

Carer Support Programs



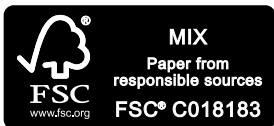
VICTORIA

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Auditor-General

Carer Support Programs

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The Hon. Bruce Atkinson MLC
President
Legislative Council
Parliament House
Melbourne

The Hon. Ken Smith MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the Audit Act 1994, I transmit my report on the audit *Carer Support Programs*.

Yours faithfully



D D R PEARSON
Auditor-General

15 August 2012

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Audit summary

A carer is someone who cares for a relative, partner or friend on an unpaid, informal basis. Carers enable many people to remain living in their homes and communities. This also reduces the financial burden on the health and human services systems. In 2010, Carers Australia estimated that informal carers provided \$40.9 billion in care services nationally. In Victoria, there are over 700 000 informal carers, including 194 000 'primary carers', providing support to someone for most of their daily living activities.

While carers contribute greatly to our community, they often do so at an emotional, physical and financial cost to themselves. Carers tend to have poorer health and wellbeing than their non-carer peers and can experience high levels of stress, anxiety and depression as a result of their care responsibilities. Younger carers and those of working age may miss educational or employment opportunities that then affect their ability to participate fully in the community.

Victorians will rely more heavily on informal care from family and friends in the coming decades. The population is ageing, and the prevalence of physical and mental illness is also on the rise. In addition, State and Commonwealth health and welfare policies continue the shift from institution-based services to community care, in recognition of the benefits of enabling people to stay in their own homes.

Given these challenges, carers need support to maintain their care role, and recognition for the contribution they make. The role of carers is an integral component to the efficient and effective operation of the health and human services systems. Supporting the sustainability and capacity of carers to maintain their role is therefore core business for system managers and service providers.

The Department of Health and the Department of Human Services fund a range of programs to support primary carers. The following departmental program areas provide and manage carer supports:

- the ageing and aged care and palliative care program areas in the Wellbeing, Integrated Care and Ageing division of the Department of Health
- the mental health program area in the Mental Health, Drugs and Regions division of the Department of Health
- the disability program area in the Disability Services division of the Department of Human Services
- the child protection program area in the Children, Youth and Families division of the Department of Human Services.

This audit examined whether the departments are effectively recognising and supporting carers.

Conclusions

The departments recognise carers as important stakeholders in the health and human services systems and the programs they manage. This is evident through the range of supports made available to carers. The departments and service providers also recognise the care relationship. They include and consider carers in policy and program development, and involve them in decision-making with the people they care for.

The departments recognise that supporting carers is core business. However, they do not treat their carer support programs with the rigour core business warrants. This is evident in gaps in data collection, the failure to assess carer needs, and a lack of outcome measurement. Greater rigour around carer support programs is essential to the ongoing development and improvement of these services. Effective carer supports are particularly important, as the departments' focus on supporting their clients to remain in their homes and communities is reliant on carers.

Carers experience barriers to accessing supports, such as poor awareness of services and difficulty navigating service systems. The departments' lack of referral processes, needs assessments, and prioritisation practices for carers across each of the program areas contributes to this. The department and service providers do not identify many carers who may benefit from support services. Inconsistent practices also raise the risk of inequity, particularly for carers trying to access high-demand services.

Despite clear program objectives, such as reduced stress or improved family functioning, the effectiveness of carer support programs is unknown. The departments do not monitor support programs against outcomes for carers and so cannot demonstrate effectiveness. This is a significant gap given the need for effective programs to support the growing community reliance on carers.

Findings

Accessing supports

The departments fund a range of carer support programs, such as counselling, respite and training. However, many eligible carers can miss out because there is limited awareness of available supports, and lack of assessment and referral processes.

Awareness of supports

Carers frequently reported to this audit that they lack awareness of the available supports. It is also a common finding of departmental evaluations of carer supports. This is despite demonstrated efforts by the departments and service providers to promote carer support programs, for example through print and web media and community expos or events. The departments have yet to attempt to understand what is not working and address the problem.

Carer identification and referral

The departments and their funded service providers do not consistently assess, either directly or by referral, the needs of carers they interact with to identify and provide assistance to those who may need and want support. It is therefore likely that some carers in need are missing out.

All program areas have systems in place to identify and record the existence of a carer. Three of the five audited program areas have guidance to prompt staff and service providers to assess carer need, or refer them for assessment and support:

- The Home and Community Care service, in the ageing and aged care program, has a standard tool to assess carer need.
- The palliative care program adopts national assessment tools for its service providers to use on a voluntary basis.
- The standard kinship carer assessment tool prompts the child protection worker to consider the carer's needs and whether they would benefit from a referral to a support service.

However, service providers and departmental staff do not consistently or reliably use the tools in palliative care and child protection.

Consultation with 12 service providers across the five program areas found there was no consistent use of a standardised tool for assessing carer needs. Better identification of carer needs, through referral and assessment processes, would facilitate carer access to supports. This information would also provide the departments with a more complete understanding of their carer population.

Equity of access

Departmental staff and service providers are prioritising carer access to supports differently, and in some cases, subjectively. Consistent prioritisation of carer need is necessary to assure equity and timely access to high-demand services for those in greatest need.

Brokerage funds provide carers with responsive and flexible financial support including assistance to purchase services or one-off material items. The departments are not adequately overseeing brokerage funds for carers, or providing enough guidance to the service providers distributing these funds. Variable practices are evident, such as different funding rules between service providers who are administering the same fund, unexplained variations in average amounts paid by service providers, and a lack of independent processes which allows the same staff to make and approve applications. These inconsistencies raise the risk of inequity for carers.

Timeliness of access

Wait time data is one indicator of the service system's ability to cope with demand. It can provide useful information to departments and service providers for service planning and development work. However, the departments and service providers do not routinely collect wait time data, which means that timeliness of access to carer supports is unknown.

Anecdotal wait times reported by consulted service providers indicate variable performance within and across program areas. Wait times are measured for one carer support only—case management in disability. Wait times for this service vary from just over a week to 12 weeks across geographical areas. Such variation makes it difficult for carers to have any expectation of how long they may wait for a support.

Experience of supports

The departments and service providers are effective in recognising carers and the care role in policy and program development and delivery. However, they cannot clearly demonstrate the effectiveness of carer support programs.

Carer recognition

There is clear departmental policy guidance to program areas and their funded service providers that states they must recognise the role of carers in their service delivery. Departments and service providers have demonstrated a commitment to realising this policy. Across the audited program areas, the audit found many examples of:

- the involvement of carers in program, policy and service development
- the involvement of carers in planning processes with the person they care for
- the inclusion of carer-related standards in quality assurance regimes.

Carers report varied experiences of recognition by the departments and service providers. Many carers we consulted related good experiences where they felt recognised. Some carers, for example, those caring for people with mental health issues, felt that awareness of their role has been increasing over the past decade. However, all had examples where this had not occurred, and in particular, where their needs as individuals were not always considered. These experiences indicate the ongoing need for effort to embed a culture of carer recognition in service provision.

Effectiveness of supports

The departments are not monitoring outcomes against program objectives to demonstrate the effectiveness of carer supports. Objectives of carer support programs include reducing carer stress, sustaining the care relationship, or improving family functioning. However, consultation with service providers revealed only isolated, ad hoc use of carer-related outcome measurement tools.

The departments have undertaken one-off evaluations of most carer support programs. However, these provide only limited assurance of effectiveness. Often evaluations do not address the objectives of the program, review only a narrow part of a service, and cannot determine effectiveness due to a lack of data on carer-related outcomes.

Recommendations

Number	Recommendation	Page
	That the Department of Health and the Department of Human Services:	
1.	identify and address gaps in the promotion of carer supports to improve carer awareness of services	15
2.	require consistent carer identification and needs assessment	15
3.	improve administration and monitoring of carer brokerage funds	15
4.	monitor and report on timeliness of access to carer supports	15
5.	develop outcome measures for carer supports and monitor outcomes.	26

Submissions and comments received

In addition to progressive engagement during the course of the audit, in accordance with section 16(3) of the *Audit Act 1994* a copy of this report was provided to the Department of Health and the Department of Human Services with a request for submissions or comments.

Agency views have been considered in reaching our audit conclusions and are represented to the extent relevant and warranted in preparing this report. Their full section 16(3) submissions and comments however, are included in Appendix A.

1 Background

1.1 Introduction

A carer is someone who cares for a relative, partner or friend on an unpaid, informal basis. They may care for someone who is aged, has a disability or mental illness, is terminally ill, or for a related child who can no longer live with their parents. A carer who supports a person in most of their daily activities, such as dressing, eating or social activities, is called a 'primary carer'.

According to the Australian Bureau of Statistics (ABS) in 2009, 703 000 people, or 13 per cent of Victoria's population, identified themselves as carers of an aged person or someone with a disability. Of this group, 194 000 identified themselves as the primary carer. The ABS figures do not include carers of people with a mental illness or those caring for related children, called kinship carers.

Kinship carers are family members who care for a child who can no longer be cared for by their parents. This arrangement can be termed 'formal', due to the involvement of child protection, or 'informal', if child protection is not involved. According to Australian Institute of Health and Welfare data, there were over 2 275 formal kinship carers in Victoria in 2011. The Department of Human Services (DHS) estimates that the number of kinship carers is approximately 10 000 when informal care is included.

Another carer group who are often unrecognised, as they do not identify with the term 'carer', are young carers. Carers Victoria estimates there are 105 000 carers under the age of 25 in Victoria.

Victoria will rely more heavily on carers over time. Census data reveals Australia's population is ageing, and the prevalence of physical and mental illness is also on the rise. As the number of people requiring care increases, and as health and welfare services have moved from institution-based to community care, society's reliance on carers will increase.

In 2010, Carers Australia estimated that informal carers provided the equivalent of \$40.9 billion in care services nationally. Care provided by informal carers reduces the financial burden on the healthcare and human services systems. To sustain the current trend of community and home-based care, carers need support to maintain their care role.

1.2 Carer needs

Carers are not a homogeneous group. They have different needs depending on their age, cultural and ethnic backgrounds and socio-economic status, as well as the needs of the person they care for. However, care responsibilities put additional strains on all carers and affect their financial position, social connections, and health and wellbeing. Commonly, carers are:

- more likely to live in households with below-average incomes. Carers of working age who have had to leave the workforce often experience immediate and future financial hardship, with lost income and less superannuation. Young carers can miss schooling and higher education opportunities
- more likely to have a disability themselves, with 35 per cent of carers having a disability compared with 22 per cent of the general population
- more at risk of mental health problems, such as stress or depression, than other people of the same age
- more likely to suffer declines in their physical health—in 2006, DHS reported that over 50 per cent of carers suffered a decline in physical health due to caring, 30 per cent reported physically injuring themselves, 70 per cent reported persistent low energy and 60 per cent reported feeling that their care role reduced their options in life opportunities.

The programs in place to support carers, therefore, need to be able to meet a range of needs, such as assistance with daily tasks, respite from the care role, and counselling and emotional support.

1.3 Carer supports

Common types of carer supports include:

- **Respite**—provides support for the person receiving care, enabling short-term breaks for carers. Respite care can include overnight stays in residential facilities, day-care or outings, in-home care, community programs, camps or other flexible arrangements.
- **Case management**—provides assistance with coordinating and facilitating access to supports and services.
- **Counselling**—provides emotional and psychological support for carers in order to reduce stress and assist with coping strategies.
- **Financial support**—provides assistance in the form of payments or brokerage funds for goods or services to assist carers to perform their care role.
- **Carer advocate/consultant**—provides advocacy and peer support.
- **Information services**—provide carers with access to information, such as: emergency services, carer support, domestic and nursing care, respite options and council services.
- **Education and training**—provides information and skills to assist carers to carry out their care role safely and effectively.

1.3.1 State-funded carer supports available

The Department of Health (DH) and DHS deliver a range of supports for primary carers. Figure 1A lists the state-funded supports available to carers, the funding provided, and available carer participation rates, as collected by departments. The Commonwealth Government also funds a range of carer supports, including carer payments and the National Respite for Carers Program that funds respite, support and counselling. It is a major contributor to Home and Community Care (HACC) services that carers, particularly those caring for older or disabled persons, can access.

Figure 1A
State-funded carer supports

	Aged care ^(a)	Palliative care	Mental health	Disability	Child protection (kinship carers)
In and out of home respite	✓	✓	✗ ^(c)	✓	✗ ^(e)
Flexible respite	✓	✓	✗	✗	✗
Case management	✓	✓	✗	✓	✓
Brokerage	✓	✓	✓	✗	✓ ^(f)
Support groups	✓	✓	✓	✓	✓
Counselling	✓	✓	✓	✗	✗
Education/Training	✓	✓	✓	✓	✓
State funding 2010–11 (million)	\$33.4	\$18	\$8.2	\$127.9	\$13.1
No. of carers accessing supports (approx.)	12 200^(b)	13 000	3 000^(d)	15 000	1 500

(a) Includes selected activities through HACC services and the Support for Carers Program.

(b) Approximate figures due to missing/incomplete records.

(c) The Commonwealth funds mental health respite services.

(d) Carers accessing carer support groups, counselling and training are not included in the figure provided as the department does not collect participation data for these activities.

(e) DHS does not fund a respite program for kinship carers. However, departmental policy states that respite is available to all children in out of home care. In practice, carers may be able to access it on an ad hoc basis through their own networks or volunteers within the foster care system. Respite carers can claim reimbursements on these occasions.

(f) Brokerage funds are available to support all children where child protection is involved, and so while kinship carers can access the funds they are not solely aimed at them.

Source: Victorian Auditor-General's Office.

The state allocates approximately \$200.6 million per year for these programs to support approximately 44 700 carers. This includes \$21.4 million to HACC respite and day programs through aged care, and \$89.4 million to disability respite. The aim of these respite programs is to provide support for the person receiving care to engage in activities (from a couple of hours during the day up to several weeks) such as community programs, camps, holidays, overnights stays, thereby providing the carer with a break from their role. HACC also provides personal care and domestic assistance services which some 40 000 carers can benefit from indirectly.

The remaining \$89.8 million goes towards supports that aim to assist the carer directly in their care role and as an individual, such as counselling, facilitation of support groups, education and training, and brokerage funds. Uniquely among the audited program areas, DH funds Carer Consultant positions located in Area Mental Health Services. Carer Consultants have lived experience of caring for someone with a mental illness. They can provide direct support to families and carers, as well as inform service and program planning activities at their service.

Volunteers play an important role in supporting carers in palliative care and disability. There is no current data on the numbers of volunteers in these areas.

1.4 Legislation

Carers Recognition Act 2012

The *Carers Recognition Act 2012* (the Act) is intended to recognise and support the needs of people in care relationships, and enact principles to 'promote understanding of the significance of care relationships'. This legislation brings Victoria in line with Commonwealth legislation and that of four states and one territory.

The Act acknowledges that carers are in a shared arrangement involving the person providing care and the family member or friend for whom they care. Each person in a care relationship should be respected, recognised and supported as an individual.

The principles supported in the Act include that a carer should:

- be recognised as an individual with his or her own needs
- be recognised for the social and economic contribution to the whole community arising from his or her role as a carer
- have his or her social wellbeing and health recognised in matters relating to the care relationship
- have the effect of his or her role as a carer on his or her participation in employment and education recognised and considered in decision-making.

Organisations receiving funds from DH and DHS to provide services or programs that directly impact on carers are obliged to make sure that staff and carers have an awareness and understanding of these principles and reflect them in developing, providing and evaluating services. Funded service providers must report compliance with these obligations in their annual report.

1.5 Departmental responsibilities and policies

DH and DHS are responsible for developing policy and delivering and funding programs to support carers. Figure 1B shows the departmental divisions and program areas that lead this work.

Figure 1B
Departmental divisions and program areas

Departmental division	Program area
Department of Health	
Wellbeing, Integrated Care and Ageing	Ageing and aged care Palliative care
Mental Health, Drugs and Regions	Mental health
Department of Human Services	
Disability Services	Disability
Children, Youth and Families	Child protection

Source: Victorian Auditor-General's Office.

The departments deliver carer supports directly but also fund a range of community service organisations to deliver carer supports. These supports target primary carers. Regional department staff monitor the performance of these service providers against funding and service agreements.

Recognising and supporting care relationships (2006)

The *Recognising and supporting care relationships* policy provides a framework for departmental staff and funded service providers to support informal care by focusing on the relationship between the carer and the person being cared for.

The policy recognises that each person in the relationship can have different needs and outlines three principles to support the care relationship:

- recognition and respect
- support
- participation.

Victorian Charter Supporting People in Care Relationships (2010)

The charter acknowledges the role of carers in our society. It articulates the rights and responsibilities of people in care relationships, and how they can be supported by organisations, governments and the community. The charter states that those in 'care relationships' should be:

- recognised and respected
- supported to access services
- supported through community awareness raising
- able to take part in care planning and making decisions about care.

The charter is aimed at people in care relationships, government departments and funded service providers. The principles in the charter were used as a foundation for the *Carers Recognition Act 2012*. A revised charter will be released in 2012 to reflect the new legislation. The Act and the charter guide DH and DHS program activity and funded service provision.

1.6 Audit objective, scope, method and cost

The audit assessed the extent to which DH and DHS are effective in recognising and supporting people who care for others by examining whether:

- supports and services are accessible to carers
- agencies' practices recognise the role of carers and provide effective support.

The audit covers the support provided and funded by the departmental divisions and program areas as shown in Figure 1B.

Funded community service organisations and carers were included as stakeholders, through interviews with 12 service providers and consultation with 37 carers.

Part 2 of the report examines carers' access to support programs. Part 3 looks at carer recognition and the effectiveness of supports.

The audit was undertaken in accordance with Australian Auditing and Assurance Standards.

The audit cost was \$290 000.

2

Access to carer supports

At a glance

Background

Carers play a vital role in the community and need support to maintain this role. This requires community awareness of the supports that exist and for carers to understand how to access them. Access processes should be transparent and equitable, and supports should be flexible and responsive to carer needs.

Conclusion

Many eligible carers miss out on support due to barriers to accessing services. Carers lack awareness of supports available despite demonstrated efforts by the Department of Health, the Department of Human Services and service providers to promote them. The departments have yet to analyse and address this problem.

Carers have difficulty navigating the service system and there is a risk of inequity in accessing supports. The departments and service providers do not routinely or systematically assess and prioritise carer need, refer them to supports, or monitor wait times for services. Access to brokerage funds is not consistent or transparent.

Findings

- Carers lack awareness of supports.
- The departments have not evaluated promotion strategies, and service providers do not routinely monitor referral sources.
- The departments and service providers do not have a consistent approach to assessing or prioritising carer needs.
- The departments do not adequately monitor brokerage funds for carer supports.
- Lack of wait time data means the timeliness of access to supports is unknown.

Recommendations

That the Department of Health and the Department of Human Services:

- identify and address gaps in promotion of carer supports to improve carer awareness of services
- require consistent carer identification and needs assessment
- improve administration and monitoring of carer brokerage funds
- monitor and report on timeliness of access to carer supports.

2.1 Introduction

Carers are a vital part of the health and human services system and provide over \$40 billion in care nationally. Care provided by informal carers reduces the financial burden on public services and helps to maintain family and community connections.

Carers need a range of flexible services to support them to continue in their care role. Supports need to be responsive to urgent needs and enable carers to build their capacity and plan for the future.

Not all carers identify with the term 'carer' and may not seek or be aware of carer support services. Staff in the broader health and human service systems play an important role in identifying carers and facilitating their access to carer support services. Consistent carer identification and referral improves opportunities for carers to access supports.

Access to supports should be transparent, equitable and timely for all carers. Consistent use of carer needs assessments and tools for prioritising urgency of need provide assurance to the community that carers are supported consistently and fairly.

2.2 Conclusion

The departments of Health (DH) and of Human Services (DHS) provide a range of supports to meet a variety of carer needs across their program areas. However, carers cannot always access the supports available to them. Carers lack awareness of supports, despite departmental and service provider efforts to promote them. The departments have not evaluated promotion strategies to determine the cause of this. Carers also have difficulty navigating the system and the departments and their funded service providers do not reliably refer carers to support programs.

There is potential unmet demand for carer supports, but its extent is unknown. Departmental and service provider staff and processes do not consistently identify carers as having needs of their own, assess these needs or refer for assessment, or monitor wait times to access services.

Improvements to the equity and accessibility of supports are necessary to assist carers to maintain their care role and to help address the higher levels of stress and poorer wellbeing they experience compared with their peers.

2.3 Awareness of carer support programs

Carers can access support through a referral from another service or by contacting the service provider directly—'self-referral'. Health and community services, such as general practitioners, hospitals, aged care homes, disability or mental health services, local government, and schools, need to identify carers and be aware of the carer supports available to facilitate access to them. Carers report a lack of awareness of supports despite demonstrated efforts by the departments and their funded service providers to promote them.

2.3.1 Promotion

The departments and their funded service providers adopt a range of promotion strategies to raise awareness of supports among carers and other health and community services. The method and extent of promotion depends on individual service providers, geographical location and the support type. Strategies include:

- networking between service providers
- distribution of brochures and promotional resources to health centres
- attendance and promotion at local and regional expos and events
- publishing information in regular newsletters, local papers and regional bulletins
- advertising on radio and television broadcasts
- website and internet promotion
- some service providers report using innovative promotional strategies such as smart phone applications and online promotional videos to market their services and raise broader community awareness
- departmental funding of advisory or peak bodies, such as the Kinship Carers Peak Advisory Body.

Effectiveness of promotion

Carers routinely report a lack of awareness of the supports available. Figure 2A provides a summary of program evaluation findings since 2001 relating to promotion and awareness of supports.

Figure 2A
Summary of promotion and awareness findings

Program area/evaluation	Finding
Support for Carers Program (SCP) evaluation (2001) ^(a)	Carers found it 'difficult to find information' about supports
Aged care	
SCP and HACC ^(b) evaluation (2011)	'...carers did not know about services'
Mental health	
Carer Support Program evaluation (2008)	'...further work in promoting availability of the [Carer Support Fund] is required'
Disability	
Respite report (2009)	There is a need to 'improve the understanding of families/carers...of the variety of respite support services available'
Respite report (2010)	'[carers] do not consider they are sufficiently informed about the types of carer supports that are available'
Child protection (kinship carers)	
Kinship care policy review (2007)	There is a 'lack of information' for kinship carers

(a) The 2001 Support for Carer Program evaluation applied to support programs across ageing and aged care, mental health and disability program areas.

(b) Home and Community Care (HACC).

Source: Victorian Auditor-General's Office.

Despite these repeated findings, the departments have not undertaken any evaluation of promotion strategies and service providers do not routinely monitor their referral sources. Consultation with 12 funded service providers revealed only one example of a service provider performing a formal evaluation of their promotion methods by asking carers how they found their service.

2.4 Carer identification and referral

The *Carers Recognition Act 2012* states that carers should be supported as a person with their own needs as well as in their role as a carer. For this to be realised, service providers need a consistent practice of carer identification and needs assessment. This would increase carers' awareness of, and access to, the supports available, and improve the departments' understanding of the carer population.

All program areas have systems in place to identify carers and to record this. However, the extent to which the departments have guidance designed to prompt their staff and service providers to assess carer need, or refer them for assessment and support, is variable. Figure 2B provides an overview of current systems and guidelines to identify carers and consider referral to carer support.

Figure 2B
Carer identification and referral

	Aged care and HACC	Palliative care	Mental health	Disability	Child protection (kinship care)
Carer identification					
System in place	✓	✓	✓	✓	✓
Reliable	✓	✓	✗	✓	✓
Carer referral					
Formal guidance	✓	✓	✗	✗	✓
Reliable	✓	✗	✗	✗	✗

Source: Victorian Auditor-General's Office.

Carer identification in Area Mental Health Services (AMHS) and Psychiatric Disability and Rehabilitation Support Services (PDRSS) is not reliable and, as a result, DH's records are incomplete. To comply with the National Mental Health Standards, all AMHS and PDRSS providers must identify carers as early as possible during their client's episode of care. However, these services do not reliably identify carers at intake. Instead, mental health clinicians often identify carers later in treatment and then do not update departmental systems.

Child protection workers reliably identify kinship carers and effective use of their assessment tool could result in a referral for carer support. However, child protection staff do not reliably or consistently undertake the assessment. The department has identified staff workload and resources as a reason for this.

Disability services guidelines for staff working with clients to plan their Individual Support Package state that they should consider family or carer needs in the planning process. However, there is no guidance to direct staff to consider referral of carers to supports specifically for them. The Disability Services division in DHS has recently produced the draft 'Family-centred, person-centred' practice guide which will address this gap and provides guidance on considering family and carer needs, and making referrals or identifying alternative funding sources for carer supports.

Departmental guidelines for aged and palliative care prompt staff to consider referring the carer to dedicated carer supports. Figure 2C provides a case study of the Home and Community Care (HACC) carer identification and assessment guidance.

Figure 2C
HACC carer identification and assessment guidance

The HACC assessment guidelines *Strengthening assessment and case planning* set out the principles and practice for assessing people's needs for community-based care to enable them to remain living as independently as possible.

HACC assessors identify and assess these needs through the 'Living at Home Assessment'. An important component of this assessment is a holistic needs assessment that looks at the needs of the individual as well as their family or carers' needs, goals and aspirations. The guidelines include carers in the target group for HACC assessments. The assessment is intended to result in the development of a care plan which takes into account services available in the broader service system, not only HACC services.

Carers of frail and elderly people participating in a focus group revealed varied experience of HACC assessors considering their needs as carers, but overall they were positive about HACC assessment.

Source: Victorian Auditor-General's Office.

2.4.1 Navigation

Participants in our five carer focus groups stated that they find navigating the system difficult:

- Carers feel either overwhelmed with information or are not able to find out enough.
- Quality case management greatly assists with system navigation, but is not readily available due to long wait times.
- Identification and referral of carers by schools, general practitioners, hospitals (including private psychiatrists and hospitals) would assist with navigation. However, this does not consistently occur and is dependent on individual practice.
- The most common way that carers found out about supports was word of mouth or through support groups.

These comments suggest there is a degree of luck involved in carers finding and accessing supports. Evaluations of carer support programs in Aged Care (2011) and Disability (2009) also highlighted carers' difficulties in navigating through the system due to lack of adequate information or referrals from other service providers.

2.5 Equity of access

Regardless of where they live or the diagnosis or condition of the person they care for, carers should expect a consistent and fair response from carer support providers. It is important that each program area has processes to assess and prioritise carer needs so that departmental and service provider staff can identify those most in need and distribute finite resources equitably.

There is a risk of inequitable access to carer supports due to inconsistent needs assessment, prioritisation and brokerage fund management practices.

2.5.1 Carer needs assessment and prioritisation

Accessibility of carer supports varies across program areas and services. The departments do not mandate the use of a carer needs assessment tool. Only one program area, palliative care, suggests a range of tools that providers could use. Among the 12 service providers consulted there is no consistent use of a standardised tool for assessing carer needs. Service providers measure urgency differently and in some cases, subjectively. This variability in needs assessment and prioritisation leads to inconsistency in providing supports and raises the risk of inequity.

Seven of the 12 service providers (two each in aged care and palliative care, one each in mental health, disability and kinship care) conduct formal needs assessments. The remaining five assess needs using informal, subjective assessments, such as conversations with carers.

Eight service providers (four in aged care, two in palliative care and one each in disability and kinship care) use a formal prioritisation tool or framework. Within program areas, there is no consistency in the tool used. One disability provider relies on subjective judgement of carer stress levels, or what the worker can 'hear in the carer's voice' when they contact the service. The three remaining service providers (two in mental health and one in kinship care) do not use any prioritisation method.

Carers in our focus groups indicated an awareness of subjective practices in use, saying they often felt they would only receive a service if they exaggerated their need, or sounded desperate. Most carers reported prompt provision of supports in a crisis. However, this was less common for carers of a person with a disability.

2.5.2 Access to brokerage funds

Brokerage funds are available to carers on request to purchase services and one-off material items. These funds should be responsive and flexible to address a wide range of carers' needs, and fund guidelines need to be able to accommodate this if the support is to be effective. However, the departments need to balance this flexibility with maintaining transparency, accountability and equity through effective monitoring and governance.

The mental health and aged care program areas offer flexible brokerage funds to support carers. However, there is inadequate oversight of spending from the funds.

The guidelines do not specify minimum expectations of service providers in assessing, prioritising or approving applications which has led to inconsistent practices and raises the risk of inequitable access for carers. Figure 2D outlines a number of oversight and equity issues evident in these brokerage funds.

Brokerage funds are not available through the Disability Services division. However, flexible support packages may indirectly support families and carers with discretionary funds to purchase supports aimed at the person with a disability.

Kinship carers can access Placement Support Grants. While they are not aimed towards supporting the carer specifically they can provide financial support through the purchase of goods or services, such as bedding or therapy, to meet immediate needs of the child in the placement. It is not possible to determine the extent to which kinship carers derive benefit from these grants as reporting and acquittal does not categorise the type of placement, either kinship or foster, that funds go to.

Figure 2D
Oversight and equity of carer support brokerage funds

Aged Care Support for Carers Program (SCP) brokerage capacity

In 2011, brokerage accounted for approximately \$560 000 of SCP funds in aged care. Consultation with two service providers revealed inconsistent practices regarding the use of funds. For example, one service limits use of funds to the purchase of respite from a number of predefined 'approved providers', while the other service will permit use of the funds for the purchase of goods or services if they consider there to be a 'genuine need'. Service providers are not required to provide acquittals to DH and it is not possible to determine how many applications for funds service providers receive each year.

Mental Health Carer Support Fund (CSF)

There are a number of issues regarding the \$1.6 million mental health CSF which relate to inadequate oversight, transparency and accountability.

DH's Mental Health, Drugs and Regions division has funded an external agency to administer the CSF since July 2009. However, there is no contract or service agreement in place stipulating conditions, targets or performance indicators for this activity.

Application and approval processes handled by staff in Area Mental Health Services (AMHS) are inconsistent and can result in a potential conflict of interest. AMHS Case Managers or Carer Consultants complete applications on a carer's behalf and applications are approved either by individuals or committees within the AMHS. In some instances the same individuals who complete the applications are responsible for approving them.

Analysis of payments from CSF allocations demonstrates wide, and unexplained variation between different AMHSs in the average amount paid per application, from just under \$200 to just over \$1 000. The statewide average is \$560.

Consultation with Carer Consultants revealed one instance of a service spending their quarterly CSF allocation within the first month. This lack of internal management of spending results in inequitable distribution of the funds to carers in that area.

Analysis of CSF reporting between June 2010 and June 2011 shows that the number of applications to the fund has increased by 17 per cent but underspending has also increased, from 12.5 per cent to 16.1 per cent. Underspending from the fund could indicate a lack of demand or inadequate promotion but ultimately it means that carers are not gaining the full benefit from the resources available to them.

Service providers consulted indicated that underspending results from not receiving timely, monthly reports on their expenditure. However, not all service providers monitor their own CSF spending.

Source: Victorian Auditor-General's Office.

2.6 Timeliness of access and wait time data

Carer supports are often intended to 'fill a gap' or meet an urgent need while waiting for other, more long-term supports, such as an ongoing funding package in aged care or disability. Responsiveness, on these occasions, is crucial to the effectiveness of the program.

The departments do not set timeliness targets and do not require reporting of wait times for carer supports, except for case management provided by the Disability Services division. Service providers do not consistently, or routinely, collect data on wait times.

A number of service providers report that they do not maintain wait lists. They state that they prefer to refer people to other services if they do not have capacity to respond, rather than keeping someone holding on for an extended period of time.

The two disability respite providers consulted monitor their unmet demand: one for internal purposes, the other voluntarily reports it to their regional departmental office. The annual disability carer respite satisfaction survey found that carers offered alternative respite options, such as in-home respite or holiday programs, report low satisfaction due in part to long wait times.

Aged care SCP respite providers do not maintain a wait list and they report they are generally able to meet demand.

2.6.1 Wait times and wait time data

For time-critical services, such as respite, financial support or counselling, a long or indefinite waiting period can have a profoundly negative effect on a carer's health and wellbeing and ultimately their ability to continue in their role. Wait time data is one indication of the service system's ability to cope with demand, and can provide useful information to departments and service providers for service planning and development work.

Formal wait time data is not available for carer supports, except for disability case management, as the departments and service providers do not routinely collect it. Departmental wait time data for disability case management shows a statewide average of 51.4 days, or just over seven weeks. The target wait time is 50 days. The data also shows a high degree of variation between departmental regions, from just under one week in one region to over 12 weeks in another.

Figure 2E outlines the anecdotal wait times reported by consulted service providers. It shows variable wait times depending on the type of support, for example access to brokerage funds usually occurs within two weeks while case management or respite can be over a month. Variability within program areas is also evident, such as case management for kinship carers. This makes it difficult for carers to have any expectations of how long they can expect to wait for a support.

Figure 2E
Anecdotal wait times

Type of support	Aged care ^(a)	Mental health	Palliative care	Disability	Child protection (kinship care)
Respite	Providers report no wait for respite	Commonwealth funded	Average 2 days	No data: one provider reports 4 months	Urgent: no wait Non-urgent: not available
Case management	Average 5 weeks	Not applicable ^(b)	No data	5–6 weeks	Variable: 0 to several weeks
Counselling	Variable: 3–6 weeks	Commonwealth funded	Variable: 0–3 days	Commonwealth funded	Not applicable ^(b)
Information/advice	Within 48 hours	Within 48 hours	No data	Within 72 hours	Within 24 hours
Training/education	No data	Variable: depends on frequency of training session	No data	No data	Sessional (max. 9 weeks)
Brokerage funds	1–2 weeks	Variable: 1–10 days	No data	No data	Not applicable ^(b)

(a) SCP service providers only.

(b) Types of supports not available to carers through these programs.

Source: Victorian Auditor-General's Office.

Carers' experiences of waiting

The experiences of carers echo the variability that service providers report. Comments from carers participating in our focus groups indicate that wait times vary depending on the condition of the person they are caring for and the type of support they are accessing. For carers of a person with a mental illness access to supports can be quick, 'but only if you are in crisis'. Kinship carers found that regular carer reimbursements can be established promptly but that the process for accessing reimbursements for one-off expenses is long and burdensome.

Carers participating in our aged care and disability focus groups reported extended periods of waiting—from a couple of months to over a year—for approval to access supports such as planned respite and case management, and then additional periods of waiting prior to receiving those supports. Their comments also indicated a lack of understanding of the reasons behind the long wait times. This suggests that the departments and their funded service providers are not adequately communicating with carers. This uncertainty adds to feelings of helplessness and increases carer stress.

Recommendations

That the Department of Health and the Department of Human Services:

1. identify and address gaps in promotion of carer supports to improve carer awareness of services
2. require consistent carer identification and needs assessment
3. improve administration and monitoring of carer brokerage funds
4. monitor and report on timeliness of access to carer supports.

3

Experience of supports

At a glance

Background

As the population ages and the prevalence of chronic disease and disability increases, supporting carers to maintain their role becomes increasingly important. Supports therefore need to effectively achieve their objectives. The Department of Health, the Department of Human Services and service providers also need to recognise carers by involving them in policy and program development, and service planning and provision.

Conclusion

The departments and service providers clearly recognise carers as a group and consistently involve them in policy and program development activities.

The effectiveness of carer support programs is unknown as the departments do not routinely monitor outcomes against program objectives. This is a significant gap given the growing community reliance on carers and increasing need for effective supports.

Findings

- The departments recognise carers as a group, for example, by:
 - routinely involving carers in policy and program development
 - applying quality assurance processes to service providers that assess carer recognition and involvement.
- The departments have evidence-based carer support programs in place.
- The departments do not use outcome measures to determine the effectiveness of their carer support services.

Recommendation

That the Department of Health and the Department of Human Services develop outcome measures for carer supports and monitor outcomes.

3.1 Introduction

Given our community's reliance on carers, supporting them to maintain their care role is crucial. As well as identifying individual carers and providing supports to them, recognition of carers as a group is also important. Not all carers will require or want direct supports. However, recognition of their role contributes to more effective and sustainable care relationships. This includes involving carers in care and treatment planning with the person they care for.

The programs designed to support carers must be evidence-based and effective. The objectives of carer support programs range from increasing social connectedness to reducing carer stress. Standardised outcome measures—comparing, for example, carer wellbeing before and after provision of supports—can be used to demonstrate effectiveness of supports against these objectives.

3.2 Conclusion

The Department of Health (DH) and the Department of Human Services (DHS) and their funded service providers recognise carers in many ways, from including them in policy and service development, to promoting policies and guidelines for carer involvement in client planning and service delivery. Quality assurance processes provide independent assurance of how service providers involve carers.

Carers in focus groups conducted for the audit, report varied experiences of recognition by service providers. This indicates the need for ongoing effort to embed a culture of carer recognition in service provision.

The departments developed the current suite of carer support programs following extensive carer consultation and using a comprehensive evidence base, consisting of academic research and program evaluation.

Given the vital need for, and benefits from, supporting carers, the departments' carer support programs are core activity and they should monitor them accordingly. However, the effectiveness of carer support programs is unknown as the departments do not apply or monitor carer-related outcome measures.

Due to the lack of effectiveness data, understanding performance relies strongly on anecdotal feedback from carers and service providers and one-off, narrowly scoped evaluations which present mixed results. A common finding of these evaluations is the need to develop outcome measures.

3.3 Carer recognition

Community, health and other care services can recognise carers by acknowledging their role, the special knowledge they have of the person they are caring for and the contribution they make to the broader community.

The departments and their funded service providers are effective in recognising carers by involving them in policy and program development activities. However, recognition at the service provision level, by involving them in care planning and decision-making, requires continued effort.

3.3.1 Carer recognition policy

There is clear departmental policy guidance to program areas and their funded service providers that they must recognise and respect the relationship between a carer and the person being cared for in their service delivery. Stakeholders and departmental program staff are familiar with the recognition principles contained in the 2006 policy *Recognising and Supporting Care Relationships* and the 2010 *Victorian charter supporting people in care relationships*.

Departments and service providers have demonstrated a commitment to realising this policy. At a strategic level, departments involve carers in program and policy development. At the level of service provision, service providers involve carers in care planning and service development.

Carer involvement in policy development

All program areas have effectively consulted with, and involved carers in, policy development. Methods for involving carers included written submissions, surveys, focus groups, one-to-one interviews and membership of committees and working groups. Figure 3A lists examples of carer involvement in policy development.

Figure 3A
Examples of carer involvement in policy development

Program/policy	Method of carer involvement
Carers' Charter (2010) and the <i>Carers Recognition Act 2012</i>	The development of the Carers Charter during 2008 involved four carer focus groups. Facilitators asked carers to identify what makes them feel service staff recognise their role, and whether they think the charter would make a difference to them. A key theme to come out of these groups was that carers felt that legislation is needed to support the principles of the charter. The recently passed <i>Carers Recognition Act 2012</i> reiterates the principles outlined in the Carers' Charter.
Mental Health Reform Strategy (2009)	DH consulted with 80 carers during the development of the 2009 Mental Health Reform Strategy. Implementation of the strategy was coordinated through five working groups, four of which included carer members.
Kinship care policy and service design (2007)	DHS sought input by calling for comments in response to an issues paper directly distributed to kinship carers and support groups and received 50 responses from carers. It also heard from a total of 71 carers at face-to-face consultation sessions held around the state. This input contributed to the development of the Victorian Kinship Care Model.

Source: Victorian Auditor-General's Office.

In late 2011, representatives from the ageing and aged care, mental health and disability program areas and the Children, Youth and Families division in DH and DHS started to meet informally and have started the process of establishing a formal 'Carers Steering Committee'. The purpose of the group is to provide advice and guidance on the implementation of carer-related policy and initiatives within DH and DHS and across government. This group resembles an earlier 'Carers Victoria Liaison Group', maintained by the former DHS. Membership of this group included Carers Victoria. The liaison group has been in recess since the split of DHS, creating DHS and DH, in August 2009. To date, membership of the newly established steering committee has not included Carers Victoria. However, the terms of reference lists Carers Victoria among its stakeholders.

Carer involvement in service provision

At a practical level, service providers can demonstrate the extent to which they recognise carers by identifying and involving them in the provision of care and service development. All audited program areas have state or national standards and monitoring regimes that include minimum requirements for carer recognition. Figure 3B summarises the range of carer-related quality assurance standards and monitoring processes in place across the five program areas.

Figure 3B
Monitoring of carer involvement in service provision

Standards	Aged care	Palliative care	Mental health		Disability	Child protection
			AMHS	PDRSS		
Carer involvement in care assessment, planning, review	x	✓	✓	x	✓	x
Carer needs assessment	✓	✓	x	x	x	x
Provision of relevant information to carers	x	✓	✓	✓	x	x
Access to relevant carer supports	x	✓	x	✓	x	x
Carer capacity building	x	x	x	x	✓	✓
Carer involvement in service development	✓	x	✓	x	x	x

Source: Victorian Auditor-General's Office.

The extent of carer involvement required by the standards and the rigour of the monitoring regimes varies across the five audited program areas. All program areas, except palliative care, require external accreditation and independent monitoring against the relevant standards at least every three years. Palliative care monitoring is voluntary and done through self-assessment.

Only the standards in aged care and palliative care explicitly require an assessment of carer needs. Standards in disability and child protection require service providers to demonstrate how they 'build carer capacity' This could include actions similar to those articulated in the standards for the other program areas, such as provision of relevant information or access to relevant supports. However, the variation in standards could result in carers' experiencing an inconsistent degree of recognition.

3.3.2 Carers' experience of recognition

Carers experience recognition to varying degrees depending on their age and the diagnosis or condition of the person they care for. A number of carers felt that the quality of recognition was as a result of the work practices of individuals rather than a consistent systemic approach. Themes on recognition from our carer focus groups include:

- Carers in the mental health focus group reported that they felt more recognised in Area Mental Health Services (AMHS) than in Psychiatric Disability Rehabilitation and Support Services (PDRSS). This may be as a result of the greater investment in, and scrutiny of, carer recognition in AMHS than in PDRSS. Some carers also noted the level of recognition had been improving over time.
- Carers in the disability focus group felt service providers do not recognise their needs as individuals. One carer in the disability focus group felt that she experienced a much greater level of recognition from service providers as the carer for her elderly mother than the carer of her son who has a disability.
- Feedback from stakeholders indicates that kinship carers feel taken for granted by the child protection system. Participants in a kinship carer focus group reported inconsistent engagement and advice from DHS staff, citing staff turnover and the resulting lack of continuity as contributing to this.
- Worryingly, young carers participating in our focus group related experiences of hospital staff, teachers and CentreLink workers not believing their descriptions of the care responsibilities they maintain.

3.4 Effectiveness of supports

Carer support programs should have clearly stated objectives, be evidence-based and draw on carer input in their design. To determine whether programs are effectively meeting their objectives, the departments and service providers need to use outcome measures to assess performance, such as before and after indicators of carer wellbeing.

The current suite of carer support programs has developed from a sound evidence base comprising a combination of research, evaluation and carer involvement. However, the extent to which the programs meet their objectives cannot be clearly determined as there is no consistent use of outcome measures.

3.4.1 Evidence base for supports

Research and evaluation

Each program area was able to provide examples of academic research and pilot program testing and evaluation that had informed the development or improvement of carer supports.

The former DHS established many of the current carer support programs in 1996 as a suite of supports known as the Support for Carers Program. The Victorian Government funded academic research to inform the development of this program, which provided the first profile of Victorian carers.

Carer involvement

Departmental practices demonstrate a strong commitment to genuine carer involvement in program development and improvement. Common consultation methods include surveys, focus groups and interviews, with subsequent reports identifying the major themes arising from the consultations. For example:

- Carer focus groups informed the Disability Services division's development of a set of principles to guide the allocation of funds for 'Innovative Respite' programs, newly funded in 2011–12.
- Consultation with kinship carers influenced the design of the Victorian Kinship Care Model.

The ageing and aged care, and mental health program areas in DH, and child protection in DHS also maintain a range of committee and working group structures that include carer membership or representation.

Figure 3C describes a pilot project, supported by the mental health program area, of an innovative service development and improvement model called Mental Health Experience Co-design, or MH ECO. A key feature of the model is the active involvement of carers and consumers. Services involved in the project pilot reported sustainable changes to their services and practices because of their participation in the program.

Figure 3C
Mental Health Experience Co-design project

The MH ECO model is designed to engage carers, consumers and service provider staff in 'co-designing' service improvements. Carers, consumers and service provider staff work together to identify areas in need of improvement in their mental health services and develop, implement and monitor a service improvement project. An important element of this approach includes the development of evaluation and project skills, particularly among carers and consumers, to enable the whole team to contribute equally to the project. The evaluation of the pilot project conducted across two sites, one AMHS and one PDRSS, during 2008–2010 found a high level of support for the model among the project participants. The report concluded that the model was successful in achieving sustainable service and practice changes, such as improved information provision for carers and consumers and support for carers.

Source: Victorian Auditor-General's Office.

3.4.2 Monitoring and evaluation

A comprehensive performance monitoring framework includes routine monitoring of activity and outcomes combined with regular evaluations addressing the objectives of the program.

Routine monitoring

Departmental monitoring of funded service providers focuses on activity. All program areas collect data relating to activity, for example hours, episodes, applications, and some carer demographic data. However, activity monitoring across programs is inconsistent. For example, respite activity within aged care and disability is measured either by time (hours, days), or episodes of service. This makes it difficult to compare activity levels with funding to assess efficiencies either between service providers or across programs. However from 2012–13 disability services will report respite provision in hours. Figure 3D outlines reporting requirements across a number of carer supports.

Figure 3D
Reporting requirements for carer supports

	Number of carers	Hours/ days	Contacts/ episodes	\$	Wait time	Other ^(a)
Aged care						
Support for Carers Program	✓	✓ (respite)	✗	✓	✗	✗
Dementia Carer support ^(b)	✓	✗	✓ (respite)	✓	✗	✓
Mental health						
Carer Support Fund	✓	✗	✓	✓	✓	✗
Disability						
Respite	✓	✗	✓	✗	✗	✓
Case management	✓	✗	✗	✗	✓	✗
Kinship	✓	✓	✓	✗	✗	✗

(a) 'Other' includes qualitative reporting, such as case studies or satisfaction surveys.

(b) Dementia carer support is a sub-activity of the Support for Carers Program.

Source: Victorian Auditor-General's Office.

The ageing and aged care, and palliative care program areas in DH and the Disability Services division in DHS collect some qualitative feedback, either through manual reporting templates or annual surveys. However, this is based on subjective assessments of service providers or service users. Figure 3E provides cases studies of the qualitative monitoring practices in these programs.

Figure 3E
Qualitative monitoring practices

Aged care

Ten aged care Support for Carers Program providers who receive additional program funding to support carers of people with dementia include qualitative case studies on client outcomes in their annual reporting. The reporting proforma requires service providers to comment on the level of carer 'enjoyment or satisfaction' in relation to the service provided.

A review of four sample reports showed that carers were satisfied with the supports. However, the service providers based their reports on different feedback channels, including an independent carer satisfaction survey, routine follow-up of carers who have received services or ad hoc personal feedback from individual carers.

The inconsistent amounts and quality of information contained in these reports do not provide a reliable indicator of effectiveness.

Disability

Disability Services conducts an annual carer respite satisfaction survey. The survey includes carer experience indicators to show the impact of respite services for carers.

Results show low carer satisfaction with respite availability, with 50 per cent of carers being 'satisfied' in 2011, down two per cent from 2010. The survey authors suggest this is due to limited service availability.

The survey report also includes a 'carer needs gap analysis'. The results of this analysis indicate that respite does not meet carer expectations of 'being less fatigued' and 'being able to do more things you enjoy'. One of the objectives of respite is to 'enhance family functioning and maintain positive family and care giving relationships'. The negative effect carer fatigue and discontent would have on family functioning and relationships suggest that respite does not reliably achieve this objective.

Source: Victorian Auditor-General's Office.

Monitoring outcomes

The departments have demonstrated work on the development of outcome measures for clients receiving mental health or disability services, but none for those receiving carer supports. The ageing and aged care and child protection program areas have not developed any outcome measures. The Disability Services division has conducted a consultation workshop to develop a set of outcome measures for the recently funded 'innovative respite' program. The division is proposing to base the measures on the objectives of the program, which include supporting family and care relationships.

The palliative care program advocates the voluntary participation of service providers in the national Palliative Care Outcomes Collective (PCOC) which includes a carer related indicator. Figure 3F provides a case study of PCOC. This model is an example of how a patient-centred monitoring system has incorporated carer outcomes to provide an overall indication of care efficacy and quality.

Figure 3F Palliative Care Outcomes Collaborative

The Palliative Care Outcomes Collaborative (PCOC) is a nationally funded program that uses standardised and validated clinical assessment tools to benchmark and measure the outcomes of palliative care. Participation is voluntary. Twenty-two of Victoria's 55 palliative care services participate in the program.

While the primary focus of the model is on the patient receiving palliative care, one of the four measures, termed Palliative Care Problem Severity Scores, includes a rating of carer and/or family physical and emotional needs. Palliative care services recognise that the carer's ability to cope is an important determinant in enabling a person to die in the place of their choice, which for many people is in their own home.

Services record these problem severity scores as the palliative care patient moves between the different pre-defined phases of care: stable, unstable, deteriorating, terminal and bereaved.

Results from the January to June 2011 report show that rates of carer stress receiving a 'severe' score were lower among Victorian in-patient palliative care services compared to the national averages in all phases, and in all phases except the terminal phase in community based services. The authors excluded the bereaved phase from the report.

The overall results suggest that carer supports in Victorian palliative care services are a significant factor in achieving lower rates of carer stress compared to the national average.

Source: Victorian Auditor-General's Office.

Consultation with 12 funded service providers revealed evidence of only three services, one each in palliative care, mental health and disability, using outcome measures at the service provision level.

The mental health provider uses two standardised tools to monitor carer stress levels before and after accessing counselling or their carer capacity building program. A formal evaluation of the capacity building program found that carer stress levels based on the 'Involvement Evaluation Questionnaire' were reduced following their participation in the program. However, the service provider used this tool during the evaluation period only and subsequently discontinued its use.

The disability service provider develops 'SMART' goals (Specific, Measurable Attainable, Relevant, Timely) with carers using a tool developed in-house. A service provider staff member and the carer revisit these goals at the end of a period of service provision to see whether the support has helped the carer reach their stated goals.

One-off evaluations

Most program areas have completed one-off evaluations of most of their carer support programs. The exceptions are child protection which commenced a kinship carer support program in 2010, and palliative care. These evaluations provide only limited assurances of program effectiveness as they either did not address the objectives of the program, or appropriate data was not available. A consistent theme identified in these evaluations is the need to develop carer-related outcome measures to determine program effectiveness.

Figure 3G shows that most program evaluations have not addressed the objectives of the program.

Figure 3G
Carer support program objectives and evaluation comparison

Program	Program objectives/aims	Evaluation objective/focus
Support for Carers Program ^(a)	Objectives include: <ul style="list-style-type: none"> • support the care relationship • reduce the stress on carers • improve access to carer support information and services 	One evaluation, 2001: <ul style="list-style-type: none"> • addressed program objectives, but found limited assurance of effectiveness.
Aged care		
Support for Carers Program	Objectives include: <ul style="list-style-type: none"> • support the care relationship • reduce the stress on carers • improve access to carer support information and services. 	One evaluation, 2011: <ul style="list-style-type: none"> • focused on providing a view of the 'current state of play' for carer supports and respite services and possible future directions • did not address program objectives directly, but findings indicate the program has not achieved its objectives.
Mental health		
Carer support fund	To meet the needs of carers by: <ul style="list-style-type: none"> • providing funding to assist carers in their role • promoting and sustaining the care relationship • improving the wellbeing of carers. 	Two evaluations, 2008 and 2011: <ul style="list-style-type: none"> • 2008 focused on strengths and barriers to supporting carers and identification of future improvements • 2011 focused on administration of the fund • neither addressed or made findings relative to program objectives.
Disability		
Respite	Aims of disability respite include: <ul style="list-style-type: none"> • enhancing family functioning • maintaining positive family and care giving relationships. 	Two reports, 2009 and 2010: <ul style="list-style-type: none"> • purpose of both reports was to inform strategic planning with a focus on identifying future directions for service delivery • findings from both reports indicate needs of carers not being meet in the current system • neither addressed program objectives.

(a) The 2001 Support for Carer Program evaluation applied to support programs across ageing and aged care, mental health and disability program areas.

Source: Victorian Auditor-General's Office.

DH has not evaluated the Psychiatric Disability and Rehabilitation Support Service carer supports, but has recently scheduled evaluations for this service.

Recommendation

5. That the Department of Health and the Department of Human Services develop outcome measures for carer supports and monitor outcomes.

Appendix A.

Audit Act 1994 section 16— submissions and comments

Introduction

In accordance with section 16(3) of the *Audit Act 1994* a copy of this report was provided to the Department of Health and the Department of Human Services with a request for submissions or comments.

The submission and comments provided are not subject to audit nor the evidentiary standards required to reach an audit conclusion. Responsibility for the accuracy, fairness and balance of those comments rests solely with the agency head.

Responses were received as follows:

Department of Health	28
Department of Human Services	39

RESPONSE provided by the Secretary, Department of Health



Department of Health

Secretary

23 JUL 2012

e2770934



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D D R Pearson
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Dear Mr Pearson ^{Des}

Thank you for your letter of 4 July 2012 to the Acting Secretary Department of Health, enclosing your proposed report on Carer Support Programs.

I welcome the sound recommendations and suggestions made by VAGO in the audit of Victoria's carer support programs, including those administered by the Department of Health in mental health, ageing and aged care, and palliative care. I understand staff of these program areas have suggested directly to your staff minor corrections of fact to the document.

The Department of Health is pleased to note the VAGO finding that the department recognises that supporting carers is core business. It welcomes the report's acknowledgement that the Department and service providers have demonstrated a commitment to realising key policy documents such as the 2006 *Recognising and Supporting Care Relationships* and the 2010 *Victorian Charter Supporting People in Care Relationships*. The Department notes that the development of the *Carers Recognition Act 2012* is a continued demonstration of the commitment to recognise the role of carers and care relationships. VAGO's recognition of the Department's work in effectively consulting with, and involving carers, in policy development is also welcomed. The Department is committed to continuing and strengthening its engagement with carers, so that its carer support programs aim to improve outcomes for Victorian carers.

Please find enclosed more detailed information, outlining the general context within which Victorian services are delivered; changing demographics, increasing longevity, and individuals' needs, preferences and living arrangements, all impact on service development and redevelopment, and service delivery.



RESPONSE provided by the Secretary, Department of Health – continued

There is also general comment on the audit report, and specific comment on each recommendation, including what departmental programs aim to achieve specifically relating to the recommendations, within the context of the current constrained financial environment.

I look forward to continuing to work with VAGO in seeking to improve services and support to Victorians.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Pradeep Philip', written in a cursive style.

Dr Pradeep Philip
Secretary

Encl:

RESPONSE provided by the Secretary, Department of Health – continued

**Victorian Auditor General's Office (VAGO)
Performance Audit
Carer Support Programs – Department of Health
July 2012**

VAGO Recommendations

That departments:

1. Identify and address gaps in the promotion of carer supports to improve carer awareness of services
2. Require consistent carer identification and needs assessment
3. Improve administration and monitoring of carer brokerage funds
4. Monitor and report on timeliness of access to carer supports
5. Develop outcome measures for carer supports and monitor outcomes.

The Department of Health accepts all recommendations. The following comments are provided to clarify and respond in detail to audit background information, conclusions and recommendations.

1. Background

Introduction/Population demographics

Understanding the changing population demographics is crucial to providing services that meet people's needs and preferences. Changing demographics of the Australian population, including the 'ageing population', result from various factors including: changing birth rates that have been low for some time, have spiked occasionally, and now are on the increase; reduced social stigma and increased community awareness about issues such as mental illness; increased self reporting of health status; better disease prevention strategies and responsive health care; and increasingly longer life spans of Australians.

Carer needs/Health status

Australian Institute of Health and Welfare (AIHW), and Australian Bureau of Statistics (ABS) 2012 reports demonstrate the complexity of the nation's health. Australians increasingly enjoy one of the highest life expectancies in the world, and level of smoking continues to fall. On the other hand, Aboriginal and Torres Strait Islander people generally fare worse on several health measures such as life expectancy, and have lower rates of access to, and use of, health services. Generally, those who are less well-off financially have less healthy lifestyles and poorer health; the further people live away from major cities, the less healthy they are likely to be; and severe or profound disability often carries an extra health burden. Furthermore, the prevalence of chronic diseases that can be related to diet, such as cardiovascular disease, diabetes and some cancers, is increasing.

RESPONSE provided by the Secretary, Department of Health – continued

Needs, preferences and living arrangements

It is estimated that there are about 194,000 primary unpaid carers in Victoria, excluding carers of people with a mental illness, who provide support to someone for at least some of their daily living activities. The Victorian Government is keen to support people living well at home for as long as possible.

Carers are a heterogeneous group with diverse needs and preferences. All carers are in a care relationship, and the needs and preferences of those being cared for in the relationship also need to be considered in delivering services and support to people. Thus services need to identify the needs and preferences of carers and those being cared for in care relationships, and seek to meet them through person centred approaches.

Most but not all carers may feel additional strain from their carer responsibilities. Likewise, most but not all carers may be negatively impacted upon regarding their financial position, social connections, and health and wellbeing. Not all carers and people in care relationships seek or desire government support and these preferences need to be respected. Not all carers perceive themselves as carers.

While many Victorians with care needs have a live-in partner, other family member or friend providing care, the number of single person households is growing. Policies, programs and services need to be able to support people who do not have carers and have care needs as well as people who do have carers.

Such heterogeneity among Victorian households, carers and those they care for means it can be complex and challenging to support Victorians in and without care relationships, and meet their diverse needs and preferences. Nevertheless, seeking to meet diverse and specific needs of individuals is a feature of departmental programs and services.

Victorian programs supporting carers

The Victorian Department of Health - Mental Health Carer Support Program, and Ageing and Aged Care Branch Support for Carers Program provide carers with respite from their care role, and other types of support. The Home and Community Care (HACC) Program, jointly funded by the Commonwealth and state governments, provides care recipients with services and support, indirectly providing respite and support to carers. Palliative care funds service providers for direct support of people with a life-threatening illness, including their family and carers; specific initiatives are funded to provide practical and psychological support for carers.

The service providers funded for these various services and support vary greatly in size, infrastructure, location, way of operating and primary purpose. While the department is mindful of applying what could be onerous requirements on smaller organisations for the sake of statewide consistency, it seeks equity for Victorians in knowing about, and being able to access services to meet Victorians' diverse needs and preferences. The department also seeks to identify appropriate ways for continuous improvement of services to occur, including developing and monitoring outcome measures.

Department of Health staff are not directly involved in service provision to support carers, but manage service agreements and other contractual arrangements with service providers for service delivery. Peak bodies such as

RESPONSE provided by the Secretary, Department of Health – continued

Carers Victoria are also funded to support carers, including carer and family capacity building and forward planning to meet care needs as they change.

Legislation

The Department of Health is pleased to note the VAGO finding that the department recognises that supporting carers is core business. It welcomes the report's acknowledgement that the Department and service providers have demonstrated a commitment to realising key policy documents such as the 2006 *Recognising and Supporting Care Relationships* and the 2010 *Victorian Charter Supporting People in Care Relationships*. The Department notes that the development of the *Carers Recognition Act 2012* is a continued demonstration of the commitment to recognise the role of carers and care relationships. VAGO's recognition of the Department's work in effectively consulting with and involving carers in policy development is also welcomed. The Department is committed to continuing and strengthening its engagement with carers, so that its carer support programs aim to improve outcomes for Victorian carers.

Carers Recognition Act 2012

On 1 July 2012, Victoria enacted the *Carers Recognition Act 2012*, supported by the Victorian charter supporting people in care relationships. Under the Act, state government departments, councils, and organisations funded by government to provide programs or services to people in care relationships, need to:

- ensure staff are aware of and understand the principles in the Act
- ensure staff promote the principles to people in care relationships, so that people in care relationships are aware of and understand the principles in the Act
- reflect the care relationship principles in developing, providing or evaluating support and assistance for those in care relationships.

The Act and charter support:

- promotion of carer supports to improve carer awareness of services. For example, organisations can put information about the Act and the charter in media promotions or community awareness strategies such as Carers Week, Mental Health Week, Dementia Awareness Week, and World Alzheimer's Day.
- consistent carer identification and needs assessment, and targeting services to meet needs, for example services that suit the cultural identity of the people in care relationships. An organisation can review its procedures and practices regarding service provision and consider how they can be aligned with the Act and charter, for example by developing a checklist that includes discussion with the people in a care relationship about their opinions being sought and acted on, from assessment to review stages.
- measures and monitoring of outcomes, for example developing an implementation plan that includes satisfaction surveys and a complaints mechanism; a funded organisation can distribute satisfaction surveys at assessment and review meetings between carers, those receiving care and workers. An organisation can use annual surveys to gain feedback about the Act and charter from people in care relationships, assess issues raised, and make improvements where required.

The Act requires that State government, councils and organisations funded by government to provide programs or services to people in care relationships report annually on how they have met their obligations under the Act.

RESPONSE provided by the Secretary, Department of Health – continued

Audit objective

The audit was to assess the extent to which the Departments of Health and of Human Services are effective in recognising and supporting people who care for others by examining whether:

- Supports and service are accessible to carers
- Agencies' practices recognise the role of carers and provide effective support.

The Department of Health considers that the relevant policies, programs and services in the Mental Health, Drugs and Regions Division, and the Wellbeing, Integrated Care and Ageing Division, seek to make supports and services accessible to carers who want supports and services, reflect recognition of the role carers play in our society, and seek to provide effective supports to carers.

Representatives of relevant program areas in the Departments of Health and of Human Services have re-established a cross program committee to achieve consistency in policy, practice and service delivery where this is appropriate and desirable. This committee is to include representation from Carers Victoria.

Networking of Support for Carers Program (SCP) funded organisations

The Ageing and Aged Care Branch (A&ACB) is supporting, through its regional contacts, the networking of local SCP agencies to:

- Enhance SCP agency awareness of carer respite and support on a regional basis
- Reinforce consistent carer identification and needs assessment, and administering and monitoring of carer brokerage funds
- Support timeliness of access to carer supports through local knowledge of other agencies
- Share examples of good practice that supports carers, including measuring and monitoring of outcomes for carers.

A&ACB is also exploring the establishment of an online site similar to MHpro, a forum for people working in mental health promotion in Victoria. The forum is used to share information on: mental health promotion experiences, new research, policy development, projects, the latest news, upcoming events or to ask for advice from fellow members on mental health promotion. User comments and opinions are encouraged, and users post their thoughts and feedback, to exchange ideas with department staff and with one another. An A&ACB online forum could be used to communicate with service providers and alert them to new initiatives etc.

Relevant Commonwealth government initiatives supporting carers

Victorian initiatives to support carers build on existing Commonwealth government funded initiatives, including:

- The National Respite for Carers Program, funded approximately \$45–50 million in Victoria.
- The Home and Community Care Program.
- The Living Longer Living Better initiative that includes supporting carers of people with dementia.
- The *Mental Health Respite Initiative* for flexible respite options for carers of people with mental illness and carers of people with intellectual disability (including autism) - approximately \$224.7 million over five years.

RESPONSE provided by the Secretary, Department of Health – continued

2. Recommendations

<p>1. Identify and address gaps in the promotion of carer supports to improve carer awareness of services</p>
<p>VAGO comment</p> <p>The VAGO report suggests that despite demonstrated efforts by the departments and service providers to promote carer support programs, carers report a lack of awareness of supports.</p>
<p>Departmental response</p> <p>The recommendation is accepted.</p> <p>Actions</p> <p>Ageing & Aged Care Branch</p> <ul style="list-style-type: none"> • Review and redevelop the HACC and Ageing and Aged Care web site to improve communication to people in care relationships about support services for carers. • Review and redevelop the HACC and Ageing and Aged Care publications to improve communication to people in care relationships about support services for carers. • Liaise with relevant key stakeholders and peak bodies involved in providing information and support to carers to review and improve information about DH funded support services for carers. • Amend the SCP guidelines and annual report template, so that: <ul style="list-style-type: none"> a) Providers need to seek the following information from carers: "How did you find out about this service?" b) Providers will report this information in the annual report template c) There will be analysis and evaluation of the responses every three years, including considering focus groups of carers, to identify if necessary appropriate promotion methods to carers of carer support services. <p>Palliative Care</p> <ul style="list-style-type: none"> • Require palliative care services from 2012-13 to report to DH that they have undertaken self assessment against the national palliative care standards in order to be recognised by DH as a specialist palliative care service. Standard Five of the national palliative care standards includes the following quality elements in relation to carers: <ul style="list-style-type: none"> ○ Assessment of carer availability and needs ○ Provision of information and resources to carers ○ Establishment of networks to support carers ○ Provision of support and information to carers to manage emergency and after-hours situations. <p>Mental Health, Drugs and Regions Division</p> <ul style="list-style-type: none"> • Consider options to identify and address gaps in the promotion of carer supports including the promotion of the Carer Support Fund, provision of advice, counselling, and respite services, and training opportunities for carers of people with a mental illness.

RESPONSE provided by the Secretary, Department of Health – continued

<p>2. Require consistent carer identification and needs assessment</p> <p>VAGO comment</p> <p>The VAGO report suggests service providers do not consistently assess, either directly or by referral, the needs of carers they interact with to identify and provide assistance to those who may need and want support.</p>
<p>Departmental response</p> <p>The recommendation is accepted.</p> <p>Actions</p> <p>Department of Health</p> <ul style="list-style-type: none"> • A recent review of the primary Care Partnership Service Co-ordination Tool Templates (SCTT) and processes has resulted in incorporation of a carer identification component. This provides a mechanism for consistent carer needs identification, and referral for follow-up. Interactive forms will be available by 1 August 2012, and it is estimated that the electronic referral tools will be available from July 2013. <p>Ageing & Aged Care Branch</p> <ul style="list-style-type: none"> • Apply the use by HACC Assessment Services of the guide “Strengthening assessment and care planning. Dementia practice guidelines for HACC assessment services”, to improve the depth and consistency of their practice in identifying the needs of carers. A&ACB notes that the VAGO report recognises the value of the HACC Assessment Guidelines and the role of HACC assessors in considering needs of families and carers as well as the primary client (older person). • Incorporate into the SCP guidelines the application of the HACC assessment principles by SCP providers, most of which are also funded by HACC. • Incorporate into the SCP guidelines use of the SCTT as one option for identifying carer needs and referral for follow-up. SCP funded organisations will need to outline the carer identification and needs assessment tool they use in their annual report. <p>Palliative Care</p> <ul style="list-style-type: none"> • Require from 2012-13, as detailed under recommendation 1, palliative care services to undertake self assessment against national standards including carer identification and needs assessment. • Undertake specific projects in 2012-13 to strengthen palliative care carer assessment in the areas of bereavement, after hours care, and paediatrics. The use of specific clinical tools to assess carer support needs and distress will be rolled out across the sector. <p>Mental Health, Drugs and Regions Division</p> <ul style="list-style-type: none"> • Explore options to better identify carers, so they are able to access the services and supports they need.

RESPONSE provided by the Secretary, Department of Health – continued

<p>3. Improve administration and monitoring of carer brokerage funds</p> <p>VAGO comment</p> <p>The VAGO report suggests consistent prioritisation of carer need is necessary for equity and timely access to high demand services for those in greatest need, and that departments could do more to provide guidance to service providers distributing brokerage funds for carers.</p>
<p>Departmental response The recommendation is accepted.</p> <p>Actions</p> <p>Ageing & Aged Care Branch</p> <ul style="list-style-type: none"> • Reinforce with service providers the purpose of the SCP to provide flexible respite and support to meet individual and unique needs and preferences of carers and those they care for. • Review the suite of SCP activities used in service agreements so that they reflect current practice and encourage innovation among service providers. Activity types currently reported via the HACC MDS (and reported quarterly to the Department of Treasury and Finance) appear to be suitable for reporting agency outputs in terms of hours of service and numbers of people receiving a service/ support in a consistent way. Funds spent on goods and equipment can be reported via the categories in the HACC MDS. • Amend the guidelines and the annual report template of the SCP, so that: <ol style="list-style-type: none"> a) The guidelines demonstrate ways for providers to assess and prioritise carer need for flexible support b) Providers describe in their annual report their process for assessing need for and prioritising provision of flexible support c) Providers annually report on how they have acquitted their funds for flexible support d) There is analysis and evaluation of the responses every three years for equity and access by carers to flexible support and seeking to address issues if there are any. <p>Palliative Care</p> <ul style="list-style-type: none"> • Update the palliative care Unassigned Bed Fund (UBF) (includes provision of respite and aids and equipment to support carers) in 2012-13 and communicate revised version to palliative care services to promote more consistent use of the UBF. Services are required to report annually to the Department on their use of the UBF. <p>Mental Health, Drugs and Regions Division</p> <ul style="list-style-type: none"> • Continue working on enhancing departmental monitoring arrangements for the Carer Support Fund (CSF). The need to enhance departmental monitoring arrangements for the CSF is acknowledged. The CSF is an important program for carers of people with a mental illness accessing the public mental health system by providing them with timely and flexible funding assistance for needs associated with their care role.

RESPONSE provided by the Secretary, Department of Health – continued

<p>4. Monitor and report on timeliness of access to carer supports</p> <p>VAGO comment</p> <p>The VAGO report suggests that departments and service providers do not routinely collect wait time data for accessing services and carer supports. Aged care respite providers report that they are generally able to meet demand.</p>
<p>Departmental response</p> <p>The recommendation is accepted, noting that it is to be determined whether the concept of 'waiting times' for respite makes sense for SCP or HACC-funded agencies. For instance, wait time is not appropriate for emergency respite or planned respite if booked weeks or months in advance. Therefore it is premature to set up a reporting framework on waiting times.</p> <p>Actions</p> <p>Ageing & Aged Care Branch</p> <ul style="list-style-type: none"> • Investigate potential waiting time measures for HACC and SCP through the following steps: <ul style="list-style-type: none"> a) Survey agencies to establish baseline data on categories of respite (such as booked, non-booked and emergency) b) Implement a pilot project to gather waiting time data and investigate practicality of setting benchmarks on timeliness in delivering respite to carers. <p>Depending on findings, outcomes can be applied uniformly to HACC and SCP, for instance by amending program guidelines and annual report template of the SCP.</p> <p>Palliative Care</p> <ul style="list-style-type: none"> • Implement the recommendations of the palliative care triage project. • Manage demand by triaging patient and carer need in preference to palliative care services establishing waiting lists. The Palliative Care Clinical Network is currently undertaking a project to develop consistent and equitable approaches to triage for palliative care service providers. <p>Mental Health, Drugs and Regions Division</p> <ul style="list-style-type: none"> • Consider options to improve monitoring and reporting processes on timelines of access to carer supports.

RESPONSE provided by the Secretary, Department of Health – continued

<p>5. Develop outcome measures for carer supports and monitor outcomes</p> <p>VAGO comment</p> <p>The VAGO report suggests that departments and service providers cannot clearly demonstrate the effectiveness of carer support programs. VAGO suggests standardised outcome measures, for example comparing carer wellbeing before and after provision of supports.</p>
<p>Departmental response</p> <p>The Department accepts the recommendation, noting that the terminology 'outcome measures' refers to immediate, not long term, outcomes for carers.</p> <p>Actions</p> <p>Department of Health</p> <ul style="list-style-type: none"> • Co-ordinate carer satisfaction surveys across DH if appropriate. <p>Ageing & Aged Care Branch</p> <ul style="list-style-type: none"> • Provides quarterly data to DTF on: departmental performance against output targets; emerging risks to future performance; financial performance; and identification of budget pressures. SCP measures include: an annual unduplicated count of the number of discrete carers supported; and the number of hours of respite and support provided quarterly. • Develop a project to work with service providers on an agreed framework of outcome measures for SCP and HACC in relation to services for carers. The project will build on the achievements of Disability Services and Palliative Care (e.g. regarding the reduction in carer stress). <p>Palliative Care</p> <ul style="list-style-type: none"> • Fund a mandatory annual survey of patient and carer satisfaction with palliative care services, the Victorian Palliative Care Satisfaction Survey (VPCSS). The survey includes a section regarding carer outcomes. • Maintain the mandatory administration of the VPCSS for palliative care services including the collection of carer outcome data. <p>Mental Health, Drugs and Regions Division</p> <ul style="list-style-type: none"> • Consider options for increasing effectiveness of carer support programs in improving outcomes for carers.

RESPONSE provided by the Secretary, Department of Human Services



Department of Human Services

Secretary

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25 JUL 2012

e2768767

Mr D D R Pearson
Auditor-General
Level 24
35 Collins Street
MELBOURNE VIC 3000



Dear Mr Pearson

Thank you for the opportunity to comment on the proposed report of the *Performance Audit of Carer Support Programs* under section 16(3) of the *Audit Act 1994*. The Department of Human Services welcomes the report and in general accepts its recommendations, which will play a key part in shaping our ongoing work to recognise and support carers.

The department's response to the recommendations of the report is enclosed.

In recognition of the vital role that carers play, the department is committed to strengthening the service system to support carers, and help build positive and resilient care relationships.

The proclamation of the *Victorian Carers Recognition Act 2012* puts a strong focus on carer support and the department is working actively with community providers and support groups to promote the principles and responsibilities outlined in the Act. This will assist the department and relevant organisations to embed a culture of carer recognition in their service provision. The department is pleased to be leading the work to support implementation of this important piece of legislation.

A Carer Action Agenda will be developed to complement the Act, describing a range of activity to improve services and create a more supportive environment for carers. The *Victorian charter supporting people in care relationships* has been updated to incorporate the expectations and requirements of the Act.

The audit report comes at a time of significant reform within the human service system. Released in December 2011 by the Ministers for Community Services and Housing, *Human Services: The case for change* outlines the need to take a new approach to the way human services are delivered in Victoria. *Services Connect* is the improved way the department and our service providers will deliver more holistic, client-centred and family focussed services to our clients in the future.



**RESPONSE provided by the Secretary, Department of Human Services –
continued**

The findings and recommendations of the audit will also inform Victoria's participation in the important development of the National Disability Insurance Scheme and response to Victoria's Vulnerable Children Strategy.

Should you wish to discuss the content of this response further, please do not hesitate to contact Mr Mike Debinski, Acting Executive Director, Disability Services on 9096 8254.

Yours sincerely



Gill Callister
Secretary

Enc.

**RESPONSE provided by the Secretary, Department of Human Services –
continued**

**Department of Human Services (the department) response to recommendations
in the proposed report of the Performance Audit of Carer Support Programs**

That Departments:

**1 identify and address gaps in the promotion of carer supports to improve carer
awareness of services**

Accepted in principle

Over recent years, the department has increased efforts to raise awareness of supports to carers of people with a disability, including the implementation of initiatives such as Respite Online, which provides carers with web based information about respite services in their local area.

The department is establishing a three year calendar of information and training sessions to support carers in CYF, and all training sessions will be available for statutory and non-statutory kinship carers. A calendar of professional development training sessions is also being developed for kinship staff who are critical in supporting kinship carers.

The department acknowledges the importance of maximising carer awareness of available supports and will investigate opportunities to strengthen effort in this area. Further commitments in relation to promotion and evaluation activities will be considered within the context of available resources.

Promotion and carer awareness of services will also be considered within the development of a Carer Action Agenda to be developed to complement the enactment of the *Carers Recognition Act* on 1 July 2012.

2 require consistent carer identification and needs assessment

Accepted

The department agrees that reliable carer identification processes exist across the two programs. There is an opportunity however to improve consistency of formal practice guidance regarding our approach and response to carer needs.

Person centred and holistic service delivery responses put the person at the centre of planning and support but are inclusive of significant others in an individual's life, including families and carers. The reorientation of disability services over recent years has led to greater choice and control for people with a disability, their families and carers in planning for, and the delivery of supports.

The *Disability Act 2006* states that planning should where relevant, consider and respect the role of family and other persons who are significant in the life of the person with a disability. As such, planning is undertaken cognisant of the needs of the person with a disability, but also the needs and subsequent supports required to sustain the care relationship.

**RESPONSE provided by the Secretary, Department of Human Services –
continued**

CYF has a standardised assessment process with three tools 'Kinship Carers assessment Part A, Part B and the annual review Part C'. These assessments identify a range of supports for carers in relation to how they will care for the child at the commencement of a placement, when the placement will be long term and at the annual review. The assessments gather information on the carer's health, identifying the needs of the carer to establish and continue a placement and commencement of caregiver reimbursement.

When Child Protection refer cases to funded kinship care services for case management or placement establishment support, assessments undertaken in this context identify the support needs of carers and form the basis of interventions and support that is tailored to meet the family needs.

The department's new approach to working with clients - *Services Connect* - will develop a more consistent approach to needs identification. It will work towards a holistic approach to understanding the range of issues impacting on the individual or family, as well as their capacity to organise and stay connected to the level of support they need.

3 improve administration and monitoring of carer brokerage funds

Accepted

People with a disability can access flexible disability services funding via a number of different models which may include a brokerage component. Flexible Support Packages for example, provide discretionary funding and/or case management to support individuals, families and carers on a short or long-term basis. Whilst the audit does not identify outstanding issues in relation to these funds, Disability Services Division will continue to consider the role of flexible funding and associated administration processes within the broader reorientation to self directed funding.

In response to an Ombudsman Victoria recommendation, CYF commenced a review of all brokerage and available funding sources across all out of home care activities in 2011. CYF is investigating options to administer all brokerage funding in a more transparent and equitable manner for eligible carers.

4 monitor and report on timeliness of access to carer supports

Accepted in principle

The department acknowledges that its carer support response could be strengthened through the collection and monitoring of data related to the timeliness of support services.

For CYF programs, reports can be generated on the timeliness of commencing caregiver reimbursements and the provision of one-off payments. Care arrangements are monitored through the Client Referral Information System (CRIS).

**RESPONSE provided by the Secretary, Department of Human Services –
continued**

Both Disability Services and CYF programs will investigate how to improve their monitoring of timeliness of carer supports. For Disability Services, this will be considered within a broader piece of work to reform respite. CYF will explore how its current assessment and referral processes could be modified to capture and monitor timeliness data. This information will inform future service improvement.

5 develop consistent outcome measures for carer supports and monitor outcomes

Accepted in principle

The department is committed to strengthening its focus on outcomes measurement and agrees that this should be inclusive of carer supports.

Outcomes measures are a component of a number of existing carer support initiatives including the 2011-12 Disability Innovative Respite program; and the updated program requirements for CYF home based care.

Work will occur to identify further opportunities to measure outcomes of carer support. This will include how to redevelop the Disability Respite Carer Satisfaction survey to provide more consistent and comprehensive information about the outcomes for carers.

Auditor-General's reports

Reports tabled during 2012–13

Report title	Date tabled
Carer Support Programs (2012–13:1)	August 2012

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