Submission to Department of Social Services

FWC Redesign

31 March 2017

1st Contact
Kate Wheller
Executive Officer
Community Information & Support Victoria
03 9672 2001
kate@cisvic.org.au

2nd Contact
Minh Nguyen
Advocacy & Research Manager
Community Information & Support Victoria
03 9672 2004
minh@cisvic.org.au

Contents

Capacity to submit 3

Submission 4

1. Discussion topic: Strategies to improve the targeting of services 5

2. Discussion topic: Strategies to increase service integration 7

2. Discussion topic: Strategies to support client outcomes 16

3. Discussion topic: Strategies to build a strong workforce 21

4. Discussion topic: Strategies to strengthen evidence, improve practice and measure outcomes? 23

REFERENCES 25

OTHER ATTACHMENTS 27

Capacity to submit

Community Information & Support Victoria (CISVic) is the peak body representing 60 community-based, not-for-profit agencies that provide local community information and support services. Its member agencies are staffed by over 320 paid staff and more than 3000 volunteers.

Our local services assist people experiencing personal and financial difficulties by providing information, referral and support services including Emergency Relief (ER), financial counselling and financial literacy. Our agencies provide free services to an average of 300,000 people every year.

We direct people who need help to local centres for services.

Helping those most in need Our main work is with the vulnerable and disadvantaged, including those on welfare payments, single parents, newly arrived, refugees, those with mental health issues, drug and alcohol issues and those experiencing family violence and family breakdown.

Emergency relief Many of our agencies provide emergency relief, both financial and practical, by providing food, food vouchers, travel cards, petrol vouchers, assistance with household bills, rent, pharmaceutical supplies and telephone bills.

One voice for many We liaise with all tiers of government and other peak bodies, conduct training and undertake sound, evidence-based research. We are grateful to the State and Federal Governments for their funding support for core and special projects.

Cooperation and connectedness We have also increasingly strengthened contact and cooperation with a range of peer organisations. This is a vital interface for not just CISVic and its members but also for the community support sector, exploring more effective use of resources, skills and funding conduits. This has included partnerships to deliver important training to volunteers and community workers.

We also participate in several state & federal government groups including a State Ministerial Advisory Council and Federal Consultative Committee and other relevant peak body advisory groups, including VCOSS (Victorian Council of Social Services), the ultimate state community peak body.

CISVic agencies are embedded in their communities.

The CISVic membership service model is placed-based and holistic in working with its communities and clients. The provision of supported services by CISVic member agencies is primarily directed at vulnerable and disadvantaged families and individuals who fall through service gaps. As generalist services providing a range of free, confidential and supported services, we connect vulnerable people and families to vital services and their communities.

Collectively, the CISVic ER Consortium of twenty-nine (29) agencies, is the second largest Federal Government funded provider of ER services in Victoria. In total, forty-five (45) CISVic agencies deliver ER across forty-eight (48) sites from a combination of government, philanthropic and donated funds. Our engagement with the community, local service providers and stakeholders is built on a strong local presence, place-based focus to problem identification and solution, and draws upon and enhances local social capital.

Submission

CISVic commends the Department of Social Services (DSS) for providing stakeholders an opportunity to respond to the proposed redesign of the Financial Wellbeing and Capability (FWC) Program. CISVic makes this submission on behalf of its membership.

CISVic commends the DSS for turning its mind to the broader questions of service delivery, systems and client outcomes in the proposed re-design. Following changes to federal funding for ER services in 2015, these are issues that continue to be actively discussed and addressed by service providers to ensure that clients seeking emergency relief (ER) services do not miss out.

ER has long been the ***'last safety net'*** for vulnerable and disadvantaged clients who fall through service gaps, or for whom access to the broader welfare system has been episodic but pivotal to financial and personal stability. Through ER, a range of financial support services (financial counselling, microfinance, financial literacy and education) are mobilised to achieve a measure of financial stability for vulnerable clients. In addition, ER service providers engage with a host of specialised social and welfare services to meet clients' needs including mental health, homelessness, family violence and employment services. Narrowing ER service delivery approaches down to prescriptive requirements relating to work-readiness and employability is at best a duplication of service, and at worst risks widening service gaps that will result in costs to the system, and crucially, to clients' wellbeing.

ER services (and to some extent microfinance and financial capability services) cannot be delivered without the contribution of a trained and capable volunteer workforce - 44% of CISVic member agencies delivering ER services are staffed solely by volunteers, and the ratio of paid to volunteer staff across CISVic ER agencies is 1 to 10. Decreased federal funding for ER have resulted in service providers putting in place a range of strategies to ensure that clients do not miss out. CISVic commends the initiative to strengthen and resource the FWC program workforce. However, FWC Redesign ('the Redesign') proposals such as increased integration, and better support for client outcomes were not sufficiently addressed in the Redesign's strong workforce measures. This reflects a lack of acknowledgement of the resourcing and support infrastructure required to deliver systems and client outcomes.

For the CISVic membership, it is increasingly clear that if structural causes of disadvantage continue to go unaddressed, client needs will continue to grow. Structural and underlying causes of disadvantage is glaringly missing from the strategies proposed under the Redesign. Policy and regulatory responses that address income security, cost of living and exploitative financial services will help increase the effectiveness of ER and other financial support services. Failing to take policy and regulatory contexts into account also problematizes how service providers characterise outcomes measures and develop meaningful evaluative frameworks.

Thus, while we commend the Redesign for making front and centre the need to enhance systems and client outcomes, CISVic questions the assumptions upon which some of the approaches taken in addressing improvements to the FWC service system are based. This and other issues of concern for CISVic and our membership will be addressed in CISVic's responses below.

1. Discussion topic: Strategies to improve the targeting of services

1.1 What impacts do you expect restricting eligibility criteria in the manner proposed by DSS will have on your service?

CISVic member agencies provide ER to people identified as experiencing 'financial and personal crisis'. Reduced funding over the years have resulted in some member agencies applying new/additional eligibility criteria for people seeking ER, whilst allowing scope for responding to local issues and contexts to meet needs. The capacity to provide for contingencies, 'out-of-the-box' situations is critical to a service that responds to crisis. This ensures that ER can be *something for everybody*.

'Financial and personal crisis' recognises that there are a range of factors that drive people to seek help. These include sudden life events, income poverty and cost of living expenses that periodically affect families living in poverty. It recognises the relationship between market failures, structural disadvantage and rising inequality, and the role of ER in filling these gaps. CISVic' member agencies regularly help clients who experience relative income poverty *and* disadvantage. Our members take the view that to deliver ER services 'beyond the bank-aid' service providers must operate from a more nuanced understanding of disadvantage. This means the disadvantage framework is viewed from "a number of broader concepts … deprivation, capabilities and social exclusion (and inclusion)" (MacLachlan et. al. 2013, p.5). Restricting service eligibility to a singular criterion of 'imminent risk of not able to pay debts' simplifies the complexities of the lived experience of income poverty and disadvantage.

Our volunteers and workers do more than drill down on client's ability to manage finances. This change will have direct impacts on the way CISVic members provide services. These include:

- **Narrowing eligibility criteria can delay identification of emerging issues**. Less flexibility to respond to clients as the focus of the intervention is on ability to pay debt and/or client's financial management. This could lead to delayed identification of emerging issues relating to personal crisis (for example, elder abuse or financial abuse). This in turn leads to gaps in services and preventive programs that could cost the community and service system further down the track.

- **Crisis support should not be about the person, it should be about the problem**. The narrowed criteria represent a shift from the issue to the person. This deficit approach is counter to service providers' strengths-based, systems approach to helping clients. This is a blunt policy instrument that does not align with experiences on the ground. The divergence in approach will have programmatic impacts as services will seek to retain the current approach whilst also meeting FWC requirements. Navigating this new approach will mean change management for volunteers, staff and clients leading to an increase in anxious, dissatisfied and disillusioned volunteers – and potential workforce attrition.

- **Increasing administrative burden and cost for community services.** Currently, ER services are funded from multiple sources, but working from the same flexible, responsive 'financial and personal crisis' model. Restricting eligibility, with its attendant reporting and outcomes measures that are different for FWC service compared to other funding sources, mean increased administrative burden and costs for service providers. Currently, it is the funds that are accountable. This will now change to not only the funds being accountable, but to also ensuring FWC services meet new eligibility requirements. This will require policy, systems and process changes. This will take time and money for a service that is already under stress: 15.5% operated a budget deficit while 63.6% of expense budgets on making grants and donations; in the context of a decrease of 30% of ER providers over 2013 and 2014 period (VCOSS 2016). This may also lead to unintended consequences, such as creating a two-tiered service system, one for FWC clients, one for clients funded from other sources (which have more flexible, responsive eligibility criteria).

1.2 What strategies can be employed to ensure that services are accessible for those who need them the most?

A range of tools can be utilised to ensure services are accessible. These form part of the best practice toolkit, policies and procedures that underpin the current CISVic service delivery model. We refer to the attachment 'CISVic ER Theory of Change' (see below: CISVic TOC) which outlines CISVic members' ER program and its relationship to outcomes for clients and communities. CISVic members have been involved in ER service delivery since the early 1980s, and currently 75% of CISVic members deliver ER services (not all of whom are funded by DSS).

CISVic member agencies employ the following strategies to ensure their services reach the most vulnerable people in their community:

- **Physical access** – includes access hours; mobility access; close to public transport or similar services; clean and functioning facilities.

- **Service access** – free interpreting; free, non-judgemental and place-based services; referral and linkages arrangements to refer clients if they can't be helped.

- **Integrated services** – integrate ER into the suite of services provided by CISVic agencies on-site. This consists of a range of services from budgeting, personal counselling to specialist services. This strategy ensures that clients are provided with specialist, professional help that improves their situation without having to go elsewhere and re-tell their stories.

- **Service and practice standards** – promoting best practice and training of volunteers and staff; ensuring CISVic member services have access to a range of supports including resources, training and incorporate CISVic guiding principles and standards to their ER programs and services. This will engender trust from clients that our services are delivered to community and client expectations.

- **Quality referrals and linkages** – ensure quality linkages by coordinating and/or attending networks that foster information sharing, training and communities of practice; engage with local service providers to establish formal and informal referral protocols; partner with service providers to co-locate or provide out-posted services on site (to be effective, these should be purposeful). In some situations, partnership arrangements aim to reduce the amount of times clients have to retell their stories to access services. These strategies ensure that clients can easily access services and/or get the right help at the right time.

- **Service promotion, including online and social media presence** – all CISVic member agencies are listed on the CISVic website directory which has a search functionality based on postcode. In addition, members maintain their own website and social media to promote, inform and connect with their clients and communities. More traditional forms of service promotion continue to be employed to reach clients with no internet access. Depending on locality, some services provide material in community languages to access CALD clients.

2. Discussion topic: Strategies to increase service integration

2.1 What would help you to strengthen cooperation with other services (e.g. family support services and job network providers) in your community? What additional support would you need to achieve this?

Lack of resourcing for formal networks is the greatest barrier to ER providers' capacity to strengthen cooperation with other services.

With 70%-90% of ER funds going directly to clients, there is little capacity left to adequately fund infrastructures to support service delivery. Due to reduced FWC funding in 2015, many ER providers have changed the way ER is provided to their communities to ensure that clients do not miss out. Strategies for doing this range from moving from a voucher system to food pantry, broadening food provision to include market gardens and other fresh food, starting social enterprises to supplement reduced funds, and utilising funds from other sources to address emerging needs (such as brokerage funds for increased education or medical costs). Capacities required to achieve these forms of efficiencies are either leveraged from other funding sources or have come from increased volunteer efforts. The pressure on volunteer only agencies have been immense, and in some circumstances, untenable. While administrative burden and red tape may have been reduced with the move to less reporting, reduced funds have led to more time and effort put into restructuring and developing new service models so that clients do not miss out.

Additional capacity building funds need to be made available to ER providers that utilise volunteer workforce to ensure that much needed support is available to those who deliver ER services to clients. Relationship building takes skill and time, especially when the focus is on service integration and inter-agency linkages. Within agencies, volunteer coordinators build volunteer capacity to deliver services to a high standard and ensure volunteer contributions are appropriately valued and counted. ER networks build capacity for ER services to share information and best practice, establish and strengthen inter-agency linkages, and foster service and program integration. Research into networks in the financial support service system has found that staff models that utilised paid, or both paid and volunteer positions, are associated with more network links. Furthermore, horizontal network is essential to the success of more formal, vertical service integration (Landvogt 2014).

CISVic agrees in principle that there is a need for more collaboration and service integration. Our members embrace the rationale and approach outlined in the discussion paper and have implemented aspects of them depending on service capacity. As a peak body, CISVic plays a crucial role in information and best practice sharing, training and sector support. However, given the lack of funding for focused coordination and sector support, the work done by CISVic and other prime providers remain limited due to severe funding restrictions. The primary focus of the FWC program is to meet immediate and material needs of clients in crisis. A delicate balance has to be struck as to the amount that could go towards material aid, as opposed to coordination expenditure; however much needed.

We submit that additional funding should be made available for:

- Volunteer coordination for each ER agency to build capacity for service delivery, focusing on service excellence and strengthening local social capital;

- Network coordination for existing ER networks to build capacity focusing on place-based responsiveness, strengthening service integration and facilitating innovative approaches to cross-sectoral collaboration and cooperation;

- establish formal ER networks where there are gaps; and

- Exploring, developing and implementing better use of technology to facilitate cooperation/collaboration within and across services (in particular, sharing client information, data and service access).

2.2 What effect will the requirement to formalise relationships with other organisations have on your service? How do you see these relationships working to maximise their effectiveness?

In principle, CISVic agrees that strong inter-agency relationships are critical to client outcomes. However, requiring all relationships to be formalised fails to recognise that there is a range of providers in the ER system, some with limited capacity to sustainably enter into formal relationships, but who are nevertheless significant in contributing to good client outcomes.

FWC services, where ER services is the ‘front door’, is a highly-networked service system of informal and formal referrals, which are the basic “building block of effective service delivery for the many clients with complex and multiple needs” (Landvogt 2014, p.111). Across the CISVic membership, a total of 45 members provide some form of ER to people in their communities. Some of these members are not funded by the DSS, but work collaboratively with DSS funded organisations in their community to meet clients’ immediate needs. The extensive network of relationships across this highly diverse group of providers ensures no client misses out. This has been, and continues to be, a fundamental tenet of ER services. All organisations providing ER have arrangements in place so clients can be helped; these arrangements depend on the variables of geography, resourcing, organisational and social capital. This diversity therefore requires collaborative mechanisms to be flexible; or risk sector attrition and ultimately, negative client outcomes.

In addition to comments in 2.1, the requirement to formalise relationships will place additional burden on our members who currently work with over-stretched resources. CISVic is concerned with how this requirement will be played out. It is not clear from the discussion paper what form this requirement will take, and the extent of reporting and administrative burden that is involved. The answer to the following questions will impact on numerous organisations’ capacity to meet the requirement. These questions are:

- What does ‘formalise relationship’ look like? Is it an agreement or MOU around referral protocols and procedures? Or is it an understanding that a referral made by one organisation to another mean that the client will automatically be serviced without the need to retell their stories?

- What does contractual requirement look like? Will it be monitored? Reported on? Are there metrics involved?

Research has found that “[L]ongevity of workers was identified as one of the most critical [structural] factors [that affects the success or otherwise of networking]: it is not one that can be designed into a service, but it is more likely in sustainably funded organisations” (Landvogt 2014, p.112). A better approach therefore, is to enable organisations to build relationships and links through strong networks; establishing and sustaining relationships with other providers around the common goal of ensuring that no client misses out. This can be done by adequately funding local ER networks, embedding the position within a larger organisation within the network to leverage for other efficiencies. This approach is grounded in research by Landvogt into formal service networks in financial support service where it was found that:

> “[L]arger organisations play a critical role for local service networks. They provide resources as specialised knowledge to the network, which can be accessed by smaller organisations. Larger organisations are able to build networks across a diversity of areas, in line with their range of programs. This means they are well placed to act as a bridge between small specialised services and larger generalised services”. (Landvogt 2014, p.12)

This approach aligns with organisational and program purpose, broader organisational structure and capacities, and has a greater chance of being strengthened over time. This approach to

building formal networks - as opposed to requiring agencies to formalise their relationships - builds the local social capital of communities, thereby amplifying its effectiveness beyond inter-agency relationships.

CISVic contends that an approach that clearly identifies client outcomes as the goal, is adequately resourced and builds on existing relationships, has a better chance of achieving effectiveness than one based on an inflexible requirement that treats all organisations equally but not equitably.

2.3 Where is integration/collaboration of FWC microfinance services with other FWC services occurring across the country? Is there a way these relationships could be better supported?

The recent review of the NILS program (development of fourth operating model and new approach to funding (GSMF 2016)), the limitations of Step Up (some locations report a freeze on Step Up loans as they have reached their cap) and long queues for financial counselling confound the current FWC program landscape. Of 45 CISVic member agencies providing ER services: 49% (22) provide financial capability (including budgeting, financial literacy) services; 40% (18) provide NILS; 20% (9) provide financial counselling and 11% (5) provide Step Up loans. While access to these services assists those living in poverty to alleviate the impact of financial crisis, they are only one part of the story.

The capacity to connect and link people to services beyond financial support is critical to ensure there is a clear pathway to improved outcomes for complex needs clients. Across 45 CISVic ER services, 44% provide casework to clients with complex needs. By working with clients to provide intensive, short-term support grounded in a strengths-based relationship, caseworkers assist clients to stabilise their lives and finances. Financial instruments such as microfinance services and innovative loans will only go some way to help clients stabilise their situation. Research in the homelessness sector (Gronda et. al. 2009), and by CISVic and The Salvation Army, have shown that caseworkers can effectively help clients to navigate service systems and get the help they need (Nguyen 2011; Brackertz 2014). Having a lynchpin that can connect ER, microfinance and financial counselling *as well as* the broader service system is key to ensuring service integration and collaboration lead to improved client outcomes. In this regard, ER caseworkers play a key role in enhancing integration between multiple services for complex needs clients - more than the availability of a microfinance service in an agency. CISVic casework data shows that 62% of services provided by our caseworkers are delivered in collaboration with other support service. In addition, CISVic member agencies deploy skilled volunteers and social work students in their paraprofessional capacity to broaden the scope of casework services to clients. CISVic builds members' capacity to provide these services through a range of sector support activities, and most crucially, through the CISVic Student Placement Program (CISVic 2013).

Building on existing structural factors such as: formal networks; informal and formal service linkages and referral processes; the provision of intensive, short-term support; on-site access to the suite of FWC programs (or place-based presence such as co-location) takes time and resources that are currently in limited supply. Providing adequate levels of funding to develop relationships and strengthen existing linkages will enhance integration/collaboration of FWC microfinance services with other FWC services. Such supports need to be place-based, flexible and responsive to emerging situations and contexts.

The lived experience of poverty and disadvantage is chaotic and complex. Working with people in crisis to stabilise their life circumstance is only one part of the puzzle. The issues that led to their crisis have roots beyond the individual's capacity to manage their finance. Structural disadvantage, financial exclusion, social isolation, and limited social capital variously contribute to underlying issues faced by ER clients. Microfinance, essentially financial instruments, have limited efficacy in helping borrowers overcome poverty (Banerjee et.al. 2015). Similarly, there are structural limitations of financial support services to address the multitude of issues confronting ER clients. Financial support services must be accompanied by better policies that address the structural contexts of poverty, rising inequality and persistent disadvantage (Landvogt 2014, p.115).

FWC funded microfinance services, in many instances, depend on volunteers. As a financial instrument, NILS applicants ultimately need to be assessed on the basis that they (i) can service their loans, and (ii) be in a stable situation over 3 month period. NILS also relies on ER providers to make the initial assessment and referral, and in addition, be able to provide on-going support to clients to ensure that loans are honoured. This inter-dependence works well, all things being

equal. NILS loans give households on low incomes more freedom over how they manage their money, and give people choice in how they manage their daily lives. However, clients on limited incomes, no matter how well they manage their finances, cannot provide for contingencies or rising costs of essential services, which has potential to throw them back into crisis

CISVic members' approach is that integration/collaboration for any service system should not be an end in itself, but a means to achieve better outcomes for clients. Thus, for FWC services to be more efficacious and relationships better supported, better policies need to be in place to facilitate successful client outcomes. These include:

- income security that lifts people above the poverty line;
- measures that redress the rising cost of essentials for low-income families (affordable housing, education, medical and utilities costs); and
- improved regulation of exploitative financial services.

2.4 What elements would need to be present to ensure a hub model is successful in your community? What additional support would you need to establish a hub in your community?

It is unclear from the discussion paper as to what the proposed hub model looks like – whether it is one based on those established in income management trial sites, or a generic multi-service model. In principle, CISVic agrees that hubs or multi-service sites can be effective in promoting service integration and collaboration. However, CISVic members cite severe limitations (canvassed below) to the creation of a hub within their localities.

Members' experience of co-location, multi-service sites are the organic, flexible, needs-driven models that traditionally respond to emerging and changing client needs. Under this model, the needs of service users are identified, and inter-agency resources are shared to enable the delivery of a service gap (typically this involves a service making space available for out-posting of a worker, which may lead to a more formal arrangement that involves co-location or establishing a service program). This means infrastructure and expansion is incremental and viable.

The creation of a hub - a more deliberate and formal process - presents some challenges. Nevertheless, for hubs to work, there should be the following elements with additional support and possible challenges noted:

- **Infrastructure** – finding building space that fits all services under the same roof can be challenging in certain localities.

- **Accessibility** – services should be accessible to clients, this includes being close to public transport, all ability accessible.

- **Build on existing social capital** – the most efficacious use of funding would be to allocate to services that are already established in an area. These services can build on its existing relationships and established reach. For example, it is not advisable that a hub be established where there has been no real community connections or linkages. Community trust and strong relationships must be pre-requisites for successful hubs – such as engaging a trusted local agency as a lead/anchor in discussions with other local providers when establishing a hub in a community.

- **Clear and common purpose** – hubs need to be purposive, not only as a general proposition, but as a service centre that aligns different services' aims and goals with client and service outcomes. Hubs should not be a group of services in the same building. There are some services that could never be conducive to hub models, such as domestic violence service.

- **Adequate resourcing** – services should be adequately resourced to sustain high levels of integration within a hub model. This involves:-

    - recognition of volunteer contribution and the support structures that need to be in place to ensure seamless and quality referrals;

    - sufficient funds to meet clients' immediate needs so that volunteers and workers can focus on addressing complex underlying needs;

    - adequate capital for technology and related infrastructure to ensure client information can be shared to enhance service efficacy and client privacy is protected.

2.5 What elements and innovative practices would be particularly key in establishing a hub model in a rural and/or remote service delivery context?

Nil comment.

2.6 How could Australian Government funding be used differently to better support integration of FWC services?

We point the DSS to the Victorian DHHS Integrated and Family Services model for an example of how inter-agency service integration can lead to a more coordinated response to families in crisis. CISVic contends that a ‘no wrong door’ policy, adequately supported by funding, cross-sector collaboration and goal setting is a critical first step to an effective service system response to complex social problems.

While we agree in principle that the focus on formal linkages could help improve service systems, we don’t agree that this is the only solution. The ER sector is heavily reliant on volunteer contribution and social capital, and the savings this represents to government is immense. While service integration and collaboration will surely improve service systems, they must be accompanied by adequate support for the work required to achieve integration. As outlined in 2.1, additional funding for network coordination will go some way to ensure improved service systems, and ultimately outcomes for clients. Similarly, additional funding should be made available for innovative practice (such as student placement programs) that build organisations’ capacity for quality referrals and service linkages.

Service integration should not only be about mechanisms to improve the system (formal/informal referrals and linkages, formalised relationships, formal networks) but also about the people that inhabit these systems - the volunteers, workers and students on placements - who make it all possible. The sector is already operating on tight budgets, and the workforce is grappling with increased demands and needs. To require more to be done on existing funding may unnecessarily overburden capacity, and risk sector attrition.

2. Discussion topic: Strategies to support client outcomes

3.1 What strategies can you utilise to support a client to improve their financial and/or employment outcomes?

CISVic member agencies provide holistic support to people in their community. Volunteers providing ER services are required to undertake accredited training to work with vulnerable clients. When people attend CISVic services, they take part in an intake and assessment process aimed at identifying immediate needs and underlying issues. Clients are then referred internally or externally depending on service capacity and availability. Clients with complex needs are referred to caseworkers, skilled volunteers or social work students on placements for intensive, short-term support. This wrap-around service model ensures that clients can address the issues that give rise to their personal and/or financial crisis. When immediate needs are met, and clients' financial situation have been stabilised, further work may be done with clients to address other issues. These issues can be risk of homelessness, financial abuse, employability, mental health and inadequate income among others.

In relation to employment outcomes, CISVic underscores that our members provide a holistic approach to client support. This means that workers and volunteers look at the client situation in its totality. This approach looks at how people interact with the service system and see where this interaction failed. This strengths-based approach empowers clients to make life decisions to improve their situation, and enables the system to better interact with clients to achieve improved personal and social outcomes.

Therefore, when working with unemployed clients, CISVic members work with clients on their 'employment journey' rather than on improving employment outcomes. Improving employment outcomes is the specialist role of JobActive providers, with their distinct goals, measurement metrics and client outcomes. To engage with clients in the same way as employment services is an unnecessary duplication, and is counter to the crisis intervention and referral role of ER. In addition, focusing on employment outcomes may lead to failure to address other issues that impact a client's life. CISVic caseworkers and volunteers work with clients to complement supports they receive elsewhere. This could be family violence service, mental health service, homelessness service or employment service. ER volunteers and caseworkers complement and supplement the broader welfare service landscape to ensure that clients do not fall through service cracks. CISVic members also report that many unemployed clients who attend our service experience other pressing issues including mental illness or other capacity to work barriers. It has also been acknowledged in the AIHW Australia's welfare 2015 Report that "[P]eople with mental illness are disproportionately represented among the unemployed and those on low incomes" (AIHW 2015, p.288)

Consequently, in our work with unemployed clients **we may engage in** any of the following activities (depending on the particular client situation):

- **Brokerage** – either through dedicated funds (sourced from philanthropies, fundraising etc.) or in partnership with other services, funds are made available for job seekers to purchase services and/or goods to prepare for job interviews. For the working poor, this may involve funds to purchase clothing or other necessities (work boots, work-wear for casual workers) to get to the next job.

- **Integrated services** – within the same organisation, or in formal partnerships with other local providers, arrange to provide material aid to a client, or work towards stabilising their situation so they could cope better with financial and day-to-day stresses. For example, Whittlesea Community Connections Housing Brokerage program, an integrated point of access providing microfinance loan coupled with case managed support, was found to be effective in helping clients rebuild new lives and cope better with financial and day-to-day stresses (see attached: Parkinson 2015).

- **Quality referrals and linkages** – cross-referrals to/from local JobActive providers.

- **Volunteering as a pathway to employment** – CISVic promotes volunteering as a pathway to employment through training program, and member agencies variously offer some form of volunteering as an employment pathway for community members and clients (see attached: SPCSIC EEP Brochure; DIVRS Urban Food Pathway).

- **Client engagement with volunteering** – provide opportunities for clients to volunteer at our services: such as kitchen garden initiatives, food collection and packing. Alternatively provide clients with volunteering opportunities in the community, particularly within member services that also run volunteer resource programs.

- **Client engagement in peer support** – establish peer support groups for clients, help build confidence and reduce social isolation for clients experiencing entrenched or multiple disadvantage.

- **Services to clients** – help with resume writing, form filling and other administrative activities.

In our work with unemployed clients **we do not and/or have limited capacity, to engage in** the following activities:

- **Enter into employment conversations** – this requires a level of training and expertise that ER workers cannot provide. Additionally, ER is about meeting immediate and presenting needs, and onward referral to appropriate, specialist services (this can be internal or external referrals).

- **Discuss employment as a primary issue** – volunteers are trained to assess need and identify appropriate services (internal and external) for referrals. Caseworkers, and some volunteers may work in a paraprofessional capacity to provide intensive, short-term support, although this is always within the context of presenting, and underlying issues whatever that may be.

- **Focus on one issue at the expense of client's need for empowerment** – a fundamental tenet of strengths-based work with clients is to focus on the client's empowerment. This is adhered to even within the ER program itself. Consequently, caseworkers do not provide ER when they work with a client. This is to negate the potential conflation of service access to ER, and the work caseworkers do with clients. CISVic is concerned that a conversation about employment tied to a service (e.g. financial counselling, ER, casework) will have a negative impact on trust and transparency between the client and worker/volunteer.

3.2 How does your service currently deal with clients who present to your services on multiple occasions? At what point should additional support and requirements apply to repeat ER clients? What form should this take? What barriers do you see in implementing these requirements with your clients? What support would you need to implement such a proposal?

Returning ER clients pose a real service issue for ER providers. Material aid is a band-aid response if the underlying causes that lead clients to return to ER services is not addressed. The wrap-around service model is a direct response to providing more than a band-aid. In this way, ER becomes a "hand-out to give a hand-up". As the last safety net, it is critical that ER services can offer the spectrum of support. This is as important within one service as it is across the whole ER service spectrum.

In response to the proposal that returning ER clients will "be required to demonstrate reasonable steps to reduce their costs, increase their income or improve their financial management", CISVic questions the assumptions that underlies this proposal. In addition to comments made in response to Q.1.1, CISVic refers to the Brotherhood of St Laurence Working Paper *Understanding financial wellbeing in times of insecurity* where it is asserted that " [A]s a work in progress financial wellbeing faces difficult conceptual challenges. We argue that relying on methodologies primarily centred on the individual distorts a framework that seeks to incorporate other domains. Rather, financial wellbeing policy design should start with concepts that centre on the social as its primary unit of analysis…Further research and debate are urgently needed to define the relationships between social and individual factors included in financial wellbeing constructs, and their relative significance in determining financial wellbeing, before effective financial wellbeing policy can be designed, implemented and evaluated." (Bowman et. al. 2017, p.5)

The discussion paper also proposes that service providers determine what actions constitute 'improvement in financial management'. Barring more detail around how service providers themselves may be required to demonstrate that their improvement test has been met, questions remain as to what end this criterion is designed to meet. This is particularly pertinent when the test is a highly subjective one.

Instead of the proposal that multiple ER visits triggers the application of a subjective test, CISVic recommends that when an ER client re-presents for assistance, a few considerations are taken into account to determine how ER services could provide "a hand-out to give a hand-up". It must be noted that the considerations listed below reflect current practice:

- **Do the barriers to changed circumstances reside in structural disadvantage?** Normally, volunteers would go through a budget with clients to determine the answer to this question. Inadequate income, regardless of client's ability to financially manage, cannot overcome unexpected costs and financial crisis. Similarly, a client assessed as not work ready, and who experiences barriers to employment, is not in a position to improve employment prospects.

- **Are there services that the client can be referred to that could help improve their circumstance?** Normally, volunteers identify clients with complex needs and refer them to caseworkers for assistance. This depends on other systemic factors such as availability of other generalist and/or specialist services in the area; current wait-lists; availability of ancillary and/or other programs within the organisation. In these identification exercises, case notes, red flags (ie. client is returning more frequently than average clients) and policy directives (in some agencies, a client returning more than a certain amount of times will be required to be referred to caseworkers) are some of the strategies that agencies use to trigger priority referrals for repeat ER clients.

- **Do services exist that meets the needs of clients?** In many instances, ER service providers may identify a service gap and work to providing services to meet that gap. For

example, there may be a spike in general health issues, so the service may create a drop-in service to cater to this need. This requires leveraging existing relationship, or creating new relationships with specialist providers. These activities often lead to innovative practices, but are resource intensive.

- **Does the organisation have capacity to service beyond immediate needs?** It must be acknowledged that ER and material aid by its very nature addresses immediate needs. The ER service spectrum is wide, with a range of services working together to address food security and material needs at one end, and client-centred, wrap around support at the other. For some services, a requirement that they do more will overburden capacity, and risk sector attrition. This in turn may lead to service gaps, poorer client outcomes and reduced social capital.

CISVic agrees in principle that a proportion of ER clients do return for support. CISVic recognises though, that crisis takes many forms and it is critical that ER services respond to them appropriately. A system of intake and assessment, of checking in with clients at each visit and assessing their circumstances can start many conversations. A well trained, well supported workforce that is equipped to respond with a client-centred, needs approach is better positioned to move a vulnerable client through the service system than one that imposes mandated requirements.

3.3 How can DSS better support early intervention and prevention opportunities?

CISVic refers to the points throughout this response about ER services being under-funded and insufficiently supported to carry out work beyond the day-to-day focus of service delivery. How we address the early intervention and prevention question is necessarily tempered by the broader contextual issues canvassed elsewhere in this response (structural and systemic factors, volunteer contribution, non-government contributors to ER funding). Consequently, CISVic refers to the CISVic ER Theory of Change (CISVic TOC), which outlines what CISVic members have identified as what it is we are trying to achieve when we do ER. From the small, dozen or so group of volunteers to multi-service, multi-site agencies, our members engage with the welfare sector in a range of capacities.

Early intervention and prevention opportunities are better supported where there is:

- **Recognition that structural and systemic issues are key drivers to personal and financial crisis** – better policies and regulatory frameworks need to be put in place to address rising inequality, income security (including inadequacy of income support payments), exploitative financial products and services, and earlier and more comprehensive financial literacy education (in school curricula, for new arrivals and vulnerable groups).

- **A focus on the problem, not the person** – addressing client needs from a strengths-based approach, focusing on empowerment and client-centred systems. This includes not imposing eligibility restrictions that fosters a deficit approach to client issues.

- **Dedicated funds towards resourcing and supporting volunteers** – provide funding to support the work of volunteers and ER networks (see responses to 2.1).

- **Investment in the broadening of casework within ER services** – caseworkers are the lynchpin to ER and other services, and more importantly are key to early intervention and prevention work with ER clients. (see responses to 2.3 & 3.1).

- **Promotion and investment in innovative programs that pick up service gaps** – such as budgeting programs that work with clients to provide a combination of material and budgeting support, proper access to entitlements, as well as appropriate referrals. (see attached: Knox Infolink Pamphlet)

3. Discussion topic: Strategies to build a strong workforce

4.1 Do ER and CFC/FC workers need to build capacity? If so, how might this be done?

As reiterated in the CISVic response to other questions, FWC program workforce require more support and will benefit from capacity building. CISVic agrees in principle with the comments outlined in topic 4 of the discussion paper. In addition to these approaches, CISVic recommends:

- **Reinforcing the significance of place-based capacity building** - while there are benefits to national standards and training, there is greater value for place-based approaches to training and information sharing. CISVic's experience with our membership is that even within metropolitan Melbourne, different regions have different foci and emerging issues. Growth corridors in the south-east, outer east and north have vastly different demographic, development history and social and cultural capital. Pockets of poverty and disadvantage similarly present complexities that are often place-based. We therefore caution the extent to which nationally based training and training providers can be utilised to help address place-specific issues.

- **Capacity building needs to be highly responsive and relevant** – emerging issues and trends may take time to feed up the line, but conversely require rapid response from service providers. This is particularly critical for the early intervention and prevention work of financial capability workers and those involved in financial education and literacy. Particularly pertinent are systems responses to exploitative financial practices and services, such as increasingly creative consumer products requiring high levels of financial literacy. For example, the energy market is extremely complex and difficult to navigate for vulnerable consumers, so how do we ensure timely community education?

- **Workforce strategies must take into account volunteer contribution to the sector** – Volunteers are by far the largest contributors to ER services. CISVic members will not be able to deliver ER without their volunteer workforce. Across our 45 services, the ratio of paid to volunteer staff is 1:10. All 45 services rely on volunteers, while 44% (20) are staffed solely by volunteers. In addition to strategies outlined in the discussion paper, CISVic recommends active promotion and support for innovative programs that address recruitment and retention of volunteer workforce.

- **Building sector capacity for evaluation and research** - investment in research and evaluation are critical to promoting best practice, program improvements and cross-sector learning. Capacities that enhance data capture, program evaluation and outcome measurements will lead to better outcomes for clients, higher quality service standards and attract higher quality volunteers and staff.

- **Acknowledgement that the sectors involved in delivering FWC services are diverse** – this requires acknowledging the different needs of providers along the service spectrum. Large and small organisations interact in complex and complementary ways. Building on these existing relationships - and leveraging them when building capacity - will lead to better service and systems outcomes.

- **Fund peak bodies' sector development work** - The work done by peak bodies is relevant and critical to improving practice and building capacity for better service and systems outcomes. Peak bodies can play a role in ensuring governance and practice standards are adhered to. Peak bodies also play a critical role in facilitating effective relationships between service providers, different levels of government and key stakeholders.

4.2 What ‘tools’ do you see as integral to the further development of the FWC services in Australia?

There is a plethora of tools publicly available in the sector that would benefit from better coordination and facilitation. Currently, these tools and resources are developed and promoted by peak bodies and/or local networks. Training and other professional development activities are also facilitated at either the local level or at regional levels. Additionally, other ‘tools’ currently employed among CISVic member agencies is the community of practice around casework, where caseworkers meet on a quarterly basis to share best practice and information, provide peer support and trial innovative approaches to case-working with clients. Bringing these together at a national level via a clearinghouse, preferably available online, could address existing coordination gaps. As an example, we would point to websites such as ourcommunity.com.au.

In response to the proposal for tools and resources that focus on employment readiness for unemployed clients, CISVic contends that the focus on unemployed clients is unnecessarily narrow. CISVic’s principal objections to the narrow focus on employment, notwithstanding background case-law, have been canvassed elsewhere in this response (see 1.1, 3.1).

In principle, CISVic does not object to the development of tools and resources that equip workers to improve practice and achieve outcomes for clients. CISVic however, questions the conditions in which these tools and resources will be mobilised. Worker-client relationships in the community sector is client-centred, goal-oriented and based on client needs. For the relationship to be effective, there should be no conditions placed on how goals and needs are reached. This would be counter to the empowerment and capacity building approach. Workers should be equipped to work with clients across a range of different areas, not only employment. CISVic strongly recommends that tools developed build worker and client capacities to address the multitude of issues that clients face.

In addition, it remains unclear as to how (or if) the focus on employment readiness impacts on clinical decisions made by financial counsellors. Will it be a mandatory requirement that employment conversations will be entered into? What will compliance look like? Are there outcome measures that financial counsellors will be required to meet? If so, how are these measures carried out? Similarly, how are financial capability workers required to incorporate an employment focus into their work with clients? Of more concern is the question – will there be consequences for clients who do not wish to enter into these conversations? Are there service access impacts? Is there a perceived service impact by the client? The answers to these questions will have repercussions for the broader ER and welfare sector if the relationship of trust between client and service is broken. CISVic points to the punitive measures in the UK with regard to benefit sanctioning which has not been shown to improve employment outcomes (Loopstra et. al. 2015). More relevantly, sanctioning appears to be closely linked with rising need for emergency food assistance (Loopstra et. al. 2016).

A better approach to the development of tools and resources would be to fund capacity building activities for local networks, peak bodies and professional bodies on the condition that these are freely available, widely shared and supports the range of providers involved in delivering FWC services.

4. Discussion topic: Strategies to strengthen evidence, improve practice and measure outcomes?

5.1 What do you see as the key issues involved in evaluating the FWC Activity?

The main aim for evaluating any program or service activity is to answer the fundamental question – did the activity do what it was designed to do? If so, how well? If not, why not? As ER is a crisis service, what is achievable and measurable is the immediate impact and intermediate impact. What is being measured must be able to be related back to the intervention.

Key elements for evaluating the FWC Activity:

- **Client outcomes measures** – to determine if we have achieved outcomes for our clients. Annual surveys of CISVic casework clients will be conducted over a 4-week period to understand the quality/impact of client-caseworker relationship. The survey also seeks to measure changes in client's situation as a result of working with their caseworker. The aim is to collect credible evidence that could be shared with other member agencies for continuous improvement and dissemination.

- **Service improvements measures** – to determine what worked, where and how well. This depends on a combination of mandatory data sets (DEX) and service, demographic and other data that contribute to service improvement. Technology is critical to agencies' capacity to engage in effective evaluation, as it has potential to identify anomalies and gaps and enable rapid response.

- **Building the evidence** – CISVic notes comments in the discussion paper citing KPMG 2015 research project, and agree that further research need to be conducted in relation to FWC service delivery models. To this, CISVic would add comments from the Brotherhood of St Laurence Working Paper calling for more research as "[C]urrent attempts to aggregate social and economic factors, particularly policies (financial inclusion and literacy) and individual behaviours, attitudes and skills in one construct are, however, theoretically and methodologically underdeveloped. We argue that the concepts underlying the design of financial wellbeing policies, programs and practices require more careful consideration if this potential is to be realised" (Bowman et al: 2017, p.4).

- **Communicating research and evaluation to the sector** – the sector recognises that the Australian Government collects an inordinate amount of data and which has the capacity to inform services about what is happening in other parts of the sector. An annual report of service activities and outcomes, or snapshots of key outcomes would be welcome by the sector. This will be of particular utility for small providers with limited capacity to make the connection between their impact and the broader service system.

- **IT infrastructure is critical to data collection and integrity** – data collection is more reliable, secure and efficient when there is up-to-date IT infrastructure. Up-to-date IT infrastructure will also enable adoption of technology and innovative products that enable immediate contact and response from clients (such as via mobile technology, apps etc.) Investment in infrastructure at the outset saves on future evaluation/research costs (for example, administering surveys will be low cost via technology compared with time and resources to administer surveys the traditional way).

5.2 What would you like to see as the main focus of the evaluation?

The focus on evaluation should be grounded in what ER does. ER is a crisis service; it provides material aid and support to clients in crisis. ER services alleviate the impact of the presenting crisis on vulnerable individuals and families by providing a range of goods and services to address immediate needs. In this context, ER is an intervention trigger for a range of welfare, social and specialist services that could assist clients to achieve longer-term outcomes.

Consequently, evaluation of ER (and other FWC programs) should be appropriately contextualised and attributable to an immediate (ER) and intermediate (casework support) impact as identified in the CISVic ER Theory of Change (CISVic TOC). This includes attention to client outcomes and service improvements. Given the structural contexts underlying complex social issues, evaluation should also account for the impact of social and public policy, and economic and regulatory changes that affect the lives of vulnerable people.

Engaging in meaningful and purposeful evaluation requires resources (financial, organisational and human capital) that are not available within current funding arrangements. Additional funds need to be allocated to develop and implement an evaluative framework for organisations delivering FWC services. By helping these services to evaluate at the intervention level, we will be in a better position to determine what works, where, how and why. We can build the evidence base that improves program, service and client outcomes.

REFERENCES

Australian Institute of Health and Welfare 2015. Australia’s welfare 2015. Australia’s wlfare series no. 12 Cat. No. AUS 189. Canberra: AIHW.

Banerjee, A., Karlan, D., Zinman, J. 2015 ‘Six randomised evaluations of microcredit: introduction and further steps’, *American Economic Journal: Applied Economics* 2015, 7(1): 1-21

Bowman, D., Banks, M., Fela, G., Russell, R, and de Silva, A. 2016 *Understanding financial wellbeing in times of insecurity,* Pre-publication Working Paper, Brotherhood of St Laurence & RMIT University: Melbourne.

Brackertz, N., 2014 *Time, Trust, Respect. Case Management in Emergency Relief: The Doorways Model*, The Salvation Army, Swinburne University of Technology: Melbourne.

CISVic, RMIT University & Victoria University 2013 *CISVic Student Placement Pilot Project: Evaluation Report*, Community Information & Support Victoria: Melbourne.

Good Shepherd Microfinance (GSMF) 2016 Discussion Paper: Strengthening NILS for client impact and reach, November 2016.

Gronda, H., 2009 *What Makes Case Management Work for People Experiencing Homelessness?*, Australian Housing and Urban Research Institute (AHURI): Melbourne.

Landvogt, Kathy 2014 Collaborating for Outcomes: Networks in the Financial Support Service System, Good Shepherd Youth & Family Service: Melbourne.

Loospstra, R., Reeves, A., McKee, M. and Stuckler, D. 2015 Do punitive approaches to unemployment benefit recipients increase welfare exit and employment? A cross-area analysis of UK sanctioning reforms, Sociology Working Papers, Paper Number 2015-01, University of Oxford: Oxford.

Loopstra, R., Fledderjohann, J., Reeves, A., and Stuckler, D. 2016 *The impact of benefit sanctioning on food insecurity: a dynamic cross-area study of food bank usage in the UK*, Sociology Working Papers, Paper Number 2016-03, University of Oxford: Oxford.

McLachlan, R., Gilfillan, G. and Gordon, J. 2013, *Deep and Persistent Disadvantage in Australia,* rev., Productivity Commission Staff Working Paper: Canberra.

Nguyen, M., 2011 *Ending the Stopgap: casework in emergency relief services*, Community Information Victoria: Melbourne.

Parkinson, S., 2015 Evaluation of the Whittlesea Community Connections Housing Brokerage & Support Project, Whittlesea Community Connections: Epping.

VCOSS (2016) *More than charity: Victoria’s community sector charities*, Victorian Council of Social Services: Melbourne.

CISVic Emergency Relief Theory of Change

Core values:

We provide high quality holistic support that *upholds the dignity of all, responds to community need, alleviates the impact of poverty* and *promotes social justice*.

INPUTS

Peak body (CISVic)
- Sector development & support
- Training
- Networking
- Research & Advocacy
- CISVic consortium
  - Client management & data system
  - Reporting
  - Funding

ER providers - membership
- Governance
- Volunteer contribution
- Volunteer management & coordination
- Casework (qualified professionals)
- Reception/Administration
- In-kind organisational (e.g. staffing, computers)
- In kind other (e.g. venue, staffing)
- Additional funding (e.g. social enterprise, fundraising, donations)
- Material Aid
- Community and inter-agency partnerships
- Client management & data system
- Interpreting
- Quality and Accreditation

	ACTIVITIES	OUTPUTS	OUTCOMES: IMMEDIATE IMPACT	OUTCOMES: INTERMEDIATE IMPACT	OUTCOMES: LONG TERM IMPACT
	Provide information and support to individuals and families experiencing personal and financial crisis.		Meet immediate needs	Informed and connected community members	Responsive, strong, and resilient communities
Service Delivery	Basic transactional support. Basic transactional support & advocacy. Wrap around service support (case work). Food security.	Individual/family circumstances are assessed Material assistance Information and advice Advocacy and support Referrals and community links	People's immediate and underlying needs are assessed by trained volunteers and workers. Basic needs are met (food, clothing, bills). Additional needs are addressed, and where relevant, linkages made to appropriate services. Respectful, non-judgemental and welcoming service.	People are making informed choices to address their financial/personal problems. Increased financial literacy, including increased access to financial services (i.e. NILS). Clients with complex needs (ie. family violence, homelessness, mental health) are linked into early prevention services.	Vulnerable and disadvantaged individuals, families and communities are financially capable and resilient. Strengthened families and relationships that enhance individual, family and community wellbeing.
CISVic Integrated Model	Consistency and expectation of service (Practice Standards). Place based services. Integrating E/R into the suite of services provided in services delivering community information & support. Flexible funding.	Constant set of guiding principles & standards Wrap around & integrated service provision Flexible funding options Training Sector Development position Communication and information platforms	Commitment to a common set of service principles and standards. Enhanced capacity to cross-pollinate, share knowledge and innovate in service delivery. Volunteer and workers are appropriately trained to support vulnerable and disadvantaged clients. Support and sector development work that enhance capacity to deliver ER.	High quality, effective and consistent ER service. Responsive, flexible and innovative delivery of ER services. Recognition and valuing of volunteer contribution in delivering ER services.	Place-based, integrated and collaborative community-led programs. Strong, inclusive and vibrant civil society sector.
Data Collection/ Advocacy & Reporting	Capturing data – on portal or other system, including: - Emergency Relief support - Casework - Client satisfaction - Volunteer satisfaction Understanding & analysing data. Reporting and advocacy.	Online database to manage data and clients Collective data to better inform research/advocacy Research and Advocacy position Client outcome measurement process	Consistent & efficient data capture. Transparent and accessible evidence-based data. Identify trends & emerging issues that can influence practice and advocacy. Centralised and supported client management system. Capture client outcomes. Efficient and accurate reporting to funding body.	Early identification and response to issues affecting vulnerable and disadvantaged communities. Evidence-based advocacy on behalf of vulnerable and disadvantaged communities. Data and reporting integrity that provide reliable information about service and client outcomes.	Evidence-based decision making by policy makers and local service providers. Targeted and well-resourced programs that address the underlying causes of disadvantage and poverty.

OTHER ATTACHMENTS

Knox Infolink Brochure

Southern Peninsula Community Information & Support (SPCIS) EEP Brochure

Darebin Information & Volunteer Resource Service (DIVRS) Urban Food Pathway

Parkinson, S., 2015 Evaluation of the Whittlesea Community Connections Housing Brokerage & Support Project, Whittlesea Community Connections: Epping.