Lutheran Community Care

Discussion paper – Financial Wellbeing and Capability Activity - January 2017

Lutheran Community Care Queensland - Submission

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About Lutheran Community Care

Lutheran Community Care (LCC) has been serving Queensland for more than 80 years.

Our not-for-profit organisation operates 10 community services (covering disability, mental health, youth, and family/crisis support) and 12 aged care, home care and retirement living services throughout Queensland.

Collectively, we deliver services to more than 6,000 people each year.

Our disability services (Graceville, Somerset, Keystone and Trinity) assist people living in the Sunshine Coast, Brisbane Valley, Logan and Gold Coast regions. Services include purpose-designed supported accommodation, skills development and group social/recreational programs, and in-home support.

Each of our disability programs harnesses organisation-wide expertise in strategic and operational management, clinical practice, quality management, finance, learning and development, creative activities, communications and facilitation, relationship management, and human resources.

Our robust corporate governance structure, including a skills-based governing Council, executive leadership team and infrastructure are well-suited to an organisation of our size and complexity (more than 1,300 staff and an annual operating budget in excess of $80 million).

Our integrated management systems promote business performance excellence, including sustainable, client-centred processes and work practices.

Lutheran Community Care (LCC) has been providing Emergency Relief (ER) assistance under the Australian Governments Financial Wellbeing and Capability (FWC) Activity from two outlets for over 27 Years.

Providing such a crucial service to people at their most vulnerable time has allowed us to touch the lives of many people, mitigating financial crisis and hardship by supporting them with timely referral and advice to gain skills and support, to move forward and plan for a better life.

Purpose of the discussion paper

This discussion paper describes a proposal for redesigning the FWC, focusing on improved targeting of services, strengthening integration, building a strong workforce, supporting the capability and employment outcomes of clients and measuring the outcomes of FWC services.

It will ensure clear links with the Australian Government's constitutional powers.

We also acknowledge the role of state and territory governments in funding financial support services and, where possible, seek to complement these and other services.

The proposals in this discussion paper relate solely to Australian Government funded services.

The purpose of this discussion paper is to:

- inform the FWC sector of proposed policy options under consideration;
- encourage providers to consider opportunities for innovation, integration and efficiency; and invite input and feedback from providers on the continued direction of redesign in the sector.

Principles of reform

The following principles guide the redesign of the FWC:

- Achieving outcomes: our focus is on ensuring services are achieving positive outcomes for clients and we will continue to work with the sector with this goal in mind.
- Evidence: we utilise evidence where it exists, while continuing to build the evidence base around service delivery outcomes (through tools such as the DSS Data Exchange) to ensure appropriate targeting of clients and services.
- Complexity: we recognise the complexity of the needs of clients and of the sector.
- Reducing red tape: we understand the effort it takes for organisations to apply for grants and, through future grant rounds, seek to streamline and simplify the process as much as possible.
- Consultation: DSS engages with the sector in discussing options, valuing their expertise and experience in delivering FWC services.

Discussion topics

1. Strategies to improve the targeting of services

Questions for discussion

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

The impacts on the LCC Wynnum ER Service would be that restricting eligibility could potentially address and alleviate overuse or dependency on supports by regular users of the service.

However, clear delivery guidelines, criteria and support will need to be made available to our front line team members to ensure consistency of delivery within and across ER Providers.

A community communication strategy would also be beneficial in educating service users on eligibility and support parameters thereby providing consistent messaging.

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

Engagement and accessibility strategies to ensure service access to those in most need tend to be built into the service eco system. With many ER Providers having extensive local community linkages and complementary servicing which assist with ensuring those most in need are linked into the supports they require at their time of criticality.

Again, a communication strategy and resources would assist these services and their networks to ensure this message is disseminated, targeted and consistent.

2. Strategies to increase service integration

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?

Resourced Networking opportunities (Departmentally facilitated) would assist in strengthening cooperation between services. With scope to plan, prioritise and respond to local areas of concern through service networks and innovative provider partnerships.

In some communities, Interagency meetings cover this. It is however not consistent. Some are driven by local MP's, rotary groups, HSC's etc.

Seed funding and grant opportunities would also encourage local innovation and responsive service development.

Communities of Practice could be established to showcase great practice and support establishment of local initiatives to test and support local collective capacity and responsiveness.

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?

The requirement for formalise relationships with other services is likely to have limited impact on LCC Wynnum and a number of other services as many providers already utilise MOU's or agreements to provide structure, support, deliverable and context to existing arrangements.

This is a model that could be broadened out to sector practice with support, tools and guidelines.

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?

Integral elements to support successful hub models include; collective goal identification, joint effort and commitment, supported structure and resources.

LCC has broad capacity to provide integrated wrap around supports within its service mix and through responsive community partnerships with both congregation and local service providers.

In LCC's experience, having access to a range of specialised supports, or assessment for same, at the time of contact with ER has been extremely beneficial in addressing identified long term systemic issues within the family and broader community.

A new hub has been established at Keystone (Bethania) recently whereby services are being encouraged to co-locate for a one stop shop service. eg housing, Centrelink etc.

At Keystone we have created an extended sense of community where day programs for disability services are on offer, access to soft entry points for expertise in areas such as homelessness, youth and domestic and family violence are available all at the one site. Students and Volunteers assist to triage and prioritise when spending time with the clients prior to service access, assessing additional support requirements to assist with long term change. The facility is child friendly and welcoming to children allowing parents time

to talk through their story. The service has the ability to provide personal hygiene packs that have been donated by generous community members and has created a welcoming environment that assists individuals to feel heard and valued to express their unmet needs.

This model is easily replicatable to our Wynnum ER service and other LCC service sites.

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?

Elements of innovative practice important for establishing hub models in rural and remote areas would include community and service uptake. The ability to have co-location of multiple services or visiting service providers allow for connection and cohesion of service delivery to the individual as a whole person.

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

Australian Government funding could be utilised to support a systemic approach to build capacity for targeted service development responsive to localised needs so that a coherent, connected and targeted strategy could be employed. This work would involve defining a practice model and benchmarks for service delivery, client supports and service pathways, service compliance and reporting.

3. Strategies to support client outcomes.

Questions for discussion

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

Strategies to support client financial and employment outcomes could include capacity for follow up or to provide Outreach support in order to address recidivism in ER service users. The ability to reconnect, refer and offer support to service users with financial literacy, training and employment, housing and tenancy matters could mitigate crisis interventions and individuals churning through the support systems.

3.2 How does your service currently deal with clients who present to your service on multiple occasions?

Clients who present on multiple occasions are advised of the limitation in visits over a financial year, a client would not be turned away if the limit was reached, however they would receive minimal financial assistance and be referred to other providers in the local area.

It is discussed with clients that ER is to provide support in emergency situations, a conversation proceeds to ascertain how the client found themselves in this situation again and if referrals provided previously to the client have been contacted by the client. We try to ascertain what has changed? If nothing has changed, how is support provided to the client to encourage them to take up referrals and responsibility using an empowerment, solution focused approach.

At what point should additional support and requirements apply to repeat ER clients?

When clients are considered "regulars" of the service, either frequenting the service on multiple occasions within a close time frame or have been known to the service for a significant period of time, e.g. Years.

What form should this take?

Rather than a brief intervention, the service could offer a basic form of case management whereby further discussion with the client to determine if previous referral (e.g. referral to financial counselling,) has been taken up.

By reviewing the progress of the client in making contact with the provided referrals, some accountability exists and this provides a catalyst for change.

Clients, who repeatedly seek out ER, tend to have more complex issues and a sense of dependency on multiple ER providers to support additional income.

The requirement for a client to follow through with a referral and participate in case management could provide a better long term outcome in terms of needs being met to ensure the individual has capacity to better manage their income but also to address other issues in their life impacting their ability to manage their finances or independence.

What barriers do you see in implementing these requirements with your clients?

This could easily be implemented however the additional time required to spend with a client would impact the number of clients that could be seen by a worker based on the funding.

The current model of service is not case management but a brief intervention.

The practice examples given in the discussion paper highlight the effectiveness of a case management model for repeat users of ER services.

In the Logan area, multiple ER providers are available and there is an awareness of a small percentage of clients accessing multiple ER services in one week.

It is difficult to determine how many clients would be accessing multiple services and how to case manage those clients if it cannot be determined who is accessing what supports and how often? A centralised client management system would assist with managing recidivism as well as effectiveness of the support and interventions provided to service users.

If clients are informed of the process, for example if they access the ER service on a certain number of occasions then they would be required to participate in case management. I believe clients would participate if they knew this was an expectation of the service. Often clients need a lot more support to address the issues that have brought them to the service in the first place e.g. Relationship breakdown, domestic violence, homelessness, Alcohol and drug issues and mental health.

The ER service may not have capacity to case manage complex clients with a multitude of needs, however by linking in with other community providers and referring clients to services that can support them, there is a better chance of building their capacity and decreasing reliance of welfare. A case management model and individualised planning based on the service users needs and barriers, with a level of accountability whereby the client has to demonstrate efforts made to follow through, would assist with coherent tracking and support of clients, their service needs and interventions employed in supporting them. As well as the success or otherwise of the supports provided.

What support would you need to implement such a proposal?

To implement such a model a standardised ER practice model would be highly beneficial and would creast the foundations so that all ER services are providing a consistent response.

We would seek out a better understanding of all the support services in the area and continue networking in the local area to understand the capability of other service providers and support available to our clients. Interagency meetings in some areas facilitate this capacity.

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

DSS can better support early intervention and prevention by the establishment and provision of outreach to first time users to allow more fulsome support with financial literacy, training and employment needs, and housing / tenancy requirements.

Further, a comprehensive strategy addressing whole of life and not just one incident of financial crisis would be highly beneficial.

Mapping the antecedents to the event, development of mitigating strategies and capacity building with the individual to broaden their support system and social capital, could become the catalyst to addressing entrenched behaviours and disadvantage.

4. Strategies to build a strong workforce

Questions for discussion

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

Building capacity is a core role of the FWC Workforce and as such it would be highly beneficial for the practitioners to receive training, skill development, support and expertise in this area.

Capacity development would require ongoing participation in the case management process to measure such success or collaboration with other providers. A shared client information platform would be very ideal. The system needs to be moved from one of dependency to one of capacity development and self determination.

Comprehensive life planning and resourced supports would be highly beneficial for many ER service users.

In some ER environments, basic worker structures of training, support and supervision are lacking. This creates an exposure both in accountability for the resources being distributed through the Program and potential risk to the workers, many of whom are volunteers, in supporting what can be a highly vulnerable and volatile client group at what can be a time of great distress and desperation.

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

Tools to support further development of FWA services include (but are not limited to):

- *Centralised Client Management System.*
- *Practice standards and guidelines.*
- *Service standards and guidelines.*
- *Ongoing professional development and support.*

A National network of all Providers would be beneficial in providing collegial / peer support and in developing and evolving practice guidelines, models and norms.

For LCC's Wynnum ER Program, Logan Interagency meeting has good representation from ER providers in the community. As does the BERN meeting in Wynnum. These types of networks provide the forum and foundation for information sharing and collegial support.

Noting that not all providers that sit within the ER framework receive funding from the Government.

5. Strategies to strengthen evidence, improve practice and measure outcomes

Questions for discussion

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

The key issues facing FWC services include a lack of consistency in practice and outcomes across Programs and providers.

A resourced National Framework with Practice Standards, supports and consistent reporting structures would be beneficial to both benchmark practice and provide opportunities for Program comparisons, practice evolution and development of consistent worker supports.

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

The main focus of the evaluation should cover recidivism and worker standards and practice structures.

Structured and supported methods of accountability for regular users of ER would be highly beneficial and well as guidelines directing this practice.