Department of Health

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A guide to services for people with dementia and their carers

2012

State Government Victoria

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This work was guided by the *Dementia services pathways – an essential guide to effective service planning (KPMG, 2011).*

This project was funded by the Commonwealth and Victorian governments through the HACC Program.

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Introduction

A guide to services for people with dementia and their carers is a resource for service providers to support timely provision of information, supports and referrals that meet the expressed needs of people with possible dementia and their carers.

The guide has been developed in collaboration with Department of Health program managers and practitioners from a range of organisations; HACC assessment services, Aged Care Assessment Services, District Nursing services, Cognitive Dementia and Memory Services, Divisions of General Practice, Alzheimer's Australia Vic, Aged Persons Mental Health, the Dementia Behaviour Management Advisory Service and Carer Respite Services.

The service guide has been structured around four management stages of dementia. These stages were used by KPMG in the national project *Dementia services pathways – an essential guide to effective service planning* (KPMG 2011).

Complementing this guide is *Strengthening assessment and care planning: Dementia practice guidelines for HACC assessment services* (Department of Health, 2012). These practice guidelines were developed for HACC assessment services, but will be useful for other service providers who work with people with dementia and their carers such as district nurses, allied health practitioners and planned activity group coordinators. The Dementia Practice guidelines are on the HACC website: www.health.vic.gov.au/hacc/assessment

Living Longer Living Better

In May 2012 the Commonwealth government announced its Aged Care Reform Package: *Living Longer Living Better.* The reforms outlined in the package include a number of measures to support people with dementia and their carers. Key measures include:

- Two additional package levels to smooth the transition from HACC to packaged care, and create an intermediary package between CACP and EACH will be introduced in 2013-2014. A total of four package levels (Levels A-D) will then be available. CACP will be a Level B and EACH will be a Level D package.
- A new Dementia Supplement to provide additional financial assistance to people with dementia receiving any of the four levels of packaged care (10 per cent of the package value).This new arrangement will be introduced on July 1 2013. EACH D packages will no longer exist.
- Expand the scope of the Dementia Behaviour Management Advisory Service
- Improved quality of care in residential care for residents with severe behavioural and psychological symptoms of dementia
- More support for younger people with dementia through access to dementia key workers.

More information can be found at <www.health.gov.au/internet/main/publishing.nsf/Content/aged-aged-care-review-measures-techdoc>

This guide will be updated in 2013, to reflect the Commonwealth's aged care reform measures.

The guide has four sections:

1. Management stages of dementia

Describes the four management stages of dementia.

2. Summary referral tables and referral chart

Four referral tables matching the four dementia management stages. Each table summarises services relevant to each stage.

A referral chart summarises dementia care needs, carer needs and support services.

3. Local dementia service directory

A template for listing local or regional contact details.

4. Service descriptions

A detailed description of each service.

How to use the service guide

Step 1	Use the summary referral tables in Section 2 to identify appropriate assessment, diagnostic or support services for a person with dementia and their carer.
Step 2	Review the service description in Section 4 for a particular service.
Step 3	Refer to the local service directory (completed at a local or regional level) to make contact with the appropriate service.

1. Management stages of dementia

Overview

Dementia services pathways – an essential guide to effective service planning (KPMG 2011) recommends four management stages of dementia as part of a dementia services pathway framework. Built into the framework are principles of care, key elements of service delivery and distinct service features required for people living with dementia and their carers. For more information see www.health.gov.au/internet/main/publishing.nsf/Content/ageing-dementia-servicespathways.htm.

Stage 1: Awareness and recognition

This stage incorporates general public and service provider recognition of dementia signs and symptoms requiring referral for further investigation, assessment, diagnosis and support..

This stage involves:

- *awareness* – understanding the signs and symptoms of dementia
- *recognition* – acknowledging dementia as a chronic, progressive and terminal disease
- referral – timely recognition and referral to health professionals and other services for symptoms that relate to a possible diagnosis of dementia.

Education, training and awareness raising are also included in this stage.

Stage 2: Initial dementia assessment, diagnosis, and post-diagnosis support

This stage incorporates the spectrum of service providers that may assist with or undertake initial dementia assessment and diagnosis. Services and specialists involved in diagnosis provide post-diagnosis information and referral to appropriate support services.

Stage 3: Management, care, support and review

This stage addresses the role of ongoing management (health and community care), review and support across the spectrum of services and across care settings in the home, the community and in residential care. Services range from post-diagnosis support, review to address fluctuations in care and support needs, care coordination where people are supported by several services, to more intensive case management and care such as HARP or EACH-D.

Stage 4: Palliative and end-of-life care

This stage incorporates the spectrum of service providers, medical and allied health professionals and community supports involved in planning and providing quality end-of-life care including palliative care services which are provided in a variety of settings (home or community based, hospitals, hospices and residential care facilities). Depending on the needs of the person with dementia and their carers, palliative care services may also be involved at other stages of care.

2. Summary referral tables and referral chart

The four summary referral tables list key services involved in each of the four management stages of dementia, at a statewide level. Each table:

- represents one stage of dementia management
- shows a breakdown of activities into sub-columns, as services may undertake some but not all of the activities in each stage
- provides a page reference to the service description.

It should be acknowledged that the referral table and service descriptions have been developed from a statewide perspective. Some variation may occur across services and programs in different regions and local areas.

These tables can be adapted for use in specific regions or sub-regions, depending on local service availability and local service configurations.

Stage 1: Awareness and recognition

	Service category	Service type	Service description	Recognition	Education	Awareness/ information
Services	Community care	Living at Home Assessment	13	✓		✓
		Support with activities of daily living	15	✓		✓
		Aids and equipment	17			
		Commonwealth funded packaged care (CACP and EACH)	19	✓		✓
		Individual Support Packages (ISP)	21	✓		✓
		Social support – planned activity groups	23	✓		✓
		Access and support	25	✓		✓
	Clinical and specialist services	General practice and practice nurses	27	✓		✓
		Nursing	29	✓		✓
		Allied health	31	✓		✓
		Medical specialists	33			
		Geriatric Evaluation and Management (GEM)[1]	35	✓	✓	✓
		Aged Care Assessment Service (ACAS)	36	✓		✓
		Aged Persons Mental Health Service (APMHS)	38	✓		✓
		Hospital Admission Risk Program (HARP)	40	✓		✓
		Palliative care	42			
	Dementia-specific supports	Information and counselling: Alzheimer's Australia Vic	44	✓	✓	✓
		Cognitive, Dementia and Memory Service (CDAMS)[2]	46	✓	✓	✓
		Dementia Behaviour Management Advisory Services (DBMAS)	49	✓	✓	✓
		Extended Aged Care at Home Dementia (EACH-D)	52	✓		✓
		Café style support services	54		✓	✓
	Supporting care relationships	Counselling and Advisory Service (Carers Victoria)	56	✓	✓	✓
		Support for Carers Program (SCP)	58	✓	✓	✓
		Support for Carers of People with Dementia Program (SCPWD)	59	✓		✓
		National Respite for Carers Program (NRCP)	60	✓		✓
		Respite (HACC funded)	62	✓		✓
	Residential care	Residential aged care services and residential respite	64	✓		✓
		Disability supported accommodation	66	✓		✓

Notes:

1. GEM services are relevant for a defined episode of care only).
2. Community group education may be offered.

Stage 2: Initial dementia assessment, diagnosis and post-diagnosis support

Services	Service category	Service type	Service description	Dementia assessment	Diagnosis	Post-diagnosis support
	Community care	Living at Home Assessment	13			
		Support with activities of daily living	15			
		Aids and equipment	17			
		Commonwealth funded packaged care (CACP and EACH)	19			
		Individual Support Packages (ISP)	21			
		Social support – planned activity groups	23			
		Access and support	25			
	Clinical and specialist services	General practice and practice nurses	27	✓	✓[1]	✓
		Nursing	29			
		Allied health	31			
		Medical specialists	33	✓	✓	✓
		Geriatric Evaluation and Management (GEM)[2]	35	✓	✓[1]	✓[2]
		Aged Care Assessment Service (ACAS)	36	✓	✓[1]	✓
		Aged Persons Mental Health Service (APMHS)	38	✓	✓[1]	✓
		Hospital Admission Risk Program (HARP)	40			
		Palliative care	42	✓		✓
	Dementia-specific supports	Information and counselling: Alzheimer's Australia Vic	44			✓
		Cognitive, Dementia and Memory Service (CDAMS)[2]	46	✓	✓	✓[2]
		Dementia Behaviour Management Advisory Services (DBMAS)	49			✓
		Extended Aged Care at Home Dementia (EACH-D)	52			
		Café style support services	54			
	Supporting care relationships	Counselling and Advisory Service (Carers Victoria)	56			✓
		Support for Carers Program (SCP)	58			
		Support for Carers of People with Dementia Program (SCPDP)	59			
		National Respite for Carers Program (NRCP)	60			
		Respite (HACC funded)	62			
	Residential care	Residential aged care services and residential respite	64	✓		✓
		Disability supported accommodation	66			

Notes:

1. Diagnosis of dementia is not a primary role.
2. GEM and CDAMS services are relevant for a defined episode of care only.

Stage 3: Management, care, support and review

Services	Service category	Service type	Service description	Management	Care and support	Review
	Community care	Living at Home Assessment	13	✓[1]	✓	✓
		Support with activities of daily living (ADLs)	15		✓	✓
		Aids and equipment	17		✓	
		Commonwealth funded packaged care (CACP and EACH)	19	✓	✓	✓
		Individual Support Packages (ISP)	21	✓	✓	✓
		Social support – planned activity groups	23		✓	✓
		Access and support	25		✓	
	Clinical and specialist services	General practice and practice nurses	27	✓	✓	✓
		Nursing	29	✓	✓	✓
		Allied health	31	✓	✓	✓
		Medical specialists	33	✓		✓
		Geriatric Evaluation and Management (GEM)[2]	35	✓		✓
		Aged Care Assessment Service (ACAS)	36	✓		✓
		Aged Persons Mental Health Service (APMHS)	38	✓		✓
		Hospital Admission Risk Program (HARP)	40	✓	✓	✓
		Palliative care	42		✓	✓
	Dementia-specific supports	Information and counselling: Alzheimer's Australia Vic	44	✓	✓	
		Cognitive, Dementia and Memory Service (CDAMS)	46			
		Dementia Behaviour Management Advisory Services (DBMAS)	49		✓	✓
		Extended Aged Care at Home Dementia (EACH-D)	52	✓	✓	✓
		Café style support services	54		✓	
	Supporting care relationships	Counselling and Advisory Service (Carers Victoria)	56		✓	
		Support for Carers Program (SCP)	58	✓	✓	✓
		Support for Carers of People with Dementia Program (SCPDP)	59	✓	✓	✓
		National Respite for Carers Program (NRCP)	60		✓	✓
		Respite (HACC funded)	62		✓	✓
	Residential care	Residential aged care services and residential respite	64	✓	✓	✓
		Disability supported accommodation	66	✓	✓	✓

Notes:

1. HACC Assessment Services not funded to provide case management but do assist with care coordination.
2. GEM services are relevant for a defined episode of care only.

Stage 4: Palliative and end-of-life care

Services	Service category	Service type	Service description	Management	Care and support	Review
	Community care	Living at Home Assessment	13		✓	✓
		Support with activities of daily living	15		✓	✓[1]
		Aids and equipment	17		✓	
		Commonwealth funded packaged care (CACP and EACH)	19	✓	✓	✓
		Individual Support Packages (ISP)	21	✓	✓	✓
		Social support – planned activity groups	23		✓	✓
		Access and support	25		✓	
	Clinical and specialist services	General practice and practice nurses	27	✓	✓	
		Nursing	29	✓	✓	✓
		Allied health	31		✓	✓
		Medical specialists	33	✓		
		Geriatric Evaluation and Management (GEM)[2]	35	✓[3]		
		Aged Care Assessment Service (ACAS)	36			✓
		Aged Persons Mental Health Service (APMHS)	38			✓
		Hospital Admission Risk Program (HARP)	40			
		Palliative care	42	✓	✓	
	Dementia-specific supports	Information and counselling: Alzheimer's Australia Vic	44		✓	
		Cognitive, Dementia and Memory Service (CDAMS)	46			
		Dementia Behaviour Management Advisory Services (DBMAS)	49		✓	✓
		Extended Aged Care at Home Dementia (EACH-D)	52	✓	✓	✓
		Café style support services	54			
	Supporting care relationships	Counselling and Advisory Service (Carers Victoria)	56		✓	
		Support for Carers Program (SCP)	58		✓	✓
		Support for Carers of People with Dementia Program (SCPWD)	59		✓	✓
		National Respite for Carers Program (NRCP)	60		✓	✓
		Respite (HACC funded)	62		✓	✓
	Residential care	Residential aged care services and residential respite	64	✓	✓	✓
		Disability supported accommodation	66	✓	✓	✓

Notes:

1. Support may be provided by HACC for carer at end-of-life stage.
2. GEM services are relevant for a defined episode of care only.
3. Management of dementia is not a primary role.

Summary referral chart

Dementia care needs	Service type
Difficulty managing daily tasks: • maximising living environment • activities of daily living • continence • IADLs.	• HACC (Living at Home Assessment, home help, personal care) • Community health service (OT, physiotherapist) • ACAS (for complex needs) • Continence clinic • Nursing • Alzheimer's Australia Vic
Financial and lifestyle issues: • forward planning • competency unclear • Power of Attorney • legal issues • decision making.	• Alzheimer's Australia Vic • Carers Victoria • Aged Care Assessment Service (ACAS) • Psychogeriatricians/geriatricians • Office of Public Advocate • Victorian Civil and Administrative Tribunal (VCAT)
Driving competency: • retesting • alternative transport options.	• VicRoads • Cognitive, Dementia and Memory Service (CDAMS) • GP
Social isolation	• HACC (planned activity groups, social support) • Alzheimer's Australia Vic • Carers Victoria
Carer support: • illness • difficulty providing appropriate care for person with dementia • prevention of carer stress.	• Carers Victoria • National Respite for Carers Program • ACAS • Support for Carers Program • Support for Carers of People with Dementia Program • Alzheimer's Australia Vic • HACC services including Café style support services
Unclear diagnosis: • suspected dementia • differential diagnosis • depression • delirium • psychosis • poly-pharmacy • anxiety.	• CDAMS • GP • Geriatrician, Psychogeriatrician • Neurologist • Aged Person's Mental Health
Challenging behaviours: • wandering • agitation • aggression • hallucinations/delusions • sexual inappropriateness • resistance to care.	• DBMAS • Aged Person's Mental Health • Alzheimer's Australia Vic (carer support and additional information) • Psychogeriatrician, geriatrician
Accommodation issues: • respite/permanent • residential aged care • homeless or risk of being homeless.	• ACAS • Alzheimer's Australia Vic

3. Local dementia services directory

Compile a list of services and contact details at the local or regional level

Service	Contact	
	Phone	Fax
	Email	
	Phone	Fax
	Email	
	Phone	Fax
	Email	
	Phone	Fax
	Email	
	Phone	Fax
	Email	
	Phone	Fax
	Email	

Service	Contact	
	Phone	Fax
	Email	
	Phone	Fax
	Email	
	Phone	Fax
	Email	
	Phone	Fax
	Email	
	Phone	Fax
	Email	
	Phone	Fax
	Email	

4. Service descriptions

This section provides detailed descriptions of the 28 services listed in the summary referral table in section 2.

Each service description includes:

- an overview of the service and target group
- details of the supports and services provided at each management stage of dementia
- triggers for referral
- referral requirements.

Community care	Page
Living at Home Assessment	13
Support with activities of daily living	15
Aids and equipment	17
Community Aged Care Package (CACP) and Extended Aged Care at Home (EACH)	19
Individual Support Package (ISP)	21
Social support – planned activity groups	23
Access and support	25
Clinical and specialist services	
General practice and practice nurses	27
Nursing	29
Allied health	31
Medical specialists	33
Geriatric and Evaluation and Management (GEM)	35
Aged Care Assessment Services (ACAS)	36
Aged Persons Mental Health Service (APMHS)	38
Hospital Admission Risk Program (HARP)	40
Palliative care	42
Dementia-specific supports	
Information and counselling (Alzheimer's Australia Vic)	44
Cognitive, Dementia and Memory Service (CDAMS)	46
Dementia Behaviour Management Advisory Service (DBMAS)	49
Extended Aged Care at Home Dementia (EACH-D)	52
Café style support services	54
Supporting care relationships	
Counselling and Advisory Service (Carers Victoria)	56
Support for Carers Program (SCP)	58
Support for Carers of People with Dementia Program (SCPWD)	59
National Respite for Carers Program (NRCP)	60
Respite (HACC funded)	62
Residential care	
Residential aged care services and residential respite	64
Disability supported accommodation	66

4.1 Living at Home Assessment

Service description

Living at Home Assessments are a HACC funded activity. They incorporate holistic assessment and care planning, service-specific assessment for the person and their carer, and care coordination as required. Assessments are provided by HACC assessment services.

Target group

Older people, people with a disability and their carers who have a need for basic maintenance and support services to enable them to live independently at home. All people in the target group are eligible for a Living at Home Assessment.

Support provided in each stage

Stage 1: Awareness, recognition

HACC assessors:

- identify signs of, or concerns about cognitive impairment or memory problems
- understand how these issues impact on the everyday life of the person and their carer
- discuss options for further information, support, education and diagnosis
- provide referrals, as agreed.

Stage 2: Initial dementia assessment, diagnosis

Most HACC assessors refer to relevant agencies for initial dementia assessment and diagnosis. RDNS and Ballarat District Nursing Service carry out initial dementia assessment. Existing HACC clients with a dementia diagnosis receive post-diagnosis support as part of a Living at Home Assessment.

Stage 3: Management, care and support

HACC assessors refer to a wide range of providers to support people with dementia and their carers.

Stage 4: Palliative and end-of-life care

HACC assessors work with palliative care providers so that the end-of-life stage is well-managed and that appropriate supports are provided.

Triggers for referral

- The person is unable to cope independently with everyday activities such as housework, showering and dressing.
- The person has poor nutrition.
- The person is becoming socially isolated, due to their inability to drive or use public transport.
- Carer stress, where the person has a carer.

Referral requirements

Referrals using the Service Coordination Tool Templates (SCTT) is preferred.

People with diverse needs

HACC funded services are delivered within the HACC Diversity Framework.

See: *Strengthening diversity planning and practice: a guide for HACC services* (Department of Health, 2011)

Strengthening assessment and care planning: a guide for HACC assessment services (Department of Health, 2010).

Other relevant information

List of HACC assessment services in each region www.health.vic.gov.au/hacc/assessment

HACC Program Manual
www.health.vic.gov.au/hacc/prog_manual/index.htm

4.2 Support with activities of daily living

Service description

Support with activities of daily living is provided through the HACC Program, Linkages packages, Veterans Home Care and community care packages such as CACP, EACH and EACH-D. Disability services provide these supports for younger people with a disability. Residential aged care also supports people in everyday tasks and activities. Many people purchase these services privately.

Target group

Eligibility depends on the program guidelines. See below for links to relevant programs.

Support provided in each stage

Stage 1: Awareness, recognition

Community care workers who provide ADL support to people with dementia in their homes (and in residential care) should be aware of typical signs of cognitive impairment and/or changes in memory or behaviour and report these to their supervisor. Supervisors should assist the person and their carer to access specialist advice and information, if they are not already doing so.

Stage 2: Initial dementia assessment, diagnosis

No role in this stage.

Stage 3: Management, care and support

Typical support covers domestic assistance, personal care, home maintenance and nutritional assistance. Personal care is a broad term and includes assistance with showering, dressing, medication, transfers, eating, shopping and attending social activities.

Stage 4: Palliative and end-of-life care

Agencies providing ADL support would work with specialist palliative care services to provide appropriate supports and minimise functional decline.

Triggers for referral

- The person is unable to cope independently with everyday activities such as housework, cooking, showering and dressing.
- The person has poor nutrition.
- The person is becoming socially isolated, due to their inability to drive or use public transport.
- Carer stress, where the person has a carer.

Referral requirements

Will depend on individual program guidelines.

People with diverse needs

Community care providers will assist people from CALD backgrounds to access interpreters.

HACC funded services are delivered within the HACC Diversity Framework.

See *Strengthening diversity planning and practice: a guide for HACC services* (Department of Health, 2011).

Other relevant information

HACC Program Manual
www.health.vic.gov.au/hacc/prog_manual/index.htm

Veterans Home Care
http://www.dva.gov.au/benefitsAndServices/home_services/Pages/index.aspx

See CACP, EACH and EACH-D service descriptions on pages 19 and page 52.

4.3 Aids and equipment

Service description

A variety of equipment and assistive technology is available to support people with dementia to build upon their strengths and live more independently. The Independent Living Centre (ILC) has occupational therapists (OT) and physiotherapists providing advice on appropriate equipment and technologies. (The ILC does NOT sell this equipment. Supplier details and relevant service information can be obtained from staff and from their website).

Following assessment by allied health staff, some subsidised or reissued equipment is available through the Victorian Aids and Equipment Program service provider – State-wide equipment program (SWEP). Veterans may be eligible for rehabilitation aids and appliances through DVA, depending on their assessed clinical needs.

Target group

Frail older people and people with disabilities.

Support provided in each stage

Stage 1: Awareness, recognition

No role in this stage.

Stage 2: Initial dementia assessment, diagnosis

No role in this stage.

Stage 3: Management, care and support

Typical equipment ideas to address frailty and memory issues.

Kitchen:

- use a timer when cooking to reduce the chance of leaving a pot on the stove
- kettle that turns off automatically
- disconnect gas stove and install a gas detector.

Other rooms:

- working smoke detector placed between kitchen/living and sleeping areas
- memory centre by the phone – whiteboard, calendar, diary, notebook, large clock with day and date, basket for bills
- administration aids for medicines
- rails and ramps if unable to navigate stairs
- wandering – alarms, sensor equipment, tracking device.

Bathroom:

- grabrails by the bath or in the shower
- commode for overnight or equipment like an overtoilet frame.

Dressing: Introduce clothing with Velcro instead of zippers and buttons.

Seek advice from a nursing service or continence clinic regarding continence products.

Stage 4: Palliative and end-of-life care

Examples of equipment required are hospital beds, pressure mattresses, hoists.

Triggers for referral

An OT or physiotherapist prescription is required for some equipment. Consult an OT or physiotherapist for ideas and for allied health involvement.

Referral requirements

Person requires equipment due to frailty, memory issues or other issues arising as a result of dementia.

People with diverse needs

The use and choice of equipment or home modifications needs to be sensitive to people with diverse needs.

Other relevant information

Independent Living Centre (ILC)
http://www.yooralla.com.au/services/independent-living/independent-living-centres

Statewide equipment program (SWEP) <swep.bhs.org.au/>

DVA <factsheets.dva.gov.au/factsheets/>

Continence Aids Payment Scheme: www.humanservices.gov.au/customer/enablers/medicare/continence-aids-payment-scheme/caps-eligibility (Note: Eligible neurological conditions include Alzheimer's, Dementia and Pick's disease in Category 5)

4.4 Community Aged Care Package (CACP) and Extended Aged Care at Home (EACH)

Service description

Community Aged Care Packages (CACPs) and Extended Aged Care At Home (EACH) packages are individually planned and coordinated packages of care tailored to help older people remain living in their own homes.

CACPs provide a level of care equivalent to low level residential care and EACH provide a level of care equivalent to high level residential care.

Target group

Older people assessed by ACAS as needing ongoing case management support. This often includes people with dementia.

Support provided in each stage

Stage 1: Awareness, recognition

When case managers identify memory loss symptoms, they work with the GP to make appropriate referrals for assessment and diagnosis and provide family members with dementia information and support. Discuss Power of Attorney (financial and or medical), guardianship and advance care planning. If appropriate, a referral to ACAS for an EACHD package assessment may occur.

Stage 2: Initial dementia assessment, diagnosis

Liaise with GP regarding referral for dementia assessment.

Stage 3: Management, care and support

CACP and EACH packages are designed to help with activities of daily living, nursing, allied health, social support and complex health care such as assistance with oxygen and/or enteral feeding (EACH only). Case managers link the person and their carer to appropriate dementia supports if needed.

Stage 4: Palliative and end-of-life care

Work with the person's family with regard to Power of Attorney and decision-making process and Advance Care Planning. Referral to specialist palliative care services when appropriate.

Triggers for referral

Complex health, social or family circumstances require ongoing case management which cannot be supported by basic HACC services.

Referral requirements

People need to be assessed as eligible by an ACAS. If approved for a package, ACAS waitlists people on the regional e-waitlist system for CACP or EACH according to their preferred provider(s). The person's preferred package provider will contact the person when a package becomes available.

People with diverse needs

Packages target particular diverse needs groups. ACAS will advise what packages are available.

Other relevant information

The Commonwealth government's Aged Care Reforms will be introduced from July 2013. When a person receiving a package has dementia, a new behaviour supplement (10 per cent of the package) will be payable. See Aged Care reforms at <www.health.gov.au/internet/main/publishing.nsf/Content/aged-aged-care-review-measures-techdoc>

CACP and EACH
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-brochure-ccp.htm
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-each.htm

Community Aged Care Package Guidelines
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-cacp-guidelines.htm

4.5 Individual Support Packages (ISP)

Service description

Individual Support Packages are Disability Services funds allocated to a person to meet their disability related support needs. The funds may be used to buy a range of disability-related supports chosen by the person to assist them to achieve their goals. Disability Services funding may complement existing informal support arrangements from family and friends and/or generally available community services.

Target group

People can register their need for an ISP on the Disability Support Register if they meet the criteria as determined under the Disability Act 2006.

People who meet the definition of disability under the Act may be considered for access to disability services if they are defined as a priority for access and if the disability service system is considered to be the most appropriate provider of supports.

See the Disability Access Policy at <www.dhs.vic.gov.au/for-individuals/disability/start-here/access-to-disability-supports>

For information about the Disability Support Register, go to <www.dhs.vic.gov.au/for-individuals/disability/start-here/disability-support-register>

Support provided in each stage

Stage 1: Awareness, recognition

When families, case managers or facilitators identify memory loss symptoms, they work with the GP to make appropriate referrals for assessment and diagnosis. Family members or carers are given dementia information and support.

Stage 2: Initial dementia assessment, diagnosis

Liaise with GP regarding referral for dementia assessment.

Stage 3: Management, care and support

People who are allocated an ISP can receive help from a facilitator to bring together the important people in their life, such as family, friends or advocates, to think about and document the supports that are needed and how they should be provided.

Stage 4: Palliative and end-of-life care

Referrals to palliative care would be made by families or service providers when appropriate. Support provided through packages would continue, with services working in collaboration with specialist palliative care services to support the person and their family.

Triggers for referral

People with a disability may register for an ISP if they have a disability as defined by the Disability Act 2006 and support needs related to their disability that cannot be met through family or friends, or other generally available community supports.

Referral requirements

Contact regional Disability Intake and Response Team on 1800 783 783.

People with diverse needs

People from culturally and linguistically diverse backgrounds have access to interpreter services and information in their preferred language.

Other information

www.dhs.vic.gov.au/for-individuals/disability/individual-support-packages

4.6 Social support – planned activity groups

Service description

For people with dementia and their carers, maintaining social contact and engaging in meaningful, enjoyable activities in the local community is vital to wellbeing.

HACC funded planned activity groups provide opportunities for making social connections and enhancing physical, intellectual and emotional wellbeing. These groups support the care relationship by assisting carers to gain some respite from the care role. Groups meet at a local venue or go on group outings.

Target group

The person or their carer needs to be in the HACC target group. People receiving CACP packages are eligible to attend HACC funded planned activity groups.

Support provided in each stage

Stage 1: Awareness, recognition

All social support program coordinators should be aware of typical signs of cognitive impairment and/or change in memory or behaviour, assisting the person and their carer to access specialist advice and information, if they are not already doing so.

Stage 2: Initial dementia assessment, diagnosis

No role in this stage.

Stage 3: Management, care and support

Planned activity groups (PAG core) provide group activities and outings for people who are independent in personal care and do not require any kind of specialist care from the PAG provider in order to participate.

- Planned activity groups (PAG high) provide activities and outings for people with personal care needs, people with moderate or severe dementia, or people with an ABI. Specially-trained staff are required for these groups.
- Activities in PAGS are designed to promote good nutrition, physical activity and emotional wellbeing, all of which are beneficial to people with dementia.

Stage 4: Palliative and end-of-life care

No role in this stage.

Triggers for referral

The person is socially isolated due to disability, memory loss, or an inability to drive or use public transport. Their carer may need support and respite from their caring responsibilities.

Referral requirements

Referrals using the Service Coordination Tool Templates (SCTT) are preferred

People with diverse needs

HACC ethno-specific planned activity groups are designed to meet the needs of specific cultural groups.

Other relevant information

HACC Program Manual
www.health.vic.gov.au/hacc/prog_manual/index.htm

4.7 Access and support

Service description

Access and support (A&S) provides direct client support to HACC-eligible people whose complex needs are due to diversity, and who need additional support to access generic HACC and other services.

The support is short term, episodic and assists the clients with diverse needs at key stages of the care pathway: initial needs identification, assessment and care planning.

Target group

People with diverse needs including:

- HACC special needs groups: people from Aboriginal and CALD backgrounds; people with dementia; people living in rural and remote areas; people experiencing financial disadvantage (including people who are homeless or at risk of homelessness)
- people with other diverse needs such as age, gender identity, sexual orientation, faith and spirituality.

Access and support assists people experiencing access difficulties due to diversity, regardless of whether their needs are low or high.

Support provided in each stage

Stage 1: Awareness, recognition

Access and support workers use an early intervention/assertive outreach approach to engage, build trust with and support HACC-eligible people who have difficulty accessing services. Workers may identify clients' memory issues at any stage of this engagement and can support people in the HACC assessment and care planning process.

Stage 2: Initial dementia assessment, diagnosis

No role in this stage.

Stage 3: Management, care and support

Management, care and support A&S is the bridge between the person and service providers, providing support during the assessment and care planning process.

A&S workers may advise providers on culturally sensitive assessment and service delivery practices.

Stage 4: Palliative and end-of-life care

Access and support workers work with palliative care services, if required, to assist them to provide culturally sensitive end-of-life care.

Triggers for referral

People with diverse needs who are experiencing difficulty accessing services, refusing services, or dropping out of services due to cultural or diversity issues.

Referral requirements

Referrals using the Service Coordination Tool Templates (SCTT) are preferred

People with diverse needs

Responding to people with diverse needs is the core Access & Support role.

Other relevant information

A&S is being implemented over 2011–15 and is not a statewide service.

Potential referrers need to contact their local HACC assessment service to identify A&S workers in a particular area.

HACC Program Manual
www.health.vic.gov.au/hacc/prog_manual/index.htm

4.8 General practice and practice nurses

Service description

General medical practice is the first point of call for most people with illness and disability. The main focus of general practice is clinical patient management, but GPs are becoming more involved in structured chronic disease management. This means that GPs are involved in comprehensive health assessments and care planning, as well as direct clinical care.

Practice nurses play a pivotal role in general practice: direct clinical care, management of disease screening activities, practice organisation and administration, facilitating access to services and care coordination. Some practices have nurse-led chronic disease clinics. Each general practice is organised differently and there are a range of activities where a practice nurse is involved directly with patients.

Practice nurses may be either Division 1 or 2 registered, and many have further qualifications in, for example, immunisation, chronic disease management or aged care.

When working with or communicating with GPs, it is important to find out how the medical practice is organised, who is the key person to contact for a particular service or if clinical information needs to be sent or received.

Target group

People of all ages.

Support provided in each stage

Stage 1: Awareness, recognition

In general practice, a person's memory and cognitive impairment may be identified by the practice nurse or the GP from a number of clues: the results of a 75+ years health assessment (55+ for Aboriginal people), frequently missed appointments, an inability to provide information at appointments, difficulty with medications, or concerns expressed by a family member or carer. The relationship that a person and their family/carer builds with the doctor or nurse over a long period of time means that the GP and practice nurse are likely to have a unique insight into that person's life. This knowledge may lead to suspicion of dementia and the need for further investigation. A number of other conditions can mask, or accompany dementia, such as depression, renal disease, acute infections, delirium, or stroke.

Stage 2: Initial dementia assessment, diagnosis

If the GP suspects cognitive and memory impairment, a comprehensive history is taken and a range of tests ordered, to exclude other causes. This includes discussion with the family or carer.

The GP manages any medical condition that might affect memory/cognition.

The GP may refer for further assessment and diagnosis to a Cognitive, Dementia and Memory Service (CDAMS), or to physicians, neurologists and private geriatricians.

CDAMS referral requires the GP to provide test results and a full history. CDAMS clinics have protocols for pre appointment tests and full history and the GP will generally manage this.

The practice nurse works closely with the GP to assess and provide support for a person with memory/cognitive decline and their family or carer.

Stage 3: Management, care and support

The GP manages any condition that might affect memory/cognition, including a including a review of medications and management of chronic and acute illness. The GP will manage the ongoing needs of the person with dementia and cognitive decline, and usually the needs of the carer, including access to respite. The GP needs to be kept informed of changes in a person's condition (so these can be investigated and managed) and in referrals and services that a person receives (so that clinical information can be provided, as necessary).

For ongoing management, the practice nurse will usually assist with care planning and health assessments and in providing information about dementia support to the person and their carer.

Depending on how the general practice is organised, the practice nurse will also be able to provide advice and assistance with referrals and clinical information,

The GP and the practice nurse are also interested in carer health. Simple carer health screening tools may be used.

Stage 4: Palliative and end-of-life care

GPs work with palliative care services and aged care facilities to provide ongoing care at end-of-life.

Triggers for referral

The GP should be notified about any change in a person's condition or care needs, or if there are issues with a carer's availability or health that interrupts their ability to care for the person with dementia.

The GP should also be notified about any subsequent referrals that a service makes for a person with dementia.

Referral requirements

A letter to the practice explaining the reason for referral, or a phone call if the matter is urgent. The referral letter should contain the relevant clinical information, change in condition (behaviours, indicators of cognitive decline and functional decline).

The practice manager oversees the organisation and administration of a general practice, and has a good knowledge of Medicare, clinical software and appointment systems. The practice manager or one of the practice administration staff is usually the first point of contact when entering or phoning the practice.

People with diverse needs

If a person has been visiting the same practice over a period of time, the GP and practice staff will understand their specific needs. GPs have access to interpreter services as required.

Other relevant information

The Victorian Department of Health has developed a number of resources for working with general practice:

Improving feedback to general practice
www.health.vic.gov.au/pch/gpp/working/index.htm

Working with general practice resource guide
www.health.vic.gov.au/pch/downloads/gp_resourceguide.pdf

4.9 Nursing

Service description

District and community nursing services are primarily funded provided through the HACC Program and Department of Veteran's Affairs (DVA) Community Nursing. This entry describes HACC funded district nursing. See below for the link to DVA Community Nursing guidelines.

The district nursing role includes:

- clinical assessment and developing strategies (including a nursing care plan) to maintain health
- clinical care and monitoring the person's health. Services incorporate general and specialised nursing, such as wound care and continence nursing.
- providing information, advice and education on health maintenance to individuals, service providers and consumer groups
- referral to appropriate health and community services as required.

District nursing is provided by Registered Nurses and Enrolled Nurses, and services may be provided either at home, in a community venue, or in a clinic.

Target group

Older people, people with a disability and their carers.

Support provided in each stage

Stage 1: Awareness, recognition

District nurses recognise the signs and symptoms of dementia, cognitive impairment or memory loss and provide the person and their carer practical support, advice, information, education and resources. Referrals are made to other health professionals and support services as required.

Stage 2: Initial dementia assessment, diagnosis

Many nurses are trained in dementia care and may use a range of validated screening tools as part of a comprehensive assessment. Referrals are made to GPs or services such as CDAMS for dementia diagnosis.

Stage 3: Management, care and support

District nurses provide a range of services to support the person with dementia in their own home, such as continence assessment, medication management and personal care for people with unstable health status or complex needs. Referrals are made to other services to support both the person with dementia and their carer.

Stage 4: Palliative and end-of-life care

Specialist palliative care nurses provide specialist nursing care, based on the needs of the patient and their carer. (See Palliative Care page 42). HACC funded nurses provide ongoing nursing care for pre-existing conditions in collaboration with palliative care services.

Triggers for referral

Referrals may be triggered due to a range of factors including nutrition, hydration, medication management, health information and education, personal care requiring nursing involvement due to unstable health and/or complex needs, need for medication administration or monitoring.

Referral requirements

Referrals using the Service Coordination Tool Templates (SCTT) are preferred

People with diverse needs

HACC funded services are delivered within the HACC Diversity Framework.

See *Strengthening diversity planning and practice: a guide for HACC services* (Department of Health, 2011).

The RDNS Homeless Persons Program is a team of specialist district nurses who work with and on behalf of individuals and groups experiencing homelessness. The program provides holistic healthcare to improve access to general community services.

Other relevant information

HACC Program Manual
www.health.vic.gov.au/hacc/prog_manual/index.htm

Guidelines for DVA community nursing www.dva.gov.au/service_providers/community_nursing/Documents/cn-guidelines.pdf

4.10 Allied health

Service description

The Department of Health funds allied health services from a range of programs in a range of settings including hospitals, sub-acute and community health. Allied health disciplines include dietetics, occupational therapy, physiotherapy, speech pathology, social work, counselling, psychology, and podiatry.

These services can be accessed through the public sector or privately. Allied health services eligible for rebates under Medicare are available for people with chronic conditions and complex care needs.

Target group

Depends on program guidelines – see below for links.

Support provided in each stage

Stage 1: Awareness, recognition

All allied health professionals should be aware of signs of cognitive impairment. Clinicians should discuss any memory problems and offer people information and referrals to assist with diagnosis or supports for everyday living.

Stage 2: Initial dementia assessment, diagnosis

Some allied health practitioners may be involved in dementia screening tests and diagnosis, for example, a multidisciplinary team such as CDAMS or ACAS.

Stage 3: Management, care and support

Typical allied health interventions:

- dietician to look at suitable dietary requirements
- speech pathology for difficulties with swallowing or chewing
- occupational therapy for aids and equipment to support independence
- physiotherapy for mobility or pain problems, falls prevention, mobility aids
- counselling and social work.

Stage 4: Palliative and end-of-life care

Allied health practitioners work with palliative care in minimising functional decline and supporting the patient at end-of-life. Typical involvement might be as for stage 3, for example, equipment for end-of-life care.

Triggers for referral

Triggers will depend on the allied health discipline. See program guidelines for more information.

Referral requirements

Referrals using the Service Coordination Tool Templates (SCTT) are preferred for publicly funded allied health.

People with diverse needs

Allied health providers will assist people from CALD backgrounds to access interpreters.

HACC funded allied health practitioners operate within the HACC Diversity Framework. See *Strengthening diversity planning and practice: a guide for HACC services* (Department of Health, 2011).

Other relevant information

HACC Program Manual
www.health.vic.gov.au/hacc/prog_manual/index.htm

Sub-acute and ambulatory services
health.vic.gov.au/subacute/overview.htm

Medicare allied health plans
www.medicareaustralia.gov.au/provider/incentives/allied-health.jsp

4.11 Medical specialists

Service description

A number of medical specialists may be involved in diagnosing cognitive impairment and dementia. These include general physicians, physicians in geriatric medicine, neurologists, psychiatrists and neuropsychiatrists. The diagnosis is generally made in the setting of outpatient clinics or private medical rooms.

Unlike the Cognitive Dementia and Memory Service (CDAMS) that provides a multidisciplinary service, a multidisciplinary team approach may not be available in the private setting or general outpatients.

The assessment process has general elements, including a thorough medical history and physical examination, preliminary cognitive assessment, and exclusion of contributing factors such as depression, delirium or drugs. Blood test screening and radio-imaging are required. Informant history is undertaken with feedback of diagnosis, and prescription of memory enhancing medication, if appropriate.

Target group

The target group depends on the specialty area. See below.

Support provided in each stage

Stage 1: Awareness, recognition

No role in this stage.

Stage 2: Initial dementia assessment, diagnosis

Consultant physicians in geriatric medicine or **geriatricians** have expertise in the diagnosis and management of complex and/or multifactorial medical disorders impacting on the cognition and functional status of older people. Geriatricians adopt a diagnostic approach to identifying reversible pathologies impacting on a person's function, psychological and social wellbeing.

- **Old age psychiatrists** focus on the assessment, treatment and prevention of mental disorders in older people. This involves an understanding of the complex interactions between the ageing process, medical factors, and the social, psychological, spiritual and cultural issues of late life. In the setting of dementia, common co-morbid conditions such as depression, psychosis and significant behaviours of concern may benefit from consultation with an old age psychiatrist.
- A **general physician** adopts a holistic approach to the person and provides high general specialist services across a spectrum of health and illness, which is not limited by the boundaries of medical subspecialties.
- A **neurologist** focusses on the diagnosis and management of diseases affecting the central, peripheral and autonomic nervous systems. Many of these conditions are chronic and disabling so, in addition, a neurologist may need to treat psychological complications, liaise with other medical and allied health professionals, and/or be involved in rehabilitation. In the dementia setting, a neurologist may be involved in assessing those with concomitant neurological disorders such as Parkinson's symptoms or more rapidly progressive dementias.
- **Neuropsychiatrists** are specialists within a mental health service and offer neuropsychiatric assessment and advice to mental health, neurological and other medical services. Patients may include those with early onset dementia, rarer neurodegenerative conditions and chronic psychotic disorders. Neuropsychiatrists are generally based within a tertiary hospital setting and work in a multidisciplinary team.

Stage 3: Management, care and support

The medical specialists described above have an ongoing role in medical management of their patients.

Stage 4: Palliative and end-of-life care

Due to the progressive nature of dementia, medical specialists may be involved in the care of those with the condition and their families, until end-of-life stage, including in residential care settings. There is increasing awareness of the need for adequate and specialist palliative care in the later stages of dementia.

Triggers for referral

- Concerns about memory loss.
- Seeking a diagnosis.
- Seeking qualification for access to subsidised medical treatment.
  Pharmaceutical Benefits Scheme (PBS) criteria for qualification of initial treatment with Cholinesterase inhibitors (donepezil, rivastigmine and galantamine) and memantine include confirmation of a diagnosis of Alzheimer's disease by a specialist/consultant physician or psychiatrist. This stipulation from PBS has enhanced referrals from GPs to medical specialists for diagnostic purposes.

Referral requirements

Referral by GP is required in most instances to obtain a Medicare rebate, however other specialists may also refer.

People with diverse needs

There are many common features that link the specialists mentioned above. They often work in an interdisciplinary manner, but bring their own strengths to the consultation. The availability of specialists, particularly in remote and rural areas, impacts on the type of clinician seen, although tele-health is an increasingly-used method of facilitating specialist diagnosis.

4.12 Geriatric Evaluation and Management (GEM)

Service description

GEM is a hospital-based program providing a comprehensive geriatric assessment for patients presenting with chronic or multiple co-morbidities associated with ageing, cognitive dysfunction, chronic illness or loss of functional ability.

Target group

The GEM client group is predominantly older people, but may include younger adults with clinical conditions generally associated with ageing, and older people with chronic and complex health problems resulting in functional decline or cognitive impairment.

Support provided in each stage

Stage 1: Awareness, recognition

This will be addressed as part of a comprehensive geriatric assessment.

Stage 2: Initial dementia assessment, diagnosis

For a patient with memory loss, one outcome of a GEM admission may be the confirmation of a diagnosis of Alzheimer's and qualification for PBS criteria for initial treatment with Cholinesterase inhibitors (donepezil, rivastigmine and galantamine) and memantine.

Stage 3: Management, care and support

GEM patients have chronic or multidimensional presenting conditions that require admission for review, treatment and management by a geriatrician and multidisciplinary team for a defined episode of care.

Health care service delivery must be coordinated and is always based on an individualised plan, containing goals and indicative timeframes.

Stage 4: Palliative and end-of-life care

If a person becomes ill during this admission, they may receive end-of-life care. This may involve specialist advice or consultancy from a palliative care service.

Triggers for referral

People who have complex and multiple medical, functional and often cognitive conditions requiring a multidisciplinary assessment.

Referral requirements

Patients are generally admitted to GEM following an acute illness requiring hospitalisation. Referrals can be made by GPs in the community or by geriatricians, where a client requires hospitalisation or is considered at risk of harm.

People with diverse needs

People from culturally and linguistically diverse backgrounds have access to interpreter services and information in their preferred language.

Other relevant information

www.health.vic.gov.au/subacute

4.13 Aged Care Assessment Service (ACAS)

Service description

The role of Aged Care Assessment Services (ACAS) is to comprehensively assess the needs of frail, older people and assist them to gain access to the most appropriate types of care. An ACAS assessment is mandatory for entry to Commonwealth funded residential care facilities, the Transition Care Program and Commonwealth packaged care, which includes Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) and EACH Dementia (EACHD).

Aged Care Assessment Services also direct frail, older people who have complex social and medical problems into appropriate services, including restorative care options. The legislative basis for the ACAS is the *Aged Care Act 1997* and associated Aged Care Principles.

Target group

Anyone can make a referral to ACAS, provided they have the consent of the person with dementia or their carer. The target group is frail, older people 65 years and over and Aboriginal people aged 50 years and over.

Support provided in each stage

Stage 1: Awareness, recognition

Early concerns about memory will be identified during the assessment process. See stage 2

Stage 2: Initial dementia assessment, diagnosis

ACAS provide assessments and referrals for services for both people with dementia and their carers, as well as initial screening for problems with memory, thinking and planning. Most ACAS teams use the Standardised Mini-Mental State Examination (SMMSE) screening tool or the Rowland Universal Dementia Assessment Scale (RUDAS). For diagnosis, the ACAS team would either refer to Cognitive Dementia and Memory Service (CDAMS) or would facilitate a diagnosis via a specialist clinic or geriatrician.

Post-diagnosis support: refer to other services and short-term care coordination as required.

Stage 3: Management, care and support

ACAS assist people to access care and support appropriate to their level of need. ACAS does not provide ongoing management or support.

Stage 4: Palliative and end-of-life care

As part of the assessment process, ACAS works closely with palliative care services to ensure people's care needs can be met. This will involve an assessment for care options including packaged care, residential care, and could include a concurrent referral for palliative care.

Triggers for referral

- A person's care needs are significant.
- An assessment is required for restorative care options or a Commonwealth-funded service.
- Carers are encouraged to be at the assessment, and referrals can be made to support the carer as required.

Referral requirements

Referrals using the Service Coordination Tool Templates (SCTT) are preferred. If unsure whether the referral is appropriate, ring the ACAS intake worker to discuss. If the referral is urgent, ring and advise the intake worker. All referrals are prioritised according to need. Always include consent, demographic data, including date of birth and a detailed description of reasons why an ACAS assessment is required, for example, memory loss, carer concerns or risks at home.

People with diverse needs

All people from CALD backgrounds should be visited with an interpreter and information provided in the appropriate language, if available. Assessments should occur with an advocate – a family member and/or an agency.

Other relevant information

See the Commonwealth web site for more information <www.health.gov.au/acats>.

ACAS has protocols or guidelines with other agencies, including: Disability Services, Office of the Public Advocate, HACC assessment services and Aboriginal Services. See <www.health.vic.gov.au/agedcare/services/assess.htm>

4.14 Aged Persons Mental Health Service (APMHS)

Service description

Public sector Aged Persons Mental Health Services (APMHS) include acute aged persons inpatient services, community case management, and aged persons mental health residential care services. At times, people with dementia and their carers will receive case management and support from the services listed in stage 3. Usually, this would not be for dementia only.

Target group

Aged persons mental health services are primarily for people with a long-standing mental illness who are now over 65 years of age, or who have developed functional illnesses such as depression and psychosis in later life. They are also for people with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia. Anyone can make a referral or enquiry by accessing the services website and psychiatric triage numbers (see below).

Support provided in each stage

Stage 1: Awareness, recognition

Early recognition may occur while the treatment of other needs is occurring.

Stage 2: Initial dementia assessment, diagnosis

Initial dementia assessment and diagnosis are not a primary service role of APMHS. This may occur in the APMH inpatient setting as part of the admission findings. Community referrals from APMH for dementia assessment and diagnosis may be made to CDAMS for further assessment, diagnosis or carer support.

Stage 3: Management, care and support

APMHS assessment and treatment services

Provide community-based assessment, treatment, rehabilitation and case management for older people. Multidisciplinary teams provide specialist expertise in: medical assessment and treatment; psychological, behavioural, social and functional assessments; a corresponding range of therapeutic interventions. The teams also provide education for consumers and carers, as well as consultation to other service providers.

APMH residential aged care services

Provide a range of specialist bed-based services to people who cannot be managed in mainstream residential aged care services due to their level of persistent cognitive, emotional or behavioural disturbance.

APMH residential aged care services are extended care facilities providing ongoing assessment, treatment and rehabilitation. They are designed to have a familiar, home-like atmosphere, and residents are encouraged to participate in a range of quality-of-life activities. Consumers may remain in these units for extended periods but opportunities are sought where possible to achieve discharge to a generic residential aged care service.

Acute inpatient services

Provide short-term inpatient management and treatment during an acute phase of mental illness, until sufficient recovery allows the person to be treated effectively in the community. These services are located with other aged care facilities and/or general hospitals. In some rural services, aged acute inpatient beds are co-located with an adult inpatient unit.

Stage 4: Palliative and end-of-life care

End-of-life care is not a primary role of APMH Services.

Triggers for referral

Typical referral triggers for a person with dementia are often related to behaviours of concern (often termed Behavioural and Psychological Symptoms of Dementia).

Referral requirements

A phone call to psychiatric triage for information assessment and referral can be taken from any source. The following items may be requested:

- GP referral with history
- diagnosis and organic clearance (chest X-ray, FBE, TFTs, LFTs, U&Es, B12, urinalysis).

People with diverse needs

Consistent with departmental service standards and Chief Psychiatrist guidelines.

Other relevant information

www.health.vic.gov.au/mentalhealth/services/index.htm

4.15 Hospital Admission Risk Program (HARP)

Service description The Hospital Admission Risk Program (HARP) prevents re-admissions to emergency departments (ED) and acute hospital settings by using a number of evidence-based approaches delivered in the community/ambulatory setting:

- care coordination
- access to specialist medical care
- self-management support
- complex psychosocial issues management.

HARP services have access to hospital systems, enabling early recognition (for example, HARP patients are flagged in EDs) and prompt referral and links either into appropriate hospital or out of hospital care pathways.

HARP is governed by the Health Independence Program (HIP) guidelines.

Target group

HARP targets those people with complex needs and moderate to severe chronic disease who frequently present to hospital. More specifically:

- The majority of HARP clients are required to have had at least one unplanned hospital presentation in 12 months.
- There is some capacity for clients who are identified as at imminent risk of hospitalisation, who have not had a hospital presentation/admission in the past 12 months and where no other local service can meet the client's needs.
- The complexity of the client's need requires care coordination.

The two streams of care provided by HARP are 'chronic disease' and 'aged and complex care':

- The chronic disease stream includes chronic heart disease, chronic respiratory disease, diabetes and other chronic disease.
- The aged and complex care stream includes complex frail aged care, people with complex psychosocial needs and people with complex needs requiring integrated care.

Usually clients have co-morbidities and psychosocial issues that impact on their care and their ability to self-manage their health care needs. HARP clients may also have a diagnosis of dementia.

Support provided in each stage

Stage 1: Awareness, recognition

HARP provides specialist medical and multidisciplinary care in the community/ambulatory setting, through an integrated response from hospital and community services.

Identification of cognitive issues impacting on the risk of re-presentation to hospital is included within a holistic, client-centred assessment.

Stage 2: Initial dementia assessment, diagnosis

Generally HARP care coordinators refer to GPs or CDAMS for dementia assessment and diagnosis. Some larger metropolitan services have the relevant medical expertise within their service.

Stage 3: Management, care and support

The HIP guidelines define the model of care and minimum service requirements for HARP. Care coordination, education, self-management, multidisciplinary team-based care and specialist medical care are core components of the program.

HARP provides a time-limited episode of care with an average episode length of 3 to 6 months. HARP does not provide ongoing case management.

The care coordinator role in HARP provides opportunity to explore the comprehensive support needs of clients and carers, and develops an interagency care plan to address these needs through sustainable primary care services.

HARP care coordinators work closely with specialist, subacute and community services to facilitate client access to necessary assessments and supports for a range of needs.

Stage 4: Palliative and end-of-life care

HARP works collaboratively with community services, including GPs, and links with specialist palliative care services for end-of-life support.

Triggers for referral

The complexity of needs exceeds the capacity of usual care, resulting in frequent presentation to hospital or imminent risk of presentation, as per the target group criteria described above.

Referral requirements

Typical referral pathways are from ED services, inpatient services, ambulatory services, community services and GPs.

People with diverse needs

HARP operates under a flexible, client-centred approach, which has the capacity to be responsive to diverse needs.

Other relevant information

HARP works closely with Sub-acute Ambulatory Care Services, Post-Acute Care services, Transition Care Program, Early Intervention in Chronic Disease and other community-based services. See <www.health.vic.gov.au/harp/index.htm>

4.16 Palliative care

Service description

'Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.' (*WHO definition*)

Palliative care in Victoria is delivered in a number of settings – from people's homes with primary health and GP support through to acute health services and highly specialised settings. Palliative care is flexible, to meet the needs of the client and their family.

In Victoria, specialist palliative care is provided through:

- community palliative care – Health Services Act
- inpatient palliative care – Health Services Act
- consultancy palliative care – Health Services Act

See <www.health.vic.gov.au/palliativecare> for a list of palliative care services funded in Victoria.

Target group

People with a life-threatening illness, with a poor prognosis.

Referrals can be made by clinicians (GP, acute health professional, community health services, HACC services, aged care services and so on) or through self-referral.

Support provided in each stage

Stage 1: Awareness, recognition

May be identified as part of initial assessment and development of a care plan.

Stage 2: Initial dementia assessment, diagnosis

Palliative care services may undertake dementia assessment as part of initial and ongoing assessment of palliative care patients and their carers. There is no preferred dementia assessment tool used by palliative care services.

Stage 3: Management, care and support

See stage 4 (below).

Stage 4: Palliative and end-of-life care

Palliative care services provide end-of-life care for people with dementia (often, but not always, as a co-morbidity) and also provide consultancy advice to health, community and aged care services.

The palliative care trajectories for people with dementia are likely to be longer than those for people with cancer and other diagnoses.

Key challenges in providing palliative care for people with dementia include accurately assessing and managing pain and managing nutrition and hydration.

Triggers for referral

People with dementia are often referred to palliative care in relation to another co-morbidity (cancer, heart/lung failure etc). Triggers for referral to palliative care for people with terminal dementia may include:

- increased confusion and disorientation
- deterioration of speech and the ability to communicate
- significant behavioural changes
- losing the ability or desire to move independently
- capacity for self-care progressively declining
- loss of ability to eat independently.

Other complications, common across a range of terminal illnesses, may be triggers for palliative care referral:

- requiring frequent interventions
- being bed-bound
- loss of appetite
- profound weakness
- trouble swallowing
- dry mouth
- weight loss
- becoming semi-conscious, with lapses into unconsciousness
- experiencing day-to-day deterioration that is not reversible [5].

Referral requirements

Individual services will have different referral requirements. SCTT referral is preferred, using the SCTT Palliative Care Supplementary Information template.

People with diverse needs

The aim of the Aboriginal palliative care program is for Aboriginal people to have access to culturally safe palliative care. It also aims to develop and increase awareness of and access to palliative care and to develop strong relationships between palliative care providers and Aboriginal Community Controlled Health Organisations.

One key deliverable has been the development of a culturally appropriate resource.
See <www.health.vic.gov.au/palliativecare/programs.htm>.

Other relevant information

www.health.vic.gov.au/palliativecare

4.17 Information and counselling (Alzheimer's Australia Vic)

Service description

Alzheimer's Australia Vic provides various Commonwealth and state government funded services, including:

- early intervention programs
- counselling by qualified psychologists, social workers and family therapists
- telephone outreach program
- education programs
- services for people with younger onset dementia
- services for people from CALD and Aboriginal communities
- written information (help sheets) and materials.

All services are available statewide.

Target group

- People with dementia
- Families and carers
- Friends
- Service providers and care workers
- The broader community.

Diagnosis of dementia is not needed to access services.

Support provided in each stage

Stage 1: Awareness, recognition

The National Dementia Helpline (Alzheimer's Australia) provides advice and support around early signs, risk reduction, mild cognitive impairment and other cognitive concerns not specifically determined to be dementia.

Alzheimer's Australia Vic runs programs to improve awareness, such as:

- Mind Your Mind program
- mild cognitive impairment group programs
- counselling for people with memory or cognitive concerns.

Stage 2: Initial dementia assessment, diagnosis

Counselling and support are available for people who are experiencing concerns about or symptoms of dementia.

Support includes assisting the person to access a diagnostic service, providing advice to families on how to encourage a person with suspected dementia to undertake a diagnostic assessment, helping to find suitable services and providing strategies to cope.

Post-diagnostic support is available through counselling, Living with Memory Loss Groups, Memory Lane Cafés, education programs and in advance care planning.

Stage 3: Management, care and support

- Counselling for people with dementia and their families.
- Information and service system navigation
- Living with Memory Loss - for people with dementia and a family member
- Younger onset key worker and programs for people diagnosed under the age of 65 years.
- Various telephone and face-to-face education and support programs.
- Family services offers support to families.

Stage 4: Palliative and end-of-life care

Counselling including assistance with end-of-life considerations, advance care planning and bereavement counselling.

Triggers for referral

For a person with dementia referrals may be triggered by: diagnosis, early planning needs, driving and employment issues, memory and cognitive strategies, accessing services, emotional support.

For a carer: diagnosis, early planning, behavioural issues, communication issues, respite needs, emotional support, carer stress, accessing services, relinquishing care, family conflict.

Referral requirements

Anyone can refer to Alzheimer's Australia Vic services, including people with dementia or their family via a phone call, SCTT referral or the referral form on the Alzheimer's Australia Vic website.

People with diverse needs

Alzheimer's Australia Vic supports people in rural regions, with offices in Geelong, Ballarat, Warrnambool, Bendigo, Swan Hill, Benalla, Lakes Entrance and Moe.

Two CALD Access Liaison workers and an Aboriginal Access Liaison worker, provide tailored programs for people from CALD and Aboriginal backgrounds, supported by information factsheets in various languages. All staff have experience working with diverse communities, and interpreting services are used as needed.

Alzheimer's Australia Vic supports people with younger onset dementia (YOD), including:

- YOD Living with Memory Loss programs and retreats
- YOD Key Worker
- counselling
- café style programs
- a Younger Onset Consumer Reference Group
- online forum for YOD.

Other relevant information

All services can be accessed via the National Dementia Helpline on 1800 100 500.
www.fightdementia.org.au

4.18 Cognitive, Dementia and Memory Service (CDAMS)

Service description

The Cognitive, Dementia and Memory Service (CDAMS) is unique to Victoria. CDAMS is one of the specialist clinics within the sub-acute ambulatory care services funded by the Victorian Government. There is at least one CDAMS in each health region in Victoria.

CDAMS is a specialist diagnostic service that aims to assist people experiencing early changes to their memory and thinking. CDAMS provides assessment and diagnosis of the psychological, medical and social difficulties associated with memory and thinking changes. It provides information and advice on management and referral to other services as appropriate.

CDAMS does not provide ongoing treatment or case management.

Target group

People requiring a diagnosis or explanation of the memory and thinking problems concerning them or their family benefit from attendance at CDAMS. The service is particularly relevant for those who would benefit from a multidisciplinary approach to their assessment.

Those for whom the diagnosis or cause of their memory and thinking problems is already known are generally not eligible for the service, unless a specialist second opinion is required.

People of any age can attend CDAMS. Whilst the clinic is predominantly focused on memory problems associated with ageing, people with younger onset dementias can attend.

Anyone can make a referral to CDAMS. However, involvement of the person's GP is preferred.

Support provided in each stage

Stage 1: Awareness, recognition

The multidisciplinary team within CDAMS provides detailed specialist assessment particularly suited to identifying very early changes to memory and thinking. This enables earlier identification and diagnosis through more detailed assessment, or acts as a baseline for future comparison, if the problems persist and deteriorate. It can reassure people whose memory problems may be due to other causes (sometimes treatable), or are normal for their age.

CDAMS can provide advice and strategies to manage problems and reduce the risk of further deterioration.

Stage 2: Initial dementia assessment, diagnosis

CDAMS provides specialist multidisciplinary assessment and diagnosis for people who are experiencing changes to their memory and thinking, where the cause for these problems has previously not been identified. A CDAMS assessment usually includes a number of medical and allied health consultations. A typical assessment would include:

- **Initial assessment:** An occupational therapist, social worker or community nurse usually completes an initial visit to discuss the history of the problem and impacts this is having on daily activities. This is often a home visit.
- **Medical assessment:** Depending on the situation, an appointment is then made with a medical specialist. This may be a neurologist, geriatrician or psychiatrist, depending on the service and the needs of the person. The medical assessment usually includes a thorough physical examination, testing of memory and thinking and assessment for any mood problems. Pathology and imaging results are also reviewed.

- **Neuropsychology assessment:** If additional testing is required, then a neuropsychologist will complete further specialised tests of memory, clear thinking and reasoning, which are then compared to expected levels of ability for age and educational background.
- **Feedback session:** Once all assessments are completed, a 'feedback' session is held to discuss the results and provide advice on recommended treatment and supports.
  Family members are encouraged to attend throughout the assessment process.
- **Follow up:** CDAMS will provide initial short-term support and referral post diagnosis, but does not provide ongoing treatment or case management.

Where a diagnosis is unclear, CDAMS will often provide repeat assessments until such time as a diagnosis is made. (Note: There would usually be several months between each assessment).

Stage 3: Management, care and support

CDAMS provides advice to people with dementia and their families/carers about options for management, referral and support, but does not provide ongoing treatment or case management.

Stage 4: Palliative and end-of-life care

CDAMS is not generally involved in care at end-of-life. However, during initial assessment and diagnosis, advice is provided on early planning, including enduring Powers of Attorney and advance care plans that may assist in informing care at end-of-life.

Triggers for referral

As part of the ageing process, some people may notice some mild slowing in their memory and thinking or in that of a family member. This is normal. If the changes become progressively more obvious and begin to impact on everyday life, an assessment of memory and thinking would be appropriate.

Accurate diagnosis is vital so that appropriate treatments and information can be recommended. Early symptoms of memory loss and changes in thinking can include:

- rapid forgetting
- repeated questions or conversations
- losing items
- forgetting appointments, birthdays, social commitments
- becoming lost while driving
- frequent problems finding words during conversations
- difficulties learning new skills
- reduced ability to perform familiar tasks; for example, bill paying, cooking
- behavioural or personality changes
- feeling overwhelmed or confused by new situations.

Referral requirements

- Anyone can refer to CDAMS (including individuals or their family, service providers or case managers).
- The GP can provide details of the person's medical history and current medications. Where possible a dementia screen should also be completed. This includes pathology (FBE, ESR, random glucose, electrolytes and creatinine, thyroid function tests, liver function, calcium and phosphate, vitamin B12, red cell folate and VDRL) and CT brain scan, if not completed in the last 12 months.
- Referrals are usually made to the health service in which the CDAMS is located. Most health services have a central point of access and will accept referrals on a SCTT or GP referral form.

People with diverse needs

- Specialist multidisciplinary approach provides for a more comprehensive assessment and diagnosis of people from CALD backgrounds. CDAMS provides interpreters for all assessments where English is not the person's preferred language.
- CDAMS are located in rural regions across Victoria.
- The specialist skills of staff in CDAMS are ideally suited to the assessment and diagnosis of people with younger onset dementias.

Other relevant information

www.health.vic.gov.au/subacute/cdams.htm

4.19 Dementia Behaviour Management Advisory Service (DBMAS)

Service description

Dementia Behaviour Management Advisory Service (DBMAS) is a Commonwealth funded program with teams in every state and territory. DBMAS provides specialised services to family members, care workers and health professionals supporting people with behavioural and psychological symptoms of dementia (BPSD) that impact on their care.

DBMAS is designed to foster capacity building and sustainability, encouraging the use of a problem-solving approach to BPSD management and a flexible and creative use of all available resources.

DBMAS Vic offers a multidisciplinary team of nursing and allied health professionals with extensive experience in dementia care, providing:

- a statewide Freecall 24-hour phone advisory service
- phone-based assessment, care planning, advice and referral services in metropolitan Melbourne
- face-to-face assessment and intervention services in regional Victoria
- mentorship and modelling of evidence-based and person-centred pharmacological and non-pharmacological BPSD management strategies
- education services on BPSD
- a clearing house for dementia-related information and services in Victoria and information on accessing key resources specific to BPSD management
- advice and tertiary consultations from old age psychiatrists.

Target group

People with moderate to severe behavioural and psychological symptoms of dementia, according to the *Seven-Tiered Model of Management of BPSD* (Brodaty et al., 2003). However, DBMAS Vic will provide behavioural management advice wherever it arises in the person's journey with dementia, so that they are directed to the most appropriate resources and services.

Support provided in each stage

Stage 1: Awareness, recognition

Awareness, recognitionIf the person has no formal diagnosis of dementia and the caller describes behaviour related to cognitive change, DBMAS Vic provides advice and directs the caller to the appropriate diagnostic pathway.

Stage 2: Initial dementia assessment, diagnosis

With agreement from the caller, DBMAS Vic may provide a copy of the behaviour assessment to the person's GP/specialist clinic, to assist with the diagnostic process.

DBMAS Vic provides post-diagnostic support and advice where BPSD occur, as well as direct the caller to counselling and other relevant services depending on needs identified.

In collaboration with the Eastern Clinical Disorders Clinic, DBMAS Vic runs a monthly support group in Kew for carers of people with fronto-temporal dementia.

Stage 3: Management, care and support

Behaviour management: Best practice principles in the management of behavioural and psychological symptoms of dementia, to help family carers and care staff to resume a 'normal' pattern of caring. DBMAS Vic behaviour consultants undertake a comprehensive assessment and analysis of the behaviour. Individualised non-pharmacological behavioural interventions are developed, based on the person's life history, abilities and preferences. These psychosocial approaches may be combined with pharmacological interventions, as advised through a tertiary consultation with old age psychiatrists. This intervention plan is then communicated with those involved in the person's care.

Risk management: The behaviour consultant determines the degree of risk presented by the BPSD. Where high physical risk exists, referral to emergency services or Aged Persons Mental Health Team will be initiated.

Information clearing house: DBMAS Vic supports callers who find it difficult to navigate the range of dementia-specific services across the spectrum of care settings, by referring or re-directing to the relevant service.

Education: DBMAS Vic provides specialist education on behavioural and psychological symptoms of dementia to community service providers and residential aged care facilities. DBMAS can provide linkage and advice in relation to most dementia education services in Victoria.

Tertiary consultations for GPs: DBMAS Vic provides GPs with tertiary consultation with old age psychiatrists. This is particularly helpful in rural and remote locations with limited access to medical specialists in small communities.

Stage 4: Palliative and end-of-life care

DBMAS Vic provides advice on:

- differentiating behavioural and psychological symptoms of dementia from terminal symptoms
- non-pharmacological and pharmacological approaches to behavioural and psychological symptoms of dementia symptom management at end-of-life
- where to get support
- how to access palliative care resources.

Triggers for referral

Person with dementia:

- behavioural and psychological symptoms of dementia causing distress or harm directly to the person with dementia, carers or others
- behavioural and psychological symptoms of dementia causing disability in excess of existing care structures
- person with early stage dementia wanting advice on the cause or management of their behavioural and psychological symptoms.

Carer:

- carer lacks knowledge on the cause of behavioural and psychological symptoms of dementia
- carer requires advice on how to manage behavioural and psychological symptoms of dementia
- carer stress/burden
- demands of behavioural and psychological symptoms of dementia exceed the carer's ability to cope or existing care/support structures.

Referral requirements

- Anyone can initiate a call to DBMAS Vic. Metro and regional DBMAS services are all contactable via a 24 hour Freecall number 1800 699 799.
  - calls during business hours go to the Central Hub in Kew, Melbourne
  - calls outside business hours are redirected to DBMAS South Australia for immediate response.
- Referrals to DBMAS can also be made via email: dbmas@svhm.org.au
- GPs and other medical staff can request tertiary consultations with DBMAS old age psychiatrists by phone (1800 699 799) or email (dbmasdoctor@gmail.com)

People with diverse needs

DBMAS Vic provides culturally appropriate approaches to support people with diverse needs:

- Translation and interpreting services are available to assist with referrals to DBMAS Vic for people from CALD and ATSI backgrounds.
- Use of the translated Alzheimer's Australia Help and Advice sheets.
- Behaviour consultants with ATSI and CALD portfolios to provide advice on specific cultural resources related to dementia.
- Advice and support that is relevant to other special needs groups such as those with atypical dementias, younger onset dementia, learning disability and dementia.
- Support for people with dementia and their carers in regional/rural Victoria, via the regional spoke services and the 24 hour Freecall number.
- Regular calendar-based education services and video-conference outreach education (under development) to all Victorian regional centres.

Other relevant information

DBMAS Vic operates under the auspices of St Vincent's Melbourne. Partnerships include Victorian Aged Persons Mental Health Services, Alzheimer's Australia Vic and the National Ageing Research Institute (NARI). See <www.dbmas.org.au>

4.20 Extended Aged Care at Home Dementia (EACH-D)

Service description

Extended Aged Care at Home – Dementia (EACH-D) packages are individually planned and coordinated packages of care tailored to help older Australians who experience difficulties in their daily life because of behavioural and psychological symptoms associated with their dementia.

EACH-D packages have a higher level of funding than EACH packages.

EACH-D packages also offer service approaches and strategies to meet the specific needs of people with dementia who experience behaviours that may impact on their daily quality of life.

Note: Commonwealth Aged Care Reforms will be introduced on July 1 2013. See information and link below.

Target group

People assessed by an ACAS as requiring high level care and who:

- experience behaviours and psychological symptoms associated with dementia that impact significantly on their ability to live independently in the community
- require a high level of residential care
- prefer to receive an EACH-D package
- are able to live at home with the support of an EACH-D package.

Support provided in each stage

Stage 1: Awareness, recognition

No role in this stage.

Stage 2: Initial dementia assessment, diagnosis

No role in this stage.

Stage 3: Management, care and support

EACH-D packages provide the same full range of services that EACH packages provide. (See description page 19 for EACH package). EACH-D providers also:

- employ care workers with dementia training or knowledge
- link to dementia-specific planned activity groups or other community groups
- link carer with supports, such as in home or residential respite
- make referrals to appropriate health professionals, such as assessment for incontinence or OT assessment for mobility
- promote strategies for managing behavioural and psychological symptoms associated with the dementia.

Stage 4: Palliative and end-of-life care

Discuss with the person's family Power of Attorney and decision-making processes, 'not for resuscitation' orders and advance care planning. Refer to palliative care when appropriate.

Triggers for referral

A referral to ACAS for the equivalent of high level residential care; people who experience behaviours and psychological symptoms associated with dementia that significantly impacts on their ability to live at home.

Referral requirements

ACAS waitlists people on the regional e-waitlist system according to their preferred provider(s). The person's preferred EACH-D provider contacts the person when a package becomes available.

People with diverse needs

EACH-D packages target particular diverse needs groups. ACAS will advise on the types of packages available.

Other relevant information

EACH-D information is on the Department of Health and Ageing website:

- www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-eachd.htm
- The Commonwealth government's aged care reforms will apply from July 1 2013. There will be four levels of packages and EACH D packages will no longer exist. When a person receiving any of these packages has dementia, a new behaviour supplement will be payable. See Aged Care reforms.
- www.health.gov.au/internet/main/publishing.nsf/Content/aged-aged-care-review-measures-techdoc

4.21 Café style support services

Service description

Café style support services (Cafés) are low key social events where people with dementia and their carers can socialise, access information and create networks with people in similar circumstances.

Café style support services include Memory Lane Cafés (MLCs) run by Alzheimer's Australia Vic (AAV) and café style support pilots currently underway in seven regions (see below for details).

Target group

The target group is any person with dementia and their carer.

Support provided in each stage

Stage 1: Awareness, recognition

No role in this stage.

Stage 2: Initial dementia assessment, diagnosis

No role in this stage.

Stage 3: Management, care and support

The **Cafés** provide a welcoming environment in which people with dementia and their carers participate in a supportive social event and can obtain information about dementia, the services that are available and more particularly to develop social networks that may support them beyond the program. The pilot Cafés are time limited. Service providers attend to provide information or answer questions.

The **MLCs** include the opportunity to maintain social connections already established by people who have attended an AAV Living with Memory Loss course. An AAV worker attends all events together with other service providers to provide information or answer questions.

Stage 4: Palliative and end-of-life care

No role in this stage.

Triggers for referral

People with dementia and their carers who would benefit from social networking, as well as information on local services.

Referral requirements

Referrals are taken from any source.

People with diverse needs

The HACC Program operates within the HACC Diversity Framework.

See *Strengthening diversity planning and practice: a guide for HACC services* (Department of Health 2011).

Some Cafés target people from CALD backgrounds.

Other information

The following agencies auspice Café pilot projects:

- Wyndham City Council (North & West region)
- Doutta Galla Community Health Service Inc (North & West region)
- Bendigo Health Care Group (Loddon Mallee region)
- Warrnambool City Council (Barwon SouthWest region)
- Moira Healthcare Alliance (Hume region)
- Alzheimer's Australia Vic auspices cafes in the three metropolitan regions, Eastern, Southern, North & West, and also in Gippsland.

4.22 Counselling and Advisory Service (Carers Victoria)

Service description

Carers Victoria – Carer Counselling and Advisory Service offers a wide range of information and support to carers. These are listed under each of the four dementia stages below.

Target group

Carers of a family member or friend who is aged and perhaps frail, has dementia, a mental illness, a disability, chronic illness or complex needs, or receives palliative care.

Support provided in each stage

Stage 1: Awareness, recognition

Specialised information about caring, including:

- information about service and support systems
- the condition of the person being cared for
- maintaining carer health and wellbeing
- money and legal issues.

Stage 2: Initial dementia assessment, diagnosis

- Assistance with finding services and supports that help to sustain the care relationship, including:
  - respite
  - counselling
  - education and training
  - carer support groups.
- Assistance communicating family carer needs to informal and formal supports.
- Emotional support and problem solving.
- Arranging short-term counselling.

Stage 3: Management, care and support

Professional counselling to assist with:

- stress management
- coping skills
- loss and grief
- dealing with change
- practical problem solving
- emotional support
- health and wellbeing.

Counselling is short term (up to six sessions) and focuses on issues related to the care role. Counselling is episodic – re-referrals may be made after a break or if a new issue arises.

Stage 4: Palliative and end-of-life care

Counselling is also available for carers if the person being cared for is at end-of-life, or has died.

Triggers for referral

Triggers include:

- recent commencement of the care role
- the death of the person with dementia
- a negative change in condition of the person with dementia
- a negative change in health of the carer
- employment issues
- the cared-for person being moved into residential care
- financial strain
- changes in formal or informal supports
- the ongoing stress of the carer role.

Referral requirements

- **Self-referral:** Carers can call 1800 242 636. Advisory line staff assess eligibility and complete the referral.
- **Third party referral:** Health professionals and case managers can complete a written referral with the carer's consent.
  The form is available at <www.carersvic.org.au/Assets/Files/nccp-referral-interactive.pdf>

People with diverse needs

Counsellors who speak languages other than English are available in some areas.

- Interpreters can be arranged and translated information is available.

Other relevant information

This is not a dementia-specific service. Families with diverse care roles and relationships are eligible.

4.23 Support for Carers Program (SCP)

Service description

The Support for Carers Program (SCP) is a state funded program which provides flexible and innovative respite and support to carers of older people. The SCP is aimed at meeting individual needs not met by other services. It includes the Support for Carers of People with Dementia Program.

Target group

Carers of older people. For carers of younger people with dementia, see description of the *Support for Carers of People with Dementia Program.*

Support provided in each stage

Stage 1: Awareness, recognition

No role in this stage.

Stage 2: Initial dementia assessment, diagnosis

No role in this stage.

Stage 3: Management, care and support

Creative, innovative and flexible respite and support designed to meet the needs of individual carers. It may include short term case management.

Stage 4: Palliative and end-of-life care

Depending on the person's circumstances (in residential care or living at home), respite and support services may continue.

Triggers for referral

Triggers relate more to carers of older people than to the person with dementia. Typical triggers related to the carer are:

- carers of older people requiring respite or other support to continue in the care role
- capacity or requirement for carer needs to be met by flexible responses outside/beyond existing service capacity
- individual care approaches that meet individual preferences and needs.

Referral requirements

Anyone can make a referral to the program. SCTT referral using the Service Coordination Tool Templates should include information about carer needs: carer stress, mental/physical ill-health, social isolation, capacity to continue in the care role.

People with diverse needs

Given the program's flexibility, SCP can meet the individual and unique needs of older carers, for example, people from CALD backgrounds, Aboriginal people, people at risk of homelessness, people living in rural or remote locations.

Other relevant information

www.carersvic.org.au
www.health.vic.gov.au/agedcare

4.24 Support for Carers of People with Dementia Program (SCPWD)

Service description

The Support for Carers of People with Dementia Program (SCPWD) is a state funded program which provides flexible and innovative respite and support to carers of people with dementia. The SCPWD is aimed at meeting individual needs not met by other services.

Target group

Carers of people with dementia including carers of people with younger onset dementia.

Support provided in each stage

Stage 1: Awareness, recognition

No role in this stage.

Stage 2: Initial dementia assessment, diagnosis

No role in this stage.

Stage 3: Management, care and support

Creative, innovative and flexible respite and support designed to meet the needs of individual carers and including the needs of younger people with dementia. May include short term case management.

Stage 4: Palliative and end-of-life care

Depending on the person's circumstances (in residential care or living at home), respite and support services may continue to be provided.

Triggers for referral

Carers of people with dementia requiring respite or other support to continue in the care role.

Capacity or requirement for carer needs to be met by flexible responses outside/beyond existing service capacity.

Individual care approaches required to meet individual preferences and needs.

Referral requirements

Anyone can make a referral to the program. Referrals using the Service Coordination Tool Templates (SCTT) are preferred. Information about individual carer needs includes: carer stress, mental/ physical ill-health, social isolation, capacity to continue the care role; capacity or requirement for carer needs to be met by flexible responses outside/ beyond existing service capacity; for example, HACC Planned Activity Groups; individual care approaches that meet individual preferences and needs.

People with diverse needs

Given the program's flexibility it can meet diverse needs. The SCPWD program is aimed at meeting individual and unique needs of carers of people with dementia, for example, people from CALD backgrounds, Aboriginal people, people at risk of homelessness, people living in rural or remote locations, and carers of younger people with dementia.

Other relevant information

www.health.vic.gov.au/agedcare

4.25 National Respite for Carers Program (NRCP)

Service description

National Respite for Carers Program (NRCP) is a Commonwealth funded program which assists carers with information, respite and other support. The NRCP consists of respite services and the national carer counselling program.

Target group

Information provision for the community, service providers, general practitioners and other health professionals.

Carer support services for a range of carers.

Support provided in each stage

Stage 1: Awareness, recognition

Respite and support workers should be aware of typical signs of cognitive impairment and/or changes in memory or behaviour and report these to their supervisor. Supervisors should assist the person and their carer to access specialist advice and information, if they want it.

Stage 2: Initial dementia assessment, diagnosis

No role in this stage.

Stage 3: Management, care and support

Short-term, creative, innovative and flexible carer support and respite designed to meet individual carer needs.

Stage 4: Palliative and end-of-life care

Depending on the person's circumstances (in residential care or living at home) respite services may continue to be provided.

Triggers for referral

Carers require respite or other support to continue in the care role.

Referral requirements

Anyone can make a referral.

Carer support: carers can self-refer via phone.

Service providers: referral requirements include information about the carer's needs including: carer stress, mental/physical health status, social isolation, current formal and informal supports, reluctance to use services, capacity to continue the care role, and carer support needs of the person with dementia.

People with diverse needs

Given the program's flexibility, it can meet diverse needs. The NRCP services are aimed at meeting individual and unique needs of carers, for example, people from CALD backgrounds, Aboriginal people, people at risk of homelessness, people living in rural or remote locations.

Other relevant information

Commonwealth Respite and Carelink Centres: Freecall 1800 052 222
National Carer Counselling Program Freecall 1800 242 636
In Victoria, contact <www.respiteseeker.com.au> for information on respite availability in your area.

4.26 Respite (HACC funded)

Service description

HACC funded respite services support the care relationship by providing carers with a break from their caring responsibilities. They also provide an opportunity for the person being cared for to have a break, or to have an outing without their usual carer.

Respite services are funded through multiple programs and both levels of government (Commonwealth and state). The National Respite for Carers Program, Support for Carers Program and the Support for Carers of People with Dementia Program are described in this guide.

For information on Disability Carer and Family Support services, see <www.dhs.vic.gov.au/for-individuals/disability/carer-and-family-support>.

Target group

People in the HACC target group: older people, people with a disability and their carers who have a need for basic maintenance and support services to enable them to live independently at home.

Support provided in each stage

Stage 1: Awareness, recognition

Respite workers should be aware of typical signs of cognitive impairment and/or changes in memory or behaviour and report these to their supervisor. Supervisors should assist the person and their carer to access specialist advice and information, if they want it.

Stage 2: Initial dementia assessment, diagnosis

No role in this stage.

Stage 3: Management, care and support

Respite services:

- respond to the individual needs of both the carer and the person being cared for
- provide enjoyable, meaningful activities for the person with dementia
- provide information to carers on support services available in the community
- are provided in a person's home or in the community, for example, a worker takes the person on an outing or to an activity of their choice.

Stage 4: Palliative and end-of-life care

Respite services may continue to be provided, in order to support the carer during the end-of-life stage.

Triggers for referral

The carer is in need of a break from their caring responsibilities, to support the care relationship and continue in their care role

Referral requirements

Use of the Service Coordination Tool Templates (SCTT) is preferred.

People with diverse needs

HACC funded services are delivered within the HACC Diversity Framework.

See *Strengthening diversity planning and practice: a guide for HACC services* (Department of Health 2011).

Other information

HACC Program Manual
www.health.vic.gov.au/hacc/prog_manual/index.htm

4.27 Residential aged care and residential respite

Service description

Residential aged care services (RACS) provides permanent care and support for people who can no longer remain living at home. Some RACS also provide residential respite.

The Commonwealth Department of Health and Ageing funds and regulates the provision of Approved Residential Aged Care Services. Approved RACS provide high and low levels of care as required to meet the needs of each resident, as specified in the *Aged Care Act 1997* and the *Quality of Care Principles 1997*. RACS are required to comply with the *Aged Care Accreditation Standards*. As a high proportion of residents living in RACS have a diagnosis of dementia, some services have purpose-built units or wings.

- Prior to entering a RACS, a resident agreement is completed between the person and the RACS. The resident agreement includes the fees and charges for services and the schedule of care and services to be provided.

Target group

To access RACS, a person must be assessed by an Aged Care Assessment Service (ACAS) to determine their eligibility. (See ACAS entry page 36)

A person is eligible if:

- they have physical, medical, social or psychological needs that require residential care
- their needs cannot be met more appropriately through non-residential care services.

Support provided in each stage

Stage 1: Awareness, recognition

Early recognition of cognitive impairment may be identified through the RACS screening processes as a component of the Aged Care Funding Instrument (ACFI).

See <www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-aboutacfi.htm>

RACS are required to access specialist care, health practitioner services and therapies for residents as part of the resident's care needs and plan.

Stage 2: Initial dementia assessment, diagnosis

A Psychogeriatric Assessment Scale (PAS) – Cognitive Impairment Scale is performed by the RACS as part of completing a resident's ACFI assessment.

Diagnosis is arranged through external referral via a GP to a specialist or specialist clinic.

Stage 3: Management, care and support

RACS support residents with dementia via person-centred care plans which include strategies for managing behavioural and psychological symptoms of dementia. Programs are developed by the care team and others, such as medical practitioners, nurses and family members.

Respite places operated by RACS support carers of people diagnosed with dementia, by providing a planned break from their care role.

Stage 4: Palliative and end-of-life care

The majority of people living in high-level residential aged care have a diagnosis of dementia. RACS provide end-of-life care to people who have dementia, and are able to access additional specialist support from community specialist palliative care services.

Triggers for referral

As per the referral to ACAS. For example, care needs that exceed the carer's ability (wandering, aggression); co-morbidities may be a deciding factor.

Referral requirements

Via the local ACAS for permanent, respite care and transition care.

People with diverse needs

All RACS are expected to provide person-centred care, including culturally appropriate care. The Partners in Culturally Appropriate Care (PICAC) program offers cross-cultural awareness training to enhance the access of people from a CALD background to aged care services, and build capacity for aged care providers to deliver culturally appropriate care.

In Victoria, there are culturally-specific residential aged care services catering for people from CALD and Aboriginal backgrounds.

See <www.health.gov.au/internet/main/publishing.nsf/Content/ageing-specneed-picac.htm.>

Other relevant information

Residential Aged Care Standards and Accreditation Agency
www.accreditation.org.au

Further information about residential aged care:

- www.agedcareaustralia.gov.au
- *Residential care, your choices. A guide for older Victorians*
  www.health.vic.gov.au/agedcare/publications
- *5 steps to Entry into Residential Aged Care* booklet
  www.health.vic.gov.au/agedcare/publications
- Dementia-friendly environments: a guide for residential care
  www.health.vic.gov.au/dementia/

4.28 Disability supported accommodation

Service description

Supported accommodation is provided to people with a disability who have high support needs. Models of supported accommodation vary and include congregate care and group homes. Group homes are the predominant model and generally provide support for four to six residents. New models are being progressively introduced that offer more individually tailored options.

Residents receive staff support in areas such as:

- household management, for example, cleaning and shopping
- general self-care, for example, eating, dressing and preparing food
- personal hygiene, for example, bathing and toileting
- participating in the local community, for example, going to a sporting match, the movies, or a hobby class.

The environment is kept home-like and support staff are not employed to work as medical, health or aged care workers. If residents need specific health or other support that disability support staff are not trained or able to provide, support should be provided by relevant community-based services as for other members of the community.

Target group

People with a disability who have high support needs. People with a lower level of need are provided with supports outside of the supported accommodation model.

People can register their need for ongoing disability support on the Disability Support Register if they meet the criteria as determined under the *Disability Act 2006*. See the Disability Access Policy: www.dhs.vic.gov.au/for-individuals/disability/start-here/access-to-disability-supports

For information about the Disability Support Register: www.dhs.vic.gov.au/for-individuals/disability/start-here/disability-support-register

Support provided in each stage

Stage 1: Awareness, recognition

If disability support staff recognise significant changes in a resident's behaviour, they are expected to support the resident to visit their GP.

Stage 2: Initial dementia assessment, diagnosis

No role in this stage.

Stage 3: Management, care and support

Where possible and practical, disability support staff will modify support and the home environment to meet individual needs. As disability support staff are generally not trained or employed to provide management, care and support for people with dementia, people with dementia will need to access community-based services as required.

Stage 4: Palliative and end-of-life care

If adequate specialist services can be put in place for a resident within supported accommodation, the person may choose to remain in the group home. If support needs can no longer be met within the supported accommodation, other options, such as residential aged care, will be considered.

Triggers for referral

If a person has support needs related to a disability that cannot be met by family, friends or other services in the community, a referral can be made for ongoing disability support from Disability Services.

Referral requirements

The Disability Support Register is a database of all the people with a confirmed need for funding to purchase supports that meet their disability needs (Individual Support Package) or for supported accommodation. The DSR is used to allocate these supports in a fair and efficient manner when funding or vacancies become available.

A number of requirements must be met before an application can be submitted. Requirements include having support needs related to the disability which are not being met and:

- are current
- are ongoing (support required for six months or more); and
- can only be met through Disability Services.

People with diverse needs

Disability Services provide person-centred services and aim to meet the needs of the individual, for example, through the provision of interpreter services.

Other relevant information

www.dhs.vic.gov.au/for-individuals/disability/accommodation

Notes