**DELIVERING AN INTEGRATED CARER SUPPORT SERVICE**

**RESPONSE TO THE DRAFT SERVICE DELIVERY MODEL**

**FROM THE CRCC NATIONAL WORKING GROUP**

**DECEMBER 2016**

1. **SERVICE DELIVERY MODEL OVERVIEW**

The Working Group endorses the aspirations outlined for the service model and the primary objectives that have informed the development of the model.

With the increased compartmentalisation and separation of aged care and disability services, it is important that carer supports be integrated, not only as its own service system but across both ageing and disability service systems. Within this context, the Working Group welcomes the intent to deliver an integrated carer support service and the provision of service coordination to facilitate integration across service systems. However, it cautions against the assumption that existing service arrangements will continue, for example, the model assumes planned respite funding arrangements will continue into the future. Given the planned amalgamation in aged care of Home Care Packages and the Commonwealth Home Support Program, it cannot be assumed that existing service and funding arrangements will continue. It is reasonable to expect that this consolidation may lead to a rationalisation of funding arrangements and service offerings. Furthermore, the focus on the care recipient both within the CHSP and NDIS will have the effect of diluting consideration of carer needs and therefore the need for planned respite in planning services for the care recipient.

The Working Group also supports the tiered structure of the service model with services provided at a national, regional and local level and the critical role given to regional hubs in the service delivery model.

1. **PROGRAM OVERVIEW**
   1. **PROGRAM STRUCTURE**

*In relation to the program overview, do you believe that the objectives, outcomes and delivery principles are appropriate for the services required to be delivered under each program? Do you believe that the services proposed to be delivered at the national, regional and local level are targeted appropriately?*

1. National Education and Training Initiative: the proposed objectives and outcomes are appropriate. While it is pleasing to have “high risk carer cohorts” acknowledged, it is disappointing that this group is not defined in the service delivery principles, for example, to consider the needs of particular cohorts of carers such as carers in rural and remote regions, carers of CALD or ATSI background.
2. Regional Hub Program: the proposed objectives and outcomes are appropriate but capacity to deliver will be dependent in part on the size of the region, for example, there are currently 54 CRCCs reflecting the HACC Planning regions. Is it planned that these regional boundaries be maintained or is the model designed for larger regional constructs, and if so, what are the criteria for their creation and definition? There are many expectations being placed on Regional Hubs – given their pivotal role; hence size will be instrumental in determining the resources they will need to engage with local service providers, identify and respond to education needs for high risk carers, identify and support local peer support initiatives, coordinate local coaching and mentoring efforts, and respond to the unique needs of specific ‘high risk’ carers. Care needs to be given to achieving a balance between resource efficiency and service effectiveness.

The Working Group welcomes the provision of service coordination and supports and so believes it is appropriate that the service delivery principles should include working with mainstream services to strengthen carer access both to carer support services and to broader community supports.

Further clarity would be helpful around what is meant by the term ‘targeted financial support’. Has the Department’s thinking changed since its exploration of this concept in the Service Concept paper? Is it intended to trial different models of financial support? The target for this support, that is, enabling carers to remain in education and/or enter the workforce, will exclude a significant proportion of current recipients of Consumer Directed Respite Care. The 2012 evaluation, for example, found that 56% of CDRC participants were aged 65 years or more.

1. National Counselling Program: the proposed objectives and, outcomes are appropriate. Service delivery principles are restrictive as they fail to recognise the reality that many carers do not possess nor access modern information technology or telephony that will provide a reliable online service. Carers, for example, in rural and remote regions have low levels of access and the technical capacity of what is available is often less than satisfactory for the delicate task of counselling. Furthermore, where carers live in isolated settings there is no support system the carer can access should they become distressed during or after a counselling session.
2. National Service Infrastructure Program: The Working Group recognises the importance of having appropriate infrastructure in place to support carer access to services and supports. However, we are concerned about the capacity of specific cohorts of carers for whom online access may be difficult either for physical/logistic reasons such as carers in remote communities, or for whom access is a challenge for economic, cultural or linguistic reasons, such as Aboriginal and Torres Strait Islander carers. While the concept of a digital account will work well for some carer cohorts, this approach will not succeed for high risk carers who are more than likely not to have access to any digital tools. We would encourage the Department to consider multi-modal approaches to supporting carer registration and access to self-assessment and support tools. This could include culturally competent and trusted outreach workers able to facilitate registration and able to work in community locations perceived to be safe places by ‘high risk’ carers.

We note the Department is looking to refer between ageing and disability service systems, and to explore information sharing. Of critical importance in this context is the desirability of limiting the number of assessment processes that a carer would be required to engage with, for example, an assessment through MyAgedcare for related aged care services for their care recipient and then an assessment for carer support for themselves. Similarly in the disability system, an assessment of need for the planning of supports for the person with a disability and then a separate assessment to access carer support. There is a real danger of carers having to repeat their story multiple times, especially where they care both for an ageing parent and for a child with a disability.

The proposed targeting of services, as outlined on page 11 of the document, provides a useful overview for carers of how services can be accessed across national, regional and local levels. We welcome the provision of service coordination support as a mechanism to facilitate cross-sectoral communication with ageing and disability service systems which are becoming self-contained silos of service. Recent research (Anglicare 2016) has highlighted the importance of support coordination in managing the interface between families and service provision. We also welcome the continued provision of emergency respite as a much needed safety net that is not available through the service packages in either the aged or disability sectors.

We note the proposed service model will not fund the provision of crisis counselling and other supports nor the provision of planned respite. As argued elsewhere, we believe the assumption of continuity of existing service arrangements in ageing and the disability sector to be ‘courageous’ and not supported by programmatic developments to date, such as, the rapid change in program guidelines in CHSP and Mental Health Carer Support. Anglicare research, *Carers: doing it tough, doing it well*, observed that “Carers’ needs and supports are not formally recognised as part of NDIS packages. There is no formal assessment of the needs of the carer, no funding package for the carer and no guarantee of involvement in the assessment of the care recipient’s needs.” Yet this research has found that the “While the provision of an NDIS plan for the person with a disability may provide a respite effect for carers it is a significant change since the carer will no longer be able to have a say in when and where the respite takes place, resulting in a loss of choice for the carer… (Furthermore) provision of respite is … associated with positive, measurable outcomes for carers.”

* 1. **REGIONAL HUBS**

*A key factor in the effectiveness of regional hubs will rely upon their ability to understand the local service landscape and identify service gaps. If you were operating a regional hub, how would you undertake service mapping for your region? How would you ensure that you had captured a complete view of the available supports for carers in your region?*

Effective service mapping requires the capture of a substantial data set that often already exists at local government and state levels. A critical task for a regional hub would be to access and collate existing data sets and structure that information in a way that is meaningful for carers. Furthermore, engagement with carers is required to identify gaps in service delivery. This activity cannot be a once-off as community needs change over time, as do service offerings, so a regular review would be required.

Of critical importance in this exercise will be the catchment size of a region. As argued above, the size of the region will impact on the capacity of regional hubs to engage effectively at a local level with local service providers and identify and respond to service gaps, not to mention obtain the resources necessary to adequately respond to these gaps. Consideration needs to be given to appropriate resourcing of Regional Hubs to ensure they have the capacity to deliver in accordance with the model.

* 1. **OUTCOMES MEASUREMENT**

*It has been identified that outcomes measurement will be essential for a future model. Outcomes measurement involves identifying how effective services are in achieving a particular objective. This commonly takes the form of a questionnaire which helps to assess aspects of the carer’s role. However, there will be a careful balance in measuring outcomes, whilst not placing undue burden on a carer to answer multiple questionnaires, particularly where they may be accessing more than one service. What are some ways that outcomes could be measured and these issues addressed?*

There exist at least two distinct models of program evaluation. One model uses an independent third party to collect data from clients to ascertain if the programme is achieving its objectives. This approach has been used by governments in the past with independent reviews such as those associated recently with MyAgedCare and with the Mental Health Review. This approach has the advantage of independence and perceived objectivity, utilising samples rather than interviewing the whole population, and providing a holistic but one-off data collection effort.

Alternatively, the Department can consider the use of outcome tools designed to be used with carers in assessing and informing progress towards their goals. Within this stream of work there has been considerable development in tools used to measure outcomes, not all of which require questionnaires. For example, the Council on Quality and Leadership, is a person-centered model based on a set of 21 personal outcomes measures that have been developed through research and measured through conversation by skilled practitioners. For participants in this process, the experience is not onerous and is meaningful as the conversation focusses on three key factors – my self, my world and my dreams – and results shared with the participant.

Another model in increasing use is Outcomes Star – a tool which is designed to be completed collaboratively between the client and worker and can be taken at regular intervals to measure progress. The Carers Star covers seven key areas - the caring role, managing at home, time for yourself, how you feel, finances and work. The Carers Star is underpinned by a model of change that has five steps: Cause for concern; Getting help; Making changes; Finding what works and As good as it can be.

The key features of both models that are worth noting are the basis of research in human service delivery that underpins both models; their person centred approach where the data/questions being asked are relevant to the person and their journey; the collaborative approach to the data collection where clients and workers are engaged together in this process; and the transparent use of the data with the client to measure and inform their service delivery and planning.

* 1. **QUALITY FRAMEWORK**

*While this model will seek to help more carers, it will be important to ensure that quality services are being delivered. What would you view as the essential components of a future quality framework?*

A future quality framework needs to be informed by what carers perceive as ‘quality’. Development of the framework should be a co-design process that enables carers to inform the definition of quality services.

As a starting point, the Working Group recommends that consideration be given to using the principles that underpin the Statement for Australia’s Carers that is in the **Carer Recognition Act (Cwth) 2010**.

1. **IMPLEMENTATION**

The Working Group notes the intention of the Department to recommend to government a phased introduction of the new Carer Support Service System, commencing with the national infrastructure program and regional hub programs. The Working Group would recommend trialling some elements of the new model, such as targeted financial support, and exploring non-digital access especially for high risk carers, before rolling out the service system. As the degree of change being introduced into the carer support service system is significant, the Working Group also recommends that the national infrastructure program and the regional hub concept be trialled and evaluated over a two-three-year period. Given the mixed experiences that clients have had with changes introduced into both the ageing and disability service systems, for example, the NDIA portal, it is imperative that the new carer service system be given every opportunity for a successful and seamless roll out. For these reasons, we believe it would be appropriate time should be allocated for testing and evaluation. During this transition, it is recommended that CRCC funding be continued to provide continuity of service for carers.

We note the intention for implementation from 1st July 2018, and raise for the Department’s consideration the timing of these changes vis-à-vis the timing of other changes that impact on carers’ lives, in particular, the NDIS roll-out and the rationalisation and tendering of the Commonwealth Home Support Program. Given the completion both of the NDIS roll out and of the CHSP transition is not until 2019, implementation of the new carer support service system will need to consider how best to manage its own transition and its role during the ageing and disability transition periods without disrupting carer access to supports. There is always the danger, during periods of considerable change, for individuals not to seek assistance because it is ‘too hard’, ‘confusing’ or for providers to inadvertently mislead clients because of the speed and scale of program change that is underway.

While we congratulate the Department on its recognition of the need for transition planning, we urge the Department not to underestimate either the scale of the changes being introduced and therefore the need for an appropriate transition period such as 2-3 years or the communication and change management activities, that will be required to ensure continuity of service, with clients and providers and recommend that the Department conduct a proactive roadshow for service providers and clients, informing them about the changes.