Discussion Paper

* 1. **What impacts will restricting eligibility have?**
* Clients unhappy/not eligible
	+ Increased aggression from clients
	+ Decrease in connection to support services
	+ Unhappy volunteers
		- Loss of volunteer staff
	+ Unhappy employed staff
		- Reduced capacity to respond to increasing case load
		- Increased aggression from clients
* Children/adults go without food
	+ No lunches for school
* Health needs compromised
* More homelessness
* Increased poverty
* Less capacity for us to be creative with people presenting in crisis

The introduction of restricting eligibility will provide the fuel for additional unhappiness and aggression from clients. As it is primarily volunteers that are delivering this program nationally this seems to be extremely unacceptable. In our own case we are fortunate to also have a team of professional case workers as well as our team of volunteers, to respond to more high need and/or complex cases, however similarly those workers do not want to be working with clients that are aggressive as they are unable to access a primary service so that they can eat, access medicine and other basics.

*Case study*

*A 45 year old female quite unwell physically, approached our organisation for ER assistance., she was accompanied by her 18 year old son. The client had been assisted on several occasions before and this was her 4th visit to the centre in as many months. She insisted on food vouchers and a prescription for medication. As she was a repeat caller we advised she would only be eligible for a food hamper. The client reacted by becoming very upset, using offensive language and banging her head on the office wall.*

*Situations such as this will increase and escalate if the ER program becomes more prescriptive and eligibility is tightened.*

For some clients one or two sessions may be quite sufficient to address crisis situations. However for others it will take a lot longer to provide assistance that may lead to some positive long term outcome. In thosecases we actually encourage clients to return to develop a rapport and over a period of time work to address issues.

A search of our database informs that 30% of people presenting for ER are Newstart recipients and only 18% of CFC clients are Newstart recipients. This is reflective of the fact that clients receiving Newstart have little funds left for bills and food after they pay rent, often this can be up to 80% of their income. However, for clients that are on such a low income there is little value in attending CFC workers as they are already doing everything they can to reduce expenditure and attempting to improve their situation.

* 1. **What strategies can be employed to ensure services are accessible for those most in need?**
* Effective training for volunteer staff
* Support and supervision for volunteer staff
* Accessible Interpreting Services
* Place based services – person centred approach

Our organisation and our consortium partners provide an integrated model of place based service delivery with various programs and support services under one roof. This wrap around approach to service delivery provides improved opportunity to better support clients with entrenched disadvantage. All 3 FWC programs are provided from at least two sites.

Clients need to be able to access services on the day that they need to. Crisis response needs to be immediate response with no waiting periods for assistance.

The provision of up to date and relevant community information is also a key to ensuring access to services. Technology has increased the potential of access and also timely provision of information with many social media sites available and well accessed by the community.

**2.1 What would help you to strengthen cooperation with other services?**

* Organisations that actually respond to contacts. Since receiving the discussion paper, I have contacted several Federally funded Employment services and have not had a return call from one.
* Clear guidelines and direction in regard to expected outcomes & roles for each party. FWC programs are funded to provide that crisis support and employment services to provide employment support. While we can work together to ensure positive linkages for clients, we do not have the capacity to undertake the support that should be provided by the employment services.
* Less competitiveness and more collaboration
* Resources to enable the co location of services eg. Community Services Hub model for areas other than those with financial management.

**2.2 What effect will the requirement to formalise relationships with others have?**

* There are already a variety of formal relationships in place. As long as each organisation is working from a similar mission this is quite achievable.

**2.3 Where is intergration/collaboration of FWC microfinance services with other FWC services occurring?**

* This is occurring within our consortium members in the municipality of Casey, with all 3 services co located. And in the Shire of Cardinia with 2 services available and linkages established with the organisation providing the 3rd.

**2.4 What elements would need to be present for Hub Model?**

* The Hub model has been embraced by members of our consortium for many years and while we do operate that model on a restricted scale due to capacity of organisational space, we would welcome an opportunity to improve and expand this model with many local services having made a commitment to this model. This has not been achievable due to lack of infrastructure.

**2.6 How could Aust Gov funding be used differently to better support integration of FWC services?**

* The direct funding of FWC programs to organisations that have the capacity to deliver all programs in one hub.
* Support and resources could be made available for agencies where FWC funding is split between two or three organisations in a similar area to co locate together or to prioritise clients from FWC funded services.

**3.1 What strategies can you utilise to support a client to improve their outcomes?**

* Our consortium members have for many years employed various strategies to improve client outcomes. These include;
	+ Provision of up to date and relevant information
	+ Linkages and referrals
	+ Case work provided for clients presenting with high need
	+ Flexibility of service delivery
	+ holistic and client centred approach to service delivery
	+ strong networking and collaborative agency approaches
	+ innovative approaches to providing ancillary services
	+ Focus on preventative programs

All clients currently presenting to our organisation and our consortium partners are interviewed and assessed prior to any assistance being provide. A holistic approach is taken when responding to client needs, to provide the most comprehensive response possible. A survey conducted in the last week shows that for Emergency Relief sessions an average of 30 minutes is taken and in some cases up to 75 minutes to assist clients with their presenting problems and for Social work professionals an average of 41 minutes is taken with up to 75+ minutes.

**3.2 How does your service currently deal with clients who present multiple times?**

* A case work model is applied to clients presenting repeatedly in a short period of time to more intensively assess and address the issues that are leading to crisis.
* The case work model consists of professional employed workers undertaking further assessment and dealing with more complex issues.
* The case notes recorded after each session provides a story and the background that has led to the need for multiple visits. This is the trigger for referral to more intensive casework.
* Our aim is to assist in times of crisis and real need, rather than as the household becomes ‘eligible’ for another grant. We have found this approach works much better and in most cases clients do present only when they need help.
* As issues are identified, clients are provided with relevant linkages and referrals for further support, both internally and externally to work towards improved outcomes.
* The barriers for this model is the capacity of our consortium members to be able to respond with intensive casework with limited resources.
* The proposal of FWC program to link clients to this model after only a 3rd or 4th visit in 12 months will place enormous pressure on an already over loaded program.

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

* The funding of case workers under the Vulnerable Groups program provided valuable support to this intervention and prevention model.
* Training for volunteers is also essential, however this will not replace the need for funded case workers. It is not within the scope of volunteers to be dealing with the extremely complex cases and often very vulnerable clients that present in crisis.
* The financial capability component of CFC provides a great opportunity to undertake preventative work. We have undertaken this work for some years now and have trialled a few approaches to what works and what does not. We have developed a workshop format that can be tailored to any particular group. This program received a National Award in 2014. The workshops are taken to established groups rather than advertising for people to attend, as this approach was trialled and did not have good response. By taking the Financial Capability workshops to established groups such as youth groups, young mums, seniors and schools this program is much more successful and well received. The introduction of specific eligibility for this program would be very limiting if all members of the group could not attend.

**4.1 Do ER and CFC/FC workers need to build capacity?**

* In Victoria the peak body for CFC/FC workers require a certain standard and number of Personal Development units are accomplished each year as well as regular professional supervision. Consequently the capacity building of this group is well covered.
* For ER workers however the same is not available due to funding restrictions. Within our organisation and our consortium partners, the provision of professional supervision to employed workers is provided, training opportunities are provided and a budget for professional development is set aside.
* However, the larger percentage of ER workers nationally are volunteers and funding for training, supervision, support and professional development is essential for this group to build capacity.