CASEWORK IN THE EMERGENCY RELIEF SECTOR:
A SCOPING STUDY

SEPTEMBER 2013
Anglicare Victoria

Anglicare Victoria provides support to 70,000 children, young people and families every year. Through a range of diverse programs and services, we work towards strengthening families and communities so they can protect and nurture the children within them. We do this directly through services like foster care, emergency food and crisis accommodation, as well as indirectly through family and community support services such as financial counselling, parent education and group work. Combined, our range of services alleviates immediate hardship while building skills and resilience to overcome future hurdles.

Community Information and Support Victoria (CISVic)

CISVic was established as an association of members in 1970 to support the growing number of community advice bureaus. Since then its role has evolved to that of peak body for the community information and support sector in Victoria. CISVic provides operational support, sector development, advocacy and representation to its member agencies. CISVic has over 60 member agencies. These community information and support centres (CISCs) are managed by autonomous, community based management committees. They operate according to the policies and standards of CISVic. CISCs provide information, referral, advocacy, emergency relief, case work, No Interest Loans, Tax Help, budgeting support, personal counselling, financial counselling, legal and settlement services.

ER Victoria

ER Victoria is the peak body for the Victorian emergency relief sector. Our membership comprises over 100 member organisations offering material aid and support to vulnerable Victorians. Our aim is to bring emergency relief agencies together, to support their work as providers, and to advocate on issues effecting disadvantaged people. We work with government, industry, and community stakeholders who have a key relationship to the ER sector. As a peak body, we focus on supporting our networks and member service providers and promote the interests of vulnerable families and individuals. Our ultimate goal is for emergency relief to be recognised and supported by the whole community as the first vital phase of welfare support, which successfully links vulnerable people into services that provide immediate response, counselling and referral.

RMIT University

RMIT is a global university of technology and design and Australia’s largest tertiary institution. The university enjoys an international reputation for excellence in practical education and outcome-oriented research. RMIT is a leader in technology, design, global business, communication, global communities, health solutions and urban sustainable futures. We are ranked in the top 100 universities in the world for engineering and technology in the 2011 QS World University Rankings.

The Salvation Army

The Salvation Army is one of the world’s largest Christian social welfare organisations with more than 1,650,000 members working 126 countries. We have been in Australia for over 133 years. Currently we have more than 8,500 active officers and staff delivering in excess of 1,000 specifically designed social programs across Australia. The Salvation Army helps more than one 1 million Australians every year – that’s one person every 30 seconds! The Salvation Army has four mission intentions: Transforming Lives,
Caring for People, Making Disciples and Reforming Society. Recognising that God is always at work in the world we value: Human Dignity, Justice, Hope, Compassion, and Community.

Acknowledgements

CISVic and ER Victoria acknowledge caseworkers, agency staff and managers who participated in the scoping surveys. CISVic also acknowledges the contributions of Reference Group members to the scoping exercise, especially their enthusiasm and commitment for the process, and the project itself.

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EXECUTIVE SUMMARY

Background

This scoping study is an emergency relief (ER) initiative led by Community Information and Support Victoria (CISVic) and ER Victoria to map innovative casework models for emergency relief clients with complex needs. Project partners included Anglicare Victoria, The Salvation Army, and RMIT University. As a relatively new – and developing – area of casework practice, the ER sector in Victoria is particularly keen to map the expansion of casework in the sector and understand the nature and types of casework models that currently exist in emergency relief services.

Project partners were keen to identify new and emerging practices in the ER sector designed to assist individuals and families experiencing immediate and personal distress due to a financial emergency or personal crisis. This report offers practitioners, policy makers and program designers with a sample of ER casework programs implemented in Victoria and parts of Tasmania, to inform policy and program development and to identify further research in this emerging area of practice.

Methodology

This scoping study included a review of the literature for known casework models in the emergency relief sector, online surveys, consultation with project partners who are the major providers of emergency relief in Victoria, and a consultation workshop with practitioners and service managers on the question of best practice. These findings were analysed using a framework derived from a synthesis of the evidence in the homelessness sector to respond to five key questions, namely:

1. What is emergency relief casework?
2. How does casework in the emergency relief sector achieve outcomes for clients with complex needs?
3. What agencies are providing casework, where are these located geographically and who is delivering casework?
4. What resources are required to deliver emergency relief casework?
5. What can we learn from current practices that inform guiding principles to casework that may be adapted more widely across the sector?

Findings in brief

Given the paucity of literature for this area of practice the findings presented in this report should be viewed in the context of an overview of casework as currently implemented in the Victorian, and to some extent, the Tasmanian ER sector. The following paragraphs of information present findings as they relate to the five key questions outlined in the methodology.

Casework in emergency relief: a new model of service delivery

ER services that are delivering a combination of transactional ER (the provision of food, material aid and once-off assistance), advocacy and referral, and client-centred support to complex needs clients represent a more comprehensive response to poverty alleviation than the transactional provision of material aid and referral. This new emerging ER service model expands service delivery ‘beyond the band-aid’, by offering a broad range of supports to all clients, one that seeks to address the underlying causes of poverty and disadvantage. In doing so, it positions service delivery to be aligned with the principles of social inclusion, one that focuses on relational issues: social participation and integration, power, and opportunity.
**What is emergency relief casework?**

Casework in emergency relief services is a partnership between the caseworker and the client, who work together to achieve goals aimed at improving clients’ circumstances. The relationship is built on trust, openness and transparency in which caseworkers are professional workers with appropriate systems knowledge and networks to leverage (through advocacy and role modelling) positive outcomes for clients. Through a period of intensive emotional and practical support, caseworkers work with their clients to move from a situation of personal and financial crisis towards emotional and social wellbeing. A casework relationship is characterised by:

- Comprehensive client-centred support that is both practical and emotional
- Professional skill-sets and effective communication skills of the caseworker
- A non-judgemental, trusting, respectful and supportive relationship

**How does casework achieve outcomes for complex needs clients?**

Although the client-caseworker relationship remains critical and core to reaching goals, client outcomes are achieved when this relationship can build on the resources and skills of both the worker and the client. Effective client outcomes occur where client needs are met, which can be a combination of events including when mutually identified goals are reached, client situations are stabilised, or clients are linked to another service. Outcomes are also achieved where there is adequate support and service capacities of the ER agency, professional networks, and the extent of inter-agency and cross-program integration in the locality.

**Where are the casework services?**

Global data (Appendix A) from project partners indicate that The Salvation Army’s case management Doorways model is currently delivered in 65 sites across Australia. Nationally, The Salvation Army delivers ER in 237 sites. Case management is delivered by Anglicare Victoria in metropolitan and outer Melbourne and regional Victoria (10 sites). Paid workers support volunteers to deliver ER across metropolitan Melbourne. CISVic member agencies deliver generalist casework across 23 sites in Victoria.

A total of 49 caseworkers and managers responded to surveys. Managers’ and caseworkers’ surveys were cross-referenced resulting in 39 casework programs offered in 49 sites across Victoria (36) and Tasmania (10), with three in unknown locations.

**Identify resources required to deliver casework**

Casework models reflect the diverse settings that they operate in. Casework does not only involve working intensively with the client over a short period of time; it also involves a whole-of-service engagement with the client’s journey. It requires innovations around the service’s capacity, the local ER network’s needs, up-skilling volunteers, and introducing an internship workforce that not only builds present capacity but also the future workforce of the sector.

Volunteers are fundamental to ER service delivery. Casework in ER is delivered in a context of largely a volunteer workforce who provide support to clients, material aid, referrals, and sometimes advocacy. The casework and volunteer ER roles are highly integrated with cross-referrals and sometimes case coordination between volunteers and caseworkers.

Casework is predominantly funded by the Department of Families, Housing, Community Services, and Indigenous Affairs (FaHCSIA). The variety and creativity with which agencies are seeking to expand upon the funding from FaHCSIA and support from philanthropies to grow casework in ER, attests not only to agencies’ commitment to the casework model but also to the precarious nature of funding, particularly where obtained from fundraising and bequests.
Current practices that can inform guiding principles to casework in emergency relief

Scoping survey responses indicate a consensus between caseworkers as to the length of time a client should be assisted to achieve goals, the skill-sets, attributes and approaches to the casework relationship that work for clients and caseworkers. In addition, there is the important role of systems engagement and integration to achieving client outcomes. As community based agencies that respond to the needs of their communities, operating contexts and shifting policy landscapes, the ability to respond with flexibility, with innovation and be context-driven is crucial to effective outcomes for clients.

Policy Implications

- The ability of service providers to respond to client needs and community context through a flexible funding structure is crucial to effective outcomes for complex needs clients. However, many services continue to supplement casework funding from other sources. This level of funding insecurity places constraints (time, resources, access) on both service and caseworker capacities to achieve optimal outcomes for clients.

- Caseworker roles, whether in a professional, volunteer or paid capacity, require high levels of support, training and professional development. Adequate levels of funding will need to incorporate components for training and support needs of staff. Consideration needs to also be made to the development and support of communities of practice across the sector to promote best practice, service integration and network capabilities.

- Volunteer training and supervision is currently under-resourced. A new emerging model of ER service delivery requires an active involvement of volunteer workers to deliver a broad range of services to vulnerable and disadvantaged clients. Developing innovative regional network responses to training and supervision needs of volunteers is one way of addressing the issue. There is scope for the roles of government, philanthropic and other funding sources to be developed to tackle the human resources challenge faced by the ER sector at this time.

- The range of casework models across ER services reflects the diversity of contexts, client and service environments of the ER sector. Innovative funding and casework models mirror the sector’s highly responsive and place-based approach to client and community needs. Maintaining this level of diversity is crucial to effective client outcomes, as it acknowledges the important role of contextual responses to client needs.

Program implications

- Casework requires an investment of time to build and maintain a relationship. This results in constraints on caseload for effective client outcomes. A combination of workload, limited hours and funding constraints have led caseworkers to prioritise time with clients over other aspects of casework, such as follow-up, attending network meetings and otherwise engaging with other professionals.

- Client engagement varies widely between three to twelve-month periods, with some client-caseworker relationships persisting over long periods of time. This is in acknowledgement that supporting complex needs clients to resolve presenting and underlying issues cannot be achieved within one intensive period.

- Effective client outcomes rely on caseworkers providing timely referrals. However, in some locations, scarcity of resources, particularly among specialist services, results in long wait-lists for services. This places a burden on caseworkers to take on roles they are not equipped to provide. Similarly, caseworkers working with people from culturally and linguistically diverse (CALD) and Aboriginal
backgrounds found it frustrating that other services either fail to use, or have limited experience in their use of, interpreting services.

- Student placements, co-location with services which promote service linkages and cross-referrals, networking and service promotion through regional ER and professional networks, and access to translation services are some of the program activities that improve access to the casework service. Having a generalist casework model that is flexible and quick to respond to crisis or need is also seen as an advantage for ER services. The open and easy access to the casework program, its service gap function, and the fact that ER is a referral pathway for complex needs clients, are part of what makes casework ‘work’ for complex needs clients.

Research Directions

As the sector works towards improving outcomes for clients, it would benefit from further evidence of how casework may improve outcomes for clients with complex needs accessing emergency relief. Similarly, an understanding of the contextual elements that enhances efficacy and efficiency in the delivery of casework could contribute to evidence-based practice in the ER sector. Although heavily reliant on a volunteer workforce, casework exemplifies a professionalisation of the ER sector through the role of paid professional workers, para-professional volunteers and students. In this context, exploration into the resources that are required, as case management best practice implies, to monitor and evaluate, build evidence and work from a best practice framework will be of benefit to ER practitioners and program designers.

RECOMMENDATIONS

The following recommendations are provided with regard to casework in emergency relief provision:

Policy

1. That funding bodies recognise that flexibility in funding arrangements promote responsive and innovative program design and service delivery for client centred outcomes. Innovation can only occur when flexibility in funding arrangements encourage the creative utilisation of available resources to enhance efficiencies and improve outcomes for clients with complex needs.

2. Funding arrangements that support innovative casework models should be long-term, and provide adequate levels for capacity building of volunteer-based agencies, professional development and training, monitoring and reporting;

3. Funding bodies actively support and resource the ER sector to engage and partner with philanthropies to support casework and innovations in service delivery;

4. That ER sector development includes resourcing emerging communities of practice in ER settings (caseworkers’ networks, ER volunteer networks) to enhance and promote service integration, and the development of best practice frameworks that lead to improved client outcomes;

Research

5. That the emergency relief sector build on the momentum of the scoping collaboration and support the partnership between the sector and RMIT University to frame potential areas for research, including but not limited to:

- Casework effectiveness in improving the situation of clients experiencing multiple and complex issues through a longitudinal study of casework intervention.

- Mapping ER’s changing operating environment, the role of volunteers and students in service delivery, and the growing presence of philanthropies in the community services sector.

- Casework intervention models and the conditions which enable the casework-client relationship to deliver beneficial outcomes for clients.
1. INTRODUCTION

1.1 Background

This scoping study is an ER sector initiative led by Community Information and Support Victoria (CISVic) and ER Victoria to map innovative casework models for ER clients with complex needs. Project partners include Anglicare Victoria, The Salvation Army, and RMIT University. As a relatively new – and developing – area of casework practice, the ER sector in Victoria was particularly keen to map the expansion of casework in the sector and understand the nature and types of casework models that currently exist in the provision of ER services. Project partners were keen to understand what new and emerging innovations were happening in the ER sector and how this may be improving the way ER providers help individuals and families experiencing immediate and personal distress due to a financial emergency or personal crisis.

The changing ER landscape over the past few decades - which includes the increase in complex needs clients, a challenging operating environment, and rapidly shifting social, economic and environmental contexts – has resulted in a more sophisticated and innovative response from some ER service providers. Increasingly, ER services are delivering a combination of transactional ER (the provision of food, material aid and once-off assistance), advocacy and referral, and client-centred support to complex needs clients through the provision of casework. The sector has experienced a changing ER service environment that expands service delivery ‘beyond the band-aid’, by offering a broad range of supports to all clients, one that seeks to address the underlying causes of poverty and disadvantage. Drawing on material from available literature, surveys of caseworkers and service managers and information from project partners, this report aimed to map the contours of emerging models of practice to inform policy and program development, and to identify research potential for this emerging area.

Key questions

The project endeavours to answer some key questions about the delivery of casework in the ER sector and make contributions to the continuing development of effective ER casework. The report will do this by identifying policy, program and research themes for these emerging approaches to practice in ER.

Key questions answered were:

1. What is emergency relief casework?
2. How does casework in the emergency relief sector achieve outcomes for clients with complex needs?
3. Where agencies are providing casework, where are they located geographically and who is delivering casework?
4. What resources are required to deliver ER casework?
5. What can we learn from current practices to inform guiding principles to casework that may be adapted more widely across the sector?

1.2 Report outline

Part 2 Methodology; sets out the reasons for adopting a scoping exercise. It explains the research method, the framework adopted for analysing findings, and limitations to the results.

Part 3 Key Concepts; presents a definition of emergency relief, charting the development of a new emerging model of casework in ER aligned with the principles of social inclusion, and how casework fits into a reconceptualised notion of emergency relief. It also provides an overview of the policy context of emergency relief.
Part 4 Analysis of Casework; presents findings from the scoping exercise and analyses them with reference to a case management framework found in the homelessness sector. The analysis will identify characteristics of the casework relationship, the contextual elements that enable effective client outcomes, and emerging best practices identified by practitioners and program designers.

Part 5 Policy, Program and Research Implications; highlights areas identified through the scoping exercise, with a view to contributing to informing policy and program development and identifying research potential for this emerging area of practice.

2. METHODOLOGY

2.1 Why a scoping exercise?

Scoping exercises are primarily used by researchers as a type of literature review to ‘map’ the relevant literature on a topic by summarising key concepts underpinning the area and main sources and types of research evidence available (Arksey & O’Malley, 2005, Mays et al 2001). Conducted with comparable rigour and transparency to a systematic review, they address the broader questions where many different study designs may be applicable, without considering the quality of individual studies (Gagliardi et al, 2009). They can be undertaken to inform a systematic review or as a stand-alone project, particularly when an area is complex or has not yet been comprehensively reviewed (Mays et al, 2001).

This scoping study took the concept and applied it in order to ‘map’ casework in the emergency relief (ER) sector. This was done because there was a paucity of existing literature on casework in emergency relief services. This area of practice is in its nascent state, although it is enjoying support from both within the sector and funding bodies.1 With this context in mind, the scoping study aimed to identify areas of potential research in the ER sector, casework, the role of para-professionals, and service delivery innovation.

2.1.1 Introducing the framework

The scoping methodology adapts the 6 stage framework proposed by Arksy and O’Malley (2005) that encourages researchers to obtain information from as many different sources as feasible. The framework is adapted as follows:

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td>Identifying the research question: How does casework achieve outcomes for clients with complex needs; where is casework offered and by whom?</td>
</tr>
<tr>
<td>2.</td>
<td>Identifying relevant studies: • Search the literature – searching databases and grey literature for studies/research about casework in the emergency relief sector • Survey the sector utilising survey monkey to (1) locate models (2) identify resources &amp; capacity around delivery of casework (3) identify best practice approaches to casework and/or service delivery to complex needs clients</td>
</tr>
<tr>
<td>3.</td>
<td>Study selection: Assess models against inclusion criteria (models &amp; typologies identified in the literature)</td>
</tr>
<tr>
<td>4.</td>
<td>Charting the data: Sift, chart and sort materials</td>
</tr>
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1 Support in the sense that casework is primarily funded by the federal government department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), philanthropies and self-funded by ER agencies.
5. Collating, summarising, reporting the results

Present an overview of the models, against the themes of who offers casework, where, and what makes casework work for complex needs clients.

6. Consultation exercise (optional)

Consultation with Reference Group and key stakeholders to obtain insights about the models and what constitutes best practice in
(1) casework
(2) service delivery to complex needs clients

2.1.2 Reference group membership

A Reference Group was convened to provide expert advice to:

- Inform the design and implementation of the project
- Assist in engaging with the emergency relief sector to identify, where they exist, best practice casework.

Claire Emerton  Assistant Divisional Social Programme Secretary, The Salvation Army
Pamela Hanney  Territorial Doorways Coordinator, The Salvation Army
Dr Sonia Martin  Lecturer & Program Director, Bachelor Social Work, Global Urban and Social Studies, RMIT University
Peter Thompson  General Manager, Parish Partnerships, Anglicare Victoria
Kate Wheller  Executive Officer, Community Information and Support Victoria (CISVic) and Secretary, ER Victoria

The Reference Group met three times during the project.

2.2 Data collection

2.2.1 Desk-top study

Information about casework models were collected from project partners and from the literature (section 3).

Databases in social science and humanities were searched using multiple combinations of the terms ‘case management’, ‘case work’, ‘emergency relief’ and ‘material aid’. Project partners were also consulted and ‘grey literature’ was sought from partner organisations such as conference papers, presentations, promotional material or brochures. Google scholar and Google search engine was utilised to search for international and national literature. Publications and policy sections of websites of Australia’s major ER providers were also searched.

2.2.2 Online surveys

Online surveys (Survey Monkey) were designed to collect information about casework models. Two surveys were developed; one was aimed at caseworkers and one at agency managers to respond to different aspects of the model.

The surveys were developed from a framework derived from an evidence-informed understanding of case management in the homelessness sector. Gondra (2009) utilised a realist synthesis to ‘find, categorise and assess the theories which currently explain how case management works’. The framework was arrived at through appraising and synthesising available evidence of case management interventions and literature in the homelessness sector. The resulting framework (Diagram 1) was utilised to develop the survey
questions in this scoping exercise, and formed the basis of the ensuing analysis of survey results and desktop findings.

Diagram 1. Case management Framework

Surveys were completed and collected over a three-week period during April 2013. Surveys were promoted widely via email to ER sector workers with the assistance of project partners.

A total of 56 surveys were collected from agency managers and caseworkers. Of these, 34 surveys were collected from caseworkers, three of which were eliminated. Two of the eliminated surveys were due to incomplete surveys – responses were insufficient to make sense of data, as both only answered up to question 6, from 16 questions (=60% of casework survey incomplete). One response was eliminated because it was determined that the site was not offering casework, but rather emergency relief with advocacy and referral as described by Diagram 2. Twenty-two surveys collected from managers, five of which were eliminated due to incompleteness - information was incoherent, couldn’t give a picture of the model or practices in place. In total, 49 responses were validly collected, of which 31 were caseworker surveys, and 18 were manager surveys.

Table 1. Online surveys collected

<table>
<thead>
<tr>
<th></th>
<th># valid</th>
<th># eliminated</th>
<th># collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caseworker survey</td>
<td>31</td>
<td>3</td>
<td>34</td>
</tr>
<tr>
<td>Manager survey</td>
<td>18</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>49</strong></td>
<td><strong>8</strong></td>
<td><strong>56</strong></td>
</tr>
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2.2.3 Consultation with stakeholders

Following data collection, a consultation with stakeholders was convened to present survey results and preliminary findings, and to obtain insights from practitioners (case workers) and program designers (service managers) about what constitutes best practice in casework and service delivery, in the context of provision of casework to complex needs clients. Two workshops were formed, one made up of caseworkers (n=15) and one of managers (n=7). Project leaders invited participants from a range of settings to ensure a diversity of viewpoints and experiences were represented.
2.3 Limitations

Factors that limited the scope of this preliminary study include the limited reach of surveys, the narrow time frame within which this study is being conducted, and inherent limitations in the use of online surveys, including:

- Limited sampling and respondent availability. Certain populations are less likely to have internet access and respond to online surveys. Additionally, many caseworkers work part-time, and very limited hours, which may reduce their participation rate considerably, especially if they have a large workload. This was mitigated by the targeted design of the surveys, and keeping surveys as short as possible. The surveys were piloted prior to release. Additionally, project leaders took efforts to identify potential participants, obtain contacts and contact lists from Reference Group members and other key ER service providers, and promoted the survey not only within the ER sector but throughout the social services sector (this was done through contacts with other peak bodies).

- Limited cooperation and response. Workers are constantly inundated with messages which can easily be deleted. The in-box of part-time workers in particular, may be longer than full-time workers as they log on less frequently. This was mitigated by project leaders sending staggered email reminders and follow-up phone calls following the initial invitation to participate. Project leaders were also ready and available for queries throughout the survey collection period.

- Limited access to, and capacity to use, technology. Respondents may have limited access to the internet, or have difficulties navigating the online survey. PDF copies of the survey were available for printing or use on a computer desktop. Two respondents adopted this method.

- Limited capacity to clarify and probe. An inability to interview, clarify and probe can possibly lead to less reliable data. Although the survey tool, Survey Monkey, provided capacity for qualitative responses, some respondents may have had difficulties understanding questions, or provided a limited response. This was mitigated by piloting the survey prior to release.

Findings are illustrative of current practices and issues, and although the study is limited to the Victorian context, the discussion may be considered of relevance to practice across the country.

The small sample size from which survey results were analysed is also another limitation, although given the aim and purpose of this study, the sample size provided sufficient data from which to draw preliminary themes and views. It is not the intention of the study to be a comprehensive report of casework, but rather to afford us a picture of an emerging service as it is currently implemented.

3. KEY CONCEPTS

3.1 Defining emergency relief

Emergency relief – also known as material aid – has a long history in the welfare sector in Victoria (Engels, 2011). Emergency relief can take the form of travel tickets, kitchen utensils, blankets and furniture, nappies and baby formulas (Barbato et al, 2006), back to school expenses, information and advice about housing, social security, taxation, immigration, careers, other community and government services, personal, budgeting or financial counselling (Engels, 2006; Engels 2009). In addition to material assistance, information and support, the literature also tells us that ER agencies play an important role in connecting people to networks of care, keeping policy makers informed of broader issues of disadvantage and poverty, and forwarding solutions (Barbato et al., 2006). There is also a wide body of ER literature that focuses on
aspects of emergency relief such as client demographics, clients’ needs, reasons for presenting, types of emergency relief provided, referrals and integration with other services (Engels 2006; Engels et al., 2009; Flanagan, 2009; King et al., 2009; Grennhal et al., 2007; ACOSS, 1999).

ER is also delivered in the main by volunteers – dedicated, well-trained, knowledgeable, and experienced (Engels, 2006; FaHCSIA 2013). Yet, the ER sector is a very diverse one. An approximate 1,350 outlets provide emergency relief throughout Australia. In Western Australia, for example, ER is delivered by the gamut of welfare services, from small church-located services, to multi-program organisations, to large national faith based organisations. These services have varying capacities, resources and capabilities to support clients, influence policy and promote inter-agency integration and linkages (WACOSS, 2012). This situation mirrors the range of ER services in Victoria (Engels, 2006). ER services face multiple challenges that include: volunteer recruitment and retention; funding insecurity; increased demand; complex reporting procedures; operating costs and complex needs clients (Engels, 2006).

3.1.1 Disadvantage, poverty and emergency relief

A recent Staff Working Paper from the Productivity Commission (McLachlan et al, 2013) exploring deep and persistent disadvantage examined the different measures of poverty and disadvantage (deprivation, capability, social exclusion and inclusion) and concluded that those at higher risk of experiencing deep and persistent disadvantage are those ‘dependent on income support, unemployed people, Indigenous Australians, people with long-term health conditions or disability, lone parents and people with low education attainment’. The report also found that ‘the proportion of adult Australians experiencing very deep exclusion remained stable over the period [2001-2010] at around 1 per cent (Social Exclusion Monitor).’

ER providers report that those living on government support increasingly rely on emergency relief to supplement the safety net income they receive from government benefits (ACOSS, 2013). Similarly, The Salvation Army’s 2013 National Economic and Social Impact Survey (ESIS) reports that 90% of respondents accessing their ER service were in receipt of government income support payments. Recently, too, the OECD Economic Surveys: Australia 2010 commented that:

‘over time, the adequacy of Newstart Allowance should be examined... an option would be to increase the Newstart Allowance for the initial period of employment to provide a more adequate safety net...’

In recent years, The Salvation Army and Anglicare Victoria have been conducting surveys with emergency relief service users. The Salvation Army’s 2013 ESIS It’s not asking too much surveyed 2,705 respondents to gauge ‘the extent of social and economic deprivation and disadvantage experienced by these individuals and their families’.

4 McLachlan et al. (2013) p.2. The Social Exclusion Monitor is an approach to measuring social exclusion developed by the Brotherhood of St Laurence and the Melbourne Institute of Applied Economic and Social Research (MIAESR) which uses the annual Household, Income and Labour Dynamics of Australia (HILDA) survey. The monitor is updated with each new wave of HILDA survey: http://www.bsl.org.au/Social-exclusion-monitor
found that multiple deprivations for those seeking ER were extremely high. Many were going without essential items rather than just a couple at any point in time. Seventy eight per cent (78%) recorded five or more indicators, simultaneously, indicating severe levels of deprivation. Anglicare’s annual Hardship Surveys, conducted since 2006, also show high levels of material deprivation amongst ER service users. The 2013 survey revealed that those seeking material assistance and/or financial counselling at Anglicare Victoria services are diverse (in age, cultural background, educational status, geographic location and living arrangements) with the majority having been out of paid work for over a year and a significant proportion (41.8%) had not been in paid work at all in the past decade.

These annual surveys are invaluable as they provide a clearer picture of the complexity of poverty and disadvantage than those based on income and other statistical measures of poverty. These surveys utilise the standardised measure of deprivation put forth by Saunders and his colleagues in Towards New Indicators of Disadvantage: Deprivation and Social Exclusion in Australia. Deprivation is a measure of relative poverty as it conceptualises poverty as an ‘inability to afford a standard of living that is consistent with community customs and norms of acceptability.’ It includes 24 items identified as those that a majority in the community regard as being things that no one in Australia should have to go without (Saunders et al 2007).

A recent Anglicare study of food insecurity in New South Wales and the ACT found that ‘Three out of four children in the surveyed sample lived in food insecure households. In 14% of households, children were forced to skip meals and in a quarter of cases children were forced to go hungry on a regular basis.’

In a study into whether there have been shifts in the demographic profile of ER clients as a result of the global financial crisis (GFC), Homel & Ryan (2012) found that ER data from major providers The Salvation Army, Anglicare and St. Vincent de Paul indicated that between 2007-2010, there were increases in the number of people and forms of assistance provided. However, they also found that the profile of ER clients was largely stable during this time, which ‘suggests that increases in the provision of emergency relief were not directed towards “new” segments of the population who would not generally seek emergency relief. Rather, it seems likely that the economic downturn contributed to worsened conditions for groups who were already disadvantaged.’ The combination of multiple deprivations, cost of living pressures, food security and underlying health and financial issues coalesce and lead to clients attending ER services. ER services are witnessing a client demographic that experiences ongoing, chronic disadvantage and complex needs.

In addition, HILDA data, showed that those seeking assistance from welfare agencies are poorer in health, had less education, lived in more disadvantaged areas and had low incomes (Homel & Ryan, 2012). It is to this demographic that the emerging ER service delivery model of wrap-around casework support is being increasingly directed.

What these various approaches to measuring poverty and identifying ER service users indicate is an ER sector that is responding to an increasingly complex client demographic and social policy environment. Although ER is still a sector that engages with clients in moments of financial and personal crisis, policy, social and economic conditions are widening the gap between those living in poverty and those who are not. By addressing clients’ underlying problems, ER services seek to improve the social and financial

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7 The Salvation Army (2013) p.4
8 ibid p.26
13 see major ER service providers annual ER reports such as, The Salvation Army (2013), Wise, S.(2013), King, S. et al (2013)

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wellbeing of individuals and families experiencing financial and personal crisis. ER service provision therefore must broaden its scope of support to clients. This increased scope may include on the one hand the provision of material support and concerns around food security and health impacts, to, on the other, capacity building and ongoing support strategies that move individuals and families beyond their current crisis.

3.1.2 Social exclusion framework and a new ER service model

Over past decades, the identification and measure of poverty have evolved to encompass concepts of deprivation, capability and exclusion (Saunders 2005). King et al (2009) describes those in our society who experience multiple disadvantages on a daily basis as the socially excluded. Utilising the social exclusion framework, King et al locates the socially excluded on a continuum spanning from income poverty, deprivation and finally social exclusion. The authors argue that social exclusion limits an individual’s capacity to participate in society – economically, socially and in terms of civic engagement. Social exclusion is a relative concept and:

‘...can arise from unemployment and poverty but is not necessarily defined by them. In some senses while poverty can be considered a static concept, social exclusion is increasingly being referred to in the literature as a dynamic concept – a process across economic, social, cultural and political paradigms.’ 14

The social exclusion framework is a conceptualisation of poverty that not only includes measures such as income and deprivation, but capabilities. The capability approach refers to the work of Amartya Sen who defines poverty in terms of low capabilities and functionings – poverty ensues when individuals lack certain minimum capabilities such as adequate income or education, poor health, lack of opportunities and a sense of powerlessness. When people experience multiple and deep disadvantage, it impacts on their ability to engage with social and economic life. King et al (2009) asserts that social exclusion focuses on relational issues: social participation and integration, power and opportunity. Thus material deprivation and low income have reverberations beyond meeting material and basic needs.

‘Emergency Relief encompasses both the poverty and the exclusion experience. It is often the last port of call in the journey of hunger, homelessness, disability, joblessness, mental and physical health issues, grief, despair, addiction and violence. While this may mean material deprivation there is often collateral damage which is emotional, social and psychological. Such impacts have long been recognised by service providers well before researchers and policy makers.’ 15

King et al (2009) call for a new conception of emergency relief, one which recognises that ER services are now being provided which goes beyond the ‘transactional’ model of material aid, to one that addresses the ‘complex, compounding and inter-related needs’ of clients – such as mental health, disability, drug and alcohol addiction, the impact of relationship breakdown and family violence. Delineating the transition of ER service delivery over time, the diagram depicts the range of service delivery models in the ER sector. The provision of casework or case management enables ER agencies to support complex needs clients, many of whom fall through service gaps, or have repeatedly attended for ER support.

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15 ... p.10
According to King et al (2009), across the ER sector, roughly two service delivery models are operating:

- **Basic transactional emergency relief** – the provision of basic needs in times of financial hardship - a ‘safety net’. It takes the form of food, chemist and transport vouchers, assistance with rent/accommodation, part payment of utility accounts and material assistance such as food parcels. This is the model currently being funded by Government.

- **Emergency relief PLUS** individual client advocacy and referral where the provision of food and bill paying is supplemented by some individual client advocacy to other agencies and government departments such as Centrelink and referral processes. This is a ‘value-add’ provided by agencies and is reliant on capacity and skills of trained volunteers (or workers) for delivery.

For these agencies, the contribution of volunteers at the ‘transaction’ end of the model is significant and substantial. It ensures that agencies meet community need for ER, it maintains interpersonal and social connections for vulnerable and disadvantaged individuals and families, and it sustains the delivery of ER at a level that cannot be matched by a paid workforce. Although difficult to measure, Langvodt (2006) estimates volunteer input to be at least 90 per cent of people involved, whilst Engels (2009) estimates the proportion of volunteers working in Victorian ER agencies to be up to 80 per cent. Funding arrangements with FaHCSIA do not provide for staffing and operating costs. Each outlet ‘may use up to 15 per cent of
their total Emergency Relief funds, or $6,000.00,... whichever is the lesser, towards administrative costs associated with the provision of Emergency Relief...’ 16

King further argues that the above two models are still not sufficient to meet the needs of clients who attend ER services. The increase in complex needs clients attending for ER – those for whom multiple issues led to their financial or personal crisis – called for an innovative response from agencies. A client-centred, intensive period of support is required to address the underlying causes of their distress. King termed this the Sustainable Living Model. It moves service delivery from transactional to relational interaction, where:

‘...an ongoing relationship could be sustained between the service and the client to ensure the client’s needs are adequately addressed and clients do not fall through the gaps in service network system. In such a model the focus would shift from simple crisis management to case management (where appropriate), case coordination and early intervention. However, this process also needs to ensure full integration with the current service network so that when required case management occurs with full ongoing referrals to appropriate services.’ 17

It is this model of ER service delivery, where the range of ER services are provided to ensure that clients’ needs are met, be they a food voucher, referral to a homeless service or the support of an Emergency Relief caseworker – that this scoping report is seeking to illuminate.

3.3 Policy context of emergency relief

Commonwealth funding of emergency relief

Although the history of ER provision in Victoria dates back to colonial times (see Cage, 1992), Commonwealth government involvement came much later. In 1979 the then Federal Coalition Government adopted a recommendation by the Henderson Commission of Inquiry into Poverty to take over the funding of ER. An annual federal budget allocation of $500,000 was made for the provision of ER, to be divided up among respective states according to the level of unemployment (McClelland & Gow, 1982). Over time, subsequent federal governments variously increased the funding pool, tweaked the funding formula, or attempted to hand funding responsibility to states which argued that social welfare was a Commonwealth responsibility (Dwyer, 1989). In the 1990s, a public review of ER funding was undertaken, in which reports revealed that the level of demand was rising. The reports

‘exposed inadequacies with the Commonwealth’s social welfare system. Unwilling to increase social welfare payments, the Howard Government decided to adopt a new funding formula in the 1997 federal budget that tied annual payments to the states and territories to their shifts in the Consumer Price Index (CPI) to better reflect rises in the cost of living (Department of Health & Family Services, 1996). Over time, other welfare payments besides the Newstart Allowance would be added to the funding formula (Disability Support, Parenting Payment, Youth Allowance, Family Tax Benefit A, and Exceptional Circumstances Relief but not Aged or Carers Pension)’. 18

This formula was retained in subsequent governments, with minimal changes. With the onset of the global financial crisis, ER funding was doubled from $36.2 million to $64.4 million from March 2009 to June 2011. In addition, $80.4 million was allocated for ER and financial counselling, plus $50 million available for...
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microfinance programs. In addition, there has been some relaxation of administrative costs of providing ER, and ER providers can also apply to have a specified percentage of ER material aid funding allocated to the employment of staff engaging in case management of ER clients. In addition there is funding under the ‘vulnerable groups’ category which is an allocation of funds for the provision of case management to identified vulnerable groups requiring short-term, intensive support, underpinning goal being to enable services to build capacity to respond to complex needs clients. This funding has been maintained for the 2011-2014 funding period. The flexible application of ER funding to encompass casework, either through ‘vulnerable groups’ funding or through additional support for case management services, enhances service providers’ capacity to respond to client needs in different contexts and settings.

As part of FaHCSIA’s Financial Management Program (FMP), ER is becoming less perceived as a means of once-off support, but increasingly recognised as a gateway to specialist services, in which ER providers play a crucial service, undertaking an integration role between the three branches of the FMP: financial counselling, microfinance and ER. The largely volunteer workforce of the ER sector has limited capacity to provide ongoing, supportive casework to complex needs clients. Although the crucial role of volunteers in the provision of material and emergency relief is still highly relevant and valued, the increasing demand of complex needs clients is providing a unique set of challenges to a largely volunteer sector. Funding support to the sector to provide casework is not only policy recognition of the needs of clients, but also the needs of the sector’s volunteer workforce. Additionally, the relaxing of rules around administrative costs and flexibility around allocation of ER funds towards casework is welcomed by the sector, affording service providers the much needed scope with which they could innovate and respond to client and community needs.

**Current policy context**

Welfare and social policy changes that impact on the most vulnerable and disadvantaged place pressure on ER agencies from time to time. Landvogt (2006) noted that pressures on ER providers increased when people were ‘breached’ under the ‘mutual obligation’ regime. More recently, the impact of changes in moving Parenting Payment recipients to Newstart, and the release of asylum seekers into the community has placed pressure on service providers. On the positive side, indirect contributions of the Victorian Government through utility, education and transport concessions provided avenues of financial relief for low income and income support recipients – though it must be noted that changes to education payments have also placed pressure on ER services to support families and individuals. In terms of service delivery, increased regulatory obligations (such as occupational health and safety, food handling, risk management, etc.) and increased reporting requirements (agencies may receive funding from all three levels of government, as well as philanthropic and project funding) place a greater burden on workers’ time and resources. The strain of these pressures is most acutely felt by volunteer-only agencies.

Policy, economic, and social contexts also place pressure on those living on low incomes, or reliant on government income support payments, to maintain financially stable and secure lives. Housing and accommodation shortages, the rising costs of utilities and other essential services, job losses, and other cost of living pressures are recurring issues that caseworkers assist clients with in the ER sector. Over the years, the demand for emergency relief rose considerably, bringing with it significant changes in the cohorts of people applying for emergency relief and the issues people are presenting to agencies. Affordable housing and the cost of essential services are the most often cited reasons for people attending

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19 The education maintenance allowance (EMA) was made up of two payments – schools and families. 2013 changes saw the family portion slightly increased and school payments discontinued altogether. Furthermore, School Start Bonus was discontinued altogether. The net result was that eligible parents were receiving less than they had prior to the changes ($355 less for prep children; $85 less for years 1 to 6; $470 less for year 7; and $220 less for years 8-10). At the time of writing, the recent decision to place a cap on state utilities concessions is a cause for concern for the sector, although it is still too early to gauge the impact (if any) this may have.
ER services for assistance and support. Moreover, the discrepancy between income support payments and the rising cost of essential services compounds financial hardship experienced by the most vulnerable people in the welfare system. These individuals and families experience social exclusion due to complex, multiple and diverse disadvantage. Flanagan (2009) reported that Tasmanian emergency relief clients in 2008 listed the five most commonly reported issues as: family/relationship breakdown, mental illness, chronic illness, chronic debt, and disability and legal issues. Most respondents were affected by one or more than one issue, and the clustering of multiple issues tended to be in five instances, rather than two or three. Flanagan suggested that this indicated the presence of a qualitatively different group of individuals (to the client demographic previously reported in the literature) who, despite financial hardship, experience a range of complex underlying issues and very high needs.

The impact of these policy contexts on vulnerable individuals and families requires a holistic approach to helping those in need. One policy response that has enhanced the ER sector’s capacity to support complex needs clients is FaHCSIA’s funding of casework in ER services. This new emerging model of ER service delivery is a preventive intervention that enables the client in financial hardship to engage more broadly with ER services and deal with complex life situations as opposed to straightforward budget problems. Flexible funding arrangements, a recognition of the broader community context and the impact of multiple and diverse disadvantage on clients are some of the policy dimensions that this scoping report seeks to make contributions.

3.4 Casework in emergency relief services

3.4.1 Casework in emergency relief services

In social work literature, casework is defined as assessing people’s problems; planning the action to be taken; implementing the action, which may include the caseworker taking responsibility for all tasks, referring some or all tasks to specialists and retaining overall responsibility for case management (Compton & Galaway, 1994). Discussions of casework or case management in the emergency relief literature refer to the provision of client-centred, wrap-around support and services aimed at providing practical and emotional support, building client capacity and resilience and working with clients to achieve client-directed goals. Of the published reports that do relate to casework and emergency relief, we refer to CISVic’s Ending the Stopgap Report (2011) and Anglicare’s Pilot Case Management Project (2010). These reports are outlined in greater detail in Appendix A, and are briefly summarised below.

**Ending the Stopgap:** this report seeks to describe the impact of casework on clients, service delivery, and volunteers across 16 community information and support services. Casework is described as a client-centred approach that is essentially collaboration between the worker and the client. Clients work with caseworkers to identify needs, address problems and build individual capacity. Caseworkers provide appropriate referrals, ongoing support and work with agencies to tailor outcomes to clients’ long-term needs. Thus the casework process is one of partnership between the client and the caseworker, with elements of practical and emotional support, capacity building and a focus on outcomes. The goal is to work with the client’s underlying issues, and through a trusted and supportive relationship, build the client’s capacity to overcome adversity, build skills and re-engage with the community.

**Sustainable Living Model:** Anglicare Sydney’s sustainable living model is a case management program that is implemented on the basis of three fundamental premises. **Efficacy:** case management provides clients with more control over decision-making and an opportunity to develop reasonable and feasible goals aimed at resolving presenting crisis and underlying issues. **Resilience:** case management breaks the cycle of recurrent crisis by improving living skills, resilience and wellbeing of the client in an environment of emotional support, trust and Christian care. **Inclusion:** case management improves service access and engagement for clients, builds wellbeing and resilience, improves individual relationships with families and
members and enhances capacity to participate in the local community. Case managers can facilitate this process due to their significant access to service network information and using a ‘warm’ referral process.

3.4.2 Relevant case management literature

There was very limited literature that related specifically to casework in emergency relief. However, the literature on case management was proliferate, and was predominantly in the care sectors; health, mental health, and aged care. There is a growing body of literature relating to case management in the homelessness sector, which aligns more closely with the ER sector than does health. Searching the literature for reference to case management in welfare, poverty alleviation and material aid or emergency relief yielded very limited results. Although there is a substantial body of literature in emergency relief, it predominantly relates to client demographics, disadvantage, poverty, and service demand. There is also an increasing body of work around food security, financial exclusion and material deprivation, but not much exists concerning intensive client intervention models or case work.

In view of the paucity of literature directly relating to case work in emergency relief, we turn to the case management models that most align with the ER setting – sourced in the homelessness sector. Case management in both the ER and homelessness sectors work directly with clients with complex needs who are experiencing an immediate crisis. In a survey of ER service providers in Victoria, it was reported that over half of all ER clients presented with a housing issue (ER Victoria, 2012). Furthermore, housing related issues, including the lack of secure and decent accommodation, and homelessness in its various forms, were identified as a major cause of deprivation in The Salvation Army 2013 ESIS Report (The Salvation Army, 2013).

Compared to the literature that can be found relating to casework in ER, which remains in the domain of grey literature, the literature on case management in the homelessness sector is substantial. The analysis of our scoping surveys therefore makes particular reference to the evidence about case management interventions in the homelessness sector, as outlined in Gronda’s (2009) research synthesis (see Appendix A). In doing so, we illuminate parallels and differences between these case management settings, and position casework in ER within the broader case management practice framework. We underscore the emergence of casework within the social inclusion framework, and chart an emerging service model that seeks to ameliorate the conditions of poverty.

4. ANALYSIS OF CASEWORK IN EMERGENCY RELIEF – AN EMERGING SERVICE MODEL

This part presents findings from three major sources: scoping survey results, desktop search results and consultations with caseworkers and ER service managers. Analysis of the findings is made with reference to Gronda’s case management framework (Diagram 1). As alluded to in the limitations section, this scoping seeks to draw from these sources to sketch the contours of an emerging service delivery model. As such, it is not meant as a comprehensive or definitive study of casework models implemented in the ER sector across Australia. The findings in this report are very much Victoria centric, and we will attempt to draw from published reports and information from other jurisdictions where available. Viewed in this context, this scoping report raises interesting insights about the current implementation of casework in ER services, and the challenges and potential they present for the effective delivery of services to clients with complex needs.

20 ‘warm’ referrals are instances where an introduction is made by direct contact, such as a phone call or visit. The person making the referral would do so on behalf of a client. There may also be discussions about the reason for referral, client history or present circumstances, and why it would be important for the client that the referral is being made to the referred service or program.
This part will answer the five key questions set out in section 1, and conclude with policy, program and research recommendations. For more detailed findings and results, please refer to Appendix A, B and C.

4.1 What is ER casework?

4.1.1 A definition of casework

Diagram 3: Casework Process

From the literature and scoping surveys, casework in ER is a new and emerging model that implicitly recognises that people experiencing multiple disadvantage and complex needs, over time, will experience social exclusion. In this part, we draw from survey responses and the Ending the Stopgap Report to flesh out the definition of casework.

Casework in emergency relief services is a partnership between the caseworker and the client, who work together to achieve goals aimed at improving clients’ circumstances. The relationship is built on trust, openness and transparency in which caseworkers are professional workers with appropriate systems knowledge and networks to leverage (through advocacy and role modelling) positive outcomes for clients. Through a period of intensive emotional and practical support, caseworkers work with their clients to move from a situation of personal and financial crisis towards emotional and social wellbeing.

4.1.2 Casework mechanism: caseworker relationship with clients

Caseworker survey respondents talk about their role as one of coordination and communication. They work with clients to meet individual needs and circumstances, liaise with other professionals and workers to coordinate services and support, and maintain communication and contact to ensure that goals and plans are reached. This communication can be in the form of informal contacts, case discussion and in writing. Caseworkers also spoke about case-conferencing with other professionals to coordinate assistance for clients. This involves a high level of service knowledge, stakeholder engagement and relationship management. Caseworkers also provide practical assistance, from simple form filling, to advocacy to service providers, to sourcing crisis accommodation for those experiencing family violence.
1. **Comprehensive client-centred support that is both practical and emotional**

In their approach to casework, ER caseworkers focus most on client engagement and the provision of client-centred support. Practical and emotional support is provided to the client, through a strengths-based approach to casework that aims to empower clients to set goals and work towards achieving them. Setting clear boundaries, that are also flexible enough to respond to the dynamics of client needs and changing circumstances, and following through with actions and plans are steps taken, sometimes incrementally towards realistic and tangible outcomes for clients. Transparency (in terms of communication as well as accountability to clients) and consistency are also valued approaches, particularly where complex needs clients are experiencing a combination of multiple deprivation and issues.

Case management interventions in homelessness settings show that comprehensive practical support is preferable to brokerage or other referral services. Additionally, comparative studies show that it is most effective when it provides direct assistance with practical and specialist support needs (Gondra, 2009). In ER casework, support was generally in the form of continuity; stability and reliability and being ‘always there’ (Nguyen, 2011). Clients identify the importance and value of both practical (or problem-based) support and emotional support. In this way, systems linkages, referrals and the provision of ongoing emotional support were of equal importance, particularly for those with limited social and personal resources and systems knowledge and navigation capability (Nguyen, 2011).

2. **Professional skill-sets and effective communication skills**

The skill-sets that have been identified as crucial to effective relationships include: listening, communication, appropriate training, problem solving and advocacy skills. This wide ranging set of skills reflect the need for caseworkers to be ‘generalist’ and holistic in their work with clients, in engaging on the one hand with a vulnerable and disadvantaged client who has limited resources and capacities, to maintaining open and constant communication with stakeholders and other professionals as advocates, enablers and co-ordinators of service delivery in the most ‘cost-effective’ and comprehensive way possible.

In Ending the Stopgap report, clients comment on caseworkers’ professional attitude and knowledge base which includes brokerage, advocacy and flexibility in the assistance they received and being treated with respect and dignity.

3. **Non-judgemental, trusting, respectful and supportive relationship**

As referred to by King (2009) and Gondra (2009), relationship is key to case management. When asked what would make an effective relationship with clients, respondent caseworkers focus on those elements that Gondra (2009) found in the homelessness literature: a non-judgemental, trusting, respectful and supportive relationship that focuses on client engagement and relationship building. Openness, honesty and good communication are also well regarded by respondents. Attributes of caseworkers that are considered crucial in a relationship with client are: being non-judgemental, creating and maintaining trust and respect. Empathy, honesty and openness are also important in relationships with clients. These attributes are crucial to effectively engage with clients at the outset, and to establish rapport and build relationship. 'Evidence from studies of service users agree that respect is key to a successful intervention, and that a form of intimacy is a critical part of case management.'

In caseworker consultation, the issue of outreach was raised by caseworkers as a worth-while caseworker role. Outreach in this context refers to caseworkers accompanying clients to appointments and other activities where the client may need additional support. This is considered for example, to be appropriate for clients with language barriers, who lack systems knowledge or are otherwise vulnerable to exploitation and misinformation. These activities are also seen as opportunities for role modelling and capacity building by providing coaching or mentoring moments.

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21 Gondra, H. (2009), op.cit. p.9
However, there is also caution about intimacy in a caseworker relationship, where professional distance and care is required in managing client anxiety and expectations. Caseworkers tread a fine line when engaging with clients, and often tackle ethical professional issues about the nature of support, empowerment and choice.

‘We have to be careful not to rescue people. Often through simply talking a situation out with us they can find their own solution and resources. While talking they are clarifying and gaining confidence to act independently. Clients often feel anxious when told they are going to see a case worker as they don’t want another person involved in their lives or feel we will be critical of them. It’s important to show respect, empathy and privacy making them comfortable to talk.’ Caseworker

Client-caseworker relationships foster increased personal capacity such as life-skills; advocacy skill through caseworker modelling; and systems knowledge and navigation, helping clients build resilience in the face of overwhelming financial and personal crisis. These skills develop over the period of support, where caseworkers adopt strategies to provide encouragement and build confidence. They aim to validate client experience through empathic interaction; demonstrating a belief in clients; being non-judgmental; providing a ‘listening-ear’ and other strengths-based strategies. (Nguyen, 2011).

4.2 How does casework achieve outcomes for clients with complex needs?

‘It is important that the worker builds a trusting relationship with the client. Professionalism, confidentiality, good listening skills, extensive knowledge of local services and ability to advocate on behalf of the client, is most important in effective case management.’ Caseworker

We seek to answer this key question by looking at aspects of casework, including program access, client engagement and disengagement, and service referrals and linkages and collaborations with other service providers. Although a client-caseworker relationships remain critical and core to reaching goals, client outcomes are achieved when this relationship can build on the resources and skills of the worker, support and service capacities of the ER agency, professional networks, and the extent of inter-agency and cross-program integration in the locality.

Managers were asked to reflect on what are the crucial elements for effective client outcomes. Client engagement, and relationship building between the caseworker and the client, were considered the most important elements for effective client outcomes. Managers also place great value on trained and skilled caseworkers, their service and systems knowledge and their professionalism. Appropriate levels of funding and resourcing for staff training and professional development were also important to achieving outcomes for clients. Managers place equal importance on the mechanism of casework and the context within which that mechanism enables outcomes.

4.2.1 Program access

‘We have attempted to make the casework program as easy as possible for clients to establish relationships with the case worker. Therefore we have not imposed any additional polices other than those of the agency.’ Manager

Managers were asked how clients access their casework program, from internal and external referrals. Internal referrals are predominantly made through the ER service, followed by other co-located services at the agency, identified as financial counselling and family services. The mode of referral is generally informal, or via agency procedures following an assessment by an ER worker. Access criteria are fairly open, with very few restrictions. Where restrictions did occur, they relate to geographic boundaries, which is a common criterion of service access in the ER sector.
Elsewhere, respondent caseworkers talk about making themselves immediately accessible where it is obvious that a client is in need of support, and where an initial short meeting secures engagement with the client. External referrals are predominantly made by other local services and government agencies, and regional network contacts. External referral processes are also fairly informal, relying on phone calls, faxes and emails, word of mouth and self-referrals.

-Limitations-

Survey respondents identified capacity, lack of resources and a high need for casework in some locations as limitations to their casework program. These largely relate to the limited hours that programs are funded to operate. In regional areas and locations with high socio-economic disadvantage, this is putting a strain on ER services as they continue to provide ‘band-aid’ assistance to clients who could otherwise be helped with dealing with the underlying causes of their financial and personal distress.

Another barrier identified by caseworker respondents during the consultation was access to and effective use of interpreting services. Agencies working with people from CALD and Aboriginal backgrounds found it frustrating that other services either fail to use, or are inexperienced in their use of, interpreting services. Linguistic competency varies between organisations, and with the increase in cultural diversity among the most vulnerable and disadvantaged in our society, it behoves service providers at all levels and across all sectors to improve on their linguistic competency in order to achieve optimal outcomes for clients, regardless of language or cultural background.

-Impact of policy-

The impact of government policy of moving asylum seekers from detention to the community have increased demand for ER services, as asylum seekers make adjustments to settling into the community. Work restrictions and living on less than those on Newstart income (at 89%), this new group of vulnerable individuals and families are accessing already strained services. The Australian Council of Social Service’s Australian Community Sector Survey (2013) reports that 75% of ER clients are wholly reliant on income support payments, and that ER services are not able to meet demand (47%).

-What works-

Student placements, co-location with services which promote service linkages and cross-referrals, networking and service promotion through regional ER and professional networks, and access to translation services are some of the program activities that improve access to the service. Having a generalist casework model that is flexible and quick to respond to crisis or need is also seen as an advantage for ER services. The opportunity to ‘journey with the client however long that may be’ offers hope and comfort to those who are isolated, overwhelmed and financially insecure. The open and easy access to the casework program, its service gap function and the fact that ER is a referral pathway for complex needs clients is part of what makes casework work for complex needs clients.

4.2.2 Intake

Intake criteria is fairly open – as long as clients have been identified as having complex needs, and whose issues cannot be resolved by one session, they are considered eligible for casework. Some agencies also report they also actively offer casework to clients who re-attend for ER. Those agencies receiving vulnerable groups funding through FaHCSIA talk about meeting funding requirements by targeting specific groups. The flexibility with which FaHCSIA ER funding has been applied to meet agencies and client needs has meant that most people needing casework do get access to it.

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22 ACOSS (2013) ACOSS Australian Community Sector Survey 2013, Strawberry Hills: ACOSS, p.9
The following account demonstrates nicely the way ER works, and how the introduction of casework is really an expansion of the service, rather than a stand-alone component of the ER model. This model of service delivery implicitly recognises the diversity and complexity of poverty and disadvantage, and addresses the range and diversity of client needs more effectively when the service has the capacity to be more immediate and responsive to clients’ crisis situations – be that a need for immediate food and material aid, or for a caseworker to help unravel the complex threads of clients’ presenting crises.

‘In conjunction with the E.R.F guidelines and Pathways Assessment tool.

- Assessment by appointment only (An allocation of 30 minutes is allocated per interview – this will streamline the waiting area)
- Each individual is assessed on his or her own individual’s needs and issues
- Any form of assistance such as Food Vouchers, Bill payment or medical expenses is based on the assessment outcome and general guidelines, which are based upon the individual’s circumstances and situation.

No two assessments are the same, as no two individuals are the same.

Documentation Required for Assurances: income statement and I.D

These two forms of documentation allow us as service providers to identify the individual and support and assess that he/she is receiving the correct amount of payment from Centrelink or their employer and support them in some budgeting if that’s requested or required.’ Manager

4.2.3 Wait-list

In gauging whether services are meeting demand, we asked the question whether there is currently a wait-list for program access. Twenty-two per cent indicated that there is currently a wait-list for their service, ranging from one to four weeks. These services are located in the City of Greater Dandenong, City of Casey and City of Yarra.

4.2.4 Client engagement

Reflecting case management in homelessness, most casework is provided over a 3 to 6 month period (45%), followed by those assisted under 3 months (29%), 6 months (23%) and over 12 months (3%).

The ‘over 12 months’ response represented one survey respondent, who identified the reason for the long client engagement as being due to complex multiple issues and clients with mental health diagnoses. Also of note is that for this particular caseworker, 75% of their caseload is 12 months. Elsewhere in the surveys and consultation, it was reported that cases lasting over 12 months involve clients with higher needs, such as CALD clients dealing with complex immigration issues, and those requiring ongoing support as a result of injury (such as acquired brain injury) and those who are beneficiaries with state trustees. Clients falling within these categories imply those who fall through service gaps, for whom specialist support may be beyond reach, but whom nevertheless, need support and assistance with systems navigation and advocacy. Homelessness evidence and literature tells us that case management over 6 months helps clients increase their self-care capacity, and that support intensity varies dynamically over time. One study found that effective support occurs in the third year for those recovering from severe mental illness, and another finds behavioural change occurring over many years with clients with personality disorders (Bradshaw et. Al, 2007; Nehls, 2001).

The survey respondents indicated that as ER caseworkers work with a diverse range of clients, client engagement was also reported to vary widely, with some client-caseworker relationships persisting over
long periods of time. For example, files may not be closed, but left open even after an issue is resolved due to a combination of the underlying issues of particular clients, and acknowledgement that capacity building of complex needs clients cannot be achieved within one intensive period. Caseworkers talk about clients ‘lurching from one crisis to the next’, reflecting both the complexity of need and depth and persistence of disadvantage of their client demographic.

Yet, one caseworker reported that the preference is for a three to six month period of support, as this is sufficient time to address issues and deters dependency on the service.

‘Between 3 – 6 months seems to be an appropriate time to work intensively with a client, although in some cases, we have worked with some clients for about 12 months. This length of time helps build the relationship with the client, address their issues and deters the worker from creating a dependency on the service.’ Caseworker

In caseworker consultation, the issue of outreach was raised by caseworkers as a worth-while caseworker role. Outreach in this context refers to caseworkers accompanying clients to appointments and other activities where the client may need additional support. This is considered for example, to be appropriate for clients with language barriers, who lack systems knowledge or are otherwise vulnerable to exploitation and misinformation. These activities are also seen as opportunities for role modelling and capacity building by providing coaching or mentoring moments.

4.2.5 Exiting Clients

Exiting clients can be a complex issue for respondent caseworkers. Caseworkers report that files are closed when plans or goals are achieved. Disengagement by clients and onward referrals round out the three most commonly cited reasons for case closures.

As capacity building is an important goal of their casework role, caseworkers also mention that clients exit the program when their lives are stabilised and they are ‘ready to go it alone’ or at

‘…such times the client appears more stable and back on track with their life. Becoming more capable of dealing with situations independently and only occasionally asking for a food parcel.’ Caseworker

There does not seem to be a hard and fast rule around exiting clients, as caseworkers and agencies acknowledge the nature of complex issues – which may reside in client characteristics (such as those diagnosed with mental health illness, or acquired brain injury), systemic issues (such as inadequacy of income support, housing affordability) or long-term unresolved problems (family violence or inter-generational poverty). Ultimately, the goal of casework, like case management, is to achieve goals negotiated with clients at the outset, and move clients away from dependency on the service.

4.2.6 Working with others to achieve client outcomes

Caseworkers were asked if they worked with others to achieve outcomes; 30 out of 31 responded with a ‘yes’. They were further asked to nominate the three services they most frequently work with to achieve client outcomes, which we broke down to three broad areas: other FaHCSIA funded financial management (FMP) services; other specialist services; and government services. One other group was mentioned – working with utilities service providers to assist clients. This would often take the form of advocacy and negotiation around utilities bills. Ending the Stopgap report found that caseworkers in agencies enhance service integration and referrals as a result of their professional and peer networks, systems knowledge and advocacy skills. Promoting greater service integration and linkages (through cross-referrals) between FMP programs is considered by FaHCSIA and service providers to support outcomes for clients experiencing
financial stress\(^{23}\). Thus, caseworkers facilitate greater service linkages and integration by working with other professionals (horizontal integration), whilst enhancing service delivery by working with volunteers and other service programs (vertical integration).

**Working with other professionals**

As generalist workers, caseworkers take a case-coordination approach to working with other service providers, especially where they are specialist services. They work with clients and other service providers to negotiate agreed goals and outcomes, and support clients through the process. Of the FMP services, financial counsellors and other ER services are the most frequently cited types of services that caseworkers work with. Among government services, Centrelink was by far the most cited service. Of the specialist services, housing, mental health and counselling are among the top three services that caseworkers work with to achieve client outcomes.

In the homelessness sector, working cooperatively, that is, where professionals communicate and work together on a case (such as in small clinical teams or multiple agencies) is regarded as the highest degree of integration (Rosenheck et al. 2003). In a ‘working with others’ survey, respondents spoke of both collaborative working, where they participate in regional networks, information sharing and training, and working cooperatively, where they work with others to achieve outcomes. Caseworkers refer to communication and checking in with other professionals who work on aspects of their clients’ cases. In this role, caseworkers take on a case-coordination and support role, and act as enablers and supporters to assist clients on the journey toward self-reliance.

Networking is important for caseworkers, as a way to maintain professional and personal connections, as well as keep up to date with information and services. In terms of systems integration, regional and professional networks are key to supporting caseworkers and their knowledge base. CISVic facilitates a caseworker network for its member agencies on a quarterly basis, and have started to rotate meetings to a regional agency once a year to increase caseworkers’ access to the network. The network is essentially a community of practice, where issues around best practice, client engagement and the caseworker-client relationship can be discussed confidentially. Peer support is also an important component of the caseworkers’ network. The network invites speakers from specialist and government agencies and advocacy groups to engage caseworkers with the systemic issues impacting on clients.

‘...networking with other agency providers locally has been really important in letting them know about the service and being able to utilise their knowledge base for the best outcome for clients.’ Caseworker

**Working with volunteers to achieve client outcomes**

‘Role of case worker also involves support for the volunteers who provide ER. They are the major source of referrals to the case worker so it is important that they understand how the role complements what they provide. Secondary consultation, debriefing and information sharing are also important components of the case worker role.’ Caseworker

It was documented in Ending the Stopgap Report that caseworkers relieve the pressure on volunteers to deal with complex needs clients. Caseworkers are also a resource and source of support for volunteers due to their systems knowledge and linkages and professional networks. As volunteer roles are often limited, both by time and skill-sets, the introduction of a caseworker role in ER agencies greatly increased the agency’s capacity to respond to complex needs clients (Nguyen, 2011).

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\(^{23}\) “Emergency Relief services are an important gateway to other services and supports that can help people deal with more complex issues, including issues that have contributed to, or are a consequence of, financial stress.”

Since the introduction of caseworker roles, some agencies have sought to place demarcation between the role of caseworker and ER workers, as there were inconsistencies around the provision of ER, as explained by one manager:

‘We recently introduced a procedure whereby the caseworker's role is separated from the ER interviewing role and the caseworker no longer delivers ER. Previously there were casework clients receiving higher amounts of ER than non-casework clients. There are instances when the caseworker can advocate for a client (e.g. a casework client required financial support to pay for his denture, having had his rotten teeth removed...)’ Manager

The diversification of volunteer roles in ER agencies brings interesting developments. On the one hand, some volunteers perform a para-professional role by taking on the caseworker role, whilst other agencies formalise the role boundaries between volunteers and caseworkers. ER services predominantly rely on a volunteer workforce. The development of a paid caseworker role within this service delivery model, one that sits within the ER program, was a direct response to complex client needs, which aims to provide the best possible outcomes for client. How this shapes the ER service delivery model, workforce roles and responsibilities, and the direction of ER services is a development worthy of further investigation and study by the sector.

There are also policy implications of funding for service providers. ER funding has conventionally been meant for distribution, with a small proportion allocated to administration. Although vulnerable groups funding is separate from general ER funds (as reflected in the different reporting requirements and funding arrangements) there has been some flexibility with which general ER funding contracts have been varied to provide greater support to casework due to increased demand for caseworker hours and resources. This emerging social inclusion model of ER broadens the possibilities to the ER sector in terms of supporting complex needs clients. However, challenges remain, uncertainty as to future funding and demand outstripping supply. Professionalisation of a predominantly volunteer sector, enhanced workforce capabilities and a more comprehensive response to poverty and disadvantage, enables a more sustainable service delivery model, for both the sector and vulnerable and disadvantaged Australians.

4.2.7 Service referrals and linkages

We asked participants whether caseworkers referred clients to other services and, in relation to both internal and external referrals, which services they most referred. Of the internal referrals, one participant mentioned government agencies. These were from a service that has a contract to provide specialist services to a government department, with the caseworker working in a council setting. Internal referrals were highest for counselling – there was no indication whether this was a co-location arrangement or an internal program, as many community information support services for example, do offer generalist counselling services. Internal referrals were also commonly made to support group programs that ER and community information support services offer. Specialist services include: legal, women’s services, and youth. Other internal referrals worth noting are: financial counselling, microfinance and housing. This indicates the development of ER services as effective ‘one-stop shops’ of related services such as FMP, therapy and counselling, material aid, advocacy and referral. Referrals were also made for life-skills or money management workshops or training. External referrals outside the ‘specialist services’ grouping worth noting are to health (which includes health professionals, allied health and community health services), government agencies, mental health and housing. Government agencies were a combination of federal, local and state level agencies, with Centrelink being the most frequently referred. Utilities referral is a combination of those relating to energy providers, the Home Energy Saving Scheme (HESS) and Utilities Relief Grant (URGs).

Phone referrals are most common, due to accessibility and the relational nature of caseworkers’ work. Formal referral processes for both internal and external referrals were mentioned most frequently. Formal
referrals include filling in forms, written referrals and following procedures set down within the agency. It also includes referrals by an appointment system. In contrast to program access, in which informality and openness are common, referrals are more structured, formal and process driven.

Service integration is another key component of the social inclusion model of ER. Integration is occurring within agencies where we see a high number of referrals to co-located services or in-house referrals to other service programs such as counselling, support groups and other specialist services. Integration across agencies is also occurring, where caseworkers work cooperatively with other specialist services to achieve client outcomes, whilst at the same time providing support and capacity building to clients. Higher levels of integration leads to lowered costs and, ultimately, improve client outcomes – as shown in Diagram 4 below, which maps a basic model for integrated services by the OECD. Further research and investigation in how service integration works in the ER casework models would be of benefit for policy makers and program designers.

Diagram 4. Basic model for integrated services delivery

Effective cooperation, through good communication, is central to improving service users’ outcome. When professionals work well together, costs can be lowered, services are not duplicated, and the identification and response to service users’ needs can occur more quickly.\(^\text{24}\)

source: OECD

4.2.8 Barriers to working with others effectively

Caseworkers identified some issues that impact on effective communication and referrals. Time limitations place restrictions on how well and effectively caseworkers can engage with other service providers in following up on client referrals. A combination of workload, limited hours and funding constraints have led caseworkers to prioritise time with clients over other aspects of casework, such as follow-up, attending network meetings and otherwise engaging with other professionals.

Scarcity of resources, particularly among specialist services, results in long wait-lists for services, placing a burden on caseworkers to take on roles they are not equipped to provide assistance for. Another barrier identified by caseworkers during the consultation was access to and effective use of interpreting services. Agencies working with people from CALD and Aboriginal backgrounds found it frustrating that other services either fail to use, or are inexperienced in their use of, interpreting services. Linguistic competency varies between organisations, and with the increase in cultural diversity among the most vulnerable and disadvantaged in our society, it behoves service providers at all levels and across all sectors to improve on

their linguistic competency in order to achieve optimal outcomes for clients, regardless of language or cultural background.

4.3 What agencies are providing casework, where are they located and who is delivering casework?

4.3.1 Where casework is offered

Data from project partners indicate that The Salvation Army’s Doorways case management model is currently delivered in 65 sites across Australia. Nationally, The Salvation Army delivers ER in 237 sites. Case management is delivered by Anglicare Victoria in metropolitan and outer Melbourne and regional Victoria (10 sites). Paid workers support volunteers to deliver ER across metropolitan Melbourne. CISVic member agencies deliver generalist casework across 23 sites in Victoria.

A total of 49 caseworkers and managers responded to surveys. Managers’ and Caseworkers’ surveys were cross-referenced resulting in 39 casework programs offered in 49 sites across Victoria (36) and Tasmania (10), with three unknown. Also from survey responses, we identified two council based casework programs. One is a partnership between an ER agency and the Council’s financial counselling program, with ER casework provided by a qualified financial counsellor. The second council based casework program provides casework in the context of an integrated family services program. There is a specific focus on families, however, access to the program is open to all clients willing to engage and for whom a 50-minute session will not resolve their presenting issues. A regional faith-based ER service was also identified by the scoping survey to provide casework to ER clients.

4.3.2 Community contexts

Agencies report providing a range of services to clients. The main issues faced by agencies’ communities are housing (includes homelessness, living in rooming houses), family violence, and mental health (followed closely by alcohol and other drugs). Issues are broad ranging, though, and caseworkers normally would deal with a combination of these when assisting clients. These issues were reported across a range of agencies, indicating that issues affecting vulnerable families and individuals do not vary greatly across Victoria or Tasmania. However, there are some contexts that deserve mention.

Regional services

Regional agencies describe a broad geographic catchment area and face challenges around resourcing and funding.

‘We also are a border town and have cross border issues around funding and service delivery for a community that is funded by another state.’ Agency manager

City of Greater Bendigo agencies service a town of 120,000 people of low to middle income, as well as a large proportion of income support recipients. Additionally,

‘[M]any clients are Aboriginal and we are increasingly seeing more refugees and asylum seekers. Single parents make up a large proportion of our client demographic.’ Manager

Housing and homelessness is also an issue for the City of Geelong, where an ER agency

‘also assist[s] a number of homeless/transient individuals and families. Mainly from Corio/Norlane and Whittington areas, with large areas of government housing, large percentage in receipt of income support, poor school retention, low school achievement and a large number of sole parent families. Problems include: substance abuse, domestic violence, mental health issues, and health issues.’ Manager
Growth corridors

Growth corridors, with their lack of public transport, accessible services and social isolation pose unique issues for communities. For example, the City of Casey has:

‘[H]igh demographic of young families and highest multicultural population in Victoria. High incidence of family breakdown and family violence. High incidence of households in mortgage stress and financial distress.’ Manager

‘This area has a large number of families, many singles living in unregistered rooming houses, and many singles and families struggling with housing stress and cost of living expenses. We are now seeing more single parents losing income due to being transitioned to Newstart, and they are reporting going without food to pay the rent and bills.’ Manager

Client issues & community context

Client issues reported in surveys broadly reflect the indicators that are documented in Anglicare Victoria’s annual Hardship Surveys and The Salvation Army’s annual National Economic and Social Impact Surveys (ESIS), both of which provide a demographic profile of poverty and disadvantage through the framework of deprivation and social exclusion. Approximately two-thirds of respondents to the ESIS 2013 Survey report that they had approached welfare or community organisations for help, and over half had asked for help from families and friends.

‘Limited economic resources place limits on the capacity of respondents to fund risk mitigation measures such as having savings, home content or car insurance. Without such options, respondents have limited capacity to respond when things go wrong, often resorting to increasing debt which they cannot afford, and borrowing from family and friends or asking for assistance from community based organisations.’

When survey respondents report about their community context, housing and homelessness, family violence and health related problems (including mental health and alcohol and other drugs) were consistently the main reasons clients attended for support. Financial hardship, as a result of mortgage stress or cost of living pressures, was also mentioned by respondents.

The 2012 NATSEM report into financial hardship in Australia found that housing stress is most prevalent in households where New Start Allowance (NSA) and job seeker Youth Allowance (YA) are the main source of income, where 49.9% pay more than 30% of their disposable income on housing. Overall, housing stress was found to affect 21.9% of households, a rate considerably lower than those living on NSA/YA, 31.5% of whom experience housing stress. The report also found a strong relationship between an increased number of deprivation and/or financial stress factors and housing stress.

Into this context, are two emerging issues impacting on the ER sector – the changes to eligibility for parenting payment, moving single parents with the youngest child over eight years, and families with the youngest child over six years to New Start Allowance. The second policy issue impacting on community contexts is the moving of asylum seekers from detention to living in the community. These policy impacts add to the complexity and shifting operating landscapes of ER service provision, and underscore the value of networks, service and program integration and diversity to the sector. As the frontline for welfare services within their own communities, efficacy and efficiency requires ER service providers to be both comprehensive and targeted in their approach to service delivery.

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25 The Salvation Army (2013) op.cit. p.19
4.3.4 The casework models

'Since its introduction into our service, three years ago, our casework model has been able to achieve significant outcomes for clients. The ability to be able to spend more time (between one or two hours) with a client for each appointment has positive benefits with both outcomes and client relationships.'

Casework in ER is one that is relational, focusing on a respectful, honest, and transparent relationship between the client and the caseworker. Client engagement and access is relatively open. Casework is client focused, holistic and task-oriented, and there were striking similarities in approach to casework and what makes a casework relationship work. In making a distinction between models, we are neither assessing them, nor are we trying to gauge a preference of one over the other. Rather, we are keen to glimpse the range of responses, and innovations, to the challenge of providing casework that works for clients with complex needs. By identifying the where and what of the models we hope, into the future, to delve into questions such as: where are the models that rely on volunteers to provide casework service? Why did this model develop in this location and not another, regardless of similarities in settings and approach? What are the challenges and successes of the models? What makes them work and why do they work?

Gronda (2009) identifies three major theories about how case management works in the homelessness literature:

1. Case management works because of the relationships developed by case managers between themselves and the clients, and between themselves and other agencies involved in the service system (and needed to assist clients)

2. Case management works because of a structured, consistent, systematic process that ensures all the client’s needs are identified and the best possible plan is made and enhanced to meet the needs and manage any risks using an efficient allocation of available resources

3. Case management works because of the coordination provided by one responsible person or agency.

From scoping survey responses, we can discern that ER casework models overlap these three theories. From response samples, one or two casework models have a strong focus on a structured approach and the majority focus on clear working processes and procedures to enhance service and client outcome efficiencies. There is not sufficient information from our surveys to arrive at clear conclusions about the models when compared against the above theories of case management. Rather, we can see clearly that the ER sector is a diverse place, where differences in agency size, community context, welfare ethos and capacities all play a role in the casework model being adopted. The nascent state of the casework model, funding uncertainty (and the low level of funding) and the very generalist nature of casework may be factors that impact on which, if any, of these models may prevail.

From scoping survey results, Table 2 sets out types of casework, with the distinction made not so much in the role and approach of the caseworker, but rather, the way casework is delivered, and by whom. This reflects the professionalisation of the ER sector, and represents the overlapping and collaborative roles and functions between paid, professional work of qualified workers and unpaid, para-professional work of trained volunteers and students. As stated elsewhere in this report, this emerging social inclusion model is driven by a desire to meet client needs. What we see with the delivery of casework programs in ER is the emergence of other drivers: resources, capacities, and communities/place. Underlying this is also a need for efficacy and efficiency – utilising the best available resources to achieve optimal client and community outcomes. Most of the models discussed in this section draw material from survey responses, which in conjunction with the Ending the Stopgap report, provide us with a more in-depth look at how they work.
They will be followed by information from The Salvation Army’s Doorways case management model and an overview of Anglicare Victoria’s casework programs.

Table 2. Casework models by type: scoping surveys

<table>
<thead>
<tr>
<th>Type of casework</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casework with identified groups</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>Caseworker and students deliver casework</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>Caseworker and volunteers and students deliver casework</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Caseworker and volunteers deliver casework</td>
<td>3</td>
<td>8%</td>
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<tr>
<td>Casework and sector development role</td>
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<td>Generalist Casework</td>
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<td>70%</td>
</tr>
<tr>
<td>Inter-agency casework</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Casework**

From the surveys we identify 27 casework programs, as generalist casework. Casework models in Table 2 incorporate ‘vulnerable groups’ models, which were initially funded by FaHCSIA on the basis that specific vulnerable groups were to be targeted for support through the ER stream. In this table, casework refers to generalist casework, offered to complex needs clients presenting at ER agencies with whom a caseworker can provide comprehensive support.

**Casework with identified groups**

Unlike casework under ‘vulnerable groups’ funding, casework with identified groups seeks to identify casework in a different setting. Three casework programs in the survey sample fall under this category. The different settings these programs operate in are: asylum seekers, integrated family services via a council service, and a Salvation Army program that targets parents via play-group or ER service. There is insufficient data to gauge what barriers there are to referrals to ER from these specialist services, other than anecdotal reports that the demand for ER exceeds capacity to respond. In terms of service integration and ease of referrals though, the council program is collaboration between the council’s financial counselling program and an ER service, whilst The Salvation Army parenting program is located on the same site as an ER service. The asylum seeker program is one that is wholly outside the ER setting as it provides specialist services to asylum seekers, and is not normally part of the Victorian emergency relief sector.

**Casework with volunteers and students**

Some agencies report they rely on volunteers and students to deliver casework. Volunteers are involved in the delivery of casework in four agencies, including one which also involved students. Two agencies involved students for the delivery of casework. In 2012 CISVic was provided with FaHCSIA funding to pilot a student placement program to build agency capacity to provide casework. The program was evaluated, and found that:

‘Student placements ensure that agencies can continue to provide intensive, supported services to clients who fall through service gaps. It also promotes and enhances professional practice within the sector (in a professional and volunteer capacity) meeting both workforce capability and service delivery needs...Students on placement can assist caseworkers by taking on administrative and follow-up tasks associated with client files.'
This frees up time for caseworker to focus on support and capacity building aspects of client work. This also means that clients can be linked into services in a timelier manner because students could make the referral phone calls, contact with a service provider which often takes up a lot of caseworker time.”

A CISVic agency participating in the 2012 student placement pilot is currently exploring options for expanding student placement within their ER service:

‘As you know, [we] highly value[s] this program and the great outcomes for clients it achieves. We are looking into a longer-term, more sustainable model to expand the program using... a team of social work students on placement under the close supervision, guidance and support of a paid manager and experienced caseworker. Stay tuned!’

Caseworker

Student placements offer an opportunity for the expansion of casework, with three agencies operating casework through a combination of paid caseworkers and students on placements. Placement students were reported to be a combination of social work and community welfare students. However, it is not necessarily a given that para-professional casework is yet another new direction of ER service delivery. At most, we can identify a trend that points towards the sector innovating towards the delivery of casework by trained volunteers and students. Volunteer recruitment and retention is becoming a serious issue of concern for many community based agencies, and this will play a significant role in determining the development of para-professional services in the community sector. Nevertheless, during consultation with managers, participants expressed there are minimal staff retention issues, and report a relatively stable volunteer workforce within their service.

Casework and sector development

This is a highly innovative casework model that is worth a mention. As quoted in the previous section, this model employs a caseworker who provides casework support to a regional ER network, as well as provides sector development support to volunteers within the network. At the same time that volunteer numbers are contracting within the ER sector, due to an ageing population, we see a concomitant rise in complex needs clients attending services. This innovative role aims to build the network’s capacity to respond to the needs of clients for short-term intensive support, whilst also building volunteers’ capacity to provide timely responses to client problems through enhanced referral processes and up-to-date information.

Inter-agency and multi-site casework

These refer to situations where one caseworker (in the case of CISVic) is employed by a larger agency to provide casework in a volunteer-only agency nearby. This enables smaller agencies with limited resources to access the services of a caseworker for complex needs clients and fill a service gap in their area. Although both sets of agencies are CISVic members, agencies are independently governed and managed. Some workers work across multiple sites of the same agency – such in the Hub Satellite Model at The Salvation Army. Anglicare Victoria and one CISVic agency also provide this type of service. Similar to the outreach model, these inter-agency and multi-site caseworker positions extend the provision of the casework service to enhance access for clients, and build agency capacity for improved service linkages and referrals, and in some instances, volunteer support (Nguyen, 2011).

Professionally supported volunteers - assessment model

This model was identified in Ending the Stopgap Report and relies heavily on a trained volunteer workforce and a support structure that was developed over time. Under this model, a supervisor provides support to interviewing volunteers and oversees all cases requiring intensive support and follow-up. The supervisor

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has carriage and control over each case that requires intensive support and allocates work as required. Volunteers providing intensive assistance to clients will not be allocated work for more than four contact periods (to minimise volunteer attachment to clients). The model is a highly developed one and aims for consistency of outcomes for clients. This model focuses on process and outcomes. It relies on intensive training and support and has established processes and guidelines in assessment and distribution of ER. Crucial to the success of the model is the selection process, volunteer training and a shared belief in the ethos and value of the model. There is consequently, a high retention rate among volunteers. The introduction of Team Leaders, in-service training and case discussion groups are some of the measures introduced to support volunteers. An ongoing issue for this model is the level of responsibility that resides in the supervisor.  

4.3.5 Casework models at Anglicare Victoria and The Salvation Army

WACOSS’ scoping of the Western Australian ER sector found that ER outlets of large faith based organisations, and multi-program organisations are well placed to integrate ER service delivery with other services (such as financial counselling, legal, family services, (WACOSS, 2012). This is reflected in project partners’ casework programs, which is summarised below (and in more detail in Appendix A). Larger agencies have greater flexibility with which to both fund and vertically integrate programs and services, and are well placed to adapt to shifting policy and practice environments. There is greater capacity too for consistency in program delivery, data collection and reporting. Diversity and flexibility are recurring themes within this scoping report, as is evidenced not only by the range of casework models, but the range of settings and organisational contexts that make up the ER operating environment. The models provided below are added here to expand the contours of what we have found in our scoping surveys. They reinforce the diversity and responsiveness of service providers to their community and client contexts. They also emphasise the need for ER to be something for everybody – that the provision of casework is but a continuum of a response to financial and personal crisis.

Anglicare Victoria: casework programs

Table 3. Casework provided by Anglicare Victoria

<table>
<thead>
<tr>
<th>Type of casework</th>
<th># sites &amp; locations</th>
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| Paid caseworker in the ER program, with part of the role supporting volunteers. ER delivery includes: transaction, advocacy and referral and in some instances, casework and/or access to other casework services such as financial counsellor, family services. | Metro Melbourne: 5  
Outer Melbourne: 2  
Regional: 3 |
| Volunteer run/delivered ER service comprising transaction, advocacy and referral and supported by a paid worker/coordinator. | Metro Melbourne: 4  
Regional: 3 |
| Paid worker delivering ER as part of their role in delivering another service (such as financial counselling and family services) | Metro Melbourne various sites |

The Salvation Army: Doorways

‘The Doorways model is trying to lessen the burden on the client by encouraging the client to direct the service and then, through a gradual process, encouraging the client to make positive steps into the future.’ Caseworker

Doorways hub: A Doorways hub is a central service from which clients can receive more in-depth assistance with their presenting needs. A Doorways hub will usually provide either case management or

Nguyen, M. (2011) op cit. p. 41
financial counselling services, together with other groups of programs that can assist clients beyond emergency assistance.

**Doorways satellite:** A Doorways satellite is a service that provides Emergency Relief to presenting clients. Satellites will work in partnership with hubs to provide ongoing and more in-depth support to clients. This partnership can be flexibly arranged with clients either being referred to the central hub for further support, or with case managers or financial counsellors from the local hub working a number of hours at a satellite centre to provide support to satellite clients.

Hubs and satellites remain independent units in terms of management, finance, administration. However, it is expected that hubs and satellites will work in partnership to provide the best outcomes for clients, through sharing of services, particularly case management and other in-depth supports to clients. Hubs and satellites will form ‘regional’ teams that provide the best support possible to clients in their region. The Salvation Army funds case management under these models through a combination of FaHCSIA and their own funds.

### 4.3.6 Innovation

These models of casework reflect the diverse settings that they operate in. They also reflect the range of available resources, and the commitment to casework and a client-centred approach to service delivery. The changing ER operating environment and landscape, with increasing complex needs clients with longer term, ongoing multiple issues and shifting policy and service delivery demands, have led service providers to look to a more comprehensive, client-centred approach to alleviating poverty. Tackling the underlying issues goes beyond ameliorating the conditions of poverty. It is a direct challenge to work with the client, to journey with them and build their capacity for self-reliance and reduce their dependency on emergency relief. It posits itself directly within a social inclusion framework that seeks to build resilience and capabilities of vulnerable and disadvantaged Australians. This involves not only working intensively with the client over a short period of time; it also involves a whole-of-service engagement with the client’s journey. It requires innovations around the service’s capacity, the local ER network’s needs, up-skilling volunteers and introducing an internship workforce that not only builds present capacity, but the future workforce of the sector.

### 4.4 Identify the resources and capacities required to deliver ER casework.

‘Obviously a well-equipped workstation and suitable office environment. A good reception. An up-to-date data base. We have also introduced improved resources in the ER program, such as meal vouchers, Kmart vouchers and a crisis fund, as well as the other mainstream ER vouchers. These additional resources do make the SW [social worker’s] job easier.’ Manager

Survey responses provide us with the material from which we could identify the capacities required to deliver ER casework. Here we discuss responses from managers that relate to the resources required to deliver casework. We were particularly interested to gauge resources required over and above those that were directly funded for the program, and to get a picture amongst other things, of the extent of the role of volunteers in the casework models, staff training and professional development.

#### 4.4.1 Organisation size

A little under half of the respondents to the question about staff numbers reported that they employ between 1 to 5 paid staff (47%), followed closely by 5 to 15 paid staff (41%). Very few employ over 15 staff members (this amounted to one organisation in each of these categories). Most organisations have 15 to 50 volunteers working in their agency (43%) with 29% (or 4 agencies) with 5 to 15 volunteer staff. This indicates that those agencies with capacity to deliver casework also have some capacities around paid staff.
and the resources that come with a paid workforce – such as qualification, professional networks and accessibility. These capacities also enhance service linkages and integration both at the agency itself (such as cross-referrals to other programs) and outside the organisation. In a scope of the ER sector in Western Australia, it was found that case management opportunities were being facilitated in a variety of ways, with larger service providers able to more easily understand concepts like referral and case management, concepts which can be embedded in policies and procedures to implement case management opportunities. In contrast, smaller church-linked agencies have limited service linkages and program knowledge and consequently limit their capacity for effective referrals. Most survey respondents operate on budgets under $500,000 per annum, putting them in the category of small to medium sized organisations, with about two-thirds of these operating on budgets ranging from $120,000 to $500,000.

4.4.2 Human resources

Manager surveys were designed to gain a picture of some of the resources required to deliver casework in ER. The Ending the Stopgap report identified some models in which volunteers play an active role in the delivery of casework, either through an assessment model in which volunteers could provide short-term support under supervision from a qualified social worker, or the ‘specialist volunteer model’ where volunteers are trained and supported to provide specific types of support (such as budget or application for grants). Managers were asked if volunteers are involved in their casework program, and how they are prepared for their role. Of the 18 responses to this question 72% indicated that volunteers are involved in delivering the casework program. Of these, four managers provided insight as to how they determine appropriate skills for the role. All referred to accredited training, combined with innate or life/work skills and experience as factors important for the role.

‘I pick volunteers to do case management based on their skills and experience. We do not allow every volunteer to provide case management. They have to be trained in ER first and show competency and they are only permitted to do case management if they have previous work experience in this area. They are oriented to the case management process prior to being permitted to do it.’ Manager

Volunteers are fundamental to ER service delivery. Casework in ER is delivered in a context of a largely volunteer workforce who provides support to clients, material aid and referrals and sometimes advocacy. The casework and volunteer ER roles are highly integrated, with cross-referrals and sometimes, case coordination between volunteers and caseworkers. Student placements and volunteers are also playing an increasing role in ER services. With their specialised skills, their contribution to both the ER volunteer workforce, and building capacity for caseworkers through administrative casework tasks and attending to short-term complex needs clients is adding immense value to the agencies’ capacity to offer casework (Nguyen, 2013).

4.4.3 Funding

Managers were asked about funding for their casework program. A total of 18 respondents answered the question. Five programs received funding from one source, and of these, three were FaHCSIA funded for a two to three day per week position. Sixteen were FaHCSIA funded, and of this cohort, one program was reported as not specifically funded for casework, but has FaHCSIA approval to utilise general ER funding to cover four hours of paid work, with another two hours made up by volunteers and students. Thirteen of these programs supplement FaHCSIA funding from either their own funds or combined with other funding or programs at the agency. One agency stated that they cover the $2000.00 in shortfall from interest earned. Two of these programs were supplemented by council-funded positions, with 2EFT in one location,

29 WACOSS (2012) Giving Shape to the Emergency Relief Sector, Perth: WACOSS, p.3
and 0.2EFT in another. These positions are funding by the same Council. Of interest also is the funding covered by a local business, which was reported to be $10,000.00 per annum.

Data from project partner, The Salvation Army indicates that FaHCSIA funding is supplemented by Salvation Army funds to increase casework capacity across 65 sites.

**Philanthropic & supplementary funding**

Data from caseworker surveys also reported philanthropic funding for an innovative casework program. Two philanthropies funded a grant to trial a caseworker position to resource a regional ER network, with part of the role also to resource and up-skill ER volunteers. The program combines casework with community education and sector development to build the ER network’s capacity to deliver services to complex needs clients.

Data elsewhere also informed us that philanthropies also funded a generalist casework program reported in our caseworker survey. Two local philanthropies provided funding of $12,700.00 and $5,000.00, which were then combined to fund a casework position. Funding was for a 12-month trial. Since then, funding has been continued by philanthropy, so the agency is now looking for funds to make up the gap.

The variety and creativity with which agencies are covering for the expansion upon FaHCSIA funded services, as well as the support from philanthropies, attests not only to agencies’ commitment to the casework model but also to the precarious nature of funding, particularly where funding is obtained from fundraising and bequests. A point raised at the consultation with managers was that 25% of ER funds that are put towards paying staff for the provision of casework is not enough to cover all staff costs. Agencies typically leverage resources from other external agencies or source funds internally to help make up the shortfall. They also point to the resources that will need to be put into raising funds and to reporting on them (to various funding bodies) every year. Furthermore, agencies are forced to make hard decisions at the approach of every financial year as competing demands stretch agency capacity and resources.

‘Funding requirements and environmental context inform the structure of the casework program in terms of EFT staffing and the allocation of funds for brokerage to other services.’ Manager

‘Increased funding would have a huge impact as this would enable us to provide a broader service, take more time with our client’s and employ additional staff or train more volunteer staff.’ Manager

ER contractual arrangements with FaHCSIA, and the flexibility with which the funds have been utilised by service providers to meet client demand, have been greatly welcomed by the sector. Managers at the consultation spoke of how this funding arrangement has resulted in enabling them to be highly responsive to their community settings, and how they are able to design casework programs according to client needs and available service resources. This is reflected too in the range of innovative models we have demonstrated in this report. Innovation can only occur when flexibility in funding arrangements encourage the creative utilisation of available resources to enhance efficiencies and improve outcomes.

4.4.4 Qualifications

As previously discussed, caseworker skill is wide-ranging. Casework is anchored in inter-personal, relationship management. Caseworkers are required to build rapport and intimate working relationship with clients, maintain professional relationships with stakeholders, and a supportive and mentoring relationship with students and volunteers. Furthermore, in the generalist casework model operating in ER services, where a holistic and integrative approach to working with clients is seen as the most effective means to achieve client outcomes, caseworkers’ professional distance, or role boundaries need to be maintained in order to ensure a planned, co-ordinated approach to problem solving can be achieved.
Of the 18 manager responses to the question about qualification, 67% report their caseworker attained a Bachelor’s Degree, and 16% qualified at a Graduate Diploma/Certificate level, mostly in social work and welfare, with a total of 11 caseworkers. Whilst finding the right person to carry out the role of caseworker is important, managers also value the right qualification and training. The skills, service knowledge, professional networks and ability to manage client relationships professionally and with respect are important considerations that come with some measure of training and qualification. Qualified social workers were viewed as extremely valuable as they have the capacity to provide supervision to other staff (including volunteers/students etc.), particularly clinical supervision. Elsewhere, from caseworker surveys and Ending the Stopgap report, we identify qualified financial counsellors in the role of generalist caseworkers.30

4.4.5 Supervision, training and support

The Ending the Stopgap report identified supervision and support as important contextual factors enabling effective casework. There, caseworkers

‘identify ongoing professional development and training as crucial to supporting the work they do with clients. Targeted and ER sector specific training and professional development would greatly improve efficiencies and outcomes in casework. Domestic violence, financial counselling, mental health, drug and alcohol and housing services have been identified by caseworkers as requiring greater service integration and collaboration with the ER sector. Professional development in these areas will see more inter-agency efficiencies and integration when caseworkers are kept up to date with government, agency and service providers’ policies, processes and general service delivery to vulnerable groups. Also identified is professional development that is targeted at developing generalist casework skills (such as client interaction and engagement).’ 31

Similarly, in the research synthesis into case management in homelessness settings, Gronda (2009) identified that ‘case-managers need a high level of support, including professional supervision and multidisciplinary collaboration to mobilise and manage the professional intimacy of the case management relationship’.32 Survey respondents report that caseworkers are provided with both formal and informal supervision, with formal supervision sometimes occurring off-site. On-site support, such as debriefing opportunities, supervision meetings and peer supervision are also cited. Off-site support, such as formal supervision arrangements, one of which includes peer supervision with employed counsellors, and network meetings that provide peer support have also been reported. Volunteers are provided with on-site support through debriefing, supervision support and planning sessions. Managers’ survey responses indicate that professional development opportunities are available to caseworkers, either on a regular basis, such as in-service training, or external training identified by caseworkers. Managers also utilise funding for professional development.

During our consultation with managers, the issue of volunteer training and supervision was one that managers identified as under-resourced. The provision and availability of training is not only a recruitment and retention issue, but in an environment of increasing complex needs and new ER clients, the quality of volunteer service, their access to up-to-date information, and continuing engagement with stakeholders and other community services are crucial to effective and efficient service delivery.

30 Nguyen, M. (2011) op cit. p.45
31 Nguyen, M. (2011) op cit., p.47
4.4.6 Reporting and compliance

Respondents identified internal policies and procedures, FaHCSIA reporting requirements and data management systems as the main source of compliance and reporting frameworks for casework. Half-yearly or yearly reporting were the most common, with monthly reporting to management reported as part of internal processes. The Salvation Army have an internal electronic system used to record all assistance and dealings with clients, as well as policies and processes that managers’ report they comply with as required.

Other agencies mention the use of database and data management systems, although there was also concern around the costs to these. One manager told us that their system was developed with the assistance of IT students under an Industry Experience project, whilst another agency is still grappling with finding the right computer database to make information retrieval easier: ‘[we are] a small not for profit organisation. We struggle with an out-dated computer system and constantly seek funding to update it to ensure organisational reporting requirements are met.

Alternatively, some agencies report that there is little differentiation between the way they report on casework compared with other programs, and utilise organisational policies and procedures (including annual financial audits and reporting to boards as benchmarks for reporting and compliance. During consultation with managers, an issue was raised with regard to government contracts with conditions as to how services are delivered, particularly where restrictions are placed around service access. It was noted that where these conditions exist, they increase administrative costs, which are often not funded for. Additionally, it is challenging to work collaboratively with other agencies when there are compliance and operating constraints on programs.

4.5 Current practices that can inform guiding principles to casework in ER

The question of best practice was directly asked at the consultation with caseworkers and service managers. Best practice is a concept that refers to ‘core standards’, or minimum levels of practice. Thus the Australian, UK and US case management guidelines and best practice sets minimum levels of practice that case managers should aim to work within. There is sufficient flexibility within these guidelines for variations between professions, practice settings and service context. These are underpinned by a duty to base practice on evidence and work towards integrating research and practice. Thus best practice can also refer to evidence informed practice, such evidence encompassing not only the elements of an intervention that worked and why, but also a consideration of resources and adequate funding to ensure efficacy and efficiency.

Those who attended the consultation described the delivery of ER services by community-based agencies that are at the coalface of poverty, social isolation and financial exclusion. The ER sector operates as a doorway to support services for vulnerable people, first through the provision of material aid and relief, and through caseworkers, with the provision of comprehensive, practical and emotional support and assistance to address the underlying problems of poverty, exclusion and personal crisis. Participants see ER as a pathway, an opportunity to address the problems that cause their clients to attend for help. These clients typically have complex needs, which can be addressed through provision of short-term support - usually between three to six months, sometimes longer – and which leads, hopefully, to them exiting the welfare system altogether.

What emerged from discussions was a series of models that worked within the context of community, agency and clients’ needs. Caseworkers work within the boundaries set by organisational context and/or philosophy, client needs, available resources and the policy landscape that impact on clients’ situations. This makes identifying an over-arching best practice approach as one that must be a work-in-progress. Not only because this is an emerging area of practice, but because there are ‘communities of practice’ that are situated within the ER landscape. These communities of practice are: information & support; asylum
seeker; community health; and homelessness. It is through these communities of practice that we arrive at best practice approaches that best suit their different settings, and that best ensure effective outcomes for their client groups.

There were also commonalities in approaches and practices that work across models, and which correspond with case management best practice approaches in other sectors (such as health, homelessness, aged services). However, it was also important not to forget that context plays a crucial role in what makes casework work for clients attending ER services. Casework mechanisms, as much as caseworker skill, organisational and social policy contexts and resources all intersect to determine agencies’ capacity to effectively respond to client needs.

Among caseworkers, when asked how to measure the success of casework the group responded by identifying the following indicators:

- Clients goals are met
- Clients effectively disengaged
- Clients linked to another service
- Clients stop coming in

From survey responses and consultations, it was very clear that outcome is at the forefront of casework intervention. Challenges around policy and practice impinge on the casework process, but for caseworkers, the ultimate goal is to ensure clients’ needs are met, and that the service itself becomes one that is no longer required. Table 4 summarises the key points made in response to the question of what makes casework work for complex needs clients, grouping them against standards of best practice in case management. When overlayed with homelessness case management evidence, we see parallels in casework mechanism and context. What comes through clearly too, from both consultation and qualitative data is the term ‘flexibility’. This underpins the ER and community information and support sectors’ generalist service delivery model. As community based agencies that respond to the needs of their communities, operating contexts and shifting policy landscapes, the ability to respond with flexibility, with innovation and be context-driven is crucial to effective outcomes for clients. Place-based is more than a geographic definition, even though this often marks service boundaries and access. It refers to the recognition that agencies are tied to their communities, to those living and working in them regardless of background, ethnicity and ability. Their communities - their ‘place’ - are a source of human capital and resource. It is a source of financial and social support. It is the means with which agencies harness a collective will to improve the quality of life of its most vulnerable and disadvantaged, thus improving the quality of life of all who share ‘this place’.
Table 4. What makes casework work for complex needs clients?

<table>
<thead>
<tr>
<th>Casework mechanism &amp; context</th>
<th></th>
</tr>
</thead>
</table>
| **Mechanism - relationship with client** | Respectful, trusting relationship with client  
Client engagement and rapport  
Provision of intensive support, education & guidance  
Provision of consistent, ongoing, flexible and meaningful support  
Client centred, needs-based, focus on needs, goals & actual outcomes |

| Context – staffing issues (skills, training, supervision) | Ongoing training  
Caseworker skills: high-level skills, administrative skills, ability to research solutions  
Staff retention |

| Context - service system design and capacity | Access: continuity, accessibility  
Effective policies and procedures that includes: clear role demarcation between volunteers and caseworkers, clear decision-making process, best practice guidelines, clear exit point  
Well-resourced: funding; brokerage; technology  
Service linkages: effective referral pathways (internal and external), linkages and collaboration with other service providers, use of interpreters, relationship with other service providers  
Strengths-based model, solution focus, triage system  
Flexibility |

| Client rights and responsibility | Clear boundaries between client and caseworker  
Client rights |

| Outcome satisfaction | Client feedback  
Consumer involvement |

| System performance | Data collection  
Client feedback |
5. POLICY, PROGRAM, AND RESEARCH IMPLICATIONS

There are many parallels between the homelessness and ER sectors in their approach to case management. The adherence within the ER sector to the definition of case management, both in practice and in spirit, indicates the sector’s commitment to casework and its effectiveness in achieving client outcomes. There is a growing consensus between caseworkers as to the length of time a client should be assisted to achieve goals, the skill sets, attributes and approaches to the casework relationship that works for clients and caseworkers, and the important role of systems engagement and integration to achieving client outcomes. Unlike the homelessness sector, ER client demographics and the nature of assistance enables caseworkers to start from a broader base, one that goes beyond an immediate need of housing and accommodation. Empowerment, capacity building and supporting clients through a period of crisis are crucial strategies that caseworkers provide to move clients towards social inclusion. The holistic approach identified by survey respondents and the ER casework literature confirms King et al’s (2009) conceptualisation of ER within a social exclusion framework whereby the compounding impacts of disadvantage and deprivation have detrimental impacts on clients’ capacity to respond to crisis. The policy, program, and research implications that arise out of this scoping study will hopefully contribute to improved outcomes for clients with complex needs.

5.1 Policy implications

- The ability of service providers to respond to client needs and community context through a flexible funding structure is crucial to effective outcomes for complex needs clients. However, many services continue to supplement casework funding from other sources. This level of funding insecurity places constraints (time, resources, access) on both service and caseworker capacities to achieve optimal outcomes for clients.

- Caseworker roles, whether in a professional, volunteer or paid capacity, require high levels of support, training and professional development. Adequate levels of funding will need to incorporate components for training and support needs of staff. Consideration needs to also be made to the development and support of communities of practice across the sector to promote best practice, service integration and network capabilities.

- Volunteer training and supervision is currently under-resourced. A new emerging model of casework in ER service delivery requires an active involvement of volunteer workers to deliver a broad range of services to vulnerable and disadvantaged clients. Developing innovative regional network responses to training and supervision needs of volunteers is one way of addressing the issue. There is scope for the roles of government, philanthropic and other funding sources to be developed to tackle the human resources challenge faced by the ER sector at this time.

- The range of casework models across ER services reflects the diversity of contexts, client and service environments of the ER sector. Innovative funding and casework models mirror the sector’s highly responsive and place-based approach to client and community needs. Maintaining this level of diversity is crucial to effective client outcomes as it acknowledges the important role of contextual responses to client needs.

5.2 Program implications

- Casework requires an investment of time for building and maintaining a relationship. This implies constraints on caseload for effective client outcomes. A combination of workload, limited hours and funding constraints have led caseworkers to prioritise time with clients over other aspects of
Casework in the Emergency Relief Sector; a Scoping Study

- Casework, such as follow-up, attending network meetings and otherwise engaging with other professionals.

- Client engagement varies widely, with some client-caseworker relationships persisting over long periods of time. This is in acknowledgement that capacity building of complex needs clients cannot be achieved within one intensive period.

- Effective client outcomes rely on caseworkers providing timely referrals. However, in some locations, scarcity of resources, particularly among specialist services, results in long wait-lists for services. This places a burden on caseworkers to take on roles they are not equipped to provide assistance for. Similarly, caseworkers working with people from CALD and Aboriginal backgrounds found it frustrating that other services either fail to use, or are inexperienced in their use of, interpreting services.

- Student placements, co-location with services which promote service linkages and cross-referrals, networking and service promotion through regional ER and professional networks, and access to translation services are some of the program activities that improve access to the casework service. Having a generalist casework model that is flexible and quick to respond to crisis or need is also seen as an advantage for ER services. The open and easy access to the casework program, its service gap function and the fact that ER is a referral pathway for complex needs clients is part of what makes casework work for complex needs clients.

5.3 Research directions

Further investigation of casework interventions to determine whether they do ameliorate the conditions of poverty, social exclusion and disadvantage, facilitates deeper understanding of casework practices and the benefits to clients that may be used to inform future practice. We note that Anglicare Victoria’s evaluation of the Sustainable Living pilot case management program demonstrated benefits in efficacy, improving client resilience and wellbeing, and enhancing clients’ capacity to participate in their local community.33 As the sector works towards improving outcomes for clients, it would benefit from further evidence of how casework may improve outcomes for clients with complex needs. Similarly, an understanding of the contextual elements that enhances efficacy and efficiency in the delivery of casework could contribute to evidence-based practice in the ER sector. Although heavily reliant on a volunteer workforce, casework exemplifies a professionalisation of the ER sector through the role of paid professional workers, para-professional volunteers and students. In this context, an exploration into the resources that are required, as case management best practice implies, to monitor and evaluate, build evidence and work from a best practice framework will be of benefit to ER practitioners and program designers.

33 King, S. (2013) op. cit. p.39
6.1. APPENDIX A: DESKTOP RESEARCH RESULTS

6.1.1. Casework in emergency relief literature

Anglicare sustainable living model

In 2010, Anglicare Sydney conducted a case management pilot in Wollongong ER service based on three fundamental premises.

**Efficacy:** Case management was to provide clients with more control over decision-making and an opportunity to develop reasonable and feasible goals. They will be assisted with individualised case plan to address specific needs through the identification of strengths and existing resources, which would be leveraged into strategies to resolve presenting crisis and underlying issues.

**Resilience:** Case management was aimed to break the cycle of recurrent crisis by improving living skills, resilience and wellbeing of the client in an environment of emotional support, trust and Christian care.

**Inclusion:** Case management would improve service access and engagement for clients, build wellbeing and resilience, improve individual relationships with families and members and enhance capacity to participate in the local community. Case managers can facilitate this process due to their significant access to service network information and using a ‘warm’ referral process.

The designers of the case management pilot ‘recognises that each individual requires a unique and personalised approach to their often complex issues and a “blanket approach” is not the best form of intervention to achieve positive and sustained outcomes. The individuals that we assist through the ER, or the Sustainable Living program, often have a multitude of complex issues and their ability to live from fortnight to fortnight can vary depending on the impact of these issues in their lives. We see that, through case management, we will have the chance to address each of these issues and create strategies and work plans in accordance with the client’s unique needs and personal goals. Case management will also equip individuals with the necessary skills and resources to improve their quality of life, wellbeing, living situation and assist towards a transition into sustainable living.’

An evaluation was carried out on the pilot and completed in 2012. It demonstrated benefits across all these domains for clients and recommended continuation and expansion of the pilot across other ER sites. As the pilot was funded by the NGO sector, and not by government, financial support is required for these innovative models of care to be expanded.

**Ending the Stopgap Report, casework in community information & support services**

The Ending the Stopgap Report (2011) describes caseworkers’ approach to casework across CISVic agencies as holistic, client-focused; strengths based and personal capacity building. Caseworkers identify the client-focused or client-centred approach to casework as the basis from which they engage and support clients. This client-centred approach is a collaborative one, where clients work with caseworkers to identify needs, address problems and build individual capacity. Under the caseworker models implemented across the 16 participating agencies, the client-centred approach ensures that issues are resolved according to client needs and circumstance. Caseworkers provide appropriate referrals, ongoing support and work with agencies to tailor outcomes to clients’ long-term needs. Thus the casework process is one of partnership between the client and the caseworker, with elements of practical and emotional support, capacity building and a focus on outcomes. The goal is to work with the client’s underlying issues, and through a trusted and supportive relationship, build the client’s capacity to overcome adversity, build skills and re-engage with the community. This process is described in the diagram below.

The report also charted the impact of casework on volunteers and service delivery, identifying different casework models operating in community information and support centres.
Impact on clients

**Building individual capacity:** Increased personal capacity such as life-skills; advocacy skill through caseworker modelling and systems knowledge and navigation helps clients build resilience in the face of overwhelming financial and personal crisis. These skills develop over the period of support, where caseworkers adopt strategies to provide encouragement and build confidence. They aim to validate client experience through empathic interaction; demonstrating a belief in clients; being non-judgemental; providing a ‘listening-ear’ and other strengths-based strategies.

**Providing ongoing support:** Support was generally in the form of continuity; stability and reliability and being ‘always there’. Clients identify the importance and value of *both* practical (or problem-based) support *and* emotional support. In this way, systems linkages, referrals and the provision of ongoing emotional support were of equal importance, particularly for those with limited social and personal resources and systems knowledge and navigation capability.

**Meeting client needs:** Clients also comment on caseworkers’ professional attitude and knowledge base which includes brokerage, advocacy and flexibility in the assistance they received and being treated with respect and dignity. Although providing practical and material assistance achieves some results in relieving the presenting stressors, it is often the support, individual capacity building and confidence that caseworkers place in their clients that start the journey of recovery for many clients. It provides hope and a sense of a future beyond their current situation.

Impact on volunteers

**Meet client needs:** Volunteers recognise their limited capacity to meet complex clients’ needs, and are clear on the role differentiation between themselves and caseworkers. Caseworkers, it was felt, were better able to provide follow-up, continuity of care and assistance ‘beyond the band-aid’. This was because of their professional networks and linkages, as well as their knowledge base and training in dealing with difficult and complex needs clients.

**Additional support and resource:** Caseworkers are perceived as more knowledgeable than volunteers with better inter-agency linkages and networks and systems knowledge. They are available as a resource for volunteers in their day-to-day activities, as someone to ‘bounce-off’ problems and issues as well as providing an immediate response to clients where volunteers could identify very early on that they do not have capacity to assist. Thus caseworker support ranges from providing immediate response to difficult situations, to modelling advocacy strategies to informal chats over coffee.

**Enhanced job satisfaction:** The additional resource, with the accompanying help received relieves stress of volunteers, not only in dealing with complex clients and situations, but also with the knowledge that the agency is better placed to provide a service that meets client needs. Caseworker support build volunteers’ confidence over the way they interact with clients.

Impact on service delivery

**Increased resource:** Caseworkers are an additional resource to the service and volunteers (see above). For smaller agencies the addition of a professional, paid staff member greatly increases the agency’s workforce capacity and the facilitation of inter-agency linkages and service integration (approximately half of the participating agencies fall in this category).

**Meeting client and service needs:** The introduction of the caseworker model adds a layer of sophistication to agency’s response to ER service delivery. It fills service gaps and creates flexibility in a context of rigid service provision in the non-ER sector. The focus on the client and individual capacity building is seen by managers as an effective strategy in reducing the long-term reliance of clients experiencing financial hardship.
Increased agency and program linkages: Positive impacts on service delivery can be seen at agency, inter-agency and community levels. Caseworkers build and maintain relationships with other welfare, specialist and government service providers; establish cross-referral protocols; and harness existing programs by linking them to clients and the ER program.

The increasingly complex operating environment of ER services is testing agencies’ capacity to respond in a way that stays true to their service ethos. A commitment to improving the well-being of their communities and a heavy reliance on a volunteer workforce provides the requisite impetus and resource for agencies to remain accessible and relevant to the most vulnerable and disadvantaged across Melbourne and Victoria.

Casework process

6.1.2. Other relevant casework literature

Standards and best practice guides

In Australia, the United Kingdom (UK) and the United States of America (US), the definitions of case management are nearly identical, and reflect a highly developed field of practice. Thus case management is defined as:

Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s holistic needs through communication and available resources to promote quality cost-effective outcomes.

The definition of case management notes the focus upon the meeting of a client’s health needs. Within the Australian context, case management can be placed within a social model of health. This framework allows for the client and case manager to work on the various aspects of the client’s life that influence the client’s health.

According to the Case Management Society of Australia (CMSA), case management is a service delivery approach that is now widely utilised across the human services and health sectors. Best practice in case management requires not only supports for service delivery but for staff and to the development of an evidence-based approach to practice. Best practice also includes elements of advocacy and engagement with systemic and policy change to support service delivery.
In lieu of the paucity of published material about casework in ER, we turn to homelessness research about case management and outcomes for homelessness clients. A 2009 Australian Housing and Urban Research Institute (AHURI) sought to review the evidence about case management in the homelessness sector ‘to provide an evidence-based understanding of how case management works and contribute to the development of more effective responses to the needs of people experiencing homelessness.’ The similarities between complex needs clients and homelessness clients provide us with parallels from which we could draw from the evidence in homelessness research that assist with analysis of the scoping survey responses.

A total of 53 sources of empirical evidence collected from the published literature were synthesised to answer research questions about what makes casework work for people experiencing homelessness. Beyond asking questions around case management intervention, and what is known about it from existing literature, the research synthesis sought to provide policy makers and practitioners with tools to improve practice, service design and implementation (Gronda 2009).

The research synthesis defined case management as an intervention that does not simply meet this or that need, but develops a person’s capacity to self-manage their own access to any support they need. It also found that the relationship between the client and case-manager or the case management team which has qualities of ‘persistence, reliability, respect and intimacy, and which delivers comprehensive, practical support.’ This direct, practical support was indeed preferable to brokerage or referral to other services, and that comparative studies show that case management is most effective when it provides direct assistance with practical and specialist support needs. The synthesis also found that the evidence shows that effective case management is a time and resource-intensive intervention, but that it is cost-effective over time as it reduces other system expenditure (such as hospitalisation and pressures on other services).

The research synthesis also identified certain conditions which enable case management relationship to deliver beneficial outcomes for people experiencing homelessness. These include:

- access to housing resources and specialist supports
- individually determined support durations
- case management staff with advanced assessment, communication and relationship skills and regular practice supervision

A persistent, reliable, intimate and respectful relationship

The synthesis found that the evidence from experimental comparisons of different case management models consistently finds that the qualities of persistence, reliability, intimacy and respect produce better client outcomes than office-based monitoring and referral. Further, two randomised controlled studies of showed that case management programs did not add to extra cost due to reductions in total systems expenditure. Qualitative studies confirm that service users overwhelmingly value persistent, reliable, intimate and respectful relationships. Two studies found that in a client-case-manager relationship, highlighting common grounds between the parties mitigate the power distance, and counteracts the isolating effects of stigma. Similarly, peer-case management has the effect of social inclusion.

A persistent and reliable relationship over six-month period helps people increase their self-care capacity, and that supportive intensity varies dynamically over time. In one study, it was found that effective support occurred in the third year for those recovering from mental illness.

Service users and providers agree that respect is key to a successful intervention, and that a form of intimacy is critical (this was synthesised from 15 qualitative and four quantitative studies, with a combined total of 5,080 research participants, including people experiencing homelessness, service providers, and clients of mental health case management). Evidence also identified two dimensions of intimacy: genuine
emotional connection that creates a relationship, and the intimate nature of case management activities (such as shopping, attending appointments, providing rides). The element of intimacy does pose some practice concerns, such emotional ambiguity, power differentials, professional boundaries and expectations. The evidence implies the need for significant support for case management staff.

Finally, the empirical evidence does not conclude that either a single person or a team is best for case management. However, the identified qualities of the relationship are necessary regardless of the case management model.

Limitations of the case management relationship

The evidence implies that the client’s starting situation is a significant factor in the time it takes to achieve outcomes. There is some indication that a client’s personal characteristics may limit the formation of a relationship, such as a longer history of homelessness, higher level of psychiatric symptoms or drug use, and less education.

Comprehensive, practical support

Comprehensive, practical support refers to direct assistance with daily living activities. Two further elements are highlighted in the evidence base: assistance with housing, and access to specialist assistance such as psychiatric and substance abuse treatment. The evidence shows that access to housing is key to enabling the case management relationship to generate beneficial outcomes with people experiencing homelessness. A review of 16 evaluations found that case management alone is not as effective as case management with housing. Furthermore, higher housing retention rates are achieved when housing is not tied to substance use treatment, while still achieving equivalent substance use reductions.

Multi-disciplinary teams are found to be more cost-effective for people who require complex service response. One study found that such teams also experience significantly higher job satisfaction and lower burnout rates, and provided some evidence that access to relevant professional colleagues had positive effective on worker experience, rather than caseload. An example of a multi-disciplinary team composition would be: social workers, psychiatrists, vocational trainers, substance abuse counsellors, nurse practitioners and housing specialists. This particular program provided case management in conjunction with permanent housing.

6.1.3. Casework information provided by project partners

Anglicare Victoria

Table 1. Casework provided by Anglicare Victoria

<table>
<thead>
<tr>
<th>Type of casework</th>
<th># sites &amp; locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid caseworker in the ER program, with part of the role supporting volunteers. ER delivery includes: transaction, advocacy and referral and in some instances, casework and/or access to other casework services such as financial counsellor, family services.</td>
<td>Metro Melbourne: 5 Outer Melbourne: 2 Regional: 3</td>
</tr>
<tr>
<td>Volunteer run/delivered ER service comprising transaction, advocacy and referral and supported by a paid worker/coordinator.</td>
<td>Metro Melbourne: 4 Regional: 3</td>
</tr>
<tr>
<td>Paid worker delivering ER as part of their role in delivering another service (such as financial counselling and family services).</td>
<td>Metro Melbourne various sites</td>
</tr>
</tbody>
</table>
The Salvation Army

The Salvation Army Doorways hub/satellite delivery model. The Salvation Army funds case management under these models through a combination of FaHCSIA and their own funds.

What is a Doorways hub?

A Doorways hub is a central service from which clients can receive more in-depth assistance with their presenting needs. A Doorways hub will usually provide either case management or financial counselling services, together with other groups of programs that can assist clients beyond emergency assistance.

What is a Doorways satellite?

A Doorways satellite is a service that provides Emergency Relief to presenting clients. Satellites will work in partnership with hubs to provide ongoing and more in-depth support to clients. This partnership can be flexibly arranged with clients either being referred to the central hub for further support, or with case managers or financial counsellors from the local hub working a number of hours at a satellite centre to provide support to satellite clients.

How do hubs and satellites work together?

Hubs and satellites remain independent units in terms of management, finance, and administration. However, it is expected that hubs and satellites will work in partnership to provide the best outcomes for clients, through sharing of services, particularly case management and other in-depth supports to clients. Hubs and satellites will form ‘regional’ teams that provide the best support possible to clients in their region.

Table 2. Casework provided by The Salvation Army

<table>
<thead>
<tr>
<th></th>
<th>Number of sites</th>
<th>Number of case managers</th>
<th>Further information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Relief sites (national total)</td>
<td>237</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sites delivering ER – case management (Doorways) nationally</td>
<td>65</td>
<td></td>
<td>44 case management sites across Victoria, Tasmania, South Australia, Western Australia and Northern Territory</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>21 case management sites in New South Wales, Queensland and ACT</td>
</tr>
<tr>
<td>Current total case management/ caseworker staff.</td>
<td></td>
<td>47</td>
<td>47 case management staff with varying EFT from 0.2 to full time. Some of these case managers support multiple sites through the hub satellite delivery model</td>
</tr>
<tr>
<td>Planned expansion 2013/2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Projected increase in case management sites</td>
<td>37 new sites</td>
<td></td>
<td>11 new case management sites in Victoria.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>16 new case management sites in Queensland in 2014</td>
</tr>
</tbody>
</table>
### CISVic member agencies

**Table 3. Casework provided by CISVic agencies**

<table>
<thead>
<tr>
<th>Casework Model</th>
<th># models</th>
<th># casework programs</th>
<th>LGA (#sites)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment casework model and Generalist casework model</td>
<td>2</td>
<td>2</td>
<td>City of Frankston</td>
</tr>
<tr>
<td>Budget casework model and Casework/sector development model</td>
<td>2</td>
<td>2</td>
<td>City of Knox</td>
</tr>
<tr>
<td>Generalist casework</td>
<td>1</td>
<td>1</td>
<td>City of Boroondara</td>
</tr>
<tr>
<td>Generalist casework</td>
<td>1</td>
<td>1</td>
<td>City of Kingston</td>
</tr>
<tr>
<td>Generalist casework</td>
<td>1</td>
<td>1</td>
<td>City of Whittlesea</td>
</tr>
<tr>
<td>Generalist casework</td>
<td>1</td>
<td>1</td>
<td>City of Bayside</td>
</tr>
<tr>
<td>Generalist casework</td>
<td>1</td>
<td>1</td>
<td>City of Glen Eira</td>
</tr>
<tr>
<td>Generalist casework: 3 sites</td>
<td>1</td>
<td>1</td>
<td>City of Manningham</td>
</tr>
<tr>
<td>Generalist casework: 2 agencies</td>
<td>2</td>
<td>City of Greater Dandenong (2)</td>
<td></td>
</tr>
<tr>
<td>Generalist casework: 2 agencies</td>
<td>2</td>
<td>City of Casey (2)</td>
<td></td>
</tr>
<tr>
<td>Generalist casework: 2 locations</td>
<td>2</td>
<td>City of Port Phillip (2)</td>
<td></td>
</tr>
<tr>
<td>Generalist casework: 3 agencies</td>
<td>3</td>
<td>Shire of Mornington Peninsula (3)</td>
<td></td>
</tr>
<tr>
<td>Inter-agency, generalist casework 1 LGA: 2 locations</td>
<td>1</td>
<td>1</td>
<td>City of Whitehorse (2)</td>
</tr>
<tr>
<td>Inter-agency, generalist casework 2 LGAs</td>
<td>1</td>
<td>City of Monash (1) &amp; City of Greater Dandenong</td>
<td></td>
</tr>
</tbody>
</table>

**Total number of casework programs**

| Total number of casework programs | 22 |
| Total number of models           | 6  |

<table>
<thead>
<tr>
<th>LGA (#sites)</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Frankston</td>
</tr>
<tr>
<td>City of Knox</td>
</tr>
<tr>
<td>City of Boroondara</td>
</tr>
<tr>
<td>City of Kingston</td>
</tr>
<tr>
<td>City of Whittlesea</td>
</tr>
<tr>
<td>City of Bayside</td>
</tr>
<tr>
<td>City of Glen Eira</td>
</tr>
<tr>
<td>City of Manningham</td>
</tr>
<tr>
<td>City of Darebin (3)</td>
</tr>
<tr>
<td>City of Greater Dandenong (2)</td>
</tr>
<tr>
<td>City of Casey (2)</td>
</tr>
<tr>
<td>City of Port Phillip (2)</td>
</tr>
<tr>
<td>Shire of Mornington Peninsula (3)</td>
</tr>
<tr>
<td>City of Whitehorse (2)</td>
</tr>
<tr>
<td>City of Monash (1) &amp; City of Greater Dandenong</td>
</tr>
</tbody>
</table>

3. King, S. et.al. (2013) op.cit. p.39
6.2. APPENDIX B: SCOPING SURVEY RESULTS

What is your casework program?

You might like to consider things like who provides casework? Why is casework offered? Is there a target group for the casework program?

Types of casework

<table>
<thead>
<tr>
<th>Type of casework</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casework with identified groups</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>Caseworker and students deliver casework</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>Caseworker, volunteers and students deliver casework</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Caseworker and volunteers deliver casework</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>Casework and sector development role</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Generalist Casework</td>
<td>27</td>
<td>70%</td>
</tr>
<tr>
<td>Inter-agency casework</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>39</td>
<td>100%</td>
</tr>
</tbody>
</table>

Organisations offering casework: scoping surveys

<table>
<thead>
<tr>
<th>Type of casework</th>
<th>Council</th>
<th>CISVic</th>
<th>The Salvation Army</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalist Casework</td>
<td>12</td>
<td>13</td>
<td>1</td>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>Casework with specified client groups</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Casework delivered by caseworkers with volunteers and/or students</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Casework &amp; sector development</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Casework delivered by a financial counsellor</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Inter-agency casework</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>Total number of programs</strong></td>
<td>2</td>
<td>20</td>
<td>14</td>
<td>3</td>
<td>39</td>
</tr>
</tbody>
</table>
How do you deliver casework?

What are crucial elements of effective client outcomes?

<table>
<thead>
<tr>
<th>Skill-sets</th>
<th>Approach to casework</th>
<th>Attributes of casework</th>
<th>Systems/Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>Support</td>
<td>Client engagement/relationship building with clients</td>
<td>Service-knowledge, linkages &amp; referrals</td>
</tr>
<tr>
<td>Communication</td>
<td>Consistency</td>
<td>Caring</td>
<td>Professionalism: - worker skills,</td>
</tr>
<tr>
<td>Relationship building</td>
<td>Client focused/choice</td>
<td>Respect/trust</td>
<td>- experience, - networks</td>
</tr>
<tr>
<td>Appropriate referral</td>
<td>Flexibility</td>
<td></td>
<td>Worker support &amp; training</td>
</tr>
<tr>
<td></td>
<td>Time</td>
<td></td>
<td>Resources (currently limited)</td>
</tr>
<tr>
<td></td>
<td>Follow-up</td>
<td></td>
<td>Funding</td>
</tr>
<tr>
<td></td>
<td>Access/accessibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Solution-focused</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What are crucial elements for effective client-casework relationship?

<table>
<thead>
<tr>
<th>Skill-sets</th>
<th>Casework role in the relationship</th>
<th>Attributes of casework</th>
<th>Systems/Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening</td>
<td>Client engage/participate</td>
<td>Non-judgemental Trust</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Client-centred</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support (practical, emotional, focused)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Goal-setting</td>
<td>Empathy</td>
<td>Service knowledge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respect</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Honest</td>
<td></td>
</tr>
<tr>
<td>Problem solving</td>
<td>Empowering client</td>
<td>Rapport</td>
<td>Confidentiality</td>
</tr>
<tr>
<td>Professional</td>
<td>Resource for client</td>
<td>Encouragement</td>
<td></td>
</tr>
<tr>
<td>Appropriate</td>
<td>Follow-up</td>
<td>Transparency</td>
<td></td>
</tr>
<tr>
<td>referral</td>
<td>Follow-through</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transparency-based</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural competency</td>
<td>Prompt response</td>
<td>Rapport</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consistency</td>
<td>Encouragement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Validating client worth</td>
<td>Transparency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accessibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Team effort/partnership (with client)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intake process</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Client charter</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Needs assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Case plan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How do clients access your casework program? What is your intake criteria?

<table>
<thead>
<tr>
<th>Internal referrals to ER casework</th>
<th>Referrals to ER casework from other agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client self-presentation</td>
<td>Client self-presentation</td>
</tr>
<tr>
<td>Through the ER service:</td>
<td>Local agencies, government services (Centrelink), network contacts</td>
</tr>
<tr>
<td>• Assessed by volunteers/workers</td>
<td>• Financial counselling</td>
</tr>
<tr>
<td>• ‘Triaged’ to internal/external referral</td>
<td>• Housing service</td>
</tr>
<tr>
<td>• Central intake system</td>
<td>• Other ER providers</td>
</tr>
<tr>
<td>Other co-located services:</td>
<td>Two respondents do not take external referrals</td>
</tr>
<tr>
<td>• Family services</td>
<td></td>
</tr>
<tr>
<td>• Financial counselling</td>
<td></td>
</tr>
<tr>
<td>Informal process: phone calls and emails</td>
<td>Informal process: phone, fax, emails.</td>
</tr>
<tr>
<td>Internal referral forms (following assessment &amp; consent from client)</td>
<td>One respondent: phone &amp; written referral</td>
</tr>
<tr>
<td>One respondent: phone &amp; written referral</td>
<td></td>
</tr>
</tbody>
</table>

Intake criteria is fairly open – as long as clients have been identified as having complex needs, and whose issues cannot be resolved by one session, they are considered eligible for casework. Some agencies also report they actively offer casework to clients who re-attend for ER.

Is there currently a wait-list for your casework program?

Is there currently a wait-list for casework?

- **No**: 78%
- **Yes**: 22%

_n=18_

Wait-lists range from one to four weeks.
What is the average period of time client is provided with casework support?

<u>Average period of time client is provided with casework</u>

Clients seen over 12 month period:
‘Complex and multiple issues and MH [mental health] diagnosis. 75% of case load is over 12 months.’ Caseworker

When do you consider an appropriate time to close a client file?

Caseworkers report that files are closed when plans or goals are achieved. Disengagement by clients and onward referrals round out the three most commonly cited reasons for file closures. As capacity building is an important goal of their casework role, caseworkers also mention that clients exit the program when their lives are stabilised and they are ‘ready to go it alone’.

One caseworker mentioned that files are rarely closed, as clients often come back with new goals. Another reported that files are usually kept open because of the client’s complex issues. Yet, one caseworker reported that the preference is for a three to six month period of support, as this is sufficient time to address issues and deters dependency on the service.

‘Between three to six months seems to be an appropriate time to work intensively with a client, although in some cases, we have worked with some clients for about 12 months. This length of time helps build the relationship with the client, address their issues and deters the worker from creating a dependency on the service.’ Caseworker

There does not seem to be a hard and fast rule around exiting clients, as caseworkers and agencies acknowledge the nature of complex issues – which may reside in client characteristics (such as those diagnosed with mental health illness, or acquired brain injury), systemic issues (such as inadequacy of welfare support, housing affordability) or long-term unresolved problems (family violence or inter-generational poverty). Ultimately, the goal of casework, like case management, is to achieve goals negotiated with clients at the outset, and hopefully, move clients out of the welfare system.
Do you refer clients?

Referrals made by caseworkers

- Utilities
- Support groups
- Specialist services
- Skills
- Microfinance
- Mental health
- In-house
- Housing
- Health
- Government agencies
- Financial Counselling
- Family services
- ER/material aid
- Counselling

Number of mentions in caseworker surveys

External referrals by caseworkers, n=31
Internal referrals by caseworkers, n=30
As a caseworker, do you work with other services/workers to achieve client outcomes?

- **No**: 3%
- **Yes**: 97%

**FMP services that caseworkers most frequently work with**
- Financial Counselling: 46%
- ER/material aid: 46%
- Microfinance: 8%

**Mode of referrals by caseworkers**

- **Phone**: 20 mentions
- **Formal**: 13 mentions
- **Informal**: 6 mentions
- **Email**: 6 mentions
- **Client self-refer**: 3 mentions

Number of mentions in caseworker surveys
What resources are required for the casework program?

**Human resources**

Are volunteers involved in your casework program?

- **NO** 28%
- **YES** 72%

**Funding**

Casework program with one source of funding (n=18)

<table>
<thead>
<tr>
<th>Funding source</th>
<th># Agencies</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>FaHCSiA</td>
<td>3</td>
<td>normally between 2-3 days per week</td>
</tr>
<tr>
<td>Federal DHS</td>
<td>1</td>
<td>0.6EFT</td>
</tr>
<tr>
<td>Local government</td>
<td>1</td>
<td>36 hours per week</td>
</tr>
<tr>
<td><strong>Total (n=)</strong></td>
<td><strong>5</strong></td>
<td></td>
</tr>
</tbody>
</table>
Casework programs with multiple sources of funding (n=18)

<table>
<thead>
<tr>
<th>Funding source</th>
<th># Agencies</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>FaHCSIA + other</td>
<td>3</td>
<td>Council (2) and Provisional psychologists support the casework for personal counselling (1)</td>
</tr>
<tr>
<td>FaHCSIA + philanthropy</td>
<td>1</td>
<td>0.3EFT paid by FaHCSIA, 0.1EFT paid by funding from a local business</td>
</tr>
<tr>
<td>FaHCSIA + self-funding</td>
<td>9</td>
<td>Self-funded to cover short falls</td>
</tr>
<tr>
<td><strong>Total (n=)</strong></td>
<td><strong>13</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Reporting & compliance**

Respondents identified internal policies and procedures, FaHCSIA reporting requirements and data management systems as the main source of compliance and reporting frameworks for casework. Half-yearly or yearly reporting were the most common, with monthly reporting to management reported as part of internal processes. The Salvation Army has an internal electronic system used to record all assistance and dealings with clients, as well as policies and processes that managers report they comply with as required.

The uses of database and data management systems were mentioned, although there was also concern around the costs to these. One manager reported that their system was developed with the assistance of IT students under an Industry Experience project, whilst another agency is still grappling with finding the right computer database to make information retrieval easier – ‘we are] a small not for profit organisation. We struggle with an out-dated computer system and constantly seek funding to update it to ensure organisational reporting requirements are met.’

Alternatively, some agencies report that there is little differentiation between the way they report on casework compared with other programs, and utilise organisational policies and procedures (including annual financial audits and reporting to boards) as benchmarks for reporting and compliance.
What skill-sets & support are required for the casework program?

Qualification

<table>
<thead>
<tr>
<th>Caseworker qualification</th>
<th>n=18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate III/IV</td>
<td>16%</td>
</tr>
<tr>
<td>Advanced Diploma</td>
<td>6%</td>
</tr>
<tr>
<td>Bachelor Degree</td>
<td>11%</td>
</tr>
<tr>
<td>Graduate Degree</td>
<td>67%</td>
</tr>
</tbody>
</table>

Supervision and support

Survey respondents report that caseworkers are provided with both formal and informal supervision, with formal supervision sometimes occurring off-site. On-site support, such as debriefing opportunities, supervision meetings and peer supervision are also cited. Off-site support, such as formal supervision arrangements, one of which includes peer supervision with employed counsellors, and network meeting that provides peer support have also been reported. Volunteers are provided with on-site support through debriefing, supervision support and planning sessions. The provision and availability of training is not only a recruitment and retention issue, but in an environment of increasing complex needs and new ER clients, the quality of volunteer service, their access to up-to-date information, and continuing engagement with stakeholders and other community services are crucial to effective and efficient service delivery.

Professional development

Managers report that professional development opportunities are available to caseworkers, either on a regular basis, such as in-service training, or external training identified by caseworkers. Managers also utilise funding for professional development.

Where is your casework program?

A total of 49 caseworkers and managers responded to surveys. Managers and Caseworkers surveys were cross-referenced resulting in 39 casework programs offered in 49 sites across Victoria (36) and Tasmania (10) with three unknown.
Casework programs offered in sites across Victoria and Tasmania with three unknown.

<table>
<thead>
<tr>
<th># Casework sites</th>
<th># Casework programs</th>
<th>Metro/Regional</th>
<th>LGA</th>
<th>State/Territory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Metro</td>
<td>City of Bayside</td>
<td>VIC</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Metro</td>
<td>City of Casey</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>Metro</td>
<td>City of Clarence</td>
<td>TAS</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>Metro</td>
<td>City of Darebin</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Metro</td>
<td>City of Frankston</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Metro</td>
<td>City of Glen Eira</td>
<td>VIC</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Regional</td>
<td>City of Greater Bendigo</td>
<td>VIC</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Metro</td>
<td>City of Greater Dandenong</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>Regional</td>
<td>City of Greater Geelong</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Regional</td>
<td>City of Greater Shepparton</td>
<td>VIC</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Metro</td>
<td>City of Kingston</td>
<td>VIC</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>Metro</td>
<td>City of Knox</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Metro</td>
<td>City of Manningham</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Metro</td>
<td>City of Melbourne</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Metro</td>
<td>City of Melton</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>Metro</td>
<td>City of Monash</td>
<td>VIC</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Metro</td>
<td>City of Port Phillip</td>
<td>VIC</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Metro</td>
<td>City of Whitehorse</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Metro</td>
<td>City of Whittlesea</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Metro</td>
<td>City of Yarra</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Regional</td>
<td>Shire of Mansfield</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Regional</td>
<td>Shire of Moira</td>
<td>VIC</td>
</tr>
<tr>
<td>9</td>
<td>3</td>
<td>Regional</td>
<td>Shire of Mornington Peninsula</td>
<td>VIC</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Regional</td>
<td>South Gippsland Shire</td>
<td>VIC</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>Regional &amp; Metro</td>
<td>Statewide</td>
<td>TAS</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

49 39 25
What is the size of your organisation?

<table>
<thead>
<tr>
<th>Agency size by staff number</th>
<th>n=14</th>
<th>n=17</th>
</tr>
</thead>
<tbody>
<tr>
<td>over 50</td>
<td>6%</td>
<td>14%</td>
</tr>
<tr>
<td>15 to 50</td>
<td>6%</td>
<td>43%</td>
</tr>
<tr>
<td>5 to 15</td>
<td>14%</td>
<td>23%</td>
</tr>
<tr>
<td>1 to 5</td>
<td>41%</td>
<td>47%</td>
</tr>
</tbody>
</table>

Is there anything about your community and service context that you would like to share?

Regional services

Regional agencies describe a broad geographic catchment area and face challenges around resourcing and funding.

‘We also are a border town and have cross border issues around funding and service delivery for a community that is funded by another state.’ Manager

City of Greater Bendigo agencies service a town of 120,000 people of low to middle income, as well as a large proportion of welfare recipients. Additionally,

‘[M]any clients are Aboriginal and we are increasingly seeing more refugees and asylum seekers. Single parents make up a large proportion of our client demographic.’ Manager

‘Housing and homelessness is also an issue for the City of Geelong, where an ER agency

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‘also assist[s] a number of homeless/transient individuals and families. Mainly from Corio/Norlane and Whittington areas large areas of government housing, large percentage in receipt of income support, low school retention, low school achievement and a large number of sole parent families. Problems include: substance abuse, domestic violence, mental health issues, and health issues.’ Manager

Growth corridors

Growth corridors, with their lack of public transport, accessible services and social isolation pose unique issues for communities. For example, the City of Casey has:

‘[H]igh demographic of young families and highest multicultural population in Victoria. High incidence of family breakdown and family violence. High incidence of households in mortgage stress and financial distress.’ Manager

‘This area has a large number of families, many singles living in unregistered rooming houses, and many singles and families struggling with housing stress and cost of living expenses. We are now seeing more single parents losing income due to being transitioned to Newstart, and they are reporting going without food to pay the rent and bills.’ Manager

Client issues

<table>
<thead>
<tr>
<th>Health</th>
<th>Family &amp; life transition</th>
<th>Financial</th>
<th>Policy impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction (including gambling)</td>
<td>Asylum seekers entering community</td>
<td>Bankruptcy</td>
<td>Government income management issues</td>
</tr>
<tr>
<td>Alcohol related issues</td>
<td>Births, deaths, divorce</td>
<td>Business failure or loss of employment</td>
<td>Moving from Parenting Payment to Newstart</td>
</tr>
<tr>
<td>Costs &amp; issues associated with health</td>
<td>Entering or exiting rehabilitation</td>
<td>Contract dispute</td>
<td></td>
</tr>
<tr>
<td>Drug abuse and related issues</td>
<td>Family violence and breakdown</td>
<td>Credit / debt or financial mismanagement</td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td>Housing &amp; homelessness</td>
<td>Financial literacy and/or budgeting</td>
<td></td>
</tr>
<tr>
<td>Physical limitations due to accident / disease</td>
<td>Moving homes or interstate</td>
<td>Gambling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relationship break down</td>
<td>Inadequate income</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rent arrears</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What makes casework work for clients with complex needs?

<table>
<thead>
<tr>
<th>Casework mechanism &amp; context</th>
<th>Survey responses</th>
</tr>
</thead>
</table>
| Mechanism - relationship with client | Respectful, trusting relationship with client  
Client engagement and rapport  
Provision of intensive support, education & guidance  
Provision of consistent, ongoing, flexible and meaningful support  
Client centred, needs-based, focus on needs, goals & actual outcomes |

| Context – staffing issues (skills, training, supervision) | Ongoing training  
Caseworker skills: high-level skills, administrative skills, ability to research solutions  
Staff retention |

| Context - service system design and capacity | Access: continuity, accessibility  
Effective policies and procedures that includes: clear role demarcation between volunteers and caseworkers, clear decision-making process, best practice guidelines, clear exit point  
Well-resourced: funding; brokerage; technology  
Service linkages: effective referral pathways (internal and external), linkages and collaboration with other service providers, use of interpreters, relationship with other service providers  
Strengths-based model, solution focus, triage system  
Flexibility |

| Client rights and responsibility | Clear boundaries between client and caseworker  
Client rights |

| Outcome satisfaction | Client feedback  
Consumer involvement |

| System performance | Data collection  
Client feedback |
6.3. APPENDIX C: CONSULTATION WITH CASEWORKERS & SERVICE MANAGERS

6.3.1. Caseworker Roundtable Discussion Outcomes

Key question: Best practice – what does this mean for casework in ER?

Caseworkers see ER as a pathway, and an opportunity to address the underlying issues of clients who attend for ER but have complex needs which can be addressed through provision of casework support. What emerges is a series of models that work within the context of community, agency and clients’ needs. Caseworkers work within the boundaries set by organisational context/philosophy, client needs, available resources and the policy landscape that impact on clients’ situations. This makes identifying an overarching best practice approach as one that must be a work-in-progress. Not only because this is an emerging area of practice, but because there are ‘communities of practice’ that are situated within the ER landscape. These communities of practice are: information & support; asylum seeker; community health; and homelessness.

There are commonalities in approaches and practices that work across models, and which correspond with case management best practice approaches in other sectors (such as health, homelessness, aged services). However, it is also important not to forget that context plays a crucial role in what makes casework work for client attending ER services. Casework mechanisms, as much as caseworker skill, organisational and social policy contexts and resources, all intersect to determine caseworkers’ capacity to effectively respond to client needs.

When asked the question: what is the measure of success of casework? The group responded by identifying the following indicators:

- Clients’ goals are met
- Clients effectively disengaged
- Clients linked to another service
- Clients stop coming in

Client outcome is at the forefront of casework intervention. Challenges around policy and practice impinge on the casework process, but for caseworkers, the ultimate goal is to ensure clients’ needs are met and that the service itself becomes one that is no longer required.

Challenges within a shifting policy landscape, and with limitations on practice include the following aspects:

- Impact of Single Parent Pension to NewStart was discussed as being seen on the ground: single mums who have had long-term plan to study whilst children are in school have plans cut short due to reduced funds
- Impact of increasing number of asylum seekers in the community: eligibility criteria for access to ER such as requirement for Health Care Card and Pension Card
- Interpreters: other services either do not know or have barriers to using interpreters, a source of frustration for caseworkers working with CALD clients
- Balancing between clients’ needs with organisational policies and eligibility criteria
- Outreach - no known policies and procedures in place - but they should be if outreach is done. The community health service has one, this is because the caseworker adopts the allied health outreach model. This includes: having a mobile phone whilst doing outreach; designate a time to be back at the office; buddy system with another worker or receptionist; carry an ID. Outreach work has potential for capacity building through role modelling with client when making visits to other services, systems navigation and service engagement
- Lack of access to specialist services puts a strain on casework capacity to deal with complex needs clients who may need to pick up on the more specialised support
Discussion about best practice in casework included the following:

- Advocacy, service linkages, and support and assistance is seen as important
- Co-location is seen as a positive
- Cases are left open, especially if long-term clients, as caseworkers expect clients to re-attend for support
- Access to casework (usually through ER service) is important
- Flexibility (allocation of support; balancing needs of client with policies and eligibility criteria; access to brokerage funds) is key
- Clear boundaries between volunteers who provide ER and caseworkers who work with client issues is important
- Using the same terms, forms and words across programs to reduce confusion and enhances integration
- Caseworkers work in close physical proximity to volunteers and ER workers to provide immediate assistance, support and access
- Networking with other caseworkers through network meetings is important, especially as this is an evolving practice area
- Agency context/philosophy that aligns with casework model provides transparency, clarity around service provision

6.3.2 Service Manager Roundtable Discussion Outcomes

Flexibility is a key component in the provision of casework. This is mainly due to the complexity of issues presented by clients and the need for agencies to work from a client centred approach. There should be a basic model of delivery that incorporates flexibility and includes the following aspects:

- A responsive service where clients can trust is positive. This aspect in other services is challenging when systems run out because the ‘three months of funding is up’. The flexibility inherent in the ER funding model enables agencies to respond in the best way we see using client centred practice that is place based and an empowerment model
- Assessment/planning & goals; the most effective response to complex needs clients is providing flexibility in casework
- Recognising and acknowledging that ER is the gateway to assessment from the start
- Understanding and recognising there will be challenges and difficulties in encouraging clients to participate/engage and that this aspect may also relate to a contractual philosophy and an agency’s position
- Challenges in identifying legitimate needs and eligibility but often, resources and funding do not provide for. It is also hard to work with other agencies collaboratively when there are contractual and operating constraints
- Length of time clients are seen/supported for; average is three to six months, however, flexibility is exercised to ensure client is satisfied issues are resolved – client focused
- ER can facilitate a ‘one stop shop’ for case management, counselling, therapy, food, advocacy
- Client context is important – trust and consistency
- Casework is about completing a comprehensive assessment with a plan and reachable goals
Discussion about the agency experience in delivering generalist casework:

- Casework has allowed agencies to support clients with complex needs that traditional ER provision did not allow for before
- There are sensitivities when a bottom line exists where income is insufficient, how is this dealt with at a higher/broader level? The survival strategy is accessing services and resources and having the dollars stretch to ensure people aren’t denied access to ER
- We see clients present with an/multiple issue(s), it/they get resolved through empowerment, they sometimes appear again for different issues. However, the process provides support which empowers a client further, providing strength for new issues
- Continuity is important as we now have been offering casework for some time
- There is a need to define flexibility within casework – casework as a series of short brief interventions?
- Referral pathways to casework in ER: ER is the gateway, internal and external (legal and asylum seekers agencies), GP’s, social workers, community members in neighbourhoods including reciprocal referral

Client outcomes:

- Complex clients have numerous goals that need to be met; a good starting point is to prioritise the most important/urgent need or one that would give the best outcome for the client to feel positive enough to tackle other issues
- Internal agency connections between staff are important, so clients know they have their caseworker but that the whole team is also there for the client, too
- We work in a structure where the system is already broken and you constantly work within the best means available to you

Human resources involved in providing casework in ER:

- The use of volunteers is fundamental to our structure; particularly the use of student volunteers (supervised) preparing to enter the workforce
- The use of students also provided a contribution to an agency’s capacity building initiatives
- Staff retention issues are minimal and relatively stable among participating manager representatives

Qualifications supervision and training:

- The experience of participants suggested those qualifications in the fields of social/welfare work (diploma and higher education) and a diploma as a minimum. Work experience was the alternative qualification including at least several years of counselling/working with welfare clients
- Qualified social workers are extremely valuable as they have the capacity to provide supervision to other staff (including volunteers/students etc.) including at times, clinical supervision
- Training offered by agencies was varied but mostly included: induction training, specific caseworker training (client engagement), supervision (both one to one and group), and ongoing refresher training
• One experience described a hierarchy system for multiple volunteers working across the agency, this is fundamental to volunteer management and assists with monitoring skills levels across your organisation/agency
• Supervision arrangements typically involve internal supervision as there was usually no funding for external supervision (also described as quite expensive). Where external supervision occurred, this was extremely valuable for the supervisors conducting internal supervision
• If funding was available to conduct external supervision this would be of great value to agencies. There is immense appetite for external supervision

Funding:
• It was acknowledged that some base funding made up the core amount for the provision of casework, however, in many instances this was supplemented by other sources of income e.g. FaHCSIA funding with internal agency funding support (donations/fundraising)
• 25% of ER funds that are put towards paying staff for the provision of casework is not enough to cover all staff costs. Agencies typically leverage resources from other external agencies or source funds internally to help make up the shortfall
• As agencies approach the end of a financial year tougher decisions are made when demand for service continues upwards (including the presentation of new clients to the service)

Innovation and further comments:
• In a north-west region of metropolitan Melbourne a unique community and history has played a role in the diversity and number of activities, subsequent ER program, and community strengthening. ER is an opportunity and a meeting point for residents and community activities and events have been conducted over the years due to historical traditions of community members. Initiatives are born out of ER and the community continues to play a role in taking care of those at risk of isolation
• Agencies agreed around the table that as they provide casework in ER, they wish to do more of it. All participant managers agreed that if they had more resources and funding for case management, they would provide more of it
• All agreed - casework supports the agency’s response to complex needs clients
• There are challenges in demonstrating and/or proving that casework makes a significant difference to complex needs clients i.e. clients are not coming as much for ER as a result
• Agency managers are seeking sustainable approaches into the future; there is a continuous challenge in supporting clients’ needs with the available resources
6.4. APPENDIX D: KEY DEFINITIONS

**Casework** is defined as assessing people’s problems, planning the action to be taken, implementing the action, which may include the caseworker taking responsibility for all tasks, referring some or all tasks to specialists and retaining overall responsibility for case management (Compton & Galaway, 1994).

**Communities of practice** refers to a group of people who share a concern or passion for something they do and learn how to do it better as they interact regularly. Although the term is recently coined by Etienne Wenger and Jean Lave, the phenomenon is an old one. Three characteristics are crucial to a community of practice:

- **the domain** needs to be a shared domain of interest, with commitment to the domain by a membership that values and shares a level of competency where they could learn from each other, even when few outside the group may value or even recognise their expertise

- **the community** in which membership of the group engages with each other is one where members engage in joint activities and discussions, help each other and share information. They build relationships that enable them to learn from each other

- **the practice** means that members of the community of practice are practitioners. They develop a repertoire of resources and a shared practice through ongoing and sustained interaction

**Emergency Relief** had undergone a few definitions over the years. Engels (2006) charted the changing boundaries within which emergency relief was defined, which reflected the political and policy environments at the time. Thus, in the 1970s and 1980s, disagreements abound as to how emergency relief was defined, sometimes narrowly, sometimes broadly, so that by the early 1980s, emergency relief was defined as:

‘...the provision of once-off assistance, and with increasing frequency, ongoing assistance to people experiencing continual and recurring crisis...’ (VERP, 1982:4)

Emergency relief normally refers to the provision of material aid (such as food, clothing, meals or other basic material needs) or assistance with utilities or other pressing debts that if unpaid, could threaten a basic right to food, shelter and education. Originally envisaged as once-off assistance, it has increasingly become apparent to those in the ER sector that the majority of ER seekers come from a section of the community that are disadvantaged or socially and/or economically excluded (Anglicare, 2010).

FaHCSIA’s definition of emergency relief is one that we see as most aptly applies to emergency relief, being:

‘...to assist people in financial crisis to deal with their immediate crisis situation in a way that maintains the dignity of the individual and encourages self-reliance.”

**Integration** usually refers to various forms of working together: service linkages, collaboration and cooperation within an agency or amongst different agencies. FaHCSIA’s Financial Management Program Guidelines encourage an integrated approach to service delivery to improve client outcomes. Collaboration and partnerships with services and agencies are also encouraged as part of a broader strategy to build financial and social well-being for vulnerable clients (FaHCSIA, 2013).

The World Health Organisation European Office for Integrated Services’ definition of integration is one that is most commonly cited:

“**Integrated care is a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health**
There is highly developed, but diverse literature on typologies of integration. The components of a typology of integration include the intensity or degree of integration (fragmented to full integration) and the ingredients, dimensions and working arrangements surrounding integration. Also important to an understanding of integration is whether services are integrated horizontally (between agencies) or vertically (within agencies), as well as clients’ experience of integrated care (Flatau et al, 2010).

Place-based or place management is used interchangeably. Green & Zappala (2000) provided the most relevant definition for community based organisations. Place-based or place management usually refers to policies and approaches that target ‘places of disadvantage’ and involve the delivery of government level services that harness the gamut of services (government, private and community) and expertise in a given location, in order to deliver outcomes that redress entrenched disadvantage. They are characterised by high levels of collaboration, coordination and consultation, with recognition of the need for local solutions to long-term problems. The model providers for a ‘place manager’ who facilitates and coordinates service providers in a process of identifying needs, local solutions to long-term problems and increase social capital and possible systemic change in order to deliver socially beneficial outcomes. 

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6.5. REFERENCES


Brachertz, N. (2012) I Wish I’d Known Sooner!: the impact of financial counselling on debt resolution and personal wellbeing. Melbourne: The Salvation Army Australia Southern Territory


CMSA Standards for Practice for Case Management (2010) can be found at http://www.cmsa.org/

CMSUK Standards & Guidelines for Best Practice (2009) can be found at http://www.cmsuk.org/


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WACOSS (2012) Giving Shape to the Emergency Relief Sector: Emergency Relief Scoping Paper, Mapping ER delivery across Western Australia, Perth, Western Australia: WACOSS

Western Australian Council of Social Services (WACOSS, 2012) Giving Shape to the Emergency Relief Sector: Emergency Relief Scoping Paper, Mapping ER Delivery across Western Australia, WACOSS: Perth
