Program Promotion

### 8.3.1 Role of DSA

DSA undertakes regular promotion and education activities with key program stakeholders prior to a unit commencing and on an ongoing basis to support the operation of units. This activity assists prospective referrers to understand eligibility criteria, the program cohort and the relevant information required to support the eligibility assessment process.

### 8.3.2 Role of the SDCP Provider

The SDCP providers are responsible for promoting the program across the aged care sector. This supports potential referrals to the program and facilitates understanding of the program and transition support available to residential care providers who may accept a resident from a SDCP unit into their residential care home.

### 8.3.3 Role of the Department

The department is responsible for promoting the program and the outcomes that are being achieved to key program stakeholders and the wider aged care sector.

## 8.4 Acknowledgement

If a SDCP provider makes a public statement about a SDCP unit funded under the program, providers are required to acknowledge the grant by using the following:

'This Specialist Dementia Care Program unit received grant funding from the Australian Government.'

# 9. Monitoring and evaluation

## 9.1 Program Monitoring and Reporting

Ongoing monitoring of the program relies on the collection of data through annual reporting by providers, state and territory governments and bi-annual reports from DSA. All information is de-identified and provides an evidence base for the continuous improvement of the program and the outcomes that are being achieved against the program objectives.

## 9.2 Program Evaluation

An evaluation of the first phase of the SDCP has been completed. This provided evidence on the implementation, outcomes, and impact of providing tailored residential care support for people living with very severe BPSD.

A copy of the evaluation can be found Specialist Dementia Care Program (SDCP) | Australian Government Department of Health, Disability and Ageing.

Evaluations will be undertaken at key stages of program implementation.

## 9.3 DSA Provider Portal

A provider portal hosted by DSA supports SDCP providers with the management of referrals to units. The portal captures information regarding the resident's journey within the SDCP including eligibility assessment information, placement and transition out information.

# 10. Review of this Framework

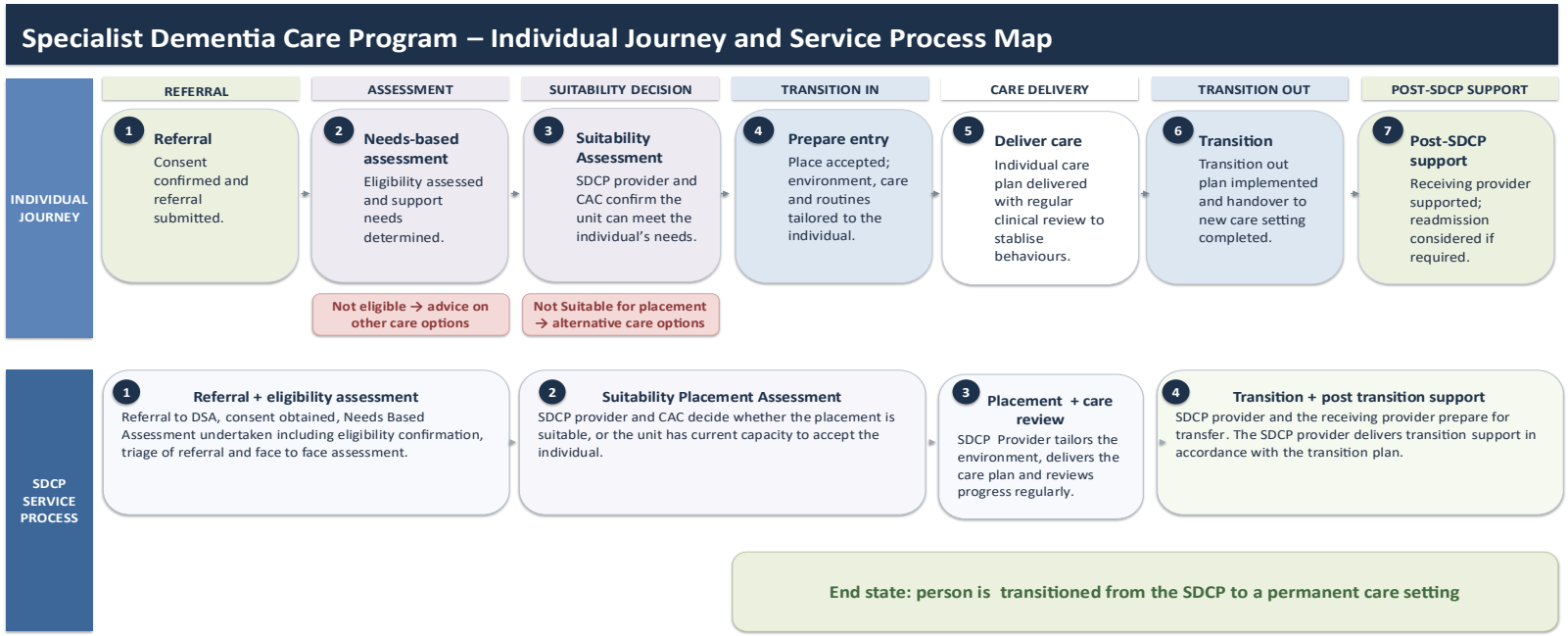
This framework will be reviewed periodically and updated as required. Please provide feedback on this document to sdcp@health.gov.au

## 10.1 Version control

| Version | Date | Issued by |
|---|---|---|
| 1.0 | December 2018 | Department of Health and Aged Care |
| 2.0 | March 2020 | Department of Health and Aged Care |
| 3.0 | September 2026 | Department of Health, Disability and Ageing |
| | | |

# Appendix A - Individual SDCP Service Journey





# Appendix B – Program Roles and Responsibilities

### Key Roles and Responsibilities of the Department of Health, Disability and Ageing include:

- Considering policy and program improvements
- Working collaboratively with all key program stakeholders to establish and implement the program in accordance with program objectives
- Working with state and territory governments to facilitate specialist clinical in-reach services through a Schedule to the Federation Funding Agreement - Health
- Managing grant rounds to establish SDCP units
- Managing grant agreements with SDCP providers and DSA
- Undertaking program monitoring and whole of program evaluation.

### Key Roles and Responsibilities of Dementia Support Australia (DSA) include:

- Undertaking comprehensive Needs Based Assessments that demonstrate eligibility for the SDCP
- Participating in case discussions at the Clinical Advisory Committee and at other times as required by the SDCP provider
- Promoting activities of the SDCP (in partnership with the SDCP provider) to generate ongoing referrals
- Supporting discharge planning for transitions to mainstream residential care homes other than the home of the SDCP provider, where required
- Collecting data on referrals, trends and themes
- Managing the national SDCP waitlist.

### Key roles and responsibilities of the SDCP Provider include:

- Building and maintaining the SDCP unit in line with the dementia enabling design principles and the National Aged Care Design Principles and Guidelines.
- Coordinating delivery of the SDCP within the SDCP unit
- Establishing and ongoing leadership of the Clinical Advisory Committee (CAC) and the Clinical Review Team (CRT)
- Developing relevant policy, protocols and clinical governance processes in conjunction with the CAC and CRT to support the safe and efficient operation of the SDCP unit
- Determining the suitability of residents for admission to the SDCP unit after consideration of the CAC recommendation
- Participating in assessments and transition planning in conjunction with the relevant health service and DSA for individuals transitioning from acute or non-acute inpatient facilities

- Managing Security of Tenure requirements for residents transitioning into and out of the SDCP unit
- Establishing, monitoring and reviewing the care plan with the resident, their families, carers and/or appointed substitute decision makers, health service and other identified health or support staff
- Providing support to each resident in line with the needs identified in their care plan and / or other relevant clinical and behaviour support plans.
- Determining readiness for resident discharge from the SDCP unit and actively leading transition planning and processes from the SDCP unit, in collaboration with the resident, carer/family and/or appointed substitute decision maker and the health service
- Ensuring that the rights of residents within the SDCP unit are respected, including in relation to privacy and confidentiality
- Developing and maintaining partnerships with a range of other stakeholders
- Establishing communication channels with the health service and DSA, and with other stakeholders
- Promptly informing the health service of any escalation in mental health / medical concerns which may impact on the wellbeing of the resident or other residents
- Liaising with the health service in the event of an emergency situation requiring an admission to an acute setting
- Informing the health service and the Commonwealth in relation to any critical incidents within agreed timeframes
- Participating in any evaluation activity of the SDCP and collaborating on joint quality improvement activities
- Promoting the activities of the SDCP (in partnership with DSA) to generate ongoing referrals and possible transition out locations
- Completing SDCP performance reports for the Commonwealth and participating in the Community of Practice meetings
- Complying with obligations under the *Aged Care Act 2024, including the Aged Care Quality Standards*

### Key Roles and Responsibilities of the health service include:

- Identifying individuals for referral to the SDCP and ensuring referrals align with the SDCP target cohort
- Assisting in the development of referral pathways and processes, including referral pathways from state/territory health services into the SDCP unit
- Contributing to clinical assessments, including providing up to date clinical risk assessments, and participating in other joint assessments and documentation processes as required with DSA
- Involving the SDCP provider in transition planning for individuals transferring from local health service inpatient facilities to the SDCP unit
- Participating in Clinical Advisory Committee and Clinical Review Team meetings, on-call support as agreed (including through existing local health service arrangements) and weekly onsite consultation visits

- Facilitating the provision of local health service support for SDCP residents in situations of clinical emergency, including inpatient admission pathways
- Working collaboratively with the SDCP provider, DSA and other partners, including relevant local health network services to ensure the best outcomes are achieved for the resident
- Establishing communication channels with the SDCP provider and DSA across varying levels of the organisations, and with other partners
- Ensuring that the rights of residents are respected, including in relation to privacy and confidentiality
- Participating in any SDCP evaluation activity and the national SDCP Clinicians Community of Practice and collaborating on joint quality improvement activities