Acknowledgements

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ANGLICARE Diocese of Sydney is the urban mission and welfare arm of the Sydney Anglican Church. ANGLICARE has been making Christ’s love real to people in need for over 150 years. Each year, ANGLICARE reaches out to thousands of people, bringing Christian care and support to those struggling with poverty, disability, illness and despair.

ANGLICARE services include emergency relief for families in crisis; foster care and adoption for children and those with special needs; counselling and support for children and youth with disabilities; migrant services; aged care through both nursing homes and community services; opportunity shops providing low-cost clothing; emergency services in times of disaster and chaplains in hospitals, prisons, mental health facilities and juvenile justice institutions.

Our Vision: Lives changing and communities growing by care through Jesus Christ.

Our Mission is to care:

- By doing good works that grow communities and address emotional, social and physical needs, and which are the fruit of the gospel of the Lord Jesus Christ.

- By seeking to bring the gospel of the Lord Jesus Christ that alone meets spiritual needs.

- In partnership with churches where possible, and the wider community where appropriate.
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Executive Summary

There are many people in our community who face multiple deprivation and experience social exclusion. This report uses longitudinal demographic data (July 2007 to February 2009) from seven ANGLICARE Emergency Relief centres to describe the different facets of deprivation that clients experience. It gives voice to clients by presenting qualitative results from a series of focus groups in which they shared what it was like to use emergency relief services. They describe powerfully the impact of social exclusion on their lives. ANGLICARE therefore argues that it is imperative that we, as a community and as a sector, develop a model of emergency relief that enhances capacity building, empowers individuals with choice and opens up new opportunities so that lives can change.

Emergency Relief (ER) is at the hard end of poverty. In its most basic form it is assistance (usually provided by community agencies) to people experiencing financial hardship or crisis. This may take the form of food parcels or vouchers, cash, support with utility bills, and sometimes household goods and clothing. It can also involve the provision of micro finance via the No Interest Loans Scheme (NILS).

Many people access these services only, in their own words, ‘when they are desperate’. ANGLICARE has long worked in the field as part of its wider ministry to the community and is increasingly coming to the view that, for positive outcomes to be achieved, both for individuals and community, the current service model needs to be transformed. This paper provides a statistical insight into the nature of poverty and its by-products of deprivation and exclusion. It highlights the particular groups of people who are vulnerable and at risk, and establishes new ways forward in terms of practice and policy.

Why use the social exclusion framework?

The social exclusion framework is one which has been adopted by the current Federal government and one which has been utilised for more than a decade in Europe to frame social service delivery and outcomes. What is the difference between income poverty, deprivation and social exclusion?

While poverty is usually conceived in terms of income – the minimum income required to survive – deprivation goes one step further along that continuum. It takes into account those material aspects of life which may not be accessible to those experiencing hardship.

Social exclusion is at the other end of the continuum because it considers the individual’s capacity to participate in society – economically, socially and in terms of civic engagement. The quantitative data analysed in this report indicates both poverty and deprivation. The social exclusion perspective is provided by the voices of the clients themselves – those who experience such exclusion on a daily basis – via focus groups.

Who are the most vulnerable and at-risk groups?

This 20 month survey of seven ANGLICARE ER centres and almost 13,000 clients of these centres indicates an over representation of people who are:

1 Focus group comment.
There is a significant proportion of the people who access ANGLICARE ER services that experience insecure housing – living in boarding houses, squats, refuges, cars or on the streets. The greater proportion of ER clients survive on incomes of less than $600 per fortnight and 95% receive government assistance. Just under half (43%) of these households have children and 58% of clients representing these households receive incomes of less than $1,000 per fortnight. A longitudinal analysis of these groups over the 20 month period of the study does not indicate any changes in the basic profile of these ‘at risk’ groups.\(^2\)

**What are the reasons for accessing ER?**

People access services for a variety of reasons. The overwhelming issue is a lack of income making it difficult to manage finances, which can include significant debt, the payment of bills and trying to avoid hunger. There are however, other issues, which include: physical health, accommodation and housing, issues with children and, for carers, mental health issues. In the delivery of services people do not just receive material assistance in the form of food, cash, vouchers and assistance with bills. Services also provide information about other agencies and about how to navigate the service network, advocacy to that network and assistance with developing budgets.

The catchment areas for ANGLICARE’s ER centres are distinct; while service users are drawn from 116 postcodes, almost one third of clients are resident in just four postcodes.

**What is the ER experience?**

For most, approaching an ER service is a humiliating and embarrassing experience. In the focus groups conducted by ANGLICARE, clients spoke of a lack of control and of a sense of shame so that some would only access the service when they were desperate. The service experience by and large appeared to be a positive one provided service staff treated people with dignity and respect. For some, the outcomes were an improvement in budgeting, being able to eat that week or feeling more in control as bills could be paid. Reinforcing the quantitative findings, the discussions with clients revealed the complexity of needs and multiple deprivations of many.

**The future of Emergency Relief**

An alternative service model is needed that enhances capacity building, empowers individuals with choice and opens up new opportunities so that lives can change. The current transactional ER model does not address the complexity of need or address the issues of social exclusion. At an agency level ANGLICARE is currently

exploring innovative models of best practice ER service delivery. However, much more is required of Government in the effective funding of ER case management and case coordination, data capture, quantitative and qualitative research, as well as support for further infrastructure development.
1. Introduction

ANGLICARE Sydney is currently one of the most significant providers of Emergency Relief (ER) in NSW, operating across seven service sites. ANGLICARE Sydney has been providing ER services for more than 40 years. In 2007 a decision was made to develop an ER data capture system. Concurrent with data capture there has been ongoing planning within ANGLICARE to develop a new and more effective model of service delivery through a review of the research literature, workshops with staff and client focus groups.

This report endeavours to provide, through statistical analysis, the material reality of poverty – who are the people experiencing it and what are the issues. However, in and of itself, such data can imply but not describe the nature of the experience. That is best left to those who know it so well – the people who come through the doors of the Emergency Relief (ER) services accessing assistance. In order to provide a clearer picture of poverty, focus groups were conducted across a number of ANGLICARE service sites. Information gathered from these groups has been utilised in this report.

This report presents the story of our ER centres and their clients in the following way. It:

1. Provides the theoretical framework for understanding the concept of social exclusion
2. Explores the demographic characteristics of our service users
3. Analyses the type and amount of assistance and other help provided by our ER centres to clients
4. Explores further a number of emerging features of social exclusion identified in the literature; and
5. Provides some reflections and recommendations for the practice and policy of ER service delivery.
2. The Social Exclusion Framework

2.1 Why this framework is used for this study

The election of the Federal Labor Government in November 2007 brought the concept of social inclusion/exclusion onto the public agenda as an important framework for Government policy. The reality was that before then, the concept had been used almost as a footnote by Government in the shadow of more well known concepts of poverty and deprivation. It was not generally part of government discourse nor were there any major studies on the Australian experience of social exclusion.

The social exclusion concept is not new – it had its origins in France in the 1970s – but became a term more widely used in the late 1980s to describe the results of radical economic and social changes that were sweeping Europe at the time. It was increasingly adopted in the UK and European policy arenas because of dissatisfaction with the concept of poverty which was seen as narrowly focusing on distributional issues (income). Exclusion was seen as being more focused on relational issues such as social participation and integration, power and opportunity. It considered the impact of current living standards on future life chances which is particularly important for children. Social exclusion increasingly became a term used to describe multiple hardships including unemployment, low levels of literacy and skills, poor health, and poverty, and the way these factors interact to exclude people from participating in mainstream society.

Social exclusion is a relative concept. It 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. This interconnectedness across domains gives rise to issues not just of economic but also social integration. It also expands the concept of poverty from just the household to the wider community and it is at this point that it becomes inextricably entwined with social capital. There are a variety of terms which have been substituted for social exclusion throughout the literature including marginalisation, social disintegration, impoverishment and deprivation. The counterpart terms to social exclusion have been varyingly social inclusion, integration, cohesion or participation.

Social exclusion is likely to occur where there is not just poverty but multiple disadvantage. This is a key point. Petra Bohnke, in a seminal paper in 2001, came to the following conclusion:

“Poverty can be seen as one precondition of social exclusion, but not necessarily, and above all, not exclusively….The most decisive precondition of perceived limitations to participate in society is the accumulation of disadvantages.”


The rapid European take-up of exclusion as a framework for policy direction occurred because it was seen as having a multi-faceted explanation of poverty which in turn led to a multi-faceted policy approach. To some extent this was supported by the work of the Indian development economist and
Nobel Laureate, Amartya Sen, who considered that escaping poverty and its intergenerational anchors could be measured by the degree of freedom one has over life’s choices.

This broader social exclusion canvas has been well defined by Megan Thibos and others:

> While the very definition of poverty implies the inability to meet basic needs such as food, clothing, or shelter, being poor also implies the absence of choice, the denial of opportunity, the inability to achieve life goals, and ultimately the loss of hope.  

In the Australian context the current social exclusion policy brief is very wide – encompassing homelessness, disability, ageing, jobless households, unemployment, early childhood, education and transport. There are also clearly established policy priorities – children in jobless households and at risk, people in situations of long term disadvantage, geographical exclusion, homelessness, disability or mental illness, and indigenous Australians.

Emergency Relief encompasses both the poverty and the exclusion experience. It is often the last port of call in a 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. What emerges from the ER data in this report is confronting and challenging evidence of poverty, deprivation and social exclusion in Sydney.

### 2.2 Definitional issues

Between 2006 and 2007 ANGLICARE Sydney participated in a joint research project with the University of NSW Social Policy Research Centre and a number of community agencies. The research endeavoured to develop New Indicators of poverty, deprivation and social exclusion. It centred on a randomly sampled national survey and a targeted survey of community agency clients. This work has currently been extended as a national study. For the purposes of that research clear definitions of poverty, deprivation and social exclusion were created. This current ANGLICARE ER study uses these definitions as an operational framework while acknowledging that there is a raft of literature on each of these concepts.

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Poverty is a situation in which someone’s income is so inadequate as to preclude them from having an acceptable standard of living. It exists when people’s actual income is below a poverty line.

Deprivation exists when a lack of resources prevents people from accessing the goods and activities that are essential. Following international convention, it is defined as an enforced lack of socially perceived essentials.

Social exclusion exists when people do not participate in key activities in society. Whereas deprivation focuses on what people cannot afford, what matters for exclusion is what people do not do.

Poverty, deprivation and social exclusion are distinct but overlapping concepts. They cover what most people understand by the term ‘social disadvantage’, which involves restricted access to resources, lack of participation and blocked opportunities. 

2.3 Who is vulnerable?

Findings from the New Indicators study indicated that deprivation was four times higher for the client survey sample than for the national random sample. Further there was evidence of multiple deprivation across a range of mutually agreed key indicators which were considered essential for a reasonable quality of life.

The ER data provided in this report shows that for almost 13,000 people using ANGLICARE services in a 20 month period, there is incontrovertible evidence of poverty (in the sense of low income) and deprivation. Qualitative data, based on focus group reporting, also supports the view that such poverty and deprivation is accompanied by significant levels of social exclusion.

The New Indicators study identified that poverty and deprivation in Australia is highest among

…Indigenous Australians, sole parent families, public housing renters, and the unemployed. On average, those renting privately fare little better than public renters.

The ANGLICARE ER data has an over representation of Indigenous people, single parent and sole person households, women and people in public housing. It is this profile which will be more fully explored throughout the remainder of the report.

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6 Ibid

7 Ibid p.ix
3. Trends And Demographic Characteristics

As part of identifying the characteristics of deprivation and social exclusion among the users of ER services, a starting point is to create a profile of ER users themselves. The general picture that emerges is as expected: people who are largely dependent upon income support payments, often living in public housing and with health related issues. The picture will also show that many service users are subject to multiple disadvantage with varying needs, which has implications for the goals and shape of ER services.

3.1 Trends and the impact of the Global Financial Crisis

Over the 20 month period, July 2007 to February 2009, 12,863 service users accessed services through some 27,000 visits. For both years there was a rise in the second half of the year. For both years there was a seasonal drop off in January. Traditionally, the ER services which are heavily reliant on volunteers close for some of the January period, as volunteers take leave. This drop in demand was furthered, according to ER Coordinators, by the Federal Government’s Christmas bonus which mitigated hardship temporarily. Apart from the number of visits, another indicator of need being met is the level and types of assistance being provided. Over the 20 month period this assistance was valued at $2.77m and included:

- Cash - $15,180
- Cheque/Creditor - $403,029
- Food - $1,132,631
- Assistance with electricity and gas payments through the Energy Accounts Payment Assistance (EAPA) scheme – $970,440
- Telstra vouchers - $163,744
- Other - $88,270

CHART 1

Visits and Assistance

- Visits
- Assistance Provided

$0
$50,000
$100,000
$150,000
$200,000
$250,000

$0
500
1,000
1,500
2,000
2,500

Jul-07 Aug-07 Sept-07 Oct-07 Nov-07 Dec-07 Jan-08 Feb-08 Mar-08 Apr-08 May-08 Jun-08 Jul-08 Aug-08 Sept-08 Oct-08 Nov-08 Dec-08 Jan-09 Feb-09
If assistance is broken down into sub categories then some interesting trends emerge – see Chart 2. The significant December spikes of the ‘Food’ category reflect the Christmas hampers which were delivered through the ER services to families in need. However other trends are also apparent. If comparing the last quarter year period of the data (December 08-February 09) with the same quarter in the previous year there is a:

- 27% rise in cheques being provided for creditors
- 19% rise in assistance with paying electricity and gas bills (EAPA)
- 7% fall in the food given out
- 17% fall in Telstra vouchers.

This changing composition of assistance reflects the changing need of clients.

**CHART 2**

**Assistance Provided 2007-2009**

Given that ER centres generally operate at capacity, there is not sufficient scope to deal with significant increases in demand. In order to assess unmet need, five of the seven ANGLICARE ER centres have also kept a log of those people who were turned away from the services because their need could not be addressed. Table 1 and Chart 3 indicate the visits for these five centres, the turn away rate and therefore the total demand for the services in terms of met and unmet need.
### Table 1: Visits and Turn Away Rates 2007-2009 for Five ER Centres

<table>
<thead>
<tr>
<th></th>
<th>Visits</th>
<th>Turn Away</th>
<th>Observed Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-07</td>
<td>977</td>
<td>498</td>
<td>1475</td>
</tr>
<tr>
<td>Aug-07</td>
<td>1100</td>
<td>628</td>
<td>1728</td>
</tr>
<tr>
<td>Sep-07</td>
<td>1103</td>
<td>619</td>
<td>1722</td>
</tr>
<tr>
<td>Oct-07</td>
<td>1118</td>
<td>761</td>
<td>1879</td>
</tr>
<tr>
<td>Nov-07</td>
<td>1113</td>
<td>1208</td>
<td>2321</td>
</tr>
<tr>
<td>Dec-07</td>
<td>1760</td>
<td>671</td>
<td>2431</td>
</tr>
<tr>
<td>Jan-08</td>
<td>749</td>
<td>626</td>
<td>1375</td>
</tr>
<tr>
<td>Feb-08</td>
<td>1194</td>
<td>956</td>
<td>2150</td>
</tr>
<tr>
<td>Mar-08</td>
<td>971</td>
<td>732</td>
<td>1703</td>
</tr>
<tr>
<td>Apr-08</td>
<td>906</td>
<td>674</td>
<td>1580</td>
</tr>
<tr>
<td>May-08</td>
<td>1029</td>
<td>764</td>
<td>1793</td>
</tr>
<tr>
<td>Jun-08</td>
<td>974</td>
<td>569</td>
<td>1543</td>
</tr>
<tr>
<td>Jul-08</td>
<td>933</td>
<td>446</td>
<td>1379</td>
</tr>
<tr>
<td>Aug-08</td>
<td>967</td>
<td>508</td>
<td>1475</td>
</tr>
<tr>
<td>Sep-08</td>
<td>1016</td>
<td>772</td>
<td>1788</td>
</tr>
<tr>
<td>Oct-08</td>
<td>1098</td>
<td>800</td>
<td>1898</td>
</tr>
<tr>
<td>Nov-08</td>
<td>1257</td>
<td>795</td>
<td>2052</td>
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<tr>
<td>Dec-08</td>
<td>1406</td>
<td>309</td>
<td>1715</td>
</tr>
<tr>
<td>Jan-09</td>
<td>674</td>
<td>390</td>
<td>1064</td>
</tr>
<tr>
<td>Feb-09</td>
<td>1098</td>
<td>814</td>
<td>1912</td>
</tr>
<tr>
<td>Total</td>
<td>21443</td>
<td>13540</td>
<td>34983</td>
</tr>
</tbody>
</table>

### CHART 3

Visits, Turn Away and Demand across Five ER Centres
It is likely that current demand is higher than the figures in Table 1 and Chart 3 would suggest. Currently some services are reporting the need to ‘sift’ clients at the intake point. This process entails a more detailed assessment when a person initially makes phone contact, rather than presenting for an interview. At the intake point, rather than the interview, many people are being referred on to other services because our ER services are operating at capacity. The service implication of this process is that, in many cases, clients with complex needs require longer assessments at the service centre. This limits the capacity of the services to deal with more clients.

The impact of the Global Financial Crisis on services is difficult to gauge when services already operate at or near full capacity. Data for the centres up to February 2009 does, however, reveal signs of upward pressure on demand for ER services towards the end of 2008 and beginning of 2009 with:

- A rising trend of visits between August and December 2008 accompanied by a rising turn away rate (Chart 3).

- A much steeper percentage rise in the turn away rate between December 2008 and February 2009 (163%) when compared with the same period in 2007/8 (42%) (Chart 3).

- A sharp increase in overall assistance provided between January/February 2009 (67%) over the same period in 2008 (37%) (Chart 1).

- A 20% increase in EAPA assistance, if the last quarter 2007 is compared with the last quarter 2008 (Chart 2).

- A continual upward trend in the Food assistance provided between July and December 2008 (Chart 2).

- A 26% increase in cheques to creditors in the last quarter year of the data when compared with the same period the previous year (Chart 2).

A clearer picture of the impact of the financial crisis will emerge once another six months of data is collected and analysed. However there would appear to be significant shifts upwards in both the turn away rate and assistance being provided in February 2009, over the same period in 2008.

### 3.2 Gender

Almost two thirds of people (63%) accessing ANGLICARE Sydney ER services are female. Women are overrepresented in the client sample when compared with the male: female ratio across Sydney, which in ratio terms is 49:51 as illustrated in Chart 2.
3.3 Age

The predominant age cohort for those people accessing ER services is 25 to 49 years of age, representing almost two thirds of service users. However it is interesting to note that 14% of service users are over the age of 55 years. Table 2 shows these trends.

Table 2: Age Cohort of People Accessing ER Services

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19yrs</td>
<td>204</td>
<td>1.7%</td>
</tr>
<tr>
<td>20-24yrs</td>
<td>865</td>
<td>7.1%</td>
</tr>
<tr>
<td>25-29yrs</td>
<td>1,456</td>
<td>11.9%</td>
</tr>
<tr>
<td>30-34yrs</td>
<td>1,790</td>
<td>14.6%</td>
</tr>
<tr>
<td>35-39yrs</td>
<td>1,971</td>
<td>16.1%</td>
</tr>
<tr>
<td>40-44yrs</td>
<td>1,702</td>
<td>13.9%</td>
</tr>
<tr>
<td>45-49yrs</td>
<td>1,438</td>
<td>11.8%</td>
</tr>
<tr>
<td>50-54yrs</td>
<td>1,025</td>
<td>8.4%</td>
</tr>
<tr>
<td>55-59yrs</td>
<td>669</td>
<td>5.5%</td>
</tr>
<tr>
<td>60-64yrs</td>
<td>512</td>
<td>4.2%</td>
</tr>
<tr>
<td>65-69yrs</td>
<td>289</td>
<td>2.4%</td>
</tr>
<tr>
<td>70-74yrs</td>
<td>156</td>
<td>1.3%</td>
</tr>
<tr>
<td>75-79yrs</td>
<td>106</td>
<td>0.9%</td>
</tr>
<tr>
<td>80+yrs</td>
<td>46</td>
<td>0.4%</td>
</tr>
<tr>
<td>Total</td>
<td>12,229</td>
<td>100%</td>
</tr>
</tbody>
</table>
Chart 5 illustrates:

- The overrepresentation of the 25-54 year age group among ER clients.
- The underrepresentation of the 54 years plus age group in the client sample. Services have noted that the retired population appears to cope better with limited income than other age groups and they do not generally have the additional responsibility and demands of children.

**CHART 5**

**Age by Gender**

<table>
<thead>
<tr>
<th>15-19yrs</th>
<th>20-24yrs</th>
<th>25-29yrs</th>
<th>30-34yrs</th>
<th>35-39yrs</th>
<th>40-44yrs</th>
<th>45-49yrs</th>
<th>50-54yrs</th>
<th>55-59yrs</th>
<th>60-64yrs</th>
<th>65-69yrs</th>
<th>70-74yrs</th>
<th>75-79yrs</th>
<th>80+ yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Male</td>
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</tbody>
</table>

**3.4 Ethnicity**

**3.4.1 Culturally and Linguistically Diverse (CALD) people**

A number of international and Australian studies have highlighted the greater propensity of migrant households to experience poverty and deprivation. A 2001 NATSEM study maintained that people from non-English speaking countries had higher rates of poverty than their Australian born or English-speaking born peers. They concluded that ‘people living in families headed by migrants made up over one third of all people living in poverty’.  

There are a number of reasons for this trend. There is the cost of settlement, and the lack of assets and networks, compounded by the lack of affordable housing. There is poor physical and mental health that sometimes requires

---

trauma and torture counselling. There are language barriers for immigrant children that can reduce positive educational outcomes. Recently arrived migrants may have difficulty finding employment, often do not have their qualifications recognised, have problems with language and English literacy, and can be segmented into niche employment areas such as cleaning, aged care, taxi driving and security work. A 2006 study confirmed that there is a massive loss of occupational status among our respondents and confirm the existence of the segmented labour market, where racially and culturally visible migrants are allocated the bottom jobs regardless of their ‘human capital’.

In the ANGLICARE ER study one in five (or 19%) of all clients indicated that they were born in a non English-speaking country (NES). This was a slight under representation if one considers that the Sydney average in 2006 for NES was 22%. However there were significant variations in the trend across regions of Sydney and the postcode data was revealing. Of the 116 postcodes serviced by the ER centres, 7 postcodes contributed more than half the non-English speaking client base. The largest of these was Liverpool, followed by Mt Druitt, Campbelltown, Marrickville, Sadleir/Green Valley, and Prospect/Blacktown. Table 3 indicates these trends by service centre locations.

Table 3: Service Users’ Ethnic Background, by ER site

<table>
<thead>
<tr>
<th>Site</th>
<th>Birthplace Australia or Overseas</th>
<th>Total</th>
<th>NES as % of all Service Users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Australia</td>
<td>Overseas - ES Country</td>
<td>Overseas - NES Country</td>
</tr>
<tr>
<td>Wollongong</td>
<td>2,487</td>
<td>233</td>
<td>297</td>
</tr>
<tr>
<td>Rooty Hill</td>
<td>1,797</td>
<td>133</td>
<td>555</td>
</tr>
<tr>
<td>Campbelltown</td>
<td>2,094</td>
<td>172</td>
<td>336</td>
</tr>
<tr>
<td>Liverpool</td>
<td>630</td>
<td>37</td>
<td>490</td>
</tr>
<tr>
<td>Marrickville</td>
<td>1,014</td>
<td>115</td>
<td>389</td>
</tr>
<tr>
<td>Bondi</td>
<td>706</td>
<td>122</td>
<td>230</td>
</tr>
<tr>
<td>Moss Vale</td>
<td>326</td>
<td>26</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>9,054</td>
<td>838</td>
<td>2,310</td>
</tr>
</tbody>
</table>

3.4.2 Indigenous Service Users

There has long been recognition that Indigenous people are more at risk of material deprivation and social exclusion than their non-Indigenous peers. A 2007 Overcoming Indigenous Disadvantage Report provided a number of key indicators of this deprivation and exclusion. It revealed lower life expectancy, higher levels of disability, kidney disease and asthma, lower levels of household income, lower levels of school retention, an unemployment rate three times higher than for non-Indigenous people, high suicide rates and a risk of imprisonment which was 13 times greater than for the non Indigenous population.\(^{11}\)

The 2007 New Indicators of Disadvantage study, using both a national and client survey sample, identified a number of particular groups in the community at higher than average risk of being socially excluded. The study reported that:

“The level of deprivation experienced by Indigenous Australians is very high – the highest in any single community sample category identified in this analysis – and it exceeds that of the non-Indigenous population by a factor of more than four-to-one.”\(^{12}\)

This deprivation took the form of limited access to regular meals, prescribed medicines, dental and medical services and decent and secure housing.

ANGLICARE Sydney’s current data on ER service users also reflects a significant over representation of Indigenous people, with more than one in ten service users (11%) identifying as Aboriginal or Torres Strait Islander. This compares with an average Sydney Indigenous population of around 1.1% of the resident population. Campbelltown had the highest number of its service user base listed as Indigenous when compared with other ER sites and Rooty Hill had the greatest proportion of Indigenous people accessing ER services as illustrated in Table 4.

**Table 4: Indigenous Service Users by ER Site**

<table>
<thead>
<tr>
<th>Site</th>
<th>Indigenous</th>
<th>Non-Indigenous</th>
<th>Total</th>
<th>% Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wollongong</td>
<td>308</td>
<td>2,510</td>
<td>2,818</td>
<td>10.9%</td>
</tr>
<tr>
<td>Rooty Hill</td>
<td>266</td>
<td>1,564</td>
<td>1,830</td>
<td>14.5%</td>
</tr>
<tr>
<td>Campbelltown</td>
<td>356</td>
<td>2,200</td>
<td>2,556</td>
<td>13.9%</td>
</tr>
<tr>
<td>Liverpool</td>
<td>74</td>
<td>1,033</td>
<td>1,107</td>
<td>6.7%</td>
</tr>
<tr>
<td>Marrickville</td>
<td>173</td>
<td>1,230</td>
<td>1,403</td>
<td>12.3%</td>
</tr>
<tr>
<td>Bondi</td>
<td>83</td>
<td>919</td>
<td>1,002</td>
<td>8.3%</td>
</tr>
<tr>
<td>Moss Vale</td>
<td>22</td>
<td>283</td>
<td>305</td>
<td>7.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,282</strong></td>
<td><strong>9,739</strong></td>
<td><strong>11,021</strong></td>
<td><strong>11.6%</strong></td>
</tr>
</tbody>
</table>


While locational concentration undoubtedly reflects higher indigenous populations in particular areas it is interesting to note that across 116 postcodes, two postcodes made up 25% of the catchment area for Indigenous service users. These were Campbelltown and Mt. Druitt.

### 3.5 Household type

Almost half the people (42%) who access the ER services are people living on their own. The second most significant client group is single parent households, representing almost one in three client households. Table 5 provides this breakdown.

**Table 5: Client Household Composition**

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
<th>% of Total Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single parent with dependent child(ren)</td>
<td>3,583</td>
<td>30.6%</td>
</tr>
<tr>
<td>Couple family with dependent child(ren)</td>
<td>1,347</td>
<td>11.5%</td>
</tr>
<tr>
<td>Couple family without dependent child(ren)</td>
<td>868</td>
<td>7.4%</td>
</tr>
<tr>
<td>Extended family</td>
<td>509</td>
<td>4.4%</td>
</tr>
<tr>
<td>Sole person household</td>
<td>4,959</td>
<td>42.4%</td>
</tr>
<tr>
<td>Other grouping</td>
<td>426</td>
<td>3.6%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>11,692</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Chart 6 compares these client household profiles with the 2006 Sydney Census average. What is immediately apparent is a significant over representation of sole person and single parent households in the ANGLICARE ER sample. Such households would therefore appear to be vulnerable to hardship and at risk of deprivation.
The ANGLICARE client household profiles are not however consistent across all the ER centres. When broken down for each site several interesting trends emerge:

- The sole person household is the predominant household client type for Marrickville, Bondi, Liverpool, Moss Vale and Wollongong. At two sites - Bondi and Marrickville - these households represented two thirds of clients presenting to the service;

- Rooty Hill and Campbelltown clients has a more even spread of household types and their largest client group is single parent households. Liverpool and Rooty Hill have the highest proportion of couple families with dependent children.

This variation across locations is important in determining the type, nature and method of service delivery and needs to be factored in to the service model. Not only do new models of ER service delivery need to cope with complex client needs, but they also need to be flexible enough to respond appropriately to specific needs in particular geographic areas. Chart 7 illustrates these trends across each service area.
The rise of the sole person or ‘solo’ household is a global western phenomenon which has received considerable commentary both in Australia and overseas. In 2006 the Joseph Rowntree Foundation (UK) explored the potential impact on poverty and income inequality of solo households. They concluded that forced transition into solo households can lead to poverty, higher living costs per household and greater labour market risks:

Although it is impossible to quantify the impact of rising solo living precisely… econometric modelling shows that demographic change has been responsible for a fifth of the enormous rise in inequality between 1979 and 2003/4, and that if Britain had had the same household composition, fertility patterns and age structure in 2003/04 as it did in 1979, there would be 240,000 fewer households in poverty, 280,000 fewer pensioners in poverty and 70,000 fewer children in poverty (with other factors remaining equal).13

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The 2001 NATSEM study also confirmed these trends in Australia:

“The picture of poverty is increasingly one of single adults, either single people or lone parents. Almost six in ten people in poverty belonged to one of these groups.”

In the ANGLICARE ER study, sole person households (4,959) make up 42% of clients accessing ER services. In this group:

- Almost 90% of clients are on incomes of less than $600 per fortnight
- Almost one in ten lives in a boarding house arrangement
- 6% indicate they are staying with friends and a further 115 or 2.4% are living on the street.
- A higher proportion of sole men (28%) experience insecure housing than sole women (15.3%).

Sole person households therefore have the highest representation of any household group accessing ANGLICARE ER services and also have the highest level of insecure housing – including homelessness.

3.6 Income

As defined for the purposes of this report, poverty is a reflection of a shortage of income. Table 6 indicates that at least 46% of clients in this study received a household income of less than $600 per fortnight. More than half (57%) are on incomes of less than $800 per fortnight. Although this is unequivalised household income, it indicates that most clients are in households below or equal to the Henderson Poverty Line for the March quarter in 2009.

**Table 6: Fortnightly Household Income of Individual Clients**

<table>
<thead>
<tr>
<th>NIL INCOME</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $200</td>
<td>58</td>
<td>0.5%</td>
</tr>
<tr>
<td>$200 to $399</td>
<td>386</td>
<td>3.0%</td>
</tr>
<tr>
<td>$400 to $599</td>
<td>4,560</td>
<td>35.5%</td>
</tr>
<tr>
<td>$600 to $799</td>
<td>1,440</td>
<td>11.2%</td>
</tr>
<tr>
<td>$800 to $999</td>
<td>1,904</td>
<td>14.8%</td>
</tr>
<tr>
<td>$1,000 to $1,199</td>
<td>1,322</td>
<td>10.3%</td>
</tr>
<tr>
<td>$1,200 to $1,399</td>
<td>655</td>
<td>5.1%</td>
</tr>
<tr>
<td>$1,400 to $1,599</td>
<td>352</td>
<td>2.7%</td>
</tr>
<tr>
<td>$1,600 to $1,799</td>
<td>165</td>
<td>1.3%</td>
</tr>
<tr>
<td>$1,800 to $1,999</td>
<td>84</td>
<td>0.7%</td>
</tr>
<tr>
<td>$2,000 to $2,999</td>
<td>88</td>
<td>0.7%</td>
</tr>
<tr>
<td>$3,000 to $3,999</td>
<td>8</td>
<td>0.1%</td>
</tr>
<tr>
<td>Not known</td>
<td>945</td>
<td>7.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12,863</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Client income varied significantly by household type (See Table 7)

- For sole person households, 86% of clients had a household income of under $600 per fortnight.
- For single parents and couple families with children, there was a greater spread of income, although 66% of clients from single parent families and 36% of clients from couple family households with children were on household incomes of less than $1,000 per fortnight.
### Table 7: Fortnightly Household Income of Clients by Household Type

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Single parent</th>
<th>Couple family with child(ren)</th>
<th>Couple family without child(ren)</th>
<th>Extended family</th>
<th>Single person</th>
<th>Other grouping</th>
</tr>
</thead>
<tbody>
<tr>
<td>NIL INCOME</td>
<td>3.0%</td>
<td>3.3%</td>
<td>4.1%</td>
<td>6.1%</td>
<td>5.7%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Less than $200</td>
<td>0.2%</td>
<td>0.9%</td>
<td>0.7%</td>
<td>0.8%</td>
<td>0.5%</td>
<td>1.1%</td>
</tr>
<tr>
<td>$200 to $399</td>
<td>0.9%</td>
<td>1.8%</td>
<td>2.3%</td>
<td>3.2%</td>
<td>5.3%</td>
<td>5.7%</td>
</tr>
<tr>
<td>$400 to $599</td>
<td>11.0%</td>
<td>5.8%</td>
<td>14.7%</td>
<td>33.4%</td>
<td>74.7%</td>
<td>46.6%</td>
</tr>
<tr>
<td>$600 to $799</td>
<td>18.8%</td>
<td>8.8%</td>
<td>11.8%</td>
<td>12.5%</td>
<td>9.3%</td>
<td>8.7%</td>
</tr>
<tr>
<td>$800 to $999</td>
<td>32.4%</td>
<td>15.3%</td>
<td>35.4%</td>
<td>12.5%</td>
<td>2.3%</td>
<td>13.6%</td>
</tr>
<tr>
<td>$1,000 to $1,199</td>
<td>19.9%</td>
<td>18.3%</td>
<td>18.5%</td>
<td>16.1%</td>
<td>1.3%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Over $1,200</td>
<td>13.7%</td>
<td>45.9%</td>
<td>12.4%</td>
<td>15.4%</td>
<td>0.8%</td>
<td>6.6%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
For people accessing the ANGLICARE Sydney ER services, the most significant source of income was usually some form of Government benefit:

- Less than 5% of people accessing ANGLICARE ER support are currently employed full time or part time.
- Just over one in four clients (27%) are on the Newstart Allowance,
- 26% are receiving Disability Benefits and
- a similar percentage, (25.7%), are receiving the Single Parenting Payment.

3.7 Tenure type
Almost half of all clients are in public housing compared with a Sydney average of 5%. One in three rent privately and only 7% are either a private house owner or purchasing a house. A further 13% could be considered to be in insecure housing if the tenure types - boarding house, refuge, hotel/motel, caravan/tent, car, staying with a friend or living on the street – are collapsed into this one category – see Table 8. What emerges from this data is a picture of people who are vulnerable in terms of both income and housing – 13% of whom could be considered to be experiencing primary, secondary or tertiary homelessness. 16

Table 8: Housing Tenure Type

<table>
<thead>
<tr>
<th>Tenure Type</th>
<th>No. of ER Clients</th>
<th>Percentage of all ER Clients</th>
<th>Sydney average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public rental</td>
<td>5,505</td>
<td>45.9%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Private rental</td>
<td>4,035</td>
<td>33.6%</td>
<td>19.8%</td>
</tr>
<tr>
<td>Private house owner</td>
<td>417</td>
<td>3.5%</td>
<td>33.5%</td>
</tr>
<tr>
<td>Purchasing house</td>
<td>441</td>
<td>3.8%</td>
<td>33.9%</td>
</tr>
<tr>
<td>Insecure Housing</td>
<td>1,606</td>
<td>13.4%</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>12,004</strong></td>
<td><strong>100.0%</strong></td>
<td></td>
</tr>
</tbody>
</table>

The variations compared with the Sydney average are immediately apparent from Chart 8. ER clients are mostly renters, either public or private. Very few own their own home or have a mortgage.

16 Primary homelessness is basically ‘rooflessness’ ie no shelter. Secondary homelessness is defined as staying in secondary accommodation. Tertiary homelessness is that accommodation which can be considered highly insecure such as boarding houses. Cf Chamberlain, C. & MacKenzie, D., (2003) Counting the Homeless 2001, Australian Census Analytic program, Australian Bureau of Statistics Publication, 2050.0
If household type is cross tabulated with housing tenure it is evident that 70% or more of each household type is in rental accommodation. The couple families with and without children are more likely than other household types to be purchasing or owners of a home. The groups most at risk of insecure housing (Table 9) are the single person households, those part of an extended family and those classified as ‘Other’.

Table 9: Household Type by Housing Tenure

<table>
<thead>
<tr>
<th></th>
<th>Couple family with dependent child(ren)</th>
<th>Couple family without dependent child(ren)</th>
<th>Extended family</th>
<th>Other grouping</th>
<th>Single parent with dependent child(ren)</th>
<th>Single person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public rental</td>
<td>36.7%</td>
<td>39.0%</td>
<td>46.8%</td>
<td>30.7%</td>
<td>52.3%</td>
<td>45.7%</td>
</tr>
<tr>
<td>Private rental</td>
<td>44.3%</td>
<td>37.9%</td>
<td>28.6%</td>
<td>40.3%</td>
<td>37.3%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Private house owner</td>
<td>5.1%</td>
<td>6.8%</td>
<td>7.2%</td>
<td>3.1%</td>
<td>2.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Purchasing house</td>
<td>10.5%</td>
<td>8.0%</td>
<td>3.8%</td>
<td>2.4%</td>
<td>3.4%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Insecure housing</td>
<td>3.4%</td>
<td>8.3%</td>
<td>13.6%</td>
<td>23.5%</td>
<td>4.8%</td>
<td>22.7%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
There are several important links between housing insecurity and social exclusion. In a recently released paper by the Australian Housing and Urban Research Institute (AHURI, 2009) six important dimensions of housing insecurity were identified. These related to instability in housing, safety, privacy, needing to move at short notice and without any control over the situation, lack of comfort and supportive relationships, and lack of connection to the local community.\(^{17}\) Housing insecurity reflects lack of security across a number of domains in the life of an individual which can be compounded by both physical and health issues.

Housing insecurity, in its various dimensions, is linked to insecurities in other areas of life, such as finances, employment, and health, insecurity of self and family instability. The consequence of living with this combination of insecurities is that a person’s key focus is on surviving from day to day. … Many of those experiencing housing insecurity also experience physical and mental health problems which pose additional difficulties in participating economically and connecting socially.\(^{18}\)

In one of the ANGLICARE ER focus groups one participant referred to the problems of living in a tent and the issues this raised for her relationship with her son. At the time of the focus group she had just been relocated to a bed sitter for which she was extremely grateful since ‘it has a kitchen and a bathroom’.\(^{19}\) Living with housing insecurity also focuses the individual on day to day survival and impedes the ability for long term planning. It also reduces the ability to forge long term connections with other people in the community and develop support networks. It can lead to isolation, disconnection and a sense of worthlessness. As one client commented:

> Every week’s a struggle…but some weeks it’s a real battle…if you don’t have any sort of back up then you, your dog, your cat and everybody goes hungry and you sit around feeling miserable’. [MD2]


\(^{18}\) Ibid p1

\(^{19}\) Client Focus Group: WG3
4. Presenting Issues

It is important to understand why people present to an ER service. Apart from indicating the type of need, visiting a centre can also indicate complexity of issues being faced by service users. Most people present with more than one issue – which often cannot be resolved in one visit. This complexity results in longer assessment times, greater need for case coordination and, in some cases, case management.

Across the ANGLICARE ER data for 12,863 clients there were more than 27,000 visits and 60,000 presenting issues. Those which ranked most highly included:

1. **Household Organisation** – a term used by staff to indicate low income leading to an inability to manage finances. This issue was cited 17,500 times by two thirds of clients.

2. **Unemployment** – This was a reason for presenting to the service on 6,376 occasions – a concern for clients in 24% of visits.

3. **Accommodation or Housing** – if the presenting issues of accommodation, homelessness and tenancy are collapsed into one category then this was the reason given on 5,261 visits.

4. **Significant financial debt and physical health** – each of these ranked almost equally, each being cited more than 4,900 times on 19% of all visits.

Other common presenting issues included parenting problems, relationships and mental health. Minor issues, in terms of a frequency of less than 1%, were addictions (drug and alcohol), assault, and prison detention and discharge.

Presenting issues varied widely depending upon the income source of the client. Across all clients the most cited issue was low income and a resulting inability to manage finances (household organisation). However beyond this common issue there were noticeable differences as indicated in Table 10.
### Table 10: Presenting Issues as Ranked by Clients

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Clients who ranked this problem SECOND most often</th>
<th>Clients who ranked this problem THIRD most often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>Clients on Disability benefits, Carers Allowance or the Aged Pension</td>
<td></td>
</tr>
<tr>
<td>Significant financial debt</td>
<td>Employed clients and clients on Single Parenting Payments</td>
<td>Clients on the Aged Pension, Partnered Parenting Payment or Carer’s Allowance</td>
</tr>
<tr>
<td>Unemployment</td>
<td>Clients on Newstart, the Partnered Parenting Payment or Youth Allowance</td>
<td>Employed clients and clients on Newstart or Youth Allowance</td>
</tr>
<tr>
<td>Accommodation/Housing</td>
<td></td>
<td>Clients on Single Parenting Payment</td>
</tr>
<tr>
<td>Issues with Children</td>
<td></td>
<td>Clients on Disability benefits</td>
</tr>
</tbody>
</table>

These differences in Table 10 often reflect the type of income support. Physical health issues would be more commonly expected among age pensioners, disability pensioners and carers than among other income types. Similarly dealing with unemployment would be expected to be a major issue for those receiving Newstart payments. However the presence of significant debt as a catalyst for seeking help across many of these income types fits with concerns expressed about levels of personal debt in the current financial climate and research regarding increases in financial stress among Australians. While the size of such debt may vary greatly, for some Australians it is enough to prompt them to seek the help of an ER service.

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5. Geographic Exclusion

All ANGLICARE ER sites have been located intentionally in areas of socio-economic disadvantage. However several have been in operation for decades - well before the current population patterns emerged. It is important to determine if these older sites (Rooty Hill and Wollongong) along with the newer sites are in the most optimal locations for meeting the greatest need.

Table 11 and Chart 9 indicate that the three largest ANGLICARE Sydney ER sites by client numbers were Wollongong, Rooty Hill and Campbelltown. However the return visitation by service users was highest at the Moss Vale Centre where each client on average accessed services more than three times each in the 20 month period of the study. The manager of the service indicated that this was a reflection of the limited services in the region, high levels of unemployment and the number of clients presenting with issues which required ongoing advocacy. This latter issue is supported by the data which indicates that more than half of the Moss Vale clients (51%) required advocacy over the 20 month period.

**Table 11: Centre Client and Visit Numbers: 2007-2009**

<table>
<thead>
<tr>
<th>Site</th>
<th>Client numbers</th>
<th>Client %</th>
<th>Visit Numbers</th>
<th>Ave Number Visits per client</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wollongong</td>
<td>3,127</td>
<td>24.3%</td>
<td>7059</td>
<td>2.26</td>
</tr>
<tr>
<td>Rooty Hill</td>
<td>2,859</td>
<td>22.2%</td>
<td>5290</td>
<td>1.85</td>
</tr>
<tr>
<td>Campbelltown</td>
<td>2,660</td>
<td>20.7%</td>
<td>5578</td>
<td>2.09</td>
</tr>
<tr>
<td>Liverpool</td>
<td>1,181</td>
<td>9.2%</td>
<td>2442</td>
<td>2.07</td>
</tr>
<tr>
<td>Marrickville</td>
<td>1,556</td>
<td>12.1%</td>
<td>3176</td>
<td>2.04</td>
</tr>
<tr>
<td>Bondi</td>
<td>1,112</td>
<td>8.6%</td>
<td>2204</td>
<td>1.98</td>
</tr>
<tr>
<td>Moss Vale</td>
<td>368</td>
<td>2.9%</td>
<td>1312</td>
<td>3.57</td>
</tr>
<tr>
<td>Total</td>
<td>12,863</td>
<td>100.0%</td>
<td>27,061</td>
<td>2.10</td>
</tr>
</tbody>
</table>
There has been considerable research into the spatial aspects of poverty and deprivation. Tony Vinson, in his compelling studies (2004, 2007) used a number of indicators to create an index of disadvantage and ranked postcodes accordingly – first in NSW and Victoria and then nationally. These indicators related to income, educational background, disability and sickness, long term unemployment, dependency ratios, criminal convictions and access to the internet.

Observations of spatial distribution of disadvantage using the ANGLICARE ER data need to be treated with some caution. People living closer to ER centres are more likely to access them. However, given this caveat, there are still some interesting findings if the postcode data for people presenting to the service is analysed. While 13,000 service users are drawn from across 116 postcodes, almost one in three (31%) resided in just four postcodes:

- 2560 – Campbelltown
- 2770 – Mt Druitt
- 2500 – Wollongong
- 2170 – Liverpool

Each of the ER centres has been mapped in Diagram 1, showing the concentration of service users in postcodes within their catchments. It is important to ascertain if these concentrations not only reflect site location but also socio-economic disadvantage. To make this assessment, the Australian Bureau of Statistics (ABS) Socio Economic indexes for Areas (SEIFA) data was used across the Sydney area. This provided quintiles of disadvantage for all areas compared with other areas in NSW. In each of the four top catchment postcodes there are Census Collection Districts ranked in the 20% most disadvantaged in NSW.

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Diagram 1

Emergency Relief Clients and Community Care Centre locations
Prepared by ANGLICARE Policy Unit, May 2009

Mapped by 2006 Postal Areas Census Geographic & Indigenous Area Digital Boundaries DataPacks Basic Community Profile Cat. no. 2069.0.30.001
Diocesan boundary derived from Australian Bureau of Statistics (2006) Australian Standard Geographical Classification Digital Boundaries DataPacks Basic Community Profile Cat. no. 2069.0.30.001
Custom Aggregation of Collectors Districts to approximate Sydney Diocesan Regions
6. From Deprivation To Exclusion

Deprivation means going without – a lack of what most people would consider to be essential for a reasonable standard of living. Social exclusion is more than that – it is the exclusion from participation in both the economic, service and social spheres – fractured social networks and disengagement with community. The qualitative data retrieved from the client focus groups would indicate that deprivation and social exclusion are linked in many different ways. This is highlighted by the following comments made by clients within the context of needing to access ER and the service experience itself.

6.1 The experience of requesting emergency relief

It was evident that for some, merely having to access services is a demeaning experience reducing sense of self worth and self esteem.24 Clients in the focus groups indicated shame and humiliation on having to access ER.

“
I was ashamed and embarrassed to come [Single mother MD3]

I only come when I am desperate [Aged pensioner MD4]

…it was pride…for me I was anxious, nervous and embarrassed ...

[after they helped me] I cried all the way home.

[CT2 grandmother helping with sick grandchild]

I just needed help with bills…I find it degrading [WG3]
"

Most people in these groups indicated that they had approached the ER services because of hunger or lack of money to pay bills. The key presenting issues focused on material deprivation – lack of food, shelter, work and physical health.

To quote one client:

“
We were starving when we came here – we were hungry. We got all our food vouchers and went to Woollies and got the food then went to the park and ate all the food vouchers in one day. We were starving. So then we went home and had to think what to do next. [CT1]
"

Bill payments in relation to rent and electricity were the most commonly cited. However there were other issues such as being ill and not being able to afford medications, needing advice on domestic violence, issues with custody of children (DoCS), some with drug and alcohol problems, and relationship breakdown.

Although accessing the service was a traumatic experience for many, the experience of the service itself generally appeared to be very positive.

24 Cf Frederick, J. and Goddard, C (2008), Sweet and Sour Charity: The Experiences of Receiving Emergency Relief in Australia, Australian Social Work: Monash University.
Workers go the extra mile [MD5 Single father]

Service is not given begrudgingly [MD6 Carer]

ANGLICARE are not busybodies but seem interested in knowing so they can help [MD5]

They go above and beyond and want to help more than the norm. They are more interested in understanding your needs [WG2 Single mother]

But the support that Anglicare provides “makes you happy and gives you an uplift”.[MD8 older single woman]

I felt comfortable safe [it] was a friendly environment. [CT4 single unemployed young man]

The detrimental impact of the experience was, lessened when staff were empathic, compassionate and non-judgmental. Social exclusion, which includes anomie, alienation and a lack of empowerment, could be addressed by the attitudes of the service provider and the way that the provider treated the service user. When staff took the time to listen and respond and when people were treated with dignity and respect, then the service experience was far better than anticipated on first entry. As one person commented:

…what was important was the front desk…empathy and compassion…

I was not made to feel like a second class citizen with no control…[CT2]

When food help was involved, the way that the food was given could add to or subtract from this sense of exclusion. Almost all focus group participants were in favour of gift cards and food vouchers rather than food hampers since this gave the client more choice and therefore more dignity – especially if gift cards were used. There was also comment about the type of food provided and the lack of choice or control experienced by the recipient.

I’ve never eaten 3 bean mix in my life… or artichokes.

I suppose that baked beans beat 3 beans mix

You should include products that everyone will eat like pasta, rice, milk, baked beans

I like biscuits in the food parcels, particularly as they are good with a cuppa.
There will always be a need for food parcels and hampers, especially in a crisis situation. In support of food parcels was one elderly person who commented that ‘food parcels are handy if you haven’t eaten all day’.

6.2 Community connections and life choices

Most people who come to the service do so for a particular reason but they are often experiencing multiple deprivation with complex causality\(^\text{25}\). This can range from physical and mental health issues, relationship breakdown, grief and bereavement, post traumatic stress, drug, alcohol or gambling addictions often reflecting a life journey that has experienced domestic violence, out-of-home care when young, family breakdown and lack of education. The need for emergency relief can be inextricably interwoven with other needs, particularly in terms of mental health and drug and alcohol problems.\(^\text{26}\)

These issues have an impact on personal aspirations, social capacity and connection to local communities. This can take the form of exclusion from services such as banking, transport, utilities and health services. It can also lead to poor social support networks and lack of support in times of crisis and social isolation. The New Indicators study for example showed that across the clients surveyed more than one third did not have a supportive family. This was even higher for those with a disability. Furthermore, around one in four did not feel accepted by their community or have regular social contact with others.\(^\text{27}\)

These findings are also seen in issues raised in the ANGLICARE ER focus groups. A selection of such issues is outlined below, and gives an idea of the many different ways that social exclusion is manifested.

6.2.1 Service exclusion

One grandmother came to the ER service because her young grandson was in hospital with leukaemia and she needed money for petrol so she could visit him and support her family – to provide them with respite. She lived a considerable distance and public transport was not an option. For others, particularly in the Wollongong area, transport exclusion was a particularly significant issue. It was difficult for some to get to the focus groups itself – as one person commented:

\[
\begin{quote}
\ldots I'm from [B…] \ldots it's hard to get here cos of the train fare\ldots home visits would be good.[WG5]
\end{quote}
\]

For non-urban residents the lack of banking facilities also proved to be an issue. People on low incomes live further from the city centre where rents are cheaper but the local transport is costly and acts as a barrier to service access.

\[
\begin{quote}
I live in B…there is no bank and I have to use the bus to get to an ATM. Every penny counts…[WG2]
\end{quote}
\]

\(^\text{25}\) Cf Frederick, J. and Goddard, C (2008), Sweet and Sour Charity: The Experiences of Receiving Emergency Relief in Australia, Australian Social Work: Monash University.

\(^\text{26}\) Ibid p279

6.2.2. Social isolation

Disconnection from others and lack of social contact were referred to in all the focus groups. This was seen by some as a particular issue for the aged and for those with disabilities or poor health:

“Some of the old people [I know] sit at home and don’t see anyone. [CT2]"

“My sister has aplastic anaemia and she feels isolated due to her disease. I am the only one she has. My mum is an alcoholic and dad works two jobs…when we go she will have no one. [MDB3]"

However such isolation was also a condition of poverty across all ages and conditions. According to one middle aged single woman:

“Every week’s a struggle…but some weeks it’s a real battle…If you don’t have any back up then you, your dog, your cat, everybody goes hungry and you just sit around miserable. [MD3]"

For another young couple who lived in Wollongong, the cost of train fares to see family who lived thirty minutes away, was prohibitive. Nor could they afford a phone – so they were cut off from their family even though they were only a train ride away. For others there was no opportunity for holidays. In one group there was discussion about the possibility of a day trip – because some in the group had never ‘seen the sea’.

Connection with community is critical. Most people who requested emergency relief have very limited social supports. Commonly they have weak links with their families and often have no connection with them at all. In addition to providing emotional support, good social support networks can help people to locate employment and housing – and provide opportunities for developing increased knowledge and abilities.

6.2.3 Limited aspirations and opportunities

Such deprivation and exclusion has a psychological impact where low self esteem and a sense of worthlessness made some reluctant to interact with others. As one client phrased it:

“You get cut off from others cos you think you’re nothing…so you can’t meet others [WG1]."

Some even found the focus groups themselves validating because they provided an opportunity to be listened to, to be heard in a way that was not judgmental. As one person put it:

“Showing we are as important as anyone else...[MD1]"
Deprivation and the constant stress of having to meet immediate needs such as food and shelter also limits both aspirations and confidence. When asked in the focus groups to consider ‘if it was possible to have one wish what would it be’ the client responses included:

“Happiness… health… seeing my kids more often… being debt free … more mobility… being less stressed… having carpet on my concrete floors… new blankets for winter… being able to afford heating… getting my baby back from DoCS.”
7. Women And Social Exclusion

7.1 The feminisation of poverty

In the early 1970s US researchers were commenting on the gendered component of poverty - women being over-represented in the poverty population. The literature refers to this trend as the ‘feminisation of poverty’ - a term that was first employed in 1978 by Diana Pearce. Pearce maintained that, in the US, two-thirds of the poor over the age of 16 were women.\(^{28}\) She argued that this was caused by a lack of government support for divorced and single women.\(^{29}\) Townson’s Canadian study (2000) also indicated that those most at risk of poverty were women heading lone parent families and unattached women over the age of 65 during the 1980-1997 survey period.\(^ {30}\) This view was further supported by US research in a 2005 study which observed that:

"Defining poverty as total cash income below half the median income in each respective country, single females were almost twice as likely as single males to live in poverty in the US."\(^ {31}\)

There are particular sub groups of women who are at greater risk. Sole parenthood is a consistent predictor of poverty, as is being a female, Indigenous, refugee or immigrant.

"Faced with economic hardship, language barriers, a lack of viable employment opportunities, and in some cases an uncertain legal status, the likelihood that [immigrant women] will be able to achieve a liveable wage is minuscule."\(^ {32}\)

The gender poverty trap is not necessarily applicable to or inevitable for all western countries. It does not apply, for example, in Italy (a reflection of attitudes to marriage), Sweden (with supported wage and employment patterns) or the Netherlands (through its transfer payments system).\(^ {33}\) A study completed in 2000 established that over the period of the 1990’s, gender inequality in relation to poverty existed for seven of the eight countries studied (Sweden being the exception). The rates of inequality varied however – with the greatest discrepancies occurring in the US followed by Australia.\(^ {34}\)


\(^{30}\) Townson, Monica (2000) Op Cit, p3


\(^{33}\) S and Kelly, E. (nd), Op Cit

The pattern is not necessarily consistent across countries. It is also a trend that has waxed and waned over time, reflecting societal changes such as rising divorce rates, more women in the paid work force, the increasing life span of women and the capacity of transfer payments to lift women out of the poverty cycle.

In Australia a number of reports indicate the feminisation of poverty. The Western Australian Council of Social Services (WACOSS) reported in 2004 that women in Australia continued to be over-represented in poverty data – a reflection of the rise of female headed single parent households, the higher levels of casual work found among women and discrepancies in the male: female wage. However a 2004 NATSEM report contradicted these generally held findings with the conclusion that poverty rates for men were greater than for women in 2001.

7.2 ANGLICARE findings

As mentioned earlier, the ANGLICARE ER data revealed an over-representation of women among ER service users, with women (63%) being twice as likely as men to present to ER services. Almost 90% of single parent households in this survey are headed by women. Women outnumber men across all household types in the ER data with the exception of single person households and the ‘other’ grouping. (see Chart 10).

**CHART 10**

![ER Service Users' Gender by Household Type](image)

---


If gender data is further broken down into age groups it emerges that the poverty gap between men and women in this study was greatest in the 35-39 year cohort and narrows considerably until age 65 when the gender ratio returned to an even spread. This is illustrated in Chart 11.

**CHART 11**

ER Service Users’ Age by Gender

The most significant issues for women presenting to ER services were:

1. Household organisation (low income resulting in financial management problems) (30%)
2. Presence of a significant debt (9%)
3. Physical health (8%)
4. Unemployment (8%)
5. Housing (6%)
6. Issues with children (6%)

It is also true that these same six issues were significant for men – although there were some minor variations. Chart 12 indicates that women more frequently than men expressed concern about household organisation, the ability to manage debt, issues with children and family relationships.
**CHART 12**

**Significant Issues by Gender for all Visits**

- **Men**
- **Women**

Issues:
- Household organisation
- Unemployment
- Physical health
- Housing
- Debt
- Mental health
- Significant financial issues
- Family relationships
- Children
- Issues with children

Graph showing percentages for each issue.
8. Children And Social Exclusion

8.1 Poverty studies

A low level of household income is considered by many to be a reasonable indicator of childhood poverty. Nationally, at the beginning of the 21st century, estimates of child poverty hovered between 12% and 15% of children, putting Australia towards the bottom end of OECD League tables for this indicator. 37 The poverty experience for children may be intermittent and irregular but there are estimates that for at least 3-5% of children in Australia the poverty experience is both persistent and chronic. 38

The high level of joblessness in association with poor families and in particular single parent families, and child poverty has been commented on internationally, and Australia’s performance in this area, compared with other OECD countries is not good. 39 It is also well known that there can be poor outcomes for children born into poverty. They can suffer poorer health than their more advantaged peers, have more issues with learning and behaviour, have poorer outcomes in terms of academic achievements and become pregnant at an early age. Further they have a greater likelihood of being less skilled with poor pay, and being unemployed and welfare dependent as adults than their peers. The worst outcomes are for those who are chronically and persistently poor – especially in early childhood. 40

8.2 Deprivation

Income is not necessarily the sole barometer of hardship as it may not reflect living standards and can underestimate the costs involved in raising children. Nor does it necessarily reflect the lives of children living in hardship compared with their peers. 41

Children in low income households experience considerable deprivation. The New Indicators study revealed high levels of deprivation for children living in poor households. In that study 268 households (40%) identified as having children between the ages of 0-17 years. Of these households 16% did not have a substantial meal once a day, more than half of these children did not have access to regular dental checks and one in five indicated they did not have a safe outdoor space for play. A similar proportion (18%) did not have a separate bed for each child. There were issues with educational opportunities as well – as one third of these households could not afford school books and new school uniforms – having the potential to impact learning and academic performance. 42

37 Ibid p7
39 McDonald, C., (2007), Op Cit, p8
40 Ibid, p10
8.3 Social exclusion

However hardship is not just an issue of material deprivation. There are also issues of exclusion for such children – exclusion from school and social activities. More than one quarter of households in the 2007 New Indicators study reported that their children did not participate in school activities and over one in three indicated that their children could not afford a hobby or participation in leisure activities. This social exclusion can have a very adverse effect on young people. This has been confirmed by new research taking place which tries to gain the children’s perspective on living with economic adversity. In a review of the literature in this area Redmond concluded that:

…what concerns children is not lack of resources per se, but exclusion from activities that other children appear to take for granted, and embarrassment and shame at not being able to participate on equal terms with other children… economic disadvantage can lead to exclusion in a number of critical areas, including schooling, access to out of school activities, and interaction with peers…. leading to them lowering their own aspirations, excluding themselves from a range of activities, or engaging in activities that attract social disapproval.43

Such issues should be of significant concern to Government and policy makers. The body of literature on the impact of poverty and deprivation on children and their life chances is growing. Hardship which leads to social exclusion can have long term intergenerational effects which damage the life chances of such children and also the long term cohesion of society.

The National Centre for Social and Economic Modelling (NATSEM) has embarked on a study to provide indicators of Social Exclusion for children in Australia. Basing their parameters on the earlier work of Townsend and Burchard they maintain that children are at risk of social exclusion if their households are low income (the bottom income quintile) and they experience one of the following: living in a sole parent situation, with poor educational attainment of parents, where parents are unemployed or where at least one parent speaks a language other than English. 44

8.4 ANGLICARE findings

In this current ANGLICARE study, there are indications of poverty and hardship among the children of ER clients. Some 43% of clients identified as having children.45 More than half the clients (58%) in these households survived on incomes of less than $1000 per fortnight – see table 12. Among these client households with children, 31% were in receipt of the single parenting payment. In this study, 97% of all clients with children were not currently working – either full time or part time.

44 Daly A. (et al) (2006) Indicators of Social Exclusion for Australia’s Children: An Analysis by State and Age Groups, a paper presented at the University of Queensland Social Research centre opening
45 Households with children were considered to consist of the two categories ‘Single Parent Families’ and ‘Couple families with children’.
### Table 12: Client Fortnightly Household Income by Households with and without Children

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Households with children</th>
<th>Households without children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NIL INCOME</td>
<td>144</td>
<td>349</td>
<td>493</td>
</tr>
<tr>
<td>Less than $200 a fortnight</td>
<td>18</td>
<td>37</td>
<td>55</td>
</tr>
<tr>
<td>$200 to $399 a fortnight</td>
<td>54</td>
<td>295</td>
<td>349</td>
</tr>
<tr>
<td>$400 to $599 a fortnight</td>
<td>446</td>
<td>3,866</td>
<td>4,312</td>
</tr>
<tr>
<td>$600 to $799 a fortnight</td>
<td>747</td>
<td>615</td>
<td>1,362</td>
</tr>
<tr>
<td>$800 to $999 a fortnight</td>
<td>1,286</td>
<td>505</td>
<td>1,791</td>
</tr>
<tr>
<td>$1,000 to $1,199 a fortnight</td>
<td>904</td>
<td>330</td>
<td>1,234</td>
</tr>
<tr>
<td>$1,200 to $1,399 a fortnight</td>
<td>496</td>
<td>119</td>
<td>615</td>
</tr>
<tr>
<td>$1,400 to $1,599 a fortnight</td>
<td>290</td>
<td>46</td>
<td>336</td>
</tr>
<tr>
<td>$1,600 to $1,799 a fortnight</td>
<td>128</td>
<td>29</td>
<td>157</td>
</tr>
<tr>
<td>$1,800 to $1,999 a fortnight</td>
<td>59</td>
<td>19</td>
<td>78</td>
</tr>
<tr>
<td>$2,000 to $2,999 a fortnight</td>
<td>65</td>
<td>21</td>
<td>86</td>
</tr>
<tr>
<td>$3,000 to $3,999 a fortnight</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,643</td>
<td>6,232</td>
<td>10,875</td>
</tr>
</tbody>
</table>

Further insight is gained if households with children are cross tabulated with reasons for clients presenting at an ER centre. Of course clients can present with more than one issue. However, of the 22,601 reasons for coming to an ER centre provided in this 20 month period, for households with children, the most common (one in three) was that of ‘Household organisation’ – or low income resulting in an inability to manage finances. For 9.5%, or one in ten, there were also issues with significant financial debt. For others (more than 5%), there were problems in relation to unemployment, issues with their children, accommodation or housing, physical health and family relationships.
9.1 Best practice

The current ER service delivery model is predicated on the supply of a basic safety net – providing food and support in the payment of bills – for those in financial crisis. It is a simple transactional model which ANGLICARE Sydney has long considered inadequate in addressing the complex, compounding and interrelated needs of its clients. It ignores such issues as mental health, disability, drug and alcohol addiction, relationship breakdown and domestic violence. Hardship is narrowed by definition to one of simple financial deprivation. Indeed the literature supports this view:

“When people approach an emergency relief agency for support, they face the distinct possibility of a limited and inadequate response to their situation because the narrow focus of emergency relief limits appropriate intervention or referral. Giving people handouts without also offering a range of integrated services aimed at tackling their associated issues is unlikely to improve their long term situation.”

9.1.1 Current models

Across the community sector there are two service delivery models operating:

- Basic transactional ER – where the coordinators and ER workers simply provide basic food hampers and do not ‘value add’ to the service. In this model ER is seen as a simple safety net to support families and households in immediate crisis. 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. It is a useful safety-net service but does not provide for meeting long term or complex needs.

- ER PLUS individual client advocacy and referral (currently occurring within ANGLICARE Sydney) – 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. The ‘value add’ services provided in this model are not supported by current government funding models which is why there is a significant net cost to ANGLICARE for the service provision.

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46 Frederick, J. and Goddard, C (2008), Sweet and Sour Charity: The Experiences of Receiving Emergency Relief in Australia, Australian Social Work: Monash University, p271
The basic ER model is inadequate because it is transactional rather than relational. The focus is on the transaction, the provision of vouchers for food rather than on the person seeking assistance. The client has to prove financial hardship — other problems are secondary or unaddressed even though these may be the basis of ongoing disadvantage and deprivation. Once the financial needs are assessed or addressed then the transaction is completed and the client exits the system — possibly to return on a regular basis and with no follow up or support.

Current Government funding is limited to this model. It adopts a ‘one size fits all’ approach. This is particularly difficult for those with issues with mental health, financial literacy, drug and alcohol use and disability, since they often do not have the capacity to effectively navigate the community service support network. The key limitation in this model is that many clients do not present with one issue — their needs are complex, compounding and interrelated. Dealing with immediate need does not provide them with a long term sustainable solution. The situation is further amplified with Indigenous and NES community clients whose needs often require different approaches and strategy. As one researcher noted:

“Unfortunately, the way in which emergency relief funding is distributed by the Federal Government is problematic, because it offers no resources to agencies to provide more holistic services that would help address these more complex needs.”

ANGLICARE ER services provide additional support above and beyond provision of food and utility payment assistance. This approach is based on the fundamental principle that the ‘hand out’ or transactional ER model does not have the capacity to empower or contribute to long term sustainability. These additional supports are unfunded by Government and therefore subsidised by ANGLICARE. The top three support areas included:

1. **Information** — providing clients with information that can assist them with accessing other services, skills training, counselling and contracts with utility providers. This applied to 79% of clients but was particularly true for people experiencing insecure housing such as squats and boarding houses.

2. **Advocacy** — on behalf of the client to other agencies, service providers and government departments. Around 30% of all clients were provided with this service and this was a particular need for Non English speaking clients, particularly in Liverpool where 96% of clients required some form of advocacy.

3. **Budgeting assistance** — in the development of household budgets and bill paying that is more sustainable. This was true for 9% of clients — or almost one in ten.

The current funding model, apart from a $5,000 allocation per program, does not allow for infrastructure or employment costs. Volunteers can provide support in the packing and distribution of hampers, but assessment, advocacy and referral requires a paid staffing model. This part of the work is currently subsidised by Anglicare. Additionally people who are referred to other services often do not turn up for their appointments, but we currently do not have the capacity to follow this up.

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47 Ibid p279
9.1.2 Innovative models

What is required by services and funding is a transition to a more sustainable living ER model – with the central aim of building capacity for both communities and individuals. The simple safety net transaction model which has operated for so long is no longer the optimal approach, and while the basic ER Plus model provides for referrals and advocacy, it too is not sufficient for the broader outcomes based on sustainability.

ANGLICARE Sydney is exploring the development of a relationship model of ER service delivery to replace the transactional approach – where the whole need of the person is taken into account. Clients with complex needs could be assisted to navigate through the service system, and be provided with appropriate case coordination, follow up, skills training, counselling and social support via appropriate wrap around services. Community connection and social inclusion would be critical to the development of individual client capacity.

This new model means that an ongoing relationship could be sustained between the service and the client to ensure that the client’s needs are adequately addressed and clients do not fall through the gaps in the 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.

What would be the outcomes of such a model? It is anticipated that there would be:

- A reduced need for clients to access services – so a reduction in the number of multiple visits by clients with complex case histories
- Increased use of support services by clients with complex case histories
- An improvement in behaviour, attitude and skills – including financial literacy
- Evidence of improved capacity to cope – including an improvement in a general sense of well being, reduced levels of anxiety and stress

Effectively there would be a transition from a basic transactional ER safety net model to one incorporating referral and advocacy and finally to a fully integrated, holistic and relational model – as indicated by the diagram below.
9.2 Policy directions

New developments in Government policy in relation to ER and hardship need to take into account:

1. Complexity: There should not be a singular focus on the provision of increased funds for financial counselling. Instead this should constitute one component of the ‘suite of services’ indicated in the new policy direction. Such financial counselling would indeed go some way to address the needs of ER clients. However, the broader question in relation to clients who experience long term and multiple disadvantage is related to resourcing ER services in order to develop an integrated and holistic model which develops individual and community capacity and resilience. Such a model should recognise the complexity of need, the imperative of long term case management support and the provision of wrap around services. This goes beyond increased funding for financial counselling - although that would be welcomed and useful for part of our client base.

2. Infrastructure and Staffing: There should be a clear understanding that many of the ER services are currently operating at physical capacity – with a limited number of volunteers, staff, and
infrastructure such as interview rooms. While an increase in ER funding can lead to greater financial resourcing of existing clients, for more clients to be accommodated there needs to be provision for the further development of ER infrastructure to enable an expansion of service delivery to those in need. Such infrastructure could include increasing office and service delivery space, more paid staff and case managers, and enhancement of current IT facilities.

3. **Data:** ER services also need to be accountable for their service provision and the government needs to be better informed on changes in the ER client base – in terms of volume, demography and reasons for presentation. This assists in a flexible policy approach to enable greater responsiveness to perceived need. Such responsiveness can only be achieved with the development of comprehensive data capture systems – with capacity for full analysis and reporting to both Government and the services. Such systems require time for design, development and implementation as well as training for staff dedicated to data capture. They also require an effective reporting mechanism for such information to be meaningful. ANGLICARE Sydney has designed such a system which is currently being deployed across 7 of its sites. It is the means for assessment of trends and developments across our service system and is integral to further development of effective models of service delivery.

4. **Innovation:** Monitoring change via data to incorporate a flexible policy direction is a very effective tool, which is further enhanced by research into more innovative and effective models of service delivery – both nationally and internationally. ANGLICARE Sydney is currently embarking on a research project into innovative ER using literature searches and qualitative interviews of service providers. Funding such work could widen the scope and nature of such research.

5. **Evaluation:** This is an important process since it assists in understanding and identifying effectiveness, efficiency and areas of improvement; it makes services accountable. It facilitates organisational learning, decision making and innovation. It can ensure service sustainability. ANGLICARE Sydney is planning an ER client feedback system coupled with client focus groups to assist in such evaluation across our own service sites. However, consideration needs to be given at a global interagency level to development of effective evaluation systems to inform Government of the effectiveness and efficiency of Government funded ER services.

The Government’s current social inclusion policy agenda provides an opportunity for a transition to more effective models of ER. Government ER funding models need to take into account not just financial counselling but a range of other options if ER is to move from safety net provision to a program which builds resilience, independence and capacity. These options include case management, development of on-site wrap around services and more funding for infrastructure, research, evaluation, data capture, analysis and reporting. Community connection and social inclusion would be critical to the development of individual client capacity. Effectively there would need to be a transition from a basic transactional ER safety net model, to one incorporating referral and advocacy and finally to a fully integrated, holistic and relational model.
10. **Recommendations**

ANGLICARE Sydney recommends that the Government consider the following in relation to ER service delivery:

1. Recognition of the variety and complexity of need across all client categories and development of funding models to pilot case coordination and management in selected ER centres, with extensive evaluation across these piloted programs, to determine the effectiveness of such an approach.

2. Development of a suite of wrap-around services to support long term, marginalised and vulnerable households – including financial literacy and counselling, relationship counselling, budgeting, cooking nutritional meals on low income, interview skills development and resume assistance, parenting, and self esteem classes.

3. Funding for the development of a national ER data system building on work currently being developed in the sector. This could include facilitation of data sharing between agencies, development of guidelines for KPIs and standardised questions for assessment and even a national database system (recognising the confidentiality issues endemic to such a development).

4. Funding for a research strategy which uses both quantitative and qualitative methods to explore best practice models and evaluation.

5. Further research into innovative models of best practice ER service delivery and a commitment to fund pilot projects for such models.

6. Development of comprehensive ER evaluation systems based on client feedback.

7. Expansion of ER infrastructure and staffing to cope with the increased need emerging as a result of the global financial crisis.

8. An ongoing ER working party or steering committee of government and community agencies to assist in the development of an holistic and integrated ER service delivery model.
References


Frederick, J. and Goddard, C (2008), Sweet and Sour Charity: The Experiences of Receiving Emergency Relief in Australia, Australian Social Work: Monash University


