Carer Support Network SA
LEADERS IN CARER SUPPORT

Carer Support Network SA Comment on:

Department of Social Services (2018).
Integrated Carer Support Service: Regional Delivery Partners:
A draft regional delivery model discussion paper.

About Carer Support Network SA	The Carer Support Network SA (CSNSA) is the South Australian Consortium of carer support organisations. CSNSA submissions are developed through documented research, surveys and consultation with carers and members, working groups and focus groups of carers and service providers.
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Carer Support Network SA

The Carer Support Network SA (CSNSA) is **the South Australian Consortium of Carer Support Organisations (*'The Consortium'*).**

The CSNSA consists of five carer support organisations that operate in specific locations and areas across metropolitan and country/regional South Australia. The Consortium collaborates and is committed to using the CSNSA Carer Support model to underpin how quality carer support services are delivered.

The Consortium members are (in alphabetical order): Carer Support, Carers and Disability Link Barossa and Districts, Carers SA, Northern Carers Network and SA Country Carers. The CSNSA currently operates 20 carer support and service delivery centres across South Australia. We do this with an established carer base of more than 20,000 to 30,000 registered carers at any given time. The content of this document represents the voices of the Consortium member organisations:

| Organisation | Signatory
Name and Title | Signature |
|---|---|---|
| | Peter Sparrow, CEO | |
| | Vicki Williamson, CEO | |
| | David Militz, CEO | |
| | Maria Ross, CEO | |
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Carer Support Network SA - The Consortium - May 2018

Focus

The Department of Social Services (DSS) *Integrated Carer Support Service: Regional Delivery Partners: A draft regional delivery model* discussion paper sets in context the proposed role and potential options for distribution of Regional Delivery Partners (RDPs) within the announced Integrated Carer Support Service (ICSS).

The DSS has sought input via written submissions from stakeholders on the proposed Regional Delivery Partner service areas, identifying any specific issues and the capacity of the consortia to fulfill the role of an RDP.

In this document, the Consortium will provide comment on the following discussion points as listed in the discussion paper:

- *Key issues with the approach to structuring the service areas.*
- *Capacity and capability of organisations to establish and manage a regional presence throughout a large service area, including the ability to lead a consortia-based model, and undertake service area planning.*
- *How to ensure the breadth and reach of services provided under the proposed service area models, including the incorporation of local service providers.*
- *Are there any alternate RDP service area models that you think the Department should consider? If so, on what basis? Your statistical analysis and / or evidence base should be provided to support this.*

Important note (caveat):

Details regarding funding arrangements for the proposed Models 1 and 2 and for the service related components are currently still under consideration by the funder. This limits the scope of informed comments which the Consortium can provide to some of the key discussion issues (i.e. evaluation of models and service outcome expectations) – in this first discussion round.

The Consortium is interested in providing advice with regards to the funding levels with a particular focus on the regional and local delivery components of the ICSS delivery model.

Discussion point 1: Key issues
Key issues with the approach to structuring the service areas.

General Comments:

a) The Consortium already operates and specialises in the provision of highly successful carer support services to communities across metropolitan, regional and remote areas of South Australia.

The carer support model is based on the recognition of the value of caring and the need for carers to maintain a balanced quality of life.

It recognises that carers are unique individuals capable of shaping their own destinies, and seeks to provide support by walking alongside carers to help them find the strength and information they need to maintain their caring roles and lifestyles.

The key characteristics of the model are:
- o Aligned with social justice principles and the model is directly linked with the SA Carers' Charter and the State Strategic Plan.
- o Carers are partners in service provision.
- o Carers form a majority of members on the Board of Directors or Steering Committee of member organisations, including executive positions (i.e. Chairperson/Vice Chairperson) within this structure.
- o The focus is firmly on the carer and their health and wellbeing.
- o Support is designed to help overcome the isolation and disconnectedness that carers may feel within their role and to ensure that carers are given the opportunity to link with other carers.
- o The support provided is always carer-driven; carers are listened to and the role of the service provider is to facilitate meeting the identified need.
- o The carer is supported to develop resilience in their caring role.
- o Information is provided that is relevant to their caring role and which will help carers to access the support, services, information, and/or skills training they need.
- o The carer-driven support activities provided by member organisations are positive and encouraging, and designed to assist the carer to express their own personal interests, separate to their role as a carer.
- o Carer Support organisations form strong partnerships with other service providers and community organisations for the benefit of carers. Such organisations are locally based, community owned and managed, and directed by carers.

The specific local knowledge and experience providing carer services offered by the Consortium is valued by the community and is evidenced by ongoing service satisfaction and consumer feedback survey[1] conducted across 1,688 South Australian carers in 2017.

b) Although an informed evaluation of the impact of 1 or 2 Regional Delivery Partners (RDP) envisaged in models 1 and 2 (Option A and Option B) cannot be made without further model funding details, the Consortium is confident that our group of established providers across the state can ensure a streamlined transition to a new carer service model, an efficient introduction of new services models whilst achieving positive outcomes for South Australian carers.

The Consortium acknowledges that consistency of service delivery is important and believe in-state agreements formalising congruency of operational practice across RDP areas amongst Consortium members would ensure uniformity of service experience and quality for the carer while still allowing for strategies to address local specific needs.

The Consortium has some concerns regarding the North/South Metropolitan split of boundaries suggested in Model 1 – Option A. Such an inter-metropolitan split would a) further divide the North vs South perceptions held by some of the metropolitan community of people accessing services; and b) the Consortium believes that service consistency across the expanse of metropolitan Adelaide would be best served via a specific metropolitan service area.

This leads into an alternative RDP model of three in South Australia which would enable a Metropolitan RDP, Northern Country RDP and Southern Country RDP to provide responses to local area specific needs. For example, a Northern Country RDP via this Consortium would be able to apply existing specialist knowledge and

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[1] Survey of 1688 Unpaid Carers – Carers Count 2017 report available online: http://bit.ly/2GscHOD

practices to support the culturally specific needs of Aboriginal carers in remote communities, for example, communities in Roxby Downs and Cooper Pedy. For further detail please note: [Discussion point 4:](#) Alternative RDP service area models.

c) The Consortium has concerns regarding some of the inconsistencies that seem to flow through the descriptions of service models. On the one hand, a clear intention for a preventative model is raised. On the other hand stated service details regarding Emergency Respite list an eligibility caveat (Appendix B p.15): *"when all other options have been exhausted"* – which is different to the criteria stated in the ICSS Service Blueprint p.36, listing a more reasonable criteria of *"when no other services are available"* which is also consistent with respite guidelines under current funding arrangements.

The Consortium asserts that replacement care for the person who is cared for should be available for carers as a stand-alone service *when it is called for and as a strategy to prevent detrimental issues to carer health and wellbeing*. Emergency Respite eligibility should certainly not come with the stated caveat: "when all other options have been exhausted". The latter statement implies that even in an emergency, the onus to focus on cost saving overrides the immediate and unexpected need for urgent support – hence cancelling out the intentions to provide a preventative service model for carers.

Within the Consortium there is an established experience of a correlation between service flexibility and effective supports that includes early interventions and a reduction of accessed Emergency Respite over time.

d) Any delivery model needs to allow for flexibility and cannot be delivered in a way that reduces the emphasis on carers being the experts of their lives and capable of shaping their own destiny. The way to reduce reliance on the provision of services (reduce the cost to the government) is to deliver the model in a way that allows carers to come in and out of service delivery grounded in strength based philosophy – a way that does not create a service dependency, a service that was not needed or desired in the first place. Reliance on services is a risk, particularly with delivery across the regions of a one size fits all approach, or a strict adherence to a service regime, or the emphasis on a support worker taking on the role of an expert in individual carers' lives.

The model under which the Consortium (currently) deliver services, focuses on carer involvement, creating better outcomes, reducing service dependency and service delivery costs.

Transition and Equity

e) Streamlined and efficient introduction of new services and service models is vitally important as delays in the introduction or in the uptake of new services by carers will inevitably exert additional, undue pressures on local health and mental health services.

f) The government should be acutely aware that the reform to carer services coincides and overlaps with disability reform and the fine tuning of the aged care sector. Carers are impacted heavily in all of these reforms.

A positive and smooth experience for carers shifting to services under ICSS will provide welcome community goodwill in times of substantial system changes across several health and service sectors. RDPs should be agencies that have a good working knowledge of best practice in delivery of locally accessible services for carers and persons receiving care. This will facilitate a seamless transition for carers and their families and a timely adoption of the new model.

g) The Consortium has significant concerns regarding accessibility and compromise of equity principles. Without funding details for services under each model, concerns remain regarding South Australian issues for regional and remote carers who are affected by distance and lower levels of available technology.

South Australian carers, particularly those in regional and remote areas, still have substantial difficulties with mobile network coverage and internet access.

Online service or telephone service delivery and mobile staffing form a rather substantial part of the ICSS proposal under discussion. Therefore digital literacy and accessibility for isolated or remote carers, and for carers on low incomes who struggle to achieve or maintain a digital/online presence is an issue that is unlikely to be resolved without specific support.

h) It is foreseeable that the new one point entry based and leanly structured ICCS model (centralised system) will experience delays in responding to carers, due to expected demand - especially during the transition period.

This may result in carers having strained start-up connections to the new service system. Carers already report stress related issues and substantial delays when accessing (or attempting to access via telephone or online) Centrelink, the NDIS and My Aged Care systems due to lengthy response times or difficulties in obtaining the support carers could be entitled to.

Considering all of the factors, carers who are generally time-poor and experience higher levels of stress may cease attempting to access services with potentially devastating consequences for carers, their families and communities.

Community, real-time contact and 'being a part of something' is very important to all carers who can be isolated by distance or simply by the commitments they have to the person(s) receiving care.

i) In programs, where services are delivered at a regional level with a key focus on overall cost-efficiency and on 'economy of scale' savings measures, unwanted outcomes such as locations of concentrated delivery and inequitable access to services, particularly face to face support, can occur. The planned 'consolidation' of existing services into larger service outlets has the potential to provide budget savings but may, in some areas, severely restrict equitable access to services for those carers who require a person to person approach. Innovation in business models by the Consortium will address some of these concerns. At this point however, an appropriate evaluation of this issue within the models cannot be made without additional funding details for services.

A service focus which economises face to face service options to a minimum number of centres will by default exclude carers who live outside of available transport systems, those who *require* face to face support, or those who prefer personal interactions to establish initial rapport in order to confidently disclose issues and service needs. Note that for South Australian carers, transport and distance is a major issue and accessing such further centralised service outlets may not be a viable option for many regional or remotely located carers.

Objective

j) The paper states in commissioning the ICCS model, the Australian Government objective is to '***Improve carer wellbeing, increase their capacity and support their participation, socially and economically'.*** This appears to be a broad and aspirational statement as the ICCS service elements do not seem to fully reflect the objectives as outlined.

   o Firstly, the very nature of the caring role is personal and from the Consortium's experience and evidenced in our carer surveys, South

Australian carers highly value personal contact. It is the rapport and trust established through personal contact that elicits carers' recommendations to their peers, especially to hidden carers, regarding carer information and service providers.

Carers report that they benefit from informal face to face contact from their local carer support service because they can just pop in and there is always someone available to talk to. This process leads to more open disclosure and early identification of emerging issues which can be addressed quickly and preventative measures set in place.

There are concerns that the benefits of informal face to face contact with carers will be restricted or even lost, as it is unclear whether appropriate resources will be allocated to this component of the model.

- o Secondly, it is well known that carers are time-poor and most put the needs of those they care for before their own. Demands of caring roles and issues such as transport and distance can make it difficult for carers to leave the home and break away from their caring responsibilities. This significantly impacts carer health and wellbeing. For example: Social media closed groups such as the Facebook Carer Support Group Australia which was established and is moderated by a network member, provide much needed networking and peer support opportunities for carers.

    Resources need to be allocated to this area. There is ample evidence that such investment improves carer health and wellbeing and supports a continuing carer relationship and/or supports economic participation.

- o Thirdly, a strong focus on standardisation of carer support services has echoed through the paper which is concerning. The general blanket approach may meet efficiency and large scale system requirements but may initiate unintended consequences for vulnerable populations that do not fit the bell-curve considerations.

    Care should be taken to avoid a dis-enfranchisement of a community services sector / not for profit sector which has traditionally provided tacit in-kind work with people beyond the call of duty, added compassion to service delivery and applied specialised experience that resulted in evidenced, sustainable outcomes.

- o The very nature of the caring role is diverse and different depending on the unique experience of individual carer journeys. In order to acknowledge this, a flexible service response allowing localised innovation should be applied to these models in order support as broad a range of carers as possible.

    Carers deserve such support.

Service Outlets

k) The current funding information available is not sufficient to confirm confidence in:
- o service access equity specifically for vulnerable or otherwise disadvantaged carer populations
- o appropriate funding available for staff training and professional development
- o staff wellbeing i.e. to support remotely operating staff: team building, incident debriefing, vicarious traumatisation prevention
- o maintaining and managing sub-contracting arrangements for services
- o reporting requirements

- o establishing additional and maintaining currently existing collaborative networks and connections without maintaining a core physical presence in a localised areas

l) The design of the model and services has been stated to be based on considerations to avoid "cherry picking" by service providers who see advantages in concentrating service delivery mainly within a metropolitan area.

The Consortium members are established and have and excellent presence and focus on rural carer support that is delivered locally which will combat this concern.

The cost of delivery in rural and remote areas is potentially higher from a single centralised location. However Consortium experiences show that delivering from and within the rural communities can be cheaper due to local financial support, increased community goodwill and volunteering.

m) Relationships are still extremely important to the success of carer support or any service delivery where you are engaging at a personal level. The suggested models may have the unintended consequence of enabling business models where neither the RDP(s) nor the local services provide a consistent place for carers to cement a relationship and establish rapport and trust with staff. This potential 'lack of place' is not an outcome that the Consortium would support.

In South Australia, carer groups and face to face interactions and personal contact with service providers and others provide important opportunities to engage community members, especially isolated carers. The benefits of social connection are well research and documented. For example: The Australian Institute for Family Studies' 2016 report **Community Engagement: A key strategy for improving outcomes for Australian families**[2] confirms that establishing an effective partnership between service systems and communities results in a greater sense of ownership, greater take-up of services, and better outcomes for children and families (p.8). The document also warns that non-participation (in terms of access and agency) in meaningful engagement in its various forms is evidenced as damaging to health and wellbeing.

The opportunity to meet with other carers where there is a welcoming and familiar face, where they are guaranteed privacy, and acceptance of their circumstances and needs helps develop ongoing support network relationships outside of formal support. Carers report to us that such opportunities gives carers strength!

n) The Consortium's quality carer support services include appropriate time allocated to tasks like: intake, assessments and for planning. Carers tell us they feel increasingly comfortable in their caring roles. Knowing that trusted support is available when needed through carer support services which is provided by committed, reliable staff and based on honest relationships with workers and local peer networks is vital for this to occur.

o) Having a base to come to is particularly important for carers who are members of a rural community. Rural communities have seen many services taken away or become available only via outreach or online. It cannot be stated often enough that social isolation is a major issue for carers, and the sense of feeling connected is particularly important for regional carers. A base with consistent workers is part of this and is part of any business model currently operated by the Consortium.

[2] Available online via AIFS website: https://aifs.gov.au/cfca/sites/default/files/cfca39-community-engagement.pdf

p) Appendix A of the discussion paper includes an ICSS Outcomes Framework. The rationale for the timing associated with some service episodes is unclear and at times seems to undervalue the time required to achieve the stated outcome.

Discussion point 2: Coverage of service areas and consortia based models
Capacity and capability of organisations to establish and manage a regional presence throughout a large service area, including the ability to lead a consortia-based model, and undertake service area planning.

a) The Consortium agrees that a consortia is well placed to establish and manage a metropolitan and regional presence across a state that requires large and varied service delivery types like South Australia.

b) This Consortium for example would be in a strong position to cover the proposed service area for SA. Represented by five organisations with a strong presence in metropolitan, rural and remote South Australia, it is well placed to deliver an integrated model of support to carers in the state. In fact Consortium members are currently delivering an integrated model of care bringing together disability, aged care and carer services. The current structure supports both the delivery of regional and local carer services which are well established, with specialised and highly skilled staff ready to deliver support to carers. We do this with an established carer base of more than 20,000 to 30,000 registered carers at any given time. We work within established partnerships and networks, physical infrastructure for local services to utilise, peer support staff, skilled staff in counselling, education and training, and coaching a substantial volunteer base and experience in delivering face to face, online and telephone support and information to carers.

c) Consortia members have successfully worked together for over 20+ years, sharing information, resources, connections and joint projects. Collaboration on joint projects has brought benefits to both regional and metropolitan carers and strengthened the capacity of organisations to deliver quality carer support, counselling and respite.

d) Service area planning has been a critical part of the establishment of a program of carer support that covers the whole of South Australia. Service area planning continues to be an integral part of the ongoing practices of the CSNSA Consortia, and a proven success factor in the gaining of funding that spans organisational boundaries. For example, the Consortium has an abiding mutually respectful relationship with State Government Departments and Ministers, which facilitated negotiations that secured an extension of carer funding and will prevent loss of funding for carers during the transition to the NDIS.

Discussion point 3: Breadth and reach of services
How to ensure the breadth and reach of services provided under the proposed service area models, including the incorporation of local service providers.

a) We suggest that a consortia is one of the workable solutions under both of the proposed service area models.

b) As five financially viable organisations, the Consortium is in a position to ensure a wide breadth and expansive service reach across South Australia. The Consortium already has an existing solid and expansive carer-client base. Carers in South Australia know who is there – and where to go for support.

c) Apart from such existing network and service goodwill, established networks and being embedded across most South Australian communities brings valuable time saving advantages to an established consortium – especially during times of services transition.

Each member of the Consortium already possesses well established relationships with Allied and Primary Health, the Mental Health sector and other relevant service providers within their region. Members are operating services under the NDIS and My Aged Care, Primary Health Networks advisory groups and have great links with local government bodies, community groups, incorporated associations, State/Federal funding bodies and the local business community. Members are involved in auspice and/or lead collaborative projects across local or larger areas and serve on steering committees and working groups.

Members of the Consortium who are regional providers also understand the 'tyranny of distance' issues faced by carers in regional areas and the specific issues faced by carers within a metropolitan setting.

d) Breadth and reach is only one part of creating the best possible support for carers.

The other equally important part is the ability to connect with carers and their communities. Caution should be taken not to come in over the top of established carer communities and effectively shut down community grown carer supports.

Discussion point 4: Alternative RDP service area models
Are there any alternate RDP service area models that you think the Department should consider? If so, on what basis

The Consortium can suggest an alternative model of three RDP's for South Australia which would enable a Metropolitan RDP, Northern Country RDP and Southern Country RDP to provide responses to local area specific needs and guarantee a consistent service approach across the state. The following suggestions are based on established South Australian central and regional service flow knowledge:

- a Northern Country South Australia RDP via this Consortium would be able to apply existing specialist knowledge and practices supporting the culturally specific needs of Aboriginal Carers in remote communities for example, communities in Roxby Downs and Cooper Pedy
- a Central Metropolitan Adelaide RPD provides services to all metropolitan carers with assured consistency without splitting neighbourhoods and
- a South East / Murray River Mallee RDP can attend to the southern region with localised attention.

The Consortium would for this model envisage a state-wide operational agreement to ensure service consistency in the spirit of the Outcome Framework.

The Consortium asserts that an offset of regional cost with metropolitan economy of scale considerations which is mentioned in the discussion paper cannot be stated or assumed without details regarding service budgets and would depend on the design of business models.

Furthermore, such cost offset based considerations, when serving as budget efficiency strategies for a combined metropolitan and regional service RDPs may result in even less personalised and face to face service access opportunities for regional/remote carers. As community engaging and rapport building services result in better individual and family / community outcomes, a model that relies on such cost offset strategies between

metropolitan and regional areas may therefore run the risk of reduced service outcomes, in particular for those most disadvantaged / isolated carers.

The Consortium is best placed to deliver quality and locally inclusive services. Our existing collaborative partners and other networks across the state will enable the Consortium to engage additional, subcontracted services or engage additional service partners across the whole state of South Australia as needed.

This can be stated with confidence, as the Consortium members have long standing experience in delivering the successful South Australian Carer Support Model, which produces sustainable long-term outcomes by putting the carer at the center of focus in service design, service delivery and evaluation. This model is formally acknowledged in our current State funding agreements with the South Australian Department of Human Services.

The South Australian Carer Support Model has the following characteristics:

The carer support model is based on the recognition of the value of caring and the need for carers to maintain a balanced quality of life.

It recognises that carers are unique individuals capable of shaping their own destinies, and seeks to provide support by walking alongside carers to help them find the strength and information they need to maintain their caring roles and life styles.

The key characteristics of the model are:

- Aligned with social justice principles, and is directly linked with the SA Carers' Charter and the State Strategic Plan.
- Carers are partners in service provision.
- Carers form a majority of members on the Board of Directors or Steering Committee of member organisations, including executive positions (i.e. Chairperson/Vice Chairperson) within this structure.
- The focus is firmly on the carer and their health and wellbeing.
- Support is designed to help overcome the isolation and disconnectedness that carers may feel within their role, and to ensure that carers are given the opportunity to link with other carers.
- The support provided is always carer-driven; carers are listened to and the role of the service provider is to facilitate meeting the identified need.
- The carer is supported to develop resilience in their caring role.
- Information is provided that is relevant to their caring role and which will help them to access the support, services, information, and/or skills training they need.
- The carer-driven support activities provided by member organisations are positive and encouraging, and designed to assist the carer to express their own personal interests, separate to their role as a carer. Carer Support organisations form strong partnerships with other service providers and community organisations for the benefit of carers. Such organisations are locally based, community owned and managed, and directed by carers.