Advancing practice in the care of people with dementia

4th Edition

Module 3:
Diagnosing dementia

Dementia Training Australia

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Contents

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Introduction

Dementia is an umbrella term for several neurodegenerative conditions, of which Alzheimer's disease is the most common. It is a clinical diagnosis and there is no single step to diagnosing the syndrome. Differential diagnoses must be considered and excluded before a diagnosis of dementia can be made. This module discusses the importance of accurate diagnosis as well as the process by which a diagnosis of dementia is determined. The module also includes information about some of the available screening and assessment tools.

Objectives

On completion of this module you will be able to:

- Understand the differential diagnoses of dementia
- Understand the importance of differentiating between the various types of dementia
- Explain the importance of early diagnosis of dementia
- Describe the diagnostic criteria for dementia
- Understand the steps involved in diagnosing dementia
- Understand the various screening instruments and assessment tools which can be applied in the diagnostic process
- Debate issues relating to informing the client and family of the diagnosis
- Understand the importance of referral and follow-up

Module topics

Diagnostic criteria

Differential diagnoses of dementia

Mild cognitive impairment

Delirium

Depression

Other differential diagnoses

Differential diagnoses of sub-types of dementia

Early diagnosis

Diagnostic tools, steps and tests

Overview of tools and tests

Culturally and linguistically diverse groups

Informing the person and their family

Referral and follow-up

Suggested reading for this module

Dementia Australia. (2018). *Help-sheet: Diagnostic criteria*. https://www.dementia.org.au/files/helpsheets/Helpsheet-DementiaQandA11-DiagnosticCriteriaForDementia_english.pdf

Dyer, S. Laver, K. Pond, C. Cumming, R. Whitehead, C & Crotty, M. (2016). Clinical practice guidelines and principles of care for people with dementia in Australia. *Australian Family Physician. Vol 45*(12). Pp.884-889.

Kane, J. & Thomas, A. (2017). Ch 4: What is dementia, and how do you assess it? Definitions, diagnostic criteria and assessment. In Ames, D. O'Brien, J. & Burns, A. (2017). *Dementia*. 5th Edition. Boca Raton. CRC Press.

World Health Organisation. (2019). Fact sheet: *Dementia*. https://www.who.int/news-room/fact-sheets/detail/dementia

Diagnostic criteria

A diagnosis of dementia can only be made if the cognitive impairment is progressive and not due to drugs, a medical condition or delirium.

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) presents a different approach by replacing the term 'Dementia' with 'Minor Neurocognitive Disorder' and 'Major Neurocognitive Disorder' and proffering new diagnostic criteria.

Minor Neurocognitive Disorder diagnostic criteria

A. *Evidence of modest cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:*
   - *Concern of the individual, a knowledgeable informant, or the clinician that there has been a mild decline in cognitive function; and*
   - *A modest impairment in cognitive performance, preferably documented by standardized neuropsychological testing, or, in its absence, another quantified clinical assessment.*

B. *The cognitive deficits do not interfere with capacity for independence in everyday activities (i.e., complex instrumental activities of daily living such as paying bills or managing medications are preserved, but greater effort, compensatory strategies, or accommodation may be required).*

C. *C. The cognitive deficits do not occur exclusively in the context of a delirium.*

D. *D. The cognitive deficits are not better explained by another mental disorder (e.g., major depressive disorder, schizophrenia).*

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Major Neurocognitive Disorder diagnostic criteria

A. *Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:*
   - *Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and*
   - *A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.*

B. *The cognitive deficits interfere with independence in everyday activities (i.e., at a minimum, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications).*

C. *C. The cognitive deficits do not occur exclusively in the context of a delirium.*

D. *D. The cognitive deficits are not better explained by another mental disorder (e.g., major depressive disorder, schizophrenia).*

(American Psychiatric Association [DSM-V], 2013)

Despite this change in terminology it is anticipated that the term "dementia" will continue to be used.

Other references include:

Dementia Australia. (2017). *Help-sheet: What is dementia?* https://www.dementia.org.au/files/helpsheets/Helpsheet-AboutDementia01-WhatIsDementia_english.pdf

Criteria for all-cause Dementia

- Dementia is diagnosed when cognitive and behavioural symptoms:
- Interfere with work or usual social activities; and
- Represent a decline from prior levels of functioning and performing; and
- Are not explained by delirium or a major psychiatric disorder.
- Cognitive impairment is detected and diagnosed through a combination of history-taking from the patient, a knowledgeable informant and an objective cognitive assessment, either a 'bedside' mental status examination or neuropsychological testing, and involves at least two of the following domains:
- Impaired ability to acquire and remember new information – symptoms: repetitive questions or conversations, misplacing personal belongings, forgetting events or appointments, getting lost on a familiar route
- Impaired reasoning and handling of complex tasks, poor judgment – symptoms: poor understanding of safety risks, inability to manage finances, poor decision-making ability, inability to plan complex or sequential activities
- Impaired visual and spatial abilities – symptoms: inability to recognise faces or common objects or to find objects in direct view despite good acuity, inability to operate simple implements or orient clothing to the body
- Impaired language functions (speaking, reading, writing) – symptoms: difficulty thinking of common words while speaking, hesitations, speech, spelling and writing errors

- Changes in personality/usual character, impaired motivation, initiative – symptoms: increasing apathy, loss of drive; social withdrawal, decreased interest in previous activities.

(Dyer et al, 2016).

Criteria for the Diagnosis of Alzheimer's Disease Dementia

Insidious onset

Symptoms have a gradual onset over months to years, and the onset was not sudden over hours or days

Clear-cut history of worsening of cognition by report or observation

Cognitive deficits are evident on history and examination in one of the two categories:

1. **Amnestic presentation:** The most common syndromic presentation of Alzheimer's disease dementia. The deficits should include impairment in learning and recall of recently learnt information. There should also be evidence of cognitive dysfunction in other cognitive domains as defined above.
2. **Non-amnestic presentations:**
   - *Language presentation* – the most prominent deficits are in word-finding, but dysfunction in other cognitive domains should be present.
   - *Visual presentation* – the most prominent deficits are in spatial cognition, including object agnosia, impaired face recognition, simultanagnosia and alexia. Deficits in other cognitive domains should be present.
   - *Executive dysfunction* – the most prominent deficits are in impaired reasoning, judgment and problem solving. Deficits in other cognitive domains should be present.

Dementia Australia. (2018). Help-sheet: Diagnostic criteria. https://www.dementia.org.au/files/helpsheets/Helpsheet-DementiaQandA11-DiagnosticCriteriaForDementia_english.pdf

Differential diagnoses of dementia

Cognitive impairment and dementia

A differential diagnosis of cognitive impairment is the first step towards diagnosing dementia, as many causes of cognitive impairment are reversible and should be identified or excluded before dementia is diagnosed. Cognitive impairment is often mistakenly labelled as dementia. Further, it is important to be aware that cognitive impairment may be due to a combination of dementia and another disease.

Therefore, always consider and exclude Mild Cognitive Impairment (MCI) in early presentations and differentiate the other big Ds:

- Delirium
- Neuropsychiatric symptoms such as depression are common in people living with dementia, up to 50% of people with a diagnosis of dementia have depression as a co-morbidity (Singh-Manoux et al, 2018). Dementia and depression can share similar

symptoms such as social withdrawal, lack of interest in self or others, low initiative and poor motivation (Kitching, 2015).

It can be challenging to differentiate between dementia, delirium and depression. These conditions are debilitating and distressing. It is important to distinguish between these so that appropriate treatment and support can be implemented (Dening, 2020).

Mild cognitive impairment (MCI)

Mild cognitive impairment (MCI) is an important clinical syndrome which has been given at least ten names and presents as cognitive impairment with preserved independent function. The commonly accepted criteria for dementia are not met in this condition. Prevalence estimates range from 3-22% (Geda, Krell-Roesch, Pink, Spangehl & Petersen, 2017).

Research indicates there is an increased risk of progressing from MCI to dementia between 10 to 15% (Geda et al, 2017). The Sydney Memory and Ageing Study found over 80% of people with dementia had been diagnosed with MCI two years before the dementia diagnosis (Aerts et al, 2017). MCI does not automatically progress to dementia. Some people with MCI may revert to normal cognitive function while others may remain stable (Lautenschlager & Kurz, 2017).

Further:

- It is unclear if MCI is a precursor to developing dementia; therefore, misdiagnosis of MCI as dementia has substantial psychological, social and legal ramifications for the patient and the practitioner
- There are currently no approved medications to treat people with MCI
- Galantamine: No benefit; in fact, there were increased deaths
- Non-pharmacological strategies such as reducing modifiable risk factors for dementia may be useful
- Protective factors for preventing dementia such as cognitive and physical activities may be helpful

(Lautenschlager & Kurz, 2017).

Delirium

Delirium is characterised by a disturbance of consciousness and a change in cognition that develops over a short period of time. The disorder tends to fluctuate during the day, and there is evidence from the history, examination or investigations that the delirium is a direct consequence of a general medical condition, drug withdrawal or intoxication (American Psychiatric Association [DSM-V], 2013). It is a common complication in older adults and is present in 40% of hospital admissions from residential aged care facilities. 50% of older adults develop delirium during a period of hospitalization (Blevins, 2020).

Delirium is known to increase:

- Length of stay in hospital
- Transfer to long-term care settings, and
- Mortality

(Teodorczuk & Davis, 2017).

Risk factors for delirium:

- Increased age
- Comorbidities
- Infection
- Medications
- Post-operative status
- Immobility
- Sensory impairment
- Urinary catheterisation
- Urea and electrolyte imbalances
- Malnutrition
- Anaemia
- Physical restraint
- Sleep deprivation

(Blevins, 2020).

See this video from Leicester's Hospitals: Delirium: A patient story. This short video about David and Gloria describes the experience of delirium. Delirium - A patient story

Depression

Depression is not a normal part of ageing. Prevalence depends on the clinical context: ranging from 5-10% of older adults in the community to 50% of people in residential aged care facilities in the first 12 months of placement (McKenzie & Sexton, 2020). Rates of depression among people living in residential aged-care facilities in Australia are estimated at 49% (AIHW, 2018).

Factors that can increase an older person's risk of developing anxiety or depression include:

- An increase in physical health problems/conditions
- Chronic pain
- Side-effects from medications
- Losses: relationships, independence, work and income, self-worth, mobility and flexibility
- Social isolation
- Significant change in living arrangements e.g. moving from living independently to a care setting
- Admission to hospital
- Anniversaries and the memories they evoke

(Beyond Blue, 2020).

Symptoms of Depression in older people can be difficult to recognize as they may present differently from younger people. Older people are likely to under-report depressive symptoms. Common depressive symptoms such as loss of interest in life, poor sleep, or impaired memory are attributed to ageing or cognitive impairment. Typical symptoms of depression in an older person include:

- Chronic unexplained physical symptoms
  E.g. dizziness, chronic aches and pains, constipation, weight loss, or insomnia
- Memory loss
  This will improve if the depression is treated, unless there is also an underlying cognitive decline
- Behavioural changes
  E.g. avoiding going out, refusing to eat, shoplifting, hoarding behaviours, alcohol abuse, preoccupations with wills etc., giving away personal possessions, talking about death, or a new interest in firearms etc.

(Black Dog Institute, 2020).

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Underlying cognitive status cannot be accurately assessed in the presence of depression. An antidepressant treatment trial is indicated (Morimoto, Yuen, Beres & Alexopoulos, 2017; Kitching, 2015). Being older does not mean treatment for depression is less effective. Improvement and recovery are possible with the right treatment and strategies. However, antidepressant medication may take longer to work so trials of six to eight weeks may be required (Black Dog Institute, 2020).

The table below provides a guide to differentiating between dementia, delirium and depression

Feature	Dementia	Delirium	Depression
Onset and duration	Slow and insidious onset; deterioration is progressive over time	Sudden onset – over hours or days; duration – hours to less than one month but can be longer.	Recent change in mood persisting for at least two weeks – may coincide with life changes – can last for months or years.
Course	Symptoms are progressive over a long period of time; not reversible.	Short and fluctuating; often worse at night and on waking. Usually reversible with treatment of the underlying condition.	Typically, worse in the morning. Usually reversible with treatment.
Psychomotor activity	Wandering/exit seeking Agitated Withdrawn (may be related to coexisting depression)	Hyperactive delirium: agitation, restlessness, hallucinations Hypoactive delirium: sleepy, slow-moving Mixed: alternating features of the above.	Usually withdrawn Apathy May include agitation
Alertness	Generally normal	Fluctuates, may be hyper-vigilant through to very lethargic.	Normal
Attention	Generally normal	Impaired or fluctuates, difficulty following conversation.	May appear impaired
Mood	Depression may be present in early dementia	Fluctuating emotions – for example: anger, tearful outbursts, fear	Depressed mood
Thinking	Difficulty with word-finding and abstraction	Disorganised, distorted, fragmented	Intact; themes of helplessness and hopelessness present
Perception	Misperceptions usually absent (can be present in Lewy body dementia)	Distorted – illusions, hallucinations, delusions; difficulty distinguishing between reality and misperceptions	Usually intact (hallucinations and delusions only present

Source: State Government of Victoria, Department of Health & Human Services, 2017.

Other differential diagnoses

The testing for dementia presumes that the person being assessed can engage at a certain level of interaction; however, there are states/conditions which may impact on the person's ability to function that must be considered. Always consider the person's lifetime level of function before embarking on testing for dementia.

Important states/conditions to consider include:

- Level of education and literacy
- Developmental disability
- Unrecognised medical or psychiatric illness
- Sensory deficits (especially relevant to testing / screening)
- Known presence of mild cognitive impairment
- Culture and language
- The setting in which the test is being conducted.

Differential diagnoses of sub-types of dementia

A formal diagnosis of the sub-type of dementia is important in order to inform treatment and management options. It is especially critical for people who are young, those who may benefit or be harmed by therapeutic interventions, and where a detailed prognosis is required.

In future, as better diagnostic tests and therapeutic options increase and become more specific, clinicians will need to be able to diagnose sub-types. Formal specific diagnosis of the sub-types usually requires referral to and evaluation by a specialist service.

It is important to note that:

- Many patients will have a mixed form of dementia, the most common being a combination of vascular dementia and Alzheimer's disease
- A differential diagnosis (DDx) assists in determining the range and extent of investigations required
- The DDx may be divided according to incidence, aetiology, and whether the condition is deemed reversible/treatable
- Mixed types of dementia are common. This fact is poorly understood by clinicians and patients.

Early diagnosis

The availability of pharmaceutical treatments and recognition of the need for advanced planning brought about a move towards seeking early diagnosis of dementia. Early diagnosis is possible. Caution is necessary when considering an early diagnosis as there are drawbacks as well as benefits.

The benefits of early diagnosis include:

- Allowing legal and life decisions to be made and advance care plans to be put in place whilst the person can actively participate

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- Allowing planning for and the implementation of strategies for person and community safety (e.g., implications for driving and other work, lifestyle issues)
- Earlier provision of information and implementation of support services can minimise early stresses on carers and family.
- The drawbacks to early diagnosis might include:
- Fear of being labelled and stigmatised, which in turn may increase stress and risk of depression
- Implications for life insurance and or work once a diagnosis has been made
- A risk that early diagnosis of dementia may be a misdiagnosis of mild cognitive impairment (MCI). See information above on MCI.
- Evidence suggests that despite some reluctance on the part of carers and health professionals, those with dementia want to know their diagnosis.

(Phillips et al, 2012).

Early diagnosis in younger people

Specialist Diagnostic Service/Memory Assessment Services (Clinic) are available in each state and territory in Australia. Further details of the closest clinic in your area can be obtained from Dementia Australia: https://www.dementia.org.au/about-us/dementia-australia/contact-us

These specialist multi-disciplinary services are best placed to do the assessment and early diagnosis of younger people.

The assessment and formulation of the diagnosis should not be made in isolation as this may increase the likelihood of misdiagnosis.

It must be noted that diagnosis has significant implications for patient and family.

Diagnostic tools, steps and tests

No single test will diagnose dementia—it is a clinical diagnosis. The ideal clinical approach is to obtain the patient's history directly from the patient and a collateral history from their family, followed by a detailed physical examination, before proceeding to simple non-invasive investigations. The following must be considered:

- Dementia is difficult to diagnose early. There are several cognitive screening tools that can be used. E.g. MMSE, RUDAS, GPCOG, MoCA. The clock drawing test should be included in the assessment.
- Key informant/carer reports are critical in providing evidence of deterioration over time; the first key marker for diagnosis
- A detailed medical history is vital to exclude depression or other reversible medical conditions. e.g. hypothyroidism.
- Physical examination including neurological examination may assist in identifying sub-types of dementia and identifying other diseases (e.g., strokes)
- Pathology tests:
    - Blood tests – full blood count (FBC), electrolytes, urea and creatinine (EUC), liver function tests (LFTs), B12, folate, calcium, thyroid function

  - Urine examination – mid-stream urine sample, microscopy, culture and sensitivity
  - In patients who are at high risk of infections – syphilis serology, HIV testing
- Imaging
  - Computerised tomography (CT) is routine, but in the absence of focal neurological signs is helpful in only a small number of cases
  - Magnetic resonance imaging (MRI) – assessment of medial temporal structures, can be helpful in MCI
- Neuropsychology assessment for complex cases or to support management.

Overview of tools and tests

A wide range of tools and tests exist to assess cognitive impairment in different patient populations. More information regarding these resources can be found at Dementia Australia: https://www.dementia.org.au/information/for-health-professionals/clinical-resources/cognitive-screening-and-assessment

It is important to note that these tools are not a diagnostic test and that no assessment tool used in isolation will confirm a diagnosis of dementia.

Dementia assessment tools

- Are useful for monitoring patient progress in the clinical setting and are used by specialist services to assist diagnosis of dementia sub-types
- May be necessary for some prescribed PBS drugs under the PBS listing. The full PI needs to be checked for recommended indications
- May assist in substantiating a subjective impression for legal requirements such as appointing a medical power of attorney or guardian.

All available tools have limitations. Clinicians using any of the available tools have a responsibility to be aware of these limitations and how these influence the interpretation of test results.

It is recommended that clinicians:

- Be familiar with a small range of tools considered most useful in their area of practice
- Understand the utility and limitations of tools

Especially

- When to administer
- What the results mean

Mini-Mental State Examination (MMSE)

The MMSE was developed in 1975 primarily to assess cognitive functioning in psychiatric patients; it is now the most widely used cognitive screening tool (Folstein, Folstein & McHugh, 1975).

The instrument is administered by asking a series of questions and giving instructions that enable assessment of orientation, registration, attention and calculation, recall, language and visual construction.

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The total possible score is 30 points and a score of less than 23–25 is suggestive of cognitive impairment.

The MMSE has been copyrighted by Psychological Assessment Resources.

The Independent Hospital Pricing Authority (IHPA) has purchased the Australian IP rights to the Standardised MMSE (SMMSE). IHPA has granted permission for all health care facilities and aged care services throughout Australia to use the SMMSE for free. https://www.ihpa.gov.au/what-we-do/standardised-mini-mental-state-examination-smmse

Advantages of the MMSE

- t is simple and quick to administer; taking ten to fifteen minutes to complete
- It can be used to monitor progression over time and is one of the most commonly used tests
- It is quick and simple test to use in an office setting
- It is currently required for the initial prescription of cognitive enhancers on the PBS in Australia

Limitations of the MMSE

- Does not allow for sensory losses
- Incorrect interpretations may create harm
- It is a screening tool not a diagnostic tool
- It does not diagnose dementia
- It requires a minimum level of education
- It is culturally and linguistically specific; as such there is some indication that it is of limited value in culturally and linguistically diverse (CALD) populations
- It is less sensitive than other tests
- Now subject to copyright costs (see note above regarding Australian availability).

General Practitioner test of cognition (GPCoG)

General Practitioner test of cognition (GPCoG) has these advantages:

- One of the most commonly used tests
- Quick and simple test to use
- Involves carers in the assessment
- Not subject to copyright restrictions

More information about the GPCOG can be found here: http://gpcog.com.au/

Further reading to review cognitive assessment tools: Woodford, H. & George, J. (2007). Cognitive assessment in the elderly: a review of clinical methods. *QJM. Vol 100*(8). Pp 469-484. DOI:10.1093/qjmed/hcm051

Several other instruments may be used in specific circumstances, predominantly by specialists / specialist centres or where educational or sensory limitations are marked (e.g. Clinicians Global Impression).

Rowland universal dementia assessment scale (RUDAS)

Developed in Sydney, New South Wales, the RUDAS is suitable for people from culturally and linguistically diverse (CALD) backgrounds as its reliability does not appear to be affected when translated into languages other than English. It is also not affected by years of education as with the MMSE. The RUDAS is a 6-item test which is easy to administer (Storey, Rowland, Conforti, & Dickson, 2004).

The original article is available here: http://journals.cambridge.org/action/

RUDAS may be accessed via Dementia Australia: https://www.dementia.org.au/resources/rowland-universal-dementia-assessment-scale-rudas

Montreal cognitive assessment (MoCA)

The Montreal Cognitive Assessment (MoCA) was designed as a rapid screening instrument for mild cognitive dysfunction and is available in a number of languages: http://www.mocatest.org

In order to utilise this assessment scale, you need to be registered and complete the online training module. Training is estimated to take one hour and has a fee.

Cognitive screening and assessment in Aboriginal and Torres Strait Islander populations

As discussed above, most of the commonly used screening and diagnostic tools are culturally specific and not suitable for culturally and linguistically diverse and Aboriginal and Torres Strait Islander populations—one exception being the RUDAS. Much research is being undertaken to develop culturally appropriate tools.

KICA-Cog

The KICA-Cog was designed specifically to assess cognition in older Indigenous people in the Kimberley region of Western Australia (LoGiudice et al., 2006). This assessment tool has since been validated for use in other Indigenous populations in Australia (Radford et al, 2015).

More information on the use of the KICA is available here: http://kams.org.au/wp-content/uploads/2015/04/KICA-Tool-2006.pdf

The decision to disclose the diagnosis

Informing the person and their family

Health professionals are in the position of informing the patient and their family of the diagnosis. A diagnosis of dementia has enormous implications for the person concerned and their family.

It remains essentially a diagnosis of a degenerative condition for which there is no available curative treatment; as such informing the person and the family causes great anxiety to health professionals and carers.

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Some health professionals experience anxiety about disclosing the diagnosis. Research also reveals use of obscure language that makes it more difficult for the person to understand the diagnosis. These anxieties are largely unfounded; research has demonstrated that catastrophic reactions to the diagnosis are rare (Cheng & Lam, 2018). People generally want to know the diagnosis. They are more likely to be anxious if there is poor follow up with additional information and support (Abley et al, 2013). The discussion needs to be a process rather than as a single event (Bailey, Dooley & McCabe, 2019).

Dementia Australia has some tips regarding communicating the diagnosis here: https://www.dementia.org.au/information/for-health-professionals/clinical-resources/communicating-the-diagnosis

Breaking the news

Informing the person and the family requires a sensitive approach. What is said and how to say it are important considerations in sharing results of diagnostic tests with the person tested and their family. No two situations are the same and each situation, as far as is possible, requires careful consideration of the needs of all those who will be affected by the diagnosis.

Referral and follow up

Dementia is a complex, chronic syndrome and as such planning for care requires an interdisciplinary approach that includes:

- Optimal management of co-morbid conditions to improve quality of life and delay need for relocation to residential care
- Access to services designed for specific patient needs, including a range of specialty clinics (e.g., CADMS, ACAS)
- Consideration of treatment options for any underlying condition or behavioural manifestations
- Incorporation of rapidly changing knowledge in speciality areas
- Contact with Dementia Australia for information, support and education.

Appropriate referral and follow-up

- Optimises health and social wellbeing of patient and carers
- Patients want formal diagnosis and prognostic information
- Support groups.

Carers require ongoing support and follow-up as dementia has a high impact on carers—including higher rates of depression—even after the person living with dementia has been admitted to residential care.

Summary

This module has described the process and importance of diagnosing dementia. It has provided an overview of the assessment and screening tools available to assist the clinician and discussed the importance of the history and excluding other possible causes of cognitive impairment. The sensitivities relating to informing the client and family of the diagnosis and the importance of referral and follow-up were also discussed

Resources

Dementia Australia: **1800 100 500** or https://www.dementia.org.au/

Dementia Australia - *The Dementia Guide*: https://www.dementia.org.au/resources/the-dementia-guide

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