HOBART CITY MISSION INC

SUBMISSION PAPER

FOR

The Proposal for Redesigning Financial Wellbeing and Capability

Hobart City Mission (HCM) welcomes the opportunity to participate and contribute to the proposed redesign, HCM receives funding for Emergency Relief, and all our comments are based on this program only.

Below is a brief summary on how we operate and distribute Emergency relief in southern Tasmanian:

The Hobart City Mission Inc started in 1852 as a Christian organisation providing welfare, family and community support in southern Tasmania. The main reason for HCM establishing itself in Hobart was the convict past and lack of employment and food. HCM was well known for delivering food on pushbikes all over Hobart.

This has continued and Emergency Relief is provided through our Community Support Officers in Hobart & Moonah and considered a core program to assist those in crisis and need by providing food packs, food vouchers, clothing, bedding and furniture, Aurora vouchers and Telstra vouchers.

Emergency Relief is office based and appointments are in Hobart & Moonah, HCM employees 1.8 FTE'S to distribute the funding paid at level 5. Our use of professional staff is our point of difference, and enables us to assess the underlying root cause of their "emergency", and to refer them to other appropriate organisations for specific assistance (housing, family support, budgeting training, etc.)

HCM further agrees and supports the overarching "Principles of reform" however we have some concerns and comments regarding the strategies regarding the principals and moving forward in the best interest of the clients accessing ER.

Discussion topics

1. **Strategies to improve the targeting of services**

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

HCM feel that the proposed restrictions by naming up specific cohorts would not be in the best interest of clients in Southern Tasmanian. Limiting the service to only:

- *ER and Commonwealth Financial Counselling (CFC) services would be restricted to those at imminent risk of not being able to pay their debts; and*
- *As a complement to the income support safety net, Financial Capability would be restricted towards:*
    - *people in receipt of an Australian Government social welfare allowance, pension or benefit,*

- *people experiencing domestic and family violence, and*
- *Immigrants/non-citizens.*

Your first point refers to anyone in crisis which I believe is clear in our current contracts however it only mentions imminent risk of not being able to pay their debts, HCM hope that this also cover client who have paid their bills but have left no money to purchase food etc.

Your second dot point by naming up particular cohorts is quite concerning, HCM would hope that these are suggested cohorts and not the only clients permitted to receive assistance.

If this is correct HCM would have concerns for the working poor, for example people may not be receiving social welfare as they are on the limit for assistance however may be on specific medication that is not on the PBS and this medication can cost over $100.00 for each script. A member of a family is working however have a partner who may have a drug and or alcohol problem and possibly gamble, which takes away most of their income. Having these people excluded from the service is very detrimental to getting support. HCM believe that ER services are often the first point of call for assistance and after a few visits the client discloses what is happening in their home. Our qualified staff are then able to assist them in reaching out to the appropriate place for support. HCM also have concerns for clients who are homeless and live on the streets, who are also not receiving social welfare as it has been cut off for many reason. It could be that they have no fixed address, are illiterate and or have mental health issues and not able to remain in contact with DSS.

HCM believes that restricting the service to specific cohorts will leave the above mentioned clients vulnerable. HCM employ professional paid staff and by restricting the service to specific persons it is taking away and minimising the qualifications of staff to make the decision and determine if the client is in imminent risk and offer the appropriate support.

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

HCM believes that if organisations are funded to employ qualified staff then appropriate training and assessments can be undertaken to assess imminent risk, for anyone attending the service. I do understand that many organisations rely on volunteers to deliver the service and that this is often done over the counter with little follow up. HCM can understand why some organisation have this model as funding does not cover wages. HCM pays qualified staff to conduct assessments, funded by donations, however this is not sustainable in years to come and without paid staff the clients attending HCM would be at risk of not being able to be referred to appropriate support agencies. Having qualified staff HCM feel that a strategy that can be used by other organisations that HCM use is having clear assessments and having set appointments. We find that if clients understand that an assessment is taking place and they need to produce clear documentation of why they require assistance, lowers the level of clients using the service as a top up to their income and they often do not come back because they are unable to justify or prove imminent risk. Ensuring accessibility should be situational and not categorising clients into status.

2. Strategies to increase service integration

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

Many organisation with other programs have what is referred to as practitioner meetings and invite other organisation to their meetings either as full participants and or regular guests. These seem to work extremely well and all workers enjoy attending them. Please note these are for on ground workers and not for managers. If this was to be introduced within the FWC model these network meetings would need one organisation to be funded to host and coordinate the meetings.

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?

HCM do not believe that formalising relationships with other organisations will have any implications for us as an organisation. To maximise commitment and attendance at these forums, you really need to have paid staff. Volunteers attending these meetings would not always occur and it would be most likely different volunteers attending all the time and consistency and forming relationships is hard when turnover is high.

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?

Not able to comment

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?

Using volunteers and or unqualified staff who live and work in the rural area is often a down fall, most communities are small and people do not want others to know they are struggling. For the model to be successful each hub and rural area would need to be assessed – not one model will fit each rural area so flexibility is the key to success.

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?

Hub models are a great idea however it is important that the one organisation does not do the whole thing. Hubs would need to be a collaboration from different organisation. Furthermore depending on

the location, HCM feel that finding professional staff (not volunteers) who may reside in the rural areas may not be achievable, therefore travel for staff to be employed would need to be considered.

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

Apart from funding ER organising to employ qualified staff, mandating organisations to work together should not be difficult. Organisations may have paid coordinators and or Managers that oversee programs but true collaboration and networking must be done at the on ground level with staff delivering the service. If organisations rely on volunteers it would be an extra time to the volunteer and many volunteer to do the work and would not attend forums? It is extremely important that all organisations delivering ER have one framework designed by DSS to work from. It's not always about policies and procedures as they tend to be black and white, clients requiring ER are clearly not, many have complex needs and if there is a framework to work from this will support the integration of all services. Requiring organisations to implement case plans whereby outcomes and achievable goals are a requirement. If this was to occur DSS would need to offer training in all of the above and fund wages for employees distributing ER. DSS would also need to enforce one common language within the model.

3. Strategies to support client outcomes

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

HCM believes that for clients to demonstrate that they are taking reasonable steps to reduce their costs, organisations would need to work with the client on clear and achievable Case Plans. Case plans will identify goals and actions that the client will use to improve their situation. In addition to case plans service agreements between the client and the organisation will need to occur. (Copies of what HCM use can be made available if required)

3.2 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?

Client who presently attend HCM on multiple occasion for assistance are first reminded by the employee of what the service is actually for and what we are not for. If they attend again the client will be informed that the next time they request assistance the assessment will be

conducted by the coordinator of the program. HCM believes that all clients have the right to attend the service however not all clients will be assisted in the manner they think they should be. The reason we do not turn clients away is that we feel that the majority of clients tend to be at their lowest and often just wanted someone to talk to. ER employees have morphed into counsellors, mental health workers, housing workers and the list could go on. HCM believes that our current system works to the best of our ability, however case plans and more importantly a case management model whereby longer appointments for fully comprehensive assessments can occur. If clients are aware that this is a requirement when requesting assistance then it could possibly lessen the burden on DSS with the extensive amount of funding they distribute for ER. If this model is implemented it would cost more for DSS in the short term however in the longer term the organisation would be able to have proven outcomes and assist with clients break the circle of poverty and maybe remove the belief of entitlement that we **must help them.**

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

The only way HCM can see to better support early intervention is to have paid qualified staff equipped with the understanding of the needs of the community, training in case management and case plans. Including ER, HCM do not have any programs that are not staffed by qualified staff. With regard to DSS support organisations who utilise volunteers to administer funding for ER, HCM feels that volunteers are amazing and personally save many organisation thousands of dollars in assistance. ER should not be one of these programs. Early intervention for clients at imminent risk and having the skill to understand and evaluate the risk is complex and clients often require professional staff to conduct these assessments. ER is also not about imminent risk only for what the program is designed for. Clients often discuss suicidal thoughts, family violence, gambling, etc. These need to be considered as early intervention.

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?

HCM is pleased that DSS acknowledges the below statement:

"The FWC workforce is diverse and multifaceted. It ranges from qualified professionals at one end to a large volunteer base at the other…….. Clients presenting for FWC services are disclosing more complex needs and it is important that workers have the skills necessary to manage the transition of these clients into appropriate services that will meet their needs."

In regard to ER having funds available for qualified staff it is currently very minimal and if utilised for wages it takes away funding that is/should be used in addressing imminent risk for clients. ER workers definitely need to build capacity, through ongoing extensive training either by the organisation or DSS to cover and understand the complex needs of the client presenting. This can only be done by organisations having full funding to employ and pay qualified people, having access to training across client needs. The Emergency Relief Handbook 2011 states " that if Volunteers and or unqualified person distribute Emergency Relief on behalf of a funded organisation they are not permitted to act as: a personal counsellor, social worker, drug and alcohol worker or psychologist, the volunteer must at all times refer the client onto professional staff for further assistance".

For the reason above and the acknowledgment that client needs are becoming more complex, ER should only be operated by qualified staff.

One of the most difficult aspects for ER workers is the ability to define where the responsibility of crisis assistance begins and ends. A common mistake for ER workers is to allow the client to discuss their entire life history and then try to solve the problem for them. Having sympathy for clients and wanting to help are admirable qualities for ER wworkers and this is often the reason why people enter the profession, however, without extensive formal qualifications, the ability to maintain a level of balance between worker and rescuer can be difficult. Significant amount of supervision and support is required to build resilience in this area. This sort of professional support is most effectively provided to workers or volunteers who have continuity in their role.

Those who irregularly perform such a role are unlikely to receive the appropriate level of support. It is also important to have a cohesive mutually supportive group of workers to manage this type of stress. This is more easily achieved in a small group.
When providing ER to clients who have complex needs it is important to have a clear understanding of self-care. The role can at times be very stressful and demanding.
Burnout is very common, not only for qualified workers but especially for Volunteers. Burnout is commonly associated with work that requires intense emotional involvement and is defined as the outcome of chronic stress.

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

- Trained Case Managers who can do case plans and set specific goals with clients.
- Funding to pay for qualified staff
- Trust in each service do determine imminent risk to clients needing assistance
- Shared framework to operate
- Set outcomes and reporting
- Ability to share information between services so clients are not able to shop around
- All organisation required to have set times for full and comprehensive assessments

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?

HCM believes that for organisation to be able to conducted measurable evaluations and outcomes for the clients, clients need to case plans, service agreements which is a case management model of working.

Currently DSS via DEX requires organisation to collect data on more things relating to collecting statistical numbers that can be counted, to be able to get the full picture outcomes to need to able to set a story with achievable outcomes that tells the story of the clients life moving from A to Z. currently there are many proven outcome frameworks that capture the client life and set realistic goals that will be more accurate in evaluating ER clients. One that is utilised by Housing Connect in Tasmanian is “outcome star”. Evaluating FWC activity must be able to tell a story of the client’s life, successes, and barriers to moving forward, not just numbers and how often they attend the service the question needs to be asked why they are attending the service.

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

As mentioned above the focus for evaluation needs to be on the client and their movement through the ever challenging life experiences that have lead them to seek assistance with ER what are the barriers in make choices to improve their life. It needs to be also acknowledged that there is no magic wand nor can clients work to a strict timeframe for change, every client and life issues are different and evaluating outcomes and how fast they move through them is unrealistic and not client focused. If clients are not treated as individuals with their own goals and case plans then the model discussed will not be in the client best interest.