***Questions for discussion 1.***

1. **What impacts do you expect restricting eligibility criteria in the manner proposed above will have on your service?**

The exclusion of persons experiencing financial hardship through under-employment, housing and/or mortgage stress, family breakdown other than thorough domestic or family violence.

Whole family groups impacted by bereavement resulting from suicide or unexpected loss, a huge issue in our region.

Centrelink exclusion periods. Individuals waiting up to 12 weeks to access Newstart. In addition to waiting periods experienced when applying for Youth Allowance, Disability or Carers at times exceeding 6 months.

Uncertainty on individual outcomes as NDIS commences rollout regionally in July 2017.

Specialist Homelessness Services are reporting overwhelming need for service given lack of affordable housing in our region.

Transport continues to have significant impact on accessing specialist services. Limited or no public options available in some areas of the region, forcing individuals seeking employment or support to be isolated and unable to improve their circumstances as a result.

Supporting individuals outside the proposed restricted eligibility may enable their circumstances to improve so not to need further crisis intervention. For example, families on low incomes accessing FWC may enable them to keep their tenancies, and therefore their employment, preventing them from becoming unemployed.

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

Multiple access points for community. Soft entry model. Co-located services and outreach. Service delivery partnerships.

Service delivery through Case coordination model is proving to be beneficial to client engagement and is having a positive outcome for many. In providing material aid to address immediate need, along with referral to address underlying issues impacting on financial wellbeing, case coordination is proving to address entrench behaviour of some individuals having identified patterns of use and enabling service delivery to support positive change.

***Questions for discussion 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?**

These relationships already exist within our outlets. Partnerships are in place and outreach services including legal advice, financial counselling, and homelessness support being made available to community in a variety of locations. Job seekers, Work Development Orders and/or Community Services work placements occur regionally across all outlets.

We have adopted community engagement strategies incorporating jobseekers in volunteering roles to support delivery of Foodbank initiatives, community meals, and community gardens. This provides an opportunity for the individuals to actively meet their obligations, whilst encouraging community participation and providing training and education to further improve their social wellbeing and connectedness to community. Presenting further soft entry into additional wrap around services within each centre, for example, specialist domestic and family violence programs, early intervention, family support, playgroups, and youth programs.

Opportunity for community participation across a variety of programs of requires financial support to ensure skilled workers are available to offer supervision and support to all participants.

***Case Study:***

*Client A was a former Corrections client. Correctives Services see clients in our building once a fortnight. This client was phased out of Corrective Services on Parole and in to see our Nurse Practitioner.*

*Upon client A’s first visit, our Nurse Practitioner established that this client was sleeping rough, had not eaten in a few days and had not received their first emergency payment from Centrelink upon release from jail.*

*The Nurse Practitioner came to see me about what wrap around and/or emergency relief we could provide.*

*First we went to the Centrelink Agent (located in our building) who rang Centrelink about client A’s initial payment on release from jail.*

*Once that was sorted out I organised for the client to receive some food that was appropriate to the clients living circumstances (no cooking facilities) and also receive a swag to make sleeping in the bush safer, more comfortable and eliminate further health problems from being exposed to damp/rain and bites.*

1. **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?**

Our organisations already provide service delivery in this manner. The requirement to formalise relationships will only strengthen and enhance current service delivery.

For those organisations not already operating in this manner, it will only serve to promote outward relationships. Clients will benefit from additional referral pathways to support.

It will also improve transparency within current service delivery.

Each outlet we operate has a variety of relationships with other organisations to meet client needs, especially in relation to emergency accommodation and additional food relief. The outlet model within our Centres creates easy access to other services and supports which dovetail into and out of FWC providing a continuum of care.

1. **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?**

Across our region there are a few locations where microfinance services have integration within other FWC services. For all those that outside these areas access to microfinance is challenging and creates many barriers. Being admin, heavy obtaining the required documentation is only made more difficult when presented with transport barriers.

Increased organisations providing microfinance service will enable more clients to seek this as option, especially if new organisations become available to provide this service increasing consumer choice.

1. **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?**

We already operate community hubs that are addressing a host of complexities and presenting cases, highlighting the negative social issues and changing family cycles/patterns and the need to view cases holistically.

The need for more funding to strengthen our partnership development strategies, case coordination practices and enable ongoing work to procure a wider range of material aid options.

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

Integrated service delivery.

Partnerships with other stakeholders including Local Aboriginal Land Councils, Aboriginal Medical Services, Commonwealth Home Support Programs, Integrated Domestic Violence services and family support programs.

Funded skilled positions promoting healthy relationships, positive change and creating opportunity for participation.

Collaboration with community seeking to ascertain their concerns and their worries, including their suggestions for improvement.

**Case study**

An example of integrated service delivery provided to a mother of three children aged 11, 9 & 7 and is expecting her fourth child. She is currently fleeing a violent partner who stole her mobile (hence the need for a replacement ASAP). She is being seen by an OTCP worker regarding her accommodation issues and is being counselled relating to DV trauma by Gisela at Community Health.

**From:** Angela Maxwell [<mailto:angela@pbnc.org.au>]   
**Sent:** Tuesday, 28 February 2017 3:14 PM  
**To:** Gisela Matteucci <[Gisela.Matteucci@ncahs.health.nsw.gov.au](mailto:Gisela.Matteucci@ncahs.health.nsw.gov.au)>  
**Subject:** XX  
**Importance:** High

Hi Gisela,

Thank you for your referral today.

Just a quick update on XX who has given consent to share the following information with you.

PBNC was able to:

         provide a second hand Telstra compatible mobile phone and charger and Telstra sim card start up pack

         set up XX’s new telephone number **XXXXXXXXXX**

         assist her to access one of the Telstra phone credit cards that you provided

         issue her with a $50 fuel card (via a partnership with Northern Rivers Community Legal Centre’s Women’s DVCAS)

         provide free access to a computer in our technology Centre to attend to online processes associated with her studies and updating real estate agents on her new contact details re accommodation options

         provide information about other supports and services at PBNC (including our Child and Family Support Service – Tweed Valley). XX is interested in catching up with Kym (Family Support Worker) in Murwillumbah, in the near future, regarding access to our Child and Family Support Service.

Kind regards,

Angela Maxwell, Manager

Thank you so much Angela

Great work!

Regards

Gisela Matteucci  
Generalist Social Worker **l Counsellor**

MON l TUE l THU l FRI                                                              WEDNESDAY

Murwillumbah Community Health Centre                                     Health One - Pottsville

8-10 Nullum St, Murwillumbah, NSW 2484                                  10B Elizabeth Street, Pottsville, NSW 2489  
Tel (02) 6670 9400 **|** Mob: 0427061972 **l** Fax (02) 6672 5133     Tel (02) 6670 4900 **l** Fax (02) 6676 4256

E.mail: [Gisela.Matteucci@ncahs.health.nsw.gov.au](mailto:Gisela.Matteucci@ncahs.health.nsw.gov.au)

Our pleasure, Gisela! It’s always good to be able to combine services, products and expertise to work in an integrated way!

Kind regards,

Angela Maxwell, Manager

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

Implementing of case coordinated service delivery across all community centres.

**Case Study Song 2016**  
  
XX came service seeking assistance in 2016. She is a 30 year old Thai woman with two children, XX 2yo, and XX 4yo. She and the children were all visibly nervous and upset. XX was fleeing domestic violence and the family had nowhere safe to live.  
Through case coordination incorporating assisted referral and material aid I was able to provide the following:

* A referral to On Track Community Programs for accommodation, setting up an appointment at PBNC
* Two petrol vouchers to assist with her travel while re-establishing her home, via a partnership with Northern Rivers Women’s Domestic Violence Advocacy Services
* A Share the Dignity bag of toiletries
* A voucher to Opp Shop, where XX was able to select clothes for herself and the children, and linen for their future home
* A referral to a social worker based at
* A referral to St Vincent’s de Paul, for XX to receive vouchers for Woolworths for groceries etc

When XX and the family were safely in their new home, XX revisited the centre, and I gave her a voucher for furniture and electrical items from second-hand furniture store. As she required ongoing support, I referred her to Child and Family Service for immediate support while she waited for a place in the Brighter Futures program.  
XX and her children appeared much happier and XX said she was particularly relieved to find that she could access so much from the centre without having to travel continuously to other places for assistance.

***Questions for discussion 3.***

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

Case Coordination within trauma informed service delivery.

Change models and ability to identify and support an individual to access the appropriate services to support their needs.

Wrap around service delivery. Community capacity building initiatives and opportunity for education and employment.

* 1. **How does your service currently deal with clients who present to your service 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?**

Case Coordination model incorporates referral to address underlying issues, prioritising those issues having significant impact of one’s financial wellbeing.

Provision of interim support until the client develops an awareness of their issue and moves to a place of change. Depending on the individual’s circumstances and environmental factors this can take multiple occasions of service, and until certain factors change, for example, homelessness, other vulnerabilities they are experiencing will not improve.

Changing behaviours towards welfare dependency and entrenched property is not easily solved. Restricting access to a specific number of occasions may result in many clients falling through the gaps, or their circumstances deteriorating further.

Rapport to address certain issues like co-dependency, dual diagnosis, and untreated mental health is vital, and takes commit and time to establish.

Intake and assessment and utilising screening tools.

Issues arising when children are involved. Continuation of service delivery is paramount to ensure safety, whilst other supports and referral options are being explored and established.

**Case Study: CLIENT A**

A male client of the CW office has visited at differing occasions over approximately five (5) years.  During this time he displayed mental health issues however he did not wish to engage with any referral pathways.  On most occasions he sought food and other welfare assistance for himself and for his dog.  He had always refused further assistance due to his beliefs in certain conspiracy theories and in particular that if he asks for too much of anything ‘they’ will know and 'take him away'.  The last time he visited the office he requested food for himself and his dog.  He was not looking well and seemed distracted and less clear than on previous occasions.  CW made another attempt to refer him into mental health services and he agreed to see the local Mental Health Nurse Practitioner and signed a referral consent form.  Some months later CW made inquiries to his welfare to the Nimbin Integrated Services Nurse Practitioner, who advised that he had made healthy progress and was staying in contact with the Nurse Practitioner.  Since his initial referral he has not returned to seek any further ER/material aid assistance.

* 1. **How can DSS better support early intervention and prevention opportunities?**

Increased funding to enable the employment of full time, dedicated positions to allow service delivery to be available to meet presenting needs. An example as follows;

**Case Study: CLIENT X:**

As Front of House Co-ordinator it is vital that I ensure clients respect the space and that all other clients and staff remain safe. An example of managing this would be Client X.

Client X presented at the service. He is homeless on a Disability Pension but has no money and no food. Client X is agitated and unknown to me or the service. He is demanding emergency accommodation, food and that Centrelink give him an emergency payment.

In this situation I initially worked on de-escalation, by giving him some hot soup and a hot cup of tea and took him outside to the front verandah so that other clients in the space were not intimidated by his aggressiveness.

In that time I was conversing with Client X… I was able to get his name and a last known address. While he was eating and calmer than he had been previously, I consulted with the Nurse Practitioner, who was then, based on my information was able to look up his medical history.

Client X was a diagnosed schizophrenic and not on any medication. The Nurse Practitioner and I then went together and consulted with our Community Worker about what resources as far as emergency relief and services we were able to support him with.

Aside from providing Client X with a swag and some food there was nothing else our service could provide for him. I then had to explain all this to Client X.

After this initial day Client X presented every day, multiple times a day aggressively demanding food and coffee. In consultation with the Nurse Practitioner and Community Worker, we, as a collaborative team, created a management plan around Client X that involved his compliance with consistent and firm boundaries around acceptable behavior , while also encouraging him to engage with mental health services available locally.

As part of implementing this plan, I then had to ensure the entire front of house staff body was aware of Client X and that they adhered to the management plan we had created. The confidential communication of this information was absolutely vital to the appropriate implementation of the management plan because often times the front desk (first place any client presents) is manned by any number of different volunteers. This sharing of information was just as important to the staff as it was to providing appropriate and quality care to Client X.

***Questions for discussion 4.***

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

Training opportunities are promoted regionally within the consortium across all outlet staff as they become available through networks.

Participation in child protection identification and responding has been undertaken by all outlets.

Specialised domestic and family violence services are delivered throughout the outlets

A recent partnership with TAFE North Coast NSW is providing opportunity for 40 employees regionally to partake in Part Qualification Skill Set training in April/May 2017. Participants include paid employees and volunteers and across all aspect of service delivery within each centre, including administration, reception and finances.

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

Financial Wellbeing screening tools to improve consistency in service delivery across all FWC services.

Trauma informed framework.

***Questions for discussion 5.***

1. **What do you see as the key issues involved in evaluating the FWC Activity?**

Variations in service delivery across broad spectrum of organisations.

**Good news story. Demonstrating wrap around service delivery and local knowledge.**

XX came to PBNC’s Assisted Referral and Material Aid (ARMA) in April 2016.

XX is twenty-six years old and has a six-year-old son, XX. She and XX came from a small town in outback NSW and had arrived on the Tweed Coast earlier this year. She had moved into a house at Cudgera, a semi-rural village, and was finding it quite isolated. She was sharing with a stranger, a man who she said she did not feel very comfortable around, especially as she had her son to consider. Her casual job had just ceased and she was in tears. She said all she needed was a job, and another place to live. I gave her a referral to St Vincents Cabarita for food vouchers to assist her to get by and, through ARMA Opp Shop vouchers, she accessed PBNC’s Opp Shop for clothing and linen. I told her that the local caravan park was looking to employ cleaners. She applied and got the job and was very elated about that.   
Accommodation is difficult to come by in this area, so I rang a complex whose manager I knew well and where I had previously lived for 4 years. I referred XX to him, as I believed she would be a reliable and good tenant for him, and that XX was a well behaved and happy child who would not cause problems at the complex.   
The manager Tom agreed to XX renting a one bedroom apartment. I saw XX at the shops a few weeks later. She was very happy. She said she loved the apartments as they were quiet, well run and close to Cabarita, a town with a supermarket and many other shops, and with easy access to the beach and lake. XX loved being able to ride his tricycle around the complex and together they took many walks around the area. XX was only a short distance from her work at the local caravan park and her hours were fitting in with XX’s school hours.  
She thanked me profusely and said she thought PBNC was wonderful and that the ARMA service had been very supportive for her and XX. As she needed and wanted ongoing support, and had no family here, I referred her to the Brighter Futures program based at PBNC for further support.

1. **What would you like to see as the main focus of the evaluation?**

Wrap around service delivery with services to refer to available for all consumers regards of location. Financial wellbeing impacted by substance misuse is only further exacerbated in our region by the significant lack of detox facilities. With nowhere to refer to, individual circumstances and needs cannot be addressed.

Case management vs. Crisis support. Ability to expand case coordination model.

Continuity of service delivery. Focusing on underlying issues impacting financial wellbeing over long term change

Implementing standardised screening that can be adapted to suit local communities.