

# About The Benevolent Society

The Benevolent Society is Australia’s first charity. We’re a not-for-profit and non-religious organisation and we’ve helped people, families and communities achieve positive change for 200 years.

We help people change their lives through support and education, and we speak out for a just society where everyone thrives.

The Benevolent Society helps the most vulnerable people in society, and supports people from all backgrounds including Aboriginal and Torres Strait Islanders and people from culturally and linguistically diverse communities. We believe that building stronger communities will lead to a fairer Australia.

Our focus is to foster wellbeing throughout life – from infancy to older age – with services that:

prevent problems or reduce their negative impact

tackle problems early before they become entrenched

help people use their strengths to solve their own problems

give priority to people experiencing social and financial disadvantage.

The Benevolent Society delivers a diverse range of community aged care and disability services across the Sydney metropolitan area and regional NSW including Home Care Packages, Commonwealth Home Support Program services such as domestic assistance, personal care, respite, Assistance with Care & Housing for the Aged (ACHA), specialist disability supports for children and young people and support for people with mental health issues.

**Snapshot**

1. The Benevolent Society is a secular non-profit organisation with 912 staff and 588 volunteers who, in 2014/15, supported more than 75,270 children and adults primarily in New South Wales and Queensland.
2. We deliver services from 62 locations with support from local, state and federal governments, businesses, community partners, trusts and foundations.
3. We support people across the lifespan, delivering services for children and families, older people, women and people with mental illness, and through community development and social leadership programs.
4. 10% of our services are aged care and disability programs, employing 267 staff.
5. Our revenue in 2014/15 was $108 million.
6. In 2014/15, 79% of our income came from government sources. Private fundraising, trust and foundation grants provided another 4%, client fees generated 7% and investment income contributed 10%.
7. The Benevolent Society is a company limited by guarantee with an independent Board.

## Design Approach

The Benevolent Society (TBS) supports the use of co-design principles in developing a new integrated carer support service system which uses both evidence sourced from literature and consultation with Departmental and external groups such as Carer Gateway Advisory Group, Subject Matter Experts and the Carer Working Group.

This approach acknowledges that carers are not a homogenous group, many people who are carers don’t acknowledge their role and that good evidence of what works comes from a range of sources. It also needs to be acknowledged that a lack of good evidence does not always mean that something doesn’t work. It could mean that the research hasn’t been done, hasn’t been published or hasn’t looked for the right outcomes in the right way.

The Benevolent Society would also support a consumer directed approach to carer support which is underpinned by strong carer assessment processes, program logic and an outcomes framework. A program logic captures why the program should succeed. Like a roadmap, it describes why the program is in place, why it does what it does and what (outcomes) it is hoping to achieve. The process of developing a Program Logic is a method of defining what ‘best practice’ in the program looks like.

TBS would also support an approach which allocates resources according to need with need being comprehensively assessed through intake, assessment and planning processes. Such an approach would allow a tiered resource allocation formula such as that used for Home Care Packages (HCP) and give carers more choice and control over which evidence based services they can choose to best meet their needs at their stage in caring.

## Carers and Economic Value

It’s interesting to note the large gap between the estimated economic value of the caring role (around $60.3 billion or 60% of the health and social work expenditure in 2015 – Page 8) and the total cost of carer support services ($170.219 million in 2014-15 on carer programs and $7 billion on social security payments. (Page 9)

## Drivers for Change

An acceptance of the large amount of unmet need such as long waiting lists for services – not just for carer services but also for care recipient services, carers not acknowledging their role(Page 15) and the fragmentation of the current carer support system, is also important.

These pressures for change will increase as the Australian population ages and the number of family carers decline. Other challenges include the greater focus of emerging support programs on the care recipient rather than the carer e.g. The National Disability Insurance Scheme (NDIS) Tier 3, My Aged Care (MAC) and the Commonwealth Home Support Program (CHSP).

## A shift towards prevention

In terms of the evidence analysed and the accompanying design considerations, comments below are made for each service element. Overall, the view is that an outcomes framework should be developed to collate the evidence for proposed supports according to the strength of its effectiveness, preferably for the different stages in the caring role if possible, and use this to design a suite of supports that carers can choose from according to what suits them best at the stage they are at. Carer needs for different supports will vary over time according to their individual situation. As affordability may be an issue, both for funders and carers, the cost- effectiveness of each intervention needs to be assessed.

***Awareness Raising*** is important particularly to be able to reach those carers who do not acknowledge their role and also to identify carers early so effective preventive supports can be put in place. This can be done even before someone is thinking of becoming a carer. Multiple avenues and methods should be used to raise awareness and these should be targeted depending on the audience e.g awareness raising in Aboriginal communities will require a different approach to that for young carers who are still at school or supporting someone who is receiving healthcare.

***Information provision*** is similar to awareness raising in that it needs to be targeted and tailored to individual carers situations and stage in the caring role. We agree that information provision should be individualised and could be provided as part of any service type.

***Intake***  should be a mandatory process where needs are thoroughly assessed and, if done well, can guide carers to the most effective and timely intervention for the stage they are at in their caring role. Intake may be done at several time points e.g. initially for emergency assistance and later for ongoing supports. The most important thing with intake is that carers don’t have to keep repeating their story, there is a central record and a ‘one stop shop’. There seems to be evidence that self-assessment approaches do work. [[1]](#footnote-1)

***Education*** as with awareness raising and information provision, education should be tailored and targeted. Effectiveness seems to be well established but the challenge will be designing an education support programme which is cost effective, and which has the most effective elements at its core. Innovative access to education also needs to be available i.e. on-line, respite available for the care recipient if face to face attendance is required/preferred. As with other education and training programs the 70:20:10 rule applies i.e. 70% of learning comes from practical experiences - working on tasks and problems; about 20% from feedback and working around good and bad examples; and 10% from courses and reading*.* [[2]](#footnote-2)

***Peer support*** there are already organisations such as Carers Australia, which provide these services. Again offering peer support which has flexible delivery options such as on-line, phone, face to face is important. Carers could register themselves as being available to offer peer support. Registration may require the completion of prior learning and other checks.

***Needs identification and planning*** should be linked with *Intake* and be part of the prioritisation process. If there are markers which can identify carers at the early stages these would be invaluable to use at Intake & Planning to reduce the use of more costly services later on. As mentioned in *Intake* above, there is evidence that this can be done effectively through self-assessment. Goal based planning can be done easily using standard tools such as the Goal Attainment Scale (GAS).[[3]](#footnote-3)

***Multicomponent interventions*** should be the preferred approach to supporting carers. As mentioned previously, using those interventions which have been shown to be most effective and make them available either individually or as a flexible package of carer support services based on need. It would be through *Intake* and *Needs identification and planning* that skilled assessors (or smart systems) should be able to prioritise recipients.

The Benevolent Society delivers a ***Consumer Directed Respite Care (CDRC)*** programme which has proved to be very positively received by our clients. Our observations of the benefits and limitations of CDRC are:

***Benefits of CDRC:***

*Flexibility*– the carer chooses how the funding is spent to help achieve their goal (which is usually to get a break from the caring role e.g. a long awaited holiday knowing that the person they care for is being supported). CDRC can be used flexibly to pay for residential respite, equipment, day centre respite etc.

*Complementary* – where there is high carer stress and the person being cared for is receiving a low level Home Care Package but is waiting for a higher level, then CDRC can be used to fund a service gap for the carer while they wait.

*Transparent* – the carer gets to see how the funding is being used and how much it is costing

*Choice* –the carer gets decide to who delivers the respite care and when

*Increased respite* - with short-term emergency respite there can be limits to the amount of support service providers can give e.g. short term emergency respite can fund a maximum of 2-3 nights whereas CDRC can fund around 4-5 nights.

*Effective* – TBS has done a short survey with some CDRC carers. 100% of those surveyed felt much more supported and much more involved in the decision making.

***Limitations of CDRC:***

*Short-term* – the total CDRC budget of $4200 provides around 88 hours of support, once per financial year. This makes it difficult to support carer’s needing more.

*Age limitation* - Priority eligibility for CDRC is for care recipients over 65 years or over 50 for Aboriginal people.

The benefits reported above are similar to those reported in the KPMG evaluation of CDRC in 2012.

*Direct Cash Payments* need not necessarily be the way to fund carer supports but could be optional for carers who demonstrate capacity and are willing to take on the administration. The way CDRC and Consumer Directed Care Home Care Packages operate is another option which seems to work well and one that providers and consumers are familiar with.

The National Disability Insurance Scheme does not operate as a direct cash payment scheme and is still able to provide affordable disability supports based on assessed need and prices are currently controlled.

*Counselling*education, information provision and peer support are interventions where there is evidence they can be provided effectively through a variety of mediums such as online and telephone, face to face to consumers in a much more cost-effective and timely way than face to face counselling. If consumer preference is for face to face then possibly co-payments could be an option to support the greater cost.

*Supporting all Carers*as mentioned previously whatever carer support options are offered, there needs to be tailoring for the audience such materials provided in different languages, at different venues, by different service providers.

For carers either currently working or returning to the workforce, carer supports need to be able to extend across , during and after working hours. This has sometimes been a shortcoming of existing respite services.

Carer support should not cease immediately when the caring role finishes. Post-care support, even if for a short period, should be an option.

*Providing integrated support*to care recipients either directly or through a carer can be provided through other services such as: information provision; education; peer support; intake, and needs identification and planning.

## Summary

In summary, TBS does support a multicomponent service design which is underpinned by an outcomes framework. This would provide the added benefit of the most effective service elements being linked to outcomes expected at different stages in the caring journey. TBS also supports the consumer directed approach to funding where although direct payments may not be available, consumers do have a flexible budget and can choose the supports which best suit their needs at the time they need them. This could operate in the same way that Consumer Directed Care in Home Care Packages does.

1. Designing the new integrated carer support service. Carer Support Needs Assessment Tool P 32. [↑](#footnote-ref-1)
2. Lombardo, Michael M; Eichinger, Robert W (1996). The Career Architect Development Planner (1st ed.). Minneapolis: Lominger. p. iv. [*ISBN*](https://en.wikipedia.org/wiki/International_Standard_Book_Number) [*0-9655712-1-1*](https://en.wikipedia.org/wiki/Special:BookSources/0-9655712-1-1). [↑](#footnote-ref-2)
3. Kiresuk, Thomas J.; Robert E. Sherman (1968). "Goal Attainment Scaling: A General Method for Evaluating Comprehensive Community Mental Health Programs". Community Mental Health Journal **4** (6): 443–453. [*doi*](https://en.wikipedia.org/wiki/Digital_object_identifier):[*10.1007/BF01530764*](https://dx.doi.org/10.1007%2FBF01530764). [↑](#footnote-ref-3)