The Specialist Dementia Care Program two years on

The articles on the following pages look at the first two years of Australia's Specialist Dementia Care Program, with contributions from care providers, a clinician, Dementia Support Australia, which assesses eligibility, and the Department of Health, which funds the program

Specialised support: introducing the SDCP

By **Robert Day**, Assistant Secretary, Dementia, Diversity and Design, Australian Government Department of Health

The Specialist Dementia Care Program (SDCP) is an Australian Government initiative to provide temporary residential care to meet the needs of people living with very severe behaviours and psychological symptoms of dementia (BPSD*).

The program was established to complement other Australian Government-funded dementia behaviour support programs: Dementia Behaviour Management Advisory Service (DBMAS) and Severe Behaviour Response Teams (SBRT), which support people living with mild, moderate and severe BPSD.

The SDCP funds specialised eight-bed units in aged care homes, with clinical in-reach support such as psychogeriatricians and clinical nurse consultants, provided through local health services. The SDCP units focus on reducing and stabilising symptoms within 12 months and supporting transition to less intensive care settings.

The SDCP draws on the Brodaty, Draper and Low seven-tiered model of service delivery for BPSD (Brodaty *et al* 2003), and specifically targets individuals with Tier 6 care needs. These are people living with dementia with very severe responsive behaviours including physical aggression, severe depression and suicidal tendencies (Brodaty *et al* 2003).

The first SDCP unit opened in 2019 with a prototype service at Brightwater Care Group's The Village in Western Australia (see article next page). A further nine units were established across eight Primary Health Network (PHN) regions as part of the first phase of the program's implementation.

An independent program evaluation by Deloitte Access Economics, commissioned by the Department of Health, is underway which is informing incremental program adjustments, with a final report due in March 2023. Initial indications are the SDCP is achieving its objectives and successfully supporting people exhibiting very severe BPSD.

As of 1 December 2021, 134 people have been accepted into care in SDCP units, with 45 successfully transitioning to mainstream residential aged care.

The Australian Government Department of Health is preparing to implement the second phase of the program, anticipating the establishment of additional units in 2022. The rollout will involve close collaboration with jurisdictions on demand for the program within specific PHN regions and to facilitate the clinical in-reach support. The Australian Government is committed to the establishment of 35 units across the 31 PHN regions by 2024. ■

Reference

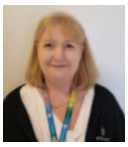
Brodaty H, Draper BM, Low L (2003) Behavioural and Psychological Symptoms Of Dementia: A Seven-Tiered Model Of Service Delivery. *The Medical Journal of Australia* 178(5) 231-234. Available at: https://bit.ly/mja-seven-tiered-model.

Online information and resources: The Department of Health website (www.health.gov.au/initiatives-and-programs/specialist-dementia-care-program-sdcp) has detailed information that includes:

- What is the Specialist Dementia Care Program (SDCP) and its role
- Eligibility
- SDCP locations
- Contact information
- Links to Dementia Support Australia's website for Needs Based Assessment, consent, and referral forms: https://dementia.com.au/services/needs-based-assessment-program
- The Specialist Dementia Care Program Framework document: www.health.gov.au/resources/publications/specialist-dementia-care-program-framework
- A Specialist Dementia Care Program fact sheet on length of stay, fees and security of tenure: www.health.gov.au/resources/publications/specialist-dementia-care-program-length-of-stay-fees-and-security-of-tenure

*** Editors' Note:** The *Australian Journal of Dementia Care* (AJDC) acknowledges there is ongoing debate over the use of the term BPSD or 'behavioural and psychological symptoms of dementia' in relation to people living with dementia. The *AJDC*'s editorial policy is to use the term 'responsive behaviour/s' to underline the importance of seeing agitation, calling out, aggression, constant walking and disinhibition primarily as expressions of need requiring an individual response in each case. However, we do publish articles that include the terms when it is clear they are used in the context of the research or practice being described and the author's intent is to promote person-centred care.

Brightwater's experience as the first SDCP provider



By **Cathy O'Brien**, Service Manager, The Village Brightwater Care Group

Brightwater Care Group (Brightwater) provides care for 751 residential aged care clients across 12 sites in Western Australia from Madeley in the north of Perth to The Cove, Mandurah in the south. Brightwater, The Village is located in Inglewood, Western Australia.

Araluen is an eight-bed Specialist Dementia Care Unit (SDCU) located at The Village (pictured). The SDCU opened on 5 September 2019, starting with two admissions and within five months was operating at full capacity. On 4 April 2020, SDCU discharged its first client who transferred into a mainstream house at The Village, where they continue to live.

To date, 21 clients have been admitted into Araluen with 13 successful discharges. At the time of writing, eight clients are still in the SDCU and of the 13 clients discharged, 10 have transferred into Brightwater, The Village. Families of the other three clients live quite a distance from Inglewood and chose to relocate their loved ones closer to their home.

The success of SDCU starts from the outset with a fully informed admission process and collaborative relationships with external stakeholders. Dementia Support Australia or Older Adult Mental Health ensure the client and their family have a full understanding of the process for admission, the care that will be provided and the benefits that their loved ones will gain from an admission to the SDCU. The staff-to-client ratio is higher than mainstream aged care. Therapy assistant hours are higher in the unit for the eight clients compared to mainstream aged care. The Village has an open garden with paths that are set up for walking and wheelchair access. The gardens have many trees giving shade during the hotter months and families enjoy the grounds and the atmosphere that The Village provides.

Nursing and mental health input is high as both the Specialised Clinical Nurse and the Consultant Psychiatrist (older adult mental health) visit and see clients twice weekly. These intensive nursing and medical interventions are not available for mainstream residential aged care. This is a true multidisciplinary approach providing a high level of care that helps make the program the success it is. The achievement of the client's journey is based on the personalised care provided to each client, which enables them to achieve maximum benefit from their stay. There is a continued focus on discharge planning throughout the client journey. This is achieved through collaboration with families and the client to enable a successful transition to home or permanent care.

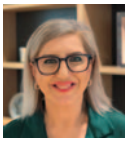
Families are aware that the timeframe for each client to discharge is different and that some may remain in the unit for less than the 12 months or may require an extended stay. The unit has a 'bounce-back' bed which is available to clients for up to three months post-discharge. The client can be re-admitted to Araluen within this time if required. This safety net provides a level of reassurance to families. To date, there have been no re-admissions.

When clients are ready for discharge to an external provider, one of our staff will accompany them to their new home and assist them with settling in. Brightwater ensures the staff member is someone familiar to the client who understands their needs and clinical care. Brightwater also maintains contact with families post-discharge to answer any concerns or queries they may have.

Governance for the SDCU program is provided in collaboration with North Metropolitan Mental Health Services and Brightwater. There are regular multi-disciplinary team meetings which ensures ongoing sustainable health care and success for the clients.

In partnership with this team, we are developing mental health education programs for our staff. This will see them spend time at Osborne Lodge, part of the Osborne Park Older Adult Mental Health Service, to increase their knowledge in this area and continue to grow that stakeholder relationship and network between Brightwater and the Older Adult Mental Health units throughout the Western Australian Hospital network, for the benefit of clients and their families. ■

Accessing the Specialist Dementia Care Program



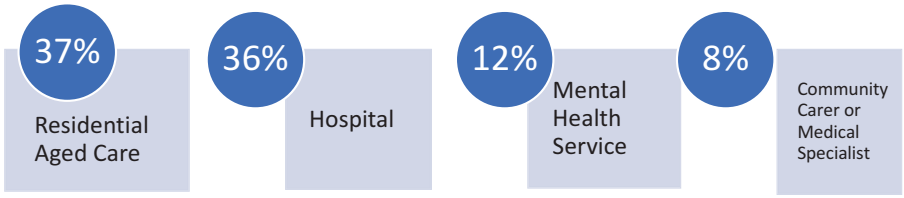
By **Marie Alford**, Head of Dementia Support Australia, HammondCare

Behaviours and psychological symptoms of dementia (BPSD*) are common, experienced by up to 90% of all people living with dementia (Lyketsos *et al* 2002). However, some behaviours, such as severe physical aggression, cannot be supported by mainstream aged care or specialist psychosocial interventions such as those provided by Dementia Support Australia's Dementia Behaviour Management Advisory Services (DBMAS) or Severe Behaviour Response Team (SBRT) support programs (Macfarlane *et al* 2021).

Dementia Support Australia (DSA) received additional funding to extend and complement its existing services to undertake a needs-based assessment to determine eligibility for each person's placement within an SDCP. This Needs Based Assessment Program (NBA) provides nationally consistent assessment for the SDCP.

Early in the project, DSA worked with Professor Henry Brodaty to develop a risk-assessment matrix [for internal use by DSA]. This assessment tool is part of the decision-making process but also includes a review by a clinical associate from the DSA program (such as a geriatrician or old aged psychiatrist). Previously the tool assessed more on the elements of physical risk but now includes the psychological impact on the carer and carer burden.

The tool takes into account whether the carer in the community requires in-home support; whether staff within residential aged care require additional supports, or the person can't be cared for in the aged



Referral for source: Needs Based Assessment Program (September 2019 – December 2021)

care environment and is being sent to hospital; or while in acute care the person needs more than one carer or security when providing care.

Often the hospital setting has a different view on risk and severity of a behaviour compared to a carer in the community. It is important that we have a good understanding of risk and severity because the SDCP is a very specific care environment and is not equipped to care for those people who are still requiring constant one-to-one care or a security presence.

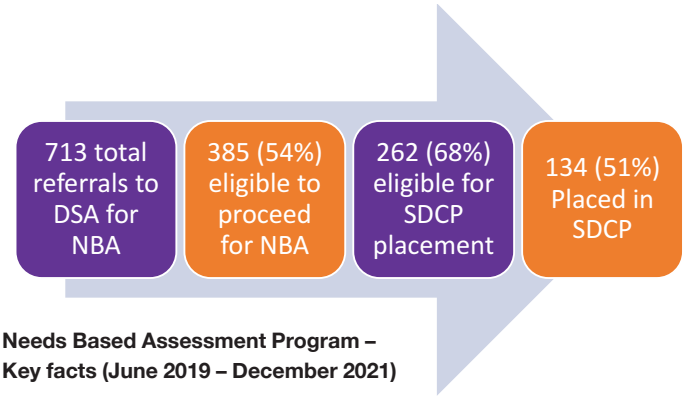
To be eligible for consideration of a SDCP placement, there must be evidence of the person experiencing severe or very severe complex BPSD as a result of dementia that have not responded to management by other specialist services, including pharmacological and non-pharmacological interventions. The primary behaviours resulting in the need for assessment are physical aggression (57%), agitation (20%) and verbal aggression (6%). These are experienced individually and differently by each person living with dementia and are not experienced by every person with dementia. The program's environment, multidisciplinary staff and services are tailored to a very specific group of people with dementia. That doesn't negate other co-morbid conditions such as mental health from being present, however the behaviours must be a result of a dementia.

The profile of clients for referral into the service are more likely to be male (70%) living with Alzheimer's type dementia and experiencing severe behaviours such as those associated with physical aggression (54%) and agitation (21%)* that have been unresponsive to other interventions (*data supplied by Dementia Support Australia for period June 2019 – 1 December 2021).

Key to understanding the requirement for this limited, more specialised support is on-site assessment which includes spending time with the person living with dementia; speaking with their family, guardian and carers to gather relevant social history and reviewing their medical and medication history, such as medical correspondence and hospital discharge summaries. This enables the team to prepare a comprehensive report on their potential eligibility for future placement.

Many of the clients referred for assessment have been prescribed numerous medications, including antipsychotics. This is likely due to the severity of the symptoms and the intractable nature of those symptoms, however there are many opportunities to review their suitability and consider alternative supports. A key assessment component is evidence that alternative supports and interventions have been implemented without success – including non-pharmacological interventions such as modification of the environment, carer approach and communication.

Once the assessment process is complete and eligibility for SDCP determined, the assessment report is passed on for consideration to the Clinical Advisory Committee of the SDCP provider. DSA continues to be involved until a decision is made for placement, waitlisting or other services. ■



Needs Based Assessment Program – Key facts (June 2019 – December 2021)

References

Lyketsos CG, Lopez O, Jones B, Fitzpatrick AL, Breitner J, DeKosky S (2002) Prevalence of Neuropsychiatric Symptoms In Dementia and Mild Cognitive Impairment: Results From The Cardiovascular Health Study. *JAMA* 2881475-1483.

Macfarlane S, Atee M, Morris T, Whiting D, Healy M, Alford M, Cunningham C (2021) Evaluating The Clinical Impact Of National Dementia Behaviour Support Programs On Neuropsychiatric Outcomes In Australia. *Frontiers In Psychiatry* 12 367.

Finding friendship and purpose

Una (pictured) has lived an interesting life. She had been a teacher in Melbourne, ran a backpacker hostel in Mackay, built a yacht and raised a family. Late in life, Una was diagnosed with mixed dementia and as it progressed, she became more aggressive, especially when receiving personal care. Her partner could no longer care for her at home and in June 2020, Una moved into an aged care home.

Following admission, staff reported that Una's aggressive behaviours were continuing and, after medical assessment, she was prescribed the antipsychotic medication risperidone. The impact of this drug regime caused Una to fall and experience hallucinations. Unfortunately, she continued to experience increased behaviours including physical and verbal aggression towards staff and residents, flipping trays and smashing plates in the dining room. These were worse in the afternoon.

The care home contacted Dementia Support Australia and in January 2021 Una was assessed for entry into the Specialist Dementia Care Program (SDCP) and transferred to the HammondCare Caulfield SDCP unit. Una thrived in the domestic family model at Caulfield and was able to build meaningful relationships with staff and residents and find purpose in day-to-day activities.

Within the SDCP Una was able to build her own care routine, providing her with a sense of independence and purpose. She loves to talk to people and share her story and staff were able to spend time with her, building trust.

Una spent five months in the SDCP and has now successfully transitioned to a mainstream dementia-specific cottage. Her day now comprises mainly socialising, reading books, listening to music, dancing, and shopping in the care home's Village Store.

How to refer a person with dementia for entry into the SDCP

If a person's symptoms are impacting their care, you can refer them for a Needs Based Assessment (NBA):

- The first step is to contact DSA by calling 1800 699 799 or visiting www.dementia.com.au.
- DSA can take referrals from anyone including families, care home staff, hospitals, GPs, specialists and Aged Care Assessment Teams.
- Referrals require supporting documentation from a treating clinician.
- Written consent must be obtained from the person's guardian/substitute decision maker before the assessment can take place.

For more information on NBA and to make a referral go to: https://bit.ly/needs-based-assessment

Reflections of Uniting Eabrai on delivering the SDCP

By **Gregory Buckley**, Clinical Lead, Uniting ACT, SDCU-Eabrai, Mirinjani, Amala

Uniting Eabrai was first commissioned as a new development for people living with dementia in 1992 as part of the Uniting Mirinjani aged care service. The Uniting Eabrai Specialist Dementia Care Unit (SDCU, pictured below) officially opened on 1 July 2020.

Uniting Eabrai SDCU is a small-scale eight-bed unit with an additional bed available for a person who has recently transitioned out to return to our SDCP. The units incorporate dementia design principles from the Uniting Design Guide (an internal Uniting document) and learnings from a visit by representatives of Uniting Ageing and Uniting Mirinjani to the first SDCP provider, Brightwater, Perth, Western Australia SDCP (see article p29).

The people we support for placement at Uniting Eabrai have very complex behaviours. Families advised that at their previous aged care homes, they were 'uncooperative' and 'combative' with care.

However, we have not found this to be the case at Eabrai SDCU on most occasions. In fact, we see the opposite. Since opening, we have had minimal use of behaviour-modifying medication. Similarly, there have been only a few incidents of aggression between residents. Our experience to date is that the residents are settled, co-operative and staff are easily able to engage with them.

SDCU staff are key to the success of the program. Staff took part in an intensive internal education program before the unit opened where they developed skills in being able to monitor resident behaviour and, in most cases, can intervene by separating and redirecting residents before agitation turns into aggression and an incident occurs. This has allowed us to build a team around core beliefs and values of respecting the individual and providing an enabling approach to care. The culture is relaxed, calm and resident-focused, with one Registered Nurse and two trained carers to support the eight residents.

If a resident is experiencing aggressive and violent behaviours and poses a safety risk to themselves, staff or the environment, we initiate an escalation policy, developed with Canberra Health Service, Canberra District Ambulance, and the Australian Federal Police. This involves transferring the person to a hospital emergency department to be assessed by a treating geriatrician. We have used this process on three occasions.

We have an easily accessible outdoor area for residents which is highly successful and is in continuous use. With glass doors and large windows, the unit itself is open, spacious, light and airy and allows the outside world in. The design allows for dedicated sitting and dining areas and the outside area provides an easily accessible activity space.

The residents seem to be most relaxed when they can move about freely and are supported to do as much as they can. Staff are proactive in facilitating activities that allow the person to be stress-free and engaging freely in their environment. Staff are focused on what residents can still do – working to their strengths and providing activities that allow individuals to be successful. Staff set up the residents to succeed.

Since the SDCU opened we have accepted 25 people with very severe BPSD, mostly men in their late 70s, with most being referred due to physical aggression. As this is transitional accommodation, the average length of stay has been nine months.

In the first 12 months of operation, we have had eight people transition (including two deaths). Of the six who transitioned to less intensive behaviour support facilities, four were within Uniting Care and two were interstate. Since February 2021, we have been at full capacity.

We are now sharing our learnings of the importance of staff education and training as well as the enabling environment from the SDCP to inform care in other dementia home settings within Uniting Care, including Richards Cottage. We have had families tell us how nice it is to receive a positive phone call from us to let us know how their loved one is progressing. The positive impact of the SDCP program for these families has been significant. We will continue to support and assist the people living in Eabrai to participate to the rhythm of their own lives. ■

A clinician's perspective

By **Dr Madeleine Healy**, Clinical Specialist, Geriatrician, Monash Health, Victoria

Hospitals are challenging places for people living with dementia. Like many clinicians, I've seen countless people experiencing severe behaviours and psychological symptoms of dementia (BPSD) admitted to acute hospital wards from residential aged care or home. The hospital staff do their best, but nothing can change the hospital environment. Too often there are 'code greys' (a hospital emergency call for physical aggression) and antipsychotic medication administered while the person is waiting for other more suitable accommodation.

When the SDCP began, I was fortunate to have the opportunity to work in the Caulfield SDCP (pictured) from inception, in partnership with Monash Health, in the South Eastern Primary Health Network.

The unit opened in January 2020 in a purpose-built, home-like setting at HammondCare Caulfield. In conjunction with the Clinical Advisory Committee (CAC) we received our first referrals from Dementia Support Australia's Needs Based Assessment team.

Many of the referrals had been by colleagues throughout the region in emergency departments, acute psychiatry or general medical wards, and even from home through community mental health services. This included people who had been waiting in acute hospitals for many months, unable to find appropriate accommodation in the community. These people experienced distress levels beyond those manageable in residential care, some even having tried multiple care homes. They had often been sent via ambulance into hospital following a crisis, usually precipitated by severe distress in the form of agitation or aggression.

The SDCP exceeded our expectations as the majority of people admitted to the cottage settled within weeks. We saw more than a 50% drop in antipsychotic use within three months, and in some cases, antipsychotics ceased altogether. Some residents never displayed the distress or agitation described in the settings they had come from.

This was immensely rewarding for staff, and a reflection of their person-centred care. In my visits, I often saw residents cooking with staff, helping wipe kitchen benches, or listening to music while having a cup of tea – all activities any of us do in a day. Life continued as normal. Clinical care continued in the background.

For some residents, their symptoms were so severe that even in the quiet home-like environment, they remained severely distressed, and at times hard to support. This was challenging and exhausting for staff. To address this, we've improved our admission and discharge preparation and handover, as well as increasing support and education for staff. Prior to the person's admission an extensive admission document educates the staff about who the person is, as well as planning sessions and nomination of a staff member who is the 'key person' for each resident who makes a comprehensive and holistic plan for the person, communicating to the team and the family. On discharge we now often fund one of our carers to go with the person for their first day in their new care home to model the positive interactions and strategies which have been so successful in the cottage. Despite these improved processes, there are still difficult days for staff and the residents living with dementia.

Some residents have transitioned into mainstream residential care, a minority have returned to the cottage after their new accommodation couldn't meet their needs. Another minority have needed end-of-life care within the 12 months of the program.

We continue to learn from our experiences and increasingly can support people with more severe BPSD. As other SDCPs gradually open there will be more beds and more options for people living with severe BPSD. There are still many people in the hospital system and community needing support. ■

Opportunities for the future

By **Marie Alford**, Head of Dementia Support Australia, HammondCare

Restrictions imposed by the COVID-19 pandemic have posed challenges across all areas of the aged care sector, however the assessment and placement programs have continued as a necessary support. This work continues today.

The delivery of the first 10 SDCP units has had significant positive outcomes for people living with dementia. The geographic limitations of where the current SDCPs are located will be eased once future units open. Lessons are being learned from sites in regional areas such as Mackay, in Queensland and consultation is occurring in the Northern Territory to understand the specific needs of staff and residents in remote areas.

The SDCP has begun to address a gap for those people for whom mainstream residential homes cannot provide care by building supports and care that addresses their specific and individual needs. The development of specialised training for the SDCP workforce and the ongoing evaluation of outcomes will help shape our understanding of future services.

The partnership across these units; with residential providers, community, acute and older adult mental health, and services like Dementia Support Australia can only lead to better outcomes for people living with severe behaviours and psychological symptoms of dementia.

The Dementia Support Australia (DSA) team is available to visit any care setting to provide assessment (pending consent). For further information on the program and eligibility, contact DSA at www.dementia.com.au or 1800 699 700.

Detailed information about the Specialist Dementia Care Program is also available at: https://bit.ly/sdcp-framework and on the Dementia Support Australia website at https://bit.ly/needs-based-assessment

Footnote: The Royal Commission into Aged Care Quality and Safety noted that at the time of sitting, the SDCP was in its infancy. The Commission handed down a recommendation that a review of the SDCP take place by mid-2023 with respect to the number of units meeting the needs, and if the units currently in operation are successful.