DSS/FWC - DISCUSSION PAPER – 31.03.17

Capacity to Submit

Community Support Frankston (CSF) is one of the largest single outlet providers of Emergency Relief (ER) funds in Victoria and has a contract to deliver ER funds in it's own right under the FWC activity. Our agency is primarily staffed by skilled volunteer workers who contribute more than 13,000 hours each year to CSF's services.

When CSF commenced ER in 1978 it was already the leading information and referral agency in Frankston, so was able to refer people to other community organisations to have their needs met, not that there were many agencies in town at that time to which people could be referred.

CSF produced a book on ER funded by the Federal Government and distributed to every community service it funded under the then Emergency Relief Program. The book advocated an integrated approach to ER and the importance of providing a providing a multi-dimensional service.

While our service has come from humble beginnings and lacks the resources of large contract holders we hope that this response will assist to inform the conversation. CSF is also a member of peak body Community Information & Support Victoria (CISVic) and supports the FWC redesign paper that CSF provided feedback for.

Rather that seeking to double up on these responses we hope that the information provided in this submission highlights some key messages while also giving a frontline service perspective on the five discussion points.

Strategies to improve the targeting of services

In response to the suggested changes to the FWC guidelines, restricting ER and CFC to those at immediate risk of not being able to pay their debts, shouldn't present significant issues to what's already occurring in the FWC activity. Using CSF's ER policy as an example, clients requesting DSS funded ER need to show evidence of their final hardship and are taken through an income and expenditure assessment to assist with money management. It is also part of our assessment in helping to determine the best way we can address the immediate needs of someone presenting in financial crisis. However, limiting ER to people in current receipt of a government supported

payment may be problematic for groups including: those receiving no income, the working poor and those in the process of waiting for or transitioning onto a Government benefit. While a majority of clients accessing FWC activities at CSF are on a government benefit we would suggest that inflexible guideline changes (for example: no healthcare card = no ER support) could cause potential problems for a smaller number of vulnerable people (for example: those sleeping rough, are service resistant, illiterate, not engaged/willing to engage with more specialist providers and those with significant memory, emotional and psychological barriers).

Service providers need to communicate very clearly with those who are seeking services the guidelines that exist (ER Policy). These messages need to be conveyed in a way that understands and respects that people requesting ER and FC are often desperate, emotional and not engaged with other specialist services.

ER services and volunteers often act as a soft entry point and first sight of engagement for people with immediate needs during times of financial crisis. Guideline changes that lead to a more restricted provisions of ER need to address what safety net is left in place for people that, often due to circumstances outside of their control, are living through a time of sustained and persistent financial crisis. Changes that ask ER services to be more punitive in their approach to re-presenting clients run the risk of further marginalising already vulnerable people.

People need adequate income and intensive support to address social and emotional problems and unfortunately when we have clients trying to make ends meet with very limited income, a budget will often show that there simply isn't enough income coming in support even a very modest standard of living, let alone be able to respond to a single or persisting crisis.

ER Services need to have innovative partnerships with other service providers, including those that are outside of the FWC activity to ensure more intensive supports are available to people who need them most. It's not always feasible to have these supports/ workers and resources physicals on site but ER providers need to have these relationships. Review of data, re-presenting (more chronic service users) and changing community needs has to be considered regularly and services should be encouraged (where resources permit) to pro-actively engage other services in the work they are doing.

Strategies to increase service integration

Services can be strengthened and brought closer together through the likes of Emergency Relief Networks (at the local level), bringing agencies and workers that are working in the 'vulnerable persons' together to discuss opportunities for collaborations. At the Frankston level this is the Frankston Emergency Relief Providers (FERP) network that brings together services and workers, included those funded under the FWC activity locally, to come together and information share. CSF chairs this network and over the years it's provided many opportunities for collaborations and even co-location of workers. Often smaller service providers (i.e. single service providers or those only with a local remit) will already have a good mix of formal and informal relationships with other serves and have a good understanding of how to strengthen cooperation with other services. With the right resources, ER services are in a good position to be more of a 'soft entry' point for those who need help and are often the first point of contact for members of public than find themselves in a crisis situation. It's important to note that the right resources aren't always about expecting more from less, particularly when 70 – 90% of ER funds are put into direct material aids for clients (CISVic figures). In CSF's case, more than 80% of funds are spent on direct material aid for clients. If no additional funding or resources are expected with the re-design of the FWC activity and the expectation is for largely volunteer driven services to strengthen cooperation with largely staff funded services, this will need some consideration. CSF has a very capable volunteer team but increased expectations on services to do more with the same resources will become cumbersome. The discussion paper emphasis that FWC won't reduce current levels of funding, but to achieve the things is talks about in the paper it will need to increase funding rather than just re-prioritise spending areas. The current guidelines have reduced red-tape and do allow contract holders greater flexibility in how DSS funds are spent (i.e. special projects) but when funding has been on the decline, it becomes an ethical consideration for services in terms of how much funding it directs to material aid for people in need vs. staffing and other costs.

Changes to the FWC guidelines that contractually require its providers to establish 'formal relationships' shouldn't be too difficult for agencies that are already working with these funded activities and shouldn't be excluded to just FWC activities. The guidelines would however need to be very clear about how an agency proves these formal relationships and requesting that the likes of ER agencies enter into the likes formal MoU's might be challenging for some agencies. If the guidelines are more interested in just making sure that FWC agencies are working together and have/are establishing greater referral pathways between their activities then we see this as a positive in many instances that's capable of providing more connection between FWC activities. However,

if the guidelines are heading on a trajectory to see smaller agencies -that don't have the luxury of a large service hub space – and therefore the ability to co-locate services, we're worried this would provide a very restrictive framework than would minimize service effectiveness.

At a local level CSF has had a long-standing formal relationship with a state funded FC and microfinance service over a decade. Having these services on site is great for service wrap around and collaborations as it allows our staff and volunteers an opportunity to make more monitored referrals and liaise directly with these services. While not constituting a direct integration of services, this strong collaboration between our organisations allow for greater opportunity for a client who is presenting at an ER request level, the opportunity to go through our income and expenditure assessment and then be directly referred to the microfinance team for the likes of a NILS, Step UP or Pathways loan assessment. Additional resources fall back to the need of additional workers. The Vulnerable Groups (DSS case manager funding) that ceased under the new grant scheme was a big loss and was able to do some of this more intensive bridging work from ER to financial counseling and other services. When people are experiencing very complex problems, as ER clients tend to be, it's difficult to provide increasingly professional services on a shoestring. Serious efforts at helping people solve their problems, achieving greater independence from welfare services, locate and maintain a job, find permanent affordable accommodation, etc. requires far more from government than simply rearranging services with the same amount of funding, more adequate resourcing is needed.

DSS funding that was advertised for the service Hub model in 2016 was very geographically specific and didn't include our region. FWC funding (capital expenditure) and a commitment for the Local and State governments may also be required, both in terms of funding and identifying either a new space or building and resource expansion for an existing agency, potentially one already delivering a FWC activity and a demonstrated working relationship with others in the funded area. Ideally the service would also be collaborating with arrange of other services appropriate to the communities needs.

Strategies to support client outcomes

As mentioned in the CISVic response paper, CSF takes a holistic approach to client support and our volunteers look at the client situation in its totality. A majority (more than 95%) of our client's are recipients of some form of Government supported payment and while gainful employment would certainly make a big impact on their finances, for many there are complex barriers when it comes to finding and retaining employment. At a local leave we do engage directly with a WFD program (based at CSF) and more broadly we interact on an informal basis with JSA providers. CSF also provides direct material aid to assist people (who are job ready) to get to appointments (i.e. travel cards/ petrol costs) and will also assist with uniforms and other expenses (i.e. car registration) where there is no other assistance is available for a client who's looking for a job or is doing their very best to retain one.

In terms of our approach to dealing with repeat clients, all clients are triaged as potentially having a 'new crisis' and largely treated as though it's their first visit. Having said that, we keep very detailed case histories on our clients and set very clear expectations that are supported by our ER policy. Our limited paid staff (operations team) and volunteer leaders do look to try and work more closely with frequent presenters to establish if they are engaging with specialist support services or if they need further support.

Quite often - those who are more chronic presenters have the most complex problems and have significant mental, social, behavioral and emotional needs that aren't being met by specialist providers. At a local level, CSF has a reputation for being very well connected with welfare services and having the right connections and partnerships and not having suitable referral pathways in place isn't the concern. More often then not it's extensive waiting lists and barriers that clients have with accessing these services.

It's important to mention that CSF delivers a range of complementary services, some in formal relationships with MoU's such as Good Shepherd microfinance and the co-location of the Royal District Nursing Service Homeless person program. Mention how frontline ER services can actively engage the likes of mental health providers, Legal services, Job service providers, family relationship groups with having a 'physical presence' (similar to service hub models) even with limited space.. appointment and non-rigid 'drop in' type models and not being scared to try trial 'new' partnerships and collaborations.. important that FWC are able to show to the DSS how it's

working at the local level and how this is more that an MoU.

FWC – could look at how it's using the information it receives not just from the DEX data reports but the half-yearly service stock takes, the 'case studies' that show how FWC services are achieving better outcomes for clients through working together and highlight gaps where collaboration/ partnership is needed further..

Strategies to build a strong workforce

It's important to distinguish between paid workers in the CFC and microfinance activity compared with the largely unpaid staff (i.e. volunteer community workers) that is the 'engine room' of services such as CSF. Our volunteers are already expected to participate in debrief, professional training and ongoing skill development – to expect much more in the way of capacity building for volunteer workers that as been described above is questionable.

In response to the proposal for tools and resources, the focus on employment readiness in relation to ER clients is narrow. Capacity building for our sector, and personnel, needs to be considered in much broader terms. For example, at a local level our stats are showing a much higher than average number of clients disclosing psychiatric problems. More appropriate capacity building for our volunteers and service would then dictate a more 'health/ mental health' related wrap around with a focus on more training such as 'mental health first aid' and how to assist increasingly complex clients. Our community interviewers operate from a client-centered approach to really assisting clients with their presenting problems and there shouldn't be conditions or agency level agenda's imposed on the important work that happens to support clients attending these assistance sessions.

Strategies to strengthen evidence, improve practice and measure outcomes

Concise and consistent reporting across the FWC activities should be a priority moving forward. It's important that the department takes leadership on this front to ensure that agencies, such as all those participating in the ER or CFC activity are in unison with methodology and processes from reporting back on client outcomes. It's also important that the qualitative work being done, and reported back on in the likes of service stock takes, is being acknowledged and that feedback is provided.

Some of this may come through the partnership approach but it certainly needs more work and better communication with the sector. Research and evaluation of the sector is crucial for continuous improvement. More often than not, agencies can lack the necessary funds and resources to conduct whole program evaluations; very few have the thousands of dollars that are needed for independent reviews. Offering this type of a service to agencies, which are prepared to open up their service to review, feedback and improvement could be of particular benefit.