

The Evaluation of Community Options in New South Wales

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The Evaluation of Community Options in New South Wales

by

Sara Graham, Russell Ross and Toni Payne
with the assistance of George Matheson



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Foreword

The study of community support services has been one of the four major strands of the research agenda of the Social Policy Research Centre since 1988. This is a recognition of the importance of assistance provided to vulnerable people living at home and the significance of community support policies for the future development of health and welfare services for an ageing population.

The Community Options Program, initiated by the Federal Government in 1986, is an innovative approach to the care of dependent frail elderly people and people with complex care needs. It aims to plan services around the needs of clients rather than expecting individuals to fit into established service patterns. The opportunity to take part in a national evaluation of the program (by carrying out the evaluation in New South Wales) was welcomed by the Centre which is becoming increasingly involved in research in the area of community care as well as developing its skills in the growing field of evaluative studies.

The evaluation of major policy initiatives can make a considerable contribution to the evolution of policies. Governments can use the findings of such evaluations to refine and further develop policy instruments. An initiative as flexible as Community Options, still in the early years of its operation, can benefit greatly from the insights gained by independent researchers. In addition, evaluations can be of considerable value to workers in the field. They provide an opportunity, rarely presented to service organisations, for self-appraisal and examination of their own aims and the ways in which their procedures match those aims. Ultimately, this can only be to the benefit of all concerned, especially the clients of services.

The evaluation discussed in this Report was wide ranging, not only in terms of the geographical area and the number of projects involved but also in the number of issues addressed. The evaluation considered Community Options in New South Wales from three perspectives: that of people working in the projects as service co-ordinators or case managers; that of the clients or consumers of the services provided by Community Options; and that of other local providers of community services with whom Community Options interacts. The information gathered from these sources provides a rich and diverse body of knowledge which we hope will inform governments responsible for the formulation of guidelines for the future operation of the Community Options program and others associated with the support of vulnerable people living in the community.

For these reasons we welcome the opportunity to publish this evaluation and hope that the detailed account of the methodology and findings will contribute to a greater understanding of the issues involved in helping those in need of assistance to remain in their own homes and avoid unnecessary or premature moves to residential care. The research underlying the report was funded by a grant from the New South Wales Department of Family and Community Services. However the views expressed are not necessarily those of the Department of Community Services or the State Government of New South Wales.

Peter Saunders
Director

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We should also like to express our thanks to the Community Options clients and carers who participated in the client and carer survey. The experiences they related to us have provided the basis for much of this report.

We are grateful for the advice we received from Professor Henry Brodaty (Prince Henry Hospital, Sydney) on the identification of dementia, from Dr Andrew Mackinnon (National Health and Medical Research Council Social Psychiatry Research Unit, The Australian National University) and Ms Michelle Singh (Clinical Research Unit for Anxiety Disorders, University of New South Wales), on the use and interpretation of the General Health Questionnaire and to Mr Kevin Maynard (Department of Geography, University of New South Wales) for preparing the map showing the locations of Community Options projects in New South Wales. We appreciate the discussions we had with Professor Adrian Webb of Loughborough University. These helped us greatly in the interpretation of the data we collected.

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Contents

Foreword	i
Acknowledgements	ii
List of tables	iv
List of figures	vii
1 Introduction	1
2 Stage One: The Fourteen Community Options	7
3 Stage Two: The Client and Carer Survey in the Five Case Study Areas	110
4 Stage Two: The Survey of Service Providers	150
5 Overview	180
Appendix One: List of Problems Found in the Minimum Data Set	215
Appendix Two: Client Dependency Form	218
Appendix Three: A Note of the Proceedings of the Senior Co-ordinators' Workshop	222
Appendix Four: Map Showing Community Options Projects' Locations	228
Appendix Five: Short Biographical Notes on Clients with Low Dependency	229
Appendix Six: A List of 'Other' Contributor Types	232
Appendix Seven: A List of Organisations Interviewed in the Service Provider Survey	233
References	234

List of Tables

2.1:	Selected Characteristics of Areas and Populations Served by Each Community Options Project	12
2.2:	Community Options Target Population as Proportion of Population Potentially at Risk in Each Area	15
2.3a:	Selected Characteristics of Projects	16
2.3b:	Selected Characteristics of 14 Projects Included in the Evaluation	17
2.4:	Selected Aspects of Conditions of Employment of 39 Co-ordinators	18
2.5:	Selected Characteristics of 39 Co-ordinators	19
2.6:	Additional Training Considered Helpful for Improved Job Performance	22
2.7:	Major Rewards of Job as Community Options Co-ordinator	23
2.8:	Major Sources of Stress for Community Options Co-ordinators	23
2.9:	Relationship of Community Options Projects with Their Auspice Bodies	26
2.10:	Structure of Management/Advisory Committees	33
2.11:	Referral of Clients	36
2.12:	Reasons for Non-acceptance of Referrals	37
2.13:	Symptoms of Dementia and Prior Residential Approval	39
2.14:	Selected Characteristics of Clients Accepted in Reference Year	40
2.15:	Selected Characteristics of Carers	42
2.16:	Level of Dependency of Clients Entering in the Period 2.4.90 - 29.6.90	44
2.17:	Proportion of Community Options Clients Needing Assistance with Selected ADLs Compared with Severely Handicapped Population Living in Households in New South Wales	45
2.18:	IADL Dependency Scores and Living Arrangements	46
2.19:	RCI Category and Approval for Various Types of Residential Care	46

2.20:	Summary of Major Characteristics of Client Group	50
2.21:	Length of Time as Client and Month of Entry During Reference Year	51
2.22:	Reason for Exit and Length of Time as Client	52
2.23:	Client Group and Reason for Exit	53
2.24:	Characteristics of all Clients who Left Community Options, Those who Entered Long-term Care and Those who Died	55
2.25:	Dependency Level of Clients Entering Long-term Care	57
2.26:	Number of Services Received in Each Week of the Three Month Period	60
2.27:	Service Provision Before Entering Program	64
2.28:	'One-off' Services	65
2.29:	Number of Service Providers in Each Funding Category	72
2.30:	Service Types and who Pays for Them	74
2.31:	Most Common Price Paid for Government Funded Services and for Services Purchased from Private Contractors	80
2.32:	Recurrent Costs, an Overview (\$ Per Client Per Week)	83
2.33:	Recurrent Costs, Individual Projects (\$ Per Client Per Week)	87
2.34:	Approved Subsidy Rate, Actual Recurrent Expenditure and Approved Brokerage Fee (Per Client Per Week)	91
2.35:	Recurrent Costs by Age Groups (\$ Per Client Per Week)	92
2.36:	Recurrent Costs by Dementia Status and Age (\$ Per Client Per Week)	93
2.37:	Recurrent Costs by Living Arrangements and Age (\$ Per Client Per Week)	95
2.38:	Recurrent Costs by Domestic Circumstances (\$ Per Client Per Week)	97
2.39:	Recurrent Costs by Type of Locality (\$ Per Client Per Week)	99
2.40:	Estimated Impact on Weekly Recurrent Expenditure of Selected Characteristics (\$ Per Client Per Week)	101

2.41:	Recurrent Costs by Resident Classification Instrument Category (\$ Per Client Per Week)	103
3.1:	Number of Clients and Carers in the Five Projects in Stage Two of Evaluation	118
3.2:	Selected Demographic Characteristics of Clients and Carers	119
3.3:	Occupational Background of Clients who Had Been Employed	120
3.4:	Clients' Main Source of Income	120
3.5:	Clients' Social Contact	121
3.6:	Current Number of Chronic Health Problems Suffered by Clients	122
3.7:	Clients' Incontinence	122
3.8:	Length of Stay in Hospital	123
3.9:	Clients' IADL Scores	125
3.10:	Clients' ADL Scores	125
3.11:	Household Type by Dementia: Rating by the Co-ordinator	126
3.12:	Age Group of Clients by Dementia Status	127
3.13:	Dementia Status, Cognitive and Social Impairment and Presence of Carer	128
3.14:	Relationship of Carer to Client and Residency of Carer	129
3.15:	Length of Time Carer has Been Caring for Client by Clients' Age	129
3.16:	Relationship of Carer to Client, Health Problems of Carer and Client and Dependency Level of Client	131
3.17:	Stress Levels of Carers Measured on General Health Questionnaire	132
3.18:	Areas of Life Affected by Caring	134
3.19:	Initial Source of Information About Community Options	136
3.20:	Reason for Initial Involvement with Community Options	136
3.21:	Frequency of Contact Between Clients and Community Options Co-ordinators	138
3.22:	Help Received by Clients	138

3.23:	Source of Help with Activity by Household Type	139
3.24:	Ways in Which Community Options Co-ordinator Helps Carers	141
3.25:	Types of Help Not Currently Received, Wanted by Clients	144
3.26:	Types of Help Most Useful for Managing at Home	144
3.27:	Ways Community Options has Affected Attitudes Towards Living at Home	145
3.28:	Impact of Community Options on Areas of Carers' Lives	147
3.29:	Main Benefit of Having Co-ordinator as Perceived by Clients and Carers	148

List of Figures

2.1:	Frequency and Size of 'One-off' Expenditures	66
2.2:	Percentage of Gross Costs from HACC, COPS and Other	105
2.3:	Percentage of Net Costs from HACC, COPS and Other	106

1 Introduction

1.1 Policy Context

Australia, along with other modern nations, has now accepted the notion that even when physical and mental health is damaged to such a degree that people become dependent on others, it is preferable that they should live in their own homes rather than in long-stay residential care facilities. Though it is acknowledged that people can be so severely disabled and dependent on others that they need the kind and level of care that can most efficiently be provided in a specialised institutional setting, current official thinking and policy conceives of such care as suitable only when other support systems are not appropriate to meet their needs.

Community Options represents one of a number of approaches to the support of people with disabilities at home. During the 1980s, at least three national policy initiatives were launched by government, all of which were intended to contribute to the support of people with disabilities and to enable them to stay in their own homes for as long as possible, avoiding what the Programs' Guidelines describe as 'inappropriate institutionalisation'. These initiatives were the Home and Community Care Program (HACC), Geriatric Assessment Teams (GATs) and Community Options. This evaluation focuses on Community Options but since the three initiatives, though essentially discrete, all have broadly the same guiding principles and in the case of HACC and Community Options, broadly the same target populations, it will be worth providing a brief description of their most salient features from the stand-point of the present evaluation. It should also be useful to say something of the way in which these initiatives are intended to inter-relate.

The Home and Community Care Act was introduced in 1985 in order to consolidate existing community and domiciliary services and to increase their range, mix and quantity so as to enhance the capacity of people with moderate to severe disabilities to continue living in their own homes. The Program was also intended to provide support for the informal carers of such people. Under the Home and Community Care Program, a number of separate community-based community and domiciliary service organisations, some of which provide a single service and others a combination of services, are funded to provide 'hands-on' support. Assessment and prioritisation based on assessment are important features of HACC services and the Guidelines specify that appropriate assessment services should be used to determine clients' needs and appropriate ways of meeting them. Expenditure on HACC, which is funded jointly by Commonwealth and State governments, has grown by 98 per cent since its inception in 1985. In 1990-91 Commonwealth/State expenditure on this program was \$449.9 million nationally and in New South Wales was \$161.8 million.

The Home Care Service, which is the largest HACC agency in New South Wales, both in terms of the amount of its funding and the number of its clients, provides a

multiplicity of domiciliary and community services and has a well defined bureaucratic structure with a network of branches and service outlets throughout the State. At the time of writing, branch managers had delegation to spend up to \$700 on an individual client over the period of a week. Approval for expenditure above this amount can be given by the regional office.

Geriatric Assessment Teams (GATs) were first set up in 1983 with Commonwealth funding, since which time the network has grown substantially in co-operation with State governments. According to the Commonwealth Guidelines for Assessment Services, the objectives of GATs are firstly 'to assess and where appropriate re-assess the physical, medical, psychological and social needs of all aged people to assist them to choose the most appropriate combination of services to meet their needs' and secondly 'to refer them to the combination of available services that best meets their needs and expressed wishes'. Some GATs already exercise delegation on behalf of the Commonwealth in determining eligibility for nursing home admission and it is proposed by government that all GATs will exercise delegation for nursing home and hostel admissions in the future. The GAT may also provide 'hands on' therapeutic services of one kind or another to clients in their own homes. They may also co-ordinate a set of services from the existing pool of government-funded services. The GATs have particularly strong links with the acute medical services and they are often located in hospital settings, but they also have crucial links with service personnel in the community. Though a very high proportion of their clientele are elderly, HACC services and Community Options provide support for people of all ages. There is a good deal of variation between GATs in respect of their size, the professional disciplines they include and the areas they cover. In 1990-91 Federal expenditure on this program was \$25.0 million.¹

Community Options, unlike the other two initiatives, is funded solely by Commonwealth Government. In 1990-91 expenditure on this program was \$24.3 million nationally and in New South Wales was \$12.9 million.

In 1986, the Government announced its intention of making funds available to encourage the development of this new service for frail aged and younger people with disabilities who 'must be at high risk of entering a nursing home, hostel or other institution even though they could remain in the community with some basic support at home'. (Community Options Guidelines.) There is no actual definition of the term 'basic' in the Guidelines but it can best be represented by the maximum weekly expenditure permitted on an individual client. During the period to which our financial data relate this sum was \$200, calculated in terms of the Commonwealth

1 It has not been possible to obtain the figure for State expenditure on Geriatric Assessment Teams.

contribution to government funded services received by Community Options clients.²

This service has been modelled on arrangements developed in Kent (UK) and Wisconsin (USA). The principal distinguishing innovation of the service is the introduction of a service co-ordinator (also known as a case manager)³ whose role it is 'to develop flexible, individually tailored care packages for their clients starting with the question "what assistance do you need to stay at home?" The case manager then negotiates with relevant service providers to arrange assistance and purchases services where necessary.' (Quoted from the Consultancy Brief which set out the background and terms of reference as defined by the NSW Government Department of Family and Community Services, in a letter dated 30 May 1990).

As a method of service delivery Community Options starts with the recognition that there are some people who, because of the level and nature of their disabilities and the inadequacy of their social supports, are at high risk of institutionalisation. A proportion of these people, though undeniably finding it difficult to cope at home, are not in need of the sort of intensive medical and nursing care that is implied by long stay residential arrangements. They could be enabled to stay in their own homes given the right sort of help. They are at risk not because of their disability *per se*, but rather because of their incapacity to arrange the supports they need for themselves. These may range from simple, even single needs, for example, for someone to check that they have eaten their meals, to a large number and wide range of support arrangements. These supports may well be available in the client's locality but remain effectively out of reach, because obtaining them calls for a level of knowledge, persistence, effort and financial resources that many people, particularly those with severe disabilities, simply do not have. A problem

2 This amount has subsequently been raised to \$400, calculated in terms of both the Commonwealth and State contributions to government funded services received by Community Options clients.

3 In the research literature, a person who both arranges a package of services and has the resources to purchase necessary services is usually referred to as a 'case manager'. However, although we found that the term case manager was occasionally used by Community Options co-ordinators in New South Wales, there seems to be a preference for the person performing this function to be termed a 'co-ordinator'. The function itself is referred to as 'brokerage' or the 'co-ordination of services', these terms being used interchangeably. We were told that the reason the term 'case-manager' is avoided is because it has connotations of control or manipulation whereas the philosophy of Community Options favours the notion of partnership, with a strong emphasis on the client, not as a case but as a person. In this report we shall follow the New South Wales usage, employing the terms 'co-ordinator' and 'co-ordination'. From time to time, however, we were told by Community Options co-ordinators, that a client had a 'case manager'. It appears that such workers are distinguished from co-ordinators because, although having primary responsibility for determining the overall care and service needs of clients, they cannot actually implement the total care package. This is because, unlike co-ordinators, they do not control the necessary resources. While the current research literature usually refers to such a person as a 'key worker', we shall again follow New South Wales usage and retain the term 'case manager'. (For a useful discussion of terminology see Dant and Gearing, 1990).

consistently highlighted in the literature is that the publicly funded service delivery system consists of a large number of separate, unco-ordinated bureaucratic service organisations daunting to even the strongest. But the problem does not end there. Many needs are simply not catered for by the conventional publicly funded services. Access to other privately-provided services may present no less of a problem for a frail or disabled person.

To overcome these difficulties, Community Options, as it has been developed in New South Wales, uses a brokerage model in which a service co-ordinator negotiates a set of appropriate support arrangements on behalf of, and in full consultation with, the client or the client's carer. To meet these needs for support the co-ordinator is required first to call upon existing HACC services in the locality. However, co-ordinators also have at their disposal funds, within limits, to purchase services needed by the client which HACC cannot provide. Community Options thus has two distinguishing features. First it provides the capacity to design, access and co-ordinate an appropriate comprehensive service package on behalf of a client and/or a carer. Secondly it provides additional resources to buy those services not available from government sources which clients cannot afford to purchase for themselves. The Guidelines for the Operation of Community Options Projects included in the Consultancy Brief mentioned above, spell out the principles, broad aims, client and service selection criteria, operating principles and other features of the Program.

Although there are now 48 Community Options projects in New South Wales, between 1987 and 1989, 18 such projects were established throughout the State, of which four were specialist (catering specifically for the needs of younger people with disabilities and for dementia sufferers) and 14 were non-specialist. These were set up on a pilot or experimental basis. The Consultancy Brief for the evaluation of the Community Options Program in New South Wales required the evaluation to be confined to the 14 non-specialist projects.

The projects are highly dispersed and, as we shall see, serve a wide range of settings and populations. The projects also have widely differing characteristics in respect of their sizes, their locations, their auspice bodies and the size of their funding. These differences were quite deliberately contrived to test the efficacy of different models of service.

1.2 The Purpose and Nature of the Evaluation

The main objective of Community Options is described in the Guidelines for the Operation of Community Options projects. It is to **strive to prevent the premature or inappropriate use of long-term institutional care by frail aged and younger people with disabilities**. There are, however, a number of other objectives which relate to both clients and services. Amongst these are:

- to develop close working relationships with assessment services and other home and community care organisations serving the area. Projects were also expected to exercise a positive influence on HACC services in the locality, especially in the realm of cross-service relationships;
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- to ascertain the care requirements on equal terms with the client and his or her carer; and
- to provide continuing personal contact to give clients a sense of security in remaining at home and to monitor their needs, particularly in times of crisis.

The Guidelines set out in some detail the mechanisms to be employed and the maximum level of government funding to be used to achieve these objectives.

The consultancy brief for the evaluation required information as to whether and at what cost the broad objectives of Community Options were being achieved and how this differed between projects operating in different settings and with different operational arrangements. In other words, it sought information on the factors which were most likely to influence the successful implementation of the objectives of the Program. The outcome of the evaluation was to be used to **develop a set of guidelines for the targeting, funding and operation of Community Options projects and to assist with planning for the Home and Community Care Program generally.**

The consultancy brief called for the following broad questions to be addressed:

- What organisational arrangements for projects are likely to achieve the best outcomes for clients?
- Is the objective of avoiding premature and inappropriate institutionalisation more likely to be achieved in areas where there is a Community Options project?
- Which clients are most likely to benefit from Community Options?
- What impact do Community Option projects have on the other local service networks?
- What are the costs of this form of service delivery and how does this compare to the cost of residential care?

From an early stage of the evaluation it became apparent that it was over-ambitious, within the confines of the consultancy, to attempt to provide definitive answers to the first four of these questions. The reasons for this are:

- A longitudinal study would be required to examine the impact of Community Options. The nine months timescale for the evaluation was too short to allow such a study to be undertaken.
 - A controlled experimental design would be required to answer questions comparing one form of service provision with another. However, neither the projects nor the data systems had been set up in such a way as to render such a research design feasible.
-

- The central objective of Community Options, namely **the avoidance of premature or inappropriate institutionalisation** is itself too vaguely defined and broad to render it capable of evaluation.

Instead, it seemed appropriate to refine the research objectives in order to make them more limited and manageable. The present evaluation provides:

- A description of some of the characteristics of the clients served by Community Options, including their need for personal support, an account of the way these clients are selected, and a discussion of some of the issues associated with their selection;
- a description of the service packages which clients receive and some of the factors determining service needs and service provision and delivery;
- a description of the costs of service to Community Options clients and of the factors influencing variations in costs;
- an account of some of the factors that aid and impede the achievement of the objectives of Community Options;
- an account of client reactions to Community Options; and
- an account of the reactions of other local service providers to Community Options.

The evaluation was undertaken in two stages. **Stage One**, which covers the first four of the above objectives was undertaken in the 14 Community Options projects included in the evaluation, between January and April 1991. **Stage Two** which covers the last two of the above objectives was undertaken in five of the 14 projects between June and mid-July 1991. We have called these 'case study areas'. The selection of these five projects is described in detail in the second part of this report.

This volume is in five sections. Section 2 describes Stage One and Sections 3 and 4 describe Stage Two of the evaluation. The various components of the evaluation are brought together in Section 5 which provides an account of the principal findings and issues that have emerged from the evaluation. The findings presented in this report pertain to the situation which existed in each project at the time data were collected and fieldwork was carried out. Section 5, the Overview, is designed also to be read on its own and may repeat material contained in earlier sections.

During the course of the evaluation a great deal of information was collected which, in the time available, we have not been able to utilise fully. The findings we present are inevitably selective and are intended to reflect those issues which we have identified as the most important.

We hope that this evaluation will nevertheless highlight some of the main achievements and difficulties of the Community Options Program and provide the basis for an informed discussion of this form of service delivery.

2 Stage One - The Fourteen Community Options Projects

2.1 Broad Aims and Research Methodology

Stage One of the evaluation had four main aims:

- to describe some of the characteristics of the clients served by Community Options, including their need for personal support, to provide an account of the way these clients are selected, and to consider some of the issues associated with their selection;
- to describe the service packages which clients receive and some of the factors determining service needs and service provision and delivery;
- to describe the costs of service to Community Options clients and of the factors influencing variations in costs; and
- to provide an account of some of the factors that aid and impede the achievement of the objectives of Community Options.

This stage of the evaluation included the following projects:

- Fairfield Live at Home Service
- Inner West Live at Home Program
- St George Live at Home Service
- Hornsby/Ku-ring-gai Community Options
- Newcastle/Lake Macquarie Live at Home Service
- Wollongong Community Options
- Wyong Community Options
- North West Aboriginal Community Options
- North West Area Community Options
- Shoalhaven Live at Home Project
- Hastings Valley Community Options
- North East New England Community Options
- Temora Community Options
- Liverpool Live at Home Service

To achieve the aims of Stage One of the evaluation as set out above four principal tools were used:

- **The Minimum Data Set (MDS).** The statistical or quantitative data are derived, for the most part, from the Minimum Data Set. This data set relates to those people who were clients of the fourteen projects on 1 July 1989 or were accepted onto a project between that date and 30 June 1990. In the evaluation
-

we refer to this period as **the reference year**. The MDS has been compiled from a series of forms which project staff complete for each of their clients and up-date as appropriate. The information on the forms is transferred onto a computer by project administrative staff using the DBASE IV Data Software. The computerised data is sent to the Community Options section of the New South Wales Department of Family and Community Services (FACS),⁴ now the Department of Community Services.

The data set comprises information on:

- client profiles
- types of service received by clients
- service providers
- all changes in services received
- all changes in service providers
- costs of services and who incurred the cost
- source of and reasons for client referrals
- clients discharged from, or terminating with, Community Options and reasons

Because DBASE IV was not properly operational until about April 1990 information was transposed retrospectively from the manually completed forms to a computerised form. The MDS contains a number of gaps and inaccuracies. An up-to-date list of these is provided in Appendix 1. These have arisen partly because of the inevitability of error in retrospective operations of this sort and partly because of the ambiguity of some instructions and of inconsistency in the interpretation of some items on the forms and the coding schemes. Staff often lacked relevant experience and received inadequate training and support, which aggravated these basic problems. Moreover the computerised data do not appear to have been subjected to ongoing checks and validation.

- **The Client Dependency Form (CDF).** The Minimum Data Set did not contain adequate information on the client's need for personal support. Because this was considered such important information in understanding the service packages received by clients it was collected as part of a special exercise using a form designed for the purpose. The forms were completed retrospectively by project co-ordinators for clients accepted by their projects in the last three months of the reference year. Appendix 2 contains a copy of the Client Dependency Form.

4 Throughout this report we shall refer to the government departments by their names at the time of the evaluation. The NSW Department of Family and Community Services (FACS) is, at the time of writing, the Department of Community Services (DOCS) and the Commonwealth Department of Community Services and Health (DCS and H) is at the time of writing, the Department of Health, Housing and Community Services (DHH and CS).

- **The Senior Co-ordinators Workshop.** At the commencement of the evaluation, senior co-ordinators were invited to a Workshop. The purpose of the Workshop was twofold. Firstly, it was to provide an opportunity for senior co-ordinators and the Evaluation Team to meet so that the Team could outline the purposes and methods of the evaluation and answer questions from the senior co-ordinators. Secondly, it was designed to identify key issues of concern to the co-ordinators which could be explored in more detail in Stage One of the evaluation. The Workshop proved particularly helpful. A note of the proceedings is provided in Appendix 3.

Personal Interviews with Senior Co-ordinators, Co-ordinators and Representatives of Auspice Bodies. Three questionnaires were used in this part of the evaluation. The questionnaire for senior co-ordinators dealt with the following broad areas:

- the history, organisation and staffing of the project;
- project objectives and the circumstances that aid and constrain the achievement of these objectives;
- clients and their selection;
- the service environment;
- the impact of the project on other local services;
- relations with the auspice body;
- relations with management/advisory committee; and
- relations with the NSW Department of Family and Community Services (FACS) and the Department of Community Services and Health (DCS and H).

The questionnaire for co-ordinators, which was also completed by senior co-ordinators, dealt with the following broad areas:

- occupational and educational background
- training received and needed;
- employment conditions;
- stresses and rewards of the present position;
- allocation of time between tasks;
- importance attached to various aspects of the role of co-ordinator;
- the criteria involved in the selection of clients;
- the service environment and the adequacy of local services in meeting the needs of clients; and
- the extent to which the policies and guidelines for Community Options facilitate or impede the achievement of the objectives of the Program.

These questionnaires were sent to each project staff member individually with a request that they should be completed without discussion with colleagues. The questions were by and large open-ended, calling for opinions rather than precoded responses. All co-ordinators completed their questionnaires and it was clear that in most cases substantial and serious consideration had been given to the questions. Subsequently each project was visited by a member of the Evaluation Team for between one and three days. During this period, follow up interviews were

conducted with all co-ordinators during which the major themes and issues to emerge from the responses were followed up and amplified. The length of interviews ranged from two to five hours. All interviews were tape recorded.

It was clear from the interviews that co-ordinators were taking the evaluation seriously. Some even believed, unfortunately for our purposes, that the future of the Program, of their projects and of their own jobs hung directly on the results of the evaluation. This misapprehension was not always easy to dispel, but it was most important to do so before any useful enquiry could begin. We were at pains to insist that it was our job to evaluate the Program rather than individual workers or projects and to emphasise the complete confidentiality of all interview data. It would have been completely inimical to the objectives of our enquiry to have project co-ordinators regarding the investigators as representing some sort of inspectorate. We are confident that this danger was ultimately overcome in those places where it seemed to threaten. In all cases, project co-ordinators were extremely cooperative, set aside undisturbed blocks of time for the purposes of the interview, and were in many other ways as helpful and sympathetic to the objectives of the evaluation as they were committed to the success of their projects. Most co-ordinators appeared to welcome greatly the opportunity to talk about their work with someone whose attention was entirely focused, in a non judgemental way, on work that clearly mattered a great deal to them. We were told by some co-ordinators that the questionnaires and interviews had provided them with a valuable opportunity to reflect on their work. It would be difficult to exaggerate the enthusiasm and high level of motivation that co-ordinators showed for the work they do. We found immense identification with the objectives of Community Options amongst the staff.

Interviews were also conducted with a representative of the auspice body of all projects. The individual identified by the auspice body itself as having the greatest involvement with the project was the person selected for interview. A formal questionnaire was not used, but discussion was structured around the following broad themes:

- the setting up of the project;
- the organisational links between the project and the auspice body;
- the services the auspice body provides for the project;
- the project's accountability to the auspice body;
- the involvement of the auspice body in the day-to-day running of the project; and
- the auspice body's perceptions of the value and future of the project specifically and the Program generally.

Interviews with representatives of auspice bodies lasted between one hour and a half and three hours and except in one case were tape recorded.

2.2 A Descriptive Overview of the Projects⁵

It will perhaps be useful first to describe some of the physical aspects of Community Options projects so that readers can visualise where and how the activities with which this report is concerned take place.

A project normally occupies an office or set of offices in a commercial building, or sometimes a former dwelling. The building may be located on a busy main road or, less commonly, in a relatively quiet suburban setting. The project may be the sole occupant of the building, but more frequently shares it with other organisations. These may include its own auspice body, but more usually are organisations providing residential care, day care or other such community services.

All projects have at least one co-ordinator and one administrative/clerical worker but vary a great deal in the numbers of staff they employ and in the ratio of co-ordinators to administrative/clerical staff. The number of staff is related in most, but not all cases, to the number of clients and also to whether the staff work full or part time.

In general, administrative staff enter data from the co-ordinators' assessment forms onto the computer. The administrative/clerical worker is usually also the receptionist/telephonist, and will take referrals over the phone. She may also, in clear-cut cases, take decisions about referrals, for example, as to whether or not they can be accepted and, if so, to which particular co-ordinator a client should be referred.

Space often presents a problem. The senior co-ordinator normally, but not always, has a separate office. In most cases, co-ordinators share their offices either with other co-ordinators or with the administrator/clerk. In a few instances the co-ordinator shares an open plan office with the staff from the auspice body. Not uncommonly accommodation is quite crowded and there is little privacy. Visits from clients are rare, most contact being either over the phone or in the client's or carer's home. In fact, we saw no client or carer in a project office during our visits. In such crowded conditions it would be difficult to preserve client confidentiality.

Project Settings: Geographical Locations and Demographic Characteristics

It is clear from Table 2.1 that the nature of the areas served by Community Options projects varies considerably in ways that might be expected to affect the role and functioning of these projects, for example in the size and densities of their

5 Results for all projects combined appear in the body of this report. Data on costs for individual projects also appear in the report. Data were collected on all variables for each individual project, but little variation was found.

Table 2.1: Selected Characteristics of Areas and Populations Served by Each Community Options Project

Community Options Project	Population	Area (Sq Km)	Population (ps/km ²)	% 65yrs & Over	% 65-69yrs of 65yrs+	% 70-74yrs of 65yrs+	% 75yrs+ of 65yrs+	% 65yrs+ of Labour Force	% Pop.-from NESB	% (a) 0-14yrs With Severe Disability at Home	% (a) 15-64yrs With Severe Disability at Home	% (a) 65yrs+ With Severe Disability at Home
Fairfield(d)	153,531	101	1520.11	6.2	39.5	28.8	31.7	13.6	52.3	0.9	2.4	15.2
Inner West	148,005	49	3020.51	15.0	28.7	26.3	44.7	30.7	39.6	(b)	1.9	14.1
St George	192,732	66	2920.18	15.7	33.4	28.5	38.1	33.0	27.7	2.0	1.8	5.5
Hornsby/Ku-ring-gai	217,647	555	392.16	12.1	30.6	25.3	44.1	25.3	10.6	1.2	0.5	6.2
Newcastle(d)	285,158	835	341.51	12.6	35.1	28.4	36.4	28.9	7.2	1.1	4.1	8.0
Wollongong(d)	168,983	681	248.14	10.1	36.7	29.3	33.9	22.6	21.8	3.2	2.6	11.3
Wyong	82,899	745	111.27	18.1	37.3	30.3	32.4	51.5	4.6	2.1	2.9	13.1
N.W. Aboriginal	45,842	55,498	0.83	8.4	34.4	29.7	35.7	18.7	4.8	2.4	2.2	12.1
N.W. Area	15,354	52,066	0.29	8.3	38.0	28.4	33.6	18.3	5.9	2.4	2.2	12.1
Shoalhaven	56,484	4,566	12.37	14.6	39.5	30.0	30.6	38.1	4.4	1.4	1.9	11.4
Hastings Valley	40,420	3,749	10.78	17.4	37.2	30.0	32.8	46.3	3.6	1.1	3.4	8.8
N.E. New England	37,308	29,521	1.26	12.4	32.9	28.2	38.7	29.2	3.2	2.4	2.2	12.1
Temora	6,364	2,806	2.27	15.1	30.7	26.3	43.0	36.1	2.5	(b)	2.7	13.3
Liverpool(c)	93,500	304	307.57	5.4	36.7	27.5	35.8	11.5	25.1	0.9	2.4	15.2

Notes: The highest and lowest values in each column are highlighted.

- a) Proportions correspond to the larger areas (SSDs and SDs) employed in the ABS *Survey of Disabled and Aged, Australia, 1988*. Consequently some error has been introduced and a degree of geographical variation obscured. Nevertheless, the figures do provide a broad indication of regional variations. The proportions are of the total population.
- b) Not published in original source due to small numbers.
- c) Project with dementia focus.
- d) Project with NESB focus.

Sources: Based on ABS 1986 Census of Population and Housing; and ABS (1989), *Survey of Disability and Aged Persons, Australia, 1988*, Catalogue No. 4118.0.

populations, in the proportions of their populations who are elderly, have severe disabilities, or are from non-English-speaking backgrounds (NESB). Whilst we do not intend to provide a detailed commentary on the Table, it is worth drawing attention to a few of its more salient features.

We have already noted that the projects under review are widely dispersed throughout New South Wales. Appendix 4 contains a map of New South Wales showing their locations. The demographic variability of the State is reflected in the populations served by the projects themselves. Note first the range of areas covered by projects. At one extreme we have the Inner West project of Sydney serving a dense population concentrated in 49 square kilometres. At the other extreme, the North West Aboriginal project serves a sparsely populated area covering 55 thousand square kilometres. Geographic distributions obviously have a crucial impact on the role of Community Options. Of course, in many of the more sparsely populated areas, Community Options clients tend to be concentrated in the small townships. But in most of the rural projects an important minority live in the outlying areas and they present particular problems of both servicing and monitoring. Co-ordinators provided us with graphic accounts of the challenge of finding people, particularly private contractors, prepared to provide essential services in these remote areas, which are often only accessible by very poor roads, which cause the rapid deterioration of vehicles, and in bad weather may actually be impassable. Such conditions not only make services hard to deliver but also, of course, immensely costly.

The injection of Community Options not only as an additional and special service but also as a source of additional government funding is immensely important in areas with such poor service infrastructures. It is perhaps not surprising that 'one-off' payments assume a particular importance in these areas. The telephone, the washing machine, the microwave oven and the Vitalcall serve to supplement and sometimes to take the place of the deficient human services. Most rural co-ordinators pointed to the inadequacy of the amount allowed for 'one-off' payments. Such complaints were not confined to co-ordinators working in rural areas, however.

Another important function which we found some Community Option staff had performed in rural areas was to set up peripatetic paramedical services as well as transport to convey isolated people to town for hospital visits, or such important paramedical services as podiatry, for day care, for shopping expeditions or sometimes just for company.

Community Options finds most of its clients amongst the frail elderly. Once again, as Table 2.1 reveals, there is considerable variation in the proportion of the elderly in the areas served by Community Options. Central Coast areas have particularly high proportions of elderly people, as indeed do the most highly urbanised areas. Our attention was drawn to the particular problems of elderly people who have migrated after retirement to coastal areas which tend to lack the service infrastructures to deal with the problems of an aged population. Such people, in the ordinary course,

experience frailty but, being migrants, lack the support of younger members of their immediate families.

It is perhaps worth interjecting here that the Community Options Program serves an extremely small proportion of the population 'at risk'. If we relate the target clientele of each project to the estimated number of people with severe disabilities⁶ in the areas they serve we see that this ranges from 1.5 to 21.5 per cent (see Table 2.2).

This is not to imply that those people with severe disabilities not served by Community Options are necessarily neglected. In the first place, the people who are identified in the ABS 1988 Survey of Disabled and Aged Persons as having a severe disability are not necessarily at risk of institutionalisation. Indeed, the ABS definition of handicap allows for a very broad interpretation of who would constitute a person with a disability. Second, many people with severe disabilities will not be in need of Community Options support, either because they are being adequately supported by other HACC-type services or by informal carers, or both. Nevertheless, the figures give perhaps the best indication we have of the **potential** target populations of Community Options. It would be useful to know how many people at equivalent levels of disability and 'at risk' of institutionalisation are **not** serviced by Community Options in the localities in which the projects are operating. Data are unavailable however.

Selected Characteristics of the Projects

We have noted that these experimental projects were deliberately set up to be quite different from each other in character, in the hope that this might help the evaluation to identify those features which had proved particularly efficacious. On most variables we were unable to find any direct association between the characteristics of the project and the characteristics of the population it served. For example, we could find no direct association between the number of clients assisted by projects and the size of the population, or even of the elderly or disabled population served by them. Similarly, there appears to be no direct association between size of project and budget allocation for administrative expenses or between level of brokerage fee and type of area. We do not, of course, suggest that there is no logic to the various administrative features of the projects, simply that it is not immediately apparent.

The data presented in Table 2.3a are provided in a different form in Table 2.3b, which better illustrates the variation between projects. With the exception of item 5, the clients and funding levels described in these tables are determined by FACS as

6 Severe handicap is defined by the ABS as requiring personal help or supervision because the person is unable to perform one or more of the following tasks: self-care, mobility and verbal communication. In this report we use the term 'disability', which is synonymous with the ABS term 'handicap'.

Table 2.2: Community Options Target Population as Proportion of Population Potentially at Risk^(a) in Each Project Area

Project	Per cent
Fairfield	2.0
Inner West	1.9
St George	2.0
Hornsby/Ku-ring-gai	4.4
Newcastle	1.5
Wollongong	1.6
Wyong	3.4
N.W. Aboriginal	4.0
N.W. Area	8.3
Shoalhaven	3.5
Hastings Valley	6.0
N.E. New England	3.7
Temora	21.5
Liverpool	3.6

Notes: a) Population with a severe disability living at home.

The figures are subject to the same caveats as those noted on Table 2.1.

Source: Based on ABS (1989), *Disabled and Aged Persons, Australia, 1988*, Catalogue No. 4180.

the funding body. In the case of item 5, it is clear that there is considerable variation between projects in the ratio of targeted clientele to co-ordinators. Where the ratio is high, as for example in the project with 75 clients to one co-ordinator, it probably means that the project is understaffed. Where the ratio is low, for example in the project where there are only 21 clients to one co-ordinator, it may mean either that the project has reached its targeted number of staff but not its targeted number of clients, or that for some reason it has been afforded special consideration by FACS, perhaps on grounds of the area it serves. This can hardly be a consistently applied policy however, because staff:client ratios for areas with widely dispersed populations vary quite considerably. The question of what constitutes an appropriate level of staff for a given number of clients is complex. Suffice it to say here that by and large the answer will depend on what is expected of staff, especially by way of monitoring clients.

The Employment Conditions and Selected Characteristics of Co-ordinators

Tables 2.4 and 2.5 focus respectively on the employment conditions of project co-ordinators and on selected characteristics of the co-ordinators themselves. For the purposes of this report, we shall draw attention to only a limited number of the variables investigated.

Table 2.3a: Selected Characteristics of Projects

Community Options Project	Auspice Body	Type	Recurrent Admin. Target No. of Clients 1989-1990	Current Weekly Expenditure: Budget Allocation (\$)	Current Weekly Brokerage Per Client (\$)	Subsidy Per Client
Fairfield	Centacare	Charitable/Voluntary	100	182,459	34.95	46.41
Inner West	Central Sydney Area Health Services	Health	100	130,134	24.92	39.07
St George	Home Care Service	Home Care Service	100	125,381	24.01	39.07
Hornsby/Ku-ring-gai	Mercy Family Life Centre	Charitable/Voluntary	135	198,872	28.22	50.36
Newcastle	Dept. of Health Hunter Region	Health	170	297,927	33.57	42.26
Wollongong	Wollongong City Council	Local Government	100	165,693	31.74	72.58
Wyang	Wyang Aged & Disabled Support Services	Community-based	145	223,479	29.52	71.32
N.W. Aboriginal	Home Care Service	Home Care Service	60	153,359	48.96	65.39
N.W. Area	Home Care Service	Home Care Service	40	102,239	48.96	65.39
Shoalhaven	Home Care Service	Home Care Service	70	74,697	20.44	59.77
Hastings Valley	Hastings District Hospital	Health	100	87,207	16.70	54.79
N.E. New England	Glen Innes Municipal Council	Local Government	n.a.(a)	n.a.(a)	n.a.(a)	n.a.(a)
Temora	Temora Shire Council	Local Government	50	62,913	24.10	24.11
Liverpool	Centacare	Charitable/Voluntary	100	151,855	30.69	46.41
Note: a) not available.			Range - Budget Allocation Per Annum Per Client \$872 - \$2555		Range \$16.70 - \$48.96	Range \$24.11 - \$72.58

Table 2.3b: Selected Characteristics of 14 Projects Included in the Evaluation

1	Auspice Body		4	Target Number of Clients	
	Health Authority	3 Projects		40	1 Project
	Home Care	4 Projects		50	2 Projects
	Local Government	3 Projects		60	1 Project
	Voluntary/Charitable	3 Projects		70	1 Project
	Community Based	1 Project		100	6 Projects
				135	1 Project
2	Project Shares Premises with Auspice Body			145	1 Project
	Yes	5 Projects		170	1 Project
	No	9 Projects			
3	Project Shares Premises with Relevant Service Providing Organisation		5	Number of Clients to Each Co-ordinator - Range	
	Yes	10 Projects		21-75 clients	
	No	4 Projects			

Table 2.4: Selected Aspects of Conditions of Employment of 39 Co-ordinators

Position in Project	Full or Part-time (number)	Hours Worked Per Week	No. of Clients in Caseload	Salary (Hourly) Average	Salary (Hourly) Range	Annual Salary Range
Senior Co-ordinator	F(4)	38	30,35,35,75	\$17.75	\$12.90 to \$19.70	\$23,478 to \$35,854
	F(7)	35	13,20,20,25,33,40,41			
	P(2)	28	7,40			
	P(1)	21	40			
Co-ordinator	F(2)	40	40,48	\$17.00	\$14.00 to \$19.00	\$25,480 to \$34,580
	F(4)	38	35,40,40,40			
	F(8)	35	23,24,35,40,40,41,49,60			
	P(1)	28	32			
	P(2)	21	16,28			
	P(2)	18	20,20			
	P(1)	14	4			
	P(4)	7	7,8,11,12			
	P(1)	unknown	unknown			

Notes: F = Full-time; P = Part-time.

In respect of hours worked we note that senior co-ordinators or project managers are much more likely than co-ordinators to be working full-time. However, in one project, the part-time co-ordinators combine this job with work commitment to the Home Care Service. Whilst this combination did not appear to create any substantial conflict of loyalty, indeed their joint appointment was generally perceived by the co-ordinators we spoke to as helpful to the performance of both jobs, there appeared to be considerable lack of clarity with regard to organisational responsibilities and there were some complaints that the seven or 14 hour a week commitment to Community Options was not enough to do the job properly. Nearly all co-ordinators at both levels found themselves stretched to perform the job within ordinary working hours and many said that they frequently took work home, as a rule 'to catch up on the paper work' but sometimes to make contact with a service, a client or, more frequently, with a working carer. Co-ordinators working part time complained most about the difficulty of maintaining adequate job performance in the time available.

As we see from Table 2.4 there is a very considerable variation in the number of clients for which co-ordinators are responsible. In the case of senior co-ordinators or project managers this is often a reflection of the tendency of senior co-ordinators to reduce their client load in order to spend more time on their project management and community development roles. Project managers, in particular, do seem to attend a very large number of meetings.

Table 2.5: Selected Characteristics of the 39 Co-ordinators

<hr/>			
1	Sex		
	Females	38	
	Males	1	
2	Average Age		
	Senior Co-ordinators	40 years	Range 22 - 55 years
	Co-ordinators	36 years	Range 24 - 55 years
3	No. of Co-Residential Dependent Children		
	Senior Co-ordinators		
	0 Children	4	
	1 Child	3	
	2 Children	5	
	3 Children	1	
	4+ Children	1	
	Co-ordinators		
	0 Children	11	
	1 Child	4	
	2 Children	8	
	3 Children	0	
	4+ Children	2	
4	Educational Qualifications - Post Secondary School		
	Senior Co-ordinators		
	Degree in Social Sciences	1	
	Degree in Other Discipline	2	
	Welfare Certificate	3	
	General Nursing Certificate	4	
	None	4	
	Co-ordinators		
	Degree in Social Sciences	8	
	Degree in Other Discipline	2	
	Certificate in Welfare	2	
	General Nursing Certificate	2	
	Teachers Qualification	3	
	Other	1	
	None	7	
5	Main Occupational Experience		
		Senior Co-ordinators	Co-ordinators
	Community Options/Linkages	1	1
	Home Care	4	5
	Community Development/Social Work	3	12
	Nursing	4	5
	General Health	1	0
	Work with Minority/Ethnic Groups	0	1
	Administrative/Secretarial	1	1

One of the most striking aspects of the working conditions of co-ordinators to emerge was the wide variation in salary levels, particularly those of the senior co-ordinators. Of course, salary level reflects the level in its job hierarchy at which the auspice body chooses to place the co-ordinator. There does seem to be a case, however, for the government funding body to exercise rather more influence in the matter of salaries. The present position is clearly quite inequitable, which seems an anomaly given that equity is represented as a guiding principle of the HACC Program.

Turning now to selected characteristics of the co-ordinators themselves, we find that this is a field dominated by women. Only one of the co-ordinators in the projects included in the evaluation was a man. Co-ordinators are, in general, approaching their middle working years. This seems entirely appropriate in view of the kinds and level of experience that the job of co-ordinator could be expected to call for, though this is not intended to suggest that younger people might not manage the work perfectly well. It is worth noting, however, that very little is offered in terms of career prospects within the job itself. As Community Options is currently structured, it is to be expected that anybody with a little ambition is likely to want to move on after a time. If the Program develops, one can perhaps envisage an alternative structure in which there could be greater co-ordination between projects at a local level and therefore an extended hierarchy of positions and responsibility. However, for most of the people working in Community Options, its non-bureaucratic structure represents one of its most attractive features, often contrasted favourably with the Home Care Service.

With regard to previous work experience, most senior co-ordinators have had Home Care Service or nursing experience, whilst the majority of co-ordinators have a background in social work. Auspice bodies, whatever their own affiliations, cannot be said to have selected co-ordinators on grounds of their specific occupational backgrounds, even in the case of auspice bodies associated with health authorities. Though some individuals with nursing backgrounds were appointed as co-ordinators by these bodies, the choice was certainly not automatic.

The question of whether or not it is desirable for a project to contain workers from different disciplines was explored in the senior co-ordinator's questionnaire. A very high proportion of senior co-ordinators thought that a multi-disciplinary team was most appropriate, mainly because they saw both individual clients and the clientele as a whole as representing a range of problems both medical and social, for which it was useful to have a wide range of skills immediately available. Although the conditions for formal and informal interaction between co-ordinators were certainly present in projects, we were unable to observe how much discussion did in fact take place between co-ordinators about individual clients. We were given to understand that in many projects it occurred a great deal both in regular team meetings and more informally. However, rarely, if ever, was a client allocated to a co-ordinator on grounds of the appropriateness of the professional background of the latter.

Neither amongst auspice bodies nor co-ordinators were obvious preferences expressed for one type of professional background over another, although this was not a topic we explored in any detail. In the few cases where it was **not** felt that it was important to have a multi-disciplinary staff, either the notion of a multi-disciplinary team was considered spurious, or co-ordinators said that they could easily seek professional advice from outside their team, from a Geriatric Assessment Team (GAT), for example, if they felt they needed it. We have thus far been discussing the relative merits of a nursing or social work background and we have noted that neither emerged as the preferred choice. Another issue is whether a professional background of any description is important in this job. We have no reason to believe that those co-ordinators without professional qualifications performed any less effectively. However, the view expressed on some occasions was that unless Community Options employed people with professional backgrounds they were unlikely to be taken seriously by other service providers, particularly those in medical fields. Community Options are small organisations, dealing with relatively small numbers of clients, and consequently do not have a particularly high profile. As their success depends to a considerable degree on their capacity to establish effective liaison with a wide range of other organisations, it is not hard to understand their feeling that a well-qualified professional staff is desirable in order to command respect.

Table 2.6 describes the kinds of additional training which co-ordinators thought would help them to improve their work performance. There appears to be no relationship between the kind of training they would like and the kind of training which they have already received. They attached greatest importance to additional training which would make them better informed, competent practitioners. Assessment skills and a greater knowledge of dementia were ranked high. Training in communication skills was also favoured - there is no doubt that many co-ordinators found that negotiation with other services was a quite harrowing aspect of their job.

Finally, in this section we comment briefly on the major sources of satisfaction and stress that co-ordinators said that they experienced in their work. We have already alluded to the sense of great job satisfaction that was universally expressed and the strong identification of co-ordinators with the official objectives of Community Options. The rewards that co-ordinators receive from their work are listed in Table 2.7 and speak for themselves. What does not perhaps emerge from this table is that in general co-ordinators felt that Community Options indicated the right way forward for service delivery in Australia. The paramount importance given to the wishes of the individual, the emphasis on the 'whole person' and on flexibility were the aspects of the Community Options philosophy meeting with greatest approval from co-ordinators. It was in these respects that co-ordinators contrasted their own styles of working with those of the more bureaucratised services which they had encountered either in their own earlier work experience or in the course of current contact. In contrast the Community Options co-ordinator emerges as a carer, friend, and advocate who has the additional advantage of being well informed about local

Table 2.6: Additional Training Considered Helpful for Improved Job Performance

Area of Additional Training		No. of Times Mentioned
1	Additional information about disability/health	15
	Dementia - assessment/management	6
	Assessment	4
	General problems of the elderly	1
	Specific information about diseases	1
	What multi-disciplinary rehabilitation teams do	1
	When to refer a client to a professional and which professional	1
	New equipment available for disabled people	1
2	Communication	12
	Conflict resolution	6
	General communication skills	3
	Negotiation skills	1
	Writing submissions	1
	Public Speaking	1
3	Guardianship and legal issues	6
	Guardianship and public trusteeship	2
	Social justice	2
	Legal/industrial issues	1
	Domestic violence	1
4	Computing and data management	5
5	Time management	3
6	Counselling, including bereavement counselling	3
7	Management	2
8	Assertiveness training and stress management	2

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

Many of the stresses of the work were thought to be caused by bureaucratic requirements which interfered with positive achievements of the kind just mentioned (see Table 2.8). The paper work, the form-filling and data entry appeared, as far as the projects themselves were concerned, to serve no useful purpose, that is, none of these tasks helped them to improve their own performance. Except for purposes of this evaluation, it was unclear what purposes they were serving for the funding bodies either. This is clearly a complex and important area which needs detailed and probably separate treatment.

Table 2.7: Major Rewards of Job as Community Options Co-ordinator

	Reward	No. of Times Mentioned
1	Enabling people to stay in their own homes	17
2	Building up a service/getting satisfaction from working for something one really believes in	14
3	Enabling people to achieve a better quality of life	9
4	Providing support to vulnerable people and responding to individual needs	9
5	Empowering people/enabling people to be more independent	8
6	Personal contact with clients/being appreciated	7
7	Networking with other services/building up a better service system	6
8	Having the capacity to organise a package of services	5
9	Other	2

Table 2.8: Major Sources of Stress for Community Options Co-ordinators

	Cause of Stress	No. of Times Mentioned
1	Insufficient time/too much paper work/the competing claims of client-oriented work and paper work and data management.	20
2	Other services - their funding restrictions or lack of co-operation	14
3	Community Option policies and guidelines, for example the use of private services, lack of clarity over insurance matters, inconsistencies in guidelines (avoid premature institutionalisation, be flexible, be client oriented but do not use private services unless absolutely necessary)	6
4	The upsetting circumstances of clients	4
5	Finding private contractors and carers (especially in rural/remote areas)	3
6	Interpersonal problems	3
7	Distances to travel	3
8	Auspice arrangements	2
9	Other	3

The need for additional training in negotiation and communication skills, which many co-ordinators identified, is undoubtedly associated with the frustrations they experience in their dealings with other services. It should be noted, however, that most co-ordinators also spoke of the gradual improvement in their relations with other services as they became better established and more confident. Other services, in turn, gained a better appreciation of and respect for the role of Community Options. Some co-ordinators were also at pains to point out that they enjoyed excellent relations with other services. Although one cannot generalise with confidence, it did seem that those projects which had greater familiarity with other services and **their** problems either because staff had previously worked in those services or because they shared premises had a more understanding relationship.

With certain exceptions, it was clear that co-ordinators felt frustrated by the requirement that they should enter the service system through the publicly funded service door. Although not moved by any ideological preference for private as against public provision, many felt that, on the whole, private services gave them a better, more cost effective deal than the public services and enabled them to meet the needs of their clients more flexibly. They would have preferred more freedom to use private services. They not only felt frustrated by the rules relating to their use, but also by conflicting advice on this question from the funding bodies and by delays in the resolution of legal issues affecting the use of private contractors. Exceptions to this general preference for private sector provision were found amongst some who were strongly committed in principle to the public services and who felt that resort to private services served to disguise the inadequacy of public provision.

In this context it is worth indicating which types of clients gave co-ordinators the greatest difficulty in terms of meeting needs. Overall, dementia sufferers and younger people with severe physical disabilities presented co-ordinators, by their own account, with the greatest challenges. For these groups, the problems were widespread across projects. In the case of both client groups, co-ordinators experienced particular difficulty in finding people who had adequate skills and sufficient understanding of the conditions and who were also prepared to provide the care with the flexibility required in the circumstances. This could either be respite or other forms of domiciliary or day care. In the case of younger people with very severe disabilities a further barrier was the cost of providing care at the level of intensity often needed. For this group, too, co-ordinators felt that there was insufficient funding available for equipment. Of course, problems were by no means confined to these groups of clients, as we shall see when we come to consider the types and source of funding of services used by Community Options. Nevertheless, they were the problems mentioned most frequently.

Auspice Bodies

From the Perspective of the Senior Co-ordinators. We have already alluded on a number of occasions to the projects' auspice bodies. These are the organisations which sponsor the projects, are legally responsible for the administration of their

funds and for ensuring that these are used as efficiently and effectively as possible. As part of its remit the auspice body is responsible for the employment of the project staff who are subject to its own terms and conditions of employment. This, as we have noted, has led to considerable variability between projects, especially apparent in the salary scales of co-ordinators. It seems likely that in some cases the auspice body is unclear precisely where to locate co-ordinators in its own employment hierarchy perhaps because the organisation had no equivalent position. This has led to some anomalies between projects.

Table 2.1 indicated the types of auspice bodies for the fourteen different projects. We found considerable variability in the way that auspice bodies interpret their role and in this respect there did not seem to be a clear relationship between the type of auspice body and its administrative arrangements with the project. Many auspice bodies delegate most administrative tasks to the projects, even the payment of staff salaries and other accounts. Others provide the projects with a great deal of administrative support, from the payment of all accounts to the purchase of cars for co-ordinators, the ordering of stationery and changing washers on taps. Clearly the amount of administration that is devolved to the projects will affect their own workloads, in particular those of the senior co-ordinators and this extra workload may, as we have noted, have a flow on effect to other staff, both co-ordinator and clerical staff. But the devolvement of administrative and financial responsibility was not necessarily a cause for concern. Some co-ordinators appeared to like the greater control that this gave them over the management of their budgets. Certainly this did not emerge as a significant issue. A greater cause for concern was the sometimes lax and inefficient administration of funds and particularly the embarrassingly slow payment of accounts by some auspice bodies.

Table 2.9 provides a picture of the range of difficulties that projects experienced with their auspice bodies. Half of the projects did not identify any difficulties at all. Apart from the inefficient administration of funds, two other problems emerged. In one case it seemed that lines of accountability were unclear and access to the appropriate administrator was a difficulty. In the other, the auspice body used the resources of the Community Options project, inappropriately, for its own ends.

As the table indicates, all but one project seemed to have at least some positive comment to make about its auspice body and in some cases projects found the auspice body very supportive. Three aspects emerged as very important. One was that the auspice body seemed to understand what the project was trying to achieve and combined a genuine interest in its successful development with a non-intrusiveness. Another was that the auspice body was generous with its own resources and in particular shared its own administrative expertise with the project. Third, in a limited number of cases the auspice body had acted as a helpful advocate and intermediary between the funding bodies (FACS or DCS and H) and the project; this role was also valued.

Table 2.9: Relationship of Community Options Projects with Their Auspice Bodies

Auspice Body	Influence on selecting clients, if any	Positive contribution of auspice body	Difficulties with auspice body
1	None. Initially many referrals that were mostly inappropriate, but now little influence.	Writing of cheques. May provide services in an emergency.	Budget estimates cause difficulties as different used (calendar v. financial). Processes are very slow. They do not understand the CO Program.
2	None	Happy to work together with us. Supportive and helps with problems.	None
3	None	Prestige of organisation and being able to call on its resources if required.	None
4	None	None	Delays in drawing of cheques. Unnecessarily required to adhere to the bureaucratic requirements of the auspice body
5	Makes appropriate referrals	Support, flexibility, autonomy, trust	Insufficient availability for advice and support. Complex administrative structure means no clear lines of accountability
6	Many referrals of a particular type of client	Easy access to professional advice	Uses CO resources, staff and facilities. Co-location with auspice results in project being away from mainstream service providers
7	None	Very supportive, non-interfering but interested and knowledgeable. Allows flexibility.	In past, conflict of interest between CO and some members over staff conditions. Maintaining the right mix of people with different types of expertise on committee
8	None	Supportive of aims of CO particularly client self-determination	None
9	None	Annual appraisal of staff. Regular meetings with assistant director. Generally very co-operative	None
10	Significant. Auspice has a good reputation and thus attracts clients and service agencies. Service provided by auspice result in appropriate high-risk referrals	Access to resources and services as well as philosophical and financial/administrative support. Supportive in encouraging risk-taking. Allows flexibility	None
11	Performs role of watchdog to ensure appropriate clients selected.	Provides relief staff and information. Helps with insurance. Fosters understanding and co-operation, especially in problem solving	Difficulty with being expected to have a policy on everything when project is only new. CO must be assertive about its uniqueness/flexibility
12	None	One member of auspice is particularly supportive in sorting out operational problems	None
13	None	Mutually beneficial and supportive relationship between CO and auspice	Incompetent administration led to a change in arrangements
14	None	Provides support to employees	None

Auspice bodies are charged with the responsibility of ensuring that projects use their funds as efficiently as possible. Though this might seem to involve a risk of unwelcome intervention by auspice bodies in the management of projects, as the table shows, there were relatively few instances of any kind of intrusion by auspice bodies in day to day administration. Some auspice bodies were more demanding than others, in terms of the burden of administration they expected projects to bear, but this is clearly a different matter from direct attempts to influence the selection of clients or to determine the pattern of service provision in particular cases. Instances of these occurred but were rare.

From the Perspective of Representatives of Auspice Bodies. We interviewed a representative from each of the 13 auspice bodies sponsoring the 14 projects included in the evaluation.⁷ We spoke to the person who, in each case, was deemed by the auspice body itself to have the greatest responsibility for the Community Options project. Selecting the respondents in this way led to some variation in the functions they performed in the auspice organisations. Thus, whilst all the respondents held managerial positions, in some cases their role was purely administrative, and in other much more frequent instances, they combined administration with a professional, planning or policy development role. Whatever the role of the respondent in their organisation, we found an impressive amount of knowledge about the objectives and administrative functioning of Community Options, in some cases in part gleaned from membership of the project's management committee. We found some variation, however, in the degree of interest respondents expressed in the 'issues' surrounding Community Options. Although there were important exceptions, those who held purely administrative positions in their organisations were perhaps less thoroughly acquainted or interested than others in the policy rationale of Community Options and its place in the structure of community and domiciliary services more generally.

In the case of three projects the initial auspice arrangements had had to be altered. One project had been jointly auspiced by two agencies. It appeared that not only did these agencies have diametrically opposing views as to how the project should develop but there were also serious problems of accountability. It was only when one of the auspice bodies had withdrawn that the project was able to move forward. In another case the project was co-managed by a Home Care Service branch manager. That arrangement had proved unsatisfactory not on account of any personal friction but because the task had proved to be too great for the branch manager. Apparently it had not been appreciated that the job of a co-ordinator is very demanding, not least when a project is being set up. It is not surprising that this was not understood until it was experienced. A Home Care Service co-ordinator can have as many as 350 clients whereas a Community Options co-ordinator is limited to 40-50. No wonder it seemed as though the small case load could be easily assimilated into the Home Care Service branch if the difference in roles of the two co-ordinators was not fully understood. We were told that the Community Options

7 Centacare was responsible for two projects, Liverpool and Fairfield.

work was increasingly borne by the part time Community Options co-ordinator who effectively proceeded to manage the project without commensurate recognition in terms of her position in the organisation or salary enhancement. Attempts to rectify this situation by means of negotiations with FACS had apparently proved fruitless. In the third case the local authority had been the auspice body. Whereas at the purely administrative level this had proved a satisfactory arrangement, there had been problems at the level of professional management. The local authority had simply not been equipped to offer the kind of support needed. The problem was resolved with the setting up of a management committee to which the project was responsible for client-related and professional matters, thus separating the administrative and managerial functions. This was apparently proving to be a much more satisfactory arrangement and more in line with that commonly found amongst the other projects.

We found universal support for the notion of Community Options from the representatives of the auspice bodies. Some, particularly those who represented local government councils, saw Community Options as bringing useful additional resources for community services for the elderly to their locality and for this reason were anxious that the project should not underspend. Most thought their projects were doing an excellent job and performing a very valuable role in the community. Praise was almost universally positive. Although, as we have noted, some senior project co-ordinators had experienced difficulties with their auspice bodies, from the perspective of the auspice body, the administrative arrangements universally appeared to be operating smoothly. Interpersonal relations between the auspice body and the Community Options project staff seemed on the whole good and although some representatives of auspice bodies might, on occasion, have been a little equivocal about an individual staff member in their project, we certainly experienced no serious criticisms either about the proper and efficient management of the projects or their staff. 'A project is as good as its staff' was a widely articulated view and most auspice bodies seemed very happy with the staff they had selected. The generally positive sentiments of the senior co-ordinators towards the auspice bodies were thus reflected back by the representatives of the auspice bodies.

The same could not be said of the relationship of the auspice bodies to DCS and H and FACS. The most serious complaints were levelled at FACS. Although the occasional FACS staff member was singled out as excellent, there was extensive dissatisfaction with FACS on a number of grounds. For example, FACS staff gave conflicting advice to co-ordinators and representatives of the auspice bodies. Advice was rarely put in writing, indeed letters were rarely answered and follow up phone calls to letters were almost always required. Even these frequently yielded no further response. Obtaining advice on the employment of casual staff, on whether money given to clients to employ staff represented income that could affect the clients pension, and on insurance matters were particularly singled out as a major difficulties. Auspice body representatives complained that neither DCS and H nor FACS had thought through what the implications of the guidelines would be once these were operationalised. When inconsistencies and anomalies were pointed out to them they were still unprepared to provide guidance, invoking the evaluation of

Community Options as the reason for their inability to resolve the issues. This too was the reason they gave for their reluctance to allow the employment of additional project staff, even when the case for an additional staff member appeared to be clear cut.

Another area of considerable dissatisfaction was that of data management. We received many criticisms from auspice bodies concerning the way that the data management system had been set up. It appears that in many cases the co-ordinators had sought the technical advice of their auspice bodies on problems they experienced in this area.

Yet a further problem concerned the management of staff. It appeared that some instructions to projects did not go through the auspice bodies and a number of representatives of auspice bodies complained that the co-ordinator would be invited to attend a training course given by FACS but that the auspice body as employer had not been notified or asked for agreement for the release of their staff.

Many of the anomalies, rigidities and apparent contradictions associated with the Community Options guidelines that had been identified by the co-ordinators were also raised in our discussions with the auspice bodies. This is hardly surprising. Presumably the auspice body had been the first port of call of the co-ordinators for the resolution of these problems. No doubt a part of the dissatisfaction of the auspice bodies with DCS and H and FACS was that they felt that they had had as little luck in getting these issues resolved with the relevant government departments as had the co-ordinators themselves.

Although specific topics were covered in all interviews, there was no doubt that many of the respondents used the opportunity of the interview to express opinions that they held about the role and future of Community Options, for example, to whom it 'rightfully' belonged and why, and where its future should lie. As might be expected, whether or not Community Options rightfully belonged in the sphere of health was the issue that raised the greatest heat. All representatives of auspice bodies associated with the health system were of the view that the connection with health was very important, given the nature of the clientele, but how it should be administratively connected generated less uniformity of opinion and varying degrees of conviction and commitment. At **one** extreme there was the view held with immense conviction that Community Options should be part of the health system and at the **other** there was preparedness see a relationship which involved less control and allowed for a considerable degree of autonomy for Community Options.

None of the representatives of auspice bodies which were not associated with the health system thought that a health authority had any automatic or necessary role in Community Options; indeed quite the reverse. Whilst it was felt that Community Options should certainly seek the advice of health professionals when it seemed appropriate, that, it was believed, was as far as the relationship should go. To go further would undoubtedly result in domination by health professionals, (notorious, it was said, for the control they exercised over patients and for their predisposition to support those family members who wished to commit their relatives to residential

care) such that the essential social and welfare functions of Community Options would be lost entirely. A number of representatives of auspice bodies spoke of the way in which the local health services had deliberately sabotaged Community Options in its early days. Some said this was done out of a sense of pique where the health services had not been appointed to sponsor the project.

Equally, all the Home Care Service representatives thought that the logical place for Community Options was, in fact, with their service. This was because the philosophies, aims and functions of the two organisations overlapped and also because the Home Care Service had the longer established right kind of 'know how'. In some cases the rationale for integration was that it would enhance the capacities of the Home Care Service and enable it to do better what it was already doing. But one Home Care Service representative cautioned that although the Home Care Service was the most obvious sponsor of Community Options, the organisations should not be co-located because this would undermine the advocacy role of Community Options - a client would not be prepared to complain about the Home Care Service if it and Community Options shared the same premises or telephone.

There is another significant difference between auspice bodies which not only affect the opinions of respondents but also the strength of conviction with which these are expressed. These seem to depend on how far Community Options is perceived as directly implementing the goals of the auspice body itself, acting simply as an additional resource, or whether Community Options is seen as having an independent place amongst other local service providers, as a community resource. Sometimes Community Options was undoubtedly perceived not just as a responsibility of, but as a resource belonging to, the auspice body. In these instances the auspice bodies appeared to be more prescriptive and involved in the day-to-day operation of the Community Options projects. We found that whilst some projects found this degree of involvement obtrusive, others found it quite acceptable, even helpful. In the case of one of the auspice bodies which was a voluntary organisation, Community Options was part of a network of services provided by that organisation for the same client group. The relationship between the auspice body and Community Options, as far as we could see, was non-competitive and exceptionally supportive. The auspice body could advocate and support the project in its sometimes difficult and more competitive interactions with other external service agencies. In this particular case the auspice body appeared to act almost like an 'at risk' committee. Any one client could be the concern of a number of the various component agencies of the auspice body and clients might be discussed between the managers of these separate parts of the auspice body. Another interesting feature of this agency was that it could provide, from its own network, casual staff who could be employed by its Community Options project. This particular auspice body had amongst its concerns sole parents and wives who had been abused and who needed employment. This group of women constituted a ready-made work force for Community Options. It was little wonder that the auspice body strongly favoured the use of private contractors.

In some cases the relationship of the auspice body to the project lacked clarity and consistency. This was the case with the Home Care Service, which was prepared to give some projects autonomy such that they were set up as a separate and independent branch, whereas in others there was a much closer integration of the Home Care Service and Community Options. We have already referred to a case where integration seemed to have been taken to an extreme. The Community Project was set up as part of the Home Care Service branch so that the manager of the branch was the line manager of the Community Options co-ordinator. This arrangement, as we noted above, failed primarily, it appears because the co-ordinator was not able to manage both jobs. In rural areas staff may be jointly appointed by the Home Care Service and Community Options. Where appropriately qualified staff are few and far between such joint arrangements allow, we were told, for a more viable job to be constituted. There is a much greater incentive for a person to take a full time job which is a joint Home Care Service and Community Options job than to take a one or two day a week job, which is all that would be possible in a small rural area, with Community Options. Whilst there would seem to be considerable force to this argument, we note elsewhere that joint appointments can lead to problems of accountability in respect of line management and in certain cases a confusion in role and organisational loyalty. Some co-ordinators appear to manage this better than others, perhaps due to their personal security or because of particularly supportive management.

Finally, many pointed to the inter-service rivalries that had been fuelled by the appearance of Community Options on the scene. They sympathetically described how difficult it had been for Community Options to gain acceptance in the world of local services because they seemed to be taking over a role that other services formerly had seen as exclusively theirs. Sometimes auspice bodies saw themselves as almost adjudicating between these various interests. At the same time some of the service-delivering auspice bodies used the opportunity of the evaluation to point out some of the limitations of local community service provision more generally. In a sense they were identifying themselves as fellow victims of Community Options. The inadequacy of hostel places, of respite services for people with disabilities and their carers, the poor service infrastructures particularly in rural areas which lead to a very important role for Community Options' 'one-off' payments, were all matters of a more general nature raised by the auspice bodies.

Management and Advisory Committees

Most of the projects had advisory or management committees which in all but one case consisted of the major local service providers, in most cases at least one consumer representative as well as representatives of key local community groups. It was a little surprising that Meals on Wheels was represented on only one of the Committees. In many cases, a representative of the auspice body was included as a member of the committee. In the majority of cases, the members had been selected by senior co-ordinators of the project but whether this was the case or not did not

seem to affect how the senior co-ordinators perceived the value or success of the committee.

As Table 2.10 indicates, the reaction to management/advisory committees of the 14 projects was in general positive rather than negative, but this was not an area which was explored in great depth in the evaluation and hence it is not possible to describe in any detail how the service linkages which were established through the committees were utilised to facilitate relations between Community Options and the other services, or to develop guidelines for the regulation of interagency relations. The impression gained from other aspects of the evaluation was that these linkages served to inform other services about Community Options and vice versa but not to establish guidelines determining inter-service expectations.

Suggestions for Improvements

At the conclusion of our interviews with co-ordinators we asked for their views about the ways in which they thought Community Options could be improved.

We first asked all co-ordinators what changes in the policies and guidelines they thought would enable them to support their clients more effectively than at present. Four of the 39 co-ordinators did not suggest any changes. Of those who did, the two changes most frequently mentioned (in each case by five co-ordinators) were:

- a greater flexibility in the use of private services; and
- a clearer definition of the target population.

Other changes each suggested by at least three co-ordinators were:

- greater flexibility with the guidelines so that they could enable a broader group of people to be accepted as clients, for example, those in need of palliative care;
- greater flexibility with the guidelines so that it should be possible to use the 'one-off' money and the subsidy money interchangeably; and
- clearer instructions concerning the employment of private workers and insurance coverage for them are needed, to make them more precise and consistent across projects.

We next asked co-ordinators what improvements they could suggest to their own projects. Only two co-ordinators made no suggestions. Amongst the remainder it is of some interest that the majority of responses did not relate to improved work conditions but to improved job performance. Issues associated with staffing were raised most frequently. In this context the most important concerns were:

Table 2.10: Structure of Management/Advisory Committees

Project	Nature of Committee	Frequency of Meetings	Help provided in achieving Projects' objectives	Hindrances to achieving objectives
1	Management	11 times per year	Giving advice support and information. Members are available to provide advice as necessary.	None
2	Management	6 times per year	Support for objectives.	None
3	Management/Advisory	11 times per year 4 times per year	Advice on policy, protocol, target direction groups etc. from both committees. Insufficient input from consumer representative.	Inconsistencies in from meeting to meeting.
4	Advisory	4 times per year	None	None. Creates extra work - no help.
5	None, but Advisory group planned.	N/A	N/A	N/A
6	Management	4 times per year	Gives advice on management issues. Approves expenditures. Evaluates performance of workers.	None
7	Management Sub-committee	12 times per year 12 times per year	See comments on auspice body	See comments on auspice body.
8	Advisory	6 times per year	Researches local issues relevant to project	None
9	Advisory	6 times per year	Discusses issues of relevance	None. Difficult to get input.
10	None	N/A	N/A	N/A
11	None, because of difficulties with distance to be travelled	N/A	N/A	N/A
12	Advisory	6 times per year	Provides support and information. Assists with priorities of project. Helps publicise/provide information about CO.	None
13	Defunct Support Committee. Members had insufficient interest	N/A	N/A	N/A
14	None	N/A	N/A	N/A

- a desire for more training to enhance skills and job performance;
- the need for lower staff/client ratios which would enable the closer monitoring of clients at risk. In this context some co-ordinators also felt that monitors should be built into staff establishments; and
- the belief that co-ordinators were engaged in an excessive amount of administrative work which it would be more appropriate for the projects' administrative and clerical workers to undertake.

Other needs that were specially emphasised were:

- a greater flexibility in the use of the funds. In this context the issue was raised again of interchangeability of 'one-off' and subsidy money as well as an actual increase in the subsidy money, (although not in the overall \$200/\$400 funding limit), so that projects could accept more people with a higher level of need than is possible at present;
- increased funding of other HACC services to enable clients' needs to be met; and
- better relations with other services. What is most needed, it was felt, is more helpful and structured relations with other services, (both with HACC services and GATs), clearer expectations in respect of what other services could be expected to provide, and better and more up-to-date feedback from other services about clients' current conditions.

2.3 Findings

Community Options Clients and Carers

In this section we describe how people came to be clients of Community Options and how they came to leave the Program. We also provide a profile of clients.

Referrals and Non-Acceptance. As for other services, for the most part, Community Options clients are referred by other service agencies. Most co-ordinators told us that in the early days of their projects many of the people who were referred to them were, for a variety of reasons, not appropriate as clients of Community Options. There seem to have been two reasons for this. In the first place other services had been inadequately briefed as to the type of client Community Options was intended to serve. Secondly, other services were inclined to regard Community Options merely as a source of extra funding or a convenient device for off-loading clients that they could not deal with themselves. These inappropriate referrals may have been people whose needs were not great enough for the service off-loading them and also not sufficient to qualify them for Community Options. They were sometimes, on the other hand, people with such very great needs that Community Options could not afford to take them on as clients. There were

also people being referred whose entire needs could well have been met by other services. The co-ordinators we spoke to described how, at the very time that they were trying to establish themselves, these inappropriate referrals placed them in the invidious position of having to reject both the requests of services and the requests of would-be clients. They felt they gained an undeservedly bad reputation in the world of local services both for being negative and for taking an apparently elitist position. Most co-ordinators felt that far more work should have been done before the establishment of the project in educating the existing services about the proper role and function of Community Options.

Sources of Referrals. Despite the problems described above, referrals come from very much the sources to be expected given the nature of the clientele for whom Community Options is intended, namely frail elderly people (see Table 2.11). About half (49.7%) of the 1,257 accepted as clients during the reference year were referred by health workers: a hospital social worker or 'discharge planner', a home or community nurse, a Geriatric Assessment Team or, much more rarely, a GP. Over half of the clients (53.1%) were referred by a Geriatric Assessment Team, the Home Care Service, Home/Community Nursing, a Community Aid or Advice Centre or Meals on Wheels and were thus already clearly within the local community or domiciliary service network. A significant proportion (about one-fifth) might be described as 'private referrals' that is, referrals by carers, relatives or friends or by the clients themselves. There is no information about how such private individuals came to hear about Community Options but this is clearly a matter of some interest.

There are considerable variations between projects in respect of the sources of referral. There is no strict correlation between the source of referral and the orientation of a project's auspice body. We would conjecture that the presence or absence of different types of service in a given locality, the dominating influence of a particular service (for example, the Home Care Service or a GAT) and the professional background of the Project Manager all exercise some influence on sources of referral, but we are not in a position to provide definitive answers to this question.

It is hardly surprising that the main reason for the referral of clients was ill-health and increasing frailty (see Table 2.11). The next most common set of reasons has to do with the carers' need for support. This was the case in all but two projects.

There were three main grounds for deeming a referred person to be an appropriate client. The first was that the person or their carer had needs that could not be met, for whatever reason, by existing government funded services. The second was that their needs were complex and they were unable by themselves to set up the package of care they required. The third was that their health or social circumstances were volatile or precarious and needed to be monitored continuously.

Inappropriate Referrals and Non-acceptance. As Table 2.12 shows, only about a third of those who were referred were, in fact, accepted. There is considerable variation between projects in the ratio of non-accepted to accepted referrals.

Table 2.11: Referral of Clients

	No.	All Projects %
1 Referring Organisation		
Self	72	5.7
Carer	28	2.2
Relative/friend	157	12.5
Local GP	28	2.2
Hospital	203	16.1
Home Care	174	13.8
Home Nursing	227	18.1
Meals on Wheels	16	1.3
GAT	167	13.3
Community Aid/Info Centre	84	6.7
Local Govt.	8	0.6
Other	93	7.4
Total	1,257	100.0
2 Referral Reason		
Does not wish to live alone	1	0.1
Own ill health/increasing frailty	573	45.6
Condition of own home	45	3.6
Not want to be burden on others	32	2.5
Planning for the future	45	3.6
Decision of carer/relatives	107	8.5
Carer cannot provide adequate assistance	251	20.0
Client rejects residential care	50	4.0
Other	147	11.7
Respite	6	0.5
Total	1,257	100.0

At Hornsby, almost twice as many were not accepted as accepted, whereas in the Hastings Valley, only one referral was not accepted, according to the Minimum Data Set.

In many cases applicants who were not accepted were referred to other services because the co-ordinator felt that their needs could be met adequately there. In a substantial number of other cases clients were not accepted because their need was not considered great enough or because the services they were already receiving were thought to be adequate for their needs. However, it will be observed from Table 2.12 that in many cases no clear explanation for non acceptance emerged. This is a reflection of the unsatisfactory scheme of coding categories from which co-ordinators were asked to choose, which encouraged frequent use of the response 'other'.

Table 2.12: Reasons for Non-acceptance of Referrals

Reason Given in Coding Scheme	All Projects	
	No.	%
Referral to other agency	157	24.7
Entered long-term care	38	6.0
Limited resources	12	1.9
Beyond client limit	11	1.7
Low level of need	67	10.6
Receiving adequate service	83	13.1
Deceased	30	4.7
Refused Community Options assistance	82	12.9
Additional family assistance to be provided	32	5.0
Moved out of area	4	0.6
Other	102	16.1
No reason given	17	2.7
Total	635	100.0
Number of non-acceptances as a percentage of number of acceptances		50.5

Two points need to be made about inappropriate referrals. Firstly, even when a person is not accepted, the work of investigating and referring that client to another service can entail home visits and numerous phone calls, taking up many hours, sometimes extending over a period of several weeks of co-ordinator time. Secondly, though this work can represent a very valuable service for both the client and the service provider it is not reflected in any way in the information concerning the work of projects transmitted to the funding bodies. It is very important that local services know the guidelines of Community Options so that they can make the best use of Community Options and of the co-ordinators' time.

Clients Who are Accepted

The Decision Making Process. Although a person may be rejected as a client of Community Options without a visit from a co-ordinator, acceptance as a client without either a home or hospital visit from a co-ordinator is, from all accounts, very rare. Frequently it is only after two or more visits and a most careful assessment of the totality of circumstances that a co-ordinator will make a decision.

We found that in general co-ordinators do not base such decisions on rigidly applied criteria or rigorous assessment of functional incapacity or disability. Indeed, most co-ordinators we met thought that such procedures were quite inappropriate for their vulnerable clientele, many expressing a dislike of what they perceived as the highly bureaucratised and intimidating method used by the Home Care Service. In contrast, co-ordinators placed a great deal of emphasis on employing a non-threatening

approach to tease out the needs and circumstances of their potential clients. We were told that initial visits rarely lasted less than an hour to an hour and a half.

The fact that criteria for the acceptance of a Community Options client are, as we have noted elsewhere, not well defined is a source of anxiety to co-ordinators. Particularly when they are relatively inexperienced, they fear that they may fail the funding body by 'taking on wrong or inappropriate people as clients'. Alternatively they are anxious about the possibility of inadvertently rejecting someone in dire need. In many cases co-ordinators felt under further pressure from the scrutiny of more established services lest they be seen as 'over-servicing'. On the other hand, co-ordinators found the exercise of judgement a rewarding and challenging exercise and valued the flexibility that the Community Options guidelines allowed them.

Criteria for Accepting a Client. We asked co-ordinators what were the main criteria they employed in deciding whether or not to accept a person as a client. It is hardly surprising that broadly they cite those laid down in the guidelines, that is, they accept as clients those they judge to be at risk of premature or inappropriate institutionalisation. In certain cases the co-ordinator does not have to make the judgement as to whether a person is at risk of institutionalisation, because a residential placement has already been approved. Though administratively **appropriate** in this strict sense, such placement may still be **premature** in so far as the client and/or his or her carer maintain a strong preference for care at home. As Table 2.13, which looks at the relationship between approval for residential care and dementia shows, approximately 35 per cent of the people accepted as clients had been deemed suitable for residential care, this proportion rising to about 54 per cent for dementia sufferers or those displaying symptoms of dementia. But what of the clients who, for whatever reason, have not been deemed eligible for residential care, either because they have not undergone an assessment of their eligibility or because they have undergone an assessment and have been deemed ineligible? From co-ordinators' responses it would appear that the crucial factors are: apparent level of vulnerability, 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, inability to deal with the bureaucracy, poverty or family circumstances. Each one of these factors calls for unavoidably subjective assessment but it does not follow that final judgements are erratic or unsound. We solicited a large number of case studies from co-ordinators and in most instances it would have been hard to disagree with their conclusions. Finally, we would note that the great majority of co-ordinators said that they do not attempt to take into account the length of time it will be possible to help the client to remain at home since this is clearly an imponderable. It also seems to be the case that in accepting a client many co-ordinators do not **consciously** weigh the likely cost of that client's services against the cost of other clients who make up their case load although they remain aware of the importance of this general issue. Each case would appear to be judged on its own merits.

Table 2.13: Symptoms of Dementia and Prior Residential Approval

Approval		Yes	Dementia No	Unknown	Total
Yes	- no.	132	283	25	440
		54.3	30.9	25.5	35.0
		30.0	64.3	5.7	100.0
Approval pending	- no.	14	30	1	45
		5.8	3.3	1.0	3.6
		31.1	66.7	2.2	100.0
No	- no.	78	507	9	594
		32.1	55.3	9.2	47.3
		13.1	85.4	1.5	100.0
Unknown	- no.	19	96	63	178
		7.8	10.5	64.3	14.2
		10.7	53.9	35.4	100.0
Total		243	916	98	1,257
		100.0	100.0	100.0	
		19.3	72.9	7.8	100.0

Notes: Percentages add to 100 down columns; bold percentages add to 100 across columns.

A Profile of Clients. Table 2.14 provides a profile of the 1,257 people who were accepted as Community Options clients during the reference year. Selected characteristics of clients are listed below. Comparisons are made when possible with the population included in the ABS 1988 Survey of Disabled and Aged Persons.

- The majority of the clients are elderly, having an average age of 71 years. The youngest client is one year old and the oldest is 102 years of age. A large proportion of clients falls within the 70 to 89 age range. Younger people with disabilities (that is, those under 65 years) account for about one fifth of the clients. It should be noted that co-ordinators were quite unclear about the suitability of these younger clients for the Community Options program since the defining characteristic of a Community Options client, that is, someone at risk of inappropriate or premature institutionalisation, appeared to be inappropriate for younger people with disabilities. Some claimed to have received verbal instructions that no more than 15 per cent of their clients should be younger people with disabilities. Others quoted an upper limit of three per cent for this group. It is worth noting that compared with the population included in the ABS Survey, elderly Community Options clients are considerably over-represented;

Table 2.14: Selected Characteristics of Clients Accepted in Reference Year

	No.	All Projects %	% ABS(a)
Total Clients	1,257	100.0	
Age			
0-9	26	2.1	
10-19	28	2.2	
20-29	26	2.1	
30-39	25	2.0	
40-49	31	2.5	
50-59	64	5.1	
60-69	162	12.9	
70-79	411	32.7	
80-89	410	32.6	
90 and over	74	5.9	
Younger clients			
0-14 years	40	3.2	10.9
15-64 years	217	17.3	49.2
Older clients			
65 and over	1,000	79.6	39.0
Sex			
Male	479	38.1	41.3
Female	778	61.9	58.7
Ethnicity			
Aboriginal	36	2.9	
Australian/English speaking background	1043	83.0	
Non-English speaking background	178	14.2	
Dementia			
Yes/displays symptoms	250	19.9	
No	927	73.7	
Unknown	80	6.4	
Pensioners			
Yes	1071	85.2	
No	156	12.4	
Unknown	30	2.4	
Carer			
Yes	901	71.7	
No	326	25.9	
Unknown	30	2.4	
Live Alone			
Yes	471	37.5	12.9
No	756	60.1	87.0
Unknown	30	2.4	

Note: a) Based on ABS (1989) *Survey of Disabled and Aged Persons, Australia, 1988*, Catalogue 4118.0.

- nearly two thirds (62%) of the clients are women, reflecting the greater female expectation of life and the greater likelihood that women in old age will live alone. The sex ratio of Community Options clients is very similar to the population included in the ABS Survey;
- the great majority of clients (83.0%) are from an English speaking background. Aborigines make up 2.9 per cent of the total. People from non-English speaking backgrounds make up 14.2 per cent of the population covered by the 14 projects and would therefore appear to be somewhat under-represented amongst clients. However, it would be rash to draw any firm conclusions partly because of possible differences in the age structure of the enumerated population and the Community Options clientele but also because of the possibility of differences in definitions used in the Census and in the coding scheme devised for the Minimum Data Set;
- about one-fifth (19.9%) of the clients had either been diagnosed by a GP as suffering from dementia or (according to the co-ordinator) displayed signs of dementia;
- not unexpectedly, given their ages, a large majority (85.2%) are pensioners. About 86 per cent of those classed as pensioners also had a Health Benefits Card;
- nearly three-quarters (71.7%) of the clients have a carer. (Table 2.15 provides more information about carers); and
- just over a third (37.5%) of the clients live alone, a considerably higher proportion than the population included in the ABS Survey. This suggests that Community Options clients are likely to be a particularly vulnerable group.

Individual projects have broadly the same patterns though with some differences in detail. For example, Liverpool, as a project with a dementia focus, does indeed have a disproportionately large number of clients who are dementia sufferers and Wollongong, Newcastle and Fairfield, all of which have an NESB focus, do indeed tend to have a relatively high proportion of clients from such backgrounds. As might be expected, practically all the Aboriginal clients are clients of the Aboriginal project. This project also has on average, more younger clients than the other projects, reflecting, no doubt, the lower life expectancy of Aboriginal people.

Carers of Clients. Table 2.15 presents information on carers. The Table shows that most carers are either spouses (38.5%) or the daughters (26.3%) of clients. Sons are the next largest group (10.2%), then mothers (8.5%). Friends account for only 6.9 per cent of carers. About 59.2 per cent of carers are females and 28.8 per cent are males. The sex of 11.9 per cent of carers could not be determined from the Minimum Data Set.

Table 2.15: Selected Characteristics of Carers

	No.	%
Clients with Carers	901	100
Relationship of Carer to Client		
spouse	347	38.5
daughter	237	26.3
son	92	10.2
mother	77	8.5
friend	62	6.9
relative	27	3.0
sister	22	2.4
neighbour	18	2.0
father	10	1.1
brother	9	1.0
Carer's Age		
15-29	22	2.4
30-39	70	7.8
40-49	173	19.2
50-59	198	22.0
60-69	183	20.3
70-79	178	19.8
80 and over	77	8.5
Amount of Care From Carer		
Lives with carer	649	72.0
Daily visits	77	8.5
More than 1 visit per week	100	11.1
1 visit per week	44	4.9
Less than 1 visit per week	31	3.4

The reported ages of carers are often based on estimates made by co-ordinators. These values can only be treated as approximate, therefore. The average age of carers is in the region of 58 years, the youngest carer being 15 years old, the oldest 92.

Although for about a quarter of clients there was no one who was designated by the co-ordinators as a carer, clients who do have carers tend to be in reasonably close contact with them. In nearly three-quarters of cases the carer is co-resident. Clients receiving daily visits from their carers comprise 8.5 per cent of the total. Another 11.1 per cent receive more than one visit a week from their carer. Thus as many as 91.6 per cent of clients with a carer see that person more than once a week.

Clients' Levels of Dependency. One of the most important issues is whether the people accepted as clients of Community Options are really those people for whom the Program is intended. As we have already noted it is difficult to determine with any certainty whether a person is at risk of premature or inappropriate

institutionalisation. The most that we can do is to examine the level of dependency, that is the level of their need for personal and perhaps other types of assistance and even to make a judgement as Community Options co-ordinators do, on the basis of some individual cases.

We now look at the level of dependency or need for personal assistance of Community Options clients. Because this information was not included in the Minimum Data Set it was collected in a special exercise using a form designed for the purpose, the Client Dependency Form (CDF). Project co-ordinators were asked to complete these for all clients they accepted between 1 April and 29 June, 1990. In order to be able to compare clients' level of need for support in the areas of nursing and personal care with that of nursing home residents, the CDF included the Resident Classification Instrument (RCI), which is used to determine nursing subsidy levels, of which one component is the estimated number of nursing hours each day required by the resident. In addition, the CDF records information on clients' need for support in four other areas: food preparation, home upkeep, mobility outside the home and shopping, that is, in some of the Instrumental Activities of Daily Living (IADL).

Table 2.16 presents a cross tabulation of clients according to two categories. The measure at the top of the Table is the category into which the client falls for the eleven items included on the RCI (range 1-5 where 1 is high dependency, and on the RCI would imply that the resident of a nursing home would need 3.86 hours of nursing per day, and 5 is low and implies 1.29 hours of nursing per day; category 6 indicates a zero total for the eleven items). The measure down the table is a summary score for the four additional IADL items described above (range 0-12, where 12 is high dependency and 0 is none). This score was derived by adding the totals on each of the four questions, where the four categories within each question were assigned a value of 0, 1, 2, or 3. These scores are arbitrary and do not pretend to quantify dependency exactly. The scores merely rank dependency levels from low to high.

Looking at the figures in bold in the 'total' row in Table 2.16, we see that most clients are classified as being in the lowest RCI category (5) with the second largest group being in the second lowest category. Only one client fell into each of RCI categories 1 and 2, indicating high to very high dependency on nursing and personal care. Finally, 13.2 per cent of clients had no score for the eleven questions.

When we look at the total column down the right hand side, scores for the four other levels of IADL dependency were much higher. Approximately half had very high scores (in the range 10-12) and another 27.8 per cent had moderately high scores. Only seven clients had no dependency in the four IADL areas.

Finally this Table shows that the higher the score on the RCI, the higher tends to be the score in the four additional areas of dependency.

Table 2.16: Level of Dependency of Clients Entering in the Period 2.4.90 - 29.6.90

Four additional areas of dependency	Resident Classification Instrument						Total
	Low 6	5	4	3	2	High 1	
Low 0	5(a)	2					7
	14.7	1.3					2.7
	1.9	0.8					
1-3	10	8					18
	29.4	5.0					7.0
	3.9	3.1					
4-6	10	23	1				34
	29.4	14.4	2.3				13.2
	3.9	8.9	0.4				
7-9	6	55	10	1			72
	17.6	34.4	23.3	5.3			27.9
	2.3	21.3	3.9	0.4			
High 10-12	3	72	32	18	1	1	127
	8.8	45.0	74.4	94.7	100.0	100.0	49.2
	1.2	27.9	12.4	7.0	0.4	0.4	
Total	34	160	43	19	1	1	258
	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	13.2	62.0	16.7	7.4	0.4	0.4	

Note: a) Each cell contains the number of cases and column per cent, with per cent over total sample in bold.

Table 2.17 compares the need for assistance of Community Options clients with a comparable population in New South Wales, that is people with severe disabilities who are living at home. Data collected in the ABS 1988 Disabled and Aged Persons Survey allow us to compare on nine items, five of which (transferring, bathing/showering, dressing, eating and mobility in the home) are found in the RCI and four of which (food preparation, home upkeep, shopping and mobility outside the home) are equivalent to the IADL items included in the CDF. On the RCI items the clients and the ABS survey population show a similar pattern except for showering and bathing. For this activity a considerably higher proportion of Community Options clients than ABS survey respondents needed assistance. However, a far higher proportion of Community Options clients than ABS survey respondents needed assistance on all the IADL items, suggesting that Community Options clients are a particularly vulnerable group in the population. The need for assistance amongst both Community Options clients and ABS survey respondents was greater for IADL items than RCI items.

Table 2.17: Proportion of Community Options Clients Needing Assistance with Selected ADLs Compared with Severely Handicapped Population Living in Households in New South Wales

Activities	Community Options Clients %	People with Severe Disabilities in New South Wales ^(a) %
Transferring	26.8	26.9
Bathing/showering	56.6	39.1
Dressing	45.4	32.7
Mobility in the home	20.2	23.9
Eating	15.9	22.5
Food preparation	76.0	34.7
Home keep	93.0	72.3
Mobility outside home	61.2	23.7 ^(b)
Shopping	87.6	49.3

Notes: a) Based on ABS (1989), *Disabled and Aged Persons Survey, Australia, 1988*, Catalogue No. 4118.0.

b) Using public transport.

We should not, of course, be surprised by the relatively low RCI scores which, in any case, as we have just shown, are comparable to those of the general population. Although it is conceivable that some very highly dependent people who are still living at home have not come to the notice of the services, in general we would expect the amount of care needed by people with very high scores to be beyond the capacity of Community Options alone. As we found, such people may still be at home only by virtue of their own financial resources and the efforts of their carers which are an indispensable addition to the help provided by the services and Community Options. As Table 2.18 shows, clients who live with other people are much more dependent on others for assistance than are those who live alone. Nevertheless, as this table also indicates, moderate to high dependency by no means precludes a person from living alone.

Even though, overall, the RCI levels of the 258 clients were low, as noted above, those clients assessed as eligible for entry into a nursing home tended to have higher RCI scores than those without such approval. In Table 2.19, the percentage of clients in each RCI category is shown according to whether or not they have approval for entry into residential care. People who have approval for entry into a nursing home are, in general, likely to be in a higher RCI category than those who do not have such approval. Interestingly, however, neither of the clients in the higher dependency categories (1 and 2) has approval for entry into a nursing home. Their situations are described below. The pattern described for nursing homes is reversed when approval for entry into a hostel is considered. Clients with approval to enter a hostel are more likely to be in a low RCI category than in a high one.

Table 2.18: IADL Dependency Scores and Living Arrangements^(a)

Score on IADL		Clients who live alone		Clients who do not live alone	
		No.	%	No.	%
Low	0	2	2.2	4	2.6
	1-3	7	7.6	10	6.5
	4-6	19	20.7	12	7.7
	7-9	34	37.0	35	22.6
High	10-12	30	32.6	94	60.6
Total		92	100.0	155	100.0
Average IADL Score:		7.83		9.19	
Standard Deviation:		3.06		3.10	

Note: a) Table is based on 247 clients on MDS for whom residency status and dependency score is known.

Table 2.19: RCI Category and Approval for Various Types of Residential Care

Has the client been approved for residential care?		RCI Category						No.
		(High) 1	2	3	4	5	(Low) 6	
1 Nursing Home	Yes	-	-	15.9	27.5	49.3	7.2	(69)
	Pending	-	-	14.3	42.9	42.9	-	(7)
	No	0.7	0.7	4.4	11.8	66.2	16.2	(136)
	Unknown	-	-	2.2	10.9	71.7	15.2	(46)
2 Hostel	Yes	-	-	-	11.5	73.1	15.4	(26)
	Pending	-	-	-	25.0	75.0	-	(4)
	No	0.5	0.5	8.2	18.5	58.7	13.6	(184)
	Unknown	-	-	9.1	11.4	68.2	11.4	(44)

Notes: Percentages add to 100 across rows; Table is based on 258 clients.

Clients with High Dependency: two case studies. Of the two people with the highest scores on the RCI one was a 92 year old woman, now deceased. This client suffered from osteoporosis, a heart condition, Paget's Disease and confusion. She had had an unsuccessful operation for a hip replacement and was now bedridden. Her 60 year old son who had an intellectual disability lived with her. Her 55 year old daughter lived next door and was the principal carer. It was the daughter who contacted Community Options for assistance because she could no longer cope. Although she was clearly eligible for a place in a nursing home, both the client and her family were adamant that she should remain at home, and it was there that she died.

At the time she was accepted as a Community Options client this lady was receiving help with personal care from the Home Nursing Service three times a week. The services requested on her behalf by her daughter were a full-time live-in housekeeper and home-based respite care. These services were provided by Community Options until her death about two months after she had been accepted. The cost of these services would have taken the client above the funding limit but for the fact that the son had also been taken on as a client. The cost of the services which was in the region of \$300 (at the time that the funding limit was \$200) could therefore be divided between the two of them.

The second person with a very high RCI score was a 58 year old man suffering from terminal bone cancer, now also deceased. He had lived with his wife but had been in and out of hospitals. He was referred to Community Options by the Nursing Service with a request for additional nursing care. The co-ordinator was fully aware that this client, whose primary need was for palliative care, was not, in fact, appropriate for Community Options. However, the Nursing Service was apparently unable to provide sufficient care to enable him to remain at home.

In the event, Community Options did provide a level of additional nursing which took the client over the funding limit (by about \$50) but this was only for a week. The client entered long term care, where he died.

Some Problems of Measuring Level of Dependency. The RCI scores suggest that by itself the RCI is too sharp an instrument for our purposes as it is focused on a narrow group of people with high need for personal and nursing care, for whom, it could be argued, Community Options is not the appropriate service mechanism. On the other hand, relatively high scores on the IADL-like items suggest that, overall, projects are selecting their clients appropriately and that many Community Option clients are vulnerable people, in high need of support for assistance in crucial areas of their lives. However, in many cases, hostel accommodation would be much more appropriate, particularly where social support is lacking at home.

The CDF is clearly, by itself an inadequate instrument for defining the full nature of vulnerability. For example, neither it nor the MDS provides any indication of clients' health problems which were, as we shall see later when we describe the Client and Carer Survey, in many cases, numerous. Nor does the CDF elicit the complex reality of the circumstances of clients whose dependency is, *prima facie*,

low. For example, a person who is rated as low dependency solely on the grounds that she only requires assistance with mobility outside the home, may, in practice, never be able to leave her home and may therefore lead a life of total isolation. This illustrates that we cannot understand a person's need for assistance simply in terms of specific physical or mental incapacities. The viability of social support arrangements must also be considered. This is apparent from the short biographical notes of a number of the people who, though Community Options clients, are low on either the RCI or IADL items or on both. A full list of these people is provided in Appendix 5 and it will be apparent from these notes that such people are found in a very wide range of circumstances.

Clients with Low Dependency - some case studies. Here we provide three examples from Appendix 5.

- An elderly man with arthritis (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 hip-replacement. The Home Care Service formed the view that he needed other forms of help as well, but lacked the 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 sufferers 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 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.
 - 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.

A Summary Profile of Clients. In considering the tasks of the Community Options co-ordinator the nature of the clientele must always be borne in mind. These are typically frail elderly people at high risk of acute illness and of fluctuations in their health status. In many cases their spouses are in a similar condition. This makes the monitoring role of Community Options so crucial. We gained the strong impression during our interviews that monitoring is not routinely undertaken with all clients but rather on what is judged to be an 'at need' basis. Though in some projects apparently adequate alternative arrangements have been made for monitoring clients, few co-ordinators were satisfied with the amount of monitoring they themselves were able to undertake in the time available to them. It is the area of work most likely to suffer on account of the other commitments of the job, in particular the 'paper work', which most co-ordinators resent greatly, believing it, for the most part, to be of no benefit to themselves or to their clients.

Summarising the major characteristics of the client group according to three variables (the presence or absence of dementia or dementia symptoms, the presence or absence of a carer and whether or not the client lives alone or with others) we can observe that the largest group of clients do not have dementia, have carers and do not live alone (37.9%) (see Table 2.20). This group is over twice the size of the next largest group consisting of people who do not have dementia do not have a carer and do live alone (17.1%). Third, and roughly equal in magnitude are two other groups, one consisting of people who do not have dementia, do have a carer but live alone, and the other of people who have dementia, have a carer and do not live alone. The four groups described above constitute 82.5 per cent of the clients accepted by Community Options in the course of the year covered by the evaluation. The largest group are probably those who, in terms of their disabilities and social circumstances, can be most easily and successfully maintained at home. It would have been of some interest to examine how the characteristics of Community Option clients compares with the disabled population living at home which was identified in the ABS 1988 Disabled and Aged Persons Survey. Unfortunately comparisons are not possible because people with dementia in the ABS survey are not an identifiable group.

Table 2.20: Summary of Major Characteristics of Client Group

Client Characteristics	No.	%
Has dementia, has a carer, lives alone	38	3.0
Has dementia, has a carer, does not live alone	174	13.8
Has dementia, does not have a carer, lives alone	29	2.3
Has dementia, does not have a carer, does not live alone	9	0.7
Does not have dementia, has a carer, lives alone	172	13.7
Does not have dementia, has a carer, does not live alone	477	37.9
Does not have dementia, does not have a carer, lives alone	215	17.1
Does not have dementia, does not have a carer, does not live alone	63	5.0
Unknown	80	6.4
Total Clients	1,257	100.0

Clients who Leave Community Options.⁸

Some clues concerning the nature of Community Option clients are provided by information concerning those who leave the Program and the reasons for this.

Length of Time as Community Options Clients. We first look at the length of time people spend as Community Options clients, confining this part of the analysis to those who became clients during the first six months of the reference year. From Table 2.21 we see that the majority of people remain clients for reasonably long periods of time. However more than 10 per cent ceased to be clients within two months and it is of some interest to observe that those accepted during the early part of the reference year were more likely to remain clients for only a short time than those who entered later in the reference year. Perhaps co-ordinators were accepting less appropriate people as clients in the early days. Certainly we were told that the number of inappropriate referrals was particularly large when the projects started.

Table 2.22 looks at the relationship between the length of time people remain Community Options clients and their reasons for leaving the program. No clear pattern emerges although it is of some interest that over 50 per cent of those who died had been clients for no more than eight weeks suggesting that Community

⁸ The total number of clients leaving Community Options varies between Tables 22, 23 and 24. The variation is due to errors in coding on the MDS.

Table 2.21: Length of Time as Client and Month of Entry During Reference Year

Length of time as client (weeks) ^(b)	Month of Entry ^(a)											
	July 1989		Aug. 1989		Sept. 1989		Oct. 1989		Nov. 1989		Dec. 1989	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Maximum possible	52 wks		48 wks		44 wks		40 wks		36 wks		32 wks	
Up to 4 weeks	6	7.8	14	14.6	17	9.7	10	9.3	10	9.1	7	8.6
5-8 weeks	17	22.1	10	10.4	9	5.1	7	6.5	6	5.5	7	8.6
9-12 weeks	8	10.4	6	6.3	5	2.8	6	5.6	8	7.3	7	8.6
13-16 weeks	2	2.6	1	1.0	3	1.7	3	2.8	8	7.3	3	3.7
17-20 weeks	2	2.6	3	3.1	9	5.1	4	3.7	4	3.6	1	1.2
21-24 weeks	3	3.9	4	4.2	1	0.6	2	1.9	5	4.5	1	1.2
25-28 weeks	2	2.6	4	4.2	5	2.8	1	0.9	3	2.7	26	32.1
29-32 weeks	2	2.6	3	3.1	2	1.1	2	1.9	34	30.9	29	35.8
33-36 weeks	-	-	-	-	6	3.4	24	22.2	32	29.1	-	-
37-40 weeks	3	3.9	2	2.1	84	47.7	49	45.4	-	-	-	-
41-44 weeks	3	3.9	10	10.4	35	19.9	-	-	-	-	-	-
45-48 weeks	4	5.2	39	40.6	-	-	-	-	-	-	-	-
49-52 weeks	25	32.5	-	-	-	-	-	-	-	-	-	-
Total	77	100.0	96	100.0	176	100.0	108	100.0	110	100.0	81	100.0

Notes: a) These 'months' actually stand for successive four week periods.

b) Calculated as at 29.6.90.

Options does not balk at accepting people as clients who are very frail. People who remain as clients for long periods most commonly leave in order to enter long term care.

Why People Cease to be Community Options Clients. Table 2.23 looks at the reasons for the exit of clients during the reference year, according to some of their characteristics. Altogether 410 were recorded. Of these, the largest group (29%), entered long term care, and a further 14 per cent died. Another 24 per cent were now receiving adequate services and no longer needed the assistance of the Program. At the purely administrative level, and perhaps in terms of cost effectiveness, these represent the most successful cases. Anecdotal evidence provided by co-ordinators suggests that as a result of becoming a Community Options client some people have experienced marked improvements in their health status, and have gained in confidence so that they are now able to manage with fewer services. They can leave Community Options and manage with the services provided through HACC. For these clients it would appear that Community Options has served a genuinely

Table 2.22: Reason for Exit and Length of Time as Client

Reason for exiting	Length of Time (Weeks)							Total %
	0-4 %	5-8 %	9-12 %	13-20 %	21-28 %	29-40 %	41 or more %	
Deceased	35.9 19.3	21.9 13.5	10.9 10.0	14.1 12.9	3.1 4.7	10.9 17.1	3.1 16.7	100.0 13.9
Entered long-term care	20.6 23.5	22.8 29.8	11.8 22.9	20.6 40.0	10.3 32.6	10.3 34.1	3.7 41.7	100.0 29.6
Low level of need	20.8 4.2	4.2 1.0	29.2 10.0	8.3 2.9	29.2 16.3	8.3 4.9	- -	100.0 5.2
Moved out of area	15.8 2.5	42.1 7.7	26.3 7.1	5.3 1.4	5.3 2.3	5.3 2.4	- -	100.0 4.1
Additional family assistance to be provided	29.6 6.7	25.9 6.7	18.5 7.1	7.4 2.9	11.1 7.0	3.7 2.4	3.7 8.3	100.0 5.9
Client refused CO assistance	22.2 3.4	27.8 4.8	22.2 5.7	11.1 2.9	11.1 4.7	5.6 2.4	- -	100.0 3.9
Receiving adequate services	24.8 21.8	21.0 21.2	15.2 22.9	21.0 31.4	8.6 20.9	6.7 17.1	2.9 25.0	100.0 22.9
Referral to other agency	34.8 13.4	17.4 7.7	13.0 8.6	8.7 5.7	10.9 11.6	13.0 14.6	2.2 8.3	100.0 10.0
Beyond \$200 client limit	- -	50.0 1.0	50.0 1.4	- -	- -	- -	- -	100.0 0.4
Other	33.3 5.0	38.9 6.7	16.7 4.3	- -	- -	11.1 4.9	- -	100.0 3.9
Total:	25.9 100.0	22.7 100.0	15.3 100.0	15.3 100.0	9.4 100.0	8.9 100.0	2.6 100.0	100.0 100.0

Notes:

- Table is based on 459 clients.
- Regular percentages add to 100 across rows.
- Bold percentages add to 100 down columns.

preventative function. However, in humanitarian terms those who died at home or had the opportunity to spend a little longer at home than they might otherwise have done, are also part of a success story. Certainly, most co-ordinators we spoke to would have felt that the efforts they had made on behalf of these clients had been worthwhile, whatever the outcome.

Table 2.23: Client Group and Reason for Exit

Reason for Exit	Client Group				Total Sample (N = 410) %
	Under 65 years (N = 62) %	65+ years No dementia (N = 236) %	65+ years with dementia/ displaying symptoms (N = 96) %	65+ years dementia status unknown (N = 16) %	
Deceased	3.4 3.2	72.9 18.2	22.0 13.5	1.7 6.3	100.0 14.4
Entered long-term care	9.2 17.7	50.8 25.8	37.5 46.9	2.5 18.8	100.0 29.3
Low level of need	19.0 6.5	52.4 4.7	19.0 4.2	9.5 12.5	100.0 5.1
Moved out of area	29.4 8.1	47.1 3.4	11.8 2.1	11.8 12.5	100.0 4.1
Additional family assistance to be provided	22.7 8.1	45.5 4.2	31.8 7.3	- -	100.0 5.4
Client refused Community Options assistance	- -	76.5 5.5	23.5 4.2	- -	100.0 4.1
Receiving adequate services	27.0 43.5	57.0 24.2	15.0 15.6	1.0 6.3	100.0 24.4
Referral to other agency	14.7 8.1	61.8 8.9	11.8 4.2	11.8 25.0	100.0 8.3
Beyond \$200 client limit	- -	100.0 0.8	- -	- -	100.0 0.5
Other	16.7 4.8	55.6 4.2	11.1 2.1	16.7 18.8	100.0 4.4
Total	15.1 100.0	57.6 100.0	3.9 100.0	23.4 100.0	100.0 100.0

Notes:

- Table is based on 410 clients who entered and exited in the reference year.
- Regular percentages add to 100 across rows.
- Bold percentages add to 100 down columns.

Although the most common reason for leaving was entry to long term care, Table 2.23 shows that leaving clients who were over 65 years and had dementia were almost twice as likely to enter long term care as those of the same age group who did not suffer from dementia. Clients under 65 were less likely than those over 65 to leave the program for long term care. The most common reason for the exit of these clients was that they were now receiving adequate services. This was very much less likely to happen with clients who were over 65 years of age, particularly if they were dementia sufferers.

In considering the characteristics of people who have ceased to be clients of Community Options we compare the group as a whole (see Table 2.14) with those who have entered residential care or died. A comparison of the values of Table 2.14 with those of Table 2.24 show that clients who left in the year covered by the evaluation were slightly older than those who were accepted as clients during that year. Clients entering long term care were older again and those who died were the oldest of the four groups under consideration.

About a fifth (19.9%) of all clients had dementia or dementia symptoms. A quarter of those who left were classified in this way and an even higher proportion (40%) of those who entered long term care. Twenty per cent of the clients who died at home had dementia. This suggests that clients with dementia are less easily maintained at home than other clients, even with the benefit of Community Options.

Of all the clients who left, 72 per cent had a carer, about the same proportion as for clients as a whole (see Table 2.14). About 78 per cent of those entering long term care had a carer, as did a similar percentage of those who died. It is difficult to draw any conclusions about the impact of carers because the issues are complex and the data rather crude. However, the evidence suggests, in line with common sense, that people who have carers are easier to maintain at home until death.

This hypothesis is supported by the finding, that those who died at home (rather than in long term care) had a particularly high level of support from their carers. About 70 per cent of those who died at home either lived with or received a daily visit from their carer, whereas only 59 per cent of all those who left and 63 per cent of those moving to residential care enjoyed such a high level of support.

The table suggests that whether or not a client lived alone did not greatly affect the outcome. This is a surprising result and would suggest that highly vulnerable people living alone either do not come into contact with Community Options or are more likely to enter residential care, or to die, than people who live with others.

Finally we may note from this table that clients leaving were far more likely than clients generally to have gained prior approval for residential care. Those moving to long term care were, not surprisingly, far more likely than those leaving on other grounds or those dying at home to have gained such approval.

Table 2.24: Characteristics of all Clients who Left Community Options, Those who Entered Long-term Care and Those who Died

Characteristics of Clients	All clients who exited		Those who entered long-term care		Those who died	
	403		136		64	
	No.	%	No.	%	No.	%
Age						
1-9	10	2.5	1	0.7	-	-
10-19	4	1.0	-	-	-	-
20-29	9	2.2	1	0.7	-	-
30-39	5	1.2	-	-	1	1.6
40-49	7	1.7	1	0.7	-	-
50-59	12	3.0	5	3.7	1	1.6
60-69	41	10.2	11	8.1	8	12.5
70-79	142	35.2	48	35.3	24	37.5
80-89	149	37.0	58	42.6	24	37.5
90 and over	24	6.0	11	8.1	6	9.4
Dementia						
Yes/displays symptoms	101	25.1	53	39.0	13	20.3
No	284	70.5	56.6	47	73.4	
Unknown	18	4.5	6	4.4	4	6.3
Carer						
Yes	291	72.2	106	77.9	50	78.1
No	105	26.1	28	20.6	14	21.9
Unknown	7	1.7	2	1.5	-	-
Level of Assistance						
Lives with carer	208	51.6	75	55.1	37	57.8
Daily visits	29	7.2	11	8.1	8	12.5
More than 1 visit per week	34	8.4	11	8.1	4	6.3
1 visit per week	12	3.0	7	5.1	-	-
Less than 1 visit per week	8	2.0	2	1.5	1	1.6
Don't know	112	27.8	30	22.1	14	21.9
Live Alone						
Yes	148	36.7	52	38.2	24	37.5
No	248	61.5	82	60.3	40	62.5
Unknown	7	1.7	2	1.5	-	-
Prior Residential Approval						
Yes	177	43.9	86	63.2	33	51.6
No	226	56.1	50	36.8	31	48.4

One would expect that clients with the greatest need for assistance would be those most likely to enter some form of long term of residential care. Table 2.25 compares the dependency levels of those entering long term care with clients as a whole, broadly confirms this expectation.

Client dependency information, it will be recalled, is only available for the 258 clients accepted by the projects during the last three months of the reference year. Thirty five (14%) of these clients entered a nursing home during the reference year and 11 (4%) entered a hostel. The numbers are small because the clients were those who entered towards the end of the reference year and there was therefore relatively little time for them to have made this move. It would be interesting to see where these clients are now, at the time of writing.

The two clients with the highest RCI scores (1 and 2), as we have noted elsewhere, had died at home. The highest RCI score amongst those entering long term care was 3. At the highest dependency levels, that is with an RCI score of 3 and an IADL score of 11 or 12, clients were twice as likely to enter a nursing home as were clients in general. Moving down the scale of dependency to an RCI score of 4, clients were less likely to enter a nursing home, but still more likely to do so than members of the sample as a whole. This, no doubt was because the IADL scores of this group were, on the whole, high. At the lowest RCI score of 5, clients were slightly less likely than the sample as a whole to enter a nursing home and the fact that a number still did, probably reflects the high IADL scores of a number of this group.

Those entering a hostel tended to have relatively low RCI scores (4 and 5) but reasonably high IADL scores especially when the RCI score was at its lowest (5).

Whilst it looks as though clients who enter residential care are being appropriately placed, the data are tantalising and it would certainly be interesting to know more about the situation of individuals with similar levels of dependency but whose residential outcomes were different. This would provide a better idea of the trigger factors for residential care and the part Community Options and the other services have played in these outcomes.

Services for Clients

One of the most important aspects of the work of a Community Options co-ordinator is to ascertain the needs of clients and to devise appropriate ways of meeting them. Co-ordinators may do this either by building on or adapting the services which the client is already receiving, or by assembling a new package.

We shall be looking at the service packages received by clients from two perspectives. The first will consider the **content** of packages in terms of their size and of the range and mix of services contained within them. The second will bear upon the context or service environment in which service packages are provided. Here we shall be concerned with the source of the services, that is, with **service providers**.

Table 2.25: Dependency Level of Clients Entering Long-term Care

Those entering a nursing home:		No.	%	
Dependency level (in decreasing order)		35	100	% of 258 in this RCI Category
RCI	IADL			
3	12	4	14.3	7.4
3	11	1		
4	12	1		
4	11	3		
4	10	2	22.9	16.7
4	9	1		
4	8	1		
5	12	4		
5	11	2		
5	10	5		
5	9	2	60.0	62.0
5	8	5		
5	7	1		
5	5	1		
5	3	1		
6	10	1	2.9	13.2
Those entering a hostel:		No.	%	
Dependency level (in decreasing order)		11	100	
RCI	IADL			
4	11	1		
4	8	1	27.3	16.7
4	6	1		
5	12	2		
5	11	2		
5	11	2	72.7	62.0
5	10	1		
5	8	1		
5	7	1		

In this section of the report we confine our analysis to the clients who were accepted at any time during the last three months of the period covered by the evaluation, that is between 2 April 1990 and 29 June 1990. This is partly because the data set for the entire year proved too large to undertake the kind of detailed analysis required but also because we only had data on the dependency levels of clients for the shorter period.

It should be noted that our analysis is based on 'transactions', that is, steps taken to alter the existing terms of service delivery to clients. This includes the new provision, the termination or the modification of services.

Service Packages. We have alluded above to the complexity of the data on services. This is well illustrated by the number of different combinations of service types which a single package may contain. **With a full separation of services**, that is counting each service provider separately even when two or more are providing the same service, (for example if respite is provided by the Home Care Service and also by a paid neighbour it has been counted below as two separate service-types) there were the following variations.

- **The mix of service packages**

- 26 different packages of one service type only
- 59 different packages combining two service types
- 58 different packages combining three service types
- 49 different packages combining four service types
- 24 different packages combining five service types
- 7 different packages combining six service types
- 1 package combining seven service types
- 1 package combining eight service types

This complexity makes it very difficult to consider, say, how the components of people's service packages change over time, when other relevant variables may also be changing at the same time, for example the number of hours of each of the services delivered in a given package. We feel consequently that the data can sometimes be understood better by means of case studies rather than by manipulation of aggregated statistics.

- **The number of services in clients' service packages**

Table 2.26 shows that, in the main, clients' service packages were small. During the 13 weeks under consideration most clients' service packages contained two services or less. The proportion receiving three services never exceeded 23 per cent and the proportion receiving four services never exceeded 19 per cent of all clients during this period.

It will be useful to examine in detail the six clients who received the largest service packages. Information on these clients and on the content and cost of their service packages is set out below. It is to be noted that the costs of large service packages can vary greatly.

Client 1: An 84 year old woman, living alone, with no carer. She received six services at one time. These were:

- alarm system
- monitoring
- home-based respite
- home-delivered meals
- direct transport
- general home nursing

The net cost of this package was \$227.26, without the brokerage fee.

Client 2: A 58 year old, with dementia, living alone, and receiving daily visits from carer who is a friend. She received eight services at one time. These were:

- housekeeping (recurring)
- home-help - laundry
- home-help - personal care (excl. overnight)
- general home nursing
- social support service - neighbour aid/volunteer service
- minor home maintenance (exterior)
- major home maintenance ('one-off')
- home-delivered meals

The net cost of this package was \$384.08, without the brokerage fee.

During another week this client received seven services. These were:

- housekeeping (recurring)
- housekeeping ('one-off')
- laundry
- general home nursing
- home-delivered meals
- social support service - neighbour aid/volunteer service
- home help - personal care (excl. overnight)

The net cost of this package was \$192.90, without the brokerage fee.

During a third week the client received six services. These were:

- housekeeping (recurring)
 - linen laundry
 - general home nursing
-

Table 2.26: Number of Services Received in Each Week of the Three Month Period

Week Ending	0		1		2		3		4	
	No.	%	No.	%	No.	%	No.	%	No.	%
6 April 90	-	-	9	33.3	10	37.0	2	7.4	5	18.5
13 April 90	3	8.3	16	44.4	8	22.2	4	11.1	4	11.1
20 April 90	4	9.8	13	13.7	9	22.0	6	14.6	6	14.6
27 April 90	7	13.0	11	20.4	15	27.8	9	16.7	8	14.8
4 May 90	7	9.9	19	26.8	15	21.1	16	22.5	7	9.9
11 May 90	16	17.8	25	27.8	19	21.1	16	17.8	8	8.9
18 May 90	12	11.3	32	30.2	22	20.8	18	17.0	7	6.6
25 May 90	23	18.9	40	32.8	23	18.9	16	13.1	8	6.6
1 June 90	23	19.8	33	28.4	27	23.3	16	13.8	7	6.0
8 June 90	24	17.9	42	31.3	32	23.9	17	12.7	7	5.2
15 June 90	25	16.9	49	33.1	33	22.3	16	10.8	15	10.1
22 June 90	30	18.9	40	25.2	35	22.0	20	12.6	15	9.4
29 June 90	34	19.0	42	23.5	44	24.6	25	14.0	20	11.2

Notes: a) A client is considered 'missing' if there were transactions in weeks both before and after a week in which there is no listing for that client.

This Table is based on a full separation of service types (see note in text).
Percentages add to 100 across rows.

- home-delivered meals
- social support service
- home-help - personal care (excl. overnight)

The net cost of this package was \$193.67, without the brokerage fee.

Client 3: A 79 year old man, living with a carer who is a relative. He received six services at one time. These were:

- shopping
- housekeeping
- general home nursing
- home-delivered meals
- meal preparation
- home-help - personal care (excl. overnight)

Over the period they were being received, the net cost of these services ranged from \$147.65 to \$177.34, without the brokerage fee.

5		6		7		8		Missing ^(a)		Total number of clients with dependency inform- ation being serviced
No.	%	No.	%	No.	%	No.	%	No.	%	
1	3.7	-	-	-	-	-	-	-	-	27
-	-	-	-	-	-	-	-	1	2.8	36
-	-	-	-	-	-	-	-	3	7.3	41
1	1.9	-	-	-	-	-	-	3	5.6	54
3	4.2	1	1.4	-	-	-	-	3	4.2	71
3	3.3	1	1.1	-	-	-	-	2	2.2	90
5	4.7	1	0.9	-	-	-	-	9	8.5	106
7	5.7	1	0.8	-	-	-	-	4	3.3	122
4	3.4	1	0.9	-	-	-	-	5	4.3	116
7	5.2	3	2.2	-	-	-	-	2	1.5	134
7	4.7	1	0.7	1	0.7	-	-	1	0.7	148
6	3.8	1	0.6	-	-	1	0.6	11	6.9	159
9	5.0	5	2.8	-	-	-	-	-	-	179

Client 4: An 86 year old woman, displaying symptoms of dementia who lives alone without a carer. She received six services at one time. these were:

- housekeeping
- meal preparation
- shopping
- general home nursing
- home-delivered meals
- 'one-off' equipment

The net cost of this package was \$122.70, without the brokerage fee.

Client 5: A 75 year old woman, living alone, whose son is her carer. He visits her at least once a week. She received six services. These were:

- housekeeping
- home-help - personal care (excl. overnight)
- delivered meals
- delivered meals from two different sources

- 'other' home-based services
- 'other' home-based services from two different sources

The net cost of these services was \$63.05, without the brokerage fee.

Client 6: A 92 year old woman who lives alone and receives daily visits from her neighbour. She received six services. These were:

- housekeeping
- transport direct
- transport direct from two different sources
- home nursing - personal care (excl. overnight)
- centre-based respite
- centre-based respite from two different sources

Over the period they were being received, the net cost of these services ranged from \$115.67 to \$126.47, without the brokerage fee.

These cost figures should be interpreted with some caution, as in one instance we discovered that two different costs were given for identical service packages.

As the six cases illustrate, a large proportion of these clients lived alone. Our analysis suggests that clients who lived alone tended to receive larger service packages than those who lived with a carer, regardless of their dependency levels. The cases above were all of people whose dependency, measured on the RCI, was 5 or 6. All the clients whose dependency on this scale was higher but who lived with a carer were in fact receiving smaller service packages.

• Variations in service packages

We have noted that the complexity of service packages makes it difficult to give a meaningful account of change over time. But this obviously only arises in cases where changes have, in fact, occurred. Of the 232 clients on whom we have transaction information over the three month period from 2 April 1989 to 30 June 1990, 201 were clients for more than one week. Thirty one were clients for no more than one week and were therefore scarcely able to experience changes in their service packages. Of the 201 people who were clients for more than one week 17 (8.5%) were listed as having no services in any week that they were clients; another 46 (or 22.4%) received the same service package every week; 52 (25.9%) had only one change each in their service packages while clients, and the remaining 86 (43%) had more than one change in the service types they were receiving, not taking into account any change in the number of hours received.

The most common service packages were:

- one or two instances of respite (home and/or centre based)
 - general housekeeping and daytime personal care
 - social skill development
-

- general housekeeping on its own
- daytime personal care on its own
- minor exterior home maintenance
- general housekeeping and home-delivered meals
- general home nursing and respite
- daytime personal care and respite
- general housekeeping and respite

Due to the large variation in packages, even the most common service packages tended to occur only up to a dozen times in any one week. The remaining individually-tailored service packages usually occurred only once or twice in any week.

- **Services received before and after acceptance by Community Options**

In order to assess the impact of Community Options it is important to take account of the way in which becoming a client affects the services a person is likely to receive. As Table 2.27 shows, relatively large percentages of Community Options clients had already been receiving the most frequently used services (housekeeping, home nursing, respite care, delivered meals and personal care) before they were accepted as clients. This is not to suggest, of course, that Community Options is only providing what could easily be arranged without its intervention. The table shows nothing directly about the effect of the packaging of services. However, it does indicate that as clients of Community Options people were receiving, overall, as many services again as they had been receiving before their acceptance. What it also shows is that outside the group of four or five most heavily used services, there is a wide range of others, testifying to the flexibility of Community Options and its delivery of services aimed at meeting specific needs, particularly those enhancing the quality of peoples' lives. The alarms and other equipment, full-time living-in housekeepers, the help with shopping, the overnight personal care, the monitoring and paramedical care, the social support and information, the transport and other services all contribute, either singly or in combination, to the achievement of this broad objective.

- **'One-off' services**

Table 2.28 is based on transactions described on the MDS as 'one-off'. In this table all clients of Community Options during the year 1 July 1989 to 30 June 1990 are included.

'One-off' transactions relate to items or services purchased on a single occasion. Projects are funded to the level of \$106 per client per year for 'one-off' items. The most common form of such expenditure (21.8%) was on medical or disability-related equipment, a not unsurprising finding in view of the clientele of Community Options. The next most common expenditure after 'other' was on items of a related

Table 2.27: Service Provision Before Entering Program

Service Type	Service was being received before person became CO client		Service was not being received before person became CO client	
	No.	%	No.	%
Alarm system	30	0.1	705	1.2
Other centre-based services	418	0.9	479	0.8
Delivered meals	7,413	15.5	5,618	9.3
Equipment	83	0.2	394	0.7
Full-time live-in housekeeper	9	0.0	86	0.1
Home help				
- housekeeping	13,629	28.4	9,898	16.4
- laundry	537	1.1	549	0.9
- shopping	612	1.3	1,545	2.6
- meal preparation	482	1.0	1,967	3.2
- personal care (excl. o'night)	3,507	7.3	3,977	6.6
- personal care (incl. o'night)	113	0.2	286	0.6
- physiotherapy	12	0.0	-	-
Home nursing	11,776	24.6	9,044	14.9
Interpreter	-	-	3	0.0
Other home-based services	207	0.4	1,665	2.8
Home maintenance	644	1.3	1,796	3.0
Home modification	12	0.0	23	0.0
Monitoring	19	0.0	487	0.8
Paramedical (home or centre based)	580	1.2	937	1.5
Recreation	-	-	15	0.0
Respite	5,045	10.5	7,773	12.8
Social skill development	45	0.1	732	1.2
Social support service	748	1.6	1,610	2.7
Support and information	368	0.8	1,272	2.1
Transport				
- direct	919	1.9	2,045	3.4
- indirect	252	0.5	1,057	1.7
Unknown	450	0.9	6,466	10.7
Total	47,910	100.0	60,529	100.0

Note: There were 595 services for which it was unknown as to whether the client was receiving the service before they became a CO client.

kind, namely special fixtures and modifications to the home. Furniture or household items, washing machines and microwave ovens, for example, are the next largest category, closely followed by alarm systems of various sorts. Although the various types of house repair and maintenance taken separately constitute relatively small proportions of the total, taken together they constitute another very important class of 'one-off' payments.

Table 2.28: 'One-off' Services

	All Projects	
Total number of 'one-off' services in year:	597	
	No.	%
Service Type:		
Alarm systems	68	11.4
Equipment (Medical/Disability)	130	21.8
Furniture or Household Items	75	12.6
Household Maintenance (Major Cleanup)	33	5.5
Modifications (Fixtures)	99	16.6
Power/Telephone (Accounts)	30	5.0
Repairs/Plumbing/Connections	47	7.9
Training (Personal Care, etc)	9	1.5
Yard Maintenance (Major)	22	3.7
Other	84	14.1

We found that the views of co-ordinators varied considerably on the subject of the funding limits for payments of this type. In some projects, most often but by no means exclusively rural, where a combination of isolation and poverty seem to make payments for such needs as wood chopping, house insulation, telephone installation particularly important, the amount available for 'one-off' payments was considered far too small. We have already noted that in some rural areas, actual servicing presents problems and 'one-off' purchases, for example, on washing machines and microwave ovens can at least partially alleviate such problems. Some co-ordinators would not only have liked an increase in the actual amount for such payments but also would also, as we have noted elsewhere, would have liked to have been allowed to use some of the subsidy money for 'one-off' payments. In fact Table 2.27, which refers to recurrent expenditure, suggests that the distinction between recurrent items and 'one-off' items of expenditure is quite blurred. Quite a number of the items listed in this table, for example, equipment, alarm systems, home modifications and home maintenance would seem to more appropriately categorised as 'one-off' items than items of recurrent expenditure.

- **Expenditure on 'one-off' items**

The distribution of 'one-off' costs by Community Options projects is shown in Figure 2.1. In this figure, the vertical axis on each graph shows the midpoint in each of a series of fifty dollar ranges for expenditure on 'one-off' items. For example, the \$25.00 figure is the midpoint of the fifty dollar range \$0-\$50, the \$75.00 figure is the midpoint of the \$50-\$100 range and so on. All amounts greater than one thousand

Figure 2.1: Frequency and Size of One-off Expenditures

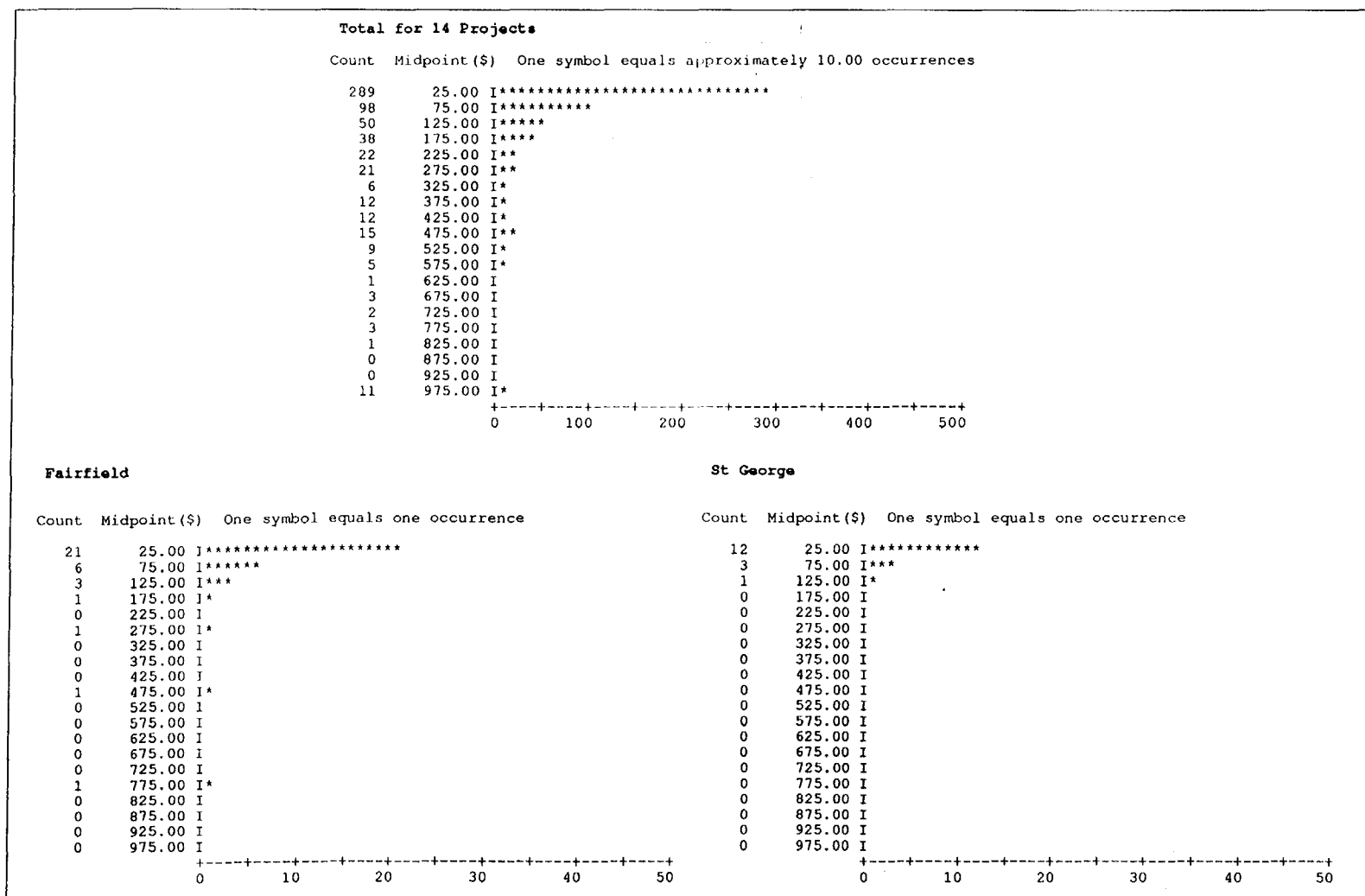


Figure 2.1 (cont.)

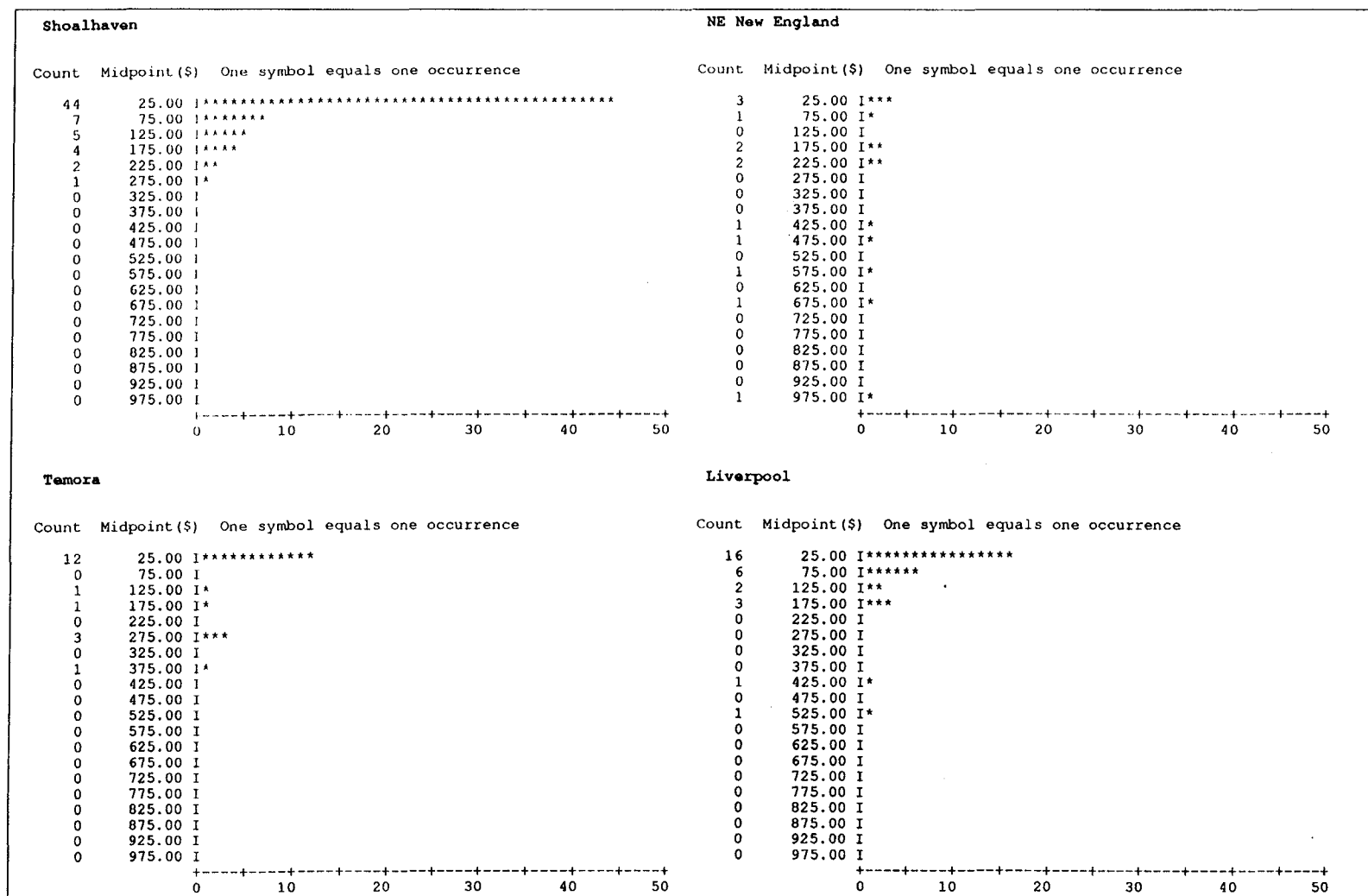


Figure 2.1 (cont.)

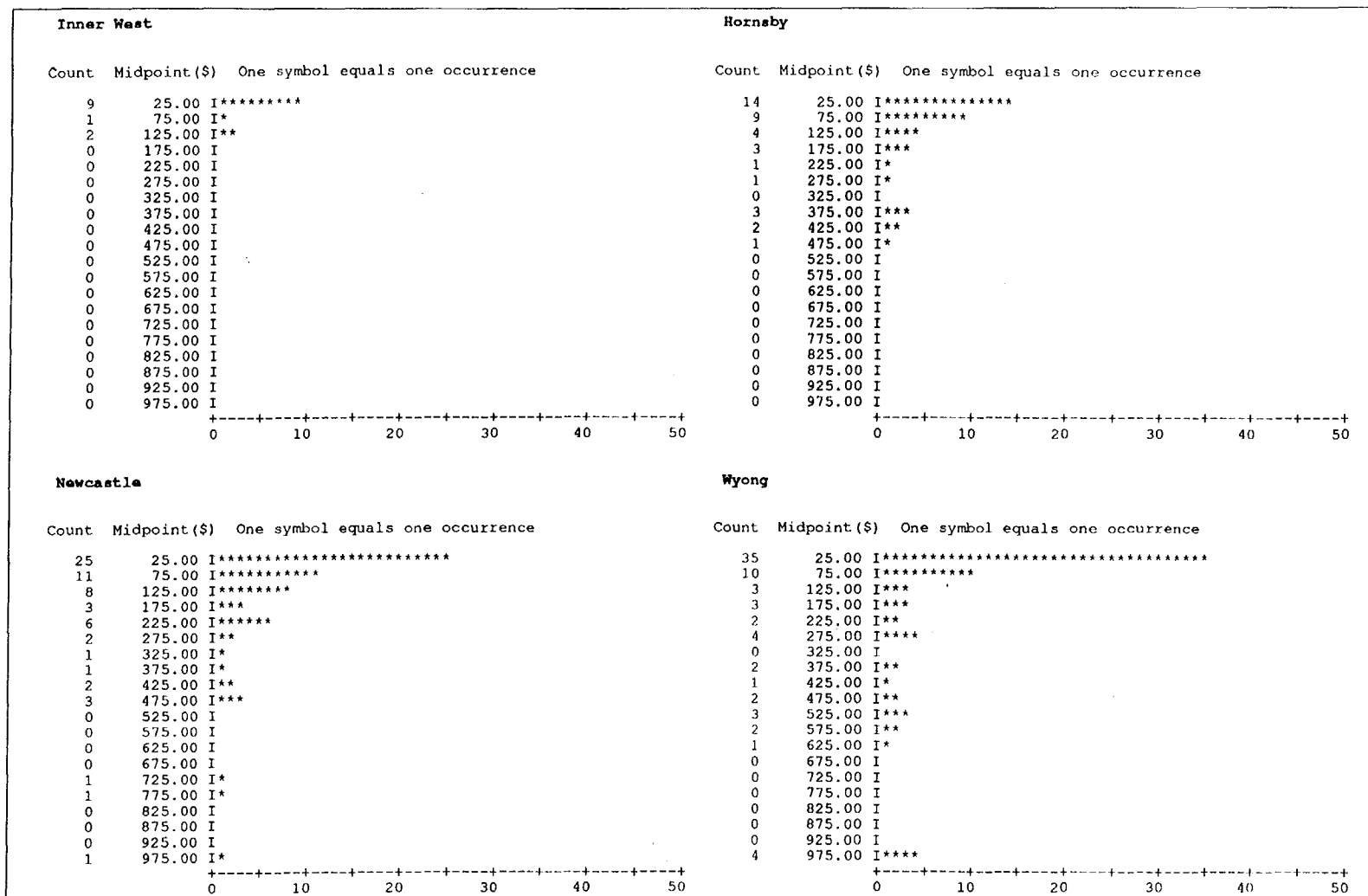
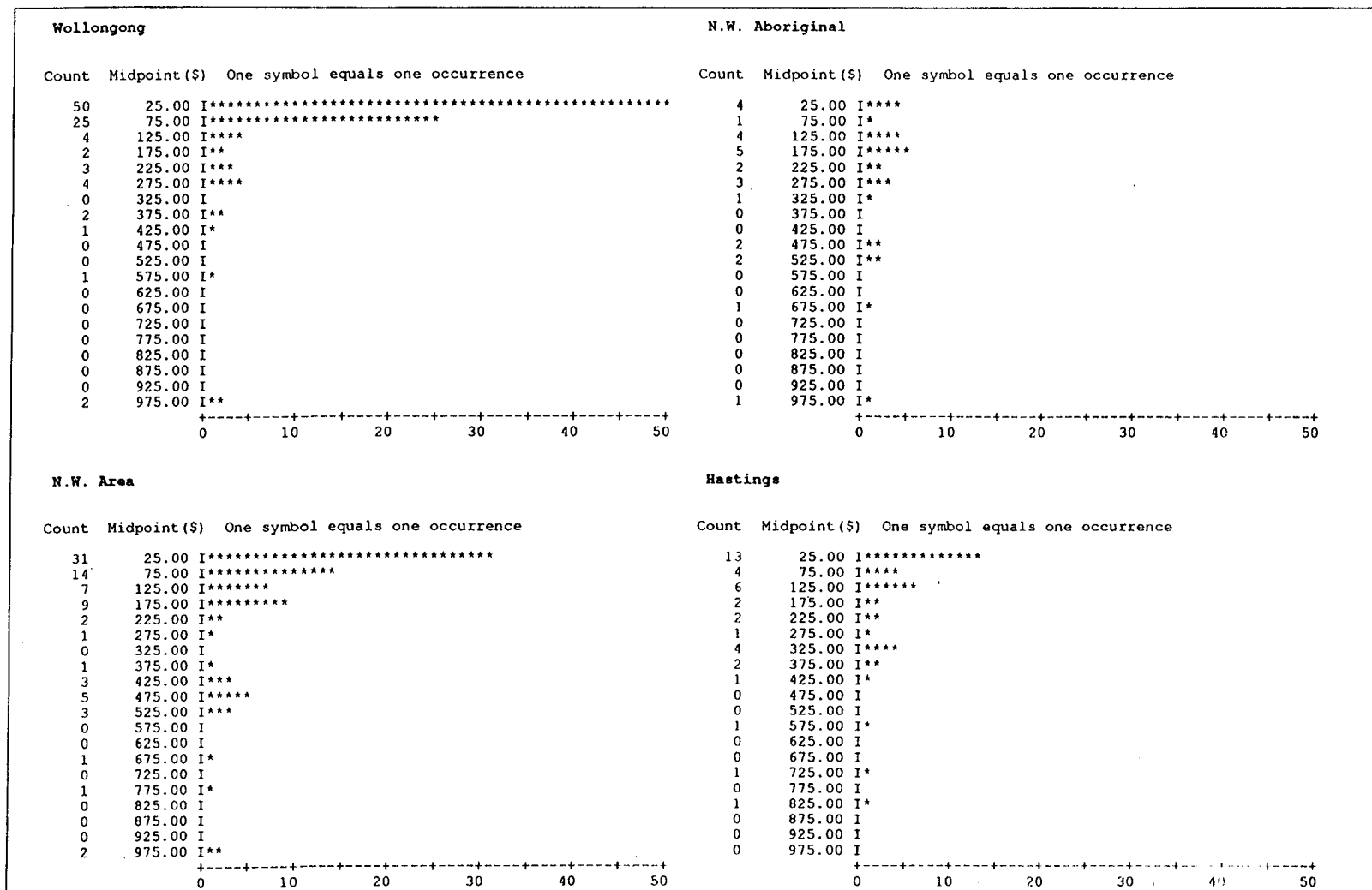


Figure 2.1 (cont.)



dollars per single 'one-off' expenditure have been recoded as one thousand dollars, and thereby fall into the range \$950-\$1,000. A great deal of caution must be exercised when interpreting data on 'one-off' expenditures. A detailed examination of some high cost transaction records has shown that some of the high 'one-off' expenditures have been incorrectly recorded against **recurrent** transaction records. For example, one project had a major electrical home maintenance listed as a 'one-off' transaction with a unit cost of \$2,290. However, the total for this transaction was recorded against a different transaction record which classified it as recurrent. This also happened in another project when the total for a home modification worth \$5,109 was recorded against a recurrent cost transaction record. Yet another project did the same for a home modification worth \$2,605. Therefore, many of the highest 'one-off' expenditures are excluded from the costs shown in Figure 2.1. This has undoubtedly reduced the average 'one-off' expenditure figure for some projects.

Transactions involving 'one-off' expenditures are comparatively rare, and usually modest in cost: around half involve outlays of fifty dollars or less, and almost two-thirds amount to less than \$100 each. On the other hand, a tiny proportion do entail substantial costs: eleven transactions came to more than \$1000 each, and one appears to have exceeded \$4000. There are of course variations from project to project in the incidence and scale of 'one-off' costs. In metropolitan localities, such expenditures, to the extent that they occur at all, usually range between nil and \$150. Apart from a handful of high-cost items in the suburbs of Liverpool and Fairfield, the only notable exception to this pattern is Hornsby, where six of the 38 'one-off' transactions involved over \$350, and another five over \$150. Among the other urban projects, Newcastle's profile is not unlike Hornsby's, given the former's larger client group; if anything, it has a tendency to larger 'one-off' expenditures. Wollongong has (relatively speaking) quite a large proportion of 'one-off' expenditures, although most of these are minor expenses, 80 per cent costing less than \$100 each. Turning to the non-urban projects, Shoalhaven can be characterised as having a comparatively large number of fairly low-cost 'one-off' transactions, in contrast to Wyong, where a sizeable minority of such transactions are quite expensive, four of them exceeding \$1000 apiece. Temora's few 'one-off' costs tend to be inexpensive (mostly fifty dollars or less), while those of the other council-auspiced regional project, in N.E. New England, are rather evenly spread from the cheapest to the most costly. The project associated with Hastings District Hospital displays a pattern somewhere between these two extremes. One of the more notable contrasts is to be found in the two projects in the northwestern region: the North West Area project has quite a number of 'one-off' costs, more than half of these below the \$100 mark, while its Aboriginal counterpart has but a few, of widely varying amounts. In summary, while the overall distribution for the fourteen projects gives a reasonable indication of the extent of 'one-off' expenditures, the latter evidently play a different part from one local context to another.

Some examples of services that 'one-off' money is used to provide are given here.

\$330 spent on gravel as part of a home modification, probably for a pathway to or around a house.

A project in a rural area spent \$240 on the installation of a telephone for a client.

A project in a remote area spent \$1,210 to have a water tank installed for a client.

\$120 was spent purchasing a portable toilet for a client whose bathroom had disintegrated and would have been extremely expensive to repair.

Aluminium doors were provided at a cost of \$473 to a client who was possibly afraid to live alone and needed some sense of security.

Electrical appliances, furniture for disabled clients, plumbers and painters are also services for which Community Options uses its 'one-off' money, illustrating that quite a varied range of services is paid for from this source. It is not unlikely that this type of expenditure will considerably enhance the clients capacity to remain in their own homes.

Service Providers

The Funding Category of Service Providers. Table 2.29 presents a frequency distribution of the funding categories in which the various service providers are found. In this table each service provider is listed only once, regardless of the different types of service they may provide. Nor does this Table imply anything about which service providers are used most commonly. Its main purpose is to show the number of different organisations in each funding category that are available to provide services. More than a half of the service providers used by Community Options, as the table shows, are non-government. One-third are private bodies providing HACC type services. A further quarter are private and providing non-HACC type services, such as medical/disability equipment, alarm systems, recreation and social skill development. HACC service providers comprise 18 per cent of all providers, and HACC-type service providers funded partially or totally by other areas of government comprise a further 16.6 per cent of the total. The final 6.0 per cent of service providers are in the category of non-HACC services, funded by government.

Caution is needed in interpreting this Table as some service providers have been listed in the data set with incorrect funding category codes and we have not been able in the time available to rectify these errors. However, we know that their magnitudes are small and the general pattern of the table is probably not seriously distorted.

The Funding Sources of Different Types of Service. Table 2.30 provides a very detailed breakdown of the funding sources for different service types. Any service provided to a Community Options client can be paid for by a single organisation or by any combination of organisations. The purpose of this table is to show which

Table 2.29: Number of Service Providers in Each Funding Category^(a)

All Projects		
Total Number of Service Providers:	989	
Funding Category	No.	%
HACC Service	178	18.0
HACC-type (Government)	164	16.6
HACC-type (Private)	332	33.6
Non-HACC (Government)	59	6.0
Non-HACC (Private)	256	25.9

Note: a) HACC services are those provided by HACC funded agencies. HACC-type (Government) are services of the same type as those provided by HACC agencies but provided by other Government agencies, for example Community Nursing. HACC-type (Private) are these same service types but provided by private agencies or contractors. Housekeeping not provided by the Home Care Service would be an example of a HACC-type (Private) service. The non-HACC service types are equipment (medical/disability), alarm systems, recreation and social skill development. These service types are never provided by HACC agencies. They are either provided by other government agencies (that is, non-HACC Government) or by private service providers (that is, non-HACC Private).

organisation, or combination of organisations, is paying for particular services. This table is based on all transactions made during the reference year and therefore relates to all clients receiving services in that year, not just those accepted in that year. The table also includes 'one-off' transactions as well as recurring expenditure.

This table must be interpreted carefully, as practice regarding the entry of transaction and cost data has varied between projects. For example, in cases where HACC and Community Options have paid jointly for a particular service, some projects will have entered a single transaction showing both organisations as having paid for it, whilst others will probably have listed the service twice showing HACC paying once and Community Options a second time. The result is that the same circumstances are likely to have been represented in different ways in the original data on which this table is based. The extent to which the various projects follow different practices is not clear, so it is not possible to offer any kind of exact correction. The likely effect of this problem, however, will have been an understatement of the values in those columns of the table relating to services paid for by more than one service provider and some corresponding overstatement of the values in columns

relating to services for which single providers have paid. Unit costs have also occasionally been put in the columns applying to all three sources of funding (HACC, COPs and Other when, in fact, only one has been paying (see Appendix 1).

We should note that the funding sources which comprise the 'Other' category in Table 2.30 are listed in Appendix 6.

We shall not attempt to describe the content of the table in detail but merely draw attention to the main findings. Bearing the above caveats in mind, it appears that HACC is the organisation most often paying for services. HACC payments alone account for 39,617 transactions. Looking down the columns we see that HACC-only payments are made most frequently for general housekeeping and home-delivered meals, whereas the COPs subsidy money which pays for 28,280 transactions is, like HACC money, most frequently spent on general housekeeping. The second largest item of COPs expenditure is for home nursing and personal care.

The percentage figures in brackets (which add to 100% across rows) are perhaps even more interesting for they show that COPs subsidy money is paying for many important services for clients. It is paying for a substantial amount of the housekeeping services, but perhaps more interesting it is a major source of funding for those services which both enhance the quality of the client's or the carer's life and enable participation in the ordinary life of the community. As we noted earlier such services include home-based respite care, overnight care, the preparation of meals in the clients' home, podiatry, transport and major home maintenance items.

Many transactions, even for the conventional HACC type services, are being paid for by the injection of Community Options subsidy money and certainly the 'icing on the cake' is being provided out of these funds. This table therefore enables us to consider not only the value of Community Options as a funding source but also the adequacy of the resources more generally available to provide support at home for people with severe disabilities. There are many people of this kind outside the present scope of the Community Options Program.

The Most Expensive Service Packages in Individual Community Options Projects. Even though, as we shall show, Community Options projects on average spend less than the permitted amounts of both government money and client subsidy money, in a few instances these levels are exceeded. It is interesting to look at these particular service packages, the clients for whom they are and the circumstances in which they are put together, in order to get a glimpse of how Community Options assists frail elderly or disabled people to remain in their own homes. This information has been taken from the Minimum Data Set and is therefore limited to what has been collected for that purpose. The cases described below refer to the highest expenditure incurred by the project **over a period of one week** on behalf of any client of that project.

- A 71 year old woman received 66 hours of care. The client lived alone and had no carer. Her source of income was the Age Pension. She had approval for entry into a nursing home.
-

Table 2.30: Service Types and who Pays for Them

	HACC Only Pays		COPs Only Pays		Other Only Pays		HACC & COPs Pay	
Number of transactions	39,617		28,280		14,142		1,173	
Service Type:	No.	%	No.	%	No.	%	No.	%
Alarm Systems	8	0.0 (1.0%)	687	2.4 (89.8%)	70	0.5 (9.2%)	-	-
Other Centre-Based Services								
- psychological and other counselling	-	-	-	-	38	0.3 (100.0%)	-	-
- training in living skills	-	-	-	-	-	-	-	-
- other	603	1.5 (81.6%)	86	0.3 (11.6%)	50	0.4 (6.8%)	-	-
Delivered Meals								
- home delivered	7,969	20.1 (66.5%)	1,512	5.3 (12.6%)	32	0.2 (0.3%)	10	0.9 (0.1%)
- centre delivered	92	0.2 (8.8%)	69	0.2 (6.6%)	880	6.2 (84.5%)	-	-
Equipment	13	0.0 (2.7%)	420	1.5 (88.2%)	12	0.1 (2.5%)	1	0.1 (0.2%)
Full-time Live-in Housekeeper	-	-	71	0.3 (95.9%)	-	-	-	-
Home Help								
- general housekeeping	11,561	29.2 (49.2%)	5,412	19.1 (23.0%)	537	3.9 (2.3%)	639	54.5 (2.7%)
- linen laundry	318	0.8 (29.5%)	177	0.6 (16.4%)	57	0.4 (5.3%)	-	-
- shopping	1,148	2.9 (54.0%)	529	1.9 (24.9%)	142	1.0 (6.7%)	1	0.1 (0.0%)
- meal preparation	706	1.8 (28.8%)	1,430	5.1 (58.4%)	53	0.4 (2.2%)	2	0.2 (0.1%)
- personal care (excl. overnight)	3,847	9.7 (51.5%)	1,756	6.2 (23.5%)	100	0.7 (1.3%)	228	19.4 (3.0%)
- personal care (overnight)	112	0.3 (22.4%)	256	0.9 (51.3%)	15	0.1 (3.0%)	-	-
- physiotherapy	-	-	12	0.0 (100.0%)	-	-	-	-
Home Nursing								
- general	4,245	10.7 (42.4%)	662	2.3 (6.6%)	4,335	30.7 (43.1%)	2	0.2 (0.0%)
- personal care (excl. overnight)	2,992	7.6 (28.2%)	3,422	12.1 (32.3%)	1,758	12.4 (16.6%)	25	2.1 (0.2%)
- personal care (overnight)	-	-	100	0.4 (70.9%)	33	0.2 (23.4%)	-	-
Interpreter	-	-	-	-	-	-	-	-
Other Home-Based Services								
- material assistance (excl. food)	-	-	95	0.3 (77.2%)	28	0.2 (22.8%)	-	-
- paying bills (incl. rentals)	-	-	33	0.1 (73.3%)	12	0.1 (26.7%)	-	-
- psychological and other counselling	31	0.1 (8.9%)	200	0.7 (57.5%)	107	0.8 (30.7%)	-	-
- training in living skills	-	-	31	0.1 (47.7%)	34	0.2 (52.3%)	-	-
- other	1	0.0 (0.1%)	1,227	4.3 (91.1%)	58	0.4 (4.3%)	4	0.3 (0.3%)
Home Maintenance								
- minor (interior)	82	0.2 (60.3%)	39	0.1 (28.7%)	2	0.0 (1.5%)	-	-
- minor (exterior)	407	1.0 (17.5%)	920	3.3 (39.6%)	381	2.7 (16.4%)	7	0.6 (0.3%)
- major (eg. new roof, guttering, etc)	-	-	28	0.1 (90.3%)	-	-	2	0.2 (6.5%)
Home Modification	20	0.1 (18.5%)	85	0.3 (78.7%)	1	0.0 (0.9%)	2	0.2 (1.9%)
Monitoring	10	0.0 (2.0%)	492	1.7 (97.2%)	4	0.0 (0.8%)	-	-
Paramedical (Home or Centre Based)								
- physiotherapy	25	0.1 (3.3%)	58	0.2 (7.6%)	410	2.9 (53.6%)	-	-
- podiatry	21	0.1 (11.5%)	92	0.3 (50.5%)	69	0.5 (37.9%)	-	-
- occupational therapy	12	0.0 (6.6%)	16	0.1 (8.8%)	148	1.0 (81.3%)	-	-
- speech therapy	-	-	-	-	39	0.3 (100.0%)	-	-
- dietician/nutritionist	-	-	-	-	-	-	-	-
- other	251	0.6 (73.2%)	16	0.1 (4.7%)	59	0.4 (17.2%)	-	-
Recreation	1	0.0 (6.7%)	-	-	14	0.1 (93.3%)	-	-
Respite Care								
- home-based	1,581	4.0 (24.5%)	2,749	9.7 (42.6%)	193	1.4 (3.0%)	207	17.6 (3.2%)
- centre-based (day care)	2,166	5.5 (36.0%)	104	0.4 (1.7%)	2,814	19.9 (46.7%)	26	2.2 (0.4%)
- lost family	-	-	-	-	-	-	-	-
- peer support	55	0.1 (43.3%)	35	0.1 (18.8%)	29	0.2 (22.8%)	1	0.1 (0.8%)
- residential institution	5	0.0 (5.0%)	19	0.1 (74.3%)	75	0.5 (74.3%)	-	-
Social Skill Development	-	-	81	0.3 (10.4%)	9	0.1 (1.2%)	7	0.6 (0.9%)
Social Support Service								
- neighbour aid/volunteer services	311	0.8 (27.8%)	586	2.1 (52.5%)	208	1.5 (18.6%)	-	-
- companionship	21	0.1 (2.2%)	729	2.6 (77.2%)	14	0.1 (1.5%)	1	0.1 (0.1%)
Support and Information								
- co-ordination of welfare services	31	0.1 (2.6%)	1,044	3.7 (87.6%)	117	0.8 (9.8%)	-	-
- education and training for carers	-	-	22	0.1 (95.7%)	1	0.0 (4.3%)	-	-
- assessment by multi-disciplinary team	4	0.0 (0.9%)	-	-	416	2.9 (98.6%)	-	-
- referral to other agency	-	-	-	-	-	-	-	-
Transport								
- direct: with service-owned vehicle	866	2.2 (30.4%)	1,144	4.0 (40.1%)	724	5.1 (25.4%)	7	0.6 (0.2%)
- indirect: taxi service	5	0.0 (2.6%)	184	0.7 (97.4%)	-	-	-	-
- indirect: arrange taxis, travel vouchers etc.	63	0.2 (5.9%)	657	2.3 (61.7%)	26	0.2 (2.4%)	-	-
Don't know	34	0.1 (2.7%)	993	3.5 (79.0%)	38	0.3 (3.0%)	1	0.1 (0.1%)

* Percentages in brackets add to 100 across rows.

HACC & Other Pays		HACC Plus Additional Cost to COPs		COPs & Other Pay		COPs & Additional Cost to COPs		HACC & COPs & Other Pays		HACC & COPs & Other Plus Additional Cost to COPs		Total
103		769		1,163		1,476		15,256		280		102,259
No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
-	-	-	-	-	-	-	-	-	-	-	-	765
-	-	-	-	-	-	-	-	-	-	-	-	38
-	-	-	-	-	-	-	-	59	0.4 (100.0%)	-	-	59
-	-	-	-	-	-	-	-	-	-	-	-	739
26	25.2 (0.2%)	587	76.3 (4.9%)	1	0.1 (0.0%)	-	-	1,730	11.3 (14.4%)	112	40.0 (0.9%)	11,979
-	-	-	-	-	-	-	-	-	-	-	-	1,041
-	-	-	-	1	0.1 (0.2%)	7	0.5 (1.5%)	22	0.1 (4.6%)	-	-	476
-	-	-	-	1	0.1 (1.4%)	2	0.1 (2.7%)	-	-	-	-	74
6	5.8 (0.0%)	107	13.9 (0.5%)	44	3.8 (0.2%)	380	25.7 (1.6%)	4,801	31.5 (20.4%)	27	9.6 (0.1%)	23,514
-	-	-	-	-	-	-	-	521	3.4 (48.3%)	5	1.8 (0.5%)	1,078
-	-	1	0.1 (0.0%)	-	-	50	3.4 (2.4%)	256	1.7 (12.0%)	-	-	2,127
1	1.0 (0.0%)	-	-	2	0.2 (0.1%)	40	2.7 (1.6%)	215	1.4 (8.8%)	-	-	2,449
18	17.5 (0.2%)	26	3.4 (0.3%)	1	0.1 (0.0%)	4	0.3 (0.1%)	1,491	9.8 (19.9%)	6	2.1 (0.1%)	7,477
-	-	-	-	54	4.6 (10.8%)	11	0.7 (2.2%)	51	0.3 (10.2%)	-	-	499
-	-	-	-	-	-	-	-	-	-	-	-	12
3	2.9 (0.0%)	-	-	-	-	4	0.3 (0.0%)	809	5.3 (8.0%)	-	-	10,060
26	25.2 (0.2%)	1	0.1 (0.0%)	16	1.4 (0.2%)	1	0.1 (0.0%)	2,353	15.4 (22.2%)	10	3.6 (0.1%)	10,604
-	-	-	-	-	-	-	-	8	0.1 (5.7%)	-	-	141
-	-	-	-	-	-	-	-	-	-	-	-	0
-	-	-	-	-	-	-	-	-	-	-	-	123
-	-	-	-	-	-	-	-	-	-	-	-	45
-	-	-	-	-	-	-	-	10	0.1 (2.9%)	-	-	348
-	-	-	-	-	-	-	-	-	-	-	-	65
-	-	-	-	2	0.2 (0.1%)	34	2.3 (2.5%)	21	0.1 (1.6%)	-	-	1,347
-	-	1	0.1 (0.7%)	-	-	-	-	12	0.1 (8.8%)	-	-	136
-	-	1	0.1 (0.0%)	14	1.2 (0.6%)	1	0.1 (0.0%)	587	3.8 (25.2%)	7	2.5 (0.3%)	2,325
-	-	-	-	1	0.1 (3.2%)	-	-	-	-	-	-	31
-	-	-	-	-	-	-	-	-	-	-	-	108
-	-	-	-	-	-	-	-	-	-	-	-	506
-	-	-	-	1	0.1 (0.1%)	24	1.6 (3.1%)	247	1.6 (32.3%)	-	-	765
-	-	-	-	-	-	-	-	-	3.3 (3.3%)	-	-	182
-	-	-	-	-	-	-	-	6	0.0 (100.0%)	-	-	182
-	-	-	-	-	-	-	-	-	-	-	-	39
-	-	-	-	-	-	-	-	18	0.1	-	-	18
2	1.9 (0.6%)	14	1.8 (4.1%)	1	0.1 (0.3%)	-	-	-	-	-	-	343
-	-	-	-	-	-	-	-	-	-	-	-	15
4	3.9 (0.1%)	8	1.0 (0.1%)	136	11.7 (2.1%)	424	28.7 (6.6%)	1,141	7.5 (17.7%)	17	6.1 (0.3%)	6,460
14	13.6 (0.2%)	1	0.1 (0.0%)	869	74.7 (14.4%)	-	-	29	0.2 (0.5%)	-	-	6,023
-	-	-	-	-	-	-	-	-	-	-	-	-
-	-	-	-	2	0.2 (1.6%)	5	0.3 (3.9%)	-	-	-	-	127
-	-	-	-	2	0.2 (2.0%)	-	-	-	-	-	-	101
-	-	-	-	-	-	-	-	592	3.9 (76.0%)	90	32.1 (11.6%)	779
-	-	-	-	1	0.1 (0.1%)	10	0.7 (0.9%)	1	0.0 (0.1%)	-	-	1,117
-	-	-	-	-	-	162	11.0 (17.2%)	11	0.1 (1.2%)	6	2.1 (0.6%)	944
-	-	-	-	-	-	-	-	-	-	-	-	1,192
-	-	-	-	-	-	-	-	-	-	-	-	23
2	1.9 (0.5%)	-	-	-	-	-	-	-	-	-	-	422
-	-	-	-	-	-	-	-	-	-	-	-	-
-	-	1	0.1 (0.0%)	1	0.1 (0.0%)	11	0.7 (0.4%)	96	0.6 (3.4%)	-	-	2,850
-	-	-	-	-	-	-	-	-	-	-	-	189
1	1.0 (0.1%)	-	-	12	1.0 (1.1%)	306	20.7 (28.7%)	-	-	-	-	1,065
-	-	21	2.7 (1.7%)	1	0.1 (0.1%)	-	-	169	1.1 (13.4%)	-	-	1,257

Her service package which cost \$1,232 consisted of:

- 63 hours of (daytime) personal care (at \$18.67 per hour) provided and paid for by HACC (total cost \$1,176)
- 3 hours of home nursing (personal care) (also \$18.67 per hour) provided by a HACC-type government provider and paid for by 'Other' (total cost \$56).

This particular service package was provided for only one week. The week following its receipt the client entered long-term residential care.

- An 11 year old client cared for by her mother and who had approval for entry into residential care received a service package costing \$1,272. This consisted of:
 - 106 hours of home-based respite (at \$12 per hour) provided by a private contractor and paid for completely by Community Options.

The client received a similar (though not quite as large) service package the week before and the week after this one. Altogether she was a client for about six weeks, after which she left Community Options because she was receiving adequate services.

- A 92 year old woman whose 71 year old daughter was her carer received services costing \$2,355. The client had been diagnosed as having dementia by a Geriatric Assessment Team and had nursing home approval. The services in this package consisted of:
 - a 'one-off' major home maintenance item (electrical), paid for by Community Options and provided by a private contractor costing \$2,290
 - 1 hour a day of personal care provided by a community nurse (at \$15.67 per hour)
 - 1.25 hours of housekeeping (at \$15.85 per hour)
 - 1.25 hours of home-based respite (at \$17.41 per hour)
 - 3 home delivered meals (at \$2.70 each)

The personal care was provided by a HACC-type government agency (and listed as being paid for by HACC); the remaining three services were all paid for and provided by HACC. Without the major home maintenance, this service package cost \$65.34 and included four services. The client continued to receive this package of four services and was still a Community Options client at the end of the reference year.

- A 61 year old man who lived alone and did not have a carer received services costing \$5,313. The service package consisted of:
 - a home modification costing \$5,109, provided by HACC (\$4,109 of which was paid for by HACC and the remaining \$1,000 by Community Options).
 - 6 delivered meals (at \$2.95 each) provided by a private service agency and paid for by Community Options (total cost \$17.70)
 - 7 hours of general home nursing (\$19.78 per hour) provided by a HACC-type government provider and paid for by HACC (total cost \$138.46)
 - 3 hours of housekeeping (at \$15.97 per hour) provided and paid for by HACC (total cost \$47.91)

This client had been a client of Community Options for at least 6 months, but normally received a smaller service package. A few weeks later he was 'receiving adequate services', and ceased to receive Community Options services.

- A 64 year old man, cared for by his 65 year old wife received a service package costing \$1,224 which consisted of 107 hours of personal care, monitoring, delivered meals and housekeeping. This man was referred to Community Options by the Home Care Service because his wife could no longer provide adequate assistance. The man was not listed as being eligible for entry to any form of residential care. The details of his service package are as follows:
 - 1 hour of housekeeping (at \$15.97 per hour) provided by HACC but paid for by Community Options
 - 7 delivered meals (at \$4.78 each) provided by a private agency and also paid for by Community Options
 - monitoring (at \$31.03) listed as a HACC-type government service paid for by Community Options
 - 3 hours of daytime personal care (17.41 per hour) provided and paid for by HACC, and finally,
 - 70 hours of personal care (at \$8.86 per hour - regular)
 10 hours of personal care (at \$10.80 per hours - Saturdays)
 10 hours of personal care (at \$14.40 per hour - Sundays)
 14 hours of personal care (at \$15.67 per hour - overnight)

All personal care was provided by a private nursing agency and paid for by Community Options. The personal care alone provided to this client cost \$1,143. The client had received this large service package on alternate weeks for at least six months. In the alternate week though the package was still

large, there was no weekend personal care. He was still a client at the end of the reference year.

- An 82 year old man living with his 58 year old son, who was also acting as his carer, was provided with a relatively modest package of services which cost \$680. The client has approval for entry into a nursing home.

His service package consisted of:

- 33¹/₂ hours of home-based respite (at \$10 per hour) provided by two different private contractors and paid for by Community Options (total cost \$335)
- 2 hours of personal care (at \$15.67 per hour) provided and paid for by HACC (total cost \$31.34)
- 2 instances of a live-in person providing personal care (at \$157 each) also provided and paid for by HACC (total cost \$314)

He continued to receive personal care on a somewhat reduced scale for the next 6 months and was still a client at the end of the reference year.

- A 58 year old woman who lived alone received a service package worth \$749. This client's brother, who visited her less than once a week, was her carer. She had approval for entry into a nursing home and lived on the Age Pension. Her service package consisted of:

- 14 hours of privately provided live-in personal care (including overnight) paid for by Community Options (a total of \$560, at \$40 per hour)
- 7¹/₂ hours of meal preparation (at \$15.85 per hour), provided and paid for by HACC
- half an hour of shopping help (also at \$15.85 per hour), again provided and paid for by HACC
- 1 hour of housekeeping (same cost and provision as per shopping help)
- 3 hours of general home nursing provided (at \$15.67 per hour) by a HACC-type government provider and listed as being paid for by HACC

She received a package of the same services excluding the home nursing, for the two weeks following. After this the client was not recorded as receiving any services, but she had not been officially taken off the program at the end of the reference year.

An indication of the level of error in the Minimum Data Set is that in the remaining seven projects the examples of the highest cost service packages all contained errors so great that they were unusable. Since our analysis was confined to data recording

recurrent expenditure it is clear from the accounts above that some of the larger expenditures items have been inappropriately classified as items of recurrent expenditure.

It is interesting to note that in all but the first example given, very large amounts of personal care were provided by private contractors and paid for by Community Options. Of the seven examples given, only two clients were not eligible for entry into a nursing home and for one client his eligibility was unknown.

Overall, the above examples illustrate that it is easy for Community Options to spend a considerable amount of money in meeting the personal care and respite needs of clients without delivering a great many services or providing a particularly lavish or elaborate package. It can also be seen that Community Options has a particular role co-ordinating services from a number of different service agencies.

The Cost of Private Services. We noted earlier that many Community Options co-ordinators were favourably disposed to using private contractors, partly because they were cheaper and partly because it gave them more control over the delivery of their services. Table 2.31 below compares the most common price of a number of services when purchased from private contractors and when purchased from government funded service agencies. It is clear that private services are, on the whole the cheaper option. Although the table describes the most usual prices paid, our data suggest that those services purchased on the private market occasionally but only rarely cost more than those that are publicly funded. Of course this tells us nothing about the quality of services or the industrial award conditions that pertain to the private services.

Related to this, the use of private services released Community Options 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.

The Financial Costs of Community Options

This section examines some of the financial issues raised in the consultancy brief. The information is presented in a series of tables describing the results of an analysis

Table 2.31: Most Common Price Paid for Government Funded Services and for Services Purchased from Private Contractors

Most common price when purchased from Government funded service		Most common price when purchased from a private contractor	
Service			
Meal Preparation	\$15.85/hr	\$11.80/hr	(also purchased at \$17.70 & \$9.00/hr)
Shopping	\$15.85/hr	\$9.00/hr	(also purchased at \$15.85 & \$12.00/hr)
Housekeeping	\$15.85/hr	\$9.00/hr	(also purchased at \$10, \$14, \$15, \$8 & 12/hr)
Home nursing HACC-type	\$19.78/hr	\$16.95/hr	(also purchased at \$17.24 & \$15.67/hr)
Personal care	\$18.67/hr	\$9.00/hr	(also purchased at \$12 & \$10/hr)
Minor home maintenance	\$17.17/hr	\$15.00/hr	
Home delivered meals	\$2.65/\$2.70 up to \$3.35	\$4.72/\$5.00	(\$2.95 was lowest price)
Home-based respite	\$17.41/hr	\$9.00/hr	(also purchased at \$10 & \$8/hr)
Centre-based respite	\$4.50/hr & \$5.00/hr	\$19.82/day	

of **recurrent** expenditure patterns. Throughout the tables, the focus is on the level of average weekly recurrent costs **per client**. In the analysis, attention is also given to the extent by which weekly recurrent expenditures vary between projects, and between clients with different characteristics; age, dementia status, living arrangements, and locality. Monthly statistics of the average costs per client per week are presented, broken down by gross and net costs incurred by HACC, by COPS, and by all other sources. Net costs are defined here as the gross cost less any contributions from, or on behalf of, the client.

Although the focus is on 'per-client, per-week' averages, a range of other statistics are also presented in the tables. This has been done because the averages do not indicate the extent of the variations in costs among clients of a Community Options project. There is a great amount of variation in the averages per client **across** the projects. There is also even more variation in costs per client **within** projects.

In addition, average costs per client per week are presented for a number of sub-groups of clients, and for sub-groups of projects. The sub-groups of clients are based on three characteristics: age, dementia, and living arrangements. The sub-

groups of projects are based on type of locality. These sub-groupings of clients and projects are examined in order to assess whether the levels of costs per client vary between clients and/or projects in a systematic manner. The definitions of the various sub-groups of clients used are:

Age Groups:

aged up to 20,
aged 21 to 64,
aged 65 to 79,
aged 80 or over.

Living Arrangements:

living alone,
not living alone.

Dementia:

having dementia (either diagnosed or showing symptoms of dementia),
not having dementia.

Locality:

metropolitan,
large cities,
provincial centres,
rural/remote areas.

The structure of the information in Tables 2.32, 2.33, 2.35, 2.39 and 2.41 is as follows. The first entries in each cell (i.e. the bolded entries in the rows labelled Mean) are the weekly averages. These weekly averages per client are decomposed into costs associated with HACC services, costs associated with COPS services, and costs associated with all other services. A full list of the services covered by the Other category is in Appendix 6. The gross costs incurred on behalf of the client are indicated in the first four columns of each table and are labelled Gross HACC, Gross COPS, Gross Other and Gross Total respectively. The next four columns, i.e. the fifth to eighth columns, indicate the corresponding net costs. These columns are labelled Net HACC, Net COPS, Net Other, and Net Total, respectively. The net costs are calculated as the gross costs less any client contributions received for a particular service. The final column, labelled Client, indicates by how much the total gross costs were reduced by contributions from the client receiving the services. The other entries in each cell give an indication of the variation in the costs underlying the weekly averages.

To derive these figures, the information on each separate transaction for one client was pooled on a weekly basis. The costs associated with each transaction were then added together to determine a figure for the gross total weekly cost per client. From this gross total figure, any client contributions were deducted to reach a net (i.e. net of client contributions) weekly cost per client.

The row labelled Deviation presents the standard deviations for the cell. The standard deviation reflects the range within which the weekly recurrent costs are most common by indicating the range within which two-thirds of all weekly recurrent costs fell. That is, the standard deviation figure indicates that two-thirds of all individual client figures diverged from the mean figure by no more than the dollar value of the standard deviation. Therefore, when comparing two or more cells, a cell with a higher standard deviation indicates that the individual figures making up that cell's mean are more spread out than is the case for a cell with a lower standard deviation.

The figures in the rows labelled Maximum indicate the highest recorded weekly recurrent expenditure figure for any client covered by the cell. Minimum values are not presented in the tables as *in every cell* the minimum value was zero. Thus the Maximum entries also indicate the range of recurrent costs per client per week within the cell.

The Expenditure entry indicates the level of total expenditure incurred over all clients during the period covered by the cell. The Client-Weeks entry indicates the number of client-weeks on which the other entries in the cell are based.

Weekly Recurrent Costs Per Client: An Overview

Table 2.32 presents an overall picture of average weekly costs per client for all 14 projects combined. In the remainder of the tables in this section, the information presented in Table 2.32 is disaggregated by a series of indicators:

- project (Table 2.33),
- age (Table 2.35),
- dementia status and age (Table 2.36),
- living arrangements (Tables 2.37 and 2.38),
- type of locality (Table 2.39), and
- RCI categories (Table 2.41).

In addition, there are two other tables in this section. Table 2.34 compares the weekly recurrent expenditures with the levels of the brokerage fees, administrative costs, and approved subsidy levels for each of the 14 projects. Table 2.40 presents the results of a multivariate regression analysis in which the relative importance of each characteristic (age, dementia status, living arrangements, locality, etc.) to weekly costs is estimated.

Average Costs Per Client, All Projects Combined. Table 2.32 presents the weekly averages of costs per client for all 14 projects combined, for each calendar month of the period covered by the MDS. The final set of figures in Table 2.32 indicates that, for all 14 projects over the entire 12 month period, the average gross costs of services to clients was \$99.18 (see final entry in the Gross Total column), of which \$39.84 was for COPS services (see final entry in the Gross COPS column), \$42.45 was for HACC services (see final entry in the Gross HACC column) and \$17.42 was

[illegible]

Table 2.32 (cont.)

Month	Gross HACC	Gross COPS	Gross Other	Gross Total	Net HACC	Net COPS	Net Other	Net Total	Client
May									
Mean	48.91	35.02	15.61	98.86	44.38	27.58	12.32	84.29	14.58
Deviation	69.79	75.69	57.35	113.05	65.71	59.77	39.92	95.47	55.36
Maximum	627.22	2290.00	1225.00	2339.67	621.22	2200.00	610.61	2239.93	1225.00
Expenditure(\$)	192810.99	138068.21	61516.09	389725.22	174964.51	108708.77	48579.33	332252.61	57472.61
Client-Weeks	3942	3942	3942	3942	3942	3942	3942	3942	3942
June									
Mean	50.06	35.02	18.27	102.65	45.40	26.76	14.29	86.44	16.20
Deviation	73.69	67.43	63.59	114.88	69.59	44.56	44.17	94.14	61.57
Maximum	1176.20	605.00	1225.00	1232.21	1176.20	558.00	591.94	1232.21	1225.00
Expenditure(\$)	201195.41	140755.48	73432.36	412536.05	182446.36	107541.57	57427.03	347414.96	65121.09
Client-Weeks	4019	4019	4019	4019	4019	4019	4019	4019	4019
Total									
Mean	42.45	39.84	17.42	99.18	38.62	33.33	13.14	85.08	14.10
Deviation	66.57	78.02	81.94	134.09	61.29	63.11	60.34	111.85	65.24
Maximum	4109.00	2605.00	2664.85	5265.16	3287.20	2605.00	2664.85	4428.96	2103.00
Expenditure(\$)	1874587.41	1759278.91	769081.55	4380017.15	1705596.48	1471770.62	580155.12	3757522.22	622494.93
Client-Weeks	44162	44162	44162	44162	44162	44162	44162	44162	44162

The Gross HACC column includes only the imputed costs for services provided **and paid for** by HACC. Purchase of service from HACC agencies which is paid for by COPS is included in the Gross COPS column. The Gross Other column includes costs to those organisations listed in Appendix 6. It does not include client contributions to **Community Options**. It may include a client's contribution directly to a private service provider.

for all other services (see final entry in the Gross Other column). After allowing for client contributions, these costs reduced to \$85.08, \$33.33, \$38.62, and \$13.14 respectively (see final entries in corresponding net columns). Client contributions, on average, amounted to \$14.10 per week (see Client column). Thus, COPS clients were contributing, on average throughout the year, around fourteen per cent of the gross costs incurred in the delivery of the services they were receiving.

The net cost to the COPS projects figure has shown a steady decline over the review period. In July 1989, weekly recurrent expenditure per client averaged \$41.14, but by June 1990 the figure was considerably lower at \$26.76. By contrast, the net costs of HACC services rose from \$35.98 to \$45.40, with almost all of this increase occurring in the last four months (i.e. March-June 1990). Client contributions also rose over this period, from \$10.82 in July 1989 up to \$16.20 in June 1990. As a proportion of total gross costs, client contributions rose from 10.16 per cent in July 1989 to 15.78 per cent in June 1990.

In every month, there were instances of some very large expenditures on individual clients. These are shown in the rows labelled Maximum in Table 2.32. It can be seen that these instances reflect payments which are well in excess of the then COPS limit of \$200 per client per week. For example, the highest weekly net COPS expenditure on one client was \$2605.00, which occurred in September 1989. Although these instances were relatively rare, they do indicate that the \$200 limit was inadequate in some circumstances. Indeed, in every month the highest net cost to COPS was in excess of the revised limit of \$400 (less the applicable brokerage fee). In fact, in nine of the twelve months, the highest recorded expenditure on an individual client was in excess of \$1,000. However, it should be noted that it is anticipated that at least some of these very high expenditures on individuals **may** turn out to be 'one-off' expenditures which have been incorrectly coded as recurrent expenditure. An examination of the instances of very high recurrent expenditures indicates that many occur either for only one week or for two consecutive weeks. This suggests that they may in fact really be 'one-off' expenditures, some of which have been paid for over a two week period.

Average Costs Per Client, Individual Projects. Table 2.33 presents the expenditure patterns for each of the 14 projects. There is considerable variation in the levels of weekly recurrent expenditure per client among the projects. The project with the highest average weekly gross expenditure per client was the Liverpool project, with a figure of \$132.37. At the other extreme, the lowest average weekly gross expenditure per client was \$21.38, which occurred in the NW Aboriginal project. In general, the rural projects tended to have lower gross expenditure levels per client than was the case for metropolitan projects; see, also, the gross figures for the NW Area, Hastings, and Temora projects. The variations in expenditure levels by type of locality is explored more systematically in Table 2.39 below.

It is interesting to note that the projects with the highest levels of gross costs are not also the projects with the highest net COPS costs. On this basis, the New England project has the highest net COPS costs, at \$59.32, while the NW Area project has the

[illegible]

Table 2.33 (cont.)

Project ID	Gross HACC	Gross COPS	Gross Other	Gross Total	Net HACC	Net COPS	Net Other	Net Total	Client
Hastings									
Mean	30.65	39.62	3.13	73.39	27.23	33.19	2.95	63.37	10.02
Deviation	51.92	52.14	18.79	75.45	46.57	38.52	18.35	63.92	28.97
Maximum	833.16	574.00	320.00	833.16	783.16	448.00	320.00	783.16	452.00
Expenditure	79354.82	102567.95	8093.00	190015.77	70499.81	85926.90	7645.00	164071.71	25944.06
Client-Weeks	2589	2589	2589	2589	2589	2589	2589	2589	2589
NE New England									
Mean	30.30	78.18	2.80	111.23	28.37	59.32	.57	88.27	22.96
Deviation	59.27	83.36	18.23	111.25	56.27	59.09	5.72	82.36	47.08
Maximum	448.08	579.67	140.00	680.42	448.08	544.67	65.00	656.37	203.01
Expenditure	33182.94	85608.08	3067.45	121796.37	31070.40	64953.04	627.50	96650.94	25145.43
Client-Weeks	1095	1095	1095	1095	1095	1095	1095	1095	1095
Temora									
Mean	46.53	42.04	1.89	90.45	40.73	38.89	1.76	81.37	9.08
Deviation	63.79	47.85	8.23	97.45	43.64	46.58	7.86	72.41	34.13
Maximum	1704.66	1149.20	100.00	2853.86	499.66	1149.20	100.00	1648.86	1205.00
Expenditure	64116.45	57929.26	2599.07	124644.78	56123.19	53590.04	2420.42	112133.65	12511.13
Client-Weeks	1378	1378	1378	1378	1378	1378	1378	1378	1378
Liverpool									
Mean	67.48	27.59	37.30	132.37	62.39	26.16	37.27	125.82	6.55
Deviation	86.47	79.83	37.52	106.64	83.61	75.98	37.49	102.87	12.19
Maximum	487.48	600.00	166.52	600.00	480.48	558.00	166.52	558.00	210.00
Expenditure	32121.42	13131.05	17756.13	63008.60	29696.92	12451.79	17742.13	59890.84	3117.76
Client-Weeks	476	476	476	476	476	476	476	476	476
Total									
Mean	42.45	39.84	17.42	99.18	38.62	33.33	13.14	85.08	14.10
Deviation	66.57	78.02	81.94	134.09	61.29	63.11	60.34	111.85	65.24
Maximum	4109.00	2605.00	2664.85	5265.16	3287.20	2605.00	2664.85	4428.96	2103.00
Expenditure	1874587.41	1759278.91	769081.55	4380017.15	1705596.48	1471770.62	580155.12	3757522.22	622494.93
Client-Weeks	44162	44162	44162	44162	44162	44162	44162	44162	44162

lowest, at \$10.33. Indeed, Liverpool - the project with the highest gross costs - has below average net COPS costs.

It is also interesting to note that there appears not to be a strong relationship between a project's gross costs and the level of client contributions. One hypothesis which had been advanced was that the client contributions were likely to be higher in projects in which the gross costs were highest. However, the information in the total gross expenditure and client contributions columns of Table 2.33 does not bear this out. The project with the highest total gross expenditure, Liverpool, has the ninth highest (i.e. sixth lowest) client contributions. The project with the second highest total gross expenditure, Fairfield, has the tenth highest (i.e. fifth lowest) client contributions. At the other extreme, the project with the lowest total gross expenditure, NW Aboriginal, does have the lowest client contributions, although the project with the second lowest total gross expenditure, Hastings, has the sixth highest (i.e. ninth lowest) client contributions. The relationship between the level of weekly recurrent expenditures per client and the composition of those expenditures is explored further below.

Administration Costs, Brokerage Fees, Recurrent Subsidy Limits and Actual Recurrent Expenditure. Table 2.34 compares brokerage fees and client expenditure for each of the 14 projects. Each project is permitted to levy a brokerage fee to cover the administrative costs of running the project. The level of the brokerage fee is calculated by dividing the estimated total annual administrative costs by the product of the approved number of clients and 52.2 (i.e. the average number of weeks per year). This results in a brokerage fee per client per week. If the project maintains a full quota of clients each week, and remains within its budgeted annual administrative costs, the aggregate annual brokerage fee money will cover all project overheads. Inspection of Table 2.34 indicates that there are considerable variations in the magnitudes of each of the three components: approved subsidy level, recurrent expenditure (as measured by the net COPS figures), and brokerage fee. The approved subsidy levels per client per week vary from a high of \$72.85 (Wollongong) to a low of \$39.22 (for both the Inner West and St. George projects). Inspection of the second column of Table 2.34 reveals that most projects appear to be underspending. In all but one project weekly recurrent expenditure per client is lower than the approved subsidy level. The exception is the New England project, where average weekly recurrent expenditure per client is slightly above the approved level (\$59.32 compared to \$55.00). Of the other projects, only Hornsby would appear to be spending near to its approved level (\$49.79 compared to \$55.00). The other twelve projects would all appear to be underspending substantially. Indeed, in five projects - Fairfield, Inner West, NW Aboriginal, NW Area, and Shoalhaven - recurrent expenditure is less than half the approved subsidy level.

The brokerage fees also vary widely, ranging from a high of \$48.96 per client per week to a low of \$16.70 per client per week, although most are in the range \$24 to \$35. The two projects with the highest brokerage fees - NW Aboriginal and NW

Table 2.34: Approved Subsidy Rate, Actual Recurrent Expenditure and Approved Brokerage Fee (Per Client Per Week)

Project	Approved Subsidy \$	Recurrent Expenditure (per Client per Week) \$	Brokerage Fee \$
Fairfield	44.55	14.20	34.95
Inner West	39.22	15.63	24.92
St George	39.22	21.66	24.01
Hornsby	55.00	49.79	28.22
Newcastle	64.99	34.71	33.57
Wollongong	72.85	44.48	31.74
Wyong	69.25	42.44	29.52
NW Aboriginal	60.00	18.47	48.96
NW Area	63.00	10.33	48.96
Shoalhaven	59.77	19.88	20.44
Hastings	54.79	33.19	16.70
NE New England	55.00	59.32	42.65
Temora	50.00	38.89	24.10
Liverpool	44.50	26.16	30.69

Note: The figures in the **Approved Subsidy** and **Brokerage Fee** columns were provided by the individual projects and/or the COPS Unit at the NSW Department of Family and Community Services. The figures in the **Recurrent Expenditure** column are the per client average weekly recurrent expenditure figures from the Net COPS column of Table 2.32.

Area - are in the remotest settings and their brokerage fees undoubtedly reflect the higher costs of administering projects in areas in which the population density is low and a considerable amount of time needs to be spent on travel.

Weekly Recurrent Costs for Client: Selected Characteristics

Average Costs Per Client, Age Groups. Table 2.35 shows how the recurrent expenditure patterns vary for four age groups: 20 and under, 21-64, 65-79 and 80 and over. Three quarters of the clients, or rather client-weeks, are spread evenly over the latter two age groupings. The oldest age group (80 or over) had the highest gross total expenditure, the highest gross and net HACC costs, and the highest level of client contributions. However, the group which had the highest net COPS costs (at \$55.85) was the youngest age group - the under 20s - who also had the highest level of net total costs (\$91.26) and the lowest level of client contributions (\$3.72).

Average Costs Per Client, Dementia Status. Table 2.36 shows how weekly recurrent costs vary by dementia status and age for clients aged 65 and over. Expenditures for clients with dementia are higher in both age groups than are those

[illegible]

for clients who are not dementia sufferers. Dementia sufferers have higher costs for both HACC services and, especially, COPS services than do other clients.

Among dementia sufferers, recurrent costs tend to be higher for the younger (i.e. aged 65-79) sufferers, although this cost differential is entirely attributable to the Other costs categories, as there is very little difference in the weekly levels of expenditure on both HACC and COPS services as between dementia sufferers aged 65-79 and those aged 80 or over. Further, the age differential in the higher costs for dementia sufferers is accentuated by greater levels of client contributions from the older sufferers. Thus, whereas the younger dementia sufferers have Client contributions of \$17.86 per week on average, the figure for the older (80+) age group is \$27.37 per week.

Average Costs Per Client, Living Arrangements. Table 2.37 presents recurrent expenditures on the basis of living arrangements, disaggregated by age. Within each of the three age groups shown, gross total costs for clients living alone are only a few dollars less than the gross total costs for those clients who are not living alone. For clients living alone, gross weekly costs are \$85.03 (21-64 age group), \$93.48 (65-79 age group) and \$106.49 (80+ age group); the corresponding figures for clients not living alone are \$87.10, \$98.11 and \$108.44 respectively. The pattern is slightly different in relation to net total costs however. Although the same general pattern (i.e. net total costs are slightly lower for clients who live alone) is apparent for the two youngest age groups (e.g. for the 65-79 age group, the figures are \$82.16 and \$85.86 respectively), the reverse is the case for the very oldest clients. For those clients aged 80 or over, total costs are slightly higher for clients who live alone (\$88.19) than they are for those who do not live alone (\$86.15). The reason for this reversal can be seen in the levels of client contributions. These contributions are highest (at \$22.29 per week) for clients aged 80 or over who do not live alone.

An interesting feature of Table 2.37, however, is the figure for the clients for whom living arrangements could not be determined from the Minimum Data Set. For this group, gross total costs were considerably higher, at \$124.88, than for either of the groups with known living arrangements. Net total expenditures were also higher (\$91.08), but the gap was reduced by the comparatively large client contributions which, at \$33.80, were two-and-a-half times greater than for either of the other two groups. The figures for this group should be treated with caution as the number of individuals in the group is very small, being equivalent to twenty-five individuals per annum (i.e. the number of client-weeks for this group is only 1,290 and this is equivalent to 24.7 client-years). They have comparatively high COPS costs (net COPS figure is \$56.14) and slightly lower levels of HACC costs (at \$31.23) compared to the two groups for whom living arrangements are known.

Average Costs Per Client, Living Arrangements and Carer Status. Table 2.38 focuses on the relationship between living arrangements and the presence/absence of a primary carer. Four combinations of living/carers arrangements are possible: not living alone/has a carer; not living alone/no carer; living alone/has a carer; and living alone/no carer. The most common combination is the 'not living alone/has a carer'

[illegible]

[illegible]

[illegible]

combination; of the 1,257 clients in the Minimum Data Set, 649 (or 51.6%) are in this category (see Table 2.15).

Table 2.38 shows that clients who had carers also had the highest weekly recurrent costs, and that, among clients with carers, there is no real difference in costs due to living arrangements. Thus, for clients in the 'not living alone/has a carer' combination, average total weekly costs are \$106.01 while for clients in the 'living alone/has a carer' combination, the figure is \$106.75. The main difference in costs for clients with carers is in the composition of the weekly costs rather than in the level of weekly costs. Clients who live alone but have a carer have greater levels of expenditure on HACC services than do clients who do not live alone (and have a carer).

For clients who do not have a primary carer, weekly recurrent expenditures are more sensitive to living arrangements. Clients who live alone (and have no carer) have total gross costs which are twice as high as those for clients who do not live alone but have no carer; the figures are \$91.06 and \$47.35 respectively. The main factor causing this difference is the far greater use of HACC services, although COPS and Other costs are also higher for clients who live alone than they are for those clients who do live alone (and do not have a carer).

Average Costs Per Client, Type of Locality. The issue of the importance of locality in the incidence of expenditures was referred to in the discussion of Table 2.33, which compared expenditures across projects. This issue is further explored in Table 2.39, which compares expenditures on the basis of four types of locality: metropolitan, other urban, provincial and rural/remote. This comparison reveals that gross total costs are highest in the Metropolitan and Other Urban localities, and that they are lowest in the more remote areas. The explanation of these figures may reflect the lack of availability of many formal services in remote areas rather than higher unit costs of formal services in the more densely populated areas. That is, weekly recurrent expenditure is higher in the more densely populated areas simply because of greater access to and, therefore, more frequent use of services by projects located in these areas. Thus, the higher recurrent expenditure figures in the more densely populated areas merely indicate a greater level of provision of formal services in these areas.

Multivariate Regression Analysis. Tables 2.33 to 2.39 give an indication of the variations in weekly costs between clients for a range of different characteristics. However, these tables do not indicate the relative importance of each particular characteristic in determining *why* the costs vary and by how much the costs vary. In order to isolate the impact of each characteristic on weekly recurrent expenditure, a multivariate regression analysis was carried out. In this analysis, one extra characteristic not discussed in Tables 2.32 to 2.39 above was included. This characteristic concerned the nature of the auspicing body for each project. A four-way classification of auspicing bodies was used: charity/community, health, Home Care Service, and municipality. A full list of the characteristics included in the multivariate regression analysis is:

[illegible]

Age:	20 or under; 21-64; 65-79; and 80 and over.
Auspecting Body:	charity/community group; health service; Home Care Service; and local government council.
Dementia:	sufferer; not a sufferer.
Living and Carer Arrangements:	not living alone/has a carer; not living alone/no carer; living alone/has a carer; and living alone/no carer.
Locality:	metropolitan; other urban; provincial city/town; and remote.
Project:	each individual project identified.

The multivariate analysis enables us to estimate the impact of each characteristic on a client's weekly costs. The results are summarised in Table 2.40. The interpretation of the figures in Table 2.40 is as follows. First, the impacts are estimated relative to clients with a hypothetical reference set of characteristics. This hypothetical reference group consists of those clients with the following characteristics: live in the metropolitan region, are clients of the St. George project, are aged 21-64, are not dementia sufferers, do not live alone, have a carer, are clients of a project with an auspecting body of the charity/community type. For this reference group, the gross recurrent costs are estimated to be \$102.54 per client per week (see notes to Table 2.40).

Second, a positive amount in the column labelled Estimated Impact indicates that, relative to the reference group, an increase in the characteristic is estimated to result in an increase in the level of gross weekly recurrent costs by the amount specified, while a negative amount in this column indicates that an increase in the characteristic is estimated to lead to a corresponding decrease in the level of weekly costs. The figure in the column labelled Standard Error is a guide to the accuracy of the estimated impact, and is to be read in conjunction with the information in the final column, Level of Significance. For those characteristics with a '-' in the final column, the estimates are to be interpreted as being zero; that is, changes in the characteristic have **no** impact on weekly costs. For the characteristics with an '*' or '**' in the last column, we can be very confident that the estimates presented in the first column are a reliable guide to the impact of changes in the level of the characteristic on the level of weekly costs.

The impact of age on weekly costs is isolated to the oldest age group only. That is, other things being equal, it is only clients who are aged 80 or over for whom costs are different to those for the age reference group (age 21-64). For clients in the 80 and over age group, weekly costs are estimated to be \$5.50 higher than for identical clients who are younger than 80.

The results with respect to auspecting bodies indicate that the only type of auspecting body for whom weekly costs are different to those for the auspecting body reference

Table 2.40: Estimated Impact on Weekly Recurrent Expenditure of Selected Characteristics (\$ Per Client Per Week)

Characteristic	Estimated Impact ^(a)	Standard Error	Level of Significance ^(b)
Age			
Under 20	-4.75	3.78	-
21 to 64	0.00		
65 to 79	-2.36	1.79	-
80 and over	5.49	1.88	**
Living/Carer arrangements			
Living alone/no carer	-8.99	1.68	**
Not living alone/no carer	-25.41	2.75	**
Living alone/has a carer	-0.89	1.79	-
Not living alone/has a carer	0.00		
Don't know status	31.82	5.37	**
Dementia Status			
A sufferer	27.52	1.85	**
Not a sufferer	0.00		
Not known	-7.46	3.47	*
Auspicing Body			
Charity/Community group	0.00		
Health Service	-1.00		
Home Care Service	-1.00		
Local government council	12.04	2.93	**
Locality			
Metropolitan	0.00		
Other urban	-1.00		
Provincial City/town	-6.54	2.84	-
Remote	-1.00		
Project			
Coonamble	-67.38	3.65	**
Fairfield	16.01	3.07	**
Hastings	-24.85	3.16	**
Hornsby	4.37	2.82	-
Inner West	-12.83	4.41	**
Liverpool	25.35	6.46	**
Newcastle	4.23	2.79	-
New England	-0.14	5.25	-
Shoalhaven	-11.05	3.50	**
St George	0.00		
Temora	-22.71	4.93	**
Walgett	-18.19	3.74	**
Wollongong	-1.00		
Wyang	-1.00		

- Notes:**
- a) In this column, a '0.00' indicates that the characteristic is the reference group, while a '-1.00' indicated that the characteristic was eliminated from the regression as it was too highly correlated with another characteristic.
 - b) In this column, '**' indicates that the characteristic is significant at the 99% level of confidence, '*' indicates that the characteristic is significant at the 95% level of confidence, while a '-' indicates that the characteristic is not significant at all.
 - Sample size is 44,162 client-weeks
 - Mean value of weekly recurrent expenditure per client in the reference group was \$102.54
 - Adjusted R² was 0.041
 - F=statistic was 84.669 (significant at the .0000 level)

group is the municipality category. Weekly costs for projects with local government council auspicing bodies are estimated to be \$12.04 higher than for otherwise identical projects with a different auspicing body.

Dementia sufferers are estimated to have weekly costs which are \$27.52 higher than those for clients who are equal in all other respects except that they are not dementia sufferers. There were a small number of clients for whom dementia status was not recorded on the MDS. Weekly costs for these clients was estimated to be \$7.46 lower than for the clients for whom it was known that they definitely were not dementia sufferers.

The differences in weekly costs associated with different living and carer arrangements are estimated to be as follows. Clients in the living alone/has a carer combination have the same level of weekly cost as do clients in the reference group (i.e. not living alone/has a carer). However, clients who do not have a carer have lower weekly costs than do clients with carers. Other things being equal, clients who live alone and have no carer are estimated to have weekly costs which are \$8.99 lower than those for the reference group, while clients who do not live alone and have no carer are estimated to have weekly costs which are \$25.41 lower than those for the reference group. The living and carer arrangements were not recorded on the MDS for a small number of clients. For these clients, weekly costs were estimated to be \$31.82 above those for the reference group.

The impact of locality on weekly costs was minimal. Compared to the reference group of metropolitan based projects, the only type of locality that had significantly different costs was the 'provincial city/town' category. For projects in this type of locality, weekly costs were \$6.54 lower than they were for otherwise equal clients in all other types of locality.

After allowing for the possible influences of all the above types of characteristics, there appears to be some significant project-specific influences on weekly recurrent costs per client in eight projects. For example, Hastings, Inner West, North West Aboriginal, North West Area, Shoalhaven and Temora all have relatively low weekly expenditures per client and Fairfield and Liverpool have relatively high weekly expenditures per client after allowing for the impact of all the other characteristics discussed above.

Average Costs Per Client, RCI Category. Table 2.41 describes the relationship between weekly recurrent costs and the clients' levels of dependency as measured by the Resident Classification Instrument. As discussed earlier, the Minimum Data Set (MDS) did not contain any information on clients levels of dependency. Therefore this table is based on the sub-set of 258 clients for whom additional information on dependency levels was sought via the Client Dependency Form exercise already described. Further, due to the very small number of clients in the three highest categories of dependency (see Table 2.16), these three categories have been combined in Table 2.41. Nevertheless, Table 2.41 indicates that weekly recurrent costs per client are directly related to the client's dependency level and that there are substantial differences in the composition of costs per client. Weekly gross total

Table 2.41: Recurrent Costs by Resident Classification Instrument Category (\$ Per Client Per Week)

RCI Category	Gross HACC	Gross COPS	Gross Other	Gross Total	Net HACC	Net COPS	Net Other	Net Total	Clients
1/2/3									
Mean	69.60	37.80	15.60	117.95	64.92	29.00	12.23	106.17	11.78
Deviation	108.45	58.77	32.13	121.48	104.10	38.01	30.37	117.21	40.93
Maximum	487.48	283.50	279.00	559.67	480.48	206.04	279.00	500.26	194.88
Expenditure	9200.50	4994.86	1980.65	1980.65	8570.86	3829.16	1614.70	14014.72	1555.29
Client-Weeks	132	132	132	132	132	132	132	132	132
4									
Mean	30.84	50.23	18.38	99.25	26.88	40.65	17.83	85.37	13.88
Deviation	56.29	63.05	75.73	119.32	53.16	50.52	75.22	113.93	25.22
Maximum	293.08	266.00	591.94	983.32	289.08	181.45	591.94	983.32	156.00
Expenditure	8142.68	13260.74	4852.34	26201.76	7096.12	10731.98	4708.34	22536.44	3665.32
Client-Weeks	264	264	264	264	264	264	264	264	264
5									
Mean	39.89	41.06	17.37	98.32	36.23	33.20	15.58	85.01	13.31
Deviation	56.41	88.15	48.51	110.60	53.79	78.74	47.08	101.60	34.65
Maximum	348.98	927.90	320.80	1070.19	333.26	927.90	320.80	1070.19	210.0
Expenditure	32467.55	33422.78	14141.39	80033.72	29494.78	27022.50	12682.53	69199.81	10833.91
Client-Weeks	814	814	814	814	814	814	814	814	814
6									
Mean	22.20	16.83	7.06	46.08	20.68	15.31	6.85	42.84	3.25
Deviation	40.68	26.44	18.92	52.85	38.07	22.76	18.70	49.66	7.56
Maximum	280.73	150.00	138.46	301.23	258.73	118.54	138.46	279.23	50.00
Expenditure	4883.99	3702.16	1552.42	10138.57	4548.89	3368.32	1507.02	9424.23	714.34
Client-Weeks	220	220	220	220	220	220	220	220	220
Total									
Mean	38.25	38.73	15.75	92.27	34.76	31.43	14.34	80.54	11.73
Deviation	63.09	75.42	50.69	108.78	60.08	65.50	49.62	101.18	31.50
Maximum	487.48	927.90	591.94	1070.19	480.48	927.90	591.94	1070.19	210.00
Expenditure	54694.72	55377.54	22526.80	131944.06	49710.65	44951.96	20512.59	115175.20	16768.86
Client-Weeks	1430	1430	1430	1430	1430	1430	1430	1430	1430

Note: This table is based on the smaller sample of 258 clients; see text.

costs for clients in RCI categories 1/2/3 averaged \$117.95 per client, compared to \$46.08 for clients in RCI category 6. In between these two extremes, clients in categories 4 and 5 have very similar weekly gross total costs (\$99.25 and \$98.32 respectively).

Inspection of Table 2.41 shows that the main factor in the higher costs for clients with the highest levels of dependency are associated with greater use of HACC services. Clients in the RCI 1/2/3 categories used \$69.60 worth of HACC services per client per week compared to an average over all clients of \$38.25, and only \$22.20 for clients in the RCI 6 category. By contrast, RCI 1/2/3 clients had slightly lower than average use of COPS services (\$37.80 per week compared to an average of \$38.73 over all RCI categories) although not as low as the RCI 6 group, for whom Gross COPS costs were only \$16.83 per client per week. A similar pattern is seen in the levels of Gross Other costs. Both RCI 1/2/3 and RCI 6 groups had lower than average levels of weekly cost for services other than those funded by HACC or COPS.

Relationship between the Level and Composition of Costs per Client

Two hypotheses which had been advanced to us concerned the relationship between the level of weekly expenditure on COPS clients and the composition of these costs. The first hypothesis was to the effect that client contributions are highest (lowest) in projects in which gross total costs are highest (lowest). The second hypothesis was that COPS services were relatively more important than HACC services for clients with higher levels of weekly recurrent expenditures. Although the information presented in Table 2.34 on the expenditure patterns by project did not support the first hypothesis at the project level, a more disaggregated examination of the data does in fact give credence to that hypothesis. The evidence on the relative importance of COPS services to higher costs clients does suggest that the second hypothesis is also valid. Figure 2.2 depicts the relative importance of the costs of COPS, HACC and Other services to gross weekly recurrent expenditure per client. It is clear from Figure 2.2 that HACC services are more important than are COPS services for clients with gross expenditures below \$150 per week but that above this level the reverse tends to be the case. That is, there is a clear trend that HACC services diminish in relative importance as the level of weekly costs rises. Conversely, the relative importance of COPS services rises as weekly expenditure per client rises. Figure 2.2 also shows that the relative importance of the Other services, including client contributions, is slightly greater for higher cost clients.

Figure 2.3 depicts the relative importance of the costs of COPS, HACC and Other services to *net* weekly recurrent expenditure per client, i.e. after allowing for any client contributions. Here the conclusions are somewhat different to those from Figure 2.2. The trend evident in Figure 2.2 is not repeated in Figure 2.3. Other than for clients with net weekly expenditures in the range \$150 to \$180, HACC services are always more important than are COPS services for *all* client regardless of the level of weekly expenditures. Indeed, to the extent that clear trends can be drawn

Figure 2.2: Percentage of Gross Costs from HACC, COPS and Other

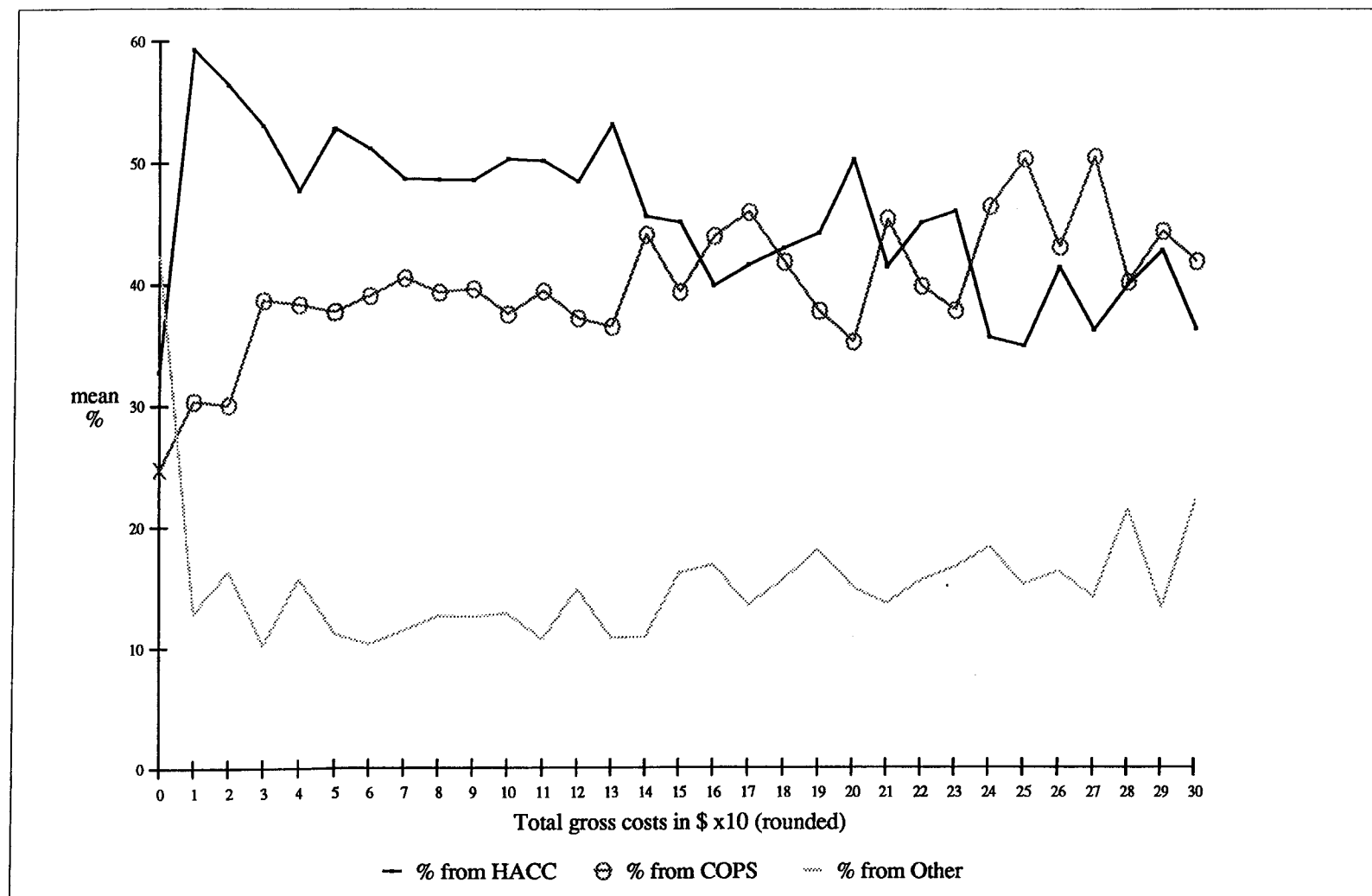
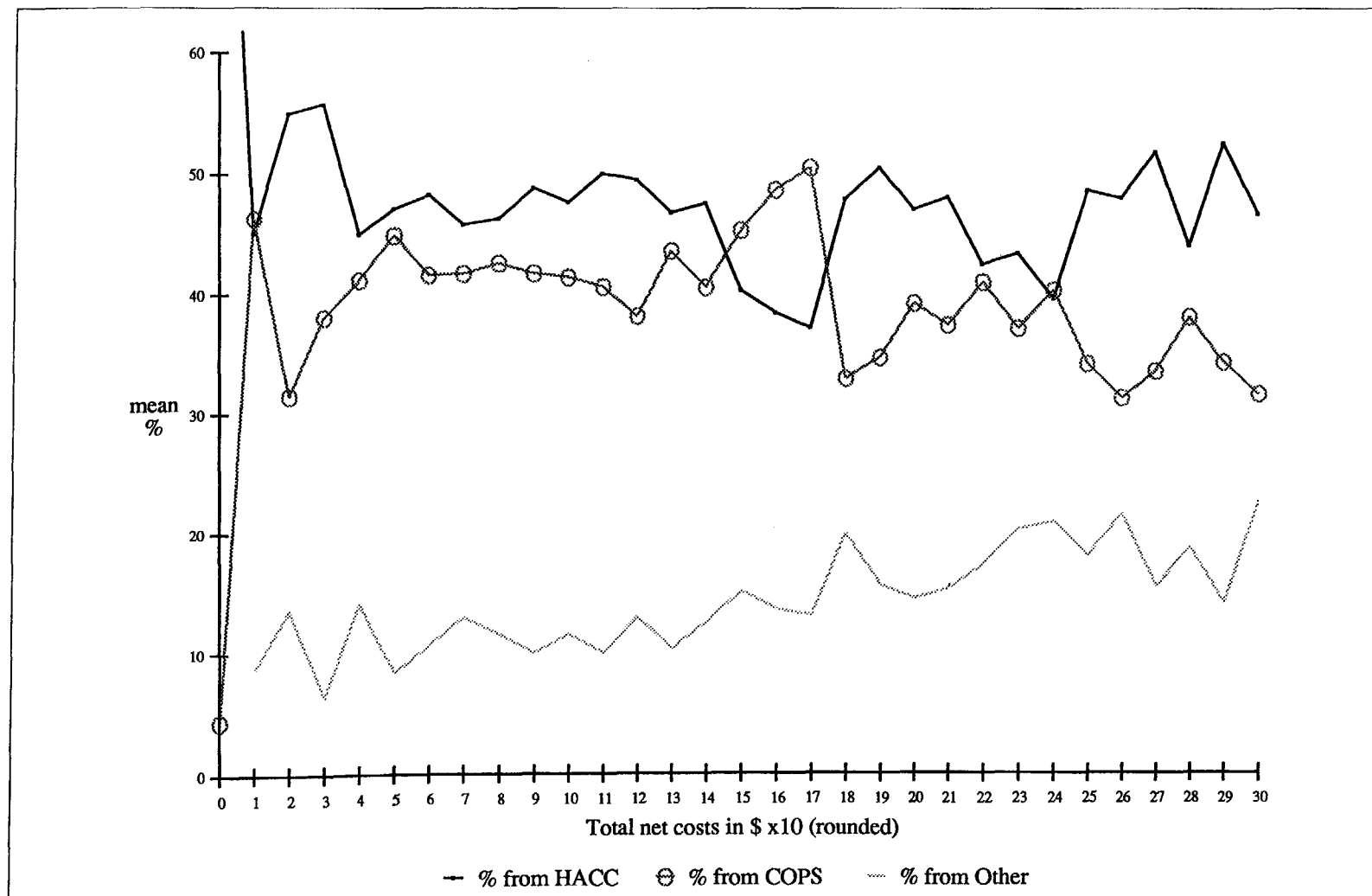


Figure 2.3: Percentage of Net Costs from HACC, COPS and Other



from Figure 2.3 the trends are that HACC services comprise a fairly constant proportion of net weekly costs, while COPS services decrease in proportional terms, albeit slightly, and the Other services rise in proportional terms, as weekly net costs per client rise.

2.4 Summary of Principal Findings

Community Options Clients and Carers

- Overall, the largest proportion of Community Options clients was referred from a health source and the main reasons for the referral were the clients' ill health and increasing frailty and the carers' inability to provide adequate assistance.
 - Although there were variations between projects, overall, a third of referrals to Community Options projects were considered inappropriate and these referrals were not accepted as clients. The reason most commonly given for considering the referral inappropriate was that the person's needs could be met adequately by other services and that the intervention of Community Options was not necessary. Processing inappropriate referrals was in many cases found to be very time-consuming
 - Just over a third of those accepted by Community Options projects had approval for entry to residential care
 - During the year covered by the evaluation, 1257 people were accepted as Community Options clients. Selected demographic characteristics of these clients were as follows: 3.2 per cent were under 15 years old, 17.3 per cent were 15-64 and 79.6 per cent were 65 years or over. About 62 per cent were women. The great majority (83%) were from English speaking backgrounds. A very high proportion, too, were pensioners (85.2%) and of these 86 per cent had a Health Benefits Card implying that they received a full or almost full pension.
 - About 72 per cent of the clients had carers and of these, the same proportion lived with their carers. Of those who did not live with their carers, just under a third received daily visits, and just over three-quarters received a visit at least once a week, from their carers. Most of the carers were spouses or daughters. The average age of the carers was about 58 years.
 - About 38 per cent of the clients lived alone and just over half of these had carers.
 - In terms of their disabilities, 20 per cent had either been diagnosed as suffering from dementia or were showing signs of dementia. When clients were classified according to the Resident Classification Instrument, the majority showed relatively low dependence on the assistance of others for their personal
-

care but a high proportion were dependent on others for other important activities of daily living. When compared with those classified as severely handicapped in the ABS 1988 Disabled and Aged Persons Survey, Community Options clients showed a relatively high dependence on the assistance of others.

- The reason most frequently given for leaving Community Options was that clients were moving into residential care (about 30%). However, nearly a quarter of the clients left the Program because they were deemed to be receiving adequate services and no longer required the assistance of Community Options.

Services for Clients

- Most service packages received by clients contained two services or fewer. The maximum number of services received at one time during the three month period for which analysis of this data was undertaken was eight. The net cost of the largest service packages varied considerably.
- Despite the generally small size of service packages they contained a very considerable range of service types.
- Although service packages, once arranged, remained, on the whole, fairly constant, the packages of just over 40 per cent of clients changed more than once during the three months for which the analysis was undertaken.
- A high proportion of service providers (just over 50 %) were privately contracted. On the whole, the same service types were more expensive when purchased from government-funded agencies than when purchased from private contractors.
- Though in terms of service transactions HACC is the major contributor, and provided most of the housekeeping and delivered meals services, there was substantial supplementation to HACC services from Community Options, especially in the areas of housekeeping and personal care. Community Options also provided a substantial proportion of those services associated with the enhancement of the quality of clients and carers lives which the conventional government funded services seemed less able to provide to the extent that they were needed.

The Financial Costs of Community Options

The information presented in Tables 2.32 to 2.41 indicate that weekly recurrent expenditures varied considerably across clients and across projects. The main factors which enabled us to distinguish between high cost and low cost clients could be summarised as follows:

- clients who were dementia sufferers had, on average, higher levels of recurrent expenditures than did clients who did not suffer from dementia;
 - clients aged eighty or over had the highest gross costs but also had the highest levels of client contributions, while the very youngest clients tended to have the highest net COPS costs;
 - the information in Table 2.38 indicated that living arrangements appeared to have no impact on the level of weekly costs, although clients who lived alone had relatively higher expenditures on HACC services and lower expenditures on COPS services than did clients who did not live alone. However, the information in the multivariate analysis indicated that it was the presence or absence of a primary carer which influenced weekly costs, with clients with a carer having higher costs than those clients without a carer; and
 - it had been anticipated that projects in the less densely populated areas would have lower costs, partly at least due to the lack of access to many services rather than any inherently higher costs of services in the more densely populated areas. However, this was not found to be the case. No relationship between type of locality and weekly costs could be established in the multivariate analysis.
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3 Stage Two: The Client and Carer Survey in the Five Case Study Areas

3.1 Introduction

The first stage of the evaluation was undertaken largely from the perspective of the 14 projects themselves. It provided a description of the characteristics and circumstances of Community Options clients and of the nature and costs of the services they receive. On the basis of interviews with project co-ordinators it looked at the characteristics of the projects themselves, at the nature and process of service co-ordination and at how the projects relate to the wider local service environments of which they are a part. The second stage, which this section of the report describes, broadens the evaluation to take account of the perceptions of Community Options held both by its clients and by the principal local service providers upon whom Community Options projects depend to meet the needs of their clients.

The Community Options Projects Included in Stage Two of the Evaluation

Stage Two of the evaluation was undertaken in five of the 14 projects covered by the first stage. These five projects were selected in consultation with the New South Wales Department of Family and Community Services (FACS), with three requirements in mind:

- that each of the five types of organisations which are 'auspice' bodies or sponsor Community Options projects in New South Wales should be represented;
- that projects located in urban, small town and rural localities and rural areas should all be represented;
- that the North West Aboriginal project should be included.

In the event the following five projects were selected for Stage Two of the evaluation:

The Liverpool Live-at-Home Service (urban), sponsored by Centacare;

Newcastle/Lake Macquarie Live at Home Service (urban), sponsored by the Department of Health, Hunter Region;

North East New England Community Options project (rural), sponsored by Glen Innes Municipal Council;

North West Aboriginal Community Options (rural), sponsored by the Home Care Service (N.S.W.);

Wyong Shire Community Options (small town), sponsored by Wyong Aged and Disabled Support Services - a community based organisation.

Some Characteristics of the Projects Selected

Selected characteristics of the areas and populations served by each of these projects are set out in Table 2.1 earlier in this report. Selected characteristics of the projects themselves appear in Table 2.2.

Quite apart from the criteria for the selection of these projects, each of them has distinctive features which seem likely to affect their relationship both with their clients and with local community services. For example, The North West Aboriginal project has sub-offices in five of the small towns it serves. The Community Options offices are, in all but one case, located in the same suite of offices and in very close proximity to the Home Care Service. In one case a co-ordinator works for both the Home Care Service and for Community Options. It is little wonder that both clients and other service providers are, in many instances, barely able to distinguish the activities of the Home Care Service from those of Community Options. The situation is exacerbated by the fact that links of the sort described above for the Aboriginal project are even stronger for the equivalent non-Aboriginal project (the North West Area project). Interestingly, most local service providers we spoke to perceived no organisational difference between the two projects beyond the fact that they serve different populations.

In the other rural project, in North East New England, the pattern is quite different. Although this project similarly serves a number of small towns and also people who live outside of these towns, sometimes in quite remote areas, the project is centralised, with all activity conducted from a single office in Glen Innes, involving a great deal of travel. The absence of a local representative in the outlying towns was noted in our enquiries. A unique feature of this project is that its clients are typically recruited through an 'at risk' committee. It would appear that the co-ordinator is thus unable to act altogether autonomously and is under somewhat closer scrutiny than is the case in many of the other projects. Another feature of this project is that the co-ordinator is a relative newcomer to the area. This was something that did not go un-noted in this rather tight knit and traditional rural area.

In services as small and localised as Community Options it is sometimes extraordinarily difficult to separate the person from the service. Contrast the position of the 'outsider' co-ordinator of Glen Innes with the relatively long established relationship which the senior co-ordinator of the Wyong Shire project has with the area and its services. This co-ordinator has built up a wealth of service networks, knowledge and credibility which was held to stand her in very good stead. In addition, the recent co-location of Community Options with some of the other

major services with which the project interacts was also thought to have an important bearing on the way those services perceive Community Options.

The Newcastle/Lake Macquarie project covers a large and heterogeneous population and interacts with an extraordinarily large number of community and domiciliary services each of which of course has its own history and interests. As a relative newcomer to the world of services, Community Options has had to find a place for itself in this complex and not always accepting service environment. In contrast to Wyong and most of the other projects in Stage Two of the evaluation, this project is not co-located with any other service, which has probably made its task more difficult. There was evidence that this project has worked very hard to establish a *modus vivendi* with other services striving at the same time to retain its own identity. Of course, that is the problem for all Community Options projects. To an outside observer, spending only a limited time in each of the five areas, the Newcastle/Lake Macquarie project seemed to have a particularly hard task.

The Liverpool Live-at-Home Service is the most recent of the five projects and is still building up its case load. Like the Newcastle/Lake Macquarie project it was not at the time of our visit co-located with any other service. However, the local service organisation is relatively simple and the Liverpool project is required to interact with only one branch of each of the main community and domiciliary services, unlike the Newcastle/Lake Macquarie which at the time of the evaluation had working links with 5 Home Care Service branches and 16 Meals on Wheels services. The senior co-ordinator has worked in the Liverpool area for a number of years in a professional capacity and has long standing links with many of the established services and their staff. The project has had the benefit of another Community Options project, also sponsored by Centacare, close at hand and is clearly able to benefit from the advice and support of this older project.

We have not attempted to provide an exhaustive account of the kinds of external circumstances which can influence the ways that clients and services interact with their local Community Options projects but rather to convey our impressions of some of the more significant factors. During the course of our field work we were made aware of the role of personalities and personal connections, of service histories, interests and organisational frameworks, and of location and physical environment as powerful influences on client/service and service/service relationships and perceptions. These 'informal' factors can assume particular importance because of the lack of any formal regulatory mechanisms between community services and because of the absence of professional models. Community Options is not quite like any other service and, in the absence of a clear model, projects find themselves in an alien environment, where their reception may depend on any one of a number of factors, some beyond their control and some having little to do with their proper functions.

Stage Two has two distinct components. The first is the Survey of Clients and Carers; the second is the Survey of Service Providers. These sub-studies will be reported separately. For the most part, our account will be confined to a description

of the two surveys. In both cases our presentation of findings will inevitably be selective. In the final section the various components of the evaluation will be integrated and the issues to emerge in the process of the evaluation will be discussed.

3.2 Broad Aims and Research Methodology

Community Options in Australia represents a new approach to the home and community care of frail aged people and younger people with disabilities who are at high risk of institutionalisation. Its broad aim is to prevent 'the inappropriate and premature institutionalisation' of such people and as it has developed in New South Wales, it uses a brokerage model in which a service co-ordinator negotiates a set of support arrangements on behalf of and in full consultation with the client or the client's carer, or both, to achieve this aim.

Although a central concern in the appraisal of any service initiative must be how far it achieves its objectives and whether it does so cost effectively, for reasons described in some detail earlier in this report, this evaluation was not set up to provide answers to these specific questions. However, another important series of questions, which also addresses the issue of outcomes, relates to whether the service provides for the people for whom it is intended, whether it meets the needs of the clients as they themselves perceive them, and whether it does so in a manner which they find acceptable.

The Topics Covered

The Survey of Clients and Carers was intended to provide answers to these questions by means of a personal interview. Separate questionnaires were used to interview clients and carers. These were modified versions of questionnaires developed for the evaluation of the equivalent Western Australia program.

In the case of clients the following issues were explored through the client questionnaire:

- recent health problems and hospitalisation;
 - ability to perform the activities of daily living (ADL) and instrumental activities of daily living(IADL);
 - household and living arrangements;
 - amount of social contact;
 - availability of help when needed;
 - employment and financial circumstances;
 - help provided in ADLs and IADLs, by whom is help given, by whom the help is organised and the frequency of the help;
 - payment for help received and any difficulties with payment;
 - satisfaction with help received;
 - cultural appropriateness of help received;
 - how Community Options was accessed;
-

- satisfaction with and main benefits of Community Options; and
- plans for the future.

In the case of carers, the following issues were explored through the carer questionnaire:

- relationship to client, length of time caring, who else provides care;
- physical and emotional health and recent hospitalisation;
- employment and financial situation;
- perceived impact of caring on employment, financial situation, family life, social life, physical and emotional health;
- relief from caring needed and received;
- capacity to continue to care;
- type of help given to the client by the carer and frequency with which this help is given;
- how much help the carer receives in his or her caring role and how this help has been arranged;
- adequacy of the help;
- cultural appropriateness of help received;
- how Community Options was accessed;
- satisfaction with and main benefits of Community Options; and
- carer's perception of the role of Community Options in helping the client to continue to live at home.

In addition to the above topics, carers were asked to complete two health questionnaires. One related to their own physical and mental health and included the 12-item version of the General Health Questionnaire. This questionnaire is essentially a screening instrument which is capable of identifying people who potentially have non psychotic psychological impairment and is widely used to measure the level of psychological distress associated with caring. This scale is widely considered to have a high level of reliability and validity (Tennant, 1977). The second questionnaire, the Clinical Dementia Rating Scale (CDR) which carers were asked to complete, related to the client, and was intended to indicate whether the client suffered from dementia and if so to what degree. Where there was no carer available to complete the CDR, the interviewer completed it. In our analysis we treat separately the carer and interviewer completed scales (Hughes et al., 1982; Berg and Storandt, 1988).

Copies of final questionnaires, which had been extensively piloted amongst clients and carers of the Inner West Live-at-Home-Service, were sent for information to the five participating Community Options project co-ordinators. Some of them expressed surprise at the detail of the information we were seeking and, by implication, at the length of the questionnaire. Of course, it would have been very much simpler to confine the questionnaire to issues directly related to Community Options. For several reasons we did not do this. First we were anxious to gain a reasonably full picture of the social context in which Community Options operates, that is, how it fits into the fabric of clients' and carers' lives. Secondly, we wanted

to know how Community Options fits into the total range of support. Thirdly, we wanted to gain a full picture of the health of clients and carers which, as we discussed earlier, are matters inadequately dealt with in the Community Options assessment forms. Finally, since we were using a number of outside interviewers, we needed to ensure standardisation. It is partly for this reason that the questionnaire is balanced on the side of factual, quantifiable information rather than on attitudinal and qualitative response.

Some co-ordinators expressed a further concern as to the credibility of clients' responses especially amongst those who were confused. There was a fear that many clients are not aware of the distinction between Community Options and the other services, and that responses and opinions supposedly relating to Community Options might just as easily relate to another service or services. We believe this fear is well grounded, and under some circumstances attach greater confidence to the carer than the client response. As the Instructions for Interviewers indicate we were at great pains to obtain valid and reliable information and to be in a position to differentiate between information to which some doubt must be attached and information which can be treated as reasonably reliable.

Sample Selection

In each of the five Community Options projects included in Stage Two of the evaluation, 20 clients and their principal carers were selected for interview. These clients were selected by the five project co-ordinators. Co-ordinators were advised as to how to select the sample on a systematic and non-arbitrary basis. The following criteria governed the selection:

- in an attempt to ensure that the clients who were interviewed would have some familiarity with the project, only people who had been Community Options clients for at least two months were to be selected; and
- only people who were both still living at home and still clients were to be selected.

Bearing these conditions in mind the co-ordinators were asked to select the last 10 clients who had been categorised on their assessment forms as being dementia sufferers or as having symptoms of dementia, and the last 10 clients who had not been categorised in this way. Some projects did not have 10 clients who were dementia sufferers and who met the other criteria for selection. In some cases, it seemed, this was because at the time of the selection of the sample there had been a fairly rapid movement of people with dementia into residential care. In these cases co-ordinators were asked to fill their quota of 20 clients by including additional clients who were not dementia sufferers. In the event, 31 clients assessed as either suffering from dementia or displaying signs were included in the survey.

The co-ordinators were asked to contact the clients who had been selected to gain their agreement to an interview. Nine of the clients/carers who were approached

were unwilling to be interviewed. Substitutes for these clients were selected using the same procedure as for the main sample. Only when clients had given their agreement were their names passed on to the research team and subsequently to the interviewers. The only client and carer details which were passed to the research team were the name, address, phone number, date of acceptance as a client, ID number and whether or not the client was a dementia sufferer. Hence when the interviewer visited the client, she had virtually no knowledge of that client which might prompt her to pre-judge his or her situation.

The Field Work

The selected clients and their main carers were personally interviewed in their own homes. Where possible clients and carers were interviewed separately but when it proved necessary to interview clients and carers together some questions were omitted to avoid possible distress to either party.

The recruitment of interviewers required considerable care and preliminary enquiry because it was necessary that they should live in the general locality of their projects and also possess appropriate educational backgrounds and personal qualities for this rather sensitive work. Four of the interviewers we were able to recruit were well educationally qualified nurses with additional welfare or community service and survey research experience; one was a regional manager with the Australian Bureau of Statistics who also had a considerable amount of experience as a survey interviewer, and the sixth was an Aboriginal pre-school education student who was selected to interview clients of the Aboriginal project.

The concerns expressed by some co-ordinators about the length of the questionnaire do not appear to have been justified. The response to the Client and Carer Survey was high (94%). There appears to have been virtually no negative feedback from clients and carers to the projects concerning the questionnaire or interview. Indeed, the reaction which we received was very positive. Our experience and that of other researchers in this area is that most elderly people, many of whom are housebound and with restricted social contacts, greatly welcome the opportunity provided by such interviews to talk at length to an interested audience. Only one serious complaint was reported back to us. This was of an interviewer (a nurse) who seems to have overstepped her role by providing the client with some professional advice.

3.3 Findings

The data we present are broadly divided into two parts. The first relates to the characteristics of the clients and carers we interviewed. The second is concerned with their use of Community Options, how they perceive its contribution and their satisfaction with it. In this section, we also look at clients' use of and satisfaction with other services.

The Clients and Carers

Response. Although it was our intention to interview twenty clients and their carers from each project this was not always possible either because they could not be contacted (5 cases) or were too ill to be interviewed (1 case) or refused to be interviewed (2 cases). In addition, data on two people were thought to be too unreliable to be included. The result was that 94 clients and 58 carers were interviewed. Of the 94 clients, 60 (63.8%) answered the questions unassisted whilst the remaining 34 (36.2%) needed their carers to answer on their behalf or to help them answer. Four of these 34 clients also required an interpreter. However, in some cases, even though the client could have answered the questions unassisted, the carer was present. This was so for 40 of the 60 clients. In these cases, as will be observed from the questionnaire, a number of the more sensitive questions were not asked. It is this that accounts for most of the missing data in the survey.

The number of clients and carers interviewed in each project is shown in Table 3.1.

Age, Sex and Household Circumstances. In order that the information from the Client and Carer Survey in Stage Two can be compared with the Minimum Data Set (MDS) used in the first stage of the evaluation, we shall look at the new information on clients and carers in much the same way as we did in Stage One. Fortunately, however, there is somewhat more detailed information on both clients and carers available from our survey. We shall analyse this with a view to providing a fuller picture of the lives of Community Options clients and their carers than was possible from our analysis of the MDS data.

Selected characteristics of the clients and carers are shown in Table 3.2 or are otherwise derived from the survey data. As this table shows, the majority of both clients (64.9%) and carers (67.2%) were women. Only three (3.2%) of the clients were under fifteen years of age, whilst the majority were over 65 years (71.3%). The average age of clients was 68 years. The youngest client was a disabled child of two, the oldest 95 years of age. As the table shows, our sample is on average somewhat younger than the group of people included in the MDS. This may be either due to chance or to an actual change in the age distribution of the projects between the year covered by the MDS data collection (the reference year) and the survey. However, the demographic characteristics of our sample are, in general, reassuringly similar to those of people included in the MDS.

Sixty-four of the clients (68.1%) had carers, but for the reasons mentioned earlier, only 58 of those carers were interviewed. Just under 72 per cent of the client group included in the MDS had carers. The lower percentage of carers in the survey group is probably due to the greater weighting of the Aboriginal project (one project in five rather than one in 14), where a person designated as a main carer is far less common than in the majority of projects. Forty-five of the clients who had carers lived with them, which is to say, nearly 75 per cent of carers lived with those they cared for.

Table 3.1: Number of Clients and Carers in the Five Projects in Stage Two of Evaluation

Project	Number of Clients	Number of Carers
Liverpool Live-at-Home Service	20	15
Newcastle/Lake Macquarie Live-at-Home Service	20	12
North East New England Community Options	18	16
North West Aboriginal Community Options	17	4
Wyong Shire Community Options	19	11
Total	94	58

The average age of carers in our survey group was 56 years, the youngest being 30 and the oldest 81. As one would expect, the average age of carers varied according to their relationship with the client. Spouse-carers had an average age of 67 years (the oldest group of carers), parent-carers an average of 47 years (the youngest group). All other carers averaged 52 years of age.

Spouse-carers in our sample were, not surprisingly, always co-resident as were parent-carers (only two of whom were caring for people over 18 years of age). Children caring for one of their parents were in many cases non-resident, though nearly 60 per cent of daughters and 44 per cent of sons were co-resident. Forty-five per cent of all clients lived alone. Of those without a carer, 80 per cent lived alone. The fairly substantial difference in this respect between our sample and the group included in the MDS may once again be attributable to the inclusion of the Aboriginal project far more of whose clients were living alone than was the case in any other of the 14 original projects.

Occupation and Income. It is sometimes held that people in the higher socioeconomic groups make greater use of services than other people. This does not appear to have been the case with the clients included in the survey. We used occupational background as a surrogate for socioeconomic group, asking clients what their main occupation had been during their working lives.

The occupational background of clients is shown in Table 3.3 below. We omit from this table twenty-two clients who had never been in the workforce and nine others for whom either the information was not relevant (three children under working age) or was missing. Those who had not been in the workforce were all women and had been employed in house duties. For all but three of these women the main source of their income was cited as a pension.

The picture is not entirely clear cut, but Table 3.3 suggests a tendency for clients to be drawn disproportionately from groups of lower socioeconomic status.

Table 3.2: Selected Demographic Characteristics of Clients and Carers

Selected Characteristics	Clients		% (a)	Carers		
	No.	%		No.	%	
Total	94	100.0		58	100.0	
Sex						
Male	33	35.1	(38.1)	19	32.8	
Female	61	64.9	(61.9)	39	67.2	
Age						
0-14 years	3	3.2	(3.2)	-	-	
15-64 years	23	24.5	(17.3)	43	74.1	
65 years and over	67	71.3	(79.6)	15	25.9	
Unknown	1	1.1		-	-	
Presence of Carer						
Yes	64	68.1	(71.7)			
No	30	31.9	(25.9)			
Lives Alone						
Yes	42	44.7	(37.5)			
No	52	55.3	(60.1)			
Lives with Carer	45	47.9	(51.6)	43	74.1	Lives with client
Does not live with carer	19	20.2	(20.1)	15	25.9	Does not live with client
Does not have a carer	30	31.9	(25.9)			

Notes: (a) Figures in brackets are the equivalent figures from the MDS. The percentages may not add to 100 as the 'Unknowns' in the MDS are not shown in this table.

Number of clients with carers is slightly higher than number of carers interviewed.

Further confirmation of this is provided by the fact that the main source of income of 85 per cent of the clients was a government pension (see Table 3.4). Indeed, only 4.3 per cent of the clients in the survey had a main source of income other than a government pension or superannuation. Nevertheless, most clients considered their income to be sufficient for their needs (72.3% of our group). The two groups most likely to see their income as insufficient were Aboriginal clients, some of whom said they had difficulty paying their bills, and those who required many medicines and other purchases from chemists. Eighty-five per cent of the client group had a Health Benefits Card.

Table 3.3: Occupational Background of Clients who Had Been Employed

Occupational Background	Clients No.	%	Population ^(a) %
Manager/Administrator	9	14.3	11.1
Professional	3	4.8	13.2
Para-professional	2	3.2	5.9
Tradesperson	18	28.6	15.0
Clerk	6	9.5	17.3
Salesperson/Personal Service	9	14.3	14.8
Plant, Machine Operator/Driver	2	3.2	7.4
Labourers/Related Workers	14	22.2	15.3
Total	63	100.0	

Note: a) Based on ABS (1991), *The Labour Force Australia, May 1991*, Catalogue No. 6203.0.

Table 3.4: Clients' Main Source of Income

Main Source of Income	No.	%
Government Pension	80	85.1
Superannuation	7	7.4
Other	4	4.3
Not relevant/unknown	3	3.2
Total	94	100.0

Social Contacts. The social contacts of Community Options clients measured in terms of the frequency of phone calls and visits from relatives, friends or neighbours, is shown in Table 3.5. This table suggests that a small proportion of clients are very isolated socially. On the whole, however, clients are not without social contact with people outside the home, although those who live with other people have less social contact of all kinds with people outside the home than do those who live alone. Most clients would also, of course, have some contact with the Community Options co-ordinator and with those service providers who regularly come into their homes. This contact is highly valued and we shall discuss it in more detail later.

Table 3.5: Clients' Social Contact

How often do you speak to a relative, friend or neighbour on the telephone?	Those who live alone		Those who live with others	
	No.	%	No.	%
Not applicable (e.g. developmentally delayed child)	-	-	3	5.8
Once a day or more	22	52.4	20	38.5
A few times a week	11	26.2	9	17.3
About once a week	2	4.8	4	7.7
Less than once a week	7	16.7	8	15.4
Not at all	-	-	8	15.4
Total	42	100.0	52	100.0

How often do you spend time with a relative, friend or neighbour?	Those who live alone		Those who live with others	
	No.	%	No.	%
At least once a day	16	38.1	24	46.2
A few times a week	11	26.2	9	17.3
About once a week	7	16.7	4	7.7
Less than once a week	7	16.7	9	17.3
Not at all	1	2.4	6	11.5
Total	42	100.0	52	100.0

Clients' Health and Ability to Perform the Activities of Daily Living. In this section we look at the health problems of the clients, their recent histories of hospitalisation and their need for assistance in the various essential activities of daily living. The accumulated evidence suggests that the clients included in our survey had substantial frailty and disability.

Nearly 65 per cent of clients have four or more chronic health problems and nearly 34 per cent have seven or more. A maximum of 12 health problems were coded for each client though in a few cases clients had even more. The distribution is set out in Table 3.6.

The 94 clients listed 529 chronic health problems between them (an average of 5.6 each). The most common were walking problems, mentioned by 50 per cent of clients, followed by arthritis or rheumatism (44.7%), then heart trouble (38.3%), memory loss (34.0%), high blood pressure (33.0%), difficulties with balance (30.9%) and circulation trouble in arms or legs (26.6%). Problems with falls (24.5%), incontinence (22.3%) and blindness/sight problems (21.3%) were also quite frequently mentioned. Over 20 per cent of clients had had at least one stroke and were still affected by this to some degree. There is obviously scope in certain cases

Table 3.6: Current Number of Chronic Health Problems Suffered by Clients

No. of health problems	Clients	
	No.	%
1-3	33	35.1
4-6	29	30.9
7-9	14	14.9
10-12	18	19.1
Total	94	100.0

Table 3.7: Clients' Incontinence

Incontinence	No.	%
Not incontinent at all	60	63.8
Bladder incontinent only	10	10.6
Bowel incontinent only	3	3.2
Both bladder and bowel incontinent	21	22.3
Total	94	100.0

for some form of rehabilitation or therapy. Unfortunately we did not ask specifically about the involvement of clients in rehabilitation programs. We do know however, that 18 clients were receiving some form of therapy at the time of the survey interview. As we might expect, a very high proportion of these clients (about 75%) had problems with mobility and balance, usually resulting from muscular problems such as arthritis or rheumatism, stroke or a heart condition.

Incontinence is known to be a difficult condition to manage at home and a major cause of distress to informal carers. It is clear that a substantial proportion of clients, and consequently carers, were affected. Although the majority of clients were not incontinent (63.8%), as many as one in five were incontinent as to both bladder and bowels (22.3%).

Exactly half of the clients (that is 47) had been in hospital in the past twelve months. The length of time they spent in hospital is shown in Table 3.8.

Table 3.8: Length of Stay in Hospital

Length of Stay	No.	%
Up to 1 week	9	19.1
>1 to 2 weeks	9	19.1
>2 to 4 weeks	10	21.3
>4 to 6 weeks	1	2.1
>6 to 8 weeks	3	6.4
>8 to 12 weeks	4	8.5
>12 weeks ^(a)	8	17.0
Not stated	3	6.4
Total	47	100.0

Notes: (a) Maximum stay was 43 weeks.

In a small number of cases where clients had more than one stay in hospital during the previous 12 months, the total time spent in hospital has been added.

Just over a quarter of the 47 clients who had been hospitalised during the 12 months prior to the interview had stayed in hospital for two months or longer. Of the remainder, 50 per cent had stayed for periods of over a week. Eight had been in hospital for respite. The remaining clients (except for four who gave no reason) were hospitalised for an episode of acute illness or for an operation. The illnesses mentioned included respiratory problems such as asthma, bronchitis, pneumonia, emphysema (9 clients) dislocated or broken hips (3 clients), strokes (4 clients), having 'turns' or falls (3 clients), blood pressure problems, by-pass surgery, diabetes and various forms of surgery.

The health problems of clients, as outlined above, meant that most were either partially or completely unable to perform many of the activities of daily living. Clients were asked, firstly, about the activities included on the IADL scale. These activities were: getting to places out of walking distance, shopping, preparing meals, housework, gardening, minor and major home maintenance, using the telephone and handling money and finances. Clients were then asked about activities, associated with their personal care which comprise the ADL scale. These activities were: taking medicine, eating, dressing, grooming, getting around the house, getting in and out of bed, bathing and using the toilet. For each question on both scales a score of 1 was given if the person could perform the task without help.

A score of 9 on the IADL scale indicates that a person can perform all nine activities without help. A score of 18 means that a person needs **some** help with all nine activities or can manage some of them without help but is quite incapable of at least

two or three of the others. A score of 36 is the maximum possible for this scale. The distribution of total scores on the IADLs scale is shown in Table 3.9.

Only one client was able to perform, unassisted, all of the nine activities included in the IADL. Thirty two (34%) had scores of 27 or more, indicating a complete inability to perform any of these activities. Thus, overall, the clients included in the survey were a highly dependent group of people.

As Table 3.9 shows, clients who lived with their carers were more dependent than others for assistance with the activities of daily living. In turn, those clients with non-co-resident carers were more dependent than those who were without a carer.

Clients were rated as more able on the activities covered by the ADL scale (these are the personal care activities described above). For the ADL scale the minimum score is 8, which indicates that no help is required with any of the activities. As many as 35 per cent of the client group had a score of 8 while about 43 per cent fell in the range 9 to 15. Twenty-two per cent of the clients had a score of 16 or more, indicating a need for at least some help in all eight activities. Only one had the maximum score of 24. When we look at the pattern of dependency for activities associated with personal care we see, once again, that clients who have a carer, are more likely to have a greater need for assistance than those who do not have a carer, especially when the carer is co-resident. The findings described in Table 3.9 and 3.10 provide strong support for the commonsense assumption that it is difficult for highly dependent people to remain in their own homes unless they have carers, and that having a co-resident carer represents the strongest assurance of being able to stay at home for as long as possible.

Although no direct comparisons are possible, it is clear that the sample of clients shows a similar **pattern** of dependency to Community Options clients generally, that is, in both cases, clients displayed greater competence in the activities associated with personal care (ADL) than in the instrumental activities (IADL). However, if anything, the survey clients were more frail than clients generally. More clients in our sample had problems of incontinence and a higher proportion were completely unable to perform any of the activities of personal care than were those included in the MDS. However, it is important to note that the data were derived differently. In the case of the MDS, the scores were based on the views of co-ordinators, in the case of the survey, on the self-reporting of clients.

Clients who Suffer from Dementia or Cognitive Impairment. The extent of dementia amongst the clients in our sample largely reflects our own deliberate policy of selection which was designed to over-represent dementia sufferers. Our main research questions, therefore, are concerned with a comparison of the circumstances of those with and without dementia, rather than with the prevalence of dementia itself. In this section we shall be mainly concerned with the social circumstances of the people with dementia and with whether there is a difference in these respects between clients with and without dementia.

Table 3.9: Clients' IADL Scores

Total Score on Nine IADL's	Clients living with their carer		Clients not living with their carer		Clients without a carer		All clients	
	No.	%	No.	%	No.	%	No.	%
9-17	1	2.2	2	10.5	12	40.0	15	16.0
18-26	19	42.2	12	63.2	16	53.3	47	50.0
27-36	25	55.6	5	26.3	2	6.7	32	34.0
Total	45	100.0	19	100.0	30	100.0	94	100.0
Average score:	27.38		24.74		18.80		24.11	
Standard deviation:	4.66		5.00		4.96		6.09	

Table 3.10: Clients' ADL Scores

Total Score on Eight ADL's	Clients living with their carer		Clients not living with their carer		Clients without a carer		All clients	
	No.	%	No.	%	No.	%	No.	%
Up to 8	7	15.6	3	15.8	23	76.7	33	35.1
9-15	18	40.0	15	78.9	7	23.3	40	42.6
16-23	19	42.2	1	5.3	-	-	20	21.3
24 or more	1	2.2	-	-	-	-	1	1.1
Total	45	100.0	19	100.0	30	100.0	94	100.0
Average score:	14.22		11.00		8.60		11.78	
Standard deviation:	4.82		2.83		1.48		4.42	

Table 3.11 shows that clients assessed by Community Options as having dementia were more likely to have a carer than were other clients (74.2% compared with 65.1%). When clients had carers, whether or not they had dementia, their carers were more often than not living with them. However, among clients with dementia, the proportion who had carers living elsewhere was higher than it was among clients without dementia.

Table 3.11: Household Type by Dementia: Rating by the Co-ordinator

Household Type	Dementia According to CO Rating		
	Yes or shows signs	No Dementia	Total
No carer	8 26.7% 25.8% 8.5%	22 73.3% 34.9% 23.4%	30% 100.0% 31.9%
Lives with carer	13 28.9% 41.9% 13.8%	32 71.1% 50.8% 34.0%	45 100.0% 47.9%
Has a carer who lives separately	10 52.6% 32.3% 10.6%	9 47.4% 14.3% 9.6%	19 100.0% 20.2%
Total	31 33.0% 100.0%	63 67.0% 100.0%	94 100.0% 100.0%

Notes: Figures in bold are number of clients in each group.
 First percentage figures in each cell add to 100 across rows.
 Percentage figures in italics add to 100 down columns.
 Final percentage figures are percentage of total group in each category.

Though perhaps surprising at first glance, this pattern seems to be explained by the close association of dementia with age. Dementia sufferers are older on average than non-sufferers. In the oldest age group they actually outnumber non-sufferers (Table 3.12). A higher proportion are therefore likely to be widowed and living alone, cared for by a visiting relative. Thus, only 25 per cent of the people being cared for by spouses were suffering from dementia, compared with over 50 per cent of the people being cared for by daughters.

According to the assessments of the various Community Options projects, 31 clients (or 33.0%) have dementia or show symptoms of it. In order to compare the assessment made by the interviewer or carer with that undertaken by the Community Options co-ordinator, interviewers were asked to complete a six-item questionnaire for clients without carers and were asked to get carers to do the same for the person they cared for (on the assumption that they would know these clients better than the interviewers would). Three questions pertained solely to cognitive function: those regarding Memory, Orientation, and Judgement and Problem Solving. The score on these three questions was added to give a total (labelled CDR1 in the table below).

Table 3.12: Age Group of Clients by Dementia Status

Age Group	Dementia			No Dementia			Total		
	No.	%	%	No.	%	%	No.	%	%
Under 65 years	6	23.1	19.4	20	76.9	31.7	26	100.0	27.7
65-74 years	7	28.0	22.6	18	72.0	28.6	25	100.0	26.6
75-84 years	10	34.5	32.3	19	65.5	30.2	29	100.0	30.9
85 years and over	8	57.1	25.8	6	42.9	9.5	14	100.0	14.9
Total	31	33.0	100.0	63	67.0	100.0	94	100.0	100.0

The three questions had scores ranging from a minimum of 0 to a maximum of three. They could each be scored either 0, 0.5, 1, 2 or 3 (except Orientation which had no 0.5 option). CDR1 therefore ranged from a minimum of 0 to a maximum of 9. A score of 0 on CDR1 indicates no cognitive impairment. A score of 3 indicates mild cognitive impairment, while a score of 9 indicates very severe impairment.

The three remaining questions relate to Community Affairs, Home and Hobbies, and Personal Care - all areas which are affected by **both** cognitive ability and physical mobility. As we are dealing with a very frail group of clients, it is to be expected that scores on the CDR2 (sum of three remaining question scores) would be higher (that is, worse) than those on the CDR1. CDR2 also ranges from 0 to 9, with 9 indicating the most severe impairment. Also shown in the table is CDR Total, which is the sum of the scores on CDR1 and CDR2. It therefore has a range from a minimum of 0 to a maximum of 18.

Table 3.13 shows that, as expected, people who have dementia according to the assessment of co-ordinators have higher scores on the cognitive impairment measure (CDR1) than do those without dementia. People with carers (either with or without dementia, as assessed by the co-ordinators) have higher scores on the CDR1 than do those without a carer. On the CDR2 measure, of people with dementia, those with carers also have higher scores, on average, than those without a carer. The same applies for the total measure (CDR Total).

The Carer Role. So far we have focused on some of the characteristics of clients. We now look in a little more detail at the characteristics of their main carers. Later we shall look at some of the implications of caring.

As we have already noted, the majority of the carers in our sample (67.2%) were female. There were roughly equal proportions of spouse and daughter carers (27.6% and 29.3% respectively) - the two largest groups. This was followed by sons (15.5%), and mothers (12.1%). All other relatives comprised 10.3 per cent of all carers. Only two of the main carers were not members of the clients' families.

Table 3.13: Dementia Status, Cognitive and Social Impairment and Presence of Carer

Dementia Rating According to CO	Cognitive Impairment 'CDR1'		Social Functioning 'CDR2'		(CDR1 + CDR2) CDR Total		
	No.	%	No.	%	No.	%	
With Dementia							
With Carer	0	2	9.5	-	-	0	-
	0.5-3	4	19.0	4	19.0	0.5-6	5
	3.5-6	3	14.3	5	23.8	7-12	5
	7-9	12	57.1	12	57.1	13-18	11
	Total	21	100.0	21	100.0	Total	21
Without Carer	0	1	11.1	3	33.3	0	1
	0.5-3	5	55.6	2	22.2	0.5-6	5
	3.5-6	2	22.2	4	44.4	7-12	3
	7-9	1	11.1	-	-	13-18	-
	Total	9	100.0	9	100.0	Total	9
Without Dementia							
With Carer	0	10	28.6	1	2.9	0	1
	0.5-3	22	62.9	8	22.9	0.5-6	16
	3.5-6	3	8.6	15	42.9	7-12	18
	7-9	-	-	11	31.4	13-18	-
	Total	35	100.0	35	100.0	Total	35
Without Carer	0	21	77.8	12	44.4	0	10
	0.5-3	6	22.2	6	22.2	0.5-6	11
	3.5-6	-	-	3	1.1	7-12	6
	7-9	-	-	6	22.2	13-18	-
	Total	27	100.0	27	100.0	Total	27

Spouse carers were, as was to be expected, always co-resident with the person they cared for, as were the parent carers who were looking after young children. It was sons, daughters and other relatives who were most likely to be non-co-resident (see Table 3.14).

Length of Caring Time. As Table 3.15 indicates many carers had been looking after clients for a considerable length of time.

Eight carers said that they had been caring for the whole of the client's life. In all cases but one, these clients were dependent offspring. Of the remainder, a high proportion had been caring for more than a year, a number for several years.

Carers' Employment Situation. Eighteen or just over 30 per cent of the carers were in paid employment at the time of the survey and just over a half of these were

Table 3.14: Relationship of Carer to Client and Residency of Carer

Relationship of Carer to Client	Carer is Co-resident		Carer is not Co-resident	
	No.	%	No.	%
Spouse	16	38.1	-	-
Mother	7	16.7	-	-
Father	1	2.4	-	-
Son	4	9.5	5	31.3
Daughter	10	23.8	7	43.8
Daughter-in-law	-	-	1	6.3
Sister	1	2.4	-	-
Other relative	2	4.8	2	12.5
Non-related paid helper	-	-	-	-
Other	1	2.4	1	6.3
Total	42	100.0	16	100.0

Table 3.15: Length of Time Carer has been Caring for Client by Clients' Age

Clients' Age	Length of Time Caring	No.
0-14 years	Whole of life	3
	(2 years, 10 years and 14 years)	
15-64 years	1-2 years	1
	3-4 years	1
	5-6 years	1
	7-8 years	2
	More than 8 years	8
65 and over	Up to 1 year	4
	1-2 years	15
	3-4 years	4
	5-6 years	4
	7-8 years	2
	More than 8 years	13
Total		58

working full time. The remainder worked part time or on a casual basis. Nineteen of the carers of working age were not, in fact, working and three quarters of these lived with clients. Twenty one of the carers had permanently retired.

None of the four carers who were looking after younger people with disabilities (their ages were 2, 10, 14 and 15) were in paid employment. These young people had developmental disabilities and required constant attention which made it difficult for their main carers to go out to work. None of the spouse-carers worked and, in fact, three quarters of them had permanently retired. By contrast, though none of the parent-carers had actually retired, for the reasons just mentioned, more than half were not in employment. Most daughter and son carers also did no paid work (55.5% and 52.9% respectively), although in both these groups large minorities were in employment.

Overall, male carers were more likely than female carers to have paid jobs, (36.8% compared with 28.2%). Over 28 per cent of carers said that caring had had no effect on their work situation. However a further 23.7 per cent (14 carers) said that their work situation had been affected. Six had given up work altogether, three had reduced their hours of work, one had obtained paid work to help cover the costs of caring, three said that there was some other effect (for example altering the times worked). Fifteen per cent said that they had been forced either to leave work or to reduce their working hours as a result of their caring.

Carers' Health. The carers, as might be expected were, generally speaking, healthier, than those they care for. However, only 14 of the 59 carers had no chronic health problems at all. The remaining 45 reported a total of 125 health problems, an average of 2.7 each, which nevertheless compares quite favourably with the average of 5.6 suffered by clients. Whereas nearly half of all clients had reported five or more chronic health problems, only a little over 10 per cent of the carers had as many. The most common health problems of carers were similar to those cited by clients: arthritis (37.8% of 45 carers with problems), high blood pressure (31.1%), walking problems (17.8%), heart trouble (15.6%) and bad backs, crushed vertebrae etc. (13.3%). Bronchitis, diabetes, ulcers and kidney problems were each mentioned by 8.9 per cent.

Not surprisingly, spouse carers, who tended to be older, had most health problems. Where there were two frail elderly people in the same household, the services being provided often supported both, though only one is listed as a client. Community Options can maximise the number of people they help support by nominating only one person as a client when there are, in fact, two frail elderly persons in the household. In some cases, of course, the couple are mutually dependent and neither could remain at home without the other.

Table 3.16 shows that the spouse-carers, who, on average are the oldest group of carers, not only have most health problems themselves but are caring for people with the most problems. Parents, who are the youngest group of carers and have fewest health problems, are looking after the clients who are amongst the least able to look after themselves, that is, children with developmental disabilities.

Table 3.16: Relationship of Carer to Client, Health Problems of Carer and Client and Dependency Level of Client

Relationship	Mean	Standard Deviation	Range
Spouse (mean age-67 years)			
Carer's average number of health problems	3.9	2.9	
Client's average number of health problems	6.6	4.0	
Client's total IADL score	41.2	6.7	28-52
Parent (mean age-47 years)			
Carer's average number of health problems	1.3	1.4	
Client's average number of health problems	6.1	4.7	
Client's total IADL score	46.8	7.0	39-58
Child (mean age-51 years)			
Carer's average number of health problems	1.6	1.7	
Client's average number of health problems	5.8	3.3	
Client's total IADL score	38.4	8.9	23-55
Sibling (mean age-62 years)			
Carer's average number of health problems	4.0	-	
Client's average number of health problems	7.0	-	
Client's total IADL score	36.0	-	(1 observation)
Other (mean age-52 years)			
Carer's average number of health problems	1.5	1.5	
Client's average number of health problems	5.2	4.2	
Client's total IADL score	36.7	6.1	30-47

The Mental Health of Carers and Their Ability to Care. Carers are clearly providing a wide range of very regular help to the people they look after. Many studies of carers have shown that their levels of psychological distress are high in relation to the general population and this study is no exception.

Carers were asked to complete a 12-item version of the General Health Questionnaire which as we have noted earlier, has been used to measure psychological distress though it can tell us nothing about its causes. The scores out of a maximum possible 12 are shown in Table 3.17.

Any score of two or above on this scale indicates that the person is experiencing a level of distress such that he or she is at risk of developing a psychological disorder. The higher the score the greater the risk. As the Table shows, 43 per cent of the carers were not experiencing any distress at the time they completed the questionnaire and an additional 12 per cent had a score of 1. The remaining 44 per cent had a score of 2 or higher. The equivalent proportion in the general population is only in the region of 20 per cent (Wells et al., 1990). This suggests, clearly

Table 3.17: Stress Levels of Carers Measured on General Health Questionnaire

Score out of 12	No.	%
Zero	25	43.1
1	7	12.1
2	6	10.3
3	1	1.7
4	5	8.6
5	3	5.2
6	2	3.4
7	3	5.2
8	2	3.4
9	1	1.7
12	2	3.4
Missing	1	1.7
Total	58	100.0

enough, a relatively high level of distress amongst carers in the survey. It is hardly surprising given that caregiving can be a full-time occupation from which there may be little relief. More than a third of the carers interviewed (37.9%) had had no break at all from caring in the past 12 months and a further 31.0 per cent had only had one break during that time. Seven carers (12.1%) had had only two breaks from caring. This means that 81.0% per cent of the carers had had two breaks or fewer in the last 12 months. Of the thirty-six carers who had at least one break during the last year, a third said the Community Options had organised this for them. The remaining two-thirds were presumably organised by carers themselves, family and friends or other respite services.

Most carers were completely dedicated to their caring. When asked whether there was anything that could lead them to decide that they would no longer carry on, more than a quarter (27.6%) answered 'no'. (13.8% of carers were not asked this question because the client was present). Of the 31 carers who acknowledged the possibility that they could find themselves unable to care for the client any longer, 80.6 per cent gave reasons having to do with their own physical incapacity. Fifty-three per cent said that they would no longer be able to care if they became very ill and 27.6 per cent said that if the clients' health deteriorated and they became physically difficult to handle, it might no longer be possible to care for them. The remaining six reasons were each given by one carer:

- If _____ got any 'madder' I could no longer care for him (client is dementing);
- I could no longer care for _____ if services were not available or if another member of the family became seriously ill;

- If I just couldn't manage any more;
- I couldn't care any more if _____'s condition deteriorated and his poor behaviour became worse;
- If _____ was bedridden; and
- If the services were unreliable (I'd worry about _____ being looked after).

The Impact of Caring, How Community Options Helps and What the Future Holds. Apart from causing anxieties and difficulties for carers, caregiving can also affect other aspects of their lives, for example, family responsibilities, general health, emotional health, social life and financial situation. The percentage of carers who thought that caring had had an impact upon any of these areas were as shown in Table 3.18.

Not surprisingly, emotional health was most frequently mentioned. Worry about the sick relative or feeling that the world was on their shoulders was common among carers.

When asked whether they found any particular aspect of caring worrying or difficult, twenty-one of the carers (35.6%) said they did not experience any problems with caring. However, more than half (57%) found some aspects difficult. Some mentioned the demands of caring and the resulting stress. They said that they were exhausted all the time, or that they were worried about the impact on their family and the extra costs involved, or that they could hardly bear the constant supervision that was required or that they had no time for themselves and that their social life and hobbies had been curtailed. Other carers worried about the people they were caring for and about their coping capacities. They said that they were worried about the vulnerability of their charges and about what could happen in their own absence. Yet other carers felt tied down and were angry that they could no longer do the things they would like to do and they felt that they never seemed to get a break from caregiving.

Over three quarters of the 37 carers who were asked whether Community Options had helped them with the worrying aspects of caring said that it had done so. Those who said that they had not been helped may, of course, have had anxieties beyond the capacity of Community Options to alleviate. However, Community Options had helped in a wide range of ways. The most common answer related to services, and the fact that the Community Options co-ordinator had accessed and organised services for the client and/or carer. Just over half (56.0%) of the carers who felt that Community Options had helped them gave this reason. Sixteen per cent of carers said that simply knowing help is there if needed allayed their worries. Most of the remaining carers said that 'support' and 'arranging a break for the carer/arranging respite' were the ways that Community options had helped them.

Table 3.18: Areas of Life Affected by Caring

Area of Life	Carers who said area of life was affected %
Family life	44.0
General health	42.4
Emotional health	60.8
Social life	52.0
Financial situation	22.2

Other forms of help, mentioned in each case by a small number of carers were:

- Community Options has provided items that make caring easier (e.g. rails, a shower chair);
- Community Options has helped by removing a lot of strain/it has taken the pressure off;
- There is now someone to supervise _____ when I'm not there;
- Community Options has organised an activity to occupy _____'s time (and therefore I don't have to do it;
- Helps _____ to have a better quality of life;
- Organising weekend homecare to help me;
- There's someone who speaks _____'s language and understands her problems;
- Community Options planned a meeting of service providers to discuss what _____ needed to cope at home;
- Community Options helped with specialist knowledge and referrals (to a geriatrician); and
- The alarm helped. Now I'm not so worried about _____ being left alone.

It is evident that most carers do not see their role as one that should be taken over by services or other people unless absolutely necessary. When asked what they thought would happen to the client if they could no longer care, more than half (65.1%) said that they thought the client would have to go into residential care. One carer thought the client would have to go into hospital. Nine (20.9%) thought that other family members would step in and help out if they could no longer care. Two who

did not want to stop caring in any circumstances said that additional services would be sought in order to allow the client to remain at home. Two carers didn't know what would happen to the client in these circumstances, and another said that there was no-one else to care and feared the client might commit suicide. In fact, only seven clients (7.4%) had taken any steps towards moving into permanent residential care before their involvement with Community Options. Most clients were determined to stay in their own homes at all costs. This came through quite clearly from the questionnaire responses and is supported by the figures on the question 'If you didn't receive help from Community Options do you think you would still be living here?' More than three quarters of clients (78.7%) said 'yes'.

It is unclear whether these clients had particular fears about entering residential care. It is, of course, generalised anxiety about loss of contact with family and friends, loss of control over their lives or simply resistance to being labelled 'sick' or 'old'.

Involvement with Community Options

How Clients First Heard About and Became Involved with Community Options. Clients and carers heard about and became involved with Community Options in a variety of ways. The two tables below set out separately the client and carer responses to these questions. Carers were more likely to have known about Community Options than were clients, but a substantial proportion of both could not remember or did not know why and how they had become involved with Community Options. Many people said that the first time they had heard of Community Options was when the co-ordinator had telephoned or appeared on their doorstep. Table 3.19 indicates that other service agencies were overwhelmingly the initial source of information about the existence of Community Options and that, amongst the services, the community nurse was the most common initial point of contact.

As we shall see later, in many cases the services which the clients in our survey received, had not, in fact been organised by Community Options, because the clients were already receiving them at the time of their initial contact with Community Options. This is also consistent with data from the MDS which show that many of the more conventional services, such as housekeeping, community nursing and Meals on Wheels were being received by clients before they were accepted as a Community Options clients (see Table 2.27).

The main reason clients gave for becoming involved with Community Options was that they had been ill/had a stroke/had been hurt or had been in hospital (see Table 3.20). The second most common reason was that the clients were not coping or managing on their own. The need for help with particular tasks such as showering or house cleaning and the need for respite or day care by the client or carer were also cited by several respondents as reasons for contact with Community Options.

Table 3.19: Initial Source of Information About Community Options

How did you first hear about CO?	Client Responses		Carer Responses	
	No.	%	No.	%
Don't know/can't remember	40	42.6	15	25.9
Through a Community Nurse/Nursing Agency	16	17.0	12	20.7
Through a relative or friend	8	8.5	5	8.6
Through Home Care	7	7.4	5	8.6
Through local GP	5	5.3	2	3.4
Phone book/pamphlet	2	2.1	1	1.7
Through day care/respite	3	3.2	3	5.2
Through hospital social worker	6	6.4	7	12.1
Through neighbourhood/community centre	2	2.1	-	-
Through other service agencies/HACC	5	5.3	8	13.8
Total	94	100.0	58	100.0

Table 3.20: Reason for Initial Involvement with Community Options

Why did you first become involved in CO?	Client Responses		Carer Responses	
	No.	%	No.	%
Don't know/can't remember	31	33.0	10	17.2
Client had been ill/had stroke/been in hospital/was hurt	19	20.2	10	17.2
Client or carer needed/wanted (extra) respite or day care	7	7.4	7	12.1
Client was not coping/functioning properly on own/needed help to live at home	9	9.6	3	5.2
Carer was ill/hurt/away or otherwise incapacitated	4	4.3	4	6.9
Client/carers needed help with a particular task	8	8.5	6	10.3
A service provider suggested it/thought it would be a good idea (carer needed help).	2	2.1	4	6.9
A relative/friend arranged it/family concerned about clients' health	3	3.2	1	1.7
Clients' service levels were being cut/Home Care short of funds	2	2.1	-	-
Carer couldn't cope/needed help/had to be out during day	1	1.1	7	12.1
Doctor thought that client needed help to live at home/otherwise would have to go into nursing home	1	1.1	2	3.4
Client was thinking about residential care	2	2.1	-	-
Advice on services needed/need to find out what is available for elderly	1	1.1	2	3.4
Client lonely/doing nothing all day	2	2.1	-	-
Other - living situation inappropriate, client had been in respite, needed financial help	2	2.1	2	3.4
Total	94	100.0	58	100.0

The most common reason given by carers was the same as that given by clients, that is deterioration in health which placed the client at particular risk of institutionalisation. It is at this point, too, that the carers, many of them elderly, find themselves unable to cope with the additional burdens. Indeed they may find themselves at risk of institutionalisation. Other reasons frequently given by carers for becoming involved with Community Options include their need for respite or day care or for help with a particular task. In this way the responses of carers tended to follow closely those given by the clients.

Frequency of Contact with Community Options. Clients were asked about the frequency with which their Community Options co-ordinator contacted them and whether they felt this was often enough. If they felt that the co-ordinator did not contact them often enough, they were asked to specify how often they thought would be sufficient. The results are shown in Table 3.21.

The most usual frequency of contact by a co-ordinator was once a month or less (24.5% being contacted once a month and 28.7% being contacted less frequently). Seventeen per cent of the clients did not know how often their co-ordinator contacted them.

A substantial majority of clients stated that they were happy with the amount of contact they had with their co-ordinators (69 or 73.4%). Only 10 people (10.6%) expressed dissatisfaction and half of these were being contacted less than once a month. One client who was unhappy about the frequency of contact could not say how frequent it was and two other clients said that they had not ever been contacted. Of the 10 dissatisfied people, seven suggested a satisfactory frequency: two a few times a week, one once a week, two once a fortnight and a further two thought that once a month would be often enough. It appears that, on the whole, provided they are being contacted at least once a month by their co-ordinators, few clients will feel that they are being neglected. Of course, it is probably not the frequency of contact in itself that is of concern to clients and carers, but whether co-ordinators are available when required. It would appear that for the most part they are.

Help Received by Clients. Clients were asked whether they were receiving any help with 27 different items regarding their personal care, financial matters, emotional and other general aspects of their lives. Table 3.22 shows the number of items with which clients receive help from **any source**.

Clients without carers, on the whole, received help on fewer items than those clients who had carers. At first sight this may seem paradoxical. However, it will be recalled that clients without carers were somewhat less dependent on the assistance of others than those with a carer. Furthermore, particularly when the carer is elderly, it is likely that assistance is being received by both carer and client. It may also be the case, although we have no evidence of this, that carers are able to make more effective demands on the service delivery system. Carers have traditionally been a neglected group and it may well be that Community Options is, for this very reason, paying particular attention to their needs.

Table 3.21: Frequency of Contact Between Clients and Community Options Co-ordinators

How often does you Community Options co-ordinator contact you?	No.	%
A few times a week	4	4.3
About once a week	6	6.4
About once a fortnight	13	13.8
About once a month	23	24.5
Less than once a month	27	28.7
Has not contacted me/us	4	4.3
Don't know	16	17.0
Not applicable	1	1.1
Total	94	100.0

Table 3.22: Help Received by Clients

No. of Items	Those with a carer		Those without a carer	
	No.	%	No.	%
1-5	-	-	6	16.7
6-10	14	24.1	18	50.0
11-15	25	43.1	10	27.8
16-20	18	31.0	2	5.6
21 or more	1	1.7	-	-
Total	58	100.0	36	100.0

Table 3.23 shows the source from which clients obtain help and relates this to the question of whether or not they have a carer and, if so, whether they live with their carer.

Clients who have a carer with whom they live are most likely to receive help from their carer with : (in descending order) meal preparation, financial affairs, shopping and taking medication. More than half of all clients received help with at least one of these tasks. A high proportion of clients also received help from their co-resident carer with housework, gardening, home and yard maintenance, dressing and transport. Clients who have a carer who is not co-resident are likely to receive help from their carer with fewer activities. Non-co-resident carers most commonly help with shopping, financial matters, over night care, transport and hairdressing.

Table 3.23: Source of Help with Activity by Household Type

Activity	Client lives with carer (n = 45)			Client Does Not Live With Carer (n = 19)			Client Does Not Have a Carer (n = 30)	
	% of clients who get help from main carer	% of clients who get help from family/friends	% of clients who get help from service or contractor	% of clients who get help from main carer	% of clients who get help from family/friends	% of clients who get help from service or contractor	% of clients who get help from family/friends	% of clients who get help from a service or contractor
Meals on Wheels/delivered meals	13.3	2.2	24.4	-	-	52.6	3.3	50.0
Planning, preparing, cooking meals	62.2	8.9	15.6	-	5.3	52.6	10.0	16.7
Transport	40.0	15.6	33.3	21.1	36.8	26.3	20.0	60.0
Shopping	57.8	20.0	6.7	36.8	26.3	15.8	36.7	23.3
Housework	46.7	4.4	40.0	5.3	-	78.9	6.7	73.3
Gardening/lawnmowing	46.7	17.8	17.8	15.8	36.8	36.8	23.3	40.0
Home/yard maintenance	46.7	15.6	15.6	10.5	47.4	21.1	16.7	36.7
Home nursing	8.9	2.2	46.7	-	-	42.1	-	30.0
Taking medication	57.8	4.4	4.4	10.5	-	31.6	-	10.0
Bathing/showering	28.9	4.4	42.2	10.5	-	52.6	-	13.3
Dressing	40.0	4.4	20.0	5.3	-	21.1	3.3	3.3
Getting in/out bed	37.8	2.2	6.7	5.3	-	5.3	-	3.3
Toileting	37.8	2.2	8.9	5.3	-	-	-	3.3
Therapy	4.4	-	20.0	5.3	-	5.3	3.3	13.3
Podiatry	13.3	2.2	20.0	-	5.3	42.1	-	23.3
Hairdressing	17.8	6.7	33.3	21.1	21.1	21.1	6.7	26.7
Dietary advice	2.2	-	15.6	5.3	-	10.5	-	-
Home aids/modifications	2.2	4.4	44.4	-	-	31.6	-	16.7
Visits from a companion	2.2	13.3	4.4	-	10.5	15.8	13.3	10.0
Out of home respite	2.2	4.4	28.9	5.3	5.3	15.8	13.3	3.3
Overnight care	20.0	11.1	6.7	21.1	15.8	15.8	33.3	-
Recreation	2.2	2.2	28.9	5.3	-	36.8	13.3	23.3
Visits from a doctor	-	-	40.0	5.3	-	36.8	-	33.3
Counselling	-	-	-	-	-	-	3.3	3.3
Assistance with financial-affairs	62.2	8.9	-	36.8	15.8	-	10.0	13.3
Financial assistance	13.3	4.4	4.4	5.3	-	5.3	3.3	3.3
Emergency call arrangements/alarm	-	11.1	15.6	-	15.3	36.8	33.3	26.7

Clients with co-resident carers received help from family and friends on a greater range of tasks than did those with non-co-resident carers or those without any carer, although they were slightly less likely to receive help with the basic activities such as housework as well as with activities such as overnight care and emergency call arrangements.

Clients without carers and those with non-co-resident carers were, on the whole, more likely to receive help from a service organisation or private contractor with basic every day activities such as delivered meals, shopping, housework or gardening than were those living with carers. Those clients living with carers were more likely than other clients to receive help from a service organisation or private contractor with activities such as home nursing, getting in and out of bed, toileting or therapy. This would appear to support the finding that people with co-resident carers are of a higher dependency than those without carers or those whose carers do not live with them. The assertion that Community Options cannot maintain highly dependent clients at home unless they have hardworking co-resident carers appears to be supported by Table 3.24. Without carers it is unlikely that Community Options could afford to maintain such clients in their own homes.

Carers were asked whether they had ever been refused help by a service when Community Options had been involved. Only one carer said she had, but did not say why. Fifty-four carers had not been refused services when Community Options was involved and the remaining three did not answer the question.

When asked whether they had been involved in the decision about the sorts of help they should get to help them manage at home, about two-thirds of all clients said that they had. Roughly one in five (19%) were **not** involved in this decision. A further 13.8 per cent were unable to say whether they had been involved or not.

When they were asked whether they had been happy about their involvement in the decision-making process about two thirds of the clients said that they had. Only three clients had not been happy. Over a quarter of them were not able to say. Either they could not recall, or the issue simply had no meaning for them. Whilst the involvement of clients in the decision making process is an important guiding principle of Community Options, we should not expect that all clients will necessarily attach the same significance to this matter.

How Community Options helps. Clients were asked to say in what ways they felt the Community Options co-ordinator had helped them. About a fifth of the clients could not or did not answer this question. Of the remaining clients, nearly half (48.7%) said that the co-ordinator had helped them by organising services and attending to any problems with these. A further 17 per cent mentioned one or more of the services they had received. Presumably some of these clients have difficulty distinguishing the co-ordinator from the services he or she arranges for them. About 10 per cent of the clients mentioned 'support' or 'comfort and understanding' as the way in which the co-ordinator had helped them. Small numbers of clients described the numerous ways in which they had been helped, for example, by the co-ordinator

Table 3.24: Ways in Which Community Options Co-ordinator Helps Carers

How Community Options helps	No.	%
Relieves some of burden/makes it easier to cope/less worry	19	50.0
Support/having an understanding person to talk to	8	21.1
Enables carer to get out of house/have a break from caring	4	10.5
Knowledge that services are available/co-ordinator is there	3	7.9
Allows extra time to be spent with rest of family	2	5.3
Client is better looked after	1	2.6
Relieves financial burden and burden of caring	1	2.6
Total	38	100.0

talking to them or giving them good advice, by the financial assistance they had received in the form of free services, by the improvement in the quality of their lives, by the co-ordinator keeping an eye on them and by 'helping me to live at home'.

Carers were asked whether, since they had been involved with Community Options, they felt that caring had become easier, more difficult or had stayed the same. No carer said that Community Options had made caring more difficult. The majority said that it had made things easier (69.0%). The reasons they gave are described in Table 3.24 below.

For about half of the carers Community Options had relieved the burden of caring, had made it easier for them to cope or had meant that they had had less to worry about. For a further 21 per cent it was the support that Community Options had offered that they had found helpful. One in ten carers said that Community Options had made things easier for them by providing a break from caring.

Both clients and carers expressed a great deal of satisfaction with the help that they had received from their Community Options co-ordinators. Eighty-four per cent of clients and a similar percentage of carers said that they were 'very satisfied' with this help and a further 7 and 12 per cent respectively indicated that they were 'fairly satisfied' with the help from the co-ordinator. In all, then, 91.4 per cent of clients and a similar proportion of carers were satisfied. Only two carers and no clients said that they were 'not satisfied' with the help they had received.

The reasons given for dissatisfaction were not directly related to Community Options. They were:

- difficulty finding a good 'live-in' home help;
- a client wanting someone (presumably the co-ordinator) to 'pop in' and check that she's OK;
- wanting more housekeeping;

- wanting more companionship;
- respite care not organised promptly enough (a reason given 3 times);
- that the co-ordinator could not arrange the extra hours of respite requested by the carer;
- that the carer never hears from Community Options; and
- that the carer had only seen the co-ordinator once (and felt that this was not enough).

In general, dissatisfaction with Community Options was associated with insufficient help from the services rather than with Community Options *per se* and indeed it also appears that some clients (and carers) had trouble distinguishing the work of their co-ordinator from that of the other services. This is understandable when clients receive only periodic phone calls from the co-ordinator but never see or hear of what goes on 'behind the scenes'. It is clear, also, that whilst co-ordinators may follow-up the requests of clients and carers, it is sometimes beyond their power to provide all they want.

Help from Other Services. Clients and carers were also overwhelmingly satisfied with the help they received from other service organisations. Eighty three per cent of clients and a similar percentage of carers were 'very satisfied' with this help while over 10 per cent of both were 'fairly satisfied'. Only one client and one carer expressed dissatisfaction.

In all, ten comments about problems with service organisations were made by clients and carers, a few having more than one complaint. Five complaints were made about Meals on Wheels: that the food was cold and inadequate or just not palatable, that there is nothing for vegetarians and that delivery times are inappropriate or unreliable. That shower times did not correspond to peak need times (for example, for incontinent clients) was mentioned twice. Other complaints (each raised only once) were:

- there is no 'after hours' nursing service;
 - the gardening is not done properly;
 - not getting enough companionship;
 - needs more hours of homecare;
 - Home Care cut hours of housework without warning;
 - Home Care helpers are unreliable and sometimes do not show up;
 - made to feel guilty and to grovel for services; and
 - the Community Nurse does not do her job properly.
-

When clients (and their carers) are receiving a number of different services, each one from an organisation which has its own staff and has responsibility for different tasks, it means that quite a number of different people may be coming into the client's home. Obviously, the more services that are received, the more 'hands-on' service providers who will be involved. Clients were asked to say whether they thought too many different people were helping them. Only six clients expressed dissatisfaction on this score. One of these people mentioned privacy as an issue, commenting: 'My house sometimes feels like a public home'. Another found the change of staff difficult at times when she felt unwell. One client, according to her carer, 'just gets confused', while two others mentioned duplication 'they can't keep track', and disorganisation: 'too many homecare people who have to be taught what to do'.

Whilst clients and carers expressed great satisfaction with the help they received from service organisations, as many as 39 clients (41.5%) said that there was also some help they would have liked but were not currently receiving. These clients (or their carers) between them gave 49 types of additional help they would have liked to receive (see Table 3.25). Paramedical services, more personal care and more companionship were mentioned most frequently. There are numerous reasons given for not receiving the help which they felt they needed: that they knew that no help was available so there was no point in asking for it, that they would not be able to afford it, that they could not trust anybody, that they simply had not thought to ask for it. The co-ordinator was never blamed for not being able to meet these unmet needs. Unfortunately, we did not ask the respondents whether they had ever raised the matter with their co-ordinators, but we do know from the response to other questions that co-ordinators have almost always been successful in obtaining services for clients when they have been asked to do so.

The Most Useful Types of Help for Clients and Carers. The type of help which survey respondents identified as the most crucial in enabling them to manage and to remain at home were, not surprisingly, those services upon which they were most dependent. A considerable range of services reflecting the diversity of need amongst the client group were mentioned, and in many cases it was the combination of services which was important (see Table 3.26).

Homecare/housework was the service which helped the largest group of clients (almost 20%) to manage at home. But a high proportion of both clients and carers did not identify a single service, saying rather that the greatest help they received was the make-up of their service package.

How Community Options Affects Attitudes to Living at Home. Community Options has made a difference to the way in which over half the clients feel about living at home. Fifty-three (56.4%) said that it had made a difference, thirty-three (35.1%) said that it had not. Eight were not able to say. Thirty-five clients gave reasons why they felt differently about living at home. These are summarised in Table 3.27.

Table 3.25: Types of Help Not Currently Received, Wanted by Clients

Type of Help (Category)	No.	%
Home Maintenance/modification	11	22.4
Specialist services (e.g. physio, continence adviser)	10	20.4
Home help/personal care	8	16.3
Home visitor/getting out for social contact	7	14.3
Respite/Day Care/holiday	4	8.2
Financial help	3	6.1
Overnight care	2	4.1
Ethnic Day Care	1	2.0
Social and Living Skills training	1	2.0
Transport	1	2.0
Meals on Wheels (in the evening)	1	2.0
Total	49	100.0

Table 3.26: Types of Help Most Useful for Managing at Home

What helps you most to manage at home/care for client?	Carer responses		Client responses	
	No.	%	No.	%
The combination of services I/we get	16	17.0	13	22.4
Homecare ^(a) - housework/cleaning	18	19.1	5	8.6
Personal care	7	7.4	3	5.2
Home nursing	3	3.2	5	8.6
Meals on Wheels/food preparation	12	12.8	3	5.2
Day Care/respite	3	3.2	5	8.6
Special equipment (e.g. wheelchair, sleep apnoea machine)	4	4.3	1	1.7
Alarm/emergency call arrangements	3	3.2	2	3.4
Companionship/other service provider acting as companion	1	1.1	3	5.2
Financial help	1	1.1	1	1.7
Knowledge that the co-ordinator/services are there for me/ co-ordinator as problem-solver and liaison person	2	2.1	2	3.4
Gardening/lawnmowing	3	3.2	-	-
Transport/Community Bus	1	1.1	1	1.7
Constant Care/full-time day carer/home help for day-to-day running of house	2	2.1	4	6.9
Recreational/Living Skills Program	1	1.1	1	1.7
Developmental Disability Nurse	1	1.1	-	-
Home Care checking on the client	-	-	1	1.7
Helps carer to look after me	1	1.1	-	-
Physical help carrying/moving client	1	1.1	-	-
Not answered/don't know	14	14.9	8	13.8
Total	94	100.0	58	100.0

Note: a) May include some cases of personal care when only 'Homecare' was specified.

Table 3.27: Ways Community Options has Affected Attitudes Towards Living at Home

Ways Community Options affects attitudes	No.	%
Support/someone to talk to/client feels more secure/confident	21	60.0
Free services/financial help	2	5.7
Makes it possible/easier to live at home/relieves burden	6	17.1
The services received/help with tasks	3	8.6
Because co-ordinator organises services needed	2	5.7
Carer can get out of house as a result of help provided by C.O.	1	2.9
Total:	35	100.0

We have already seen evidence of the dedication of carers. This is also reflected in their responses to the question 'If you and (client) didn't receive help from your Community Options co-ordinator do you think (client) would still be living at home?' Well over half the carers (39, or 67.2%) answered in the affirmative. The impression we have gained is that these carers will struggle against all odds to keep the clients at home, and in most cases this is certainly what the client also wants. A significant proportion, however, said that they did not think that the client would still be living at home without the help provided through Community Options. The differences between those who thought that the client would still be living at home and those who did not, does not seem to be strongly related to the stress levels of carers. The average score on the General Health Questionnaire for the first group of carers was 2.18 and that for the latter group was 2.8. Also the number of activities with which the clients were receiving help (from **any** source) was on average quite similar for both groups: 13 for the former, 14 for the latter. The only noticeable, though possibly very important difference between the two groups was that those carers who thought that the client would still be living at home even without help from the co-ordinator were, on average, receiving help on 5.32 activities from service organisations or private contractors as opposed to all other clients and carers, who were receiving help on 8.13 activities from these organisations. This suggests that carers who thought that they would not be able to go on caring unaided by Community Options were looking after more dependent people than those who thought that they would be able to carry on without help. In addition, more of the clients whose carers did not think they would still be living at home had dementia (according to the Community Options' assessment) than of the other group (46.7% compared with 35.9%).

The numbers are quite small and should be interpreted with caution. Nevertheless, it seems fairly certain that the carers and clients receiving most help from service organisations were those who would be least likely to manage if the help and/or support of Community Options were not there. However, it is difficult to assess the extent to which clients' and carers' determination to stay at home can serve to override such external factors and it is important to point out that we were after all only

soliciting a subjective assessment of possible future events. The reality might in any or all cases turn out to be quite different.

Apart from making caring easier, some carers said that since they had been involved with Community Options, they had noticed a change in certain other areas of their lives. Forty-one per cent of the carers who had originally said that caring had had a negative impact upon their emotional health, reported a change for the better since their involvement with Community Options. For those who felt that caring had impacted upon their social life, 38.5 per cent had noticed a change since their involvement with the program. The figures for those people who originally felt that caring had no impact were naturally much lower. However, in the case of their work situation, **more** of those who had initially said that caring had had no impact felt that there had been a change since their involvement with Community Options (see Table 3.28).

Apart from indicating those areas in which they had noticed a change since their involvement with Community Options, carers were asked to say whether there had been any effect on their confidence in their ability to care indefinitely for the client. Roughly two thirds (65.5%) of carers said that they now felt more confident than before. One third said that they felt the same and only one carer felt less confident about caring indefinitely. A substantial proportion of carers obviously felt that they could cope better with caring into the future with the support of Community Options.

When asked to suggest ways in which Community Options might be improved, most clients and carers did not think it needed improving or could not think of any way of doing so. In fact, many commented that they thought it was wonderful and did not need to change at all. Eighty-three clients (88.3%) and 43 carers (74.1%), did not offer any suggestions for change. The most common suggestions had to do with the desire for more information and advertising about Community Options, including publicity to NESB groups and information on Alzheimers' Disease in various languages (8 of 26 suggestions). The next most common suggestion concerned increased service levels. Respite care, transport, outdoor excursions, telephone connections and clothing assistance were all mentioned. Four suggestions were made pertaining to services that were lacking. Three of these were about after-hours services/facilities and emergency contact numbers. One was about the lack of ethno-specific day care (and lack of day care in general). Three suggestions regarding the quality of services were made:

- more trained people to do home visits are needed;
 - competence in the services is what's needed!; and
 - to have someone check that jobs are being done properly.
-

Table 3.28: Impact of Community Options on Areas of Carers' Lives

Area of life	Caring had an impact	Caring did not have an impact
	% who noticed a change	% who noticed a change
General health	36.0	12.1
Emotional health	41.9	10.0
Family life	36.4	3.6
Social life	38.5	0.0
Financial situation	16.7	2.4
Work situation	0.0	12.5

The six remaining suggestions for improvements to Community Options were as follows:

- better co-ordination between services; less administration; more people doing work in the home, (mentioned twice);
- families approving the staff that work in their homes - concern was expressed about the use of an employment agency and the expertise of staff, (mentioned twice);
- there needs to be an advocate to represent the carers of disabled children in order to get them services (mentioned once); the same carer felt that she had been made to grovel to get and keep the services she already had; and
- the co-ordinator should come on a regular basis and be consistent, (mentioned once).

Some of these suggestions illustrate, once again, that clients and carers associate Community Options very closely if not entirely with the services they receive from other organisations. The requests for information about Community Options demonstrate that some people feel they do not know enough about it. The overwhelming response to this question, however, was that Community Options was doing an excellent job.

For the last word on what clients and carers thought of Community Options and how it has helped them, the answers to the question 'what has been the main benefit for you of having someone like the Community Options co-ordinator?' are summarised in Table 3.29.

It is most illuminating that the main benefits mentioned by clients are in different magnitudes from those given by carers. Clients thought that the main benefits of

Table 3.29: Main Benefit of Having Co-ordinator as Perceived by Clients and Carers

Main Benefit of co-ordinator	Client Responses		Carer Responses	
	No.	%	No.	%
Support/someone to talk to/security	40	42.6	32	55.2
The co-ordinator gets things done/has organised services/has helped a lot	14	14.9	7	12.1
Gives you dignity/enables you to stay at home/allows you to be independent and more confident	9	9.6	-	-
Getting help with a particular task	4	4.3	-	-
Financial assistance	1	1.1	1	1.7
Relieving burden on carer/saving time/letting carer get out/can continue working	1	1.1	3	5.2
No difference	1	1.1	-	-
No answer/couldn't say	24	25.5	15	25.9
Total	94	100.0	58	100.0

having the Community Options co-ordinator were the feelings of security (knowing it was there if they needed it), the fact that the co-ordinator organised their services and 'got things done', having someone to talk to, support and enabling them to live at home. On the other hand, support and security were the benefits most commonly mentioned by carers, followed by having someone to organise their services. There was less emphasis on having someone to talk to than we found amongst the clients.

3.4 Summary of Findings

This survey has shown that clients are a mostly elderly and highly dependent group of people with numerous health problems. The high level of dependency of clients is demonstrated by the number of activities with which they need help. Most of them receive help with between six and fifteen activities. Very few receive help with fewer than six. Their general frailty and lack of mobility is apparent.

Many of the clients live alone, and a significant proportion have no carer. Most have permanently retired and the great majority of these are supported by the Commonwealth Age Pension.

Carers are on average 13 years younger than the clients. They are nearly all family members. Spouses and daughters account for more than half. Mothers and sons also play a significant role. Three quarters of all carers live with the person for whom they care. Caregiving is a very time-consuming task which requires a great deal of dedication and only one-third of carers have a paid job. However, of the two-thirds who do not work outside the home, half have permanently retired. Most carers have

been providing care for at least 12 months and as many as a quarter have been doing so for more than eight years.

Even though the clients of Community Options are frail and have many health problems, most are determined to remain in their own homes. Their carers are also determined to look after them for as long as possible, most only considering giving up caring should they become physically incapable. Even so, both carers and clients are extremely grateful for the services they receive and for the help of their Community Options co-ordinator. The co-ordinator fills the role not only of an organiser, but of a supporter - someone both clients and carers can talk to about their needs and how they are managing.

Given that most clients and most carers think they would still be living at home even without the support of Community Options and other services, it would be interesting to know how this relates to perceptions of nursing homes. Further research could study these links and whether entry into residential care is, in fact, affected.

The final point to be made is that clients and carers see Community Options as very valuable. From no-one was there the slightest hint of antagonism. It is a mode of service delivery which has certainly been accepted by clients and carers, and has proved to fit very well into the pattern of their lives.

4 Stage Two: The Survey of Service Providers

4.1 Broad Aims and Research Methodology

The first stage of this evaluation was written very much from the perspective of the Community Options projects themselves. We observed the extraordinarily high level of commitment and enthusiasm that those who worked in the projects felt towards the work they were doing and for the underlying goals of Community Options as a form of service organisation. We noted that Community Options co-ordinators held the view that this form of service organisation indicated the right way forward for service delivery in Australia. But Community Options co-ordinators also saw themselves, quite realistically, as very small fish in a large service pond and furthermore in the insecure position of being on trial with an uncertain future.

Community Options is, of course, a new type of service organisation set among or, some would say, imposed upon other more established services. It is easy to see that they might not exactly welcome this **parvenu** occupying a rather privileged status and advantageous conditions in the world of services. And indeed the very enthusiasm of Community Options staff might be expected to grate somewhat on those who, from backgrounds of long experience could be inclined to see them as somewhat naive enthusiasts. Worse still, existing service providers may see these enthusiasts as doing no more than they themselves can see should be done but are unable to do because they do not have the resources.

Though the conditions for these rather resentful attitudes appear to be present we should not, of course, prejudge. The purpose of the Survey of Service Providers was to establish how other services do, in fact, perceive Community Options, what they view as its strengths and weaknesses as a form of service organisation, how they feel it impacts on clients and carers and on their own service agencies and how the service provided by Community Options could be improved. We were also interested in the amount, type and quality of the interaction between Community Options and other services and where there had been difficulties what if any deliberate steps, if any, had been taken to improve these.

The Services Included in the Survey

In their role as service co-ordinators Community Options staff interact with many local services and service personnel. All these services are important, of course, in that they all provide services which will contribute towards the packages which Community Options co-ordinators set up for their clients. However, given the nature

of their clients' needs, Community Options will naturally have more frequent contact with some services than with others.

In the event we included only three types of service agency in our survey. These are three of the four services most frequently used by Community Options: the Home Care Service, Community Nursing and the Geriatric Assessment Service. Meals on Wheels was the fourth service which it had been our original intention to include. We decided not to do so for two reasons. Firstly, we found that in many areas there was such a proliferation of small services that it would have been quite impossible to interview them all and we had no basis for making a partial selection. Secondly, early attempts to interview representatives of Meals on Wheels had indicated that the rather formal, detailed and methodical approach which we used in this survey to enable us to make systematic comparisons between responses was quite inappropriate for Meals on Wheels Services which, in contrast to the other three service types, are non-bureaucratic and non-professionalised.

Community Options co-ordinators were asked to provide the Research Team with the names and addresses of the managers of all the Home Care Service branches, Community Nursing Services and Geriatric Assessment Services with which they had contact. These 31 managers (or acting managers) were all approached and except in three instances, where the manager was on leave, all agreed to participate in the survey. However, one manager, on seeing our questionnaire, felt that her contact with Community Options was too limited to enable her to answer the questions and she joined the group of 10 other people who were not formally interviewed but who presented their views of Community Options in a rather less detailed and structured way. This group consisted almost entirely of people who we were advised might have views about Community Options which would be worth hearing.

The data we shall be presenting in this report will, for the most part, be confined to that obtained in the course of formal interviews using the questionnaire designed for the survey. A list of the 26 organisations whose representatives we interviewed is provided in Appendix 7. It will be observed from this list that whilst more or less equal numbers of representatives of the three types of service agency included were interviewed, there were considerable differences between localities in the number of interviews conducted. In part this is a reflection of the number of branches of agencies with which the Community Options projects actually interact in the different localities. However, in the case of the North West Aboriginal project we did not interview all the branch Managers of the of the Home Care Service because we had already interviewed them in connection with Stage One of this evaluation.

Field Work

Information for this survey was collected by means of personal interview with service managers. Managers were first approached by phone with a request for an interview. There were no refusals and considering the unavoidably short notice given in arranging the interviews, managers were most cooperative and eager to

accommodate. The initial phone call was followed by a letter, which confirmed the arrangements, repeated in an abbreviated form the explanation of the survey, and provided reassurances of confidentiality. The letter was, in most instances, accompanied by a copy of the questionnaire. Managers were not asked to complete the questionnaire before they were interviewed (although some did) but merely to read it through by way of preparation.

Interviews usually took place in the manager's office and lasted from one to two and a half hours. The interview was normally uninterrupted by other business. In some cases managers would invite, with our agreement, other members of her staff whom she felt would be able to contribute. In one case the interview was conducted by phone because the logistics of travelling between the three main towns covered by the project made it impossible to cover all the interviews in the time available. In another case the interview had to be cancelled because the road was closed on account of rain. To have made this journey by the circuitous route would have entailed travelling (one way) 496 kilometres, for between 5 to 6 hours and at a cost \$186 instead of the hour's journey of 122 kilometres at a cost of \$46 by the direct route. These obstacles to the smooth running of the field work were unfortunate but provided us with some salutary reminders of the problems and costs that can be involved in providing services to people who live in remote rural areas and of the problems and costs that such people may experience in accessing or using services.

Whilst managers were extremely cooperative in agreeing to be interviewed and also generous with their time, in some instances we encountered a certain reticence on their part. Although we emphasised that services and not individuals running services were under evaluation, it is understandable that in the small organisations which we were concerned with, the distinction between person and service is very difficult. Respondents were sometimes anxious to avoid what might have been taken for personal criticisms and so avoided making any critical comments at all. On the other hand, one could detect sometimes even in the same people, some gratification that they were being provided with what seemed a legitimate opportunity to comment either favourably or critically on other individuals. In some instances, the questions appeared almost irrelevant but the occasion itself provided an opportunity for the expression of views that the respondent wanted to air. Naturally we looked to the questionnaire to see whether a different formulation might have achieved a different result but on the other hand we should perhaps be glad that the interview provided a medium for the expression of such complex reactions as we describe in the summary of our findings. Overall the views of Community Options were a conglomerate of responses touching different areas: that of personality, practice, policy and politics. Our summary will attempt to put some order into this complex picture, which in a sense extends beyond the confines of Community Options into the wider world of community services.

4.2 Findings

The questionnaire was designed for the most part to elicit the opinions and perceptions of respondents on a series of topics. Very little of the information sought was of the 'how often' or 'how much' kind. We must emphasise therefore that the conclusions that we outline in this report relate to the opinions and perceptions of the people we talked to. These opinions and perceptions should not be mistaken for an entirely independent or objective description of the world. Nevertheless they are an extremely important ingredient, which needs to be taken fully into account.

The field work or data collection was carried out by only one research worker. The advantage of this, especially relevant in a study of perceptions involving a relatively small number of people, is that the researcher gains an overview of the emerging patterns of response. A danger is that the field worker's judgements are not tested against those of other observers. It is therefore particularly important that any interpretations are made extremely cautiously and they are made in the light of broader experience and knowledge.

In this account of our findings we shall not undertake statistical analysis, but simply identify issues revealed through the answers that people gave to the questions. Important issues are sometimes raised by responses or views which are widely shared, but it is sometimes the case that a view expressed by very few people, perhaps even one person only, raises an issue which we feel is so significant as to merit discussion.

To put some order into the discussion we shall explore our data through a series of 10 themes and, where it seems important, we shall do this from two perspectives, that of service agencies and that of the locations of the five Community Options projects. Thus we may look for consistencies within service agencies and within locations. However, we shall clearly only be able to do this where patterns emerge. We might expect responses associated with locations to show the greater consistency because the opportunity for sharing opinions is clearly greater where there is physical proximity. The importance of this factor was very much highlighted by our field work in Newcastle. Shortly before we undertook our fieldwork, the Community Options project there had organised a large forum to discuss issues associated with Community Options. This forum had been attended by a considerable number of local service providers, some of whom were the respondents in our survey. Our respondents frequently referred to the forum and it would be hard not to draw the conclusion that it had some influence on the views that we heard. Had we interviewed before rather than after the forum was held we feel that different, and perhaps more divergent, opinions might well have been expressed.

Another example of external factors influencing response needs to be cited. Shortly before our field work began, Home Care Service branches were issued with new guidelines as to the relationship between the Home Care Service and Community Options. These guidelines were perceived by some of the Home Care Service

providers we spoke to as placing Community Options in a dominant position. Here again, it seems likely that some of the views expressed may have been influenced by these guidelines.

These provisos are not intended to minimise the value of the data we present nor to suggest that they are invalid but merely to introduce a note of caution in taking the data at face value.

Theme 1: The Main Purpose of Community Options

This issue was raised early in the interview so opinions were expressed before respondents had had a chance to develop their ideas fully. One might have expected the main purpose of Community Options to be defined in terms of keeping people at home and out of institutions and indeed from many respondents this is what emerged. However, it is of some interest that this purpose was very rarely expressed by community nurses or by Home Care Service personnel but very frequently by those working in Geriatric Assessment Teams. In no case was this suggested as the purpose of Community Options in the Aboriginal project perhaps because there **are** no local residential care facilities for Aboriginal people. The completion of the new 22-bed hostel for Aboriginal people is eagerly awaited, however, and the answer to this question might well have been different had the hostel already been completed. It is perhaps worth mentioning in passing that one, but only one, respondent in this location expressed some concern that the hostel was being built for Aboriginal people and not for non-Aborigines.

However, we should perhaps not attach too much importance to the extent to which the 'prevention of institutionalisation' was offered by respondents as a purpose for Community Options. Many people may have thought it too obvious to suggest, and most did, in fact provide answers to this question in terms of the **mechanisms** serving to prevent institutionalisation.

Here the answers are more interesting. Regardless of service agency or location, Community Options is seen primarily as an additional source of funding - to provide services that no other service can provide (including 'one-offs'). 'Another bucket of money' was the way this was sometimes put, 'to fill the gaps' and 'pick up the slack'. In very few cases were the brokerage, case manager/co-ordination, monitoring or advocacy roles of Community Options mentioned at this stage of the interview, although these aspects tended to assume rather more importance later.

Theme 2: The Positive Aspects of Community Options, from the Point of View of Clients and Carers

A very small number of respondents said that they were unable to answer this question on behalf of other people. Although this group was small their answer reflected the difficulty that some people seemed to have in distinguishing between the impact on clients and carers and on the subsequently raised issue of the impact of

Community Options on their own service agency. It was as though, for some people, the clients and the agency were indivisible, or, to put it another way, that there was a strong identification of client/carer with service ends.

As one might have expected, the range of answers to this question was extensive, but undoubtedly the positive feature most frequently mentioned was its 'flexibility'. This clearly had something to do with funding. But what did people actually have in mind when they used the word? Firstly it was used to suggest that Community Options could move outside the normal range of services and thereby meet additional or special needs which other community services were in no position to provide. In this context, the notion of service packages was most frequently introduced, sometimes with the notions of co-ordination and case management.

'Flexibility', in the sense of having the capacity to move outside the normal range of services was most obviously said to be achieved by means of the 'one-off' purchase of goods or services such as a microwave oven, a washing machine, the installation of a telephone or 'breezer' or for more unusual services such as wood-chopping, or paying for a stroke victim to regain confidence and manual dexterity by having lessons in leather craft. Such lessons were also organised by Community Options to provide support and company to a recently bereaved husband. A 'tuck-in' service whereby elderly people are visited at bedtime and in the early mornings to check they are safe and well was mentioned as another service put in place by Community Options. This was designed to enhance the elderly clients' sense of security, especially at night and to re-assure them that their safety is a matter of concern to others.

However, 'flexibility' was also defined in terms of moving away from the rigidities and bureaucratic constraints of the conventional services. For example, the cost of helping people in remote areas can be very high for the Home Care Service, which pays a specific amount for kilometrage for its employees. Thus even a short visit may be made at considerable cost and this cost may in turn limit the frequency of visits or may result in services having to be withdrawn from lower priority clients. Community Options, on the other hand, has the flexibility to pay a local person to drop in on a frequent basis at quite low cost because it does not have to abide by the award conditions of the Home Care Service. This placed Community Options at a great advantage, as it became clear from our interviews, but also served as a tempting incentive to use the private services, which are not normally covered by the same conditions.

This kind of activity was characterised by service providers as meeting the needs of the person rather than being constrained by the rules of the service. Indeed this is related to another issue which was raised. That is, that Community Options is person-oriented and can be so precisely because it is separate from a service-delivery organisation. Its creativity and capacity for innovation and experimentation are able to flourish unimpeded by the rules governing the more established services which, it was sometimes held, tend to stymie any personalised approach to human service delivery. Thus, whilst some service providers felt that the functions of Community

Options could be performed just as well, and quite often better, by another of the established services, others saw the independence of Community Options as one of its most important features.

Of course ultimately it was the extra funding that was seen as the factor that gave Community Options the flexibility; not just the extra money, however, but the unfettered way in which it could be used.

The flexibility is exemplified in another way. Community Options points the way to the possibility of a partnership between the conventional services, Community Options and the client at the financial level. An example of this is provided by the case of a quadriplegic, recently discharged from a rehabilitation unit. It was clear that this man and his wife were going to require a great deal of help when he returned home. A series of joint meetings between Community Options, the services to be involved and the man and his wife produced not just an action plan but a way of distributing the responsibility, including the financial responsibility amongst all parties in a way that they felt comfortable with. These meetings also, it appears, had the effect of providing all parties with more confidence, because they were sharing a problem, which involved a risk for them all: a risk of the plan failing, a risk of financial over-commitment, a risk that providing this very high cost form of care would lead to the opening of floodgates. One anxiety that was raised was whether this was going to represent a form of care that all quadriplegics would come to expect. The money certainly would not run to that!

At this point it is relevant to mention that a few of the service providers approved of what Community Options could achieve, but felt that it was an elite and inequitable service. 'It's great for those who can get it. But what about those, equally disabled, who can't?' We shall return to this issue later.

The importance attached to flexibility was pervasive and crossed service and local boundaries. However it did seem to be expressed with the greatest force in remote rural areas, and many of the most telling examples of what the flexibility of Community Options had achieved were given by service providers working in such areas. There was a consistent picture of very elderly people, very much attached to their homes, living in isolation and though fiercely independent, fearful of the hazards of that isolation, indeed immensely insecure. The picture was drawn of Community Options coming to the rescue, and by the simple act of installing a telephone or a Vitalcall system, ridding old people of their fear that they might die in the night without anyone knowing. We heard about other ways in which such fears and loneliness had been alleviated. One method, highly praised by service managers in the Glen Innes area, was to arrange for a local friend or neighbour to come in, on a regular, reliable basis every day, merely to say 'goodnight' and 'good morning'.

Loneliness and insecurity could, it is easy to see, be enough to put someone into an institution. These rather simple devices, which may nevertheless require some imagination and a great deal of time to arrange, appear, on the face of it, to be both cost effective and humane ways of delaying institutionalisation until the frailty of the

individual increases to such an extent that only full time care would make it possible to remain at home.

What we heard, particularly in the Glen Innes area, did not come from the Community Options project but from other local services who generously recognised the contribution of 'Options' but sometimes claimed that they could have done exactly the same given the resources. On some occasions it was felt that the funding limits of Community Options should be raised for people with very expensive needs, to enable them to provide support at the margins of home and institutional care for a longer period than their current funding limits allow.

This leads to another issue that was raised. When families see what can be done to maintain their elderly members at home for a longer period with the help of Community Options, they are more prepared to act in a concerted way as a family to take on the financial responsibility themselves, or to share it with the client. They have, so to speak, been shown what can be achieved and having had this proved to them, are prepared to make the attempt themselves. This positive by-product was only mentioned on one occasion, but it is worth mentioning as a possible, if unproven spin-off.

In addition to its flexibility, Community Options was seen as performing a very positive role for carers. Even those who were sceptical of Community Options for reasons that we shall pursue later, admitted to the very important contribution it made to carers, in particular, on account of the respite care it could organise and sometimes pay for. Indeed in some, though admittedly a limited number of cases, it was possible to gain the impression that the service was intended for carers and that it is the conventional services that more appropriately looked after the needs of the client. This seemed to be a view that was most commonly expressed by the community nurses and we should not be surprised at this for their service is, of course, very much focused on the 'client/patient'.

Theme 3: The Advantages of Community Options Over and Above Other Services, as Far as Clients and Carers are Concerned

This theme is, of course, closely connected with the previous one and, as we might expect, many of the features that are perceived as benefiting the clients and carers are also features that other services are perceived as either possessing not at all or to a lesser degree than Community Options. Only one service provider, a manager of a Home Care Service, thought that Community Options had no advantages over other services. All the others conceded that it did have advantages and, for the most part, these were seen as stemming from the greater resources of Community Options. This is what enabled Community Options to do the many things that gave it its advantage over other services for example 'to provide extra care', 'to set up packages of care', 'to fill in the gaps', 'to buy from other services', 'to buy private services, including "one-off" goods and services'. And of course its flexibility, which we mentioned earlier, is undoubtedly also perceived as being derived from its

extra funding. A couple of service providers said that its additional funding was Community Options' only advantage and that 'if we had the money, we could do what they do' but this was not a commonly held view. Sometimes, having the ability to know how to use the extra money was also acknowledged as an attribute of Community Options.

Another advantage Community Options was perceived as having, was time. A number of service providers attributed the excellence of the Community Options service to the relatively small case load, which gave Community Options co-ordinators the time to attend in great detail to their clients' needs. This question of time was clearly a thorn in the side of some service providers particularly, it seemed, those who worked for the Home Care Service. On a few occasions we were told that the Community Options co-ordinators seem to have the time to be on the phone to them continuously! One manager noted that they had more calls from Community Options co-ordinators than they did from clients. We were told how the Community Options co-ordinators provided their Home Care Service colleagues with detailed biographical accounts of clients that they simply did not have time to listen to, and knew about anyway! On occasion we were told with some glee that now that Community Options was more established and had 'filled its books' the co-ordinators did not have quite so much time on their hands, and now knew what it was like to be a Home Care Service co-ordinator with 300 clients to provide for. We will discuss in a little more detail later the issue of inter-agency relationships.

But the smaller case loads and the extra time that was seen to result from these, were also viewed positively. Their capacity to provide a personal service, where other services are impersonal, was noted. The Geriatric Assessment Teams in particular paid tribute to Community Options on account of the confidence they felt in placing a client in their hands, knowing that client would be closely monitored. In nearly all cases members of the Geriatric Assessment Teams had considerable regard for the care, assessment skills, capacity to co-ordinate and monitor services. There were, however, marked exceptions to this favourable view which we shall discuss later.

A further positive feature of Community Options vis-a-vis other services was its capacity to understand family dynamics and to deal with client/carer conflict. Some service providers paid tribute to Community Options' holistic approach. On the other hand, some felt that Community Options co-ordinators could be too lenient and were not sufficiently insistent that other members of the family shared the responsibility of caring.

It is perhaps worth noting that the question of asking service providers to discuss the relative merits of Community Options vis-a-vis other services lends itself to the articulation of feelings of envy and the stronger emotion of resentment. As we have already noted, some of the service providers we spoke to wished that they could do for their clients what Community Options co-ordinators were able to do for theirs. But others strongly resented the fact that the extra resources had gone to Community Options and not to their own service, which they said they not only needed, not only deserved, but could actually use more effectively than could Community Options.

This latter reaction was by no means universal amongst the community nurses, who in some cases were extremely favourably disposed towards Community Options, but it was undoubtedly a view more commonly held amongst community nurses than by either members of the Home Care Service or Geriatric Assessment Teams. This resentment was sometimes coupled with the view that Community Options did not actually know what they were doing. They simply did not have the professional expertise to intervene as effectively as community nurses, or to make an informed judgement about the appropriate intervention or course of action.

Theme 4: The Difficulties and Problems of Community Options, as they Affect Clients and Carers

The majority response on this issue was that Community Options did not involve any difficulties for clients and carers as far as the respondent was aware. However, the main problem perceived was the over-zealousness of the Community co-ordinators. Representatives of all services said this but it was most commonly said by Home Care Service managers. It would appear that two main issues are involved. The first is that in the initial stages, Community Options presses unwanted support on people who are too weak to resist: that clients are taken over by over-enthusiastic co-ordinators, sometimes to their utter confusion. From relative neglect, the home becomes a hive of activity which people who are not very well sometimes have a great deal of difficulty coping with, but feel at the same time that it would seem ungracious and ungrateful to refuse. This type of over-servicing (not to be confused with the sort of over-servicing which it is believed makes the client over-dependent) has an added danger because it is sometimes associated with the withdrawal of services, once the Community Options co-ordinator realises that she has over-extended herself. As we were told by one Home Care Service manager, 'Community Options would do better with a "slowly slowly" approach. It is much less painful to add to services than to withdraw them'. Of course, we have no evidence one way or the other, but further analysis of the Minimum Data Set might provide clues, if no strong evidence, as to whether or not services are being withdrawn from clients and, if this is the case, whether it is on account of reduced need or over-extension.

Associated with the problem of over-servicing is that of over-assessment. Some services, though not blaming Community Options, expressed considerable concern at the number of assessments that some clients underwent in order for their eligibility to a service to be assessed. Whilst we found some examples of the Home Care Service and Community Options doing joint assessments and of the Home Care Service accepting, usually only initially, but sometimes in the longer term, an assessment undertaken by Community Options, this was not standard practice. We have come across some attempts to design an inter-agency assessment form but it seems that in this context there is quite a long way to go yet.

A further problem arose reasonably often because the eligibility rules for Community Options proved to be not sufficiently well defined. Whether or not a

person was accepted as a client could sometimes appear to be quite arbitrary. This was associated with the complaint made (in only one area) that Community Options do not assess clients until they are in a position to accept them. For this reason there can be no prioritisation or balancing of one person's needs against another's. Again we are not in any position to do more than report this complaint. It is worth noting, however, that there were no complaints in any area that Community Options was accepting clients with an insufficient level of need. Some people said that Community Options **had** been guilty of this in the past, when they had been very eager to get up their numbers at all costs but now that they were more established, and sometimes even had waiting lists, they were being much more careful.

In the North East New England project a specific local matter was raised. There was some feeling that in towns other than Glen Innes there was no local person to whom clients of Community Options could easily turn if they wished to discuss their services or make adjustments to them. Contacting the 'lady in Glen Innes' involved making an STD call and this was felt to be all too much for many of the elderly clients. According to this view, which, it should be noted, was not held unanimously, Community Options in this area is too highly centralised and would be improved by local representation along the lines of the two North West projects.

Theme 5: How Useful is Community Options to the Services and What are Its Strengths in Relationship to the Service Agencies?

Our over-riding impression was that, with few exceptions, other services perceived Community Options as being extremely useful to them primarily because of its additional resources. It tended for this reason to be seen as the hand maiden and enhancer of other services, conceived of as useful because it can take the load off other services and meet needs which they can identify but cannot satisfy. It is in such circumstances that the services appear most likely to refer clients to Community Options. Our enquiries suggested that it was the other services who referred clients to Community Options rather than the reverse and it was their inability to meet needs they had identified that led them to call upon Community Options. Sometimes this was articulated in fairly crude terms: 'We say what's needed and they will normally do what we ask'. Others expressed the same view more gently. One person said: 'Community Options is extremely useful. It enhances the overall capacity of services. I can do so much, but it's not easy to keep clients at home. I need Community Options to help me keep a person out of an institution'. Another person said: 'We see the need for extra services, but we don't have the money to buy them. Community Options does.'

Thus the responses to this issue are very much echoes of those the service providers gave for clients and carers. Some of the managers noted the rigidities of their own service organisations and that Community Options had a greater flexibility to meet needs, to fill the gaps left uncovered either in terms of additional service or services to meet unique needs or those that do not fall within the terms of reference of the conventional services. In other words, by and large Community Options is seen as

making good the deficiencies of the other services, rather than having a role in its own right. Remarkably few people mentioned the co-ordination, monitoring or advocacy roles of Community Options, and when these roles were recognised it was construed as a matter of helping out the service. 'They can take the case management role off us'. In a few instances the managers spontaneously noted the degree of collaboration that exist between themselves and Community Options to meet the clients needs. 'We work well together. We're one team'.

Of course, particularly in the case of the Home Care Service, their role as an additional source of funding was noted. One manager said that Community Options can provide her 'with the financial backing'. Another said: 'They help us out when our funding is tight'. The short term basis of these arrangements was usually noted in this context. One Home Care co-ordinator said that if Community Options would agree to pay for a 'live in' for one high priority client, this would enable her to help 10 of her lower priority clients for whom she would not otherwise be able to provide. This co-ordinator noted that although these 10 clients may appear to have a relatively low need for service, the small amount they received provided them with support and companionship which, in the long term, could delay their admission to residential care. This particular co-ordinator had received a considerable amount of money during the previous year as payment for the services of staff employed by the Home Care Service. She valued this money greatly. This provides a very good example of the indivisibility of service and client interests and goals as these were perceived by the manager. However, in some cases, as we shall see, these financial transactions and manipulations were seen as being more trouble than they were worth.

Theme 6: The Difficulties Services Experience with Community Options

In the area of difficulties with Community Options, a large number of problems were raised but no particular issue dominated.

Most Home Care Service managers described how the relations between their service and Community Options had, in the early days, been characterised by very considerable tension. It would appear that the respective roles of the two organisations had never been clearly spelt out to either of them and many of the disputes had been over territorial boundaries. The majority of managers quite openly described their early resentments of Community Options which seemed to have the same role as they did but with smaller case loads and more resources. The situation was clearly ripe for disagreement. However, despite occasional friction and the small underlying resentments which do still seem to persist at the level of co-ordinators rather than managers, according to every single account, the tension has considerably diminished and relations have improved beyond recognition. In most cases this seems to have come about simply by the healing process of time and by working together in ways which have clarified the distinctive and overlapping roles - by case reviews, by joint assessments and by the immense amount of phone contact which characterises their relations. Cooperation has been shown to be mutually

beneficial, though perhaps in different ways, to the goals of the two organisations. However, in the case of the Home Care Service in Newcastle, although relations seem to have improved between the two organisations, it was pointed out that Community Options added greatly to the work load at the administrative and bookkeeping levels of the Home Care Service, particularly when the cost of providing the service for a client was being shared.

The source of the problem seems to be better understood by all parties and much more solid foundations for cooperation are now being built. In a limited number of cases, efforts to improve relations are much more contrived. One or two of the managers described the planning and case review meetings that have been set up between the agencies. Managers of these services usually placed a great deal of emphasis on the value of regular and good communication between the services. In one case the improvement in relations was attributed largely to the recent co-location of the two services. This provided the conditions for both easy and informal contact between the staff of the two services. There was an opportunity to get to know each other as people rather than mere functionaries.

It was not only the Home Care Service which described the amount of extra work that Community Options involved. Simply having another organisation to liaise with in the management of a client's needs was noted by other agencies as involving extra work. Community Options were, on occasion, criticised for the insufficiency of the feedback on clients that they had taken on; that they would set up services, but fail to inform the agency which had referred the client to them. When the same service is provided by different personnel to one client the opportunities for conflict between the 'hands on' staff are clearly numerous and the resolution of these conflicts will call for discussion and negotiation between the administrative staff of each agency, which many complained was extremely time-consuming. Some felt that if Community Options simply gave them the money they could take entire control and all the additional bother could be avoided.

The use of private agencies was a source of some irritation, particularly, though not universally or exclusively, to community nurses because of the extra liaison work entailed and because further public resources were being diverted to unvetted, private, profit making organisations. This rankled with many nurses who were inclined to attribute the over-servicing of some clients to the use of private services. In other words, seen from this standpoint, the use of private services had several problems. It deprived the nursing service of resources they could have used to good effect. It led to over-servicing because it was in the interests of private organisations to over-service. It led to service of poorer quality and certainly service over which there had been no professional quality control. In general, the Home Care Service did not appear to feel nearly as strongly about these matters as the community nurses.

Many of those who were clinically qualified, as well as alleging over-servicing, charged Community Options with indulging clients. Their argument asserts an authority based on training and experience, which in their view equips them

professionally to identify clients' clinical needs. They also adopt an active therapeutic stance, insisting on the goal of maximum possible self reliance for the patient/client. What is possible in the circumstances of any given case is something, they would argue, their training enables them to judge. Community Options co-ordinators do not have this capacity, by and large, as they have no clinical training. They have no basis on which to assess the true potential of their clients, and are therefore more likely to provide things which make the clients' lives easier, without encouraging or enabling them to achieve the greater independence of which they are really capable. Self-determination and choice are Community Options watchwords; but people tend to choose what they find most comfortable, which is not necessarily what is ultimately most enabling. So the argument runs. One of the illustrations offered concerns the characteristic means by which Community Options will help a client with incontinence, that is, by providing pads, frequent showering and a linen service. However, they do not get the client involved in programs which may, at the very least, make the incontinence a more manageable condition. In other words, resources are used to support a condition which may be remediable. And this happens because the co-ordinator does not know enough about the condition of incontinence. In the long run, the Community Options course is neither cost effective nor in the best interests of the client, even though it may be precisely what the client wants. Another example was provided from the area of cognitive impairment. Some conditions associated with such impairment are known to be reversible. Community Options co-ordinators are not sufficiently *au fait* with the area to know how it can best be handled. Those who criticised Community Options on these grounds tended to argue that at least one of the staff of all projects should have a nursing qualification. Another view, very strongly held by some members of Geriatric Assessment Teams, was that all Community Options clients should be referred to a Geriatric Assessment Team and that there should be continuing consultation between the two services.

Another area of difficulty, already noted, was that Community Options was held by some to be an inequitable service. For a select few, it might be quite excellent but they remained few and they were not necessarily those in the greatest need of the service. We have already noted that the allegation that since not all referrals were assessed by Community Options they were in no position to know whether those they were accepting were the referrals with the highest needs. One view was that it would be far better to abandon the limit on clients and to confine any limits that were required to funding. Some justification for this view was provided on the grounds that while there were waiting lists of prospective Community Options clients the projects do not use all their subsidy money.

As we see later, an important requirement for a Community Options co-ordinator was held to be an extensive knowledge of local services and one or two of the projects received much praise on this account. They were clearly used as a source of advice by other services. However, this knowledge, it was conceded, could only be built up over time. One of the problems identified by service providers who had contact with the Aboriginal project was that it had not yet had sufficient continuity of staff to enable this essential expertise to be accumulated.

Another issue, clearly connected with the last, concerned the advantages of general familiarity with an area, its families and its culture. Some survey respondents held this to be an asset. Others regarded it as a pre-condition for the effective performance of the job of Community Options co-ordinator. It was argued that to do the job well one needs to know a great deal about the clients, their families, their resources, their social networks and so on. All this information comes from a good local knowledge which results from a close, long-standing association with a locality. This view was naturally most firmly expressed in the rural areas. However, there was not universal agreement. Others argued that long-standing local associations could lead to bias against or in favour of particular clients rather than objective appraisal of their circumstances and provided instances of such bias.

Theme 7: The Professional Qualifications and Special Skills Needed by Community Options Co-ordinators in the View of Other Service Providers

Some of the issues raised in the previous theme raise questions about the kinds of qualifications and skills that other service providers believe that Community Options co-ordinators should possess.

About half of the people we spoke to thought that it was important that co-ordinators should have some sort of professional training or a tertiary education. These people were more or less equally divided between those who thought the qualification should be nursing and those who thought it should be in social work or welfare. In all cases, those who thought that nurse training should be a requirement were themselves nurses. Those who thought that a professional qualification was not needed, or who favoured a qualification in social work, were most likely to be respondents working for the Home Care Service. Quite a number of people thought that a knowledge of the problems of disability and old age was important, especially of the pathology and medical problems associated with old age. On the other hand, two people thought that a professional qualification was a positive liability in a co-ordinator. The advantage of Community Options, they believed, was that it was based on common sense and was not disadvantaged by the kinds of professional misconception to which other service delivery organisations are wont to fall victim. One of these people thought that the required skills were good organising ability, a good understanding of the Program's philosophy and the strength to uphold the client's interests against other services. This person also considered that knowledge of the local community was a potential liability and predisposed the co-ordinator to take a less objective view of client needs.

It is of some interest that none of the respondents mentioned a professional training in management or administration as desirable, although the ability to manage, to administer, to negotiate, to talk to people about money and, above all, to communicate well, were all skills considered desirable for a co-ordinator. The capacity to assess and evaluate impartially was also held to be important. The possession of a close and detailed knowledge of local services and of HACC figured prominently amongst qualities required of the good co-ordinator. One of our

respondents argued that this knowledge should be held at the point of entry, rather than learnt on the job. It sometimes seemed to be the case that in listing the qualifications and skills that it was desirable for a co-ordinator to possess the respondents had in their minds the skills which they admired or thought were lacking amongst the co-ordinators in their own local Community Options project.

Theme 8: The Circumstances in Which Service Agencies Refer Clients to Community Options

We should perhaps not be surprised to discover that the circumstances in which services refer clients to Community Options are those in which they are unable to meet the clients needs themselves. This may arise, as we have noted, even though they themselves are providers of the services required. This would appear to be far more commonly the case with the Home Care Service than with community nurses. Whilst the Home Care Service will turn to Community Options for assistance when their own resources are exhausted, when they have reached their 'ceiling' or when the client lives in a remote location, community nurses appear to turn to Community Options only when the client requires a service or services other than nursing. Thus when Community Options supplements the nursing care for the client over and above the level community nurses are already providing, according to our evidence, this is likely to be a decision made by Community Options rather than nurses. It is perhaps not surprising, therefore, that the nurses seemed particularly ready to criticise Community Options for over-servicing.

Services will also refer a client to Community Options if they perceive that the client has needs which cannot be met by the conventional services, and there is a clear need to purchase a service from a private person or agency. Many of the 'one-off' goods or services fall into this category and we have seen how these tended to assume particular importance in the rural and remote areas.

Clients who have very high, multiple needs, such that they require a whole package of services are typically referred to Community Options to perform its role as service co-ordinator. As one respondent put it: 'To sort out the needs of people who might need services, because I don't have time to do it.' Not all respondents saw Community Options primarily as servants of the other services, doing the work that they did not have time to do. Some saw the co-ordinators as having a special skill and capability in the area of case management, with a broad knowledge of services and undertaking very careful and skilful assessments.

One of the ways in which Community Options seems to gain a fair number of clients is through the hospital discharge planner. It was about referrals of this kind that some service providers expressed particular anxiety. There were fears about the possible inability of Community Options to act, either because they were not able to take on further clients having reached their full capacity, or because they were not qualified to make judgements about the full range of needs required by patients recently discharged from hospital.

Theme 9: The Impact of Community Options on the Service Agencies

The questionnaire explored this issue from a number of perspectives; the general impact, the impact on the service agencies' practices and policies, on local service developments and on mechanisms set up to facilitate inter-agency relationships.

At the general level two trends could be observed, one of which from the point of view of the service agency was seen as positive, the other negative. On the positive side agencies saw that Community Options enabled them to provide a better service for their clients, to meet important needs which might otherwise have been neglected. In this regard they identify as strongly with the goals of Community Options as did the Community Options co-ordinators themselves, seeing Community Options as another resource to support people with high needs and cushion them against the risks of unnecessary institutionalisation. They were pleased that such clients were being provided with 'another option' and some spoke of the wider vision that Community Options had provided them with: that Community Options had taught them that other possibilities were available and that it was worthwhile to pursue these, even when this might be for a relatively short period. We spoke to no-one who did not support the objectives of Community Options though, as we have noted, a very few thought that the service as presently constituted was doing no more than duplicating other services.

It was recognised, however, that these advantages for clients were gained at a cost to the services themselves. The operation of an additional service agency clearly increased their work loads. Although Home Care Service respondents conceded that there had been some compensatory supplementation of their budgets by Community Options, none felt that this amounted to more than acknowledgement of the extra administrative load involved. It certainly was not regarded as full compensation.

We also asked about the impact of Community Options on service procedures, practice and policies. Whilst it is clear that at the central level there has been a considerable amount of attention paid to the interface between Community Options and, in particular, the Home Care Service, at the local level, except for some new forms to take account of inter-agency financial arrangements, there were scarcely any innovations in respect of procedures, practice or policies which respondents felt could be attributed to the advent of Community Options. One exception to this was a service record form which had been recently introduced in Liverpool. The form was kept in the client's home and provided essential biographical details and the schedules of the services which were attending the client. The design of this form had resulted, we understood, from the endeavours of the local inter-agency planning committee as a consequence of serious problems in inter-agency communication particularly at the 'hands-on' level.

We also considered the impact of Community Options on inter-agency committees and other mechanisms to 'oil the wheels' of inter-agency relationships. In most cases these links were established between the Home Care Service and Community Options at the level of case review, sometimes in the client's home, and discussion

of individual clients, mostly by telephone. In most cases Community Options joined pre-existing planning and case review inter-agency committees. In Liverpool, one view was that Community Options had served as a catalyst for the local bi-monthly inter-agency planning committee. The view expressed by one service provider of the way that co-location had a positive effect on inter-agency relationships in Wyong was interesting, because it suggests that natural groupings can be very effective and provide the scope for cooperative activity of the sort that Community Options is intended to foster.

An important concomitant of Community Options, though apparently not set up on account of Community Options, was the 'at risk' and neighbourhood committees through which, theoretically, all new clients of the North East New England Community Options were recruited. The purpose of these committees was, we were told, to optimise the use to which local community and domiciliary services would be put to ensure that resources would move towards those people at greatest risk of institutionalisation and particularly those living in isolated circumstances. The existence of these committees placed the Community Options in a very different position vis-a-vis other services from all the other projects we visited, in that it appeared to enjoy less autonomy. It appeared, at the same time, well integrated into the overall service system. One service provider expressed the fear that the 'at risk' committee could stand in the way of Community Options performing an advocacy role for clients since the very integration of Community Options into the service system could prevent it from mediating between the services and the client. On the whole, however, the services we spoke to appeared to favour the notion of 'at risk' committees but there is no concrete evidence, as far as we are aware, that they are achieving the desired client outcomes. Indeed this would be exceptionally difficult to establish. However, the effect of these committees on inter-agency cooperation did appear, in itself, to have positive spin-offs for services and for clients.

Questions connected with the impact of Community Options on the development of new service initiatives also yielded very little information. Whilst some of the initiatives set up by Community Options had been a source of considerable satisfaction to that organisation, they appear to have excited relatively little interest amongst other service providers.

In Newcastle, Community Options have been responsible for setting up a group consisting of local service providers who seek to identify local needs and gaps in services: an activity which was considered very useful by some but which was regarded by at least one of our respondents as rather insensitive and judgemental. This is an interesting reaction because, on the face of it, it would seem to have considerable value and to be just the sort of activity which Community Options, given its overview of the local services, would be in an excellent position to organise. One cannot help but wonder whether this criticism of the Needs and Gaps group was the natural resentment of the newcomer criticising the old hands.

The Men's Discussion Group in Wyong and the morning and night 'tuck-in' service, the wood chopping and leather craft classes initiated in the North East New England

project, the meals for Aboriginal people provided by the CDEP in Walgett were all mentioned with approbation. In the latter case the CDEP representative we spoke to was very pleased about the meals service, not simply because it provided ethnic-appropriate meals, but because their preparation, undertaken under the supervision of a TAFE cookery instructor, was providing training and useful skills for a number of unemployed Aboriginal women.

Examples of services actually initiated by Community Options did not come easily to mind and in certain cases, for example, the taxi vouchers in Dubbo, the community bus in Walgett and the ethnic meal service in Newcastle, respondents knew of their existence but were either not quite sure who had been responsible for setting them up or were not prepared to give Community Options the full credit.

It is also perhaps worth mentioning that some initiatives produce quite conflicting responses. We have already mentioned the case of the Needs and Gaps group in Newcastle. In fact some reservation was expressed by service providers in the North East New England area about providing leather craft classes from the public purse. This provides a good illustration of the way in which what one person sees as an exciting new initiative another may see as overservicing, and possibly an inappropriate use of public money.

Theme 10: Suggestions Made by Service Agencies for Improvements to Their Local Community Options/Live at Home Service

The list of improvements suggested by local service agencies was long and varied. Since it seemed that a good deal of useful information would be lost by attempting to summarise it, it is given here in full. A number of respondents suggested more than one improvement while a few felt unwilling to commit themselves to any.

Project 1

- They should increase it - Community Options should be for everyone and not just for a few.
 - It should be less selective and needs to be more preventative. They should look at what can cause early admission.
 - Haven't thought about it. Perhaps another staff member would increase the speed with which they could act and the number of people they could help.
 - We're short of resources. I don't know whether or not better outcomes would be achieved by putting the Community Options resources into the domiciliary and community services. We simply haven't got the information to say.
 - Works very well but other people who work closer to them than I do may take a different view.
 - Must be separately funded from HACC.
-

- The services should get together more.
- There should be joint assessments between services.

Project 2

- There needs to be more continuity of staff.
- More support from people at the top. They just don't have time to get around to the staff on the ground.
- It would be better if they could share the administrative staff with other services because there's a real shortage of people with the technological and administrative skills here.
- I'd like to see them publicising themselves more so that other services know about them.
- They should explain their role more.

Project 3

- I'd like to get rid of the split between the administrative and the co-ordinator positions so that one person did both.
 - I'd like enhancement money for the other services.
 - There should be more Community Options funding for high need clients who have intensive short term needs.
 - Much better communication about such things as what has happened to the people who have been referred to Community Options i.e. what action they have taken. We are often kept in the dark, there is an absence of feedback.
 - We'd like to know what the state of play is with Community Options funding, i.e., what we can and can't expect to get out of them at a given time and also in the short term.
 - Would like a co-ordinator in each town served.
 - Community Options should have the authority to define their own priorities and these should not be defined by an 'at risk' committee although the committee can usefully provide direction and influence Community Options priorities.
 - I can't fault our project.
 - I would like more funding from Commonwealth.
 - The staff need more training in how to approach clients.
-

- Needs a better knowledge of services available.
- The service has been slow to get going and needs more time, as does the program.
- The insistence that services are bought at greater cost from Home Care and Community Nursing restricts innovation and creates tensions.

Project 4

- Palliative care should be included and so should the 'no growth' areas. They don't service everyone they should.
- Pretty good as it is.
- None. It runs very well, although not all the services in this area have this view.
- The Community Options manager is excellent. Known very well locally. You wouldn't want a stranger coming into this territory.
- More consultation and sharing of information with GAT.
- There should be only one assessment procedure. We need to trust the Community Options assessment.
- More attention should have been paid to health. There needs to be a blend of professional skills.

Project 5

- A medical component should be added to the program.
 - Less duplication of services and more brokerage for services that do not exist.
 - Would do well to fund through services such as Geriatric Assessment Service, where management structure exists.
 - Community Options should be able to take on more clients.
 - It needs more funding.
 - They need to review their waiting list and assess all referrals so that they can prioritise.
 - We've worked through the problems but still don't understand how they deal with their waiting list.
 - Regular formal meetings to promote better understanding of the services.
 - Restructuring of the funding mechanisms to allow more flexibility.
-

- Restructuring of the organisation in terms of lines of communication and accountability so that Community Options is affiliated to Geriatric Assessment Team.
- Regular liaison at team meeting level and case conferences.
- They should develop formal mechanisms for liaison and co-ordination, rather than informal networking.
- There should be an increase in client numbers.

Many of these suggestions for the improvement to Community Options have already appeared in another form in the body of this report and will reappear in the summary of our findings below.

4.3 Summary of Findings

We now attempt to draw together the threads of our account and to identify some of the main issues to have emerged in the course of our enquiries. These issues are not necessarily those that occurred with the greatest frequency in our discussions with service providers, although in certain cases they did. Rather they were the ones to which we would attach the greatest weight in so far as they would appear to have the most significance for policy and practice.

One of the most powerful impressions we gained from the research was that the **notion** of Community Options meets with almost universal approval, across regions and throughout service agencies. Furthermore we spoke to a large number of people who believed that their local Community Options project was doing a very good job. One person said: 'I can't complain about them. I just feel envious' (a nurse), and in a more positive vein: 'I've become aware that when you hit a brick wall, that doesn't have to be the end. If the client is the focus and can stay at home for just one day longer, there should be a means of doing that and Community Options has made me aware that by working together we can achieve that' (a nurse).

There was widespread support for Community Options goals of providing people with the **option** of remaining in their own homes for as long as reasonably possible while relieving carers of some of the accompanying stress. It was generally recognised that it is for precisely these purposes that Community Options has been established as a program. In addition, it is broadly acknowledged that either because of their high needs (and those of their carers) or special needs that may exist because of their poverty, their geographical or social isolation, or their particular disability, such people often need support over and above the amount and type that the conventional services are currently able to provide. In describing Community Options the word most commonly used in its favour was **flexibility**. We have earlier explained the various meanings attached to this word by the people we spoke to. It was also acknowledged that many high risk people need a **package of services** and that, to bring this about, someone is required to act in a case manager or co-ordinator

role. Also, although it was not always mentioned spontaneously, we do not think that many people would have disagreed that the needs of people with severe disabilities need to be closely monitored. Indeed, especially amongst the respondents employed by Geriatric Assessment Services, the monitoring role was not only seen as important but as one Community Options staff performed very well. These respondents described their 'confidence' in Community Options staff as careful monitors of their patient/clients who were 'at risk'. Hence, in terms of its broad objectives and of its constituent elements, namely, resources, co-ordination and monitoring, which together constitute the prerequisites for achieving the Program's objectives, we found no argument.

The issue of how all this is best achieved, that is, its practical implementation, is far more contentious. In this context, the survey identified issues of two broad kinds; those concerned with practice and those concerned with planning or resource allocation. These issues are conceptually separate but also inter-connected.

What we present here are merely people's views and we need to be aware at the outset that these are very much influenced by their experience of their own local Community Options projects and by the nature, amount and the quality of their interaction with the staff of those projects.

A New Service. It is perhaps worth mentioning that the quality of the interaction between the staff of Community Options projects and other agencies did vary but that most respondents mentioned that there had been a marked improvement since the inception of the project. In no case was a deterioration in relationship mentioned. However, the potential for friction was recognised. More than one respondent observed that services were highly territorial and tight about sharing information. It was noted by some that the key to working well together is a high level of communication and that this is something that has to be worked for. One view was that mechanisms need to be established deliberately to facilitate this communication. However, in our experience, such mechanisms, deliberately set up with Community Options, are unusual. It is more common for Community Options to join existing inter-agency committees. Most improvements in inter-agency relationships did seem to have occurred simply over the passage of time, as a result of the frequent need to talk about clients' needs, as a shared concern. Sheer physical proximity was also identified as a facilitator because it made for casual and informal contact which clearly made the establishment of effective working relationships easier.

An improvement in relations was also attributed to the mellowing of what had been perceived in some cases as the rather ostentatious enthusiasm of Community Options in its early days coupled with what was construed as implicit criticism of the competence, the bureaucratic style and sometimes even the meanness of other services. A view was conveyed, sometimes with a hint of furtive satisfaction, that 'Community Options have become a bit more like us. They too have had to lop people off. They too have learnt the hard way.' Certainly it was noted that the relatively small case loads and extra resources of Community Options were not

conducive to good relations since on the face of it they place Community Options in an immensely privileged position vis-a-vis other services. It took some time for other services to learn that these apparent advantages implied a completely different role from theirs. Some respondents noted that they had been insufficiently briefed at the inception of Community Options about its role and principles. Some said that they had not even been told about Community Options 'purchase of services.' These ambiguities, so long as they have remained unresolved, have not been conducive to good relations.

Early over-enthusiasm was sometimes manifested, according to some respondents, in another way. This was to offer clients too many services, which were sometimes almost pressed upon them. We were provided with descriptions of how this enthusiastic activity sometimes led to the utter confusion of the clients who were having to accommodate an excess of service providers in their homes, certainly not understanding the source of this generosity, or knowing who, amongst the many service personnel, was actually who, or who was actually doing what. We were told by some respondents that this initial over-enthusiasm was sometimes followed by a withdrawal of services once the Community Options co-ordinator realised that she had over-extended herself financially. We have no means of knowing how general the practice may have been. We did, however, notice a tendency for one or two repeatedly cited instances of inappropriate servicing to be treated as the basis for a belief that the practice was general.

Equity Issues. One concern, not entirely unrelated to the previous one but associated as much with principle as with practice has to do with the apparently inequitable benefits of Community Options. A recurring theme, not raised by a majority but sufficiently often to be deserve comment is that Community Options is 'great for the lucky few'. It was thought that those who are clients of Community Options are privileged because they are the recipients of resources and attention over and above the amount received by other people in equivalent circumstances who are not helped by Community Options. We were not provided with any documentary evidence of this, although it would be possible, in principle, to obtain. Nevertheless, the small number of Community Options clients in relation to the very large number of people in the community with severe disabilities makes this an entirely plausible complaint. It was a criticism sometimes accompanied by further related reproaches. First that other service providers had no way of knowing how Community Options actually selected their clients and that it all seemed to them rather ad hoc and arbitrary. 'We just don't know who they'll decide to take on and who they won't'. In one locality we visited, a number of different service agencies complained that people who were referred to Community Options simply joined a waitlist without being assessed. The project did not prioritise its waitlisted clients according to need, which meant that there was no evidence that they were helping clients with the greatest needs. If this is correct, the solution would seem to be a simple procedural one, but it does not, of course, address in its entirety the problems of inequity. One solution offered was to increase the number of clients that Community Options is permitted to accept. It was held that it would be less inequitable to place a ceiling on funding than on clients. Others put forward no solution to the problems of inequity.

It is indeed a question that lies at the very roots of service delivery and resource allocation. Although the question of inequity must raise some concerns, at least some reassurance can be gained from the fact that there were no accusations that the clients of Community Options were not of sufficiently high need as to merit being part of the Community Options clientele. Maybe, it was sometimes said, they had been in the past, but now that the projects were being forced to be selective, this was no longer the case.

Assessment. In this context it is perhaps worth noting that the 'at risk' committees and neighbourhood committees that had been established in one of the localities we visited were conceived as one method of attempting to ensure that at least the relative needs of a group of clients were discussed in an open forum with a view to optimising the resources of all participating service agencies and of channelling those clients with multiple needs or special needs, that were sometimes related to their geographic isolation, to Community Options.

At the level of practice one of the most far reaching problems with important implications for planning and resource allocation was associated with the view, held primarily **though by no means universally** by clinicians, (that is those working in the Geriatric Assessment Teams and those working in the Community Nursing Services) that Community Options staff although they may well be capable of setting up an appropriate service package, are not suitably qualified to decide what services clients really need. This view was by no means confined to one locality. Amongst this group of respondents there was the view that Community Options tends to indulge clients by providing them with what they want rather than with what they need. This, they argue, is not only not cost effective, but can be positively disabling. A person who does not receive the correct treatment, for their incontinence, for example, can deteriorate unnecessarily. Some thought that it was inappropriate for public money to be spent on indulging people's wants rather than meeting their needs. This indulgence, it was noted, was often achieved with the use of private agencies which had a commercial interest in delivering as much service as they could sell, whether it was needed or not, with no guarantees as to quality.

In one sense this argument highlights quite fundamental philosophical, professional and even cultural differences between services. It was held that whilst Community Options uphold the values of self determination and choice, the clinically-oriented services place a great emphasis on self help and independence. The charge of overservicing, frequently directed at Community Options, was almost always represented as a denial to clients of the opportunity to achieve their full potential.

One implication of the above argument, most frequently, **but by no means universally**, articulated by community nurses, was that the resources that Community Options currently has at its disposal would actually be better spent if **they** had control of them. This, they argue, is because Community Options was attempting a task for which community nurses are actually better qualified as they have the training, the experience and hence the expertise to assess the clients' real needs and to determine how best to meet them. It is their job, they argue, to deal

with the clinical problems of the aged and the disabled (and their training now includes an understanding of the broader social problems of these people). As clients of Community Options are, by definition, people with medical problems, nurses are obviously the people to deal with them. Giving the resources to the nurses would also be cost effective, because they would be in a better position to prevent admissions to acute care, which, they note, is well known as the most expensive form. This group of respondents is not denying the inherent value of the objectives of Community Options, but merely observing that the resources supporting the Program are misplaced. As we have pointed out this view was not held by all the community nurses, indeed we came across some who felt that Community Options made a better job of assessment and intervention than they did themselves.

A more agnostic view was that it has simply not been shown whether the resources should go to Community Options or to the existing services, (although it was conceded that nurses were inadequately funded). The point is that there is no evidence about relative outcomes.

We noted earlier that some members of the Geriatric Assessment Team also felt that Community Options staff were insufficiently qualified to undertake the role of assessing people's needs. However, as non-service providers this view did not lead them to the same conclusions as the community nurses. An important component of their complaint, (and we should note that members of the Geriatric Assessment Team whom we interviewed were amongst both the most and the least favourably disposed to Community Options) was that Community Options staff tended to operate too independently and that they were not sufficiently accountable. Operating in isolation they were not able to benefit from the kinds of professional support and cross-fertilisation of ideas which could contribute to their much more effective operation. Those who espoused this view felt that it would be preferable for them to have some association with a Geriatric Assessment Team, in such a way that, for example, all their clients were automatically assessed by a Geriatric Assessment Team and a management plan for the client could be devised jointly and then implemented by Community Options. One view was that there were three areas definitely requiring clinical assessment and intervention. These were incontinence, mobility and dementia. Once the management plan was set in motion, the Geriatric Assessment Team should have some role in its ongoing monitoring.

The Geriatric Assessment Team and Community Options, it was noted, clearly have a great deal in common. Neither is primarily a service delivery organisation. Both are in an overarching position and in their distinctive ways, have as their main functions the assessment of clients' needs and devising or exploring ways of meeting these needs. A view held almost universally by GATs and by some other service providers, was that Community Options should be interlocked with the Geriatric Team. In this way the medical and social, both so crucial in the treatment and support of people with disabilities and of frail elderly people, could be interwoven so that the diagnostic and clinical skills of the GAT were combined with the social assessment, case management and advocacy skills of Community Options. This group of respondents was not implying that they should take over or receive the

resources of Community Options, but that Community Options would benefit greatly as a service organisation by some sort of formalised association with them. However, it was thought that Community Options would resist this suggestion, finding it unacceptably restrictive because it might constrain them from acting with that very autonomy which they felt gave them their strength and value as an organisation.

Service Organisation. Another view concerning the organisation and structure of services was also presented. We have noted that there was a tendency for services to perceive and use Community Options as their hand maiden. In this model Community Options is one amongst several more or less equal organisations with perhaps a little more clout on account of its extra resources. Another model was suggested. This is that all high need clients should be the responsibility of Community Options and that it should have first call on all services that they (and possibly the Geriatric Assessment Team) deem to be required. In this model, Community Options would occupy a much more commanding position than it currently does.

In some senses this position addresses one of the anxieties which was quite frequently expressed in connection with Community Options. This is, that it merely adds to the existing proliferation of community service organisations, all of which are basically trying to do the same thing. Community Options represented for some a duplication, a waste of resources and was enormously time consuming for the staff of the existing services. Associated with this was the issue of multiple assessments, a matter of great concern for a number of people we spoke to. Some services have, of course, tried to overcome this problem by the introduction of joint assessments in the client's home or even by the design and use of an inter-agency assessment form. But our impression is that this has met with little success. Accepting the assessment of another agency is seen as a concession or an expedient, not a habit to get into.

A view which strongly favours the Community Options model without opposing the case put forward above (but which would certainly run counter to the arguments put forward by some of the community nurses) also emanated from the Geriatric Assessment Service. This is that one of the most valuable attributes of Community Options is that it is 'people- not service-oriented'. The resources go directly to those who need it to meet their special needs. There are no rules governing how the money should be spent so long as it is spent to maintain them in the community. Thus the more rigid bureaucratic regulations governing other service organisations do not operate for Community Options. Of course, there are rules governing expenditure by Community Options, one of which is that the existing publicly funded services should be given 'first refusal'. However, there was a view that Community Options should not be forced to buy services from the conventional services; that it is in their interests and those of their clients to go to the cheapest suitable services of appropriate quality, above all those where the price is not industrial awards. This argument was expounded with particularly compelling force in rural areas where service delivery clearly presents very significant problems for the existing services. Of course, as was noted, the question of whether public money

should go directly into private services where there is no quality control, protection for employees or required standards was a cause for concern, again particularly amongst community nurses.

In a sense the complexity of the response to our questions reflects the complexities of Community Options itself. Community Options has a unique combination of roles. First, there is assessment which involves finding out what people's needs are. Second, it involves co-ordination which means designing and setting up a complex set of arrangements intended to meet the set of needs assessed. Third, there is its brokerage function which involves linking the client to a community organisation for services which must sometimes be purchased. Fourth, it involves actual delivery of service in terms of the purchase of one off capital goods or of private services sometime provided on a recurring basis. Fifth, it involves case management, which means monitoring the set of arrangements and altering those arrangements to meet changing needs. Sixth, it involves advocacy, which means the protection of clients interests in their relations with the services and sometimes also in their relations to their carers. No wonder, when other services have such overlapping functions, that there is sometimes confusion as to where respective responsibilities begin and end. In one sense the ambivalences and contradictions in perceptions, attitudes and relationships that we have identified reflect the ambiguities in the relations themselves and remind us that we are dealing with an exceptionally complex system in a constant state of change.

4.4 Concluding Comments

At the beginning of Section 3 we indicated that the two surveys will be treated as discrete entities, and that it will only be in the last Section that we shall attempt to integrate the findings obtained in the separate parts of the evaluation. Nevertheless, we shall provide here a brief, preliminary overview.

It is clear that the surveys have adopted different methodological styles; the first, on clients and carers, follows a classic survey design leading to a high degree of quantification, while the second, on service providers, uses a qualitative approach, involving a fair degree of subjectivity. Our own view is that the first approach, while it gives us a fairly clear picture of the characteristics and circumstances of the respondents and of their use of services, does not enable us to explore meanings in any depth. What is the meaning of being old, frail and housebound and of having to depend on others for so many of the things that enable one to stay at home? What is the meaning of having to care for people who are old and frail? How does all this affect the meaning of Community Options to those whose life it enters? Community Options, like so many other services is, on the one hand, a facilitator and on the other a reminder of inadequacy. Our survey does not provide us with answers to these important questions though it does offer clues at a more superficial level.

The Service Provider Survey, on the other hand, seems to provide a clearer picture of the meaning of Community Options. One might ask whether the difference lies in the research design or whether Community Options represents different realities to

different sets of respondents. What emerges from the two surveys may be merely a reflection of the fact that they view the field from different standpoints and that Community Options does have quite different meanings for clients and carers on the one hand, and for service providers on the other. For the clients, Community Options is represented above all by the person: Mary, Mike, Sue. Community Options is known through the person and will therefore be largely judged in those terms: his or her competence, reliability, usefulness, pleasantness, adaptability and so on. From the point of view of the clients, we discovered, Community Options is represented by a very helpful person (sometimes not distinguished from the other helpful people who come into the house) doing a variety of things to make life easier for clients, providing them with the help they need to enable them to remain at home a little longer than might otherwise have been possible, and giving them a little company. For the carers, Community Options is represented by the person who provided relief from some of the stress or the burden of caring and continues to provide an extremely convenient single point of access to services. Our survey suggests that carers are rather more aware of the coordinating role of Community Options than are clients. For clients and carers, though Community Options may not be grasped completely as a concept, it represents an enrichment, an extra resource, a form of enablement, personified by the co-ordinator. On the whole, Community Options was warmly praised by clients and carers. But it must be said that those from other services who, in their different ways, also helped clients and carers, were also greatly appreciated.

To the service providers, on the other hand, Community Options represents a set of administrative arrangements which are designed, by and large, to meet the same ends as those that guide their own services. It is this that provides them with their dual response to Community Options. It represents both something to be pleased about and a source of misgivings. In so far as Community Options is supporting people and enabling them to stay in their own homes longer than might otherwise have been possible, other service providers lend support to the program and readily concede that it is doing an important job. It is, after all, **their** job. Indeed they even say that Community Options should be extended, that it is at present too selective. Sometimes they express criticisms that suggest an underlying resentment. We heard from some service providers that Community Options was not doing the job quite as well as they could do it, given the right circumstances. We were told that the co-ordinators could be a little over-zealous, somewhat confusing to the old people, sometimes bringing in too many service personnel, and giving rise to too many assessments and so on. These were criticisms that were sometimes but very rarely echoed by clients and carers.

We noted that for clients and carers, Community Options represents an additional resource, an enrichment. For some service providers Community Options represents the opposite; a denial of resources which they feel should rightfully be theirs because they are expected to do the same job as Community Options, namely to maintain people in the community. As though to rub salt in their wounds, Community Options involves them in extra work, especially at the administrative level.

We have been at pains to point out in the analysis of comments from the Service Provider Survey that there was a wide range of views and that some service providers were unequivocally well disposed to Community Options. The views of service providers of different kinds were, in a general way, clearly influenced by the nature and functions of their services. There was certainly no unanimity of opinion among community nurses, for example, but it would be fair to say that there was a marked tendency for their responses to be coloured by a sense of their clinical role and its relationship to the medically defined infirmities of their clients. Home Care Service managers, on the whole, were more likely to think in terms of duplication of services and issues of resource allocation. Geriatric Assessment Teams were naturally alert to the intersection of their functions with those of Community Options, insofar as they involve decisions as to the selection of clients and the allocation of resources and services.

None of this is really surprising. Of course the views of respondents are likely to reflect the interests and preoccupations associated with their work. What is significant is the reminder this provides of the already structured service environment into which Community Options has made its entry. We are not merely talking about a variety of individual attitudes but about the realm of inter- and intra-organisational politics.

We should perhaps conclude this brief comment by drawing attention to an important point of agreement between the two surveys. This is that Community Options clients are people with very high needs indeed. There is little evidence from either survey that the service is going to the wrong people. One of the issues is whether it is going to enough of the right people.

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 Monitor⁹. 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 intertwining 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 unusable 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 interchangeability 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 or 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 be 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
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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.
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- 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
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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
