

Recognising and supporting care relationships for older Victorians



Recognising and supporting care relationships for older Victorians

Action Plan 2006–2009

Department of Human Services

Published by the Aged Care Branch, Victorian Government Department of Human Services Melbourne, Victoria

August 2006

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Printed by GT Graphics, 34 Stanley Street, Collingwood, 3066
(0190606)

Minister's foreword

There are many things that governments can do well to recognise and support care relationships. However, care and support also depend on people's good will, love for their family and friends, and commitment to quality of life for those around them. The Victorian Government seeks to support people in care relationships in various ways, however, it cannot replace the role of unpaid carers, who often keep families and relationships together through hard times and good.

Interdependence, reciprocity and mutuality feature in many care relationships. A care relationship may have more than one carer and more than one care recipient. Each care relationship is unique and relationships change over time. Needs and circumstances of individuals in a care relationship may be diverse and will also change over time. People in care relationships have individual rights, may have different needs and challenges, and may have varying degrees of:

- commitment
- willingness
- motivation
- capacity to be engaged.

What is called 'relinquishing care' can be very painful, as for example a loved one moves into a residential aged care facility. But, in many ways, a carer does not relinquish care. Carers continue to care for their loved one, even if it is a different environment. In care relationships, there is a past, a history, lives lived and memories of good and challenging times.

I am pleased to have worked with my other ministerial colleagues on a strategic vision *Recognising and supporting care relationships*, accompanied by action plans in the areas of disability services, mental health and older Victorians.

This plan aims to recognise and support those in care relationships for older Victorians. The Victorian Government continues to acknowledge the efforts of people in care relationships as they seek to maintain dignity, quality of life, comfort, purpose and happiness.



Gavin Jennings
Minister for Aged Care

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Introduction

The Department of Human Services policy framework, *Recognising and supporting care relationships*, identifies three overarching principles in focusing on care relationships.

These are:

- recognition and respect
- supporting care relationships
- participation.

To support the department's policy framework, program areas have developed action plans that acknowledge and address the important elements of care relationships.

The purpose of *Recognising and supporting care relationships for older Victorians Action Plan 2006–2009* is to improve recognition of, and support for, care relationships for older Victorians through policy and service development and delivery.

This plan identifies actions to support care relationships for older people and their unpaid carers:

- within current programs and services, including making changes to improve what program areas already do
- through new initiatives.

The action plan includes program areas primarily involved in caring for and supporting older people and their carers in their own homes, hospitals, respite facilities, supported residential accommodation and residential care. It also includes core functions that go across these settings, like support and counselling, continuous quality improvement and education and training.

Implementing the actions involves different Department of Human Services program areas, including Aged Care, Continuing Care and Clinical Service Development, Primary Care, Community Health, and Cancer and Palliative Care. The plan also seeks to engage health and community service organisations and other major stakeholders in recognising and supporting care relationships. Engaging with department program areas and community service organisations will be a continuing process. Likewise, the work to recognise and support care relationships for older Victorians may develop and evolve beyond what is identified in this action plan.

Not all people with care needs are in care relationships, especially with demographic change and as single person households increase. This action plan also recognises people who may not have relationships that provide care. Appendix 1 outlines changing demographics of Victoria, relevant to care relationships.

Putting principles into practice

To meet the needs of Victorians through health and community services, it is important for governments, community service organisations and other major stakeholders to recognise and appreciate the nature of care relationships. Many care relationships occur in a loving way and benefit those in the relationship. However, some care relationships may be difficult at times or sometimes inappropriate. This can be because of stress on one or more of the people in the relationship from demands of being a carer or care recipient, relationship history or changing circumstances involving conflict, tension, abuse or violence. With difficult or inappropriate care relationships, alternative options for care may need to be explored by health and community services professionals.

Services need to be flexible and respond to diversity and change in care relationships. For health and community services, the community, respite care, supported residential services and residential aged care, meeting the needs of care relationships is about the following.

Recognising and respecting that care relationships:

- are dynamic, diverse and can change over time
- exist within communities, as part of society
- have a history, with different key transition points
- sometimes include a need for, and legitimacy of, care outside the home
- see the carer as an important person in assisting people to live in the community and to remain at home
- include respecting the expertise and knowledge of carers.

Supporting people in care relationships by:

- providing flexible and practical support, service provision and resources like Home and Community Care (HACC) services, respite care and counselling services to meet individual needs; such needs include grief and loss, access to support groups and support during key transition points in care relationships; services need to be accessible, responsive, user friendly and high quality
- assisting people to navigate the health and community services system and enabling people to make choices about services that meet their needs
- providing relevant, timely and easy to understand information for those in care relationships, for example, understanding ill-health conditions, behaviours and needs.

Participation of people in care relationships in:

- individual care planning and delivery
- planning to improve and enhance the health and community services system
- quality assurance procedures.¹

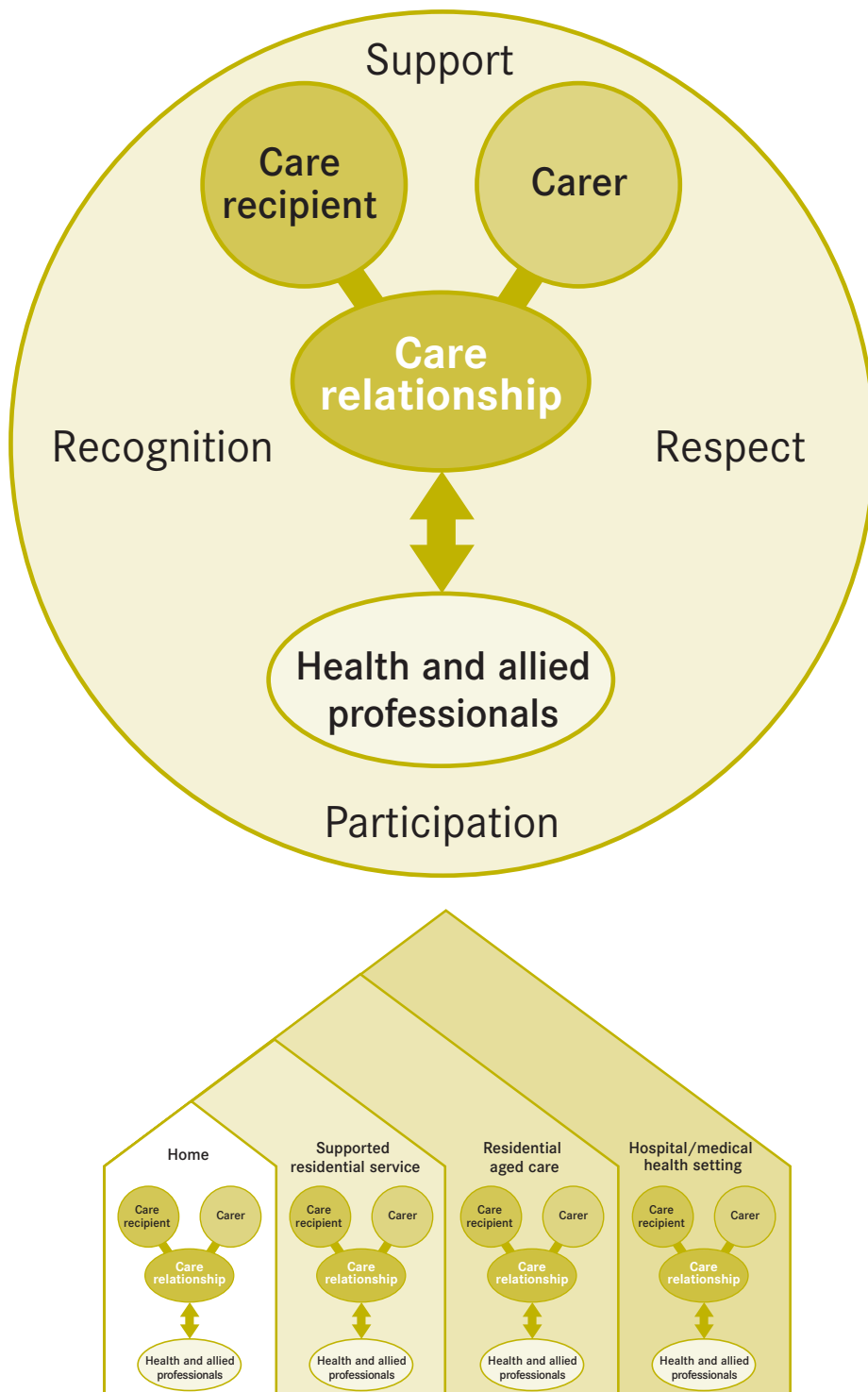
¹ For example, *Improving care for older people: a policy for Health Services* (Continuing Care Section, Programs Branch, Metropolitan Health and Aged Care Services Division, Department of Human Services, November 2003) identifies principles for the care of older people in Victorian Health Services. Principle 3 refers to placing the person at the centre of their own care and considers the needs of the person's carers in the treatment and care provided by Health Services. The key objectives are that:

- older people and, where appropriate, their carers, are actively engaged in care planning processes
- older people and their carers are given the opportunity to provide feedback for quality improvement purposes.

Recognising and supporting care relationships in specific settings

Services for people in care relationships need to be provided in people’s homes and throughout the care pathway. This includes community health, hospitals, respite facilities, supported residential services and residential aged care and involves community service organisations and staff.

Figure 1: Supporting care relationships



Approaches and actions that recognise and support care relationships for older Victorians

Approaches to program and service delivery

Various approaches underpin recognising and supporting care relationships. These approaches help maintain and improve the quality of services and include:

- health promoting approaches to maximise potential health and wellbeing of people in a care relationship
- service coordination and partnerships for better access to services as and when needed and smooth transition between services
- continuous quality improvement to identify and implement evidence-based best practice
- monitoring outputs to record and demonstrate quantity of services delivered, spread of services and access and service gaps
- accountability by service providers so that intended services are delivered.

Actions to recognise and support care relationships

The actions identified below aim to assist in recognising and supporting care relationships and help maintain the care relationship in the long term. The actions fall into two categories:

1. **Current services and initiatives** that can improve recognition and support for care relationships (see Appendix 2 for current services and initiatives).
2. **New initiatives** to recognise and support care relationships.

Within these two categories, there are:

- **specific settings** including home, hospitals, in respite facilities, in supported residential services and in residential aged care
- **core functions** that occur across all settings, including assessment; service coordination; support, counselling and information; research and development; education and training; data collection, analysis and reporting; and monitoring and evaluation.

Progress in achieving these actions is the responsibility of each program area and will be identified throughout the plan's implementation.

1. Current services and initiatives improving recognition and support for care relationships

Within different settings

Goal: Improve independence, health, wellbeing and quality of life for older people and their carers at home.

Action	Lead responsibility/partners
Develop the HACC Active Service Model project which aims to maximise client independence through person-centred and capacity building approaches. Reorientation of the service delivery model enhances the care relationship through improving independence, wellbeing and quality of life of the care recipient.	<ul style="list-style-type: none"> • Aged Care HACC Program • Community service organisations
Continue the Culturally Equitable Gateways Strategy to assist community service organisations and local governments to improve access to HACC services for older people and their carers from culturally and linguistically diverse backgrounds.	
Improve recognition and participation of care relationships in primary health services by including carers in service delivery and care for care recipients in allied health, nursing, counselling and health promotion.	<ul style="list-style-type: none"> • Primary Health Community Health Program • Community service organisations
Maintain a consumer, carer and community advisory committee to provide advice on major service development initiatives.	
Support care relationships at home after hospital episodes by providing an appropriate package of short-term community supports to assist recuperation after a hospital episode and facilitate safe and timely discharge.	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development Post Acute Care (PAC) program • Health Services² • Community-based service organisations
Review the PAC program to ensure that it meets aims of: <ul style="list-style-type: none"> • person-centred care • right care at the right time • equity of access. 	
Review the Aids and Equipment Program to identify opportunities to improve services for people with a disability, including older people and their carers.	<ul style="list-style-type: none"> • Disability Services • Aged Care HACC Program • Community service organisations

² 'Health Services' include the acute and sub-acute campuses of a Health Service as well as the additional programs that a Health Service provides in the community. Health Services are different to general health care and ongoing community support services delivered by various community service organisations in the community.

Goal: Improve care in hospitals for older people and their carers.

Action	Lead responsibility/partners
Distribute more broadly to additional hospitals the booklet <i>Dementia care in hospitals, Key findings and ideas from the evaluation of four projects July 2005</i> , including 'Ideas for supporting carer relationships'.	<ul style="list-style-type: none"> • Aged Care Dementia Services • Continuing Care and Clinical Service Development Improving Care initiative • Health Services
Fund Health Services to implement the Improving Care policy, which encourages Health Services to: <ul style="list-style-type: none"> • adopt a strong person-centred approach to care and involve patients and their carers in decisions about their health care • better understand the complexity of older people's health care needs • improve integration within and between Health Services. 	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development • Health Services
Fund and assist Health Services to implement their Improving Care work plans, which document how they will address the five key impact areas outlined in the policy: <ul style="list-style-type: none"> • person-centred care • specific care needs • physical environments • education and training • partnerships and networks. 	
Promote refocusing of culture in Health Services to recognise older people as core business of the hospital system and deliver care and services that better meet the needs of older people and their carers. Care areas being addressed include increased involvement of patients and their carers in decisions about their care.	
Establish major sub-acute centres as centres of excellence and expertise in the care of older people, so that older people and their carers recognise them as a resource to access information and services.	
Fund a project, Identifying best practice in person-centred health care by the National Ageing Research Institute (NARI), to identify best person-centred practice and develop resources to facilitate this practice throughout Health Services. A consumer/carer reference group informs the project development.	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development Improving Care initiative • National Ageing Research Institute (NARI)
Fund the implementation by Health Services of the Enhancing Practice program, being jointly undertaken by Northern Health and Council on the Ageing (COTA).	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development Improving Care initiative • Northern Health • COTA
Develop an evidence-based audit tool, <i>Improving the environment for older people in Health Services: An audit tool</i> , so that Health Services can provide environments appropriate for older people and their carers.	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development Improving Care initiative • NARI

Action	Lead responsibility/partners
Facilitate the implementation of evidence-based practice and knowledge sharing by Health Services in the Improving Care Community of Practice. Communities of practice are formed by people for collective learning around a common issue.	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development Improving Care initiative • Health Services
Implement the Dementia Management in Hospitals program, developed by Ballarat Health Service, in seven Health Services. The program includes involving and consulting with carers of patients with dementia.	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development Improving Care initiative • Aged Care Dementia Services • Ballarat Health Service • Health Services
Encourage Health Services to offer older people and their carers the opportunity to provide feedback for quality improvement purposes.	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development Improving Care initiative • Health Services
<p>Conduct quarterly forums for health professionals with information about policy direction, new resources and topics of interest. Topics to date include:</p> <ul style="list-style-type: none"> • carers • dementia • functional decline • assessment • person-centred care • improving acute aged care. 	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development Improving Care initiative • Aged Care • Health Services

Goal: Enhance flexible respite options.

Action	Lead responsibility/partners
Assess and approve frail older people for residential respite and/or other carer support services as required.	<ul style="list-style-type: none"> • Aged Care, Aged Care Assessment Program (ACAP) • Aged Care Assessment Services (ACAS)
Increase funding to the Support for Carers Program (SCP) and the development and implementation of flexible respite options.	<ul style="list-style-type: none"> • Aged Care SCP • Community service organisations
Fund projects in innovative and creative respite options to meet individual and changing needs of those in care relationships (eight in 2004–06).	

Goal: Increase participation of clients and carers in care planning in supported residential services.

Action	Lead responsibility/partners
Provide families and unpaid carers with the opportunity to have input into SRS resident care plans.	<ul style="list-style-type: none"> • Aged Care Supported Residential Services (SRS) • SRS providers
Fund training of SRS staff to promote a client-focused approach including getting family/unpaid carer input to care plan development.	
Facilitate residents and their families/unpaid carers/guardians to voice concerns about care and services in SRSs.	<ul style="list-style-type: none"> • Aged Care SRS
Fund the Community Visitor program to enquire into issues raised by residents and their families/unpaid carers.	
Monitor issues, concerns and other feedback from residents and their families/unpaid carers about SRS care, to inform legislative change, policy development and training programs.	

Goal: Increase access to information for older people and their carers/families about residential aged care.

Action	Lead responsibility/partners
Update and distribute <i>A guide for families and carers to the 'how, when, what and where' of residential care</i> , to accompany a new guide to services for frail older people and their families/carers.	<ul style="list-style-type: none"> • Aged Care SCP • Community service organisations • Peak bodies
Support training in use of the <i>Outside looking in</i> kit in residential aged care facilities to extend its implementation.	<ul style="list-style-type: none"> • Aged Care SCP • Carers Victoria • Residential aged care providers
Establish performance indicators providing information to families and carers about quality of care in public sector residential aged care services.	<ul style="list-style-type: none"> • Aged Care Residential Care Strategy • Public sector residential aged care providers

Core functions

Goal: Improve assessment to better identify ways of supporting care relationships.

Action	Lead responsibility/partners
Fund broad needs-based assessment for care recipients and carers to ensure care relationships are well supported.	<ul style="list-style-type: none"> • Aged Care HACCP Program • Community service organisations
Develop an assessment framework for the HACCP Program to increase the consistency and quality of broad needs-based assessment for clients and carers, and embed an active service model approach to service delivery.	<ul style="list-style-type: none"> • Aged Care • Community service organisations
Assess and approve frail older people for Community Aged Care Packages (CACCP), Extended Aged Care at Home (EACH) packages, and other carer support services as required.	<ul style="list-style-type: none"> • Aged Care ACAP • ACAS
Incorporate the needs and preferences of carers when carrying out a comprehensive ACAS assessment of frail older people and involve carers in the care planning process.	

Goal: Improve service coordination for better client and carer referrals and transition between services.

Action	Lead responsibility/partners
Increase the use of service coordination and referrals that support the care relationship, through the use of common protocols (PPPS) and tools, primarily the Service Coordination Tool Templates (SCTT).	<ul style="list-style-type: none"> • Primary Health - Primary Health Integration • Aged Care • Primary Care Partnerships (PCPs) • Department-funded services impacting on older people and their carers
Implement the Patient Management Frameworks (PMFs) to promote high level standardised cancer care.	<ul style="list-style-type: none"> • Cancer Care • Integrated Cancer Services

Goal: Improve support, counselling and information for people in care relationships.

Action	Lead responsibility/partners
Fund support and counselling to people in care relationships, and facilitate validating carers' roles, empowerment and advocacy for carers.	<ul style="list-style-type: none"> • Aged Care HACC Program, SCP • Carers Victoria • Community service organisations
Fund the development and support of carer support groups and networking.	<ul style="list-style-type: none"> • Aged Care SCP • Carers Victoria • Community service organisations
Fund community health services to provide bereavement support and grief counselling to families/carers.	<ul style="list-style-type: none"> • Palliative Care Bereavement Support • Community Health
Develop and disseminate the PMFs which include information and critical points on the supportive care needs of patients and their carers.	<ul style="list-style-type: none"> • Cancer Care PMFs

Goal: Conduct and review research activities and better use findings for service development.

Action	Lead responsibility/partners
Improve the use of the research on <i>What carers value</i> (by NARI for the Department of Human Services Aged Care Branch, November 2004) to maintain care relationships, as a resource for influencing service outcomes.	<ul style="list-style-type: none"> • Aged Care
Review palliative care research to identify specific research areas and gaps, including about carer and family support needs.	<ul style="list-style-type: none"> • Palliative Care

Goal: Enhance education and training in care of older people and their carers.

Action	Lead responsibility/partners
Provide opportunities for the HACC workforce to better understand how to support care relationships.	<ul style="list-style-type: none"> • Aged Care HACC Program • Community service organisations

2. New initiatives to recognise and support care relationships

Within different settings

Goal: Improve independence, health, wellbeing and quality of life for older people and their carers at home.

Action	Lead responsibility/partners
Fund the development of and distribute a guide to assist older people living at home, particularly those who are frail or have complex care needs, and their families/carers, in accessing and navigating aged care, local and community services.	<ul style="list-style-type: none"> • Aged Care • Community service organisations

Goal: Improve care in hospitals for older people and their carers.

Action	Lead responsibility/partners
Oversee a project, Development of competencies for health staff providing care to older Australians, jointly with The Health Care of Older Australians Standing Committee (previously Care of Older Australians Working Group - COAWG). ³	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development • The Health Care of Older Australians Standing Committee
Participate in initiatives of The Health Care of Older Australians Standing Committee, including to develop and distribute publications/resources to improve older people's care. Include consumer brochures to assist patients and their carers on: <ul style="list-style-type: none"> • <i>A guide to assessing older people in hospital</i> (completed) • <i>Best practice approaches to minimise functional decline in the older person across the acute, sub-acute and residential care settings</i> (completed) • <i>The stroke care journey</i> (in development) • <i>Delirium clinical guidelines</i> (in development). 	
Provide Health Services with <i>Improving the environment for older people in Health Services: An audit tool</i> for implementation, so that the physical hospital environment better meets the needs of older people and their carers.	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development Improving Care initiative • Health Services

Goal: Enhance flexible respite options.

Action	Lead responsibility/partners
Produce an ideas booklet on innovative and creative respite options, based on projects funded over 2004–06.	<ul style="list-style-type: none"> • Aged Care SCP • Community service organisations
Fund new services combining Well for Life activities for carers with respite activities for care recipients.	<ul style="list-style-type: none"> • Aged Care SCP, Well for Life • Community service organisations

³ Continuing Care and Clinical Service Development shares The Health Care of Older Australians Standing Committee Secretariat with the Commonwealth Government.

Goal: Increase participation by older people and their carers/families in processes and information about residential aged care.

Action	Lead responsibility/partners
Develop a set of quality of life indicators for public sector residential aged care, and support carers and their families to have input into the development and implementation processes.	<ul style="list-style-type: none"> • Aged Care Residential Care Strategy • Public sector residential aged care providers
Seek input from carers into the development of practice guidelines for residential aged care facilities, using the Improving Compliance in Residential Aged Care Sector initiative.	<ul style="list-style-type: none"> • Aged Care • Public sector residential aged care providers

Core functions

Goal: Improve assessment to better identify ways of supporting care relationships.

Action	Lead responsibility/partners
Participate in the development of a national HACC assessment tool that includes screening for carer needs and carer risks.	<ul style="list-style-type: none"> • Aged Care HACC Program • Community service organisations
Participate as required in the National Respite for Carers Program (NRCP) initiative to develop a carer assessment tool and screening for carer needs.	
Participate in the Palliative Care Victoria project to develop a care assessment tool for generalist providers making assessments about the level of palliative care needs for patients, including a user-friendly companion guide for consumers and carers.	<ul style="list-style-type: none"> • Palliative Care Victoria • Palliative Care
Encourage Health Services to implement comprehensive assessments of older people. Comprehensive assessment includes non-medical areas, emphasising functional ability and quality of life, and assessment of carer needs. This type of assessment also identifies changing needs over time.	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development <ul style="list-style-type: none"> - Improving Care initiative - Sub-acute Ambulatory Care Services (SACS) - HARP-Chronic Disease Management (HARP-CDM) • Health Services

Goal: Improve service coordination for better client and carer referrals and transition between services.

Action	Lead responsibility/partners
Provide a range of supports to community service organisations to extend implementation of service coordination.	<ul style="list-style-type: none"> • Primary Health - Primary Health Integration • Aged Care • Primary Care Partnerships (PCPs) • Department of Human Services funded services impacting on older people and their carers
Review the SCTT to improve identification of carers and their needs.	
Participate in the development of the Statewide Service Co-ordination Manual to highlight carer needs.	
Use PCPs to build a more integrated health promoting approach across Aged Care, Primary Health and the broader service sector, to better recognise, support and address care relationships amongst older people. This includes PCPs incorporating, in their priority setting and catchment planning, acknowledgement and consideration of the social, economic and health enablers/barriers influencing the capacity of people in care relationships to participate in health enhancing actions and settings.	<ul style="list-style-type: none"> • Aged Care • Primary Health
Promote Health Services developing a single point of access to assist older people and their carers navigate the health service system.	<ul style="list-style-type: none"> • Continuing Care and Clinical Service Development Improving Care initiative • Health Services

Goal: Improve support, counselling and information for people in care relationships.

Action	Lead responsibility/partners
Fund the update of the Web-based <i>Surviving the maze</i> sheets for navigating the service system, and develop and disseminate paper-based resources.	<ul style="list-style-type: none"> • Aged Care SCP • Carers Victoria
Fund a new position to be established in Carers Victoria to develop, maintain and enhance carer support networks.	

Goal: Conduct and review research activities and better use findings for service development.

Action	Lead responsibility/partners
<p>Undertake a research and development project to examine how well social support and respite services meet carer needs and support care relationships.</p> <ul style="list-style-type: none"> Investigate what works about respite and the barriers to effective respite, including intergrating and coordinating services for carers. Trial and document a more coordinated approach to respite service delivery in a region. Extend coordinated respite service delivery approaches to other regions. 	<ul style="list-style-type: none"> Aged Care HACCC Program, SCP Community service organisations
<p>Develop ways to better support people living by themselves with care needs. Fund research on the care needs of people living by themselves who do not have relationships that provide care, and disseminate the information to community service organisations on meeting such care needs.</p>	<ul style="list-style-type: none"> Aged Care Community service organisations
<p>Establish a new Statewide Bereavement Service to provide education and training, community development activities and specialist counselling to support people experiencing grief and bereavement.</p>	<ul style="list-style-type: none"> Palliative Care Statewide Bereavement Service
<p>Implement, where appropriate, recommendations from the Palliative Care Communications Strategy Paper to improve information to consumers and carers about palliative care services.</p>	<ul style="list-style-type: none"> Palliative Care Palliative Care Victoria

Goal: Enhance education and training in hospital care of older people and their carers.

Action	Lead responsibility/partners
<p>Establish major sub-acute centres as centres of excellence and expertise in the care of older people. Using these centres of excellence and expertise, up-skill staff in acute and community settings to improve care for older people and their carers.</p>	<ul style="list-style-type: none"> Continuing Care and Clinical Service Development Improving Care initiative Health Services

Goal: Improve information about client and carer service access and use through data collection, analysis, monitoring and evaluation.

Action	Lead responsibility/partners
<p>Analyse service and demographic data for HACCC and SCP through the HACCC MDS Version 2, for spread of services, access and service gaps.</p>	<ul style="list-style-type: none"> Aged Care Community service organisations
<p>Report from 2006–07 using the Victorian Integrated Non-Admitted Health (VINAH) dataset as the reporting mechanism for both Sub-Acute Ambulatory Care and HARP-CDM services. This provides client-centred, client level data. Health Services report de-identified demographic and service activity data, including basic data about carers.</p>	<ul style="list-style-type: none"> Continuing Care and Clinical Service Development HARP-CDM Health Services Health Data Standards and Systems

Appendix 1 Changing demographics

In 2002, of Victoria's population of 4.8 million people, 1.4 million were aged 50 years and above (29 per cent); 833,303 were aged 60 years and above (17 per cent). By 2021, the proportion of Victorians over 60 years is expected to rise to 25 per cent. Increased life expectancy means that many Victorians will be living into their 80s and 90s. Department of Sustainability and Environment's *Victoria in future 2004* population projections forecast a 21 per cent growth in the Victorian population by the year 2021 (from 4.8 million in 2001 to 5.8 million people in 2021). The growth rate for the 70–84 years age group to the year 2021 will be substantially higher at about 66 per cent (from 382,000 in 2001 to 632,000 people in 2021). The 85+ year age group will experience an even larger percentage increase, growing by 123 per cent by 2021 (from 70,000 in 2001 to 156,000 people in 2021).⁴

Currently, the majority of older Victorians enjoy healthy, active and independent lives. Most live at home; a minority are in high or low level aged care facilities or need assistance for daily living. For those over 80 years of age, one-third requires help with self-care activities, including people in residential aged care and at home.

Older people are significant users of Health Services, with people over the age of 70 years using more than 48 per cent of all multiday patient stays (VAED, 2004-05). This figure is set to increase as the population ages. Older people often experience adverse events and poor outcomes following admission or presentation to Health Services. In response to this, the government produced the policy – *Improving care for older people: A policy for Health Services* – with the aim of changing the approach to older people's health care in Victoria. *Improving care for older people: A policy for Health Services* encourages Health Services to gain a greater understanding of, and insight into, the complexities of older people's health care needs, improve coordination and integration of services and adopt a strong person-centred approach to care and services.

The Australian Bureau of Statistics *Survey of Disability, Ageing and Carers* (2003) estimates that there are more than 100,000 Victorians who are primary carers for people with disabilities or long-term conditions, or older people. The survey suggests that while approximately 70 per cent of carers are female, the differences in the proportions of women and men carers are less pronounced for those 65 years and over (58 per cent female and 42 per cent male nationally). Twenty-four per cent of primary carers in Australia are aged 64 years and over, compared to 13 per cent of the total population. Of primary carers in Victoria, 74 per cent live with the person they care for and 30.6 per cent of these carers provide an average of 40 hours or more care per week.

Many disabling and chronic conditions, such as cancer, are highly age-related. For example, the *Victorian Burden of Disease Study, Mortality and morbidity in 2001*, indicates that the per capita burden from cancer increases exponentially with age, from insignificant proportions in young adulthood to almost one fifth the total burden in older people.

⁴ Source: <http://www.dse.vic.gov.au/> See also Victorian Government Department of Human Services 2003. *Improving care for older people: a policy for Health Services*.

Given this and the increasing proportion of Victorians aged over 60, more people may need unpaid and paid care in the future. Furthermore, it is predicted that there will be a smaller number of younger people, as well as changing work and family conditions, that may reduce the desire or ability to provide unpaid care. The ratio of unpaid primary carers to older people with a disability is expected to fall over the next three decades. The main factor behind this fall is considered to be the increasing demand for care due to the increased number of people aged 65 and over. The number of unpaid primary carers is also anticipated to grow, but at a much slower rate (Aug 05 Access Economics for Carers Australia).

There is an anticipated growth in the number of people with care needs and without carers. The number of households in Melbourne is projected to grow by an average 1.1 per cent per annum between 2001 and 2042, significantly more than the projected average annual population growth rate of 0.8 per cent. This reflects a projected decline in average household size, driven by an ageing population and other social changes. Melbourne's average household size, 2.61 people in 2001, is projected to fall to 2.44 by 2016, and 2.26 by 2042. The continuing decline in household size will affect social and economic life and interact with the impacts of ageing.

Ongoing demographic change means that single parent families, couples without children and single person households will increase as household types. Many future one and two person households will be middle aged and older couples and former single parents, whose children have moved out of home. Many single person households will be divorcees and older Victorians whose partner is deceased (Department of Treasury and Finance).

Currently 43 per cent of HACC clients live alone in their own homes and more than half of all Victorians aged 75 years and over who live alone receive a HACC service.

It is suggested that the need for unpaid care will not be met by available carers in the future. Likewise formal care services will not necessarily be able to meet, or substitute services for, the unpaid care needs of people. The needs of people with dementia who self-care are of particular concern.

Appendix 2 Summary of services and initiatives directly and indirectly supporting care relationships for older Victorians

Home and Community Care (HACC) services

HACC services are jointly funded by the Commonwealth Government and State Government. The services are targeted to frail older people and people with disabilities (consumers) and to carers, providing basic support and maintenance to people living at home whose capacity for independent living is at risk or who are at risk of premature or inappropriate admission to long term residential care.

Consumers may or may not have unpaid carers and family members caring for them. Indicators of a consumer's higher level need for HACC services include:

- difficulty with a range of tasks of daily living
- need for medical or nursing help on a short-term intensive or long-term basis
- living without an unpaid carer or living with a carer who is frail, ill, stressed or has a disability
- limited or non-existent social contacts
- a physically unsafe home environment
- social or geographical isolation
- financial disadvantage.

Indicators of higher level need of carers for HACC services include:

- the person being cared for has a severe disability
- the carer is the sole carer, has limited support networks or has dependent children
- the carer is frail, ill, stressed or has a disability
- the carer has extensive commitments
- the carer is socially or geographically isolated
- the carer is financially disadvantaged

HACC services include:

- **Assessment and care management**

Where relevant, the needs of consumers and carers are identified so that services can be delivered in a manner that enhances and supports the care relationship.

- **Domestic assistance**

This includes supporting carers by undertaking activities to maintain a safe, comfortable and healthy home environment.

- **Personal care**

Services should be consumer/carer focused, planned, appropriate, responsive and reliable, to meet the needs of the consumer/carer. Service planning should involve the consumer's carer, if they have one.

- **Delivered meals**

This service is for people assessed as being nutritionally at risk, for example, if the consumer or carer is unable to cook and prepare meals due to an illness or disability.

- **Planned Activity Groups (PAGs)**

PAGs seek to maintain a person's ability to live at home and in the community by providing a planned program of activities to enhance skills required for daily living and providing physical, intellectual, emotional and social stimulation. PAGs provide opportunities for social interaction as well as respite and support for carers.

- **Allied health**

Where necessary, service options should be made available out of normal working hours, such as evenings and weekends, so that carers can accompany consumers to appointments.

- **Respite**

These services provide carers with a break from their care role or support to help them in their care role, and an opportunity for the person being cared for to have a break or an outing without their usual carer. Respite services are responsive to individual needs of those in care relationships, and provide accessible information to carers on support services available in the community. Respite can be provided in the form of planned regular respite, emergency respite, crisis respite and occasional respite. Respite may involve a respite worker accompanying the usual carer and care recipient on an outing or holiday.

- **Nursing**

Services include direct clinical care, clinical assessment and the provision of education and information, including teaching consumers and carers how best to manage their daily care in the home.

For further detail, see *Victorian Home and Community Care Program Manual, February 2003* on <http://www.health.vic.gov.au/hacc>

Primary Health - Community Health Services

Community Health Services play an important role in providing a range of health services to many Victorians. With 100 services operating from 250 sites and providing care to 200,000 registered clients, Community Health Services have become a major platform for the delivery of state-funded, population-focused and community-based health services in Victoria.

Community Health Services - creating a healthier Victoria policy establishes firm directions for the future of Community Health Services, reflects the commitment to strengthen community-based models of primary health, and aims to build more sustainable and effective community-based health services as a key component of an integrated 'whole of health' system. Consumers are seen as central to the future of Community Health Services. A key principle of the policy is that Community Health Services will empower consumers, carers and the community to be actively involved in governance, management, planning and evaluation of services.

For further detail, go to

<http://www.health.vic.gov.au/communityhealth/publications/chs.htm>

Primary Care Partnerships Strategy

Achieving better health for people and strengthening the communities they live in are critical to improving the quality of life for all Victorians. Developing a more effective primary health care system is essential for achieving these goals. The Primary Care Partnership (PCP) Strategy has demonstrated that these goals are achievable and that when providers work in partnership they can better respond to people's needs.

Older Victorians and others who have chronic or complex health and care needs can particularly benefit from more cooperative approaches. When providers work together it is easier for consumers and their carers to navigate the service system. They also receive better coordinated services that improve the continuity of their care across acute and primary health care services.

For further information about the Primary Care Partnership Strategy, go to <http://www.health.vic.gov.au/pcps/>

Improving Care initiative

Improving care for older people: a policy for Health Services supports care relationships through its philosophy and approach, and views the involvement of older people and their carers as the cornerstone to good health care. Through a person-centred approach to the delivery of care and services, older people and their carers benefit from services that are tailored to the needs of the person and their carer, whether delivered in an inpatient, community or home-based setting. These programs aim to better understand the complexity of older people's care and provide the right care at the right time, in the right place. They are directed at improving and maintaining a person's functional capacity and maximising their independence.

A principle of *Improving care for older people: a policy for Health Services* is that 'treatment and care provided by Health Services places the person at the centre of their own care and considers the needs of the older person's carer'.

Health Services are encouraged to acknowledge the role of carers in maintaining the health and well being of older people. Carers (including family members and friends) can often provide valuable knowledge about the older person's condition, previous illnesses, behaviour and attitude and, therefore, should be included in discussions about treatment and care options (with the older person's consent). The carer's willingness and ability to be involved in the care of the older person should be discussed and taken into account when planning care.

This initiative recognises that a person is often dependent upon the support of a carer, if they wish to return to or continue living in the community. It is vital that carers are consulted in the assessment and planning process, and that both the carer's and the older person's needs are identified when planning the transition back to the community. Health care professionals are encouraged to be aware of the stress and difficulties that affect the carer and offer support where appropriate, for example, through access to carer support services.

The Improving Care initiative is a three-year program and is in the second year of implementation.

For further information about *Improving care for older people: a policy for Health Services* go to: <http://www.health.vic.gov.au/older>

Sub-Acute Ambulatory Care Services

Sub-Acute Ambulatory Care Services (SACS) provide a person and family centred, interdisciplinary model of care supported by flexible service delivery in a range of settings. SACS provide non-admitted, goal oriented, time limited, individualised care to enable clients who are disabled, frail, chronically ill or recovering from traumatic injury to improve and maintain their functional capacity and maximise their independence.

SACS services include:

- centre-based rehabilitation services
- home-based rehabilitation services
- specialist assessment and management services (cognitive dementia and memory services; continence clinics; falls and mobility clinics; pain clinics; wound clinics; movement disorders clinics; and geriatric evaluation and management clinics).

For further detail, see <http://www.health.vic.gov.au/subacute/>

Post Acute Care program

The Post Acute Care program (PAC) provides community-based supports to assist a person to recuperate after a hospital episode. Assessing needs for post-hospital community-based supports should include consideration of carer burden for services to support recuperation. The objectives of the PAC program are to:

- support recuperation after a hospital episode by providing an appropriate package of community-based supports
- support Health Services to facilitate safe and timely discharge.

The principles that underpin the delivery of the PAC program are:

- person centred - the person is at the centre of care and consideration is given to the needs of their family and/or carers
- right care - people are linked into the most appropriate service providers to ensure that their short-term and long-term care needs are met
- equity of access - people have their need for post acute care considered without assumptions or generalisations about their or their family/carer's age, cultural background, socio-economic status, health status, domestic circumstances or gender
- right time - post acute care services are provided within responsive timeframes to facilitate safe and timely discharge.

The PAC program is being reviewed to ensure that it meets these objectives and principles.

For further detail, see <http://www.health.vic.gov.au/pac/>

HARP-Chronic Disease Management (HARP-CDM)

HARP-CDM programs target people with chronic lung disease, chronic heart failure, diabetes, older people with complex care needs, and people with complex psychosocial conditions who ‘present’ or are ‘at risk’ of presenting to hospital emergency departments. A care coordinator/key contact person is allocated to assist people on HARP-CDM with navigating the health care system across acute and sub-acute health care services, as well as community services. All people on HARP-CDM are linked into existing community service organisations, where possible, to avoid duplication. The care coordinator/key contact person provides education and support to people and their carers with these complex conditions, and empowers them to better understand their condition and proactively manage their own health care. Since 2001, HARP-CDM has achieved excellent health care outcomes for people with chronic disease, in particular improvements in quality of life and functional status. Significant reductions in emergency department presentations, hospital admissions and length of stay have also been achieved.

For further detail, see HARP-CDM Guidelines on

http://www.health.vic.gov.au/harp-cdm/harp_cdm_guidelines.pdf

Transition Care Program

The Transition Care Program (TCP) assists eligible older people at the conclusion of a hospital admission who require more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity, and finalise and access their longer-term care arrangements. TCP is a program jointly funded by the Commonwealth Government and Victorian Government.

The aim of TCP is to minimise the number of older people experiencing inappropriate extended hospital lengths of stay and/or being prematurely admitted to residential aged care. TCP can be delivered in the older person’s home or within a facility, such as a residential aged care facility or supported residential service.

The target group for TCP includes:

- older people who, via participation in the program, achieve further improvements to their physical, cognitive and psychosocial functioning and an improved capacity to live independently
- older people for whom the focus is on actively maintaining their functioning, while assisting them and their family/carers to make appropriate long-term care arrangements.

TCP is currently being implemented in Victoria and information about the program will be made available at <http://www.health.vic.gov.au>. The National Program Guidelines are available on the Commonwealth Department of Health and Ageing website at <http://www.health.gov.au/ageing-transition-care>

Aged Care Service Development

Support for Carers Program (SCP)

Many older people are cared for by a family member or close friend. The Aged Care SCP provides a range of flexible respite and support services to:

- Support and strengthen relationships between older people and their carers
- Promote a comprehensive network of services for carers
- Contribute to quality of life for those in care relationships
- Reduce stress on care relationships
- Facilitate an understanding and appreciation of the role of carers among community service organisations and the broader community
- Improve access to information about services available to support care relationships.

Respite services respond to the needs of the carer and the person being cared for (care recipient). Respite provides the carer with some free time while also giving the care recipient the opportunity to receive other health, care supports, social or recreational services, as well as other innovative respite options such as shopping, socialising or short term-holidays.

Respite can be provided during the day at home or outside the home on an activity; overnight at home or in a paid respite worker's home; and overnight in residential respite. This arrangement provides a short-term substitute for usual care, and has the capacity to be provided in a planned and unplanned way, during and outside normal business hours.

Support services for care relationships incorporate direct support in the form of information, advice and counselling to meet individual needs, and can be in the form of one-on-one support, or through the development and maintenance of carer support groups. Support services are targeted to meeting care relationship needs that may require an immediate response or preventative measures to be put in place. In this way, support can be one-off or ongoing, is tailored to meet individual circumstances, and is adaptable to changing needs.

SCP also aims to improve and coordinate care relationship support and respite services on a regional basis through agency networking and integration, service planning and coordinated intake and referral practices.

Support for Carers of People with Dementia Program

Provides flexible support for the carers of people with dementia.

Carers Victoria

Carers Victoria is funded to provide a range of support, counselling, information and training services to individual carers and carer network groups, and information and education to community service organisations.

Support and Links

Alzheimer's Australia Vic (AAV) is funded to provide counselling, information and support for people with dementia and their carers, including joint activities involving carers and care recipients.

Well for Life

Community service organisations will be funded to develop and deliver services combining Well for Life activities for carers with respite activities for care recipients.

Older Victorians with care needs living without a carer

Many older people in need of unpaid and formal care live alone. They may have:

- a carer who visits
- someone who cares from a distance, for example, someone arranging appointments and providing social contact
- no unpaid or formal care.

Research is being undertaken to identify the care needs of older people who may not have relationships that provide care. The research is to investigate innovative and sustainable service and informal and formal network responses to the changing requirements of people in need of care, unpaid or formal, and who may not have relationships providing care. This will include research of grey literature and good practice reviews and consultations with service organisations and other stakeholders. The long-term goal of the research is to promote, encourage and facilitate innovative service responses and networks for the care needs of older people who may not have relationships providing care.

For further detail, see <http://www.health.vic.gov.au/agedcare/>

Supported Residential Services (SRS)

SRS predominantly provide supported residential care services for people who are usually mobile but have care needs requiring assistance or supervision with daily tasks. Some residents in SRS have families and unpaid carers to support them. SRS are sometimes used to provide respite to support people with care needs. The Department of Human Services SRS Unit encourages SRSs to: provide for and respect individual and changing needs and privacy, choice and safety and security; promote people's independence; provide a supportive environment for those in care relationships; and seek input from residents, and their families and unpaid carers, regarding care and services.

For further detail, see *Meeting the need, A guide to providing quality care in Supported Residential Services (SRS)* on <http://www.health.vic.gov.au/srs>

Residential aged care

The Aged Care Branch promotes high quality residential aged care services for older people. Residential aged care providers need to recognise and support care relationships that will continue when a family member enters residential aged care. It is important that residential and community services provide support to maintain that relationship, for example, including carers and family members in decision making relating to the resident, and providing transport for carers.

The *Public sector residential aged care policy* describes how the State Government sees its role in what is primarily a Commonwealth system of residential aged care. The policy aligns with person-centred approaches to care, where the care needs and aspirations of older people and their families and carers are the prime focus. Public sector residential aged care providers are supported by quality care initiatives (accreditation support, and quality performance indicators) in the Aged Care Branch to meet statutory obligations regarding care relationships through:

- the management, delivery and improvement of residents' lifestyles and care reflecting individual needs and preferences
- processes for residents and their carers to participate in decisions about, and exercise choice and control over, their care and lifestyle
- carer inclusive practice in residential care facilities. Carer inclusion requires a systemic approach to planning quality improvements across a facility; management practices, health and personal care practices, lifestyle practices and environmental services all need to be considered in developing processes and plans aimed at improving the involvement of carers.

For further detail, see *Public sector residential aged care policy October 2004* on <http://www.health.vic.gov.au/agedcare/resicare>

Cancer and Palliative Care

Cancer and Palliative Care in the Programs Branch is responsible for coordinating the Victorian Government's cancer reform agenda and developing policy direction for, and supporting services in, the delivery of a range of palliative care services across metropolitan and regional Victoria.

The cancer reform agenda includes the implementation of a range of cancer service reforms across the state, the establishment of integrated cancer services and the introduction and spread of service improvements across a number of tumour streams in metropolitan and rural health services. A major theme of the *Cancer Services Framework for Victoria* is an integrated approach to service delivery, which focuses on delivering the right treatment and support to patients and their carers as early as possible in their cancer journey.

The *Cancer Services Framework for Victoria* outlines an integrated service model for metropolitan and regional cancer services based on the following principles:

- services will be population-based
- individuals will have access to the full range of services from prevention, screening, diagnosis, treatment, rehabilitation, supportive care and palliative care
- referral pathways are clearly defined for the range of services required
- care is multidisciplinary and coordinated
- high quality care requires a ‘critical mass’ of expertise and leadership.

Further information can be found at <http://www.health.vic.gov.au/cancer>

Strengthening palliative care: a policy for health and community care providers 2004–09 was launched in November 2004. This policy aims to strengthen service delivery for people with a life threatening illness and their carers and families by improving equity of access to specialist palliative care services, building effective links between hospitals and specialist palliative care providers and other relevant community, health and allied health providers.

The Palliative Care Program aims to achieve an integrated service across all aspects of care. This is supported by the underlying principles of the Palliative Care Program, which are:

- Care is holistic, multidisciplinary and client-centred.
- Care includes medical, nursing, allied health and volunteer services.
- Support is provided for families and friends, including grief and bereavement support.
- Patients can make informed choices about their care including the type of care and where the care is delivered.
- Service delivery is seamless between the locations where care is delivered, whether in the community or a health care facility.

Further information can be found at <http://www.health.vic.gov.au/palliativecare>

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