The Evaluation of Community Options in New South Wales

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5 Overview: Summary of Findings and Issues to Emerge

The 14 New South Wales projects differ so widely in terms of their auspice arrangements, their physical location, the extent of their territory, their links with other services, their personnel, their client base and many other factors affecting their performance, that the identification of qualities or problems specific to Community Options as a whole has proved extremely difficult. It is not at all difficult to describe the operation of Community Options in one setting or another and to identify conflicts inherent in that situation, or specific advantages of the local arrangements. But these are not necessarily found elsewhere, or capable of being repeated if desired. Teasing out the complex, heterogeneous mass of data on projects, co-ordinators, clients, carers and services to give some sense of a coherent underlying entity has not been an easy task.

We do not, in this section, provide a detailed account of the findings of the evaluation. These, as we have noted, are contained in the main report. Here we discuss some of the main findings in order to draw out some of the issues which they highlight for service practice and policy. In this section we draw together evidence from the various components of the evaluation. For ease of reference, we discuss the findings in the same order as they appear in the body of the report.

5.1 Some Organisational Features of the Projects and Their Staff

Community Options projects are small service agencies which, though autonomous in the sense that they are not structurally a part of any other agency, are under the auspices of, or sponsored by any one of a wide range of statutory and non-statutory bodies. These include health authorities, municipal councils, local voluntary and charitable organisations and the Home Care Service of New South Wales. The projects vary a great deal in the nature of their location, the density and characteristics of the populations they serve, the physical characteristics of the buildings, the spaces they occupy and certain aspects of their organisational arrangements. They also differ considerably in size, in respect of both client and staff numbers. Whilst the staff of projects display certain similarities, for example they are nearly all women tending to be in young middle age, they have a variety of occupational backgrounds, mostly in the caring professions, in such fields as nursing, social welfare and administration.

Our evaluation has drawn particular attention to the problems and costs of service delivery in areas where population density is low. Most of the 14 projects are located in single centres but in some instances they are dispersed, with offices in different localities. These latter multi-centred projects are most commonly found in rural areas, serving scattered and sometimes remote populations. There are clearly

advantages and disadvantages in this form of organisational arrangement. The internal co-ordination appears to be more difficult and there is some duplication of administration when a project is multi-centred. It would also seem to be more difficult to make decisions associated with the prioritisation and rational allocation of resources for the project as a whole. Record keeping is also likely to fall behind, although the introduction of the FAX machine has already made an important difference here. Just as important, however, is the fact that the support and supervision of staff is more time consuming and costly when the staff is dispersed. The isolation of projects in some of the rural areas was apparent and recent plans to rationalise and further centralise the operations both of the New South Wales Department of Community Services and the Home Care Service, which sponsors some of these projects, could further exacerbate their isolation.

On the other hand, multi-centred project locations have some advantages. They enable local staff to interact with and monitor their clients more easily, to know both their clients and their clients' social situations better, to respond more quickly to client needs and to gain a better idea of the local resources available to meet these needs. We are not in a position to quantify the effects of dispersion but we can fairly confidently infer that dispersion has disadvantages that are primarily organisational in character and advantages that are primarily client-related.

However, one project serving a large and scattered population has only one office. Our discussions with the project co-ordinators and local service providers lead us to suggest some consequences of this. First, such centralisation will inevitably involve project co-ordinators in a considerable amount of travel both to visit clients and to attend inter-agency meetings, using time which could be spent more cost-effectively. Clients, it was said by some local service providers, may feel somewhat abandoned when their co-ordinator is not on the spot. Centralisation in rural areas would thus seem potentially to undermine one of the key objectives of Community Options, namely close monitoring of clients. A response to this problem which we noted during the course of our field work, (but which may also occur in other areas with more dense populations) was the use of a case manager in addition to the co-ordinator. Thus another service provider may assume the overall responsibility for the client. One possible effect of separating the role of case manager from that of co-ordinator may be to emphasise the resource aspect of Community Options. When the case manager and co-ordinator roles are separated it is perhaps easier, indeed reasonable, for the co-ordinator to be seen primarily as the person with the money, to be turned to in a more purely instrumental way by other local service providers.

We should note that we have not been able to undertake any study of the cost effectiveness of different types of arrangements, and this is clearly an area where further follow up work would be useful.

Client Contact with Community Options: the Role of the Co-ordinator, the Case Manager and the Monitor[9]. The 'on the spot' worker was able to perform a

9 For an account of the distinction between a co-ordinator and a case manager see Footnote 3.

very valuable function, whether as case manager, or as monitor of client well-being. However, it is important to distinguish the case manager and monitor roles. In our experience, the case manager has no direct organisational relationship with the Community Options project, that is, she is not a member of the staff of the project, but may have overlapping functions, which can engender some conflict with the co-ordinator. Co-ordinators in some projects, we found, were sceptical of the case manager's competence and of the adequacy of her knowledge of the client's circumstances. The monitor, on the other hand, is employed solely to keep an eye on clients. Sometimes the monitor is employed by the project and is solely accountable to the project. However, the monitor is also often a 'hands on' service deliverer employed by another service agency and merely used by the Community Options co-ordinator, either on a paid or unpaid basis, for the specific purpose of keeping an eye on the client and reporting any problems she observes in the course of her other duties. This monitor may also have dual loyalties, both to her primary employer, the service agency, and to Community Options, which sometimes results in structural tensions. Those we describe are not universal, but they are sufficient to illustrate the problems that can arise when there is a proliferation of agencies which have not clarified their respective roles vis a vis each other or their clients.

Many co-ordinators have been unable to find the time to visit their clients as often as they would like, especially those whose circumstances appear to be stable. They have had to concentrate their efforts on new clients or on those whose circumstances are particularly precarious. They thus find the monitor role very helpful, in some cases, indispensable, not just in projects covering large areas, but also in more densely populated urban areas. For the client, a designated case manager or monitor, in addition to the co-ordinator, may represent another source of support and welcome company or simply one more in an already confusing array of service personnel. There is also a danger of overlap of functions. Our Client and Carer Survey suggested that many clients, though fewer carers, were unable to distinguish the roles of the various people entering their house to help them in various ways. For some, but relatively few clients, this was undoubtedly a source of distress.

We have noted that in some rural areas the service providers included in our survey sometimes felt that clients did not see their co-ordinators often enough and felt abandoned by them. We have some, albeit very limited, corroborative evidence from our Client and Carer Survey in two of the rural areas that this was the case, but it must be said that the same survey indicated a high level of client satisfaction with the amount of contact with the co-ordinator, even when this was not particularly frequent. Clearly it is not the amount of contact and monitoring as such that is important. Indeed, too much contact was said by co-ordinators of one project, to have 'crowded' clients and carers. Rather it is important that the contact should be adequate and that the co-ordinator be available when needed. In this context, it is worth noting, as many co-ordinators pointed out to us, that even though they may make visits to clients and carers out of hours and on occasion give clients their home telephone numbers, Community Options is not, essentially, a crisis, emergency or out-of-hours service. Most services do have an answer phone facility, but as we know from personal experience this rarely gives rise to consumer satisfaction. Some

service providers feel that Community Options should provide a service out of hours and this is perhaps an area where greater clarification concerning expectations is needed.

Co-location of Community Options Projects with Other Services. Another feature of the projects which serves to differentiate one from another is whether they are co-located with other community services or exist in isolation. Most projects were co-located with at least one other, sometimes several, other services. Some projects which had been alone at the beginning of the evaluation subsequently moved into premises with other services. Sometimes this appeared to represent the result of deliberate local service policy and/or an attempt to economise. Sometimes location appears to relate to the availability of an appropriate space. Sometimes it appears to spring from the desire of the project's auspice body to integrate with other services for which it is also responsible. Nearly all the project co-ordinators and other service providers drew attention to the fact that co-location made it possible to discuss shared concerns, including those that relate to individual clients. It also provided the opportunity for the staff of different services to interact informally and to learn about each other's jobs and thereby to develop more understanding of those with whom they interact. Once again we find that some of the advantages are expressed in organisational terms and others in terms of benefits for clients. For example, a good relationship with Home Care Service can 'oil the wheels' in their negotiation for services. Co-location with a day care centre can enable the co-ordinator to see her clients and her clients' carers in a setting outside the home. It also enables her to discuss her clients' needs with the day care staff.

Co-location, Auspice Arrangements and Joint Appointments. But how close is too close? During the course of our enquiries we found that at least one co-ordinator experienced some intrusion in her own sphere of responsibility from her co-located auspice body. This auspice body, very much to the irritation of the co-ordinator, used her clerical staff for auspice body work. The co-ordinator herself was asked to undertake visits and assessments of clients on behalf of her auspice body and on occasion felt under some pressure to accept clients whom she felt it was not appropriate for her to accept. The cause of this problem may not have been co-location but it is hard to avoid the conclusion that co-location made it worse. It is interesting that this represents the only case of what might loosely be termed impropriety by an auspice body brought to our attention. However, it illustrates a structural tension that was not confined to this project.

Those rural projects under the auspices of the Home Care Service are all co-located with that service and co-ordinators were in some cases jointly employed by both services. The two services are thus very closely bound together in a variety of ways. Some co-ordinators told us that both at the time of referral and in their subsequent dealings with clients, they were often unclear as to which hat they were wearing, since nearly all Community Options clients have a need for Home Care Services as well. Thus, although required by their managers and by their conditions of employment to keep the two jobs separate, effectively this is almost impossible and, in some ways, hardly worthwhile. The overlap in the actual types of support which

the two different services provide aggravates the problem, and perhaps helps to explain why so much importance is attached in these areas to the distinctive capacity of Community Options to provide 'one-off', specialised and sometimes unique services. It is perhaps no wonder, as we found from both our Client and Carer and Service Provider Surveys, that in these areas neither clients nor other service providers clearly differentiate between the Home Care Service and Community Options.

In the circumstances we have just described, there is always the possibility of friction within services, between the co-ordinators and the managers, and between services, at the managerial level. When the Community Options co-ordinator works in an office managed by the Home Care Service, the lines of accountability are particularly unclear and the Community Options manager is placed in a particularly awkward position since, as the auspice body, the Home Care Service is effectively in the superior position as the employer. We experienced some of these structural tensions both at the local and the regional levels, and we suggest that the inter-twining of auspice body, location and jointly appointed staff can result in some organisational difficulty. Unfortunately, it has not been possible within the timescale of the evaluation to pay detailed attention to any one project, so that we are not able to unravel the individual effects of these three features of the projects or, indeed the additional effect of the interaction of the specific personalities involved. Despite the difficulties which we have just described, which are related to a unique combination of circumstances, in our experience the co-location of Community Options with other services is something to be encouraged rather than avoided. Once again, however, we emphasise the importance of clarification of the structural relationships between organisations.

Finally we should note that we were told by most projects that auspice bodies interfere very little in the day to day running and management of the project and certainly in the selection of clients. Friction seems most likely to arise when there is an overlap of function between the auspice body and the project, suggesting that the auspice function should be clearly differentiated from the service function.

We now turn to a consideration of other organisational and staffing aspects of the projects which emerged as important issues both for project co-ordinators and other local service providers.

Target Client Numbers. Each project has a target client load. It is not clear how this was arrived at, but it certainly does not appear to be related to the size of the populations which the projects are intended to serve. Although it is not possible to say with any accuracy what proportion of the **eligible** population in a given area is serviced by Community Options, not least because there is no strict definition of eligibility within the Guidelines, we can say with some confidence that it will be a relatively small proportion. It was thus easy and not without justification for other services to accuse Community Options of being inequitable. One view held by other service providers was that Community Options should open its doors to more

clients and, since it was acknowledged that further resources were unlikely to be forthcoming, to spread the existing resources more thinly.

Many Community Options co-ordinators would resist this suggestion, we believe, because, as they see it, one of the unique and most valuable features of the service is its very smallness, which enables it to provide a highly individualised service and packages of care which, though not necessarily large, are carefully tailored to meet the specific needs of their clients and their clients' carers. To enlarge the service by any substantial increase in the scale of individual projects, many co-ordinators would argue, would be to destroy its very character. As organisations grow they become more bureaucratic, rule bound and less innovative in their practices. We would not disagree with this view and there is a good deal of evidence from organisational studies that this is indeed what happens.

Target Numbers and Resources. As for spreading the resources more thinly, this, co-ordinators would probably argue, would destroy the flexibility and the capacity to provide services either at an intensive level, particularly important to those at the very boundaries of home and residential care, or to meet especially expensive needs when they arise. As the data indicate, very few Community Options projects spend up to their limits, either their overall weekly dollar limit per client, or their subsidy money designated for the purchase of services, or even their allowance for 'one-off' items, and there is certainly little, if any, evidence from case material of irresponsible or lavish spending by any of the projects. But spreading the unspent money more thinly to cover the needs of a larger group of clients would surely not be the solution because it ignores an important rationale for Community Options, namely the need for flexibility.

An examination of the data on expenditure suggests that although average expenditure on clients is relatively low, recurrent expenditure on individual clients can be extraordinarily high, far exceeding the permitted amount. Furthermore there can be considerable fluctuations in expenditure on clients. Later in this report we shall be dealing in more detail with the question of costs. Suffice it now to note that whilst some extraordinarily large individual expenditures recorded in the MDS as 'recurrent' may in fact have been mis-reported and were in fact for 'one-off' items, it is equally likely that these represent high expenditures to meet short term needs, such as very intensive nursing over a short period or a short term live-in carer, perhaps whilst the usual informal carer is on holiday or in hospital, or expenditures which will be subject to frequent review. In this way, the resources available to Community Options enable it to respond flexibly to short term crisis situations or to make the life of the carer easier in the medium to long term. We shall argue later, that whilst it need not be difficult to justify high expenditure for a small number of people, it is difficult to defend this if these people have been arbitrarily and inequitably selected.

Staff: Client Ratios. Although we understand that in the early days of Community Options the case load was set at 50 clients for each co-ordinator, in our experience the normal case load for a project co-ordinator is now in the region of 40 clients.

Case loads, we understand, can fluctuate a good deal over time. Whether or not co-ordinators actually carry a case-load of 40 clients will depend partly on whether at any given time the project actually has its target case load on its books and partly on whether the project manager or senior co-ordinator carries a full case load or distributes some of her quota of clients to the co-ordinators to enable her to fulfil her managerial, administrative and community development responsibilities. The interpretation of the role of senior co-ordinator varies a good deal from project to project, and there seem to be quite considerable disparities in the administrative loads carried by senior co-ordinators. This may in part be related to the way they interpret their managerial role and to the degree of control they exercise within the project. Both would appear to vary a great deal, but we can make no comment on the impact of varying degrees of managerial control on the project and we heard no complaints from staff that they were being inadequately supported by their own managers. We were unable to detect any clear relationship between the way the project manager performed her managerial role and either the case loads of the various other staff of the projects or the quality of work, of staff interaction or project outcomes. However this may simply reflect the fact that the evaluation was not set up in such a way as to enable such relationships to be rigorously explored.

The extent to which the administrative aspects of the project are shared between the senior co-ordinator and the auspice body will also have an impact on the distribution of work within the project. We digress to discuss briefly the administrative relationship of projects to their auspice bodies. In this regard there appeared to be some variation in practice which does not seem to be directly related to the nature of the auspice bodies themselves. Some delegate most administrative tasks to the projects, even the payment of staff salaries and other accounts. We found this to be the case in projects under the auspices of the Home Care Service and Wyong Aged and Disabled Support Services. Others, for example, the municipal councils and charitable and voluntary bodies, provide the projects with a great deal of administrative support, from purchasing cars to ordering pens and changing washers on taps. In the case of the projects sponsored by health authorities we found some variation in practice. Nevertheless, we had few complaints associated with the administrative functions performed by auspice bodies. Those that were made usually related to lax and inefficient administration, in particular to the embarrassingly slow payment of accounts.

However a complaint made by only one project, sponsored by a health authority, was that it inflicted a good deal of unnecessary work by treating the project as a unit within its own organisation thereby insisting upon a very great deal of record-keeping for its own purposes. Most projects are hostile enough to the record keeping required by government. This additional imposition was greatly resented. Although the evaluation did not reveal any clear relationship between case loads and the distribution of administrative functions between projects and auspice bodies, it would be surprising if this had no impact on workloads within the projects. Presumably if Community Options were to be established on a more permanent footing standardised arrangements would be established.

Community Options co-ordinators were of course well aware that they had smaller case loads than many of the services with which they interacted - for example, the Home Care Service, Geriatric Assessment Teams and sometimes even Meals on Wheels. However, most of them felt very stretched in their jobs and two central tasks were found to be particularly onerous. The first was the negotiation with other government funded agencies for services for their clients. This was an area which some co-ordinators found stressful and in which some would have liked additional training. As we shall discuss in more detail later, it seems likely that it was partly this stressful situation which led some co-ordinators to prefer the use of private services. The other was the mandatory record keeping. This clearly weighed heavily on the co-ordinators, many of whom felt both inadequately trained for the task and unmotivated to undertake it. We discuss this aspect of the job in more detail below.

However, it was not just the administrative aspects of the job which kept the co-ordinators fully occupied despite their relatively low case loads, and there is no evidence that these should be reduced. The detailed knowledge of their clients and their changing circumstances, revealed during the evaluation when we requested from each co-ordinator case material on a number of clients, provided impressive evidence of hard work and commitment. Co-ordinators are dealing with a highly vulnerable group of people who often have high and volatile needs. There can be little doubt that they build up, through intensive and committed interaction, a very detailed and up-to-date picture of their clients needs and circumstances and of the possible changes in needs and indeed breakdown. The one problem which both we as evaluators and the co-ordinators themselves identified was the sometimes inadequate monitoring of clients.

We noted that there was a view amongst some other service providers that the clientele of Community Options represented a highly select group. We could make no comparisons with other services, but our experience certainly confirms that clients receive a service of high quality which we feel is only achievable because co-ordinators have relatively small case loads. It would seem a pity however to lower the quality of a service merely because it was being received by relatively few people. The entire point of creating this special form of delivery is that there exists a limited population of particularly vulnerable people whose needs can best be met in this way.

However, the comparison with other services may be inappropriate. Although we have no solid data, it is highly likely, given their terms of reference, that these other services will have a much more diverse clientele in terms of level of need.

The Case Load and Clients who are not Accepted. It is also important to point out that Community Options undertake a good deal of work on behalf of people who are never actually accepted as clients and who do not appear on their records as clients. During the reference year the number of those referred to Community Options who were not accepted was equal to half of the number accepted. Community Options co-ordinators may refer such clients to other services, they may

negotiate services for clients and provide advice to clients. These activities can be very time consuming but they clearly also serve a very useful purpose. The point is that the formal records do not reflect any such work unless the clients are accepted.

Data Management and Record Keeping. Co-ordinators are required to keep very detailed records on each client. These are sometimes entered from manual forms onto the computer by the co-ordinator and sometimes by the project's clerical worker. We found a good deal of ill-feeling amongst co-ordinators towards the record-keeping component of their jobs even though there was a reluctant admission from most that self monitoring could play an important part in their job performance. Co-ordinators did not always appear to appreciate the important role of accurate record-keeping and it seemed to compete unfavourably with what they perceived as more important and rewarding aspects, for example, assessment, the setting up of care packages and interaction with clients.

Co-ordinators clearly had a great deal of difficulty in keeping pace with the record keeping, and as soon as the data collection during the reference year had been completed, in many cases it fell behind, often by several months. One can clearly have little confidence in records which are completed retrospectively after such a long interval.

These problems were aggravated by serious inconsistencies in the system as a whole. Difficulties experienced in coding, for example, tended to be resolved in an ad hoc fashion for each office which raised a query, without notification of any other project offices, to ensure uniformity of practice.

We digress here to note that part of the evaluation which makes use of the MDS is quite seriously flawed by the inaccuracy and omissions which we found in the data we were provided with. No doubt there are several reasons for the poor quality of the record keeping. Insufficient training, poor motivation and higher priority being placed on other aspects of the job are probably all contributory factors.

The lack of motivation to keep the records was, to a degree, understandable. The software used apparently did not enable co-ordinators to manipulate, for their own purposes, the information they were recording. Thus, if they wanted to know how many clients they had accepted over a given period with dementia or from non-English speaking backgrounds, or who lived in a given area and were in receipt of services, they had to resort to hand tabulation. The only details they were keeping which they had found useful were the financial data which enabled them to monitor their current budgetary position. This, it was universally felt, was a poor return for the amount of effort put into record keeping.

In the evaluation, we were able to use only a small proportion of the information collected, and even that with little confidence as to its accuracy or completeness, mostly because loose definitions and ambiguous coding rendered much of it un-usable and as we have noted above, because it had often been entered retrospectively from incomplete manual forms. One can only agree with project staff that much more careful attention needs to be given to the area of record keeping and that care

should be taken to relate the objectives of the record keeping to the amount and type of information that is collected. This is certainly not the case at the moment, the most glaring omissions being detailed information on the disabilities of clients and full details of the carers' circumstances and of the available support network. The information which is collected on expenditure is excessively detailed, cumbersome and pre-disposed to error. We would recommend that record keeping is given urgent attention and that some of the experienced co-ordinators should be involved in this process of redesign. This will require a multi-disciplinary input. The skills of an accountant are certainly required, including competent advice on financial administration.

Staff of Projects. Community Options co-ordinators come from a variety of occupational backgrounds and the issue of what disciplines and professional backgrounds it was desirable to have represented within a project aroused some interest both amongst Community Option co-ordinators and service providers more generally.

The largest proportion of co-ordinators have had some welfare training and experience; others, though fewer, are trained nurses, often with experience in community nursing. About the same proportion have worked for the Home Care Service and a smaller proportion have no professional training or experience. Most co-ordinators thought that projects should encompass a range of professional backgrounds and should certainly include at least one person with a background in welfare or in nursing. As evaluators we find this apparent perception of the inter-changeability of these two different skills difficult to comprehend. A minority of co-ordinators felt that a professional background amongst the staff of a Community Options project was not important since they had access to professional expertise outside the project. They were usually thinking of the Geriatric Assessment Teams.

We have no evidence from the evaluation to indicate whether the care of clients or the service packages they devised were affected by the professional backgrounds of the co-ordinators. The evaluation does not reveal whether projects' outcomes were influenced by the professional composition of its staff. Neither can we say whether outcomes varied according to the kinds of professional advice the projects used from sources outside the project. It seems very likely that those outside critics who argued that Community Options was deficient in certain expertise would be equally unable to show how this had effected projects' outcomes.

The issue of whether co-ordinators were either adequately or appropriately qualified was a matter of considerable interest to many of the service providers with whom we spoke in the course of the Service Provider Survey. However, despite this concern, it is of some interest that in the five case study areas, only one of the people interviewed in the course of the Service Provider Survey had actually seen the form that Community Options completes for a client and this despite the fact that some of these people were on the projects' management committees. For some, particularly those who worked in the Home Care Service and saw themselves as performing roughly the same jobs as Community Options co-ordinators (but, as many

acknowledged, less thoroughly since they had larger case loads), the question of the presence or appropriateness of particular professional backgrounds and training within the project was not a matter of great concern. They saw the co-ordinator as essentially a practical rather than a professional person. However, there was a much greater tendency both amongst the Community Nurses and the professionals we spoke to in the Geriatric Assessment Teams to be of the opinion that the projects should have on their staff at least one person with professional training. Not surprisingly, since those with a clinical rather than a welfare training are dominant in these services, a nurse was usually considered to be the most appropriate type of professional. But whilst all this might suggest a need for continuing clinical input, it could just as well mean that medical needs were already well covered and that the most urgent requirement was assessment of clients' social circumstances and the setting up of social support arrangements.

What seems important is not simply that there should be professionally qualified staff but that appropriate use should be made of professional expertise. Its availability within a project is only useful to the extent that it is used and shared between the staff of the project. Many co-ordinators said that the ready availability of other professional expertise amongst their colleagues was very helpful but we do not know the extent to which, nor the circumstances under which, this was used. What did emerge, however, was that most nurses who worked within Community Options, though not underestimating the value of the professional knowledge they had brought to the project felt that their horizons had been considerably enlarged by Community Options and through contact with other disciplines. Those with a welfare background showed a similar appreciation of the nurses. It does seem that the distillation of a range of skills is very useful. Perhaps consideration should be given to the suggestion that projects should be large enough to employ at least three co-ordinators and that these should represent nursing, social welfare and administrative backgrounds.

However, the question of the appropriate training within projects cannot sensibly be separated from the availability of advice from other sources outside the project and adequacy and ease of access to these. Some of the other local service providers argued that Community Options projects were not using the available assessment services to the best advantage. One effect of this, it was maintained, was that they were not necessarily putting their clients in touch with the kind of expertise that might make their rehabilitation or, at the very least, some improvement in their functioning, a possibility. It was argued by a few that some Community Options co-ordinators were taking their advocacy role too far, indulging their clients wants rather than treating and meeting their needs, as these would be defined by a professional. Whether or not this was the case, there was no doubt that it was attributed to the inadequate use of professional expertise, either from within or from outside the project. Indeed, even projects where staff had nursing training and usually community nursing experience were subject to this criticism. The following allegedly typical example was provided. A co-ordinator would arrange for absorbent pads, daily showers and a bed linen service to be provided for someone with incontinence. But these items might well be unnecessary if the incontinence itself

were treatable. The client might really need an intervention program to reduce or eliminate the incontinence which would be a much more cost effective approach than the help provided by Community Options. Clients were not receiving the available treatments because Community Options co-ordinators were not trained to judge whether and how a condition could be treated.

We have no way of knowing how many or indeed whether any clients who could usefully be receiving rehabilitation programs were not receiving them. Nor are we in a position to know whether assessment and treatment services are reasonably accessible to Community Options clients in all locations. A further important ethical question is whether, in the event of a client's refusing treatment, other types of help should also be withdrawn. However, the real issue is whether the client has access to the full range of assistance that is available in the community, and there are compelling reasons at both the practical and the ethical levels for arguing that she or he should. We would argue that a co-ordinator should marshal the full range of community resources and encourage their use by clients. We have no evidence one way or the other, apart from the anecdotal evidence of some of the other service providers that they do not. The case studies indicate that some use is made of the available resources in the community. How appropriate or adequate this is in individual cases we are unable to say.

Many co-ordinators expressed reservations about Geriatric Assessment Teams. Some felt that the quality of their assessments left something to be desired, being often cursory and sometimes anxiety-producing. The assessment itself was rarely truly multi-disciplinary even though the team itself might be. A further problem, which some noted, were long waiting lists for their assessment services.

Clients are referred to Community Options projects because of a combination of social and medical needs and Community Options co-ordinators should ensure that both are attended to. For us, as evaluators, this is not a question of the dominance of a medical or social model. It seems clear that clients of Community Options projects, as evidenced by the fact that they have become clients, will have a wide range of needs deriving from their mental and physical conditions and their social situations and that they can be at risk of institutionalisation on account of any or all of these factors. It therefore behoves co-ordinators who are charged with caring for such people to use all the available services and advice, including clinical assessment services. It would seem to us that the good co-ordinator is one who knows the full range of resources in the community, knows her own limitations in respect of assessment and recognises when it is appropriate to seek other expert advice for the benefit of her clients. Some would argue that this does not require any particular professional background but it may well require a good deal of in-service training on how to determine the needs of clients and what to do about them. Most co-ordinators greatly appreciated the training they had had and wanted to know more, particularly about the conditions of the clients with whom they were dealing.

5.2 Clients and Carers

Many clients who are referred to Community Options projects are not accepted because, for one reason or another, the referral was not deemed appropriate. Although there are important variations in the demographic characteristics of specific projects, overall Community Options clients are much more likely to be over than under 65 years of age. Their average age is 71 years. They are also much more likely to be women than men. Over two thirds have an informal carer with whom they live in most cases. Whatever the domestic circumstances, however, if there is a carer, that person is most likely to be a woman. Nevertheless, as many as one third of clients live alone. In general, Community Options clients are not affluent. Over four-fifths receive the full Age Pension.

Community Options clients have multiple health problems but do not typically need particularly intensive nursing or personal care. On the other hand their need for help in many of the other necessary activities of daily living is high, even when compared with people in the general population who have been identified as having a severe handicap. About one-fifth of the clients have been diagnosed as suffering from dementia or are displaying signs of it. By the time they become clients about one third have been assessed as eligible for residential care of one sort of another. This is more likely to be the case for those with than for those without dementia. About a third of the clients who were included in the reference year had left the project by the end of that year and about a third of these had entered long term care. Clients with dementia are at particularly high risk.

The Level of Client Dependency. Self referrals constitute a small proportion of the total. Community Options projects depend largely for their clients on referral from other services. Although, as we shall see, a large number of referrals are judged inappropriate, Community Options will only have clients referred to them when the referrer **believes** this to be the most appropriate course of action for the client. If the referrer believes that the most suitable option in a given case is residential care and secures admission for the client, Community Options will have no opportunity to assess whether the client could be enabled to remain in the community unless the client and/or carer are adamant that he or she will not go into residential care. A high proportion of nursing home residents as we know, go directly from hospital to residential care.

Despite the fact that for this reason a number of potential clients may never be referred to Community Options, there is a good deal of evidence from the evaluation that clients of Community Options are a group with many health problems and a high dependency on the assistance of others for some of the most important activities of daily living. The Client Dependency Form and the Client and Carer Survey indicated that dependence on others for the instrumental activities of daily living was greater than dependence on others for personal care. As we note elsewhere, a very high dependence on personal care would probably make it financially impossible for Community Options to assist a client, except in the very short term, or with very considerable input from informal carers.

Whilst, according to the Client and Carer Survey undertaken in the five case study areas, as many as 35 per cent did not require help with any aspect of personal care, nevertheless at least 50 per cent did need help with bathing and showering and, nearly 50 per cent needed assistance with their medication. In contrast to this relatively low need for help with personal care, all but one client included in this survey required help in the instrumental activities of daily living, for example, getting to places out of walking distance, shopping, preparing meals, housework, gardening, minor and major home maintenance, using the telephone and handling money, and a very large proportion needed help with several of these activities. Those unable to perform any one task are unlikely to be able to perform some others. Inability to perform these tasks is often a function of problems with mobility and, as this survey indicated, a great many of the health problems identified emanated from stroke or muscular-skeletal conditions.

An incapacity in most of the areas we have just described would render a person at risk of institutionalisation were that need not to be met. However, this need for assistance does not necessarily imply large and expensive care packages. The data suggest that many clients' needs can be catered for at fairly low cost unless some extraordinary event occurs. There are probably not too many clients around the upper limit of $200 a week. It appears that clients who combine high risk with high long term need for services tend not as a rule to be accepted as clients of Community Options, and where they are accepted have a very rapid turnover, moving reasonably quickly into residential care.

In addition to the recorded levels of dependence there is other evidence that Community Options is dealing with a frail population. We have noted that a relatively high proportion, in fact about half of all referrals, are from a health source. Both from the Minimum Data Set and from the Client and Carer Survey we know that the highest proportion of these were referred by community nurses and that the next highest proportion were referred from the hospitals themselves. It is of some interest, but a finding by no means unique to this study, that a very low proportion of clients were referred by GPs. This suggests that GPs were in general not well informed about Community Options, or about their patients' full circumstances, for one might have thought that being involved with primary care they would be concerned to make use of all the available community resources.

Additional evidence of high dependence is provided by the fact that 35 per cent of clients had been deemed eligible for residential care during the reference year, and 30 per cent who were accepted as clients of Community Options during the same period had actually entered residential care by the time of the evaluation. The clients' dependency profiles certainly suggest that a hostel would be a more suitable type of residence than a nursing home for a large proportion of clients. Unfortunately the Minimum Data Set does not distinguish between hostels and nursing homes as forms of residential care. Our belief is that it should.

Finally, the fact that other service providers, who were not reluctant to criticise Community Options in other respects, were of the view that Community Options

was accepting appropriate clients gives grounds for confidence that the clients are indeed at high risk.

Selection of Community Options Clients. How do co-ordinators select their clients? How do they know whether or not they should accept a client given that no rigorous criteria for selection are offered in the Guidelines?

We should first note that a very large number of the people who are referred to Community Options are not, in fact, accepted as clients. Roughly one third of all referrals during the reference year were rejected. This is almost certainly an understatement of the number of rejections since it would appear that many people who approach Community Options are never registered as referrals. Brief enquiries, we discovered, were in many projects simply not recorded.

Evidence from the MDS shows that the most common reasons for not accepting clients are that meeting their needs would clearly cost more than $200 per week, that their needs can be totally met by the other services or that their only need is for a little bit of advice or help to get them over the next few weeks. Though such referrals are not accepted they may nevertheless be helped by the co-ordinator.

We are not in a position to state whether Community Options clients represent the highest need clients or those at greatest risk in the areas served by Community Options. To establish this we would need to undertake a community census. Perhaps more important, we also do not know whether clients of Community Options are more likely to avoid institutional care for a longer period of time than people with similar needs. The only evidence we have that Community Options delays the movement to residential care is the opinion of most Community Options co-ordinators, as well as some case studies which provide good corroborative evidence.

In fact, a very high proportion of clients included in the Client and Carer Survey said that had they not had the benefit of Community Options they would still be living at home. Whether they would or not is another matter. Many seemed mainly concerned to assert their personal determination to stay at home. But an even higher proportion acknowledged the improvement that Community Options had made to the quality of their lives and to making their lives at home easier. They valued the help of Community Options and of the services. We were sometimes given the impression by other local service providers that Community Options was particularly effective in dealing with the family situation in a holistic manner and sometimes even that Community Options is a service for carers. Our impression from the Client and Carer Survey is that this is indeed the case. We found carers highly appreciative of the support of Community Options and of their acknowledgement of the role carers perform. In fact, in cases where there is a carer, average expenditure is greater than where there is no carer, which is probably a reflection of the fact that the carers, many of whom are themselves frail, are also being supported, often with respite care, which can be provided often at quite high levels. It may also be that some carers are effective advocates.

But this does not tell us how co-ordinators **do** make their decisions. One way of furthering our knowledge of this is to find out how they select clients from their waiting lists, if they have them. Only about half the projects have what they describe as a waiting list. Where they do, some select on a first come, first served basis, but more frequently they select on the basis of their assessment of the clients' vulnerability and the extent to which they believe them to be at risk of avoidable institutionalisation, usually following extensive consultation with other service providers with whom the client is in contact.

The notion of vulnerability is extremely important. The co-ordinators judge the degree of vulnerability firstly on the perceptions and accounts of other service providers and perhaps the referrers' assessment. Co-ordinators make at least one very long visit to the client home, but they may make more than one visit before deciding to accept a client. They place a primary importance on the domestic support arrangements. Quite often there will be a period of reflection during which the co-ordinators think about the client and possible courses of action. The regular team meetings held by most projects provide an opportunity to discuss borderline cases and cases which are going to be expensive either at the level of recurrent expenditure or for 'one-off' items Our observations suggested that whilst co-ordinators have considerable autonomy, there is an opportunity in these very small and intimate working environments for advice and guidance and the sharing of experience with more experienced peers.

Some co-ordinators told us how difficult they find it in some cases to exercise this judgement, although they find it clear cut in others. They will say things like: 'She was obviously a Community Options client', and when questioned about what that means she will say: 'Well, I knew I could help her and if I didn't the whole thing was going to collapse. I could tell the carer was at breaking point', or: 'She was desperate not to leave her home and I knew she didn't have to, even though the doctors (or the family) were pressuring her'. Sometimes, the co-ordinator will admit to mistakes. 'I didn't realise that I wouldn't be able to manage it ... how near things were to the end'. Some other service providers commented that Community Options co-ordinators were over-enthusiastic, over extending themselves and finding it necessary to withdraw later because of the expense. This may happen. It is likely that every co-ordinator will have a few examples to offer of the mistakes that can be made. But we received no complaints from clients in the Client and Carer Survey about withdrawal of service and we are not in a position to say whether this occurs at all frequently.

In summary it would appear that the crucial factors determining whether or not a co-ordinator will accept a client are the apparent level of vulnerability and need for close monitoring of changes in circumstances, a strong desire on the client's part to remain at home and whether the project can provide all the necessary services within the funding limits. Vulnerability may stem from many sources: isolation and insufficiency of social support, the likely breakdown of the informal care arrangements and inability to deal with the bureaucracy, poverty or family circumstances. The judgement of any one of these is unavoidably subjective. Most

co-ordinators, in making their assessment will draw on a very wide range of sources of information about the client, including the referrer and other service personnel with whom the client has had contact. Many co-ordinators would like a more systematic and fool proof method of assuming what they take to be a considerable responsibility. They know that the criterion of being 'at risk' is essentially subjective. It is for this reason that some co-ordinators prefer to accept a client on the basis of their eligibility for residential care. If this has not already been approved they will, as a matter of course, obtain medical or other appropriate professional advice. The great majority of co-ordinators do not do this but will base their judgement on the range of circumstances described earlier in this paragraph.

It is relevant to ask whether the selection of clients on the basis of their subjectively assessed vulnerability is a justifiable way of operationalising the objectives of Community Options and of defining the eligible population. One could say that it is defensible in so far that it works. But unfortunately we have no rigorous measure of this. One might suggest that a more defensible approach would be to define the objectives as the support of those who have been **judged to be eligible** for residential care but who would prefer, if possible, to remain at home provided that, in the judgement of Community Options, they can be enabled to stay there, within the funding limits and without being a danger to themselves or others. This definition would make the selection of clients less arbitrary than at present. It is surely somewhat perverse to charge Community Options with the task of preventing 'premature' and 'inappropriate' institutionalisation, when there are already criteria for admission to residential facilities and established procedures set up to ensure compliance. These procedures must be presumed to exclude the admission to residential care of all those who do not have a need for care ('inappropriate') at least not yet ('premature'). It would be less ambiguous to identify those who are eligible but whose admission was **avoidable** in conditions they found **acceptable**. According to the information from the full range of sources employed in the evaluation we think that it is very unlikely that there are many current clients of Community Options who would not be eligible for some form of residential care.

5.3 Service Packages

Much of our analysis of service packages was confined to the last three months of the reference year. Whilst there were a very considerable number of combinations of service types within the service packages, during this period the size of packages received by clients was in general small, most containing two services or less. During this period the 14 projects together used about 1000 service providers, over half of whom provided services on a for-profit basis. About 38 per cent of all service **transactions** were funded entirely by HACC, 28 per cent by Community Options, 14 per cent from other government and non-government sources and the remaining 20 per cent by a combination of these three funding sources.

The Impact of Community Options on the Receipt of Services. Before becoming Community Options clients, many people were, of course, receiving community

services of various kinds. Those most commonly received were housekeeping, home nursing, delivered meals, respite and day time personal care. These services continue to feature prominently in the packages arranged by Community Options but are not as significant a proportion of the total, because Community Options also organises the provision of more specialised personal services. Full time or live-in housekeepers, shopping and meal preparation services, overnight personal care, other home based services such as counselling, bill paying and home maintenance, alarms or equipment, social support and transport all assume greater prominence in the wider array of services procured for clients by Community Options. It seems clear from these details that Community Options is taking into account the entire circumstances of clients' lives and adding services which increase their sense of security, their capacity to participate in social activities and thus the quality of their lives.

The Composition of Service Packages. The analysis of the data on service packages proved exceptionally difficult. This is because we were dealing with a very diverse range of information all of which can change from week to week. The range of information includes:

- the actual type of help or service type provided (e.g. personal care, home help, respite care);
- the type of provider (HACC, COPs i.e. services provided by government or private agency but paid for with COPs subsidy money or Other - usually a non-HACC government-funded service or some combination of these); and
- the unit of service, (hours per week, per fortnight etc., occasion, kilometre).

In the three month period for which we analysed the data, most clients received packages containing two services or fewer, and the number of packages containing four or more services were not received by more than a fifth of the clients. As we have noted, the smallness of packages should not be taken to indicate low dependency. A highly dependent client or carer may only feel the need for a very limited number of services. The data from the Client and Carer Survey indicate that formal services are heavily supplemented by support from informal carers. On the other hand, even the small service packages contained, overall, a large mix of service types or forms of help, indicating the very wide range of clients' needs and the versatility of the Community Options response.

Since the Home Care Service itself provides a range of service types, it is worth examining the service packages to see whether they could have been provided in their entirety by that Service. A closer look at some of the larger service packages reveals that although, by and large, they comprised services which are also provided by the Home Care Service, they usually also contained a service which the Home Care Service does not offer, for example, visits from neighbours, home nursing (as opposed to personal care), a Vitalcall or other single purchase of a piece of equipment.

There is no doubt that in some cases, all the services received by a client could be and maybe are provided by the Home Care Service. In these cases it is legitimate to ask why Community Options has become involved, apart from the fact that the person may require the kind of intensive monitoring that the Home Care Service would probably find difficult to provide. Community Options may be purchasing services from the Home Care Service because the Home Care Service is not itself in a position to provide the amount of service required. This either necessitates a subsidy from Community Options or means that the Home Care Service would have to cease providing a service to some of its own clients who are assessed as lower priority. In all but one case, respondents to whom we spoke from the Home Care Service acknowledged that Community Options was able to provide both additional services and more intensive service delivery than they themselves could. They felt, however, that but for the 'one-off' expenditures, they would be able to provide just as much as Community Options could were they to be given the additional resources. This, of course, represents for some Home Care Service staff a source of grievance with government and of resentment towards Community Options. Community nurses were also, we found, aggravated by what they perceived as the support of Community Options at their expense.

It is clear that Community Options is purchasing a considerable amount of service from the government funded agencies, indicating that these are short of resources for eligible clients as they would otherwise provide services without cost to Community Options. However, as we have noted the definition of eligibility changes according to the level of resources available. No-one has an actual entitlement to services. Since the completion of the field work for the evaluation, there has been a change in the Home Care Service Guidelines as they pertain to the relationship between the Home Care Service and Community Options. All Community Options clients are now to be treated by the Home Care Service as belonging to their highest priority category of client and **entitled** to core services at the level determined by Community Options. Except in extraordinary circumstances, Community Options will not be required to pay for any of the services after an eight week period. Unless additional resources are forthcoming from government, the almost inevitable effect of this change will be that the Home Care Service will come under some pressure to cease providing services to lower priority clients. Many Home Care Service staff are likely to be distressed about this because they see a limited service to low priority clients as serving a significant preventative function.

However, a likely consequence of the new Home Care Service Guidelines will be to enhance the resources of Community Options, no longer required, or even allowed, to buy services from the Home Care Service beyond a period of eight weeks. This will free money for Community Options to buy services from private contractors. Again, many Home Care Service managers and indeed other service providers, particularly nurses, would not see this as appropriate. Services provided by private contractors and agencies such as Dial-an-Angel, may be cheaper than some of the government-funded services but, it is maintained, that their workers rarely have the same amount of training as Home Care Service staff and are usually not protected by industrial awards. These, it would be argued, may appear restrictive and quite

possibly result in a higher cost service, but at the same time they protect both employer and employee in very important ways. For example, we understand that back problems are a serious concern with Home Care Service field staff and that new regulations relating to the maximum weight that a single field worker is permitted to lift have been introduced. The effect of the new Home Care Service Guidelines will be to increase the temptation for Community Options to use private services which do not necessarily provide adequate protection for their staff. It was also argued forcefully by some respondents that government money is being diverted to the private sector to the detriment of the public sector when the two are not competing on an equal basis.

Unfortunately, in the time available, we were unable to determine from the data recorded during the reference year how much of the COPs subsidy money is spent on private and how much on government funded services. However, information that we have on the relative costs of services bought from private contractors and publicly funded service agencies suggests that the former were considerably cheaper. Most Community Options co-ordinators we spoke to were favourably disposed to using private contractors, partly because they **were** cheaper and partly because they felt that purchasing on the private market gave them more control over the delivery of the services. Related to this, the use of private services released them from negotiating, and sometimes pleading, with other government services to help them out. The quality of private services was not a source of concern to co-ordinators. They argued that they monitor them carefully and that if there were any problems they would simply cease to use an unsatisfactory person or agency. Co-ordinators provided examples of occasions when they had done this. Most co-ordinators were not convinced that the publicly funded services were of a higher standard. However, some were not of this opinion and had a strong preference for using the public sector services, sometimes on ideological grounds, sometimes on grounds of quality, sometimes because of the fear that workers could be exploited, and sometimes on grounds of service continuity. The evaluation is not able to comment on the quality of the private services used by Community Options but it is clear that this issue has important implications for inter-agency relations and we return to the question in our conclusions.

We have noted above that service packages are relatively small. Our Client and Carer Survey indicated that a great deal of the caring, despite the contribution of the formal services, is still undertaken by informal carers. Amongst service providers we found a mixed reaction to the support provided to carers by Community Options. One of the representatives of an auspice body we spoke to said that she had a slight concern that Community Options was helping out the 'yuppie' carers, namely adult children who were using Community Options to care at government expense for their elderly parents when they could well afford to pay for private services themselves. Another Home Care Service branch manager asserted that Community Options was not good at ensuring that the immediate family 'pulled its weight'. She cited examples of strong and healthy sons and daughters who lived locally and who could well, for example, mow their parents' lawns, yet Community Options was paying for someone to come and do this for them. Yet a number of the service

providers felt that an understanding of family dynamics was a particular forte of Community Options. Some called it a 'carer service'. We saw little evidence that Community Options is undermining the roles and responsibilities of the family. Rather they could said to be reducing the burden of care and making the task more manageable. We have heard of many cases where Community Options make strenuous efforts to engage the family as a whole in the putting together of care packages.

Nevertheless we did detect a concern that people are sometimes being paid to do what one might expect them to do out of a sense of family or neighbourly responsibility. From the case study material we see that neighbours are sometimes paid by Community Options to help out clients in various ways, for example by meal preparation and sometimes just to keep an eye on clients and thereby provide them with a sense of security. This is an area which has marked ethical and ideological overtones. A strong emphasis is currently being placed on the need to nurture and support family, neighbourly and community obligations and responsibilities. But this could be said to ignore some stark social realities. For example, the absence of genuine communities, especially in urban areas, the pressures on the nuclear family and in particular families in which both partners are employed. It also ignores the reality of family and social dynamics. Many older people are reluctant to exploit the family relationship, fearing dependency and the bad feelings that can be created by imposing themselves and their needs on others. Their inability to reciprocate may reinforce their feelings of inadequacy and low self esteem. The reverse side of the coin is that families may already be under enough pressure without the additional burden of the care of older members. Indeed the inability of the carer to continue in this role was said to account for quite a high proportion of the movement of Community Options clients to residential care during the reference year. We heard from some projects that people tended to become clients too late, when the family was already on the point of breakdown, and that often a great deal more could have been done to prolong the caring capacity of the family had the client been referred to Community Options earlier. Our impression from the case study material was that, far from destroying a sense of family obligation, Community Options co-ordinators were sensitive to those factors that were most likely to nurture the family contribution in a realistic way. We have already noted that the Client and Carer Survey indicated that carers were particularly appreciative of Community Options.

5.4 Costs of Service Packages

The average overall gross expenditure of Commonwealth money per client per week was $99. The average expenditure net of client contributions was $85. There was considerable variation between projects but in no case did expenditure exceed or even approach the permitted $200 limit. Similarly nearly all Projects spent only a small proportion of their subsidy money for each client. However, the high standard deviations indicate that the variation in expenditure per client was considerable in all projects and that a few cases of high expenditure were counter balanced by a large number of clients with relatively low expenditure. As might be expected,

expenditure on clients with dementia was relatively high. Expenditure on clients with a carer was also relatively high, especially when the client and carer were co-resident.

Levels of Expenditure. The average weekly expenditure per client over the reference year was well below the maximum permitted expenditure of $200 per week per client. The highest spending project (Liverpool) spent only 63 per cent of this amount (net of client contribution). The lowest spending project, the North West Aboriginal project, spent as little as 10 per cent of the permitted level (net of client contribution). On average, the projects spent just 43 per cent of the permitted amount. However, there was quite a wide variation among the 14 projects. One spent under 30 per cent, four spent between 30 per cent and 40 per cent and the remaining nine spent 40 per cent or more of the permitted expenditure. The standard deviations were high in all cases, indicating that the averages were considerably affected by high expenditure on a few clients.

Thus the cost of providing services for this group of people ostensibly at risk of inappropriate institutionalisation is, on average, not only lower than the cost of nursing home care, but also lower than the subsidy paid by the Commonwealth to hostels when personal care is involved. However, as we have noted, clients as a group are not comparable to the population of nursing home residents in terms of their levels of dependency, being at the lower end of the spectrum. Community Options would not be in a position to pay for some one who needed a great deal of personal care. We estimate that anyone who needed more than about two and a half hours of personal care a day would not be affordable by Community Options unless a great many of their needs were being met by an informal carer.

What are the reasons for these low expenditures? There are several possible explanations, although much more analysis would need to be undertaken at the individual level (both project and client) to tease out the relative importance of the various contributory factors. However, we suggest the following:

- projects are too frugal because they are afraid of overspending. Community Options staff know that they are accused of overservicing and this makes them unnecessarily cautious in their approach;
- Community Options clients are receiving all the basic services they need but not the services providing them with as high a quality of life as they could enjoy. That is, there is some penny pinching by projects. Although it is frequently said that Community Options provides a 'Rolls Royce Service' it actually does not;
- the case loads of Community Options projects does not and cannot contain a high proportion of clients with very expensive needs. Community Options has as its clientele people who may be at high risk of residential care but who have needs which can, in most cases, be met at relatively low cost, given that informal carers provide so much assistance. In addition, the referrers may be siphoning off many of the high need/high cost clients to residential care

without sufficient consideration of the alternative possibilities in the community;

- money that should be spent on recurrent items is in fact being spent on 'one-off' items thus actually reducing the amount available for recurrent expenditure; and

- if high cost clients go into hospital, or for some other reason leave the project for periods of time (thereby ceasing to constitute a cost to the project), the effect will be to deflate the average expenditure per client and thus increase the amount by which the project underspends;

The data we have collected from the full range of sources used in the evaluation would suggest that, although any one of these factors may be operating at the level of individual projects and/or individual clients, the strongest contributory factor is the third. We have noted that although projects tend to contain a number of high cost clients, these are balanced by a larger number of low cost clients who, though at risk of or eligible for residential care, have needs that can be met at home without great expense. The question one needs to ask is: are there other clients who would be able to stay at home longer were their higher needs met? One of the questions raised by the underspending is whether projects are selecting clients as appropriately as possible. Whilst we are reasonably confident that they are selecting clients who fall within the Guidelines, one needs to ask whether they are selecting the most appropriate clients of all the potential clients within the Guidelines.

Community Options co-ordinators do not in general spend all of their subsidy money. As with the upper limit of $200, it is unclear what the basis was for the levels at which the subsidy money was set. Only one project (North East New England) overspent this allowance and one other project, Hornsby/Ku-ring-gai, spent an amount that approached the approved level. The other 12 projects greatly underspent their subsidy money and five projects spent less than 50 per cent of their permitted amount. We can suggest a number of possible explanations for this.

- Almost inevitably a relatively high use of subsidy money implies relatively low expenditure on HACC services. Thus, projects which spend a particularly low proportion of their subsidy money are likely to obtain a high proportion of their services at little or no cost from the publicly funded services. We are not in a position to demonstrate that this is the case but it is of some interest that **amongst** the lowest spenders of subsidy money are those projects under the auspices of the Home Care Service who may have received especially advantageous treatment from that service because of their special relationship.

- Under use of money intended for the purchase of services may be associated with its use for the purchase of 'one-off' items, thus depleting funds for the purchase of services. We know that this is occurring in one project, at least, and it suggests that there perhaps needs to be more interchangeability of the 'one-off' and subsidy money to take account of special local circumstances.

- High expenditure of subsidy money may be associated with pressure from other service providers. The North East New England project which, amongst all projects spends the highest proportion of its subsidy money, and indeed exceeded its allowance, displays a combination of circumstances which may account for its high expenditure. Firstly the project is strongly integrated into the service system through its membership of a number of local 'at risk' committees and there is a relatively high level of local professional commitment to the philosophy of Community Options. Secondly, the project covers a rural area and therefore calls for a high expenditure on non-statutory and 'one-off' items. (We have noted that transport costs account for the expense and relative inflexibility of services in rural areas.) It is often cheaper to pay a local private contractor than to use the publicly funded services covered by award conditions. Thirdly the level of client contributions is relatively high, suggesting a more affluent population which may be favourably placed because they are able to contribute a higher proportion to the costs and therefore can be offered more; fourthly the co-ordinator was recruited from outside the service system and may therefore be prepared to be particularly innovative in the services she provides. Hornsby/Ku-ring-gai is another relatively high spending project. It is sponsored by Mercy Family Life which also has a strong commitment to the goals of Community Options and has a strongly philosophical involvement in the provision of services more generally. By comparison with some of the other auspice bodies it takes a very active interest in Community Options and has strong views as to its direction. Like the North East New England project it also has a relatively high level of client contributions.

We are not able to tease out the importance of these influences nor are we able to say with any certainty whether they even represent valid explanations. However, it does appear from the data that there may be some disjunction between the objectives of Community Options and the permitted levels of expenditure. It may also be the case that there is insufficient scope for the flexible use of resources. We believe that there may be scope for further experimentation in this area.

5.5 Discussion

Our evaluation has shown that the concept underlying Community Options meets with virtually universal approval. The co-ordinators who are responsible for making it work feel that it indicates the right way forward for services in Australia. The paramount importance given to self determination and the wishes of the individual, the emphasis on the whole person and on flexibility, are all aspects of the philosophy of Community Options which receive warm support from co-ordinators. In these respects the co-ordinators contrast their own styles of working with those, on the one hand, of the more bureaucratised services (the Home Care Service, in particular) and, on the other, with the more medically or health-oriented services (in these cases Community Nursing and Geriatric Assessment Teams are singled out). In contrast to these, the self-image of the Community Options co-ordinator is as a carer, friend

and advocate who has the additional advantage of being well-informed about local services and how to obtain them and even has the resources to do so. In these circumstances, as most co-ordinators conceded, the Community Options approach puts into the hands of one person a capacity to persuade, influence and even control clients which must be exercised with the utmost responsibility.

Co-ordinators say that much of the stress in their work is caused by bureaucratic requirements which they see as interfering with the kind of positive achievements just mentioned. The paper work and record keeping are felt to be the most oppressive aspect. However, there are other features which many find stressful. Most co-ordinators had experienced frustrations in their dealings with the other services. This, by and large, they attribute to territoriality and the envy of the extra funding available to Community Options. Although many speak of the marked improvement in their relations over time, the potential for tensions between services is recognised as ever present. Another source of difficulty is the ambiguity in the Guidelines surrounding the definition of the eligible clientele. Some co-ordinators are concerned that they are accepting the 'right' clients. Again, many have gained more confidence with time, recognising that their decisions have to be based on a mature assessment of the totality of the clients' circumstances. So long as they make every effort to uncover these, they believe this is the best they can do. On the whole, they have confidence in their own judgement.

The rules relating to expenditure are another problem. Whilst co-ordinators do not feel that they necessarily need more money, many certainly would like to be able to use what they have more flexibly. Some would like it to be legitimate for them to use some of their subsidy money for 'one-off' items. This is a wish expressed most fervently in rural and remote areas where the purchase of 'one-off' items often appears to be the most cost efficient way of servicing people. Many co-ordinators would like greater freedom to purchase private services and feel that to be enabled to do so would be more in keeping with the philosophy of flexibility and cost effectiveness articulated in the Guidelines. Finally, some feel that they should be permitted to spend more money on their very high need clients. These co-ordinators are not asking to be allowed to go above their expenditure limit for clients overall, but merely to be able to use this as an average for all clients in much the same way as they are allowed to use their subsidy money. The underspending of most Projects clearly indicates that co-ordinators are not acting recklessly and therefore, it is thought, there would be little danger in allowing the funding to be used more flexibly. As evaluators we too would feel that there is scope for examining the impact of a more flexible use of resources. Whilst all these matters emerged as irritants, they certainly did not reduce the co-ordinators' strong commitment to Community Options as a form of service delivery.

Clients, too, have little but good to say about Community Options. Whilst most of them do not believe that they are depending on Community Options to keep them out of residential care (which does not, of course, mean to say that it is not) they feel that it is supportive, provides them with almost all the services they need and enables them to feel secure. Carers, too, have found the service almost faultless. In common

with most other surveys of consumer satisfaction with services, we had few complaints. Whilst we are not confident that all the clients and carers were able to distinguish between Community Options and the other services they were receiving, their very great enthusiasm for the services generally can be said to embrace Community Options.

Other local service providers we spoke to during the course of the evaluation are also almost universally highly supportive of the notion of Community Options. In their judgement, Community Options co-ordinators are undoubtedly selecting clients who are at high risk of residential care and express confidence in the careful attention that co-ordinators give their clients. Many freely express their envy of the extent to which Community Options can help clients. They tend to attribute this to the freedom Community Options enjoys to purchase services that clients need and, to a degree, to the co-ordinators' relatively small case loads. However, depending on the service whose views were being solicited, there are some quite serious criticisms. The most substantial of these are:

- the service is inequitable in that all people in equivalent circumstances do not have an equal opportunity to obtain the superior service of Community Options. An aspect of this criticism is that Community Options does not serve a sufficient proportion of the population at risk;
- the basis of the selection and prioritisation of clients is unclear;
- Community Options, as a separate organisation, merely adds to the existing melange of unco-ordinated services. It does nothing to deal with the problem of service fragmentation, in fact it adds to it;
- the resources currently directed to Community Options would be better spent enhancing the capacities of existing services. These urgently need additional resources and also have staff with the kind of professional capacity and experience which is needed and which those in Community Options often lack;
- Community Options uses public money to purchase private services when the quality of those services is uncertain. In any event, there are strong objections, in principle, to using public money for the benefit of the private sector and starving public services on the pretext that one is putting the two sectors into healthy competition. In fact they compete on an unfair basis since the public services are more regulated, more open to public scrutiny and are required to have conditions of employment based on industrial awards;
- Community Options fails to act in the best interests of clients by not using the existing assessment services to full advantage; and
- Community Options uses public money to indulge clients. Its philosophy emphasises client self determination. The effect of this is, at public expense, to over-service clients and indulge their whims. In contrast, Community Options should focus on clients' **needs**, on rehabilitation and an improvement of

function. In this way the same resources could be focused on more clients to better effect, and the overall goal, to avoid inappropriate institutionalisation is just as likely, if not more likely, to be accomplished.

This is an array of objections which, if sustained, would be compelling. Although many represent no more than expressions of opinion they cannot simply be dismissed on that account. Some have a degree of plausibility and they do emanate from a group of people who, though they undoubtedly have their own interests, speak with a force borne of relevant experience. It is also of interest to note that these opinions are the very reverse of almost all the favourable views of Community Options particularly emphasised by co-ordinators. These, it should be noted, were also based on very much the same amalgam of opinion and relevant experience. There is no doubt the issue is in some sense ideological.

While it is difficult to resolve this complex set of questions, it is perhaps worth standing back to look at some of the conceptual issues which underlie the debate. In doing this we shall concentrate on the distributional and structural problems rather than those of practice. This is because we cannot possibly comment on those aspects of practice which are the subject of some of the criticisms described above, since neither we, nor those who express such views, are in a position to say whether, for example, over-servicing is so widespread as to be a serious concern, or whether there are a great many clients who could have their functioning improved if only Community Options staff had the professional competence to identify them, or even whether the outcomes of professional assessment are better than the outcomes of those done by non-professionals. The most we can say is that Community Options should be **structurally well placed** to take advantage of the resources that are available in the community to meet the needs of their clients.

A further issue with strongly ideological overtones concerns the purchase of private services. It is clear that the capacity of Community Options to purchase private services is an integral part of the program, which helps to provide it with its uniqueness. It is indispensable to the flexibility which underpins the philosophy of Community Options. The question posed by critics of Community Options is how to deal with a situation in which public services are found to be so insufficient that another public agency must resort to private alternatives. It is in these circumstances that the issue comes into sharpest focus and is articulated in terms of quality, regulation, unfair competition and the deployment of resources. This important question lies at the very root of much contemporary debate. Although we have alluded to this question throughout the report, we make no attempt to resolve it here. Its resolution, we believe, must lie in the political arena.

The Eligible Population

The evaluation pointed to the fact that many Community Options clients are people with high need for support but of a particular kind; that is, social support. These needs are not necessarily of the kind that the nursing homes and, therefore the Resident Classification Instrument which we used in our evaluation, are designed to

deal with. The fact that clients appear to have a relatively low need for intensive personal care services does not mean to say that they were not people likely to end up in nursing homes. Indeed a problem of international scale is the fact that people who do not need nursing home care because of infirmity end up there for social reasons. This was precisely the problem that Community Options was designed to redress.

Community Options exists to support people who would otherwise be at risk of institutionalisation. Let us suppose that the service were to be introduced on a scale sufficient to reach the whole population in need. On present evidence, we have no way of determining the size of that population. This in itself is perhaps not an insuperable difficulty, as the level of demand would become clear enough in due course. However, it draws attention to an important question of principle which affects the operation and standing of Community Options in the service world. It helps some people and not others. If the service is to survive in the face of criticism from the public and other service providers it needs to be very clear that the basis on which it selects its clientele is fair and reasonable. One solution to this problem, which we might call the strict interpretation of the Community Options brief, is to insist that the service accepts only clients already assessed as eligible for admission to residential care. This is unambiguous. It means that the initial selection criterion is independently applied, and it is clearly in line with the expressed objectives of Community Options. It amounts to defining the task of Community Options as a sort of guardian angel, poised to rescue people on the brink.

It might be objected, however, that leaving the selection of clients to this stage is to abandon an important preventative function which Community Options might well perform earlier, which could have the effect of reducing the numbers of those reaching the brink, or at least of deferring their arrival. To widen the selection criteria in this way, however, could open Community Options to possible charges of arbitrariness and inequity.

As far as the identification of need and the realisation of objectives are concerned there are two problems. First, as we have just noted, we lack information about the distribution of needs within the population. The second is that we lack the experimental research which would simply compare populations and areas with and without Community Options to see who is going into which of the different forms of residential care and for whom, if for any group, Community Options is most effective. Both of these types of data are necessary to establish the extent of the need for services of different types and to discover how effective Community Options is in enabling people to stay at home.

Of course the issue is not just about preventing institutionalisation. It is also about the quality of life of people in and out of institutions. Research on the Kent Community Care Scheme in England has shown that people live longer and their morale is higher outside of institutions, and all achieved at no greater cost (Challis and Davies, 1985). Though people living in the community undoubtedly experience isolation, according to the results of carefully designed measurement scales, their

morale is likely to be significantly higher than it would be in a nursing home surrounded by other people.

Our evaluation has also shown that people with high needs have a strong preference for remaining in their own homes. Do we have any reason to believe that Community Options is the best way of enabling them to do this? Is there any reason to have this form of service, in addition to the existing services? This raises the fundamental question: is Community Options doing a good job? It would be possible to set out the requirements of a rigorous and exhaustive evaluation of Community Options, with matched controls, standardised measures of quality of life, specified price constraints and other refinements. Such a study would involve substantial populations, investigated over a period of years rather than months. It would be expensive and time consuming but it would be possible to answer some of the questions beyond our present capability. The evaluation on which we report here has nonetheless made some reasonably confident conclusions possible.

Community Options does help clients with high levels of need in ways that we have shown other services have not been able to do. The clients express satisfaction. Community Options staff believe they are providing an effective service and other service deliverers, despite a variety of particular reservations, generally support the principle of Community Options. Although as we have already noted, a definitive answer would require a different kind of evaluation than the one we have been able to undertake, the accumulated findings from the various strands of our evaluation suggest that Community Options is probably doing a good job.

A second question, which assumes the acceptance of the Community Options model, is whether there is any rationale for the separation of Community Options from the other two initiatives which we discussed at the beginning of this paper, that is, from one of the 'hands-on' HACC services or from GATs. Is there any rationale for three separate organisations with basically the same objectives for similar though, not in each case, identical populations. If there is no justification, which organisation does Community Options best fit with or is a new form of service system needed altogether?

To answer these two questions we need to establish what it is that Community Options brings that is distinctively valuable. We would identify two features. The first is its brokerage role, with all the other facilities that this implies. The second is its small size.

The Legitimacy of the Community Options Model

Brokerage and the Purchase of Service. A notable feature of Community Options is that it 'ring fences' or earmarks extra resources which can be used for a specific population, making possible intensive support of a kind which 'mass production services' have much more difficulty providing. 'Ring fencing' creates a capacity to concentrate resources on particular individuals and indeed to break the traditional rules of equity. That is its very purpose; to ensure that some people do receive more

help, because they need it. One could argue that the same effect could be achieved by putting the money into the ordinary services. The serious danger of this is that resources could easily be dissipated to no good effect when stretched across a larger number of people. The point about Community Options, or a service like it, is that by earmarking money it deliberately addresses a particular population selectively and, even within that population, operates selectively without attempting to meet everybody's needs. In doing this, it achieves a comprehensiveness for a small number rather than a small amount of service for a large number. It also moves out of the traditional service system.

An arrangement such as Community Options, which focuses its resources on only a small number of people, must be able to justify spending the money on those it provides for and, furthermore, not spending it on those that it passes over. It can do this either by demonstrating that it is achieving its objectives in the most cost effective way which it has not thus far been possible to do or it must demonstrate that the people for whom the money is intended are indeed the people on whom the money is being spent. It is also difficult to demonstrate this conclusively, largely because eligibility is so loosely defined.

We have raised the possibility that a tighter, more careful definition of eligibility would have some advantages and that formally assessed eligibility for residential care could provide the kind of legitimacy that Community Options needs. Indeed, we came across at least one Project which employed this criterion and we have no reason to believe that it was any more officious or unfriendly than any other project we visited. We feel that the definition of an eligible population is very important. It is not only important that people who receive the service should fall within the Guidelines but for the service to be seen to be equitable it is also important to be able to distinguish recipients from non-recipients or at least to be able to demonstrate unmet need in the eligible population.

So far we have looked at the distribution of resources and tried to justify the concentration of resources on relatively few people. We began to indicate the kind of conditions in which it is most likely to work. But does all this mean that Community Options should occupy its own sphere, separate from other services, or should it be integrated into an existing service system?

Smallness of Scale. The small scale of Community Options, we would suggest is its second distinguishing feature. The combination of small case loads and small groupings of staff, all directed towards a single goal, with a well articulated set of guiding principles creates the conditions for a caring rather than purely functional professional relations with clients. They also provide the basis for a holistic approach, which promotes flexibility and emphasises client self-determination. These qualities seemed to us as observers, to be combined in a special way in Community Options, and it is difficult to see how they could be preserved if Community Options were to be incorporated in a larger organisation. The effectiveness of the projects depends very much on the maintenance of immediate, face to face, personal ties, both between clients and staff and among staff in the

project office. All those staff we interviewed were clear that the inescapably rule-driven ethos of the large organisations was inconsistent with the spirit of Community Options. If co-ordinators sometimes seemed unreasonable in their antipathy to imperatives of administration, their instincts were nonetheless sound, we believe. There is an important sense in which selecting and arranging for the delivery of services for dependent clients calls for a level of commitment and sensitivity which is only likely to be sustained in small close knit teams of workers, unencumbered by heavy administrative structures.

In addition, Community Options is a specialised agency. It is concerned with packaging rather than delivering. Its concern is to get a comprehensive package of appropriate services to meet a range of needs and it uses advocacy and monitoring to aid it in this process and to meet the clients' real needs. In addition it can step outside the statutory services in looking for the contents of the package. This is not what producers or deliverers of services are necessarily able to do. It is not their speciality. We would suggest that different skills and organisational requirements are called for. We therefore find it difficult to envisage a continuation of the special contribution that Community Options makes were it to be assimilated by a larger organisation.

We have characterised Community Options Projects as small, autonomous, free standing agencies, each with a small group of clients whom it can help effectively because it is small and has money earmarked for that purpose. But we must address the issue of how Community Options should relate to other services, and how it can best be organised administratively. Community Options was introduced on a pilot basis employing a variety of administrative arrangements. It was intended that the evaluation would identify and assess the different effects of these organisational arrangements.

Auspice Arrangements

The auspice body is legally responsible to government for the use of the grant and the operation of the project in accordance with the funding conditions and the Community Options Guidelines. As such it is responsible for the employment of the staff of Community Options projects and also provides the projects with administrative support.

The projects covered by the evaluation had a variety of auspice bodies; service delivery organisations, voluntary bodies, a community-based group and local government. We do not wish to suggest that any one of these represents as it stands, a preferred model. We are simply concerned to identify, from the various sources of information upon which we have called during the evaluation, some of the relevant features of each.

Public sector service delivery organisations such as the Home Care Service and Health Authorities seemed to have certain advantages as auspice bodies. These lay mostly in the realm of training and professional support, though it must be conceded

that this latter was sometimes interpreted by co-ordinators as domination. In some cases, we detected quite considerable structural tensions when the employer and service deliverer roles were combined. It was seldom clear where the authority of the employer began and ended. We detected some unwelcome pressures in the day to day conduct of the job both in the case of the Home Care Service and the Health Authorities. The overlap of interests of Community Options with those of other service delivery organisations seemed to lead, if not to a competitive relationship, at least to one that was blurred. Service delivering organisations have clearly established views about how things should be done which employers can find it difficult to challenge. It sometimes seemed that as employers they had doubts about the validity of Community Options as an independent entity, because they could see it taking on tasks for which they themselves had been established: in the case of the Home Care Service providing a range of personal care and social supports, and in the case of Health Services dealing with essentially infirm people. Thus, while the objectives of Community Options were thoroughly accepted, in so far as auspice bodies saw Community Options as intruding in a sphere properly their own, there was occasionally some confusion of professional and employment relationships.

Those projects sponsored by voluntary non-profit making service delivering organisations expressed a good deal of satisfaction with their arrangements. What seemed to distinguish these auspice bodies from the publicly funded service deliverers was the non-competitive relationship which had been established although we observed with both types of service delivery organisations a similar, rather unquestioning adherence to their own role and style of operation.

Voluntary bodies seemed to have a particularly strong commitment to Community Options, and their philosophies and practices meshed well. They had not had Community Options foisted upon them; they had sought an involvement and it was in their interests to provide the kind of support that would make it work. Furthermore, the large voluntary organisations frequently have at their disposal a good deal of expertise in administration and financial management which Community Options found useful because it is what the projects themselves tended to lack. However, these organisations are not uniform in their practices, they are difficult to monitor systematically and they are located outside the public sector.

In contrast, local councils have well defined and durable administrative structures. They can provide wide ranging and reliable administrative support and they have no difficulty in confining their role to the provision of this service. They tend naturally to adopt a purely functional and neutral position vis-a-vis Community Options and their administrative support when it was combined with a committed and supportive management structure comprising key local service providers and consumers seemed, from our observations, to work reasonably well. The projects under the auspices of councils in general found them helpful, supportive and non-intrusive but with a tendency to sluggishness. No doubt the local councils find it difficult to identify with the culture and style of operation of Community Options. It is clearly a matter of the contrast between a large general-purpose organisation with continuing, legally prescribed official responsibilities touching the lives of the whole population,

and a small, flexible body with a specific task and a commitment to immediate tangible results affecting relatively few people. This simply shows up as a difference between two styles, one shaped by regulation and routine, the other distinguished by a 'problem-solving' culture and 'get-up-and-go'. Relations between Community Options and the councils were not, as far as we could see, marked by any hostility. Such difficulty as there was took the form of frustration experienced by Community Options.

Were Projects to be located with local government, an issue that would remain is that of professional support and accountability. What seems to be required is a considerable clarification, strengthening, formalising, even regulation of the relations between Community Options and the other services.

Organisational Arrangements

Community Options certainly appears to occupy a vulnerable place in the world of services. It is highly dependent on the goodwill of other services. On the whole, it lacks authority and service legitimacy. No doubt this can be attributed in large measure to its newness, to its small scale and to its experimental status. We also see it as a result of its lack of a clearly defined place amongst other services, with which it has no well articulated system of reciprocal obligations or expectation. Community Options appears to rely greatly on an informal and highly personalised acceptance rather than on a regulated and statutory system of rights and obligations. A great deal of its energy therefore goes towards a struggle for recognition and acceptance.

A major concern is Community Options' autonomy combined with its over-lapping functions with other service agencies. Greater integration or co-ordination would perhaps create the conditions for:

- rationalisation and cost saving;
- the diffusion of good practice;
- better access for clients because there would be fewer doors to open;
- reduction in the number of services and an enhancement in the resources of those remaining; and
- an enhanced capacity to co-ordinate services for clients.

Whilst we feel that it is entirely feasible to locate Community Options within an existing service we do not believe for the reasons that we have outlined earlier, that this is necessarily the best way forward. The danger is that it could suppress the very creative and imaginative qualities which seem to give Community Options its strength. We feel that whatever solution is adopted should involve a reduction of the elements of uncertainty, ambiguity and occasional rivalry between Community Options and other services. Rights, responsibilities and expectations should be

established with sufficient clarity to eliminate the wasteful dissipation of energy on case-by-case negotiation, as though co-ordinators were seeking so many personal favours.

Though our contact with the North East New England Community Options Project was limited it did impress us as a model well worth further investigation. Community Options there is under the auspices of the Glen Innes Municipal Council which is also represented on the management committee, so that the responsible officer is able to gain an insight into interagency dealings and service objectives and cultures. Whilst Community Options in this locality is in some senses autonomous, it is also well integrated into the local service systems through an 'at risk' committee structure. Like all the other services it is accountable to these committees which exist to ensure the optimal use of resources with the totality of interests of the clients in mind. The operations of each service agency are open to the scrutiny of all the others. The over-riding philosophy of the 'at risk' committees is to maintain people in their own homes and to optimise the use of the resources to ensure that this happens. No one service is in a superior position. All have their roles and that of Community Options is primarily to meet the needs that the other services cannot provide. Sometimes the Community Options co-ordinator will be the case manager and sometimes the representative of another service will be. Because this model was designed with the specific problems of service delivery in a rural area in mind, the local case manager and Community Options co-ordinator roles are often distinct, but this is not an inherent feature of the model. This 'at risk' committee structure clearly takes much of the autonomy from Community Options but, at the same time, provides it with interdisciplinary and professional support.

We do not suggest an uncritical, wholesale replication of the North East New England model but it appears to us that there is a great deal to be learnt from this case. Many of its best features relate as much to the local service environment as to the project itself. In fact, Community Options appears to have been so thoroughly integrated with the structure that it is sometimes difficult to see it as an independent entity. One might see this as a negative feature in an environment of another kind, but in North East New England the philosophy, and as far as we could judge, the practice of the 'at risk' committees completely embody the guiding principles of Community Options.

With all relevant agencies committed to the implementation of a Community Options-type program, the distinctive contribution of Community Options itself remains the earmarked money. This, though it may seem to suggest a somewhat attenuated role, should not lead us to overlook the fact that Community Options staff are full and active participants in the entire collaborative process and remain responsible for administrative continuity. The multi-agency, multi-disciplinary approach to the assessment (that is an explicit co-ordination of the medical and social approaches) and the management of clients was the outcome of a thorough process of collaborative local preparation, which is certainly one feature of the model which could be imitated widely to good advantage. As to the effectiveness of these arrangements, it is clear that Community Options suffers less questioning of its

legitimacy and greater assurance that it will enjoy the support of other services and that its clients will receive the benefit of a co-ordinated deployment of local resources. The extent to which these gains involve the sacrifice of one of its most distinctive and highly valued features, namely its advocacy role, is something that would need to be watched closely if the model were to be considered for wider adoption.

The evaluation of Community Options has revealed both commonalities and diversity among the Projects. The geographies, the characteristics of the populations served, the service environments, the scale of operation of the Projects themselves and personalities of the people involved are but some of the factors that combine to distinguish them. Yet all are highly recognisable as service agencies. We have been able to look at their operations from a variety of perspectives, to identify some of their strengths and their difficulties. The task is to overcome the early insecurity of Community Options and to regulate its relations with other services without destroying that unique character which has the potential to contribute a great deal both to its highly dependent clients and the wider service system. It has clearly made significant progress already.

Appendix One

List of Problems Found in the Minimum Data Set

There have been a number of problems with the Minimum Data Set. Due to the enormity of the data set, not all of these problems have been resolved. It is to be hoped that the most important problems and inconsistencies have been rectified, thus allowing some sense to be made of the figures provided. Some of the major problems on the client file were:

- exit dates (of clients) being before their date of entry onto the program (sometimes due to the client having left and then re-entering);
- some carers were listed as being less than 11 years old;
- multiple entries with the same client number within the same project;
- incorrect dates of birth implying a very old client (more than 110 years old);
- some clients not being on the computer at all;
- people receiving or requesting unrealistically high amounts of service at the time of assessment (for example, 45 hours of home maintenance or 70 incidences of delivered meals in one week);
- incorrect ethnicity codes being found (for example, non-existent ethnic codes being used);
- incorrect service codes (for example one-letter having been entered where a three-letter code was expected);
- clients listed as receiving or requesting services at the time of referral, without the number of hours or incidences of that service being listed;
- people listed with an exit date but no entry date;
- people with both dates and codes for non-acceptance as well as dates and codes for leaving the program (leading to double-counting);
- status codes not correlating with a persons' actual status (for example a code implying that a person is still a client when they are listed as having left);
- the question about additional assistance in mobility, personal care, toileting or housekeeping required by the client (on page two of Form B) was interpreted differently by all projects and therefore has not been used;

- many carers were listed in an incorrect relationship to the client or in a totally incorrect age-group (for example a 45 year old client had a 52 year old son as the carer; another person had a child 67 years younger as their carer;
- one client was listed as being female when in fact he was male.

On the provider file:

- one provider was listed under a project number of 110. As we are not evaluating a project with this identification number, this case was deleted;
- some services were assigned an incorrect value for their funding category variable, for example Home Care Service listed as other than HACC funded.

On the transactions file the following problems occurred:

- the amount of service being received has been listed differently by different projects. For example if a client receives 6 home-delivered meals per week, some projects have listed this as 6 incidences per week (i.e. one for each meal) while other projects list this as 1 incidence of delivered meals per week. (This also applies to the client file);
- one project informed us (and it is possible that others may do this) that they average the number of hours of service over the month and enter an equivalent figure for each week of the month, thus disguising any variation between weeks;
- where net costs were negative, client contributions may have been entered incorrectly (as too large) or no cost was entered for the service. In the latter case imputed costs were entered as the cost of the service. This was done by the Department of FACS before the data was passed on to the Centre;
- because the data-entry system used by the projects did not allow for incorrect entries to be deleted, one project added separate negative entries in order to compensate for the incorrect entries. Both the incorrect and the negative entries have been deleted leaving this project with usable data;
- cost figures were sometimes in incorrect columns (for example the hours of service were allocated to HACC, the unit cost of the service was allocated to HACC, but the total cost of the service was allocated to someone other than HACC);
- about half of the projects had no transactions listed for one week of the year. The particular week differed between projects;
- all projects had some transactions listed as ending on a date which was not the end of the week - all these dates had to be recorded so that the transactions had a consistent date for the week ending;

- some clients had transactions in weeks before they became clients (or the entry date is incorrect);
- some transaction records have no code for service type and no service provider number, but there is a service description, or else it is a 'nil service' transaction but an Other contributor is listed;
- the total cost figure for a number of transactions does not equal the number of hours or incidences multiplied by the cost per hour or incident;
- total cost figures are sometimes recorded against the wrong transaction (for example, the total for a costly one-off transaction against a recurrent service and vice versa);
- a cost is often listed against a transaction record labelled 'nil services';
- a number of the errors listed result in the figure for the total cost of a service package in a given week being either over- or underestimated;
- instances occur in which the same amount of the same service is listed twice in one week, but each with a different total cost;
- unit costs have sometimes been put in columns applying to HACC, COPS and Other, yet there is a total figure in only one of these columns.

Undoubtedly others exist which have not as yet been discovered. Some of the problems we have identified thus far on the client and transaction files obviously occur more frequently than others. When considered together they constitute a not insignificant problem.

Finally, all the data was entered retrospectively and in many cases well after the assessment or service took place. This created problems, particularly in cases where forms had not been filled out completely and/or where the relevant co-ordinator had since left the project.

As many of these problems as possible have been rectified by contacting the individual projects. **All** projects have suffered at least some of these problems. All have been extremely helpful and efficient in providing the correct information. Approximately mid-January to mid-March was spent telephoning projects, waiting for replies, uncovering new problems, writing programs to correct errors and then checking that the problems had been overcome.

Nevertheless, the data should be interpreted cautiously. The patterns illustrated rather than the actual numbers/percentages are probably most reliable. Numerous problems do still exist and cannot be rectified in the time available.

Appendix Two

Client Dependency Form

Form 1

Name of Project: ..... **Name of Project Co-ordinator:** .....

Client's Identification Number: ..... Is the client **currently** a Community Options Client 1 Yes 2 No

Please base your answers on **your** knowledge of the client, select the response that most accurately describes his/her average personal care requirements **AT THE TIME OF THE CLIENT'S ACCEPTANCE TO YOUR COMMUNITY OPTIONS PROJECT and circle the appropriate letter or number.**

- Day or daily refers to a 24 hour period.

1a	**Transfers** - includes all transfer activities i.e. to, from and within bed, chair, wheelchair, walking aids etc. Rate bedfast clients (e.g. terminally ill) C or D as appropriate.	A Required no assistance.	B Required observation/ encouragement but no 'hands on' assistance.	C Could not transfer without 'hands on' asssistance from one person.	D Could not transfer without the assistance of at least two people (includes the use of a lifting device).
1b	**If C or D**, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	
2a	**Ambulation (walking) or wheelchair** - Rate client on mobility ONLY, not transfers to and from mobility aids; these have already been accounted for in Question 1. Rate bedfast clients C or D as appropriate.	A Required no assistance to walk or used a walking aid or wheelchair.	B Required observation/ encouragement but no 'hands on' assistance to walk or use a walking aid or wheelchair.	C Could not walk or use a walking aid or wheelchair without 'hands on' assistance from one person.	D Could not walk or use a walking aid or wheelchair without the assistance of at least two people (includes the use of a lifting device).
2b	**If C or D**, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	
3a	**Toilet** - Rate clients who required bedpans, urinals and commodes, B, C or D as appropriate.	A Required no assistance or had a colostomy **and** a catheter.	B Required observation/ encouragement but no 'hands on' assistance.	C Could not toilet without 'hands on' asssistance with some but not all activities.	D Required full assistance with position, toilet hygiene and adjusting clothing.
3b	**If C or D**, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	
4a	**Bath/Shower** - Rate sponge baths C or D as appropriate. Do not include need for asssistance with transfers (Q1), mobility to bath/shower (Q2), or dressing (Q5).	A Required no assistance.	B Required observation/ encouragement but no 'hands on' assistance.	C Could not bathe without some 'hands on' asssistance.	D Required full assistance with bathing/showering.
4b	**If C or D**, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	

Client Dependency Form (cont.)

5a	**Dressing** - includes grooming, fitting of artificial limbs, hearing aids and calipers.	A Required no assistance.	B Required observation/ encouragement but no 'hands on' assistance.	C Could not dress without some 'hands on' assistance.	D Required full assistance with dressing.
5b	**If C or D**, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	
6a	**Eating** - includes fluids as well as solid food. Does not include food preparation (e.g. cutting up, vitamising).	A Required no assistance.	B Required observation/ encouragement but no 'hands on' assistance.	C Could not eat without some 'hands on' asssistance.	D Could not eat without full assistance.
6b	**If C or D**, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	
7a	**Continence: Urine** - If client was catheterised, rate A and include required care in Q10.	A Continent or had a catheter.	B Incontinent but not daily.	C Incontinent once daily.	D Incontinent regularly more than once daily.
7b	**If C or D**, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	
8a	**Continence: Faeces** - If client was catheterised, rate A and include required care in Q10.	A Continent or had a catheter.	B Incontinent but not daily.	C Incontinent once daily.	D Incontinent regularly more than once daily.
8b	**If C or D**, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	
This client regularly Required and was provided with:					
9a	**Prevention of pressure areas** - refers to frequency of attention required to prevent and care for pressure areas, including changes of position.	A Infrequent or no attention.	B Attention 1 - 3 times day (every 8 hours).	C Attention 4 - 6 times day (every 4 - 6 hours).	D Attention more than 6 times per day (more frequently than every 4 hours).
9b	**If B, C or D**, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	

Client Dependency Form (cont.)

This client regularly Required and was provided with:

10a Specialised nursing procedures - does not include routine nursing procedures. Some examples of procedures to include are colostomy/catheter care, unstable diabetes, extensive topical skin care, isolation/ barrier nursing procedures, extensive complicated dressing, inhalation therapy, administration of complex medication etc.	A No specialised nursing procedures.	B Less than $^1/_2$ hour of attention per day.	C $^1/_2$ to 1 hour of attention per day.	D More than $1^1/_2$ hours of individaul attention per day.
10b If B, C or D, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	

This client regularly Required and was provided with:

11a Behaviour - refers to behaviour which resulted in additional nursing and personal care requirements (usually a manifestation of the client's mental state). Examples include disorientation, confusion, aggresivencss, severe agitation or extreme anxiety, wandering and noisy, disruptive or self-destructive behaviour. Exclude routine or normal levels of social and emotional support.	A No additional attention.	B Less than $^1/_2$ hour of direct individual attention per day except for crisis as in C (ii).	C (i) At least $^1/_2$ hour of individual attention per day. OR (ii) Attention for 2 or more hours at least once a week on an episodic basis.	D More than 1 hour of individual attention per day.
11b If B, C or D, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	

This client's overall service need was:

12a Overall service need - Answer for client's overall need for nursing and personal services.	A Low.	B Fairly low.	C Medium.	D Fairly high.	E High.	F Very high.
12b If C or D, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both			

13a Food preparation - refers to ability to manipulate cooking implements and knobs on appliances, cut and peel, remember stove is on.	A Required no assistance.	B Required observation/ encouragement but no 'hands on' assistance.	C Could not perform without some 'hands on' asssistance.	D Required full assistance.
13b If C or D, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	

Client Dependency Form (cont.)

14a Home upkeep - cleaning - refers to ability to dust, sweep, wash dishes, wash clothes.	A Required no assistance.	B Required observation/ encouragement but no 'hands on' assistance.	C Could not perform without some 'hands on' asssistance.	D Required full assistance.
14b If C or D, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	
15a Mobility outside home - refers to ability to get out of house: either to garden or street.	A Required no assistance.	B Required observation/ encouragement but no 'hands on' assistance.	C Could not perform without some 'hands on' asssistance.	D Required full assistance.
15b If C or D, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	
16a Shopping - refers to ability to get to a shop, and purchase food/clothes and transport purchases home.	A Required no assistance.	B Required observation/ encouragement but no 'hands on' assistance.	C Could not perform without some 'hands on' asssistance.	D Required full assistance.
16b If C or D, who provided assistance?	1 Informal carer(s)	2 Service(s)	3 Both	

Questions 1-16 above refer to client's disability **at the time he/she was referred to Community Options** - The following quesions refer to the **client's current situation.**

17 Is the client still living in the same residence as when he/she was referred to Community Options? 1 Yes 2 No

If Yes, do not answer any futher questions. If no, please answer the rest of the questions. If the person is no longer a Community Options client, please answer the rest of the questions to the best of your ability.

18 When did the client leave that residence (the exact date, if known; the approximate date, otherwise)? .....

19 Why did the client leave the residence? (All reasons).

20 Where is the client now living? 1 Another person's residence. 2 Hostel. 3 Nursing home. 4 Other (specify) .....

21 Do you think there is any possibility that the client will return to his or her former residence? 1 Yes 2 No

Appendix Three

A Note of the Proceedings of the Senior Co-ordinators' Workshop

Community Options: Evaluation Workshop
State Library, Sydney: 27 November 1990

Program

10.30 Welcome and introductions

10.45 Proposals for evaluation

11.00 Discussion: Theme I: Achievements

12.30 Lunch

1.30 Discussion: Theme II: Issues of concern

3.00 Discussion: Theme III: What would we change?

4.30 Conclusion

Note of Workshop Attended by Community Option Project Co-ordinators, Held on 27 November 1990 in the State Library, Sydney, in Connection with the Evaluation of the New South Wales Community Option Projects (COPs)

Present: Representatives for all Projects included in the evaluation; Sara Graham, Co-ordinator of Evaluation, Social Policy Research Centre (SPRC); Michael Fine (member of the evaluation team, SPRC).

Discussion of issues

The workshop focused on a discussion of three themes or questions. These were:

- What, do you think, are the most positive aspects and achievements of your Community Option Project?
- What, do you think, are the main problems and issues of concern for your Community Option Project?

- What are the main things that you might want to change in your Project if you could start all over again.

What follows is a summary of the issues raised in the discussion of each question.

1 What, do you think, are the most positive aspects and achievements of your Community Option Project?

1.1 Flexibility and the personal approach, for example:

- establishing a personal relationship with clients and being able to act in a personal rather than a bureaucratic manner;
- tailoring service packages to the specific needs of individual clients;
- establishing a reputation for reliability;
- being able to respond rapidly and, as required, to client needs;
- both stimulating the development and encouraging the flexibility of other local services;
- encouraging the development of a team work approach, across services and professions.

1.2 Providing service choices for clients and carers, for example:

- identifying client needs and service options to meet these needs; helping clients to take advantage of these options and to make choices between them;
- getting together 'holistic' packages of services;
- helping disadvantaged clients (for example, Aboriginal clients and those from non-English speaking backgrounds), who might otherwise not be served, to achieve support from services;
- responding to carers' problems;
- acting as an advocate and empowering clients;
- establishing an on-going monitoring service and thereby providing a safeguard for clients.

1.3 The community development role and impact on broader community services, for example:

- contributing to improved approaches to assessment;
- contributing to the improvement of interservice liaison and referrals;
- having a co-ordinating and integrating role for local services. this has, in part been achieved by setting up and/or participating in local service provider meetings, 'at-risk' communities and so on;
- encouraging and initiating teamwork between services;
- extending ideas of what might be considered 'legitimate' levels of service provision by questioning some of the more traditional and sometimes rigid notions of 'acceptable' levels of assistance from services; and
- helping to break down some of the professional demarcations.

2 What, do you think, are the main problems and issues of concern for your Community Options Project?

2.1 Data collection and management, for example:

- initial problems in the introduction of the system were mammoth and exceptionally time-consuming. By and large it remains very time-consuming;
- some problems remain in the computer format and some of the codes are subject to a variety of interpretation. One example given was that the code for source of referral distinguishes between two broad sources of referral for people from non-English speaking backgrounds i.e. 'interpreter' and 'other'. The 'other' category is not sufficiently illuminating to be helpful e.g. to know where promotion of CO can best be targeted;
- a great deal of time and energy is expended on the keeping of records which, in many cases, are not of great use to the Projects themselves. It is often difficult to access grouped information in a way that would be helpful either to the Projects or to their Management Committees;
- insufficient training has been provided for Project staff in the use of the computer;
- serious problems, as yet unresolved, have occurred in the estimation of the computer;

- the **interpretation** of data for different Projects should take into account the availability of local services since this can seriously affect the costs of these services. However, co-ordinators expressed doubt as to whether this **is** actually taken into account. This limitation is particularly relevant in rural areas, where services are generally poorly provided; and

- the choice of the sample week, used to determine the subsidy level for new projects had been a poor one because it was atypical. Despite this, policy decisions were made on the basis of data collected during this week.

2.2 Rules/procedures and practices associated with COPs themselves, for example:

- the rules which relate to the use of non-HACC services and private services by COPs are often unrealistic, given that there is sometimes a paucity of alternatives;

- there are unresolved and complex problems associated with the employment of private services. These relate, for example, to insurance/compensation, income tax and so on. Clearer advice and standardised practices are urgently needed;

- fee collection is a problematic area because there is a conflict between the role of broker and advocate on the one hand and fee collector on the other;

- staff/client ratios, client numbers and ceilings all present difficulties in their actual implementation. The job of case manager or co-ordinator involves a complex range of tasks which are often difficult to prioritise and indeed carry out in a satisfactory manner, given staff/client ratios, for example;

- the administrative aspects of the job are very onerous and the competing claims on the available time of the administrative and case work functions present quite serious difficulties for co-ordinators workers;

- the conflicting claims on time of community networking, community development work and inter-agency liaison on the one hand and case work on the other presents difficulties; and

- guidelines or rules which arise in response to a specific situation are often ad hoc and rarely documented.

2.3 External relations with other local services, for example:

- variations exist between services in their assessment procedures and the sometimes medical dominance of their assessments;

- different HACC-funded services may give priority to specific groups, sometimes leaving the needs of COPs clients unmet. Especially difficult for the COPs co-ordinators is Home Care Service's priority treatment of people with very high dependency and its increasing emphasis on the prevision of personal care to the detriment of homecare and housekeeping tasks which many COPs clients are greatly in need of;

- the Home Care Service's charging policies in general and its 'Purchase of Service' and '8 week rule' in particular;

- the importance of matching the service worker to the client is not always recognised by the Home Care Service; and

- especially in rural areas, a lack of respite facilities and, when available, their high cost, present serious difficulties. As a result, COPs staff are not always able to pay sufficient attention to the total needs of the family.

2.4 The program itself and relations with Federal and State governments, for example:

- uncertainty about the future of the Community Options Program is anxiety-provoking;

- there are sometimes inconsistencies in information, rules and procedures provided by DCSH and FACS; on the other hand,

- there seems a desire on the part of Federal and State governments to impose rigidities and strict adherence to rules when this is inappropriate. Local circumstances call for flexible and appropriate responses which take into account individual and sometimes unique local circumstances;

- the average costs do not take sufficient account of the frequent need to purchase services. This is particularly relevant in country areas, where many public services are poorly provided; and

- the rule and sometimes the ambiguity of those rules which pertain to the targeting of services can lead to considerable dilemmas for case managers. Whilst a potential client may not fall clearly and unambiguously into the COPs target population, to deny support often seems both inhumane and poor practice. The preventative role of early intervention is not taken sufficiently into account in the guidelines.

2.5 Personal and personnel issues, for example:

- the job, whilst rewarding, is immensely responsible and stressful. The case worker is involved in several balancing acts. One of these involves the balancing of need against resources; another relates to the conflict between what seems right in practice when actually faced with a need, with what is **deemed** right in bureaucratic terms. Another involves

prioritisation and actually finding the time to perform the multiplicity of tasks involved in the job well. Given these stressors, it seems all the more important that instructions from employers are clear, unambiguous and in writing. Yet, this is currently an area of considerable dissatisfaction;

- there are wide discrepancies in the pay of Project staff, depending on their auspice body;
- training has been inadequate and poorly organised, particularly in 1990; and
- the assistance given by staff of the old projects to the new Projects and the burden that this imposed has gone largely unrecognised;

3 What are the main things that you might want to change in your Project if you could start all over again?

3.1 Staffing

- there would be a clearer demarcation between the administrative and case manager role. In practice, too much administration falls on the case manager;
- staff/client ratios would be based on quality rather than quantity of service; and
- training would be improved.

3.2 Organisational issues

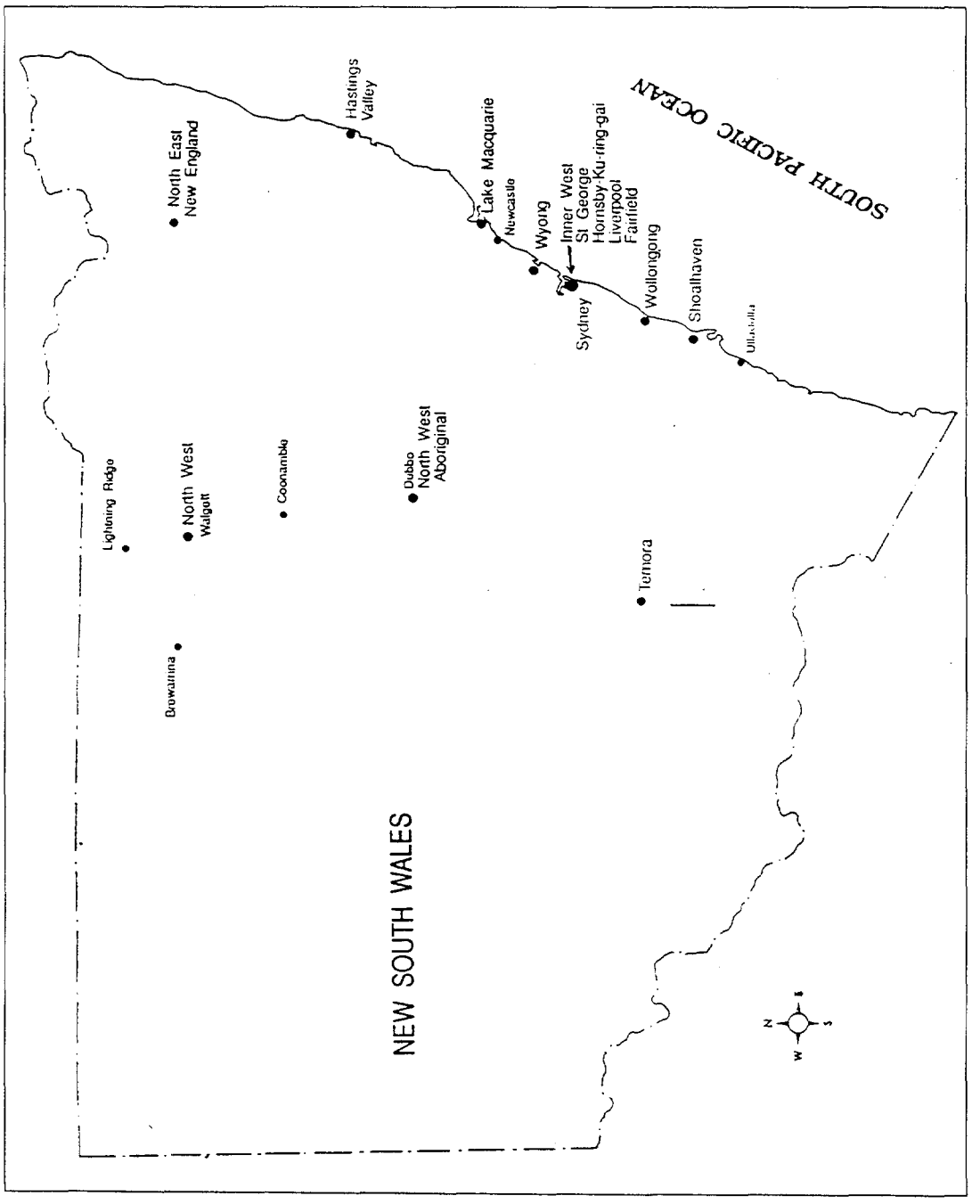
- more attention would be paid to the auspice arrangements, each of which has its own distinctive problems;
- geographical splits in Projects would be avoided as these lead to inefficiencies;
- there would be a longer lead time in the setting up of new Projects and this would include more effort given to PR work and HACC services, at the time of setting up a new Project;
- there would be more involvement at the initial stages at the policy level; and
- there would be a better data collection system.

3.3 Fee structure

- there would be one fee structure for all HACC services.

Appendix Four

Map Showing Community Options Projects' Locations



Appendix Five

Short Biographical Notes on Some Clients with Low Dependency According to the Client Dependency Form

(either graded 5 or 6 on the RCI items or 0 on the IADL-type items)

- An elderly man (RCI 6:IADL 2) first came to the notice of Community Options when he was referred by the Home Care Service. His first need had been transport to enable him to visit his wife, who was in hospital following an unsuccessful operation for a hip-replacement. The Home Care service formed the view that he needed other forms of help as well, but lacked resources at that time to provide them. Community Options therefore paid for the necessary services for six weeks, covering the period of his wife's hospitalisation and convalescence.

  These two elderly suffers from arthritis, it also emerged, lived with a 45 year old son who had an intellectual disability and required constant supervision. The co-ordinator concluded that all three were at risk of institutionalisation, given their respective disabilities and the precarious nature of their interdependence. Community Options helped with the purchase of a Vitalcall alarm and made representations to the Department of Housing about the need for modifications to their home, arguing strongly against a Departmental proposal that they should be moved after 45 years, which would have had severely destabilising consequences for them all but particularly for the son.

- A housebound sufferer from arthritis and schizophrenia (RCI 6:IADL 4) was the victim of simultaneous domestic problems. Her hot water system and her stove broke down, and she was unable to pay her household insurance premium. At great expense she had been travelling by taxi to receive medical treatment. Community Options arranged for her to attend a day care centre and for the Home Care Service to take her to the doctor once a fortnight as well as taking her shopping. She was monitored for some weeks, during which time the situation settled down. When the client agreed that the was coping satisfactorily, the co-ordinator closed her file.

- A very independent 78 year old woman (RCI 6:IADL 2) had had a car accident. Her eyesight had deteriorated considerably. She was no longer able to drive and was therefore housebound. She needed help with weekly shopping and home maintenance. Without these services the Community Options co-ordinator believed that she would be at high risk of institutionalisation. Before becoming a Community Options client she had been considering the possibility of entering a nursing home, but in the co-ordinator's view, quite limited services had made a significant difference to her situation. She was no longer thinking about nursing home admission.

- An elderly woman (RCI 6:IADL 6) referred by a community nurse, had suffered a heart attack. She had been advised to rest, but had insisted, in her independent way, on doing everything for herself. Community Options was able to arrange for help with daily meal preparation and housework for a period of recuperation. Her health improved after a short time and she no longer required services.

- A 76 year old man (RCI 6:IADL 5) had sole care of his daughter who had Down Syndrome and needed constant supervision. The father suffered from emphysema and had to use oxygen regularly. He had difficulty in preparing meals, for which Community Options arranged assistance. Although the father was nominally the sole Community Options client, this support was effectively maintaining two people, as well as monitoring their situation.

- A frail elderly woman (RCI 6:IADL 6), whose husband was dying at home in her sole care, was suffering from stress and was in need of support. The Home Care Service was providing some assistance with housework and the family was also helping but she herself badly needed time to sleep. Community Options arranged for respite care.

- A middle aged woman (RCI 6:IADL 0) was caring for her invalid husband and her aged mother. Because they lived in a remote area and had a wood-stove, they needed wood chopped. Community Options arranged for this to be done.

- A single mother (RCI 6:IADL 9) was experiencing acute stress caring for her children, one of whom had epilepsy. Respite care was provided to enable her to continue caring for the ailing child at home.

- A man in his early 30s (RCI 6:IADL 5), with a developmental disability had lived with his parents all his life. Community Options arranged for him to receive short-term residential respite care but shortly after his return home both his parents moved into a nursing home. He then went to live in a group home where he was taught such living skills as shopping and cooking, in the hope that he would ultimately become able to look after himself. He ceased to be a client, but Community Options has agreed to accept him again and set him up to live on his own if he should ever wish to leave the group home.

- This client was a lonely, frail elderly man (RCI 6:IADL 9) living in an isolated area. He needed a live-in housekeeper. Because of the isolation he had difficulty retaining housekeepers. Community Options helped him to find a replacement each time a new one was required.

- An elderly man (RCI 6:IADL: 2) became very lonely and depressed after his wife died. He became increasingly isolated socially. Community Options arranged for him to go to leather-craft classes which proved very therapeutic. the co-ordinator felt that this was a case where minimum services had achieved maximum results.

- A woman in her late 80s (RCI 6:IADL 9) and her 91 year old brother were living together. The sister suffered from osteoporosis and collapsed vertebrae. The Home Care Service was unable to meet all their needs so Community Options negotiated more extensive household help on their behalf. Though the nominal client was the sister, clearly the condition of both old people was being monitored. With more frequent visits from the woman's daughter and with some help with meal preparation from a neighbour, the situation settled down, and after a few months Community Options was able to leave them to, manage on their own.

- This client (RCI 6 IADL 3) had a developmental disability. He had been in and out of institutions all his life. His parents had both died. The hospital where he had been received treatment referred him to Community Options. Community Options found him a flat and helped him out with money, social support and also arranged for him to receive some instruction in independent living skills and with how to manage his banking. He clearly needed supervision for some tasks but it was felt that with some support he would be able to live independently.

- A frail elderly woman (RCI 5:IADL 0) living alone needed assistance, but had little experience with services and was suspicious. She did not want numbers of people coming to her house. Community Options provided social support and helped with shopping and banking, all services being economically performed by one person.

- This frail 84 year old man (RCI 6:IADL 10) living alone became a Community Options client because of his physical problems and his social isolation but he was obliged before long to have a leg amputated. On his discharge from hospital, he was admitted to a nursing home, but he was unhappy there. Community Options arranged for him to come home. Despite his physical impairment he was independent and could care for his personal needs. Once at home, however, he received help with house cleaning from the Home Care Service and Community Transport for shopping and to go to his medical treatment. He also used taxi vouchers.

- A frail 92 year old woman (RCI 6:IADL 6) partially blind and deaf, also had heart trouble. She was receiving help with cleaning, shopping and washing from the Home Care Service. She depended for company, being housebound, on the visits of a neighbour and another friend but they were feeling overburdened with the responsibility and had begun to press for her admission to a residential home. Approval for her admission had been granted. However, Community Options was able to arrange for attendance at a day care centre and for weekly participation in a 'low vision' group organised by the Royal Blind Society. Transport to these activities and to her doctor was organised and the cost subsidised by Community Options, as she would otherwise have been unable to afford it. The co-ordinator believes that the transport service was mainly responsible for keeping the client at home. She was monitored fortnightly by a community nurse and once a month by Community Options.

Appendix Six

A List of 'Other' Contributor Types

Disability Services

Program of Aids and Appliances for People with Disabilities (P.A.D.P.)

Community Welfare Fund

Residential Programs

Children's Services

Department of Health (State)

Area Assistance Scheme

Commonwealth Rehabilitation Service

Department of Veterans' Affairs

Commonwealth - Other

State - Other

Private (Commercial)

Private (Charity)

Private (Individual Benefactor)

Includes: Sydney Home Nursing Service

Repatriation

Head injuries team

Appendix Seven

A List of Organisations Interviewed in the Service Provider Survey

The Twenty Six Services with which Formal Interviews were Conducted

Liverpool	
Community Nursing	- 1 interview
Home Care Service	- 1 interview
Geriatric Assessment Service	- 1 interview
Newcastle	
Community Nursing	- 2 interviews
Home Care Service	- 4 interviews
Geriatric Assessment Service	- 3 interviews
North East New England	
Community Nursing	- 3 interviews
Home Care Service	- 3 interviews
Geriatric Assessment Service	- 2 interviews
North Western Aboriginal Project	
Aboriginal Medical Service/Community Nursing	- 1 interview
Home Care Service	- 1 interview
Geriatric Assessment Service	- 1 interview
Wyong	
Community Nursing	- 1 interview
Home Care Service	- 1 interview
Geriatric Assessment Service	- 1 interview

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