

# **DCA Working Group**

## **Review of Domiciliary Allowance Scheme**

September 2012

### **Background to DCA Working Group**

In March 2012 following a public meeting to discuss parents issues with the Domiciliary Allowance Scheme, a DCA Working Group was established with representation from Irish Autism Action, Inclusion Ireland, Special Needs Parents Association, Down Syndrome Ireland, The Midland Regional Forum of People with Disabilities and The Carers Association was subsequently invited to join the Group.

At the initial meeting of the DCA Working Group it was agreed that the Working Group would draw up a position paper on Domiciliary Care Allowance that would encompass the experiences of representations that had been made by parents members the organisations involved and at the open meeting on the 5th March.

The newly established Working group decided to document the views expressed by parents and organisations on the current operation of the DCA Scheme, note areas of concern and provide the Department of Social Protection with a solution focused paper on how improvements could be made to the scheme.

## 1. The objectives or purpose of the scheme-Background to Domiciliary Care Allowance:

In 1965, the report of the Commission of Inquiry on Mental Handicap (1965) stated “*some families need **financial assistance to cover the cost** of special food, medicines, of appliances required, the cost of excessive damage to bedding, etc. We recommend that health authorities should provide such **assistance for families** who suffer hardship in providing what is required from their own resources.*”

Several years later in 1973 Domiciliary Care Allowance was introduced in as a payment made to families of children with disabilities in recognition by the State of the additional care given in the home by such families.

*“This is specifically designed to help parents of severely handicapped children under 16 years of age. Very often these have to be cared for at home at **considerable expense** to the parents. It is my desire to help them and the children by making allowances to the parents.”*

Minister for Health Brendan Corish, Budget Speech 22<sup>nd</sup> May 1973

In 2009 the Department of Social Protection took over the administration of the DCA scheme and DCA was put on a statutory footing by way of the Social Welfare (Miscellaneous Provisions Act) 2010 which states:

*(1) A person who has not attained the age of 16 years (in this section referred to as the ‘child’) is a qualified child for the purposes of the payment of domiciliary care allowance where—*

*(a) The child has a severe disability requiring continual or continuous care and attention substantially in excess of the care and attention normally required by a child of the same age,*

*(b) The level of disability caused by that severe disability is such that the child is likely to require full-time care and attention for at least 12 consecutive months,*

*(c) The child—*

*(i) is ordinarily resident in the State, or*

*(ii) satisfies the requirements of section 219(2),*

*and*

*(d) the child is not detained in a children detention school.*

*(2) A medical assessor shall—*

*(a) assess all information provided to him or her in respect of an application for domiciliary care allowance, and*

*(b) provide an opinion as to whether the child satisfies paragraphs (a) and (b) of subsection (1).*

*(3) In determining whether a child satisfies paragraphs (a) and (b) of subsection (1), a deciding officer shall have regard to the opinion, referred to in subsection (2)(b), of the medical assessor.”*

According to the information available from the Department of Social Protection website this is translated as follows:-

*“Domiciliary Care Allowance is a monthly payment to the carer of a child with a disability so severe that the child requires care and attention and/or supervision substantially in excess of another child of the same age. This care and attention must be provided to allow the child to deal with the activities of daily living. The child must be likely to require this level of care and attention for at least 12 months”.*

Domiciliary Care Allowance is classed under EU Regulation 883/2004 as a Family Benefit, not an income support. Therefore, it is not a non means tested Carers Allowance, but is effectively a monthly payment to parents/guardians to support families where a child has a severe disability/condition.

Family Benefits<sup>1</sup> are defined as:-

*“All benefits in kind or in cash intended to meet family expenses, excluding advances of maintenance payments and special childbirth and adoption allowances mentioned in Annex 1 of the regulation”.*

Domiciliary Care Allowance is used to cover a multitude of expenses/costs incurred by a family unit, where a child has significant sensory, intellectual, medical, behavioural, physical or emotional disabilities.

Prescribing what the payment can be used for, would restrict the benefit of the payment in meeting the child’s individual needs and that of the family as a whole, as the expenses incurred by the family as a result of meeting the child’s needs is unlimited.

- ▶ Cost of any housing adaptations (income threshold €65000) General house proofing for child safety purposes e.g. Window locks, extra door locks.
- ▶ Special Clothing- Bibs, special feeding utensils, rear fastening garments, wheelchair rainwear, seamless garments & socks.

- ▶ Special needs buggies/walkers for children with certain conditions, excluding physical disabilities not sanctioned by HSE.
- ▶ Special dietary requirements.
- ▶ Therapeutic toys & sensory equipment not provided by HSE.
- ▶ House repairs-damage caused through severe behavioural episodes. Replacement of damaged goods/furnishings/bedding.
- ▶ Contenance Care- Nappies, pull-ups, pads (Where more are required than HSE limit or not provided), wipes, creams etc.
- ▶ Private Therapeutic Interventions & Assessments.
- ▶ Extra-curricular activities as recommended by therapists-hippo therapy, social skills groups, special group outings, swimming.
- ▶ Specialist childcare 1 to 1, subsidise home nursing care on top of that provided through charities/HSE.
- ▶ Sibling support-Counselling, activities
- ▶ Phone, postage, hospital parking charges, accommodation (Small tax concession from Revenue available)
- ▶ Fuel/Transport (Primary Medical Cert holders may qualify for tax reliefs)
- ▶ Cost of maintenance for Assistance Dogs.

## 2. The Application and Assessment Process

It is evident from listening to the views expressed by parents and the experience of the organisations involved that significant difficulties arise as early on in the process as the initial application form. Issues identified are consistent with all organisations experience and have been identified as follows:-

- ▶ Parents are unsure as when to make initial application as the legislation states child must have a severe disability. Parents report knowing from an early age the child has significant needs however, a long passage of time can lapse from the time parents seek referral for their child before it is actually confirmed that their child has a disability. This poses a difficulty with Q. 18 of DCA application form: - *From what date has additional care been required for this child?* It is also significant considering that reviewing the history of case is one of the three areas considered by the medical officer in forming an opinion as to whether or not the child meets the criteria for the scheme. It is also significant for a number of families who have applied for DCA since the economic downturn not because they weren't entitled to it previously but who had not applied as *"they didn't need it before now financially"*. Delay in obtaining confirmation of disability or delay in applying due to financial reasons should be taken favourably into consideration by medical officers when determining history of the case.
- ▶ Part 4 of application form gives the parent an opportunity to document difficulties in the area of communication, feeding, manual dexterity, learning, mobility, toileting and managing treatment. This part of the application poses significant difficulty for most parents both emotionally and in terms of clarity of what is required. Although the opportunity for input from the parent is most welcome it is being reported by parents that they feel a huge onus is being placed on the parent to provide excessive documentary evidence of their child's care needs. These care needs should already be stated by the professionals involved in their child's care by way of expert assessment reports. Parents report that a short note in each of the given boxes should suffice to verify their role in supporting the child's care needs as documented by professional reports but most are reporting having to provide a very detailed diary of daily activities and care. This is putting undue stress as well as emotional time and energy onto already traumatised and vulnerable parents. A more balanced approach would be a checklist of severity from the parents perspective similar to one for GP input from mild to profound in areas of daily living activities, self-care skills, community participation, home intervention programmes recommended by therapists, education and medical care.
- ▶ If further clarification is needed on a specific area or topic this should be sought by the medical officer before they give an opinion to deciding officer. This practice may in turn reduce the need for appeals or possible refusal due to lack of evidence.

- ▶ Q. 20 is an area of difficulty for parents and the relevance of the question *“Please state how often the child attends at clinics”* is somewhat questionable. For a lot of children with disabilities there are no services available but lengthy waiting lists. For some disabilities that are not medical in nature the parents are often left to accept diagnosis of disability and deal with the child’s needs as a lifelong condition that will not change substantially. It is recommended that the relevance of this question needs to be clarified and should be rephrased to indicate relevance. Also not attending any clinic should not negatively influence medical officer’s opinion.
- ▶ Under the list of services stated that child may be attending, it is recommended that a third column *“awaiting service”* should be added.
- ▶ No consideration is given to the overall family situation of parent on the application form e.g. How many other children in house-hold? Is family support available? Is there any other illness/disability in the household? A more holistic view needs to be taken on the impact of the child’s disability on the overall quality of life both for the child and also the family. It is therefore recommended that consideration be given to incorporating an impact of disability on family functioning either by way of report from professionals involved in the child’s care or from the family GP.
- ▶ Under part 6 of application form to be completed by GP it has been stated by the majority of parents that we have come into contact with that the GP is not necessarily familiar with the child’s difficulty. The family GP is normally the first point of contact for referral of the child to specialist service. It is the parent’s experience that once referral is made in a lot of cases the GP have no further involvement in the child’s on-going care. Although the GP opinion is an important part of the application and assessment process in certain cases it is felt that the relevant professionals involved with assessing and diagnosing the child’s condition are better placed to document level of on-going care needs.
- ▶ Q 3 and Q4 of Part 6 can also be problematic. In some cases a diagnosis may not be available for the child for a number of reasons e.g. a conclusion may not have been reached by assessors, their condition may be a rare disorder with no label available.
- ▶ Q 4 asked GP to fill out ICD 10 code for diagnosis it has been reported that GPs are not necessarily familiar with ICD 10 codes.

- ▶ Existence of 'More likely/Less likely' categories of ICD10 Codes, appear bias towards certain conditions and impairments. The DCA Working Group would question their purpose? Do they influence decisions? This list should be restricted to looking at the medical care needs involved and not the overall needs as a result of condition or impairment. The use of ICD10 codes should be restricted to the gathering a data for statistical analysis and should not be used as a tool to ensure uniformity of decisions made by Medical Assessors based on ICD10 codes. A quality insurance mechanism/oversight of their decision making process is necessary to ensure that comparisons are not made between cases and the level of disability therein, but that every case is measured against a child of similar age without any disability in accordance with the legislative requirements.
- ▶ The medical section questionnaire provided for the GP contains questions very much based on the medical model of and not the more relevant social model of disability. It is also noted that the questions provided are very much centred towards physical disabilities and do not allow for details relevant to children with intellectual disability, Autistic Spectrum Disorder and mental health difficulties. Learning and Intelligence are grouped together although they are two different areas with children who may have average or above average intelligence having a difficulty in their learning ability e.g. in the case of ASD. Mental Health / behaviour again are grouped together but are two entirely separate areas.
- ▶ A child may have mental health issues such as anxiety, depression or obsessive compulsive tendencies that make life extremely difficult for them and their carer but may not have behavioural issues outside of the home. Vice versa a child may have behavioural difficulties but not necessarily be assessed as having a mental health difficulty.
- ▶ It has also been reported that GPs need more guidance and information on filling out DCA form and what is required of them.
- ▶ A practical guide from the Department of Social Protection for parents on filling out application form and the information required by assessors in assessing claims would be very beneficial and would again ensure all necessary information needed is provided on application. The members of the DCA Working group are willing to engage in the development of a guide to completing applications in conjunction with the Department.

Eligibility should continue to be based on the level of care and **support** needs, which already incorporate a monetary element in providing such a level of care. However, currently there remains a level of ambiguity and subjectivity as to the measurement of “continual or continuous care and attention substantially in excess of the care and attention normally required by a child of the same age” (Social Welfare and Pensions Act 2008 Chapter 8A). This needs to be addressed and clarified in a more transparent and coherent manner by the Department taking into account, the personal impact of supporting a child with disabilities in the family home, which depends very much on access to external supports such as services, support from family members and the overall make-up of the family unit. Legislative change may be required to substitute current wording to “a level of care and support substantially in excess of.....”

Where reports are available from Healthcare professionals and schools, they should be heavily taken in to account by the Medical Assessors in supporting a claim. Parents should not be subjected to financial hardship in an effort to provide professional reports for the benefit of supporting a claim. In cases where no professional reports are available, supplementary information by the parent/guardian is essential and should be given equal weighting by the Medical Assessors, as they are the individuals who provide for their children’s needs and can more accurately reflect the level of care and incorporated costs.

Consideration should be given by the Department to drafting a supplementary information form that could be used in the application of other allowances such a Disability Allowance, Carers Allowance and any other Benefits/Allowances requiring supplementary information that would negate the need for inclusion of an often lengthy and over burdening diary.

Medical Assessors according to Department documentation must be a medical practitioner, who is fully registered in the General Register of Medical Practitioners or who is entitled to be so registered and must have at least **six** years satisfactory experience in the practice of the medical profession since registration. Significant experience in the field of Occupational Medicine/ Assessment of Disability/ Psychiatry is highly desirable, but not listed as essential. Regular training by specialists in specific areas of disability are required to ensure that they remain up to date with the impact of behavioural, physical, emotional, sensory and intellectual disabilities on a child and their family.

### **3. Communications & Decisions**

A more comprehensive set of guidelines on filling out the application form, review and appeals process would aid parents in initial stages of application. The Department may consider an automated information line that lists out details of completing the application form and what supplementary information would be of benefit. This could be adapted for all other welfare entitlements and promote accessibility for those who are visually impaired.

When a DCA application enters the system, the subsequent interaction with the parent/guardian, is to inform them via letter whether application was successful or refused. If further clarification is needed on a specific area or topic or report, this should be sought by the medical officer prior to giving an opinion to the Deciding Officer. This practice may in turn reduce the need for appeals or possible refusal due to lack of evidence.

In the interests of fairness and transparency in the case of refusal of DCA the applicant should be given an understandable and detailed reason for refusal than is currently being given. It is difficult to appeal a decision if you are not fully informed as to the reason for that decision. The Deciding Officers statement should automatically be disclosed to the unsuccessful applicant, rather than the applicant having to obtain such a statement under the Freedom of Information Act 1997 and the Medical Assessor must provide more detailed information as to why the applicant does not meet medical criteria for DCA, than what is currently being provided.

#### **Current Medical Guidelines Used in Assessing Claims and Basis for Decisions**

Having examined the current Medical Eligibility Guidelines for Domiciliary Care Allowance the DCA Working Group have the following initial observations:-

- ▶ The move of DCA scheme from health to DSP, aspired to provide a more consistent and equitable treatment of applicants, has not delivered on this aspiration. The key loss is local assessment input.
- ▶ It is noted that the membership of the Expert Medical Group was small in numbers at seven with three of the members listed as having an administrative role as opposed to a medical expert role and that the only professional discipline represented was from child psychiatry. With respect to the professionalism of the Experts involved it is the working groups opinion that input from all disciplines involved in the assessment and care of children with disabilities either by way of membership of the Expert Group or through a wider consultation process would have provided a far more robust system of guidelines and review of the scheme may not have been necessary after such a short time of change of administration.

- ▶ Under the terms of reference for the Expert Group were requested to:

1) Arrive at a consensus regarding guidelines to determine the medical eligibility to qualify for Domiciliary care Allowance.

2) Facilitate the efficient and effective processing of applications by considering:

a) Conditions which are **more likely** to result in a child requiring continual or continuous care and attention substantially in excess of that required by a child of the same age.

b) conditions which are **less likely** to result in a child requiring continual or continuous care and attention substantially in excess of that required by a child of the same age

- ▶ Overall guidance to assessors in assessing eligibility for DCA are welcomed however the current guidelines are quite confusing and contradictory in nature. The eligibility for DCA according to information from DSP is not based on the type of impairment or disease however the guidelines used are very much diagnosis and impairment or condition driven. The fact the Expert Group were requested to consider which **conditions** are more likely / less likely to result in continual or continuous care and attention is in complete contradiction to the eligibility criteria stated by DSP and the legislative requirements. It would have been more appropriate to request the Expert Group to form an opinion as to what defined a “severe disability” and what defined continual or continuous care and attention. As each application is determined on its own merits the request made would be suggestive that based on a diagnosis given it was to be assumed the applicant would not meet the eligibility requirements of the scheme. This in turn would set the bar higher if not impossibly high for some applicants to meet the eligibility criteria regardless. Also of note the legislation surrounding DCA does not state the child must have a **condition** but a “disability”.
- ▶ The Medical part of the form proposed by the Expert Group is very much based on the medical form used by DSP for applying for other disability payments aimed at adults. As already stated it is very much leaning to the physical attributes of disability and not child friendly with issues such as feeding and self-care not included. It would be beneficial to look at a more childhood relevant checklist could be developed incorporating the areas missed previously discussed.

- ▶ The children subject of DCA applications have invariably through a number of assessments by various disciplines so to require them to be reassessed for DCA would be unfair to the child. However, considering the amount of assessments that may already have been carried out on such children it is difficult to understand how a medical assessor can form an opinion, that, contrary to reports furnished by relevant professionals familiar to the child stating otherwise, that the child does not meet the requirements of the scheme. This is a situation that unfortunately the members of this DCA Working Group are all too familiar with. If a medical officer forms such an opinion, **contrary to the weight of evidence provided** by the applicant including expert opinion from therapists involved, we believe the applicant is entitled to a full explanation as to how the medical officer formed such an opinion.
  
- ▶ To assist the medical officer in reaching their opinion “normal age of attainment data is provided relevant to children less than five. This data it is agreed may be helpful in assessing eligibility for children under five however there is no indication given as to any assistive data available to medical officer for assessing applications concerning children aged five and over.
  
- ▶ Under Legislation and Definitions this DCA Working Group is concerned at the flawed basis and blurring of debate posed by the role requested of the Expert Group as previously discussed. The legislation is clear in stating the child must have a severe **disability**. However it appears the Expert Group were somewhat distracted in their deliberations by the request to advise on **conditions more likely / less likely** to require continual or continuous care and attention. This is evident by the agreement of The Expert Group that “Domiciliary Care Allowance is not awarded primarily on the basis of an impairment or disease, but on the resulting lack of function of body or mind necessitating a degree of extra care and attention required.” It is not explained how this agreement was met or if more importantly it fitted with the legislation surrounding DCA. It is also further complicated by the Expert Group contradicting the view that DCA was not awarded primarily on the basis of impairment by later stating “There was agreement that the World Health Organisation was the closest definition of disability to what was required. This decision was based on the importance of including the word “impairment” in the definition.”
  
- ▶ On the issue of Codes and Categories it is stated that “It was agreed by the Group that in order to ensure clarity and consistency in decisions codes and categories would be used. “It is questionable as to how the use of codes and categories would ensure clarity and consistency in decisions considering DCA is not awarded according

to diagnosis. Codes and categories may be useful in data collection just as the use of the multi axial diagnostic classification system may be too in case of mental illness.

- ▶ It is further stated “It is important that codes, where available, are applied to the stock of claims which will be transferred from the Health service Executive. These codes will inform the review policy for these claims.” Again the use of codes can be helpful in gathering data but the suggestion that codes would inform review policy of claims is seriously worrying. Again DCA is not awarded on diagnosis so a system where awarding of DCA is suggested by condition or impairment more or less likely to require care and attention or condition or impairment denoted by addition of code to file being used to inform review policy firstly contradicts views expressed by The Expert Group themselves and is a potential breach of the legislation surrounding DCA.

#### **4. Case Reviews**

It is recognised by the DCA Working Group, that all social welfare payments should be subject to a review, to ensure that the payments are allocated to those who continue to meet the qualifying criteria and it is welcomed that the Department took measures earlier this year to ensure that recipients would be informed of their case review date on receipt of DCA being awarded.

A review should be triggered by the date applied by the Medical Assessor. Cases should have a DNR Status if the child has a disability of a degenerative nature or where the disability is life long and is unlikely to change as the child grows older.

Only cases where the disability is of a temporary nature and likely to respond well to medical interventions should be considered for a 12 month review date. This would not apply to the majority of diagnosed disabilities, but pertain more to certain medical conditions or trauma.

Other than the above exceptions, nothing less than a minimum three year review date would be recommended, as many of the professional reports remain valid for a 2-3 year period and parents should not be subjected to undue financial hardship by the Department requiring up to date reports from Healthcare professionals for the sole purpose of maintaining the DCA payment.

DCA recipients should be notified at least six months in advance of their review date in order to be given ample time to prepare any documentation/reports required and a reminder, one month prior to review date. Reminders can be by mail or via existing text service.

Where the parent states that a child's circumstances remain unchanged, and this is supported by either General practitioner or therapist by way of letter, a full professional assessment should not be called for, as this places undue pressure on HSE and service providers resources when a parent/guardian seeks an assessment and subsequent report, purely for the purposes of maintaining a welfare entitlement.

Any medical documentation supporting a recipients DCA review, should be examined by a Medical Assessor. Should the Medical Assessor deem that the information supplied is insufficient, this should trigger a request from the recipient for further information, prior to the Medical Assessor informing the Deciding Officer of their decision. Deciding Officers role in the decision making process of both initial application and review, should be confined to establishing if the applicant meets the criteria for habitual residency and age as set out in the legislation.

## **5. Rate of Payment**

The DCA Working Group is of the opinion that the rate of payment should not be graded according to degree of disability, degree of care or age of the child at this point in time, due to lack of confidence in how this might be administered.

The multifaceted nature of how a disability/condition and the resulting effects on an individual child, is not dependent on the age of the child, nor necessarily the degree of disability.

Quantifying degrees of care and setting thresholds, given the broad spectrum of disabilities and combinations of same, would be open to challenges on the basis of subjectivity on the part of the Assessor. For example, providing a lower degree of care without external or family supports can be as challenging to a parent as providing a higher degree of care with external and family supports.

Given the variation in expenses/costs incurred by parents in supporting their child with a disability/condition, phased payments at different times of the year, would reduce the ability of the parent to meet the individual needs of their child.

## 6. Review & Appeals Process

It is a welcome change that from this point parents will be informed of review date entered by Medical Assessor under section of Medical Assessors opinion however, it is requested that explanation on reason for refusal needs to be more clearly communicated.

Currently refusals are been communicated and interpreted by parents to suggest the child involved does not require any more care and attention than a child of similar age. This is both hurtful and disrespectful to the applicant of DCA. A child with any diagnosed condition requires extra care and attention in excess of a child of a similar age but it is obviously the level of care and attention as set out in the legislation surrounding DCA that is in question, and this is what needs to be communicated more clearly.

It has also been pointed out by the Department to representative organisations that a large number of applications fail to meet criteria as not enough evidence is submitted by applicant and when further information is supplied a number of cases are subsequently granted on review. Again a request for further information required prior to refusal and a guide for parents on filling out application form from the Department of Social Protection would be useful in assisting parents on what is required of them to support their claim.

In the interests of fairness and transparency, in the case of refusal of DCA the applicant should be given an understandable and detailed reason for refusal than is currently being given. It is difficult to appeal a decision if you are not fully informed as to the reason for that decision and parents invariably find themselves back at the starting point where they are appealing the decision in all areas of the child's care needs and seeking further documentation and evidence from all specialists involved sometimes having to go privately to access reports at a great deal of expense in order to build up their case for appeal. The refusal letter currently being issued by DCA section does not explain clearly enough what a review and appeal of application by DCA section entails. A leaflet enclosed with the refusal letter and/or a link to further information would assist the applicant in deciding on what action they should take next.

There have been a variety of approximate length of waiting times for review and appeal quoted in the recent Dail debate but organisations are aware of families who have waited up to a year in recent times for an oral hearing. There are also difficulties reported on files being sent from DCA to the SWAO taking up to eight weeks for files to be transferred once notice of appeal is received by SWAO. The current backlog of appeals and the length of time incurred in appealing decisions are of serious concern to the working group. Also given the high number of appeals allowed in relation to DCA and the err of 25.6% in the decisions on applications by DSP it seem obvious to the working group that the priority of DSP in reducing the backlog of appeals should be to review and make changes to the administration of the DCA scheme and bring down that percentage of error on decisions which should subsequently bring down the number of appeals sent forward to SWAO.

The figures released by Department of Social Protection in relation to Domiciliary Care Allowance are set out in table form below:-

**Table 1 - Domiciliary Care Allowance applications - April 2009 to date**

	Applications received	Applications fully processed in year	Applications allowed incl. on review*	Applications refused
2009 (from 1 <sup>st</sup> April)	3,389	2,823	1,220	1,603
2010	5,457	5,333	2,576	2,757
2011	5,525	5,396	2,502	2,894

\* Includes cases initially disallowed but allowed on review following receipt of additional information.

**Table 2 - Domiciliary Care Allowance Appeals - April 2009 to date**

	Appeals registered	Appeals withdrawn (allowed on medical review)	Medical reviews outstanding on appeal	Appeals allowed	Appeals disallowed	Appeals outstanding
2009	836	189	0	293	353	1
2010	1858	518	0	528	728	84
2011	2270	424	293	220	421	912

These figures as set out however do not give us a full picture of what are the issues at hand.

Based on an analysis of these figures the following can be ascertained:

The figure given for DCA applications successful is given at 2502 this however includes 424 applications that were initially refused but granted on request for review. The figure of successful applicants on first application is therefore 2502 minus 424 granted on review or 2078 (38.5%). If that 424 are then added to the figure of 2894 we can see that in fact 3318 (61.5%) were refused by DSP on initial application. Appeals allowed are given as 220 but if the appeals successful on review 424 is added this gives us a figure of 644.

Taking this into consideration we can now work out a breakdown of the full DCA applications as follows:-

2078 (38.51%) Granted on initial application

644 (11.93%) Granted by way of review or appeal (38.51 + 11.93 = 50.44% granted)

1048 (19.42%) Refused and not appealed (3318 refused minus 2270 appeals lodged)

421 (7.8%) Appeals disallowed (19.42 + 7.8 = 27.22 total refused)

293 (5.43%) Medical reviews outstanding on appeal

912 (16.9%) Appeals not dealt with by year end

5396 Total DCA applications processed for 2011

Given that 293 of appeals lodged have medical reviews outstanding and are therefore incomplete and 912 appeals lodged are listed as outstanding if these are taken away from numbers of appeals lodged this gives us a figure of 1065 appeals completed in 2011 by the Social Welfare Appeals Office . Of which 644 (60.5%) were allowed on review or by way of appeal and 421 (39.5%) disallowed.

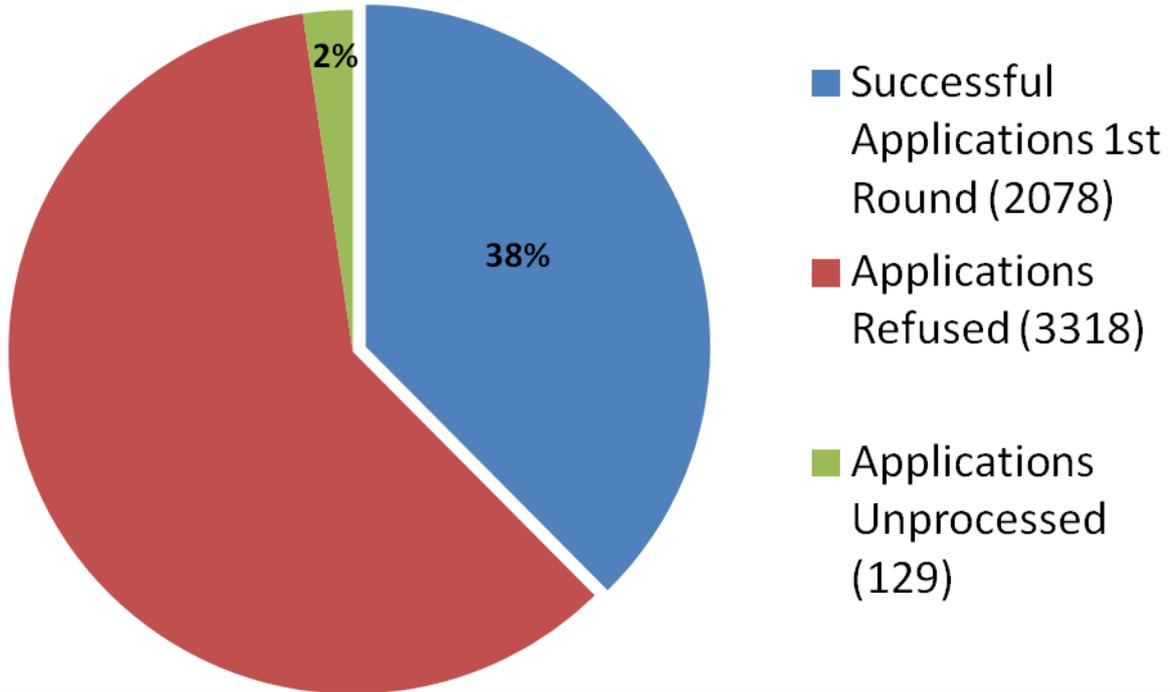
If we take the appeals that have not yet been completed 293 with medical reviews outstanding and 912 not yet dealt with from the 5396 of DCA applications made in 2011 we have a figure of 4191 DCA applications that have been completed in full including review and appeals. Of these 4191 DCA applications 2078 were approved on initial application and 644 were allowed either on appeal or review, giving us a total of 2722 (65%) of DCA applications that were completed by way of application, review and appeals were successful.

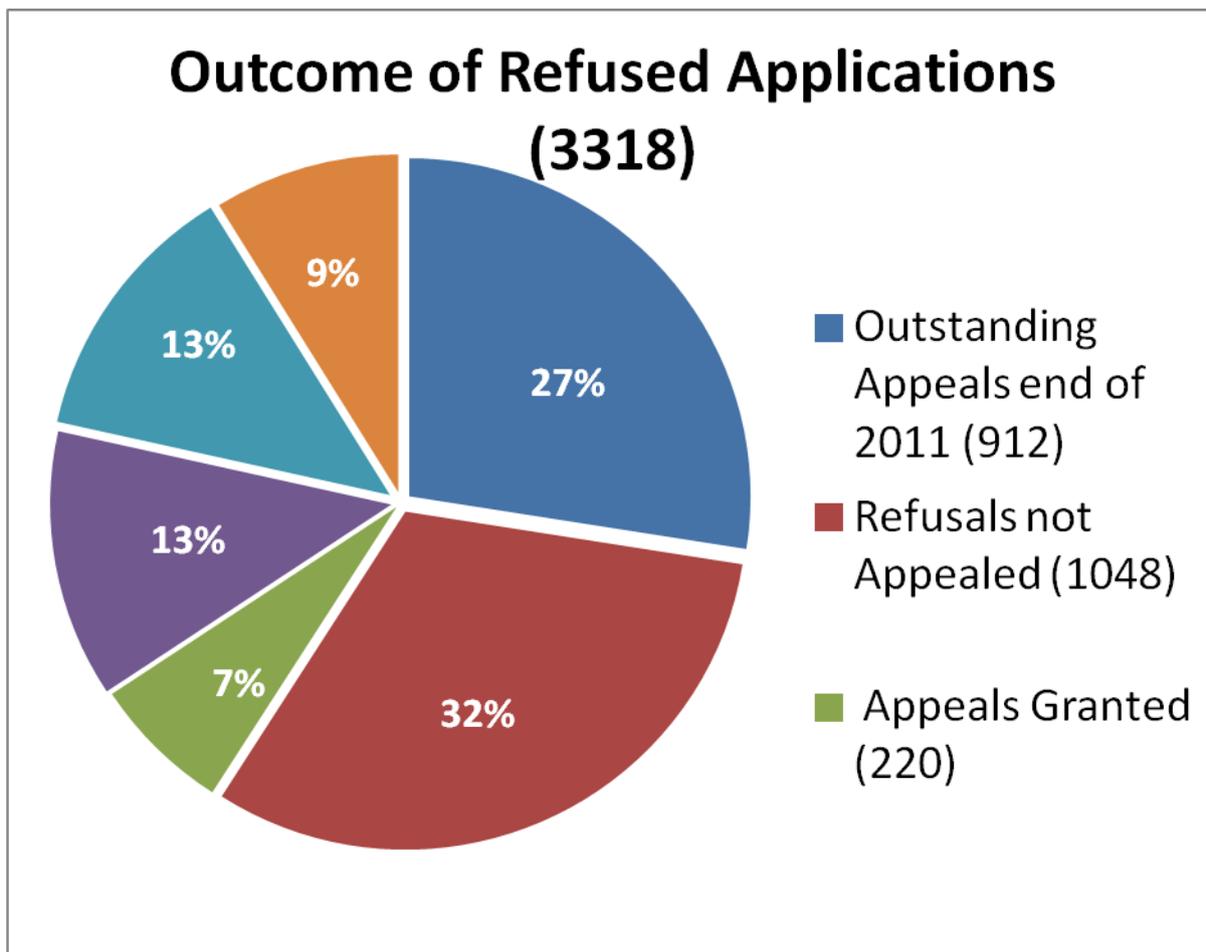
Refusals not appealed 1048 and appeals disallowed 421 give us a total of 1469 (35%) of DCA applications that were completed by way of application, review and appeals were unsuccessful. Of the 5396 DCA applications 1205 or 22.33% were still not completed with appeals process. Of the 2270 total appeals lodged in 2011, 1205 or 53% were not fully completed because of awaiting medical review or not yet dealt with.

In 2011 38.5% of initial applications to DSP were successful and 61.5% were refused. In 2011 65% of DCA applications of those dealt with completely including review and appeal were successful and 35% were unsuccessful. There is a marginal gap of 26.5% in initial applications for DCA to DSP that were successful to that of how many were proved to be successful overall. This demonstrates an error in the original decisions of DSP on DCA applications at a rate of over one in four of the applications completely processed and appeals finalised in 2011.

The DCA Working Group believe these figures show that the current system of application and assessment is obviously not fit for purpose and we welcome the commencement of a stringent review of the DCA Scheme.

## Total Applications Received (5525)





#### Recommendation on Review and Appeal Process

1. Before refusing an application any further evidence that may be of benefit in clarifying issues is sought from the applicant or healthcare professional/author of professional reports.
2. The reason for refusal is more clearly detailed to the applicant.
3. The benefit of seeking a review as opposed to appeal is more clearly explained to parents on refusal notification
4. A thorough review is made of application and assessment processes currently being used to identify gaps in the system that lead to such a high level of appeals
5. DSP work to closing the 25.6% error rate in decisions as demonstrated by the 2011 figures on DCA applications handled by DSP.
6. Appeals should be no longer that a three month waiting time for a decision to be made. Currently the waiting times for a decision can be over a year, which causes difficulty for families where they have lost a DCA payment and have appealed the decision. Regardless of whether back payments are made should the appeal be successful, it does not make it an easier on families for the duration of the lengthy appeals process.

7. In order to tackle the increasing waiting times for all social welfare appeals, the Department should give consideration to retraining and designating staff to the Office of Social Welfare Appeals.

## **7. Further Suggestions**

Currently, a parent/guardian needs to be in receipt of Domiciliary Care Allowance in order to qualify for Carers Allowance. While outside of the remit of the DCA Steering Group, we would recommend that the legislation regarding Carers Allowance be reviewed by the Department of Social protection and DCA be decoupled as a pre-requisite to applying for a Carers Allowance payment.

According to the Departments own figures, circa 40% of DCA recipients are also in receipt of Carers Allowance. When a parent/guardian losses the DCA payment following a review, Carers Allowance, Respite Grant and Household Benefits package are also immediately terminated. Where families are dependent on the income support of the Carers Allowance due to one of the parents being unable to be available for gainful employment as a result of caring for a child with disabilities and significant needs, regardless of the Departments decision to withdraw DCA, the parent/guardian may continue to be in a position where they are unavailable for work.

Children for whom Domiciliary Care Allowance is payable may be entitled to claim Disability Allowance on turning sixteen years old (Subject to revision). As was the practice with HSE it would be appropriate for DSP to forward this information with details on application process six months in advance of child's 16<sup>th</sup> birthday. Also as appears to be current practice with DSP if a review of Carers Allowance payment will be undertaken this should be communicated simultaneously.