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Evaluation of the Wesley's Team Casework Model for SHS Services

Final Report

Prepared for the Wesley Mission

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Abbreviations

ACT	Assertive Community Treatment
AHURI	Australian Housing and Urban Research Institute
CIMS	Client Information Management System
CCM	Consumer CM
CM	Case management
ICM	Intensive CM
GIPS	Group Intensive Peer Support
SCM	Standard CM
SHS	Specialist Homelessness Services
SPRC	Social Policy Research Centre
TST	Therapeutic Support Team
Wesley	Wesley Community Services Pty Ltd

Executive Summary

This report presents finding from the evaluation of Wesley Mission's team casework model across four services in Sydney and the NSW Central Coast funded through the Specialist Homelessness Services (SHS) program. It describes the key characteristics of the model, the factors that contributed to its development, the benefits derived, and potential areas for development of the model.

The evaluation involved interviews with Wesley managers, caseworkers and clients, a review of the literature on team casework models and an analysis of 2016-17 CIMS data.

The evaluation found the Wesley team casework model is well developed and there is considerable enthusiasm for the benefits it brings to clients and staff involved. The extent to which the teams have a shared caseload (a fundamental component of the model) varies, though all the teams had established some collaborative practices and demonstrated many of the characteristics of the team casework approach articulated by Wesley.

Factors contributing to the success of the team casework approach include that the teams have autonomy; accountability to the team; clear, timely and succinct communication; and, recruiting the right staff to become members of the teams.

Reaching the optimum level of autonomy for teams is an ongoing activity for management. Some teams appear more reliant on their team leader to make decisions for the team, while others report that they need more help from management and more resources, especially around administrative and financial accounting issues.

One factor influencing the impact of the model, is the size of the team. Teams that are too big seem less efficient, and their accountability more diffuse. They also run the risk of missing clients and other service providers, which can be detrimental to progressing client outcomes.

One of the challenges for the teams is engaging with service providers who are not confident with the team casework model and/or who may resist working with it. Another is the concern amongst some stakeholders that the team casework model is unsuitable and possibly detrimental for clients who have a high degree of trauma. Wesley already pays attention to these issues, and the regular liaison with service providers to inform and educate them about the teamwork model and its impact remains important.

The evidence on case management in community settings to people who are homeless or at risk of homelessness is limited, but research studies have shown that a team approach to case management can have a positive impact on client outcomes. There is also some evidence that teams are beneficial for the workforce, because better access to relevant colleagues makes a difference. Moreover, there is evidence that clients with a high level of therapeutic alliance achieve better outcomes from case management. The findings of the current evaluation lend weight to these findings, and an area for further research is the contribution that having mental health clinicians, who work one on one with clients as part of the Wesley team, has on better therapeutic alliance.

1. Introduction

Wesley Community Services Pty Ltd (Wesley Mission) approached AHURI and SPRC to evaluate the team casework approach used by Wesley in delivering a range of Specialist Homelessness Services (SHS).

The evaluation explores in detail the Wesley model of team casework and contributes to the evidence about the model and its impact on clients and the workforce.

The purpose of the evaluation was to examine the effectiveness of Wesley's team-based approach and identify any improvements that might be considered for future service delivery. The evaluation is also expected to contribute to the development of a good practice guide for replication.

1.1 The Wesley team casework model

Wesley's approach is based on the position that clients benefit from a genuine team approach to support. Clients are understood to benefit from an opportunity to form a number of relationships which can reduce the incidence of unhealthy dependence, promote a sense of security because support eggs aren't in just one basket, and improve continuity in the instance of staff changes or a particular support relationship souring. In this framework, clients benefit from the awareness that a group of people exists around them who rally in support.

The model was first implemented in the SHS based in Sydney and South Eastern Sydney, and more recently in the Fairfield/Liverpool and Central Coast Families teams.

Elements of the model

A Wesley Mission brochure (Wesley, 2016) describes the team casework model (what it is and is not, why it's good for clients and staff and what it needs to be successful), and its key elements, which are set out below.

The model is one in which the entirety of the team – its varied expertise, its range of personalities, everything – is brought to bear in the support of every client. It is a model premised on relationships and on 'intimacy'. The intention is that clients authentically relate to all team members rather than to an assigned case worker who happens to be a member of that team.

The team:

- The team has a shared caseload rather than caseworkers having a personal caseload
- As much as possible, a client's needs are met from within the diversity of the team in preference to brokering in external supports
- Team members are not thrust upon a client and it is not the case that an unknown caseworker should ever arrive to support a client unaccompanied or unannounced
- Collaboration in the teams is more than just discussion and review of another's caseload
- Autonomy rests with the team (team members act only within the discretion of their colleagues)
- Staff carry a greater burden as they have more clients to know.

Clients:

- Clients see different team members at different times and for different things
- Clients authentically relate to all team members rather than to an assigned case worker who happens to be a member of that team
- The relationship a client will have with one team member compared with another will naturally be more or less intimate for all kinds of reasons, but ultimately the relationship remains one with the team
- Clients have a say in who supports them and what they are required to discuss with particular team members
- While an important word in the model, 'intimacy' does not equate to a disregard for professional boundaries.

The model is easily undermined by unfairness or discord:

- When a team member goes it alone or keeps secrets or is reckless with a course of action designed by another
- When team members allow one to be played off against another or disregard the value or contribution of another
- When there is discrepancy between the effort, reliability or manner of some team members and that of others.

The role of management:

In simple terms management provides the environment and equipment and releases the team to act freely within the bounds of the mission.

Management nurtures the health of the team and safeguards its culture. It intervenes when staff or client safety is in question or when the team's mission or health might appear compromised.

Management is close to the ground and close to the action and is a participant in the day-to-day conversation. But the mature team is generally moderating its own activities with its management intrinsically in the loop.

1.2 Final report

This report explores the team model from the perspective of the staff and clients involved at four SHS sites. Chapter 2 sets out the evaluation methods, while chapter 3 is the literature review. Chapter 4 describes the key themes emerging from the evaluation, and chapter 5 looks at the impact of the model. Chapter 6 is a description of the clients and their outcomes, while the Annex (separate document) is a full description of the CIMS data (2016-17) for each site involved in the evaluation.

2. Evaluation methodology

In this section we outline the scope and methods used for the evaluation.

The scope of the evaluation was to examine the team-based model as it has been implemented at four Wesley SHS services: Therapeutic Support Team (TST) - Singles (Sydney and South Eastern Sydney), Prevention and Early Intervention Team (South East Sydney); TST Families Team (Fairfield/ Liverpool); and, TST Families Team (Central Coast).

The evaluation was conducted between July and October 2017. It involved multiple methods which are listed below and described in sections 2.3 – 2.5:

- a review the literature (research synthesis)
- analysis of 2016-17 CIMS data for the four sites
- site visits to conduct stakeholder interviews.

2.1 Evaluation questions

The overall purpose of the evaluation was to examine the effectiveness of the team casework model, identify the factors and mechanisms that contribute to the model's outcomes, and determine the areas for development. The questions guiding the data collection and analysis were:

- How has the Wesley team-based model been implemented at each site? What are its key features?
- What are the key factors contributing to implementation of the team-based approach? What factors, if any, have hindered its development?
- What effect does the team-based model have on service delivery, client satisfaction and workforce effectiveness?
- What are the advantages of a team-based approach over individual case management? Are there any disadvantages and, if so, what are they?
- How does the model facilitate improved outcomes (housing stability, health and wellbeing, community engagement) for people who were homeless? Are there particular client groups for whom it works better?
- What if any modifications would contribute to improving service delivery and outcomes for clients?

2.2 Ethics

The research team submitted an ethics application to the UNSW Human Research Ethics Committee (HREC) on 13 June, seeking approval for the study. HREC approved the study on 27 July: HC17517.

Human research activities are governed by the principles outlined in the National Statement on Ethical Conduct in Research Involving Humans (National Health and Medical Research Council,

2007). The Research Code of Conduct sets out the obligations on all UNSW Australia researchers, staff and students to be aware of the ethical framework governing research at the University and to comply with institutional and regulatory requirements.

2.3 A research synthesis

This is a synthesis of key findings of significant research relevant to international best practice in intensive case management for formerly homeless clients, with a focus on team-based case management.

A database search was conducted for relevant literature. After searching for relevant databases, the Social Worker Abstract Database was the most suitable. Various search terms included, "homeless*", "adult", "case management", "support", service", and "team". This produced approximately 90 documents; duplicate titles were removed; abstracts were reviewed and assessed for inclusion if the study included homeless adults AND case management; the remaining full manuscripts were read. Google Scholar was subsequently searched for additional literature utilising the same search terms as the database search.

2.4 Analysis of de identified administrative data (CIMS data)

Wesley Mission provided SPRC with de-identified data extracted from the Client Information Management System (CIMS) for the 2016-17 financial year for each of the four sites to allow analysis of service provision and client characteristics across a range of domains, for current and exited clients. Data included:

- demographic information
- presenting circumstances
- support provided to clients
- financial assistance provided by the program
- client circumstances, one week prior, at beginning and end of support period
- reason for closing the support period.

No data was available on:

- number of exited clients
- number of referrals received each month (including ineligible)
- clients' links to health services
- clients' health/wellbeing progress
- reasons for a client's success in sustaining a tenancy
- unsuccessful referrals out
- percentage of clients who did not engage after a set period of time.

2.5 Site visits

A researcher conducted site visits to interview staff and clients at each of the four sites.

Face to face (group and individual) interviews and a small number of telephone interviews were held with 26 staff and 14 clients in the period 30 August - 26 September 2017. Table 2.1 shows a breakdown of the number of interviews by site.

Table 2.1 Stakeholder interviews by site

Team	Site	Method	Caseworkers	Team leaders	Clients
TST Singles	Sydney & South Eastern Sydney	individual interviews	9	2	5
Prevention and Early Intervention Team	South Eastern Sydney	individual interviews	5	1	-*
TST Families	Fairfield/Liverpool	team interview^	4	1	1
TST Families	Central Coast	team interview^	4		8
Total			22	4	14

^ The team leader for the two TST Families teams was interviewed individually
* The Prevention and Early Intervention team chose not to include clients, as the interventions are of a short duration.

2.5.1 Client interviews

We interviewed 14 clients about their experiences of the Wesley team-based approach, benefits of support, and any recommendations for changes to the type of support provided. Clients in three locations were recruited through caseworkers, who distributed flyers and invitations. Clients gave their permission for service providers to provide the research team with their contact details. Interview topics included:

- experience of and satisfaction with the team caseworker model
- flexibility and responsiveness of services
- referrals to other services
- benefits of the service and any suggested improvements.

2.5.2 Service provider interviews

We interviewed 22 Wesley staff from across the four sites.

The Wesley coordinator and team leaders emailed their team members the invitation to participate in the evaluation and the participant information and consent form, and staff members either contacted the research team directly to express their interest in participating in an interview or let their team leader know that they were interested in participating. Interview topics included:

- experiences of working with a team-based model
- benefits and challenges of the model's implementation
- perceived outcomes for clients
- development of the model.

2.6 Caveats and limitations

The evaluation looks at how the Wesley team casework model is operating across the four teams, identifies its strengths and weaknesses and areas for development. While the evaluation reports the identified outcomes for clients, it was not possible to assess whether these outcomes can be attributed to the Wesley model, in the absence of a counterfactual.

No service providers from other agencies (other than those involved in the partnership) were interviewed for the evaluation.

3. Research synthesis

This literature review was undertaken to identify characteristics of best-practice models for case management service delivery to adults experiencing homelessness, including comparison of a team approach model compared with individualised case management. Relationship-based models were also of interest. Service trajectory timeframes are also explored within the literature to understand intake and exit models which have been shown to be successful among this population group. Additionally, this literature review sought to understand the different impacts on workforce of team approach compared with individualised case management.

There were several gaps found in the literature: the studies reviewed did not present data or analysis regarding team-based versus individual case management; the impacts of different case management models on the workforce were largely unexplored and, the reasons behind unsuccessful transitions from a specific case management model remain unclear.

3.1 Sydney's homeless population

A person is defined as "homeless" when they do not have suitable accommodation and their current living arrangement: is in a "dwelling that is inadequate"; or has "no tenure, or if their initial tenure is short and not extendable", or "does not allow them to have control of, and access to space for social relations" (ABS, 2012). It is estimated that 279,000 Australians are homeless, or 1 in 85 people. The Australian Bureau of Statistics (ABS) reports accurate population numbers of those experiencing homelessness are impossible to ascertain due to definitions of homelessness and questions on the census (ABS, 2016). The census asks whether respondents are sleeping in tents on the night of census completion, but this does not differentiate the different recreational reasons someone may choose to sleep in a tent compared with a person without a fixed address. In lieu of census reporting, homelessness estimates are based on number of people accessing, or attempting to access, specialist homelessness services (SHS) (AIHW, 2016).

Between 1 July 2015 and 30 June 2016, Australia's homelessness services received an average of 275 requests for assistance that could not be met each day (AIHW, 2016). One in 10 of those accessing SHS presented with a disability (including experiencing issues of self-care, mobility, and/or communication), 1 in 4 were experiencing current mental health issues (AIHW, 2016). Indigenous people were greatly overrepresented, accounting for 1 in 4 people accessing SHS (AIHW, 2016). People experiencing domestic or family violence accounted for 38% of those accessing SHS (AIHW, 2016). Persons recently released from custody accounted for 3% (84% of whom were adults) of those seeking SHS assistance (AIHW, 2016). The Fourth General Social Survey, a national survey contacted by the ABS, found that 28% of those who had experienced homelessness over the previous ten years had experienced episodes of homelessness of 6-month or longer (ABS, 2015). In NSW, 1 in 109 people accessed specialist homelessness services (SHS), a rate lower than the national average (AIHW, 2016).

3.2 Styles of case management

There are a range of case management (CM) service delivery models within the literature. These include standard case management (SCM), assertive community treatment (ACT), intensive case management (ICM), and supplemented support strategies such as brokered case management.

SCM services include practical support, assistance with independent living skills, and a range of other supports including crisis management and assistance with psychiatric and medical treatment (de Vet et al., 2013). The ACT model encompasses a holistic approach within a multidisciplinary team to provide “intensive, timely, and personalised services” (Bond & Drake, 2015, p. 240). Specifically, the ACT model provides 24-hour responsibility of care within a low caseload ratio (Finnerty et al., 2015). ACT is designed for clients with severe mental illness, and was initially designed as a community reintegration strategy (Bond & Drake, 2015). ICM is delivered over an indefinite time period to persons experiencing complex issues and is provided by case managers with a low case load (Dieterich et al., 2017).

Consumer case management (CCM) incorporates former clients into the roles of case managers as a peer-based strategy for connecting clients with services and providing the necessary supports associated with homeless and other needs. The Group Intensive Peer-Support (GIPS) model is a crossover approach encompassing both CCM (groups are facilitated by case managers but rely on and integrate active peer support and assistance) and ICM, whereby clients are provided with intensive CM as needed (Tsai & Rosenheck, 2012).

Another service delivery model addressed in the literature which included CM, but was not specific to CM, was the Housing First approach. Housing First provides housing to single adults or families upfront, prior to addressing other competing needs such as mental illness and substance use (hence, the Housing First name) (Collins, D'Andrea, Dean, & Crampton, 2016).

Table 3.1 is a summary of the various models. This list is not exhaustive, and reports on case management styles located within the literature. It is likely that other case management delivery models have been implemented.

Table 3.1 Case management models – summary

CM model	Target population	Level of support
Standard case management (SCM)	Homeless	Practical support, assistance with independent living skills, plus a range of additional supports including crisis management and assistance with psychiatric and medical treatment
Assertive community treatment (ACT)	Homeless and mental health	24-hour responsibility of care. A holistic approach within a multidisciplinary team. Indefinite time period / 12 months (depends on service provider)
Intensive case management (ICM)	Homeless and other complex issues	Provided indefinitely by case managers with a low case load. Indefinite time period
Consumer case management (CCM)	Homeless and other complex issues	Peer-led CM with additional supports facilitated by non-consumer case managers
Group Intensive Peer-Support (GIPS)	Homeless	Includes both ICM and CCM

CM model	Target population	Level of support
Housing First	Homeless and other complex issues	Provides housing first, then works with clients to address other chronic or ongoing issues.

3.3 Best-practice case management

A review of the evidence about case management practice for people experiencing homelessness conducted by Gronda (2009) found no empirical evidence to conclude that either a single person or a team is best for case management, but did find that multidisciplinary teams providing a case management relationship with the required qualities has been proven to deliver reduced homelessness and more client satisfaction at no extra total system cost than office-based services, for clients requiring a complex service response.

Gronda, quoting Boyer and Bond (1999), notes that "Furthermore, one study found that such teams also experience significantly higher job satisfaction and lower burnout rates, and provided some evidence that it was the access to relevant professional colleagues rather than the caseload size that had the positive effect on worker experience" (cited in Gronda 2009 p10).

In studies exploring the efficacy of different types of case management, ACT was routinely found to be one of the most effective methods of case management delivery for providing supports to the homeless population (specifically those also experiencing mental health issues). ACT encompasses a holistic approach within a multidisciplinary team to provide "intensive, timely, and personalised services" (Bond & Drake, 2015, p. 240) and has been shown to be effective in reducing experiences of homelessness and psychiatric morbidity (Bond, Drake, Mueser, & Latimer, 2001). Clients accessing ACT service models generally experience reductions in emergency department visits and hospital stays (Morse et al., 1997).

Wolf and colleagues (1997) conducted a cost-effectiveness evaluation of three different case management approaches, including brokered CM, ACT, and ACT supplemented with community workers. ACT was found to produce better outcomes among clients and was more cost-effective than the two other case management approaches. Another comparative study found that brokered case management was not effective compared with ACT or ACT supplemented with community workers. Clients receiving only ACT achieved more days in stable housing than those receiving either of the other two (ACT supplemented and brokered CM) styles of case management (Morse et al., 1997).

The GIPS model has been utilised with veterans in supported housing through the US Department of Housing and Urban Development – Veterans Affairs Supportive Housing (Tsai & Rosenheck, 2012). GIPS was found to increase social integration among clients (which may be in part due to the peer-group model), and connect clients with housing (through accessing Section 8 vouchers) (Tsai & Rosenheck, 2012).

The Housing First for Families program was conceptualised with CM completing assessments with clients once they were housed, but instead, due to the urgent need to locate accommodation within resource-constraints, CM time was utilised assisting team members and clients to locate suitable

housing (Collins et al., 2016). From the service providers' perspective on the family-focused Housing First service, it was found that families required "diverse case management expertise with supportive, resilience-focused supervision" (Collins et al., 2016). The CM model inferred to is that of ACT whereby an interdisciplinary team would be able to work collaboratively to meet the multiple and competing needs of individuals and families.

In a comparative study between CM and supplemented CM for homeless people with psychiatric morbidity and substance use issues, it was found that each service model was effective specific to certain client needs (Clark & Rich, 2003). For those with lower levels of substance use and psychiatric needs, CM was found to be beneficial (and cost-effective); for those with higher levels of substance use and greater psychiatric need, the supplemented CM model was most effective (Clark & Rich, 2003). Similar findings were obtained in a literature review comparing ACT, ICM, and service delivery with combined housing and support. The combined service delivery approach was found to be the most effective, but ACT was also shown to produce improved outcomes for clients; compared with ICM which had the weakest outcomes for effectiveness (Nelson, Aubry, & Lafrance, 2007). Likewise, in a systematic review comparing standard CM, ICM, ACT, and critical time intervention CM models, ICM was shown to be least effective (de Vet et al., 2013).

Chinman, Rosenheck, and Lam (2000) compared client outcomes (those experiencing homelessness and serious mental illness) across two different types of client relationships with case managers: high or low therapeutic alliance. Relationships were followed at three time points including baseline, 3 months, and 12 months. Clients who had high therapeutic alliance at three months with their case manager experienced significantly fewer days of homeless at the 12 month time point. This trend continued, with those reporting high alliance at 12 months reporting fewer days of homelessness compared with those reporting low therapeutic alliance. Predictably, those reporting no alliance with their case manager were found to have the least benefit of CM indicated by number of days of homelessness at 12 months. Clients reporting high therapeutic alliance at both 3 and 12 months also reported higher general life satisfaction at 12 months (Chinman et al., 2000).

3.4 Exiting clients from case management: best practice

Although ACT was initially conceptualised as delivering lifelong care to clients (Bond & Drake, 2015), this model is not evidence-based nor cost-effective (Finnerty et al., 2015). While successful care transition has been shown to be achievable (Hackman & Stowell, 2009; Rosenheck & Dennis, 2001), there are limited studies reporting on the transitional period and longer-term effects of clients moving out of intensive ACT care into lower service support models (Finnerty et al., 2015). In a study regarding clinicians' perceptions of transitioning clients out of the ACT model, team leaders identified that ACT "may inadvertently foster dependence rather than promote independence", requiring clients to "unlearn" this dependence upon transitioning out of ACT care (Finnerty et al., 2015, p. 90).

Retaining clients who were doing well (rather than transitioning them out of ACT care) was perceived to have positive effects on workplace satisfaction among the staff working with those clients (Finnerty et al., 2015). Systemic barriers to transition included availability of mental health

services, navigating access to these services, and stigma by some mental health providers towards clients with complex needs (such as those accessing ACT supports) (Finnerty et al., 2015).

Although transition is a priority, there does not appear to be a readily available criteria or assessment (see for example: Finnerty et al., 2015). A study in Florida sought to assess outcomes of clients transitioning out of ACT care. There were no significant differences between clients who successfully transitioned and those who returned to ACT care during the study period, based on demographic variables, treatment factors, or mental health diagnosis (Hackman & Stowell, 2009).

3.5 Summary

There is a paucity of literature on CM models for people experiencing homelessness. The ACT model was identified as the most cost-effective and best practice model for clients experiencing homelessness coupled with mental health. However, there is limited research available regarding other CM styles among the different homeless population groups. ACT was found to operate most-effectively with a time-end approach (rather than lifetime support). Although clients could be successfully transitioned out of ACT care, the reasons behind unsuccessful transitions remain unclear.

4. Findings: experiences of the model

This section describes the key themes emerging from the evaluation about the team casework model and the factors that have contributed to its development.

4.1 A respected model

Stakeholders, including clients, who we interviewed, had a clear understanding of the model. Case workers and team leaders gave an articulate account of the model's key features, and the ethos and culture it instils. This is an important finding as it is this shared understanding that helps to maintain the fidelity of the model as it develops, especially as the teams have a high degree of autonomy which is, in itself, an important factor contributing to success.

It was clear that the team casework model is not just the mechanics of teamwork but 'an approach to work - its culture and attitudes'. It was also clear that the model is at different stages of maturity across the sites, with some teams more self-moderating than others[1].

There was goodwill, ease and trust evident amongst team members and towards managers of the various teams. Stakeholders from across all the teams had a sense of shared responsibility for clients and an appreciation of the benefits that team casework brings to them.

Team members held each other accountable for communicating effectively about progressing clients' case plans, and for client outcomes. However, for some stakeholders, the team model was considered somewhat opaque, as no one caseworker could be held responsible for progressing clients' case plans.

Many of the clients and caseworkers we interviewed expressed their appreciation for the range of benefits arising from the Wesley's team casework model, even though for some it was not their preferred way of working or being case managed. However, some caseworkers considered the model possibly unsuitable for clients who struggle to engage with services. Some external service providers also struggle to gain an appreciation of the model, despite the agency's ongoing efforts to inform them.

The small teams (with 4-5 caseworkers), where team members share an open plan office, are seen as ideal, because 'everyone can know everything'. The size of the bigger team (with 10 or more case workers), with its large caseload, is seen as cumbersome and less efficient, and there is genuine concern that clients are 'falling through the gaps'.

[1] The Wesley brochure on team casework states that '…the mature team is generally moderating its own activities with its management intrinsically in the loop'.

4.2 Shared caseload

The Wesley team casework model is about the teams having a shared caseload rather than caseworkers having a personal caseload, and so clients will see different team members at different times and for different things.

The evaluation found that the teams varied in how they went about sharing caseloads, and this influenced clients' interactions with the teams. The TST Singles is by far the biggest team (with 12 caseworkers) and has a shared caseload for its clients. This team is bigger than planned as it combines staff from two funding packages. The two smaller TST Families' teams, in Fairfield/Liverpool and the Central Coast (each with 4-5 caseworkers and a shared team leader), have one or two key workers for each client, but a shared caseload. The South Eastern Sydney Prevention and Early Intervention Team members have a personal caseload, but team members collaborate and there is the capacity to share caseloads when required.

Below are a set of quotes, one from a member of each team, that demonstrate the shared caseload approach at each site.

"With the team model it's a bit like I'm putting a drop of oil on a pond. It just smooths everything out. So, people can effectively say "I've got 100 clients' but I can sign off tonight because I know that somebody else is going to be looking after them.". ..when you're dealing with a lot of people - there's 77 residents here - you've can't possibly just have a few each. You've got to just really be able to pick up and move around."

TST Singles

"…the program I work within has a bit of an individual and team based model…..if there's a client needing things and perhaps there wasn't quite the right fit between a case worker and the client, there's the opportunity for other case workers to assist as well, in that team model type approach. On the flip side, the good thing with our program is that I can just work individually with clients, so if they are needing things, and things are working well between us, yeah, I can follow that through myself."

South Eastern Sydney Prevention and Early Intervention Team

"…so you have your case load and you work with the client to help them to achieve, to develop goals, but when you're not around the team can also help you so it's not just about you working with the client, anybody can work with the client – yes, you are the key worker in terms of when you meet them, you do the assessment and everything like that but everybody knows all about the clients so they can just pick up where I left off, if I'm struggling with the client and I don't know where to go next then somebody else can pick up."

Fairfield/Liverpool TST Families

"…you do have sort of a main worker who might have done that initial assessment and built that sort of initial rapport and connection, however if they [the client] call up, other workers can access their information and provide them with advice and information, and then too, it's never been that, "No, I only want to talk to my worker." It's always been, "Well we can facilitate those conversations and we can support you with whatever's happening at that particular time."

Central Coast TST Families

Client feedback about their experiences of support from the various Wesley teams reflects these differences, in that some clients said they saw multiple team members, while others mostly engaged with just one or two caseworkers.[2]

Amongst clients who saw multiple team members, the feedback was mixed, though none of these clients expressed dissatisfaction with the team casework model, and some were very enthusiastic:

> *It was inspiring like meeting different workers, getting help from different people was really helpful. We made a bond and they've always said if I ever need help to just come and talk to them. They give good support.*
>
> *Like I said before, before I had personal case management, you know, and they didn't really do nothing. But these people talk to each other, communicate very well with each other as far as I'm concerned and what's happened to me. You would think – my case is very difficult and very extreme - sometimes you think well, they're young, they wouldn't really have the experience and then you think oh, wow, they blow me away. I have nothing but five stars for everyone that I've seen and for the entire time didn't waste your time. Well, it's if you have to, as the case management person, read the notes and then I'm sure they chat because there's just fluid. I've not had to fill them in.*

A concern amongst some caseworkers is that some especially vulnerable clients are expected to see too many caseworkers, which is detrimental to the clients, the caseworkers, and the relationships between them, as one caseworker explained:

> *I think the main one, coming from clients within our client group, are that they often find it difficult to develop a connection with so many people at the same time. So, at the moment there's about 10 or so people in our team, so for a client they could be meeting with any one of us depending on the day of the meeting. For a lot of them they've been through a lot of trauma, and they may not trust a lot of people, and so to be able to trust 10 different case managers and tell quite important things to 10 different people is quite difficult for some of our clients.*

For other caseworkers, the mix of staff within the teams, and the flexibility of the model means it is well suited to all the clients, as one case worker described:

> *Everyone on the team is different ages, different backgrounds, different styles. Some people are quite dot their I's, cross their t's, some are a bit more casual and easy going with clients. I think some clients probably need a bit more of a relaxed approach and low key, and not so clinical and to the point. Whereas, some people really need to have a strong figure that can go through these things and be more directive. So, it just depends on the client really. We have more of a variety of age and genders now, so, it's really good when we see that certain clients gravitate towards – they might not respond so well to a younger female, they want an older male relationship. That's good, because we can go "hey, [male worker], can you see this person".*

[2] Note that only one client from Fairfield and no Sydney South East clients were interviewed.

A specific concern is that the team casework model sometimes impedes, rather than enables client engagement with the service, particularly for vulnerable clients, as one caseworker explains:

> *You've got someone who's spent say two years on the street, or hasn't really been case managed, or had access to services for a couple of years, a lot goes into that first appointment. So, this is building a bridge into the service. And if someone [another case worker] isn't aware of how precarious that situation is, they could get lost in terms of the rapport, and they don't want service anymore.*

Another concern is that it is getting harder for a big team of case workers to look after a larger pool of clients, which means clients have less contact with case workers, tasks such as housing applications get delayed or overlooked, and clients are not followed up in a timely fashion. Staff turnover exacerbates the problem, as it can take up to 12 months for new caseworkers to learn the team approach.

For clients who mostly had contact with just one or two case workers, the majority said they were familiar with the other team members and felt comfortable to seek and/or receive their support, when required. They had been introduced to other team members and were told, from the beginning, that the service used the team casework model.

A common theme was that clients typically had a stronger relationship with a particular caseworker but benefitted from having the entire team involved in providing practical support. The following client quotes illustrate this theme:

> *…you'd have your favourite and you'd call them, but if they weren't available, or if you called the office, like if you didn't have their mobile number or their mobile number was busy, and you could talk to anyone because you knew them. You'd have met them. And they knew your story and your background, so you didn't have to go through everything over again or have someone kind of half an ear listening to you on the phone while they're trying to flip through paperwork to look at your file to see who the hell you are.*
>
> *They did help me, and if she didn't know anything because she's only quite young, she'd ask [another caseworker]. So, they did work together, and they did work good as a team, but I would rather have just one person to look after me. I mean there were girls in the office and they'd all do kinds of certain things, you know, help me get food vouchers, petrol vouchers, all kinds of stuff like that. Just any help and support that I needed. And they did work well amongst themselves sorting out stuff for me and everything, they did.*

A few clients spoke about how they were gradually introduced to other team members and were then able to engage more with them over time.

> *That first coming out of rehab to having nothing, being completely and utterly vulnerable, having those workers come and then the next week having one of them be the same but one of them different, so that you get to know them. They get to know you.*

For another client, it became obvious that working with the team was a more efficient way for getting things done:

> *Probably when I first linked in with them and was a lot more vulnerable, I could have found it really confronting and kind of been like, "Okay, just get [the caseworker] to call me", rather than actually saying, "this is what I need", which would just delay the process, because then I'd have to wait for [caseworkers] to call me for me to then say, "Hi, I need blah, blah, blah, blah, blah. Can you organise that for me?". For them to then go to their team leader and say, "Can we organise this for [client]?" It probably in some ways seems more efficient because they would have to have meetings every day in the morning to sit down, discuss this, where we're all at, who came here, what day, doing what. But for the client, to know that if you couldn't get in touch with the person you want to speak to, you could ring anybody and be comfortable speaking with them.*

Feedback from the caseworkers in the smaller teams is that the decision to have one or two caseworkers more engaged with a client, rather than the entire team, was partly to do with the logistics of managing bigger caseloads and doing the mostly outreach work with clients.

A small number of clients said they preferred having contact with a single case worker, rather than a team. One client noted:

> *Like I said I was very lucky to mainly deal with that one person. But the option was there to deal with others. I mean, I get that. But I was quite happy with that, with my little head space and my anxiety and my depression problems. I dealt better one on one. Other people might like two or three or four. But to me, in my space, that's what I preferred, and it worked for me.*

It's important to note that all the clients confirmed that their privacy and confidentiality were respected by the casework teams.

4.3 Accountability

Many caseworkers spoke of the responsibility to their team to communicate clearly and comprehensively about clients and their progress. Team members also said they share responsibility for the outcomes being achieved for the clients, and feel accountable as a team.

However, some stakeholders' experiences with the team model is that shared responsibility can mean no one is responsible for following through with decisions, which causes problems. There was frustration at wanting to know who in a team was responsible for various actions, and with having to use the team email rather than individual case workers email. Sometimes emails were not responded to, or tasks were not done, which caused further frustration, as it delayed progressing clients' applications and referrals. This was described as a lack of accountability, with the observation that certain team members seem more willing than others to follow through and do the work required.

Wesley team members recognise that in a team model, some things do inevitably get missed. Team members are also aware that the team casework model can be challenging for other service providers who are unfamiliar with it and assume that there will be just one caseworker for clients.

Wesley has various strategies in place to address these concerns, but it remains an ongoing challenge.

4.4 Autonomy

The autonomy in the model rests with the team. Autonomy is valued by team members, it places the onus on the team to make decisions and makes it clear that team members are accountable to each other, rather than rely on a team leader to supervise. As one caseworker described:

> *We don't have a supervisor or a team leader or anything like that, we're all quite equal, you know. We know that no one's better than anyone else, no one has more responsibility than anyone else, so there's really no competition.*

Much goes into supporting the autonomy of teams including strategic leadership, and cohesive relationships, built on trust. Feedback from the caseworkers indicates that management is mostly hitting the mark in terms of 'releasing the team to act freely within the bounds of the mission; that is ending for good each person's experience of homelessness' (Wesley, 2016).

One team said that managing the various aspects of the service, especially the finances, was onerous and they requested more administrative support. They also thought there was a lack of support from management when they have had to resolve delays in the financial transactions and accounting errors with the Wesley finance team.

A caseworker said that there is too much control of the purse strings and suggested that, given the caseworkers do have a lot of autonomy and trust, the monthly spending limit on the fund for clients to which teams have access be raised, as the $1,000 limit can be spent very quickly.

One caseworker suggested more rigorous monitoring of the stress amongst staff, some of whom are struggling to cope with larger caseloads. This comment was in the context of past events, and it is unclear if the same conditions apply.

4.5 Communication

When there are multiple case workers involved in someone's case, the communication lines need to be solid. Two important communication hubs for the teams are the team meetings and the CIMS database.

Feedback from caseworkers is that the weekly team meetings are beneficial, for all the reasons intended: client updates, brainstorming, staff wellbeing, and administration.

> *In team meetings we discuss all kinds of ideas and nuances that may happen to a client or the housing options say, or the mental health options that need to be discussed with the client and then we would talk about how we would approach them, how that staff member would approach them. So, it's not only thinking about all the ideas so that the client has all the options on the table, but we're also thinking collectively how to deliver that to the client because some may have a better*

relationship with the client than the others or has new staff come in and they've only seen the person twice or something.

Outside of the team meeting (and group supervision for some teams), team members are not together a lot, and teams make good use of the group SMS and email to communicate. There seems to be a distinct advantage for the teams that share open plan offices for the opportunity this gives them for sharing client updates, helping each other out, and offering informal support.

The CIMS database is where caseworkers are expected to go for updates about the clients, and the teams know that case notes need to be up-to-date, comprehensive and accurate for the teamwork model to work. Maintaining the standard of case notes requires ongoing attention. If there is too much information, it can be hard to find the actions, and if there's not enough detail, it's very difficult for the next caseworker to know exactly what's required. If there are delays in completing the paperwork, it can delay any advances that could potentially help the client.

Team leaders are continually improving case workers skills and confidence to write up their notes. The same goes for a more judicious use of the group emails rather than using them as a double up of what's in CIMS. A caseworker describes how the CIMS works for the team:

I think you have to be very trusting that another colleague will follow up on certain things, or do what they're supposed to do. We've got admin tasks like phone calls or emails – it's a lot of faith if you're not checking it to make sure things get done. Usually, it's pretty good. I think the fact that we've got a lot of new staff and there was a period of high turnover, I think some things did get dropped, just because people are still learning, which is fine. If something is major, I would probably let my team leader know, if something was not changing. But I haven't got to that point yet. Nothing too major. It might be more like documenting something, like maybe someone has seen a client a week and a half ago, but, there's nothing been put on the CIM. So, they might be either really behind in their notes, or they've just forgotten, and so, I might just remind them nicely, like hey, just FYI you need to do that because it's important.

4.6 Recruitment

Stakeholders appreciated the care that goes into recruiting new caseworkers, and how important this is for the wellbeing of the teams. In staff recruitment, there is an emphasis on case workers capacity for team work, on top of their specific skill set. There's a different rhythm in team casework and it can be difficult for new staff to adapt to this.

So, it just takes a bit longer I think, and sometimes people coming into the role will say they are quite happy to learn about the team model but when it comes down to it, each of us is vulnerable to the other person. Some people are uncomfortable with that because, for example, if I write a case note and it's not correct, I'm going to be told that in the team meeting. The discussion is as a team in every aspect.

4.7 Summary

The team casework model is well developed and well understood by a range of Wesley stakeholders: clients, caseworkers and team leaders. It was clear from the findings of the

evaluation that the model is not just about the mechanics of teamwork, and it is also the case that the model is at different stages of maturity across the sites.

A key difference in the model across the four sites is the extent to which the team has a shared caseload, with one team sharing all its clients, another using more individual case management, and the other two teams with features of both.

One concern amongst some caseworkers is that because of the model's expectation that clients will relate to all team members, it is unsuitable for clients who have a history of trauma and who struggle with forming relationships. From clients' perspective, a useful strategy is for a gradual introduction to the team, to allow time for trusting relationships to form.

Factors that are critical to the team casework model's success in effective case management include: shared accountability; that autonomy rests with the team; clear, timely and disciplined lines of communication within the team; and recruiting the right staff to become members of the teams.

For some stakeholders, the shared accountability is sometimes seen as less accountable than individual case management, especially when there are delays in progressing clients' case plans and following up with other service providers.

Stakeholders also emphasised the need for continual improvement of team members skills to communicate clearly and succinctly in CIMS and emails, and the importance of timely feedback about these channels of communication.

Reaching the optimum level of autonomy for teams is an ongoing activity for management. Some teams rely more on their team leader to make decisions for the team, while others are seeking more management and resources, especially around administrative and financial accounting issues.

5. The impact of team casework

Wesley caseworkers and managers could easily identify the benefits of the model, for themselves and their clients as well as some shortcomings. Clients also expressed their appreciation for the support they had received from the teams and spoke of the benefits for themselves.

5.1 Seamless service delivery

Many team members, especially in the smaller teams, report that they have sufficient knowledge of the clients in their team, which means that any of case workers can progress clients' case plans and respond to clients' requests, leading to a more seamless service. As a client noted:

> *Having a team meant that whoever answered the phone, you knew they knew who you were, your situation, and what was going on for you.*

It is worth noting that none of the clients we spoke to said that they had to repeat their stories to the various caseworkers with whom they worked.

However, delivering a seamless service is not always easy, especially in the bigger team, and caseworkers shared their experiences of when the support was less than seamless (outlined in the previous chapter). Seamlessness happens when team members are all on the 'same page', a phrase commonly used by caseworkers. It means that, as caseworkers described it, they are up-to-date about clients and their progress, there is a common approach to clients, a knowledge of the agreements made with the clients, and a respect for each other's expertise and contribution to each client's outcomes. It's also about recognising different approaches, as one caseworker noted:

> *…if you're in a team approach there will definitely be occasional disagreements, differences of opinion. One caseworker might assess a situation in a different way to another caseworker. So, it's important to reconcile yourself to the fact that different caseworkers have different approaches and they do assess the situation differently from you, but at the same time you still need to work together with that person and hold the client's interests close at heart. You both need to be able to do that for the team model to be effective.*

5.2 Team support

All the clients we interviewed tended to speak about 'they', meaning the Wesley team that supported them, rather than individual case workers. Some described their relationships with the team and how this provided a pool of workers who knew them and their story, and from whom they could seek emotional and social support. It is also true that many clients said they have a stronger connection to a specific case worker, though most appeared at ease with engaging with other team members.

As noted previously, team casework is not everyone's preferred method. Moreover, it can take a while for new clients to get used to engaging with the team, especially if they have only ever experienced individual case management. The same can be said for new team members and other service providers. Feedback from the case workers is that the teams are sensitive to this and will adapt the team to accommodate clients' needs. Another positive is that clients get some choice about who they engage with, which is less likely in individual case management. As one case worker noted:

It can be really good if the client's not quite sure if they like you, not comfortable, or it's not working, that's where you can get your colleague to come in and assist as well. When there's complex mental health, I think that can work really well, if they might be unhappy about something, you can get someone else to support them, it's good to offer that.

From the caseworkers' perspective, they could see that clients benefited from having access to a multidisciplinary team to offer a broader range of expertise and experience. Also, because it's a team rather than individual case management, clients are thought to be more self-reliant, and hence can make smoother transitions out of the support service.

No doubt, there are clients who struggle with the team model and feedback from the caseworkers is that this can be challenging and disappointing for them, for the clients, and for others involved in the case plan. On the other hand, the caseworkers saw the various benefits of the team model, for them as professionals and in their capacity to support clients.

5.3 Sharing the workload

A key benefit was about sharing the load, as a caseworker described:

I think it works really well for the client and for us to because a lot of the time like if we're going to take five days off or you know just go on a holiday the last thing we want is to be awake thinking "God I didn't do this I didn't do that". Knowing that everybody else can take over and not have to stress about it, because otherwise the work is on you and then you have to wait until you come back and the work gets suspended and it is very stressful. It works really well for part-timers as well. If they're only here three days and the clients need support on the days they're not here - somebody has to do to it because they're in crisis and they can't wait until the case worker returns.

For many of the caseworkers, the shared burden of decision making was a relief, as was being able to seek colleagues' advice. Not having to fix a client's problems all by yourself or figure out the way forward all on your own helped relieve workers' stress. It was also good to lean into the support the team provided, as one caseworker noted:

I like the fact that you can walk away from certain things when it's too much. When you've got really, really complex clients that are just too much and you need to say okay, I need to take a step back, I can delegate this to the next person and that's okay, and I know they're more than competent to pick it up and run with it. So, that's a nice feeling to know that you don't have to continue to see someone that might just wear you down completely.

Caseworkers learnt by observing their colleagues, gained fresh ideas, and improved their practice, as one case worker noted:

It effectively brings the standard of each caseworker up to the level that the team has set, which I think is a huge strength. So, in some areas of my work I feel like my standard has increased.

5.4 Multidisciplinary

Appreciation was expressed for the members of the Wesley teams who come in from other agencies, especially those who provide specialist mental health services to clients. They do

excellent work with clients and fill the gap for one on one therapeutic work. They also advise team members on working with particularly vulnerable clients. In light of this successful partnership, a caseworker suggested the engagement of other specialists onto the team.

Some case workers said they find it can be useful for team members with specific expertise or knowledge to do the work for the team. For example, a worker with a good knowledge of housing policy can assist clients with their housing applications. In some cases, where there's not good rapport between a team member and the agency, it can be handy to swap team members.

All the teams co locate with other agencies, including NSW Housing local offices. Sometimes it is the same Wesley team member who co locates and in other cases, team members rotate. The co locations can be beneficial for referrals and for promoting the team casework model.

5.5 Collaborating with other services

All the teams described the strong networks they have with other service providers in their area and the good collaboration they have with most. The team model can be as advantageous for other service providers, as it is for clients, but some agencies resist. The teams and managers work hard to engage with these agencies and there is ongoing liaison, promotion and education involved. The teams do try to accommodate to these agencies preferred way of working, which usually involves having the same caseworker participate in case conferences etc. However, this raises concerns as it means the workload becomes uneven, with the extra work shouldered by a few, and the team work is effectively put on hold.

As with clients, service providers do sometimes get missed by the team, and communication can become quite confusing around the team and individual emails, as one worker explained:

> *We have a team e-mail and if a service e-mails that, everybody gets that. But then we have our own e-mails, and if a service e-mails that, then we are the only person that sees that query. It's hard for us to ensure that service providers are always responding to the team e-mail, rather than to us directly. If they just hit 'reply' it just comes back to us, and then no one else sees it. If the team needs to see the e-mail I write "Please ensure that you reply to all, because I'm not here again until next Monday" at the bottom.*

5.6 Other concerns

Two other specific concerns were raised by case workers during the interviews.

One team described how the caps that services have in the numbers of clients they take on, and the lack of affordable housing, are major barriers to achieving positive outcomes for clients and fulfilling the expectations of the SHS Going Home Staying Home reforms. The team is keen to learn more about how effective the reforms have been, both within Wesley and more broadly.

Another team identified the need for more consistency in the Wesley client intake processes, noting that it can sometimes take up to three weeks for referrals to come through from the central intake. They also said that the way a case plan is set up is not so helpful, as each of the client's goals are set up as a separate case plan, rather than various goals within a single case plan, which leads to more paperwork.

5.7 Summary

Stakeholders identified a range of benefits arising from the team casework, for clients and staff.

For clients, the benefits include continuity and seamless support, and access to a team of multidisciplinary caseworkers who know them and who can bring different strategies and expertise to assist clients to progress with their goals. Some caseworkers also suggested that in the team model, it is easier to ensure that the boundaries in relationships between caseworkers and clients are managed well, and clients are better placed to make a smoother transition from the support. As noted in the research synthesis, the reasons behind unsuccessful transitions of clients out of support services remain unclear, so the findings from this evaluation should help shed some light on the role that a team casework model, compared to other models, has in facilitating transitions.

For caseworkers, a key benefit of the team model is a sharing of the casework load, and the burden of decision making. Team members learn from each other and bring each other up to the standard of casework set by the team. The inclusion of specialist mental health workers onto one team was a particular advantage as it helped to fill the gap for individual therapeutic work with clients.

As noted in the research synthesis, there is some evidence that teams have a positive impact on the workforce and that it is the access to relevant colleagues that makes the difference. The findings of the current evaluation lend weight to this finding. Moreover, there is clear evidence that clients with a high level of therapeutic alliance achieve better outcomes from case management and it maybe that having mental health clinicians, who work one on one with clients, as part of the Wesley team helps to gain high levels of therapeutic alliance.

One factor influencing the impact of the model, is the size of the team. Teams that are larger than expected seem less efficient, and their accountability more diffuse. They also run the risk of missing clients and other service providers, which can be detrimental to progressing client outcomes.

One of the challenges for the teams is engaging with service providers who are not confident with the team casework model and/or who may resist working with it. The teams are very accommodating to the different needs, and will sometimes suspended their teamwork practice while one of their caseworkers becomes the sole contact for a client and other service providers. However, this runs the risk of some caseworkers bearing more of the load. Wesley pays ongoing attention to these issues, and the regular liaison with service providers to inform and educate about the teamwork model remains important.

6. Site characteristics

In this section we describe the client characterises, the support provided, and outcomes at the four sites, using data extracted from the Wesley Mission CIMS for the period from 1 July 2016 until the 30 June 2017.[3]

Note that in the summary below, percentages are rounded up. A very detailed analysis of all the CIMS data for each site can be found in the Appendix.

Each team has a specific target group and a different mix of professionals to reflect the different client base. The table below summarises some of the key client characteristics across the four sites, to give a sense of the diversity in the client base across the sites.

Table 6.1: summary of key client characteristics by team/site

Team	Female %	Aged 25-44 years %	Aboriginal or Torres Strait Islander %	Non-English speaking background %	Previously diagnosed with a mental health condition %	Average length of support (closed support periods) days
TST Singles	35	48	9	17	77	134
Prevention and Early Intervention	64	47	13	26	47	30
TST Families Fairfield/Liverpool	54	23	12	18.5	10	113
TST Families Central Coast	65	36	16	2	16	82

Source: Specialist Homelessness Services (SHS) Client information Management System (CIMS) Statistical Profile Report for Wesley sites 1 July 2016-30 June 2017.

6.1 TST Singles, Sydney and South Eastern Sydney

The TST Singles team is by far the biggest team, with approximately 12 caseworkers. As noted previously, this team is larger than expected because it combines team members funded under two separate packages, and staff from the pilot MOPS program.

6.1.1 Client demographics

In 2016-17, there were 398 distinct clients, who received 421 support periods. Nearly two-thirds (65%) of clients in this site were male, nearly half (48%) of clients were aged 25-44 years and another 41% were aged 46-64 years. Most clients (82%) were living alone. Nine percent of clients were Aboriginal and Torres Strait islander. Most clients were Australian born, (72%) and17% were born in a non-English speaking country.

[3] Data is entered into the CIMS by caseworkers and reported monthly.

6.1.2 Presenting circumstances

All clients presented as single person units. Nearly half (48.5%) were referred by an SHS, 9% were referred by a mental health service and 11% had no formal referral.

Housing crisis was the most common reason (48%) for seeking assistance. Some clients presented with multiple reasons, with the most common being housing crisis (18%), mental health issues (16%), housing affordability (13%), and financial difficulties (10%).

Over three quarters of the clients (77%) had previously been diagnosed with a mental health condition and nearly half (48%) were currently receiving services or assistance for their mental health issue. One quarter (25%) always or sometimes needed help or supervision for self-care.

6.1.3 Support provided

For the year 2016-17, 306 clients had support periods closed and 115 clients had ongoing support periods. The most common reasons for closing support were losing contact with client (29%), client no longer requested assistance (19%) and client referred to another SHS (18%).

The average length of support was 134 days for closed periods and 170 days for closed and ongoing support periods, for a total of 49,277 support period days.

Almost three-quarters (73%) of closed support periods and 91% of ongoing support periods had had a case management plan. For those with closed support periods, 22% achieved all goals, 12% half or more, 25.5% achieved up to half and 13.7% did not achieve any at all. Most (69.6%) clients with ongoing support periods had achieved up to half of their goals.

The three most common types of support provided which were basic assistance, assistance to sustain tenancy or prevent tenancy failure or eviction, and advice/ information. Most (80.5%) of the financial assistance was used to contribute towards establishing and maintaining a tenancy, with a total of $27,527.64 paid for these purposes.

6.1.4 Changes in client circumstances

The profile of living arrangements did change over the support period. At presentation, 40% of clients were living in a house or flat, 17% in emergency accommodation, 9% in a boarding house or hotel, 4.5% in a psychiatric institution, 9% in the open, and 3% in a motor vehicle.

At the end of the support period (or data collection), 48% were living in a house or flat and the percentage living in the other forms of accommodation had decreased. However, there was a significant increase in the unknown accommodation status (from 10% to 19%).

Nearly one third (31%) of clients presented with no tenure, and at the end of the support period or data collection this had reduced to 17%, though again there was a significant increase in the don't know (16% to 24%). Increases were observed in a range of rental categories including private, public, community and transitional, and a decrease in rent free emergency accommodation.

The majority (76%) of clients were unemployed and there was a slight increase in employment and those not in the labour force. A small number (4%) of clients were studying and this number

declined at the end of the support period or data collection. For 37.5% of clients, the main source of income was the Newstart allowance, for 35%, the Disability Support Pension, and 2% had no income when presenting. A small number (2%) had employee or other income when presenting and this increased to 4.5% at the end of support period or data collection.

6.2 Prevention and Early Intervention Team, South Eastern Sydney

This team works with people who are at risk of homelessness. The service is based in Ashfield and has 4-5 caseworkers and a co-ordinator on site. The team shares an open plan office in a suburban house with other Wesley services.

6.2.1 Client demographics

In 2016-17, there were 635 distinct clients, who received 755 support periods. The majority of clients (64%) were female, and nearly half (47%) were aged 25-44 years. Around half (48%) were living alone and 35% were one parent families. Aboriginal and Torres Strait Islander people were overrepresented in the client group at 13%. Just over one quarter (26%) were born in non-English speaking countries.

6.2.2 Presenting Circumstances

Nearly one quarter (22%) of clients had no formal referral, 17% were referred from social housing, 10% from SHS, and the rest from a variety of agencies and services or by family and friends.

The main reasons for seeking assistance were financial difficulties (62%), housing crisis (21%) and housing affordability stress (6%). Over half (52%) of the clients had a permanent address the week prior to presenting, 49 were sleeping rough, and 184 in short-term or emergency accommodation.

Nearly half the clients (47%) had been previously diagnosed with a mental health issue, and 36% were currently receiving services for their mental health issues. A small number needed assistance or used aids for self-care (10%), mobility (12%) or communication (4%).

6.2.3 Support provided

Among the client group, 84% had one support period,13% had two, and 2.5% had three or more. For 2016-17, 684 support periods were closed, 71 were ongoing. For nearly two-thirds (64%) of clients, support was closed as the client's needs were met or the case management goals were achieved, and in another 13% of cases, the client no longer requested assistance. In a relatively small number of cases (8%), the service lost contact with the client.

The average length of support for closed support periods was 30 days, and 29 for all clients. In total, clients received 20,104 support period days in 2016-17. Nearly all clients had a case management plan and 55% of clients with closed support periods achieved all their case management goals, 16% achieved more than half, and 17% achieved up to half. A small group (6%) achieved none at all. Among ongoing clients, 41% achieved up to half their goals, and 27% more than half.

The most common support provided was assistance to sustain a tenancy or prevent tenancy failure or eviction, and advice and information. Around 19% of clients received material aid and/or brokerage, and other basic assistance. Twenty-five people were not provided with services, with just over half of these seeking general assistance and support, and seven seeking housing or accommodation assistance.

A total of $182,780 in financial assistance was provided to clients in the year 2016-17, with 76% of these funds used to establish or maintain a tenancy.

6.2.4 Changes in client circumstances

Most clients (76%) were living in a house or flat when presenting at the service and this increased to 79%. The type of tenure remained stable, with around 40% renting private housing and another quarter renting public housing. There was a decrease in the percentage of clients in emergency accommodation, but also an increase in the percentage of clients for whom tenure was not known (1% to 5%). There was a small increase in the number of people who were nominated on leases, from 57.5% to 60%.

The employment profile of clients remained the same during the support period with around 81% of clients being unemployed and just over 12% in employment. The main sources of income also remained stable over time: Newstart allowance (31%), Parenting payment (18%), Disability support pension (16%) and Age pension (7%). Employee income was the main source for just over 7% of clients, and 7% of clients were doing formal study or training, and this declined slightly.

6.3 TST Families Fairfield/Liverpool

This small team is located in a demountable building at Liverpool, with one team member located at Parramatta. The Team Leader is on site several days a week.

A total of 605 distinct clients (comprising 158 groups) received services with nearly all (98%) receiving one support period in 2016-17. More than half (54%) the clients were female. Almost two thirds of clients (63%) were lone parent families, 28% couple families, and 5% lone persons. Over half (60%) of clients were children under 16 years of age and almost a quarter (23%) of clients were aged 25-44 years. Aboriginal and Torres Strait Islander clients comprised 12% of clients, and 18.5% of clients had been born in a non-English speaking country.

6.3.1 Presenting Circumstances

Two thirds (67%) of the clients were the child, step child, foster child or grandchild of the head of the presenting unit. Partners of the head of the presenting unit represented 6.7% of the clients.

Over half the clients (55%) were referred by a SHS, 18% by other government or non-government agency, 6% by telephone or crisis referral agency, 5% by child protection or family and child support agency and 9% had no formal referral.

The main reason for seeking assistance was housing crisis (42%). Among all the reasons for seeking assistance, the most common were housing crisis (20%), housing affordability (18%), and financial difficulties (14%). Other housing, relationship and health factors were also reported.

In the month prior to presenting at the service, 9% of clients reported sleeping rough or in nonconventional accommodation, while 34% had used short-term or emergency accommodation, and 58% reported not being homeless. Over 50% of clients had had their last permanent address less than one month ago.

One in ten (10%) of the clients had been previously diagnosed with a mental health condition, and 6% were currently receiving services. A small proportion (4%) always/sometimes needed help and /or supervision with self-care, 2% for mobility and 2% for communication.

6.3.2 Support provided to clients

Of the 616 support periods for 2016-17, 481 were closed and 135 were ongoing. Around one third (34%) of closed support periods had ended as the client no longer requested assistance and for another third (34%), the client's immediate needs had been met or the case management goals achieved.

The average length of support was 113 days for closed periods and 131 days for closed and ongoing support periods, for a total of 57,205 support period days.

Less than one third (29%) of the closed support periods had a case management plan though 53% of clients whose support was ongoing had a case management plan. The main reason for not having a plan for 55% of closed support clients and 40% of the ongoing support clients was that these clients were part of another person's case management plan (e.g. children).

One third of clients who had a case plan and whose support period had closed achieved all their goals, while most clients in ongoing support, and with a plan, had achieved up to half of their goals.

The most frequent services provided were advice and information (24%), medium term/transitional housing (22%), other basic assistance (22%) and advocacy and liaison on behalf of client (19%). Overall, 111 clients were accommodated in medium term/transitional accommodation. Nearly half (48%) of the completed accommodation periods were over 52 weeks, while 47% of the ongoing accommodation periods were between 26 and 52 weeks. Fifty-eight persons were recorded as not being provided with services in 2016-17, with the main reasons being that the person did not accept the service (25) and the person wanted different services (12). Most requests for this group were for housing accommodation (28) or general assistance (18).

A total of $41,999 of financial assistance was used, with over three quarters (78.5%) of it going towards establishing and maintaining a tenancy.

6.3.3 Changes in client circumstances

The majority (70%) of clients were living in a house/townhouse or flat and this increased to 87% at the end of the support period or data collection. Just under one quarter (23.5%) of clients were living in emergency accommodation and this reduced to 7% at the end of the support period or data collection. Upon presentation, 25% of clients were living in rent free private housing and 18% were renters in private housing These types of tenure increased to 34% and 23% respectively at the end of the support period or data collection, with a decrease in all forms of emergency

accommodation. There was also an increase in the percentage of clients who were nominated on a lease (17% to 28%) and who were living with relatives (30% to 41%).

Most clients (excluding children) were on Parenting Payment or Newstart Allowance and other government payments. Excluding children under 16 years, 24% of clients were unemployed, 9% were not in the labour force and 3% were employed. The employment profile stayed much the same during the support periods.

6.4 TST Families Central Coast

The small Central Coast team operates from an office in Gosford.

6.4.1 Client demographics

The service provided support to 555 distinct clients in 2016-17. The majority were female (65%), around one third (36%) of clients were aged 25-44 years and 43% were children aged under 16 years. Over two thirds (69%) of client groups were one parent families, and 25% were couple families with children., and 16% of clients were of Aboriginal or Torres Strait Islander background. A small percentage (2%) were born in a non-English speaking country.

6.4.2 Presenting Circumstances

A total of 596 support periods were provided to the 555 distinct clients with most (93%) having only one support period. Around one third of clients (33%) were referred by the family and child support agency, 14% by a SHS and 15% through another government or non-government agency. Just over one fifth (21%) had no formal referral.

The main reason for seeking assistance was housing crisis (40%), previous accommodation ended (16%), housing affordability stress (15%) and financial difficulties (12%), lack of family and community support (7%) and family and domestic violence (6%). In the month before presenting, 55 clients had been sleeping rough or in non-conventional accommodation and 191 had been in short-term emergency accommodation due to lack of other options.

At the Central Coast service, 16% of clients had been previously diagnosed with a mental health concern, with 10% currently receiving services and 4% receiving services in the last 12 months. A small number (4%) of clients needed assistance or had difficulty or used aids for self-care, mobility or communication.

6.4.3 Support provided to clients

Of the 596 support periods in 2016-17, 500 periods were closed and 96 were ongoing. The main reasons identified for closing support periods were needs met /case management goals achieved (22%), the client no longer requested assistance (15%), and losing contact with client (14%).

The average length of support was 82 days for closed periods and 110 days for closed and ongoing support periods, for a total of 37,729 support period days.

Among clients for whom support had closed, 38% had a case management plan, while 67% of ongoing clients had a plan. All clients receiving ongoing support had a plan, as those who did not

have a plan with the Wesley service were part of another person's case management plan. For those with closed support periods and a case plan, 11% achieved all their goals and 13% achieved half or more. Among the 67% clients with ongoing support with a plan, 31% had achieved half or more of their goals.

The main needs were long, medium and short-term housing, material aid and brokerage, financial information and financial advice and counselling and assistance to sustain a tenancy. The main types of support were advice and information, advocacy and liaison, assistance to sustain tenancy, medium term/transitional housing and basic assistance.

Clients were provided with short term and medium term/ transitional accommodation through the service: 26 clients for 110 bed nights for short term accommodation and 88 clients for 16,444 nights in the medium-term accommodation.

Just over half (56.5%) of the $71,123 financial assistance were expended on establishing or maintaining a tenancy, and 37% on other purposes.

6.4.4 Changes in client circumstances

The majority (71%) of clients were living in a house or flat at presentation and this increased to 80% at the end of support or data collection. The percentage of clients in emergency accommodation dropped from 9% to 3%. Clients were predominantly renters of private housing (change from 32% to 34%) or living rent free in private housing (change from 20.5% to 19%). The percentage of clients who had the lease nomination in their own name increased from 36% to 45% during the support or time periods.

Around 40% of clients were children, and therefore had no labour force status. Just under one third of clients were unemployed at both time periods (33% at beginning and 29% at the end) and 21% were not in the labour force. There was a small increase in the percentage of clients employed: from 7% to 10%. Just under 45% of clients, most likely children, had no income source. Around one in six (17% to 15% at end) were recipients of Newstart allowance, 23% were receiving Parenting Payment and 6% were in receipt of Disability Support Pension. Employee income was the main source for 5% of clients at presentation and 6.5% at the end of support or data collection.

Around one third of clients were enrolled in a course of study at both the beginning and end of the support periods. Clients who were studying comprised mainly primary school students (16% at beginning and 17% at the end) and secondary school students (10% at the beginning and 11% at the end).

6.5 Summary

This brief summary of the CIMS data shows that the client profile varied across the four SHS services, reflecting the specific target groups. It also shows that the services did assist many clients to gain more secure housing, though this varied across the sites and was influenced by both the client characteristics, and the availability of transitional and other housing. The average support period also varied across the sites, in part reflecting the focus of the service (early intervention or crisis) and the complexity of clients' needs.

The clients at the TST Singles service, which is based in the inner city and south eastern area of Sydney, are predominately single men, many of whom are homeless, and have a diagnosed mental health concern. Support was provided for around four months to each client, but there were mixed outcomes, as many clients have complex needs. The service either lost contact with clients or clients no longer requested assistance, and a considerable number were referred to another of the range of inner city specialist homelessness services. However, amongst clients who stayed engaged with the service, many are achieving their case management goals, with less homelessness and a small number also securing employment or income support.

About half the clients at the Prevention and Early Intervention service based in south eastern Sydney were single adults living alone, and almost half the clients had been previously diagnosed with a mental health issue. Many clients came to the service because of financial difficulties and were obviously at risk of becoming, or were already, homeless. The average period of support was quite short, at around a month, and in that time, many clients achieved most, if not all, of their case management goals, or otherwise no longer needed the support. This service provided a much greater amount of financial support to clients compared to the other sites with most of the funds used to maintain, and for some, to establish tenancy.

The two TST Families services had similar numbers and profile of clients. Most clients were sole parent families with children, and were referred to the service due to housing crisis and/or housing affordability stress and financial difficulties. The Fairfield/Liverpool service had a greater proportion of families from a non-English speaking background, though the two services had a similar proportion of Aboriginal and/or Torres Strait Islander families. All four sites had an over representation of Aboriginal and/or Torres Strait Islander clients.

The Fairfield/Liverpool Families service provided support for an average of four months for each client. Support included transitional accommodation for some clients, advice and information and other basic assistance. The main reasons for closing the support was that clients had achieved their goals and/or no longer requested assistance, with an increase in housing security for many people.

The Central Coast TST Families service provided support for an average of three and a half months for each client. Some families were provided with medium term/transitional accommodation and there was an increase in the number of families who had more secure accommodation. A small number of clients also found employment.

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