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ACT Government Emergency Material and Financial Aid Project

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Executive summary

Emergency relief (ER) is a critical form of support for individuals and families who experience poverty and disadvantage. ER seeks to assist people who are in financial crisis to deal with their immediate situation. Ideally, this is done in a way that maintains the dignity of the individual and builds self-reliance.

ER has historically been understood as a stop-gap measure to help people with short-term financial difficulties. It generally comprises assistance in the form of food, household goods, clothing, transport, pharmacy assistance, utility payments, cash, cheques and gift vouchers.

The ACT Government is considering the nature and effectiveness of its Emergency Material and Financial Aid (EMFA) program. This will encompass the effects of poverty and disadvantage, the impact of EMFA, and possible service delivery in the future. A review of the evidence has been conducted by the Public Service Research Group, University of New South Wales, Canberra. This highlights key tensions and issues in relation to ER.

EMFA usually consists of short term assistance to address temporary crisis and includes referral to other programs to address underlying issues. In Australia, ER has historically been understood as a short term measure.

Funding for ER in the ACT is provided by the ACT and Commonwealth Governments, and charitable organisations which receive community and philanthropic donations. Federal governments have typically been disinclined to increase funding for ER services, fearing that this will lead to service dependency. ER has therefore remained a form of temporary assistance targeted to those in immediate financial crisis.

Contemporary ER services are delivered through a 'mixed economy' of providers. Recipients may also be receiving other welfare benefits. A fundamental challenge for ER provision is that underlying factors which initially led to people seeking assistance may not be addressed. A number of ER service providers have sought to re-conceptualise ER in terms of 'social inclusion' or 'financial hardship' rather than 'poverty', developing more holistic services that address complex needs. This shifts the focus from resources held by individuals or households to local community resources. Poverty is generally considered a one-dimensional understanding of disadvantage, while social exclusion is considered more multi-dimensional. Poverty is also highly gendered, with women being over-represented as recipients of ER.

There is a significant distinction between transactional ER services and those that offer ER combined with client advocacy and referral. Transactional ER services are ones that provide immediate, one-off relief and function as a safety net. Historically, governments have typically preferred to fund transactional ER. In recent years, both the Commonwealth and ACT Government have reviewed the effectiveness of providing ER in an attempt to better measure the changes it makes on the lives of individuals. In 2012 the ACT Government released the Targeted Assistance Strategy and in 2017, the Commonwealth department of Social Services released discussion paper on Financial Wellbeing and care (FWC) in order to inform the redesign of its funding to FWC.

Key challenges for ER providers include: lack of infrastructure or employment costs, small and unpredictable amounts of funding, funding that is tied to specific models or a lack of flexibility in the use of resources and insufficient administrative funding.

In recent years, the number of people requesting ER has increased and clients are presenting with more diverse and complex needs. Surveys of ER services in Australia indicate that recipients are likely to be female; aged 25-49; living in rented accommodation, living in single income households and in receipt of at least one government payment as their main income source. If employed, ER recipients tend to work part-time or casual positions. Over 80% are Australian born, with Aboriginal and Torres Strait Islander people tending to be over-represented.

Factors which increase reliance on ER include: unemployment/retrenchment; mental health and disability issues; housing stress; family violence; rising living costs; social exclusion; and inadequate income support. For some people, ER functions to supplement inadequate social welfare payments, becoming a primary support for people living at or below the poverty line.

ACT data mirrors broader patterns of client characteristics in the ER literature. However, ER recipients in the ACT include a unique group who are not eligible for Territory-based concessions and may be unfamiliar with how to access services. This group can be described as 'normal families doing it tough'. While the overall level of income inequality for the ACT is lower than many other states, this masks pockets of deep disadvantage dispersed throughout the ACT. It is generally acknowledged that there is a need not just to provide basic ER, but also to address some of the longer term structural issues that can lead people in the ACT to seek ER.

Table of Contents

Executive summary	ii
Background	1
Project objective and aims	1
Emergency material and financial aid provision in Australia	2
History of emergency relief funding in Australia	2
Emergency relief and social policy	3
Poverty and social exclusion	5
Definition and measurement of financial hardship in the emergency relief sector	7
The Australian emergency relief literature	8
Findings from the Australian emergency relief literature	12
Client characteristics	12
Client needs	12
Mechanisms and approaches to emergency relief provision	12
Emergency relief funding	15
Funding sources	16
Recommendations for emergency relief provision	21
Emergency relief provision in the ACT	22
Food Assistance	23
Financial Management Counselling and Loan Programs	23
ACT Government Concessions Programs	23
ACT Targeted Assistance Strategy	23
Findings on emergency relief in the ACT	24
Clients' characteristics in the ACT	24
Clients' needs in the ACT	26
Challenges within the ACT context	27
Adjunct services to emergency relief	29
Assistance for Aboriginal and Torres Strait Islander people	29
Housing	31
Food banks	32
Recommendations for the ACT	34
Summary	35
References	37
Appendix A	43

Figures and Tables

Table 1	9
Key studies on ER in Australia 2006 – 2015	
Table 2	14
Relational type ER approaches used in Australia	
Table 3	15
Funding issues identified by emergency relief service providers	
Figure 1	17
The Salvation Army Eastern Territory Government and non-Government funding 2015	
Figure 2	17
The Salvation Army Eastern Territory funding sources 2015	
Figure 3	18
The St Vincent de Paul Society Australia Government and non-Government funding 2015-16	
Figure 4	18
The St Vincent de Paul Society Australia funding sources 2015-16	
Figure 5	19
Source of emergency relief funding used by emergency relief providers in Metropolitan Melbourne 2004 (Adapted from Engels, B. 2006 (37))	
Table 4	20
Government and non-government funding sources used by emergency relief providers in Metropolitan Melbourne 2004 (Adapted from Engels, B. 2006 (37))	
Figure 6	26
Geographic spread of residency in the ACT over time	
Figure 7	28
Continuum of crisis	



Background

The ACT is a unique context within Australia's states and territories as it comprises a city state with the smallest land area and second smallest population. Moreover, the ACT has, relative to other Australian jurisdictions, the highest average household income (20% higher than the national average), work participation rates, and post-school qualifications (1) and the second lowest employment rate of all jurisdictions.

However, while the majority of ACT residents have a high standard of living there are still individuals and families experiencing disadvantage within the relatively affluent Canberra community, with some requiring emergency relief (1). For individuals and families experiencing times of crisis and experiencing poverty, the provision of emergency relief (ER) is a critical support. In general, ER aims to assist people in financial crisis to deal with their immediate crisis situation in a way that maintains the dignity of the individual and encourages self-reliance (2).

Emergency relief (ER) assistance can include a food voucher or food parcel, household goods, clothing and financial assistance for utilities or food (3). Providers of ER may offer additional services such as specialist counselling and advocacy services including financial counselling, transport assistance, assistance with medicine, school uniforms and books and community information services. ER is often provided by a range of different providers, usually in the non-government sector (although the largest funder of these is often the public sector) (2). It is generally accepted that usage of ER is a reliable indicator of deprivation, which comes with a personal cost, typically involving considerable time and effort.

The ACT government is currently exploring the nature and effectiveness of its Emergency Material and Financial Aid (EMFA) program. This process involves investigating how poverty affects people, the impact of this program and the identification of future services, particularly those which can be purchased by the ACT Government to have the greatest impact on life outcomes.

Project objective and aims

The objective of this research project is to gain an evidence-based insight into the most effective mechanisms in crisis responses for people in poverty and to understand the relevance of these to the ACT context. In exploring this broad objective, the research comprises a series of aims, namely:

1. Examine the evidence base relating to different mechanisms and approaches that can be used in relation to assisting individuals experiencing poverty.
2. Explore with a range of stakeholders, the specific factors within the ACT context that affect the delivery of Emergency Material and Financial Aid.
3. Make recommendations about effective crisis responses in the ACT and the kinds of services the government should purchase.

In response to aim 1, this report reviews both the academic peer-reviewed literature and the grey literature to examine evidence relating to poverty and the provision of emergency material and financial aid. In setting out this evidence base, the report begins by providing a background to ER provision in Australia and the ACT, including a history of ER funding, social welfare policy, and welfare state reforms and restructuring. Following on from this, the concepts of poverty, social exclusion, and financial hardship are then discussed in relation to the provision of ER. The final section reviews key reports on ER provision in Australia to examine the features of the delivery of these programs to date and the relative merit of different mechanisms to deliver ER. We conclude by setting out a number of key recommendations made in the ER literature.

Emergency material and financial aid provision in Australia

Provision of emergency financial and material assistance is known by a variety of terms and may be defined differently depending on which country is providing the assistance. The term 'emergency relief' (ER) is a uniquely Australian term which first began use in the late 1960s (4). ER is the provision of material or financial aid to people who are in immediate need, or referral to connect people to specialist community services (5). ER was originally designed as a stop-gap measure to help people with short-term financial difficulties and generally consists of assistance in the way of food, household goods, clothing, transport and/or pharmacy assistance, utility payments, cash, cheques, and gift vouchers or cards (3,5–7).

ER has been called the 'safety net to the safety net', (7) partly due to the fact that in Australia the majority of those seeking ER assistance also receive some form of welfare payments (3,5,7–9) from the Australian Government. However, these welfare payments have been shown to be consistently below the most widely accepted measures of poverty including the OECD 60% of median income (50% of median income) as used by the UK and European Union, and the Henderson Poverty Line) (10,11). ER has been described as a residual form of welfare provided by community agencies (12). Residual welfare refers to services offered as a safety net to 'those who are left over'(13), when there are no other means of provision available.

History of emergency relief funding in Australia

In thinking about the future of emergency relief funding it is important that we consider the history of this policy area and how this has developed over time. The history of ER funding in Australia demonstrates that traditionally, ER has been seen as something that is only to be used as a short term, stop-gap measure (i.e. residual welfare). ER has received commonwealth government funding since the Fraser Government allocated \$500,000 annually via the federal budget towards the provision of ER in 1979 (20). However, while the federal government formally entered into ER funding in the late 1970's, the majority of assistance was still financed and distributed by non-government organisations operating in the states and territories via funds from charitable donations and philanthropic organisations (12).

The 1979 federal funding scheme was quickly proved inadequate, as demand for ER services exceeded allocated funds (21). Following the 1996 federal election, the Australian Council for Social Services (ACOSS) commissioned three reports on ER use and a public review of ER funding was also undertaken (22,23). These reviews showed a rising demand for ER services and that the majority of ER applicants were already on social welfare, of working age, and had received ER assistance in the past. A key message from these reviews was that the current federal social welfare system was inadequate in preventing individuals living in extreme poverty (24).

Despite these findings, the Howard Government was, however, reluctant to increase social welfare payments and in the 1997 federal budget adopted a new funding formula tying annual payments to the states and territories to regional shifts in the Consumer Price Index, ostensibly in order to more accurately reflect the cost of living (22). This funding model remained in place when the federal government changed in 1997 and continued with minimal changes in the Rudd and Gillard government era, with funding under the Financial Management Program. With a change back to a Liberal federal government in 2013 the Department of Social Services (DSS) took over funding of emergency relief. In the 2014/15 federal budget funding cuts of \$241m over 4 years were announced for the DSS, which resulted in cuts to part (or all) of the funding for many organisations providing ER (25).

As a general trend, Australian federal governments have been disinclined to increase funding for ER since its introduction in 1979. Engels et al. (24) argue that the underlying basis of this unusual level of bipartisanship centres around the fear of both the major political parties and the community in general about the existence of “welfare abuse and dependency” (24,26). Furthermore, as discussed by Beder (27), in protestant liberal democratic welfare states such as Australia, idleness has long been viewed with some suspicion and the view that charity should not be extended to those able to work is prevalent in society. This has led to the creation of a distinction between the “deserving” poor (the elderly, disabled and ill) and the “underserving” poor (those of working age who are not working). Contemporary governments face the problem of providing a level of social welfare that will support those who are unemployed, but not act as a disincentive to the “work ethic” (27).

It has been argued that if welfare payments, or ER support, are overly-generous this will discourage the unemployed from re-entering the labour market and taking on the lowest paid jobs (28). As shown by Engels et al. (24), consecutive Labor and Coalition governments have avoided acknowledging ER as anything other than a form of temporary assistance designed to help only those in immediate financial crisis. ER has not been allowed to develop into a supplementary or new income support payment like Newstart, and ER agencies are not funded in such a way that they become competitors with Centrelink. Federal governments are only willing to fund organisations to provide short-term financial assistance despite the evidence that many, if not most, people seeking assistance are living in chronic poverty and long term financial stress (e.g. 5,6,9,12,23).

Emergency relief and social policy

Since the 1980s per capita welfare state expenditures have been rising in almost all western democracies (e.g. 24,25). This rise has been driven, in part, by the introduction of welfare state programs to meet new needs, as well as changing demographics (such as increased life expectancy) and socio-economic structures (including varied family configurations and growing labour market difficulties) that have increased the demand for social security provision (32). Despite the expansion of the welfare state, there are sustained pressures on governments to reduce welfare expenditure (e.g. 27,28). Increased spending on social welfare has been viewed as a significant hindrance to economic growth in competitive market economies and has raised concerns of the sustainability of the welfare state itself (32). These pressures have typically meant that governments have remained unwilling to significantly reform the scale and scope of emergency relief programs. Indeed, Landvogt (35) argues that the very existence of ER signifies a failure of the welfare state – if social welfare services were functioning effectively there would be no need to fund charities to provide ER.

Today the delivery of welfare services is done by a mix of different actors including government, private, not-for-profit, and voluntary sectors, often termed “the mixed economy of welfare” or “welfare pluralism” (e.g. 34). This trend has been evident not only in provision of welfare benefits on an ongoing basis, but also in the area of providing ER to those in financial and material crisis, who may or may not be already receiving welfare benefits (e.g. 30,35–37). ER services in Australia are typically purchased from a range of providers such as charities and community organisations, while other types of assistance may be directly funded by government (for example crisis payments for victims of domestic violence or natural disasters) (40). The private sector may also fund some types of income assistance programs such as the StepUP low interest loan scheme primarily funded by the National Australia Bank in partnership with Good Shepherd Youth & Family Service (2).

In 2010-11 around 705 organisations operating through 1340 outlets received ER funding via the Australian Government’s Financial Management Program (5) however there are a significant number of additional ER organisations which rely on additional funding sources. These include contribution of funds from organisations’ own budgets, state/territory and local government funding, and community and philanthropic donations (41).

A fundamental challenge with the provision of ER is that the underlying factors that have led to people seeking assistance in the first place are often not addressed (29). As Dwyer notes, the need for ER is a result of complex issues that require more than a “band aid” solution (42). Recently, given the evidence that many people seeking ER experience long-term financial hardship, the ER sector has begun to respond by attempting to help people “move from isolation and exclusion to a greater connection with and participation in all forms of community life” rather than just providing short-term financial aid (43).

It is interesting to note this move to conceptualise ER around the concept of “social inclusion” rather than “poverty” as reflected by the actions of a growing number of ER providers in Australia (see for example; 6,8,32,33). This has, however, not been mirrored in government policy, with ER providers stating that they remain underfunded (25). As Frederick and Goddard argue, the way ER funds are distributed by the Federal Government is problematic because it “offers no resources to agencies to provide more holistic services that would help address...complex needs” (29). In other words, the federal approach to these issues remains wedded to a “poverty” paradigm.

Poverty and social exclusion

Given that many recipients of ER would be classified as living in “poverty” according to certain standardised measures (i.e. OECD 50% of median income), it is important to examine how poverty is conceptualised in order to understand the basis from which ER is provided. According to 2014 data, 2.99 million people in Australia (13.3% of the population) were living below the 50% of median income poverty line (11). In exploring the literature it is clear that there is no universal definition of what exactly constitutes poverty. The terms “poverty” and “social exclusion” have sometimes been used synonymously, possibly because these terms are used not only in a scientific context but also in political discussions (32). However social exclusion is generally used to describe a problem distinct from poverty (45).

Berghman (46) provides a useful approach to differentiate poverty and social exclusion based on criteria around comprehensiveness and dynamic process. In terms of comprehensiveness, poverty is a one-dimensional disadvantage while social exclusion encompasses multi-dimensional factors. Poverty refers to individuals who are disadvantaged by only one indicator (usually income/expenditure), whereas social exclusion is used when there are a number of disadvantages (i.e. unemployment, inadequate housing, lack of food). While there may be some overlap between the concepts of poverty and social exclusion, as Heitzman (32) argues they are also mutually exclusive in part. As Berghman (46) discusses, poverty is seen as an outcome and social exclusion as a dynamic process. Impoverishment leads to poverty and social exclusion results in deprivation; poverty may be one of a number of outcomes of the process of social exclusion, or may initiate social exclusion that can further entrench poverty (32).

Room (47) expands on conceptualisations of poverty and social exclusion by including a discussion of resources. He argues that most conventional measures of poverty focus on financial resources held at a particular moment either by an individual or household. This focus has been challenged on two fronts. Firstly, that it neglects to take into account the unequal access to resources within a household (48). Secondly, it fails to include an examination of the availability or lack of resources available in a local community, which impact on the extent an individual or household can cope in times of hardship. This is especially important for those seeking ER provision which is primarily provided via community organisations. As Room points out, use of the concept of social exclusion rather than poverty shifts the focus from resources held by individuals or households to local community resources. Furthermore, an even more fundamental element in the differentiation of poverty from social exclusion is that of distributional and relational issues. The concept of poverty focuses on distributional issues: the lack of resources at hand for an individual or household. Social exclusion on the other hand concentrates principally with relational issues such as inadequate social participation and a lack of social integration and power (47).

Room (47) and Berghman (46) argue that the differences between the concepts of poverty and social exclusion derive from two distinct views of society. The idea of poverty comes primarily from Anglo-Saxon, principally British, 19th century research which promotes a liberal vision of society, where a mass of distinct individuals compete in the marketplace. The goal of social policy becomes to ensure every individual has adequate resources to survive in this competitive context (47). In contrast, concepts of social exclusion derive from a European, especially French, social analysis tradition. Society is viewed “as a number of collectives, bound together by sets of mutual rights and obligations which are rooted in some broader moral order” (47) with social exclusion a result of detachment from this moral order. The job of social policy is thus to help reintegrate people into society.

In Australia, the dominant culture of welfare provision has been influenced by the Anglo Saxon liberal, individualistic vision of society. Consequently, social welfare has focused on providing individuals with minimum resources to survive, a model based more around the concept of poverty than social exclusion. This has been particularly evident in the area of ER provision, which has long been viewed by governments as a “band-aid solution” to help prop up individuals in times of financial hardship (5). Moreover, government responses to poverty have increasingly been based on an individualistic perspective about the societal causes of poverty, whereby this problem is attributed in a variety of ways to the individual characteristics of those who are poor (49). The weakness of this explanation, as argued by Frederick and Goddard (29), is that it oversimplifies a complex phenomenon like poverty by neglecting to account for the many causal factors involved. Additionally such a reductionist perspective magnifies the significance of one factor while paying little attention to the vast evidence

documenting the importance of structural environmental factors (50). Consequently efforts at poverty reduction are focused mainly on individuals or groups without addressing structural or environmental variables (51). Despite knowledge of the contribution of structural factors to poverty rates, individualistic views remain influential in Australian society and politics, and have served to legitimise tightening eligibility requirements for receipt of welfare benefits and other coercive social welfare policies (26).

A final point to consider in relation to poverty is there is a highly gendered aspect to this debate, with women being over represented in poverty statistics (44). This is referred to in the literature as the ‘feminisation of poverty’, a term coined in 1978 by Diana Pearce who maintained that in the US two thirds of the poor over 16 were women (52). A 2005 US research study found that single females were almost twice as likely as single males to be living in poverty (53). Particular subgroups of women are also more at risk with single parenthood being a significant risk factor for poverty, as well as being Indigenous, a refugee, or migrant (44). In a study of affluent countries it was found that gender inequality in relation to poverty existed in seven of the eight countries examined (Sweden was the exception) with the largest discrepancies being in the US followed by Australia (54). The ER literature also shows that women are twice as likely as men to access ER services, with the majority of single parent households headed by women (8,37,41,44).

Definition and measurement of financial hardship in the emergency relief sector

Within the ER sector, a recent trend has emerged around the adoption of the concept of financial hardship or stress in order to provide a framework around which ER can be discussed (41). Homel and Ryan (41) argue that the term 'hardship' is preferable to 'stress', as they view 'stress' as a psychological feeling which may or may not be experienced by those in financial hardship, depending on the psychology of the individual. They also iterate that financial hardship is the not the same as income poverty, but is a multi-dimensional construct encompassing assets, debt, income, and financial management. Overall a person is in financial hardship if they are unable to meet their basic financial responsibilities due to lack of money (55).

The Australian Bureau of Statistics General Social Survey (GSS) uses a number of indicators of financial hardship such as; inability to pay utility bills on time, inability to pay mortgage or rent on time, went without meals, sought financial help from family, friends, or community organisations. In 2014, data from the GSS showed that over nearly half of unemployed people and one in five employed people had experienced one of more cash flow problems in the year prior to the survey (56). While no information is collected regarding ER use, as noted by Homel and Ryan,

the indicator "sought assistance from community organisation" is likely to depict instances where respondents sought assistance from agencies due to lack of money, thereby providing a good proxy measure of ER use. The 2014 GSS reported that in the year prior to the survey 2.3% of respondents had sought assistance from a community organisation (56). ER clients thus represent a subsection of a wider financially stressed population (41). However, the ER literature (reviewed below) shows that generally people in the ER subsection are especially disadvantaged relative to others experiencing disadvantage and that they experience a large degree of social exclusion. For many people seeking ER, there is also a long-term experience of financial hardship.

The Australian emergency relief literature

Over the past decade there have been a number of reports, journal papers and surveys of a number of ER providers and their clients carried out in Australia. These have provided an in-depth overview of the issues faced by ER agencies and the characteristics and needs of ER clients. Table 1 identifies the key reports relating to ER provision in Australia. Given the changing landscape of social demographics and welfare provision over time, only studies from the last decade have been included in order to give a more accurate overview of recent ER provision. Appendix A details the methodology used to identify the key reports.

Before considering the evidence offered in these reviews in more detail, we will first make a number of observations about the quality of this evidence. At first glance the literature describing ER in Australia seems to be substantial, with studies carried out in a range of geographical locations, across a range of services, and with significant numbers of ER recipients. These studies cover not only the demographic details of ER clients, but also examination of clients' perceptions of ER, different models of ER provision, and recommendations to improve the effectiveness and efficiency of ER services. Some of these studies have significant methodological robustness, with large sample sizes over long time periods and across geographical locations. These include: a study conducted for the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs described trends in ER provision between 2007 – 2010 in the Northern Territory, NSW, Victoria, Tasmania, South Australia, and Western Australia (41); a Sydney Anglicare report (44) was

conducted over 20 months on seven ER centres and almost 13,000 ER clients; and, a Melbourne study which gathered empirical data from 60 ER organisations operating in metropolitan Melbourne (37). In addition to these studies with larger data sets are projects using different data collection methods including surveys, focus groups, face to face and internet consultations, and interviews with ER clients, case managers, and ER sector volunteers. What this means is that there is considerable knowledge relating to the lived experience of those who access ER services, as well as those who work for ER providers.

Overall, the literature is of significant quality and provides an in-depth examination of the Australian ER sector. Many studies have remarkably similar findings. We outline these findings now and also consider how the evidence relates to ER provision in the ACT context.

Study	Year	Overview	Main Findings
Goodwin-Smith, I and Mackay, T <i>Client experiences of emergency assistance services</i>	2015	16 people aged between 27 and 55 in South Australia were interviewed to determine reasons for seeking ER and perceptions of whether these needs had been met	Participants reported seeking assistance (mainly food) due to bills, especially electricity, but also other utilities and car registration. Most people reported their needs were met but many felt they had received inappropriate or insufficient food. Recommendations included establishing compulsory service standards and partnerships, and a review of types of assistance provided
Brackertz, N <i>Time, trust, respect: Case management in emergency relief: The doorways model</i>	2014	This report was commissioned by the Salvation Army. In response to a rise in the number of people seeking ER and the increasing complexity of their needs the Salvation Army has in recent years piloted and implemented a more holistic approach to ER, called the 'Doorways philosophy'. The 'Time, trust, respect' report examined what case management under a Doorways model looked like. Interviews and case studies were conducted with managers, staff, and clients from ER centres in Victoria, Tasmania, and South Australia.	The research showed that the Doorways philosophy is an emerging model which hold significant promise in their ability to provide longitudinal client support and the flexibility to respond to client needs. The integration of ER with case management can provide a continuum of services which holistically address, over the long term, the causes of financial hardship rather than just the symptoms. Based on interviews with clients and staff, early indications of this model showed it was successful at helping people break repeated cycles of financial crisis, facilitating social inclusion, and connecting people into the wider service system.
Hemel, J and Ryan, C <i>Welfare agencies and the provision of emergency relief in Australia</i>	2012	This occasional paper for the Department of Families, Housing, Community Services and Indigenous Affairs examined recent trends in the provision of ER across Australia. The report was based on data collected by three major welfare agencies between 2007 and mid 2010. Agencies involved were Anglicare (Diocese of Sydney), the Salvation Army Southern Territory (Northern Territory, South Australia, Tasmania, and Western Australia) and St Vincent de Paul (Victoria). Data collected was used to examine the characteristics of ER clients, reasons for seeking ER, amount and type of assistance provided, and trends over 2007 – 2010.	The characteristics and needs of ER clients were shown to be remarkably similar across data sets. ER clients were predominantly female, aged 25 to 44 years old, single parents or people living alone without children, and receiving a government welfare benefit. The majority of clients sought assistance due to immediate financial crisis, but many had complex issues underlying and exacerbating financial hardship. 50 to 60 per cent of clients were assisted more than once over each data collection period. The longitudinal data revealed that over 2007 – 2010 there were clear increases in the amount of assistance provided and the number of people assisted. Overall the data confirmed previous studies on ER describing the characteristics and complex needs of ER clients.
Western Australian Council of Social Services (WACOSS) <i>Giving Shape to the Emergency Relief Sector</i>	2012		Findings showed that different service provider types have varying capacity to provide referrals or case management type ER, based on the resources of each service. Large organisations with paid staff were able to provide wrap-around services whereas small church based organisations were only able to offer basic ER. A general consensus was that financial counselling and accommodation services are in greatest demand and thus have the longest waiting lists. It was found that there is an ongoing need for the ER sector to collect, store, and collate data, not only to secure funding but to identify emerging themes and issues faced by the sector. It was recommended that further research be conducted around the capacity of the ER sector to link in with the broader community support sector and quantify the social capital generated. It was argued that federal and state governments need to recognise the social capital created by the ER sector and provide a funding model which reflects this.

Table 1. Key studies on ER in Australia 2006 – 2015 (continued over page)

Table 1. Key studies on ER in Australia 2006 – 2015

<p>ACT Government 2012 <i>ACT Targeted assistance strategy</i></p>	<p>2012 This report was the result of research by the Targeted Assistance Strategy Panel to examine the range of ACT programs designed to assist lower income Canberrans and to develop a Targeted Assistance Strategy (TAS). While not specifically examining ER, the report did cover some services which would usually be provided by ER agencies.</p>	<p>The TAS report identified a target cohort of ACT residents who were at risk of financial hardship. This cohort was unique in that they were often not in receipt of government welfare and did not recognise themselves as requiring welfare or ER assistance. Due to increasing cost of living, it was identified that more people were falling into this cohort. Community consultations were undertaken to gather suggestions for ways to better target this cohort, with suggestions in areas such as housing, schooling, jobs training, healthcare, and concessions. While many recommendations of the report did not specifically refer to ER provision, it was noted that financial health and wellbeing was a first principle in delivering all services in the ACT community. It was noted that this would require a continuum of support to be integrated with other social services in order to match the continuum of vulnerability of those in financial crisis.</p>
<p>Nguyen, M <i>Ending the stopgap: Case work in emergency relief services</i></p>	<p>2011 This report was written for Community Information Victoria & Cranbourne Information and Support Service. It examined ER casework across Community Information Support Centres (CISCs) to document the models used and their impact in 16 agencies across Victoria. Data in the form of interviews, focus groups, and qualitative and quantitative surveys with case workers, managers, volunteers, and clients from 2007 - 2011 was collected.</p>	<p>Findings showed that ER agencies unanimously felt that ER services needed to provide more than a "band aid" and seek to address the underlying causes of poverty and disadvantage through client advocacy and coordination. The casework approach to ER was a holistic, client-centred, strengths based and personal capacity building. There was collaboration between clients and case workers. Under the 16 participating agencies this approach was successful at ensuring issues were resolved according to client needs and situation, with case workers providing appropriate referrals and ongoing support in order to tailor outcomes based on clients' long term needs.</p>
<p>Corrie, T <i>Microfinance and the household economy: Financial inclusion, social and economic participation and material wellbeing</i></p>	<p>2011 Commissioned by Good Shepherd Youth and Family Service, this research report described the impacts of microfinance on enabling financial inclusion, social and economic participation, and material wellbeing within the context of peoples lived experiences. Three microfinance programs from Good Shepherd in partnership with the National Australia Bank were examined. These included a no-interest loan scheme, low interest loan scheme, and matched savings program.</p>	<p>The research showed that microfinance programs were enablers of financial inclusion, material wellbeing, and social and economic participation. These impacts were different for different groups depending on their geography, with access issues in rural and remote regions. In order to have maximum impact, it was shown that microfinance needs to operate within a context of other services and policy responses.</p>
<p>Engels, B, Nissim, R and Landvogt, K <i>Under pressure: Costs of living, financial hardship, and emergency relief in Victoria</i></p>	<p>2009 This report was a collaboration between the Victorian Council of Social Services (VCOSS), RMIT University, and the emergency relief peak body ER Victoria. Quantitative and qualitative data was collected on individuals and families seeking ER in Victoria in 2007/2008. Surveys were distributed to ER recipients via 24 ER services around Victoria and included questions on demographics, sources of income and employment, and reasons for seeking ER.</p>	<p>it was found that people already receiving some form of social welfare, especially disability support pensions, Newstart, and parenting payments were the main users of ER. Households with a single adult as the head, and renters in the private sector were also more likely to use ER. The level of need for ER across Victoria was not uniform with people in certain geographical regions experiencing greater levels of financial hardship.</p>
<p>Flanagan, K <i>Hard times: Tasmanians in financial crisis</i></p>	<p>2009 In this report a two-week snap-shot survey of ER clients and financial counselling was carried out in Tasmania. 411 participants were included.</p>	<p>Demographic details of ER clients revealed almost all were dependent on government welfare payments, especially single parenting payments, disability pension, and unemployment benefits. Most were renting and around 50% had dependent children. While financial hardship was widespread among ER clients, the severity of this experience was reported as "shocking". Nearly half of participants had financial problems regularly or always. 81% had used ER services previously and almost half were using ER services four or more times a year. Participants also reported experiencing hardship at levels far above what would be expected or accepted in the general community. In particular 75% had missed meals due to money shortages, nearly 60% had been unable to heat their home and nearly 30% had had their electricity supply disconnected. The main reason for seeking ER was that welfare payments received by participants were too low to keep them out of financial crisis. People affected by multiple underlying issues were also more likely to experience hardship.</p>

Table 1. Key studies on ER in Australia 2006 – 2015

Table 1. Key studies on ER in Australia 2006 – 2015

<p>King, S, Bellamy, J, Swann, N, Gavarratto, R and Collier, P <i>Social exclusion: The Sydney experience</i></p>	<p>2009 Anglicare Sydney conducted this study which describes the experiences and reality of financial hardship of those receiving ER by Anglicare in Sydney. A 20-month survey of 7 Anglicare ER centres, with over 13,000 clients was conducted. Quantitative and demographic details of clients and the type and amount of ER assistance received are described. Similar to the Salvation Army Doorways model, the report discusses a move towards a 'value add' service which provides ER plus individual client advocacy and referral.</p>	<p>Results of the survey revealed that there is an over representation of ER clients who are female, Indigenous, between 25-49 years, living alone or sole parents, and living in private or public rental accommodation. 95% of ER recipients were receiving government income payments. The major reason for accessing ER was a lack of income. Other factors including housing, issues with children, and mental health issues. For most people, approaching an ER service was humiliating and embarrassing, with some clients reporting a sense of shame and lack of control. However, most people reported the service they received to be a positive one. The report concluded that basic transactional ER fails to address the complexity of needs for most clients and does not effectively address issues of social exclusion. Anglicare reported it was exploring more innovative relational models of ER provision, but that this required effective Government funding.</p>
<p>Frederick, J and Goddard, C <i>Sweet and sour charity: Experiences of receiving emergency relief in Australia</i></p>	<p>2008 Frederick and Goddard conducted a qualitative, exploratory study of people's experiences when seeking ER. Semi structured interviews were conducted with 20 ER recipients from seven ER services.</p>	<p>While interviewees reported some positive experiences, they also revealed there were distinct limitations to the extent ER agencies were able to help them. The majority of assistance provided was simple help, such as food and material goods, for which participants were grateful. However they reported that there was a lack of emotional support and the experience of obtaining ER was humiliating, embarrassing, and sometimes degrading. A further limit to ER provision identified was the inability of ER agencies to provide assistance beyond basic ER. Interviewees felt a more individualised case management service would be helpful, given many people's needs were complex and longstanding.</p>
<p>Greenhalgh, E, Attwill, A and Eastgate, J <i>Too many bills: A survey of emergency relief agencies in Gold Coast City</i></p>	<p>2007 This study was prepared on behalf of the Regional Managers Coordination Network Subcommittee on Homelessness (Queensland government body) and was the first survey of ER on the Gold Coast. It was undertaken to corroborate anecdotal reports from ER agencies that an increasing number of clients seeking ER were employed homeowners rather than people reliant on welfare payments. 395 surveys of ER clients at 10 Gold Coast services were conducted to obtain information on the characteristics and needs of those seeking help.</p>	<p>Similar to other reports, it was found that most people accessing ER had done so more than once, with two thirds of recipients accessing ER seeking assistance on at least one other occasion. ER recipients were also usually on other welfare payments. It was also shown that different sorts of ER agencies (i.e. church based or community services) tend to provide different types of assistance. People seeking ER are aware of this and will frame their request accordingly.</p>
<p>Engels, B <i>The provision of emergency relief and contemporary pressures for change in metropolitan Melbourne</i></p>	<p>2006 RMIT University and Emergency Relief Victoria carried out this study to present an overview of organisations providing ER in metropolitan Melbourne in 2006. Data was collected via a survey of 60 organisations and included questions on sources of funding, procedures for providing assistance, and identification of issues and problems.</p>	<p>Victoria was shown to have a diverse range of ER providers including churches, welfare and charitable organisations, community agencies, municipal councils, and a variety of small organisations. All agencies reported being reliant on volunteers to conduct initial interviews with ER clients. This was attributed to both the tradition of the ER sector and a lack of government funding. Funding also affected the amount and form of ER provided. Most ER services provided only basic transactional ER such as food, vouchers, cash, and utility payments. Sole parents, families, and single males were found to be the most frequent ER recipients. Most people accessing ER were on social security payments such as parenting payments and Newstart.</p>

Table 1. Key studies on ER in Australia 2006 – 2015

Findings from the Australian emergency relief literature

Client characteristics

Findings from surveys of ER services in Australia show a largely consistent picture of the demographics of those accessing ER. Recipients are primarily female and aged between 25-49, largely living in rented accommodation (public and private), generally single income households – either single parents or people living alone, and most are in receipt of at least one government payment which is their main source of income (8,12,41,44). If employed, ER recipients are mostly working in less than full time casual positions (3). Over 80% are Australian born, with Aboriginal and Torres Strait Islander people tending to be over represented (44).

Client needs

People typically seek ER because of a financial crisis which means they have insufficient money to pay for essential items (57). In recent years the number people requesting ER has increased (6,9,37,41) and clients are presenting with more diverse and complex needs (8). As a consequence, rather than being services that provide assistance for short term or intermittent financial crisis, ER services must now assist many clients experiencing long-term financial hardship (3,8,9,29).

A combination of factors have been suggested as the cause of this reliance on ER including: unemployment/retrenchment, mental health and disability issues, housing stress, family violence, rising living costs, social exclusion, and inadequate income support (3,5,8,9,44). For some people ER has, to some extent, become a way for people to supplement inadequate social welfare payments (3,9,43). Indicators of this are clients repeatedly accessing ER and often using multiple ER services to help them “get by” (8). As a result ER has changed from being a short term “safety-net” to becoming a primary support for people living at or below the poverty line (8).

Mechanisms and approaches to emergency relief provision

Across the community sector there are two types of ER service delivery models in operation¹ (44) basic transactional ER and ER combined with client advocacy and referral:

- **Basic transactional ER**

ER is viewed as a simple safety net to support clients in immediate financial crisis. Clients are provided with vouchers, payment for utility bills, assistance with rent/accommodation, and material assistance such as food parcels. It is useful as a safety-net service but does not help meet clients’ long term or complex needs.

- **ER combined with client advocacy and referral**

The provision of food and financial assistance is accompanied by individual client advocacy (i.e. advocacy to other agencies and government departments, such as Centrelink) and a referral process (i.e. to assist clients to connect with services such as skills training, counselling, and contracts with utility providers).

As discussed in King’s Anglicare report, the ‘one size fits all’ transactional approach is difficult when ER services have to assist clients who present with mental health and disability issues, drug and alcohol use, and lack of financial literacy, who do not have the capacity to negotiate the range of community services they might need (44). A number of ER organisations contend that the basic model is inadequate because the focus is on the transaction, rather than on the person seeking assistance. It is up to the client to prove financial hardship and their other problems are secondary and unaddressed, even though they may be a large contributor to ongoing disadvantage (8,44). In response to the complexity of issues experienced by many ER clients, an increasing number of

¹The terms used to describe ER service delivery models are descriptive only and are not being used in the context of evaluating the effectiveness of ER service provision.

ER providers have begun to offer more holistic services which include advocacy and referral. Examples include the Salvation Army “Doorways philosophy” introduced in Tasmania in 2009 (8). The Salvation Army is a major ER provider to over 157,000 individuals and their families nationally in 2013. Since its introduction, the Doorways model has spread to 81 centres across Australia, and continues to be gradually introduced across The Salvation Army Australia wide. It includes three levels of service delivery:

1. Basic transactional ER providing safety net services such as food and material aid
2. Advocacy, referral, and information
3. A comprehensive case management model aiming to break the cycle of disadvantage

Doorways is a philosophical approach which addresses clients’ immediate needs but also facilitates more intensive assessment of the underlying causes of poverty. Thus ER and case management operate hand in hand, to focus on both the symptoms and causes of financial hardship. This model aims to help people break the cycle of repeated episodes of financial crisis and enable social inclusion.

As examined in the “Ending the stopgap” report, Community Information Support centres in Victoria have used a casework approach to ER which is holistic and client focused. In this model, clients and caseworkers collaborate to identify needs, address issues, and build individual capacity. Caseworkers provide appropriate referrals, ongoing support, and coordinate with other agencies to customise outcomes based on clients long term needs (9). The introduction of a caseworker model was shown to fill service gaps and create a much greater degree of flexibility than the more rigid transactional ER models.

Focusing on clients’ individual capacity building was seen by managers as an effective strategy to reduce the long-term dependence on ER of those in financial hardship. Further, there were positive impacts on service delivery able to be seen at agency, inter-agency, and community

levels as caseworkers built and maintained relationships with other welfare and government services. Cross-referral protocols were also able to be established and caseworkers could connect with existing programs, by linking them to clients and the ER service.

Anglicare has also focused on providing relational ER by using a “value add” service, in which additional support above and beyond food and bill payment is provided and includes:

- Information – clients are given information to assist them to access other services i.e. skills training, counselling, or contracts with utility service providers
- Advocacy – on behalf of clients to other agencies, service providers, and government departments
- Budgeting assistance to help develop household budgets and bill paying that are more sustainable

However, King et al. argue that even this type of ER service is no longer sufficient to address the complex needs of clients (44). What is needed both in services and funding is a transition to a more sustainable relationship model of ER provision. In this type of model, the whole needs of the person are considered with an ongoing relationship between the service and the client to ensure needs are adequately met and that the client does not become lost in the service network. Community connection and social inclusion are seen as vital to developing individuals’ capacity. Anglicare is exploring the development of such a service.

Separate but connected to ER services are microfinance programs, discussed in the Good Shepherd report (2), which support financial inclusion by providing access to financial services which are both affordable and appropriate to client needs. The aim here is to improve the lives of those in poverty by building long-term financial capability. To build this financial capability, Corrie (2) argues that a range of responses are needed such as financial counselling,

community education and microfinance programs. Good Shepherd in partnership with the National Australia Bank runs three microfinance programs, including no and low interest loan schemes and a matched savings program.

More than one service or policy response is required for people to make goals and achieve their aspirations. Thus, microfinance programs can work together with ER and case management, as part of a holistic response to financial hardship.

The Good Shepherd report showed that microfinance programs can enable social inclusion, material well-being and social and economic participation, but that its impacts are different for different groups. For example, rural and remote areas experience difficulties with accessibility. The report also showed that to have greatest impact, microfinance programs cannot operate in a vacuum.

Table 2 provides a summary of some of the relational type ER approaches being used by ER service providers in Australia as well as some of the strengths and limitations of relational ER approaches.

Approach	Organisation	Description	Strengths	Limitations
Doorways Philosophy	The Salvation Army	A case management model created in response to the limitations of traditional transactional ER. Provides basic safety net services such as food and material aid as well as advocacy, information and referral. Doorways also provides the option of referral into a comprehensive case management service. Doorways aims to build the capacity of ER clients and help create a pathway out of poverty and financial hardship for individuals and families, and is being progressively rolled out in centres across Australia.	<ul style="list-style-type: none"> The strengths of relational ER approaches are that they attempt to recognise and address the underlying factors leading to financial hardship rather than providing a simple band-aid solution. 	<ul style="list-style-type: none"> Providing an individualised case management service is costly as it requires both the right infrastructure and paid professional staff.
ER “value add” service	Anglicare	Anglicare provides additional support above and beyond providing basic ER such as food and utility payments. This approach is based on the principle that the “hand out” model of ER does not have the capacity to empower people or assist them to develop long term financial stability. The additional services provided include information, advocacy, and budgeting assistance. These additional services are not covered by government funding and are subsidised by Anglicare.	<ul style="list-style-type: none"> An individualised case management approach can ensure each client’s needs are being met and that they do not become lost in the service provider network. Ongoing support can be offered to clients rather than provision of a simple once off transaction. 	<ul style="list-style-type: none"> Current government funding models do not adequately fund case management approaches, meaning organisations must fund these approaches themselves, relying on charitable public and philanthropic donations.
Case work in Community Information Support Centres (CISCs)	Information Support Centres	CISCs have provided ER in their respective communities over a long time periods and have identified that holistic intervention is the best way to help those with complex needs. In 2010 research was undertaken on 16 Victorian CISCs which were using innovative casework models of ER provision. Case work was shown to be effective at meeting clients’ needs and reducing long term dependence on ER. This was achieved through an individual client centred approach which allowed for individual capacity building.	<ul style="list-style-type: none"> Focusing on individual needs helps build individuals capacity, promotes social inclusion, enhances material wellbeing, and encourages economic and social participation. 	<ul style="list-style-type: none"> Providing case management is time intensive and thus if there are inadequate resources for provision long waiting lists for these services can occur.
Microfinance Programs	Good Shepherd Youth and Family Services	Microfinance programs include no-interest, low interest, and matched savings programs. These types of programs can help build financial capacity and improve financial and material wellbeing. However to have maximum impact they need to be incorporated with other programs such as case management ER.	<ul style="list-style-type: none"> Relational ER approaches have the potential to reduce clients’ dependence on ER services. 	<ul style="list-style-type: none"> Case management requires extensive co-ordination within and between services.

Table 2: Relational type ER approaches used in Australia

Emergency relief funding

Governments have typically funded basic transactional ER (44). King et al. (44) noted that the funding provided to Anglicare did not cover infrastructure or employment costs. Volunteers were able assist with food provision, but assessment, advocacy and referral required paid staff which was subsidised by Anglicare. The Engels (37) study showed staffing problems in Melbourne due to insufficient funding to cover paid staff, who were needed to replace volunteers. Volunteers have traditionally made up the majority of the ER workforce, and the adoption of new relational models of ER, requiring more paid staff, has become especially problematic for ER providers (43). The Salvation Army report that funding models do not adequately cover costs associated with providing case management services, and to provide these type of services agencies must rely on charitable public or philanthropic donations (8).

In Western Australia, issues facing ER service users are becoming increasingly complex, with an ever widening debt-to-income ratio for individuals and families. The WACOSS report

(58) showed that small ER service providers rely solely on volunteers to provide basic ER with minimal referral capacity. Larger multi-program and faith based organisations are able to provide some case management services; however, the allocated funding does not cover all costs associated with providing this type of service. As a result, due to increasing numbers of people seeking ER and limited number of program places available, there exists substantial gaps in services and resources to provide case management and referral. It was noted that there is an expectation by governments that the ER sector will always be there as a safety net, but little willingness to recognise ER within a legitimate framework or assign it program status in the context of funding. WACOSS has thus called on governments to legitimise ER within the government welfare framework, to be seen as an ongoing program which not only provides basic ER, but also allows for funding for the infrastructure and staffing costs needed to deliver effective ER services (58).

See Table 3 for a summary of funding issues identified by major ER service providers in Australia.

Organisation	Funding Issues Identified
Anglicare	Funding models do not allow for infrastructure or employment costs of case workers to provide relational ER services. Anglicare must subsidise the provision of information, advocacy, and referral in order to provide a more holistic service which better meets clients' needs.
Victorian ER services	The 2006 report (37) showed that the funding base of the ER sector in Victoria is too small and too unpredictable. Federal and state government funding is not guaranteed and funding levels are not based upon the levels of demand experienced by services from one year to the next. Funding levels are not adequate to cover paid workers to provide the extra support, counselling, and referral needed to address the complex issues facing ER clients.
The Salvation Army	Funding models provide limited support for newly emerging ER models such as case management. Extra funds allocated in recent times from the Department of Social Services are to be used for case management and are therefore no longer available for the provision of direct material aid. This creates an either/or scenario rather than enabling the Salvation Army to provide integrated services. The policy context and funding structure for ER limit the ability of organisations to build individual capacity in clients, employ expert staff, and create an effective service.
Community Information Support Centres (CISCs)	CISCs provide case management for those seeking ER. However, in Victoria for example, only 12 caseworker positions were funded in 2011. Although funding was provided for 3 years, some funding was decreased. As a result, many agencies offered fewer casework hours. In order to provide case work in ER CISCs have called for the federal government to broaden the support for innovative programs such as case management, and for the state governments to fund CISCs to enable them to recruit professional staff.
Western Australian ER services	While some services have funded programs or community resource centre (CRC) funding there are still substantial costs associated with delivering a case management ER program which are not covered by the 15 per cent administration grant allowance. Extra funding provided during the the global financial crisis has ceased with State and Federal governments making no provision for this reduction in funding. ER clients are presenting with more complex needs and in greater numbers, with services left with fewer resources to deal with this increasing need.

Table 3: Funding issues identified by emergency relief service providers

Recently there has been increasing awareness by governments of the need to fund more relational ER models (see for example: 1,9). Between March 2009 – June 2011 there was a temporary increase in federal funding of ER from around \$35 million per annum to approximately \$64 million. Part of this increase was allocated to fund three pilot schemes to link ER with additional services, in order to provide more holistic support. One of these schemes, Emergency Relief Case Management, allowed for service providers to apply to the Department of Social Services for approval to allocate up to 30% of their funding against the costs of employing case managers (59). However, this 30% was drawn from the existing funding allocation and was not an increase in funding. As pointed out by Brackertz (8), in real terms this represented a cut to funding for material aid. However, it does show an acknowledgement by Government of the potential benefits of case management to achieve long term sustainable outcomes.

At a state level, the ACT 2012 TAS report identified financial health and wellbeing as a first principle in the delivery of services. Consequently, it was recommended that services offer a continuum of support via service integration, to be achieved through government, business, and community sectors working together. The aim was to ensure people could access services which provide not only direct assistance, but advocacy, support, and prevention to build the ability to sustain long term financial health (1). However, the report acknowledged the influence of the Commonwealth Government policies on issues such as cost of living and housing, and its primary role in determining income support and distribution of tax revenue. Thus, state governments have only some of the “policy levers” needed to address financial hardship issues (1). The Federal Government, as previously discussed, is still largely only willing to fund ER as short term type of assistance, meaning that ER services who want to provide more relational models of service are dependent on other sources of funding, such as charitable donations or funds from their own budgets.

Funding sources

As previously discussed, the funding sources and levels an organisation receives are a crucial factor in determining which model of ER provision is used and how much ER an organisation can provide. While Federal and State Governments provide funding for ER service providers, many organisations also rely on charitable or philanthropic donations in order to meet the demand for ER, especially when employing a more relational or case based model of provision. However, data on the amount and type of funding used for ER provision by different ER providers in Australia is not always clear. Often when reporting on funding large service providers may not specifically mention ER and only report broadly around expenditure on “social programs” of which ER may be a subset. Reported Government funding is also not directly attributed to ER and may encompass funding for a range of other services provided by an organisation, such as mental health and homelessness services. Nevertheless, this data still provides some information on types of funding received and amounts spent in the area of social welfare provision.

As examples, two major ER service providers - the Salvation Army and the St Vincent de Paul Society, annually report on funding sources and amounts. In 2015 the Salvation Army Eastern Territory (encompassing the ACT) received 48.7 per cent of its funding from Government (although this was not differentiated into Federal, State or Local Governments), with the remaining funding coming from non-Government sources such as fundraising, op shops, and legacies and donations (See Figures 1 and 2) (60). Of the funds raised 37.9 per cent of was spent on social programs, but it is difficult to attribute what percentage of funding and expenditure was dedicated specifically to ER. It is clear, however, that Government funding comprises less than 50 per cent of the funds required by the organisation to provide its services (60).

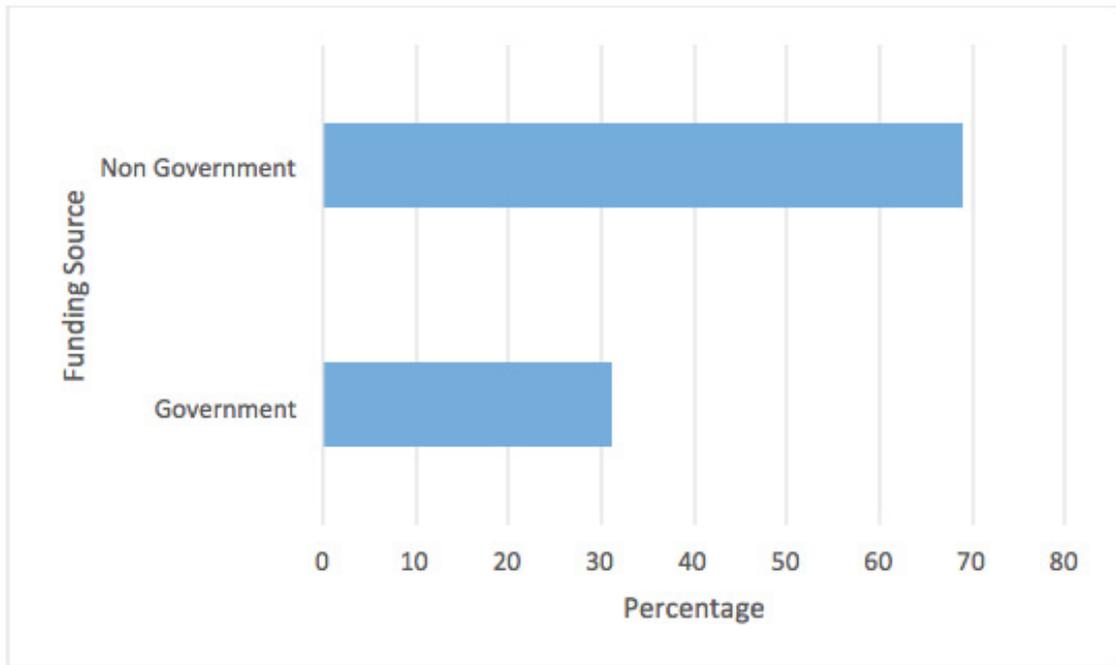


Figure 1. The Salvation Army Eastern Territory Government and non-Government funding 2015

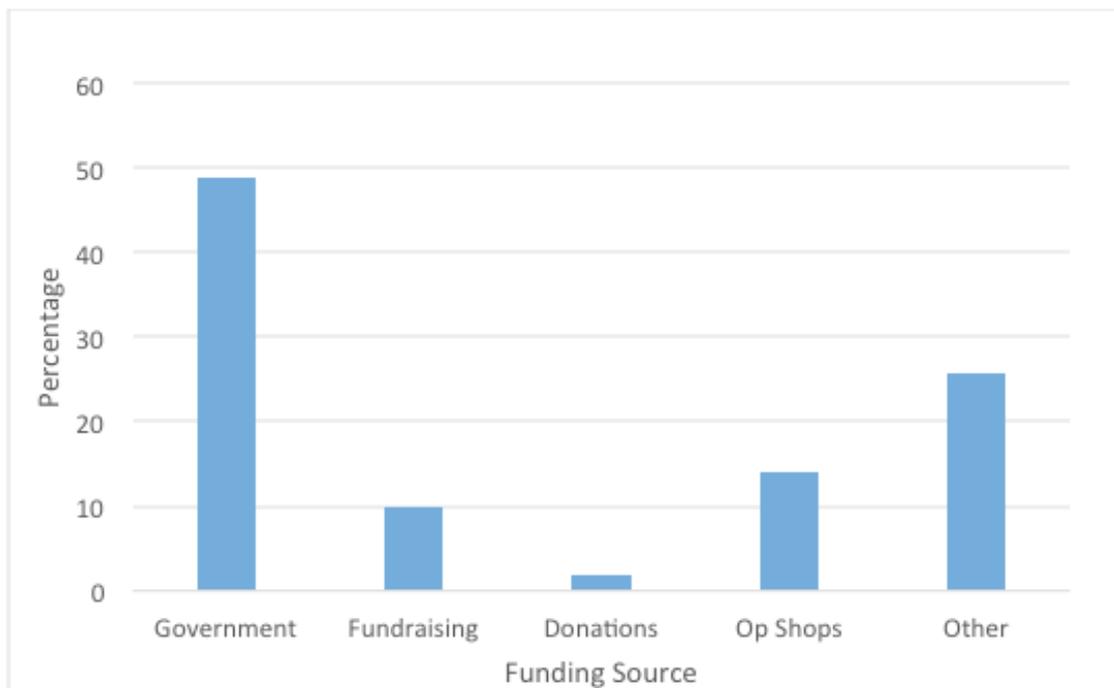


Figure 2. The Salvation Army Eastern Territory funding sources 2015

In 2015-16 the St Vincent de Paul Society (across Australia) reported receiving 31.1 per cent of its funding from Government, 45.4 per cent of funding from op shop revenue, and 10.6 per cent from donations (see Figures 4 and 5) (61) . Of the total amount available to the organisation 24.6 per cent of funds were spent on its “People in need” program, which includes ER.

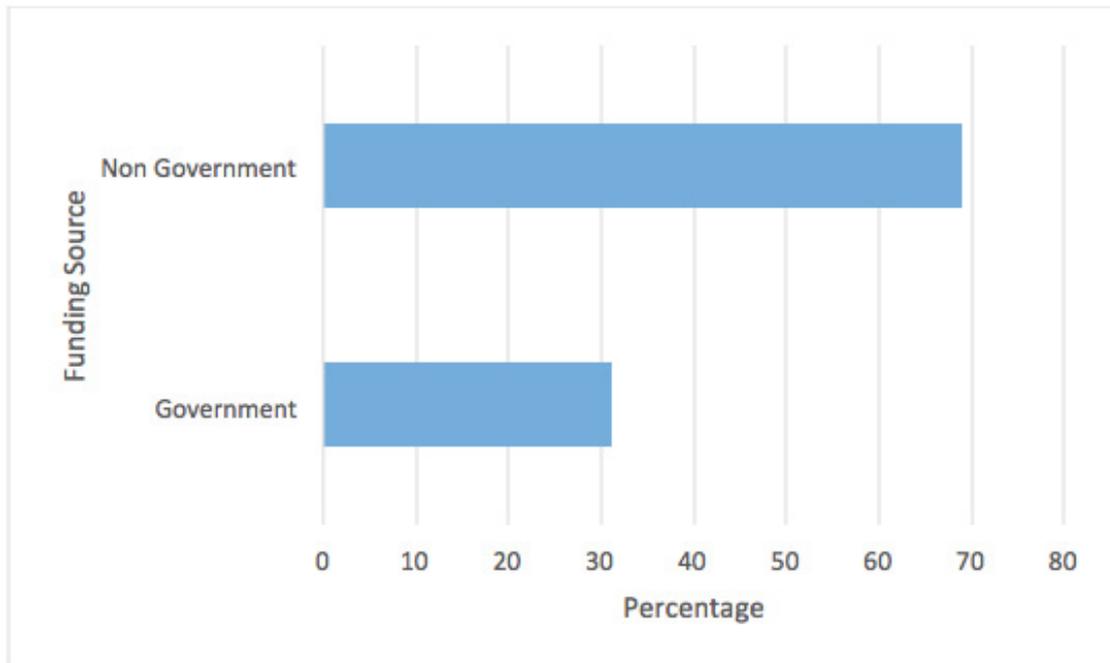


Figure 3. The St Vincent de Paul Society Australia Government and non-Government funding 2015-16

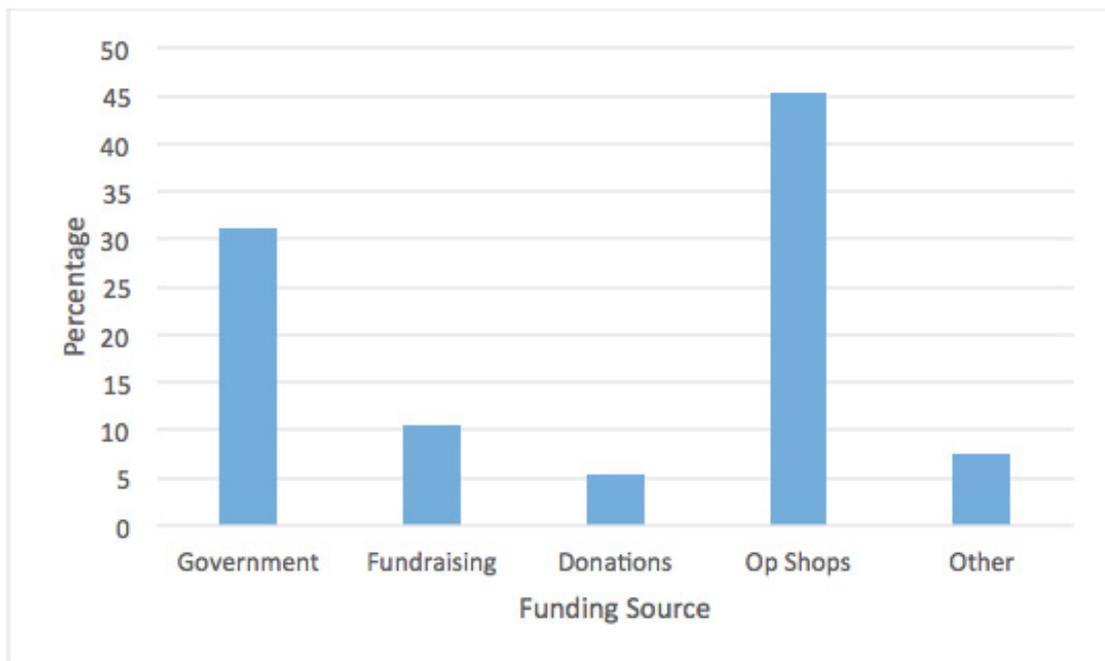


Figure 4. The St Vincent de Paul Society Australia funding sources 2015-16

While most of the ER literature has not focused on funding sources of ER organisations, the 2006 report by Engels on ER provision in Metropolitan Melbourne (37) gives a comprehensive overview of funding sources for the 60 ER service providers examined in the report. Federal Government funding was the most significant single funding source accounting for 25.5 per cent of total funding used by organisations in the study. Non-profit trusts also accounted for a considerable proportion of funding at 23.8 per cent. State Government funding was the next most significant contributor at 12.8 percent, with the remaining funding coming from a variety of other non-government sources (see Figure 5).

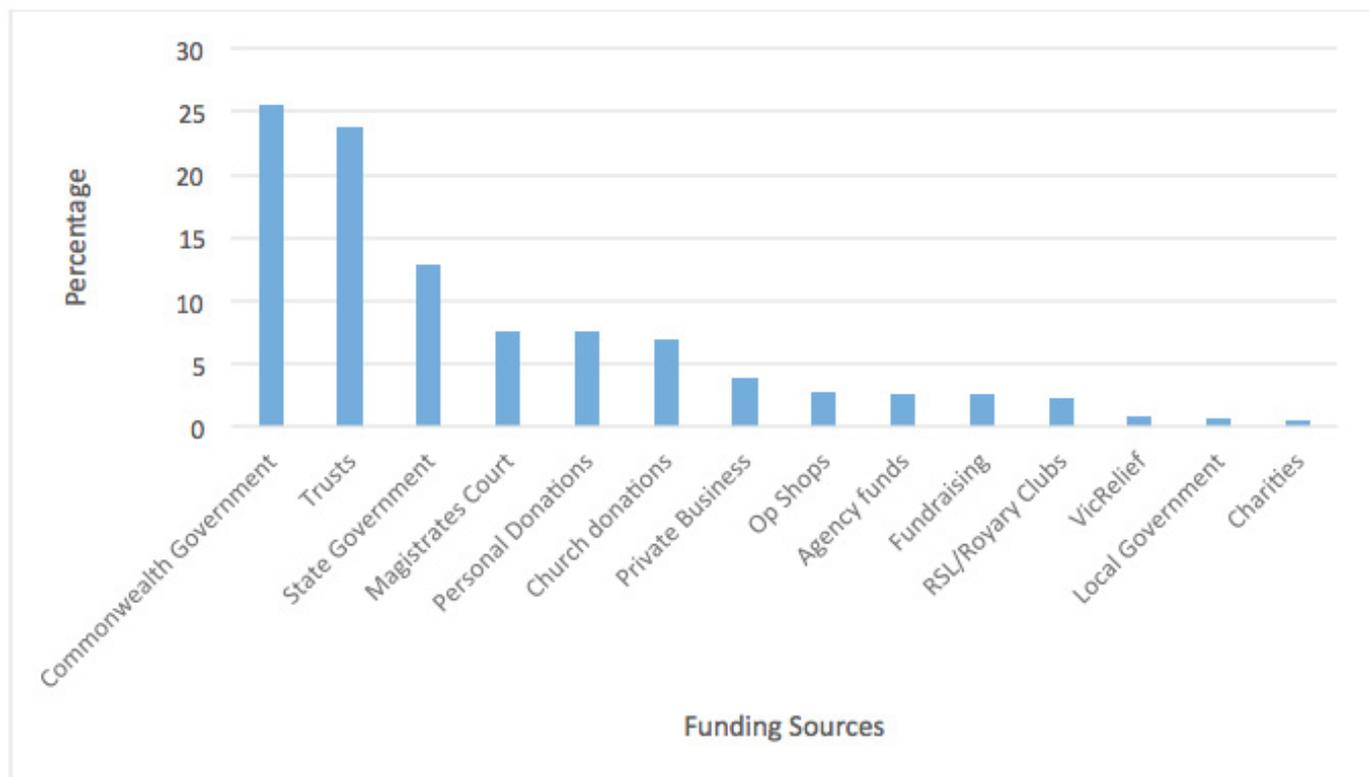


Figure 5. Source of emergency relief funding used by emergency relief providers in Metropolitan Melbourne 2004 (Adapted from Engels, B. 2006 (37))

However, as pointed out by Engels, re-aggregating the data shows a slightly different funding pattern with only 38.9% of the total funds used by the 60 sampled organisations being attributed to government funding (see Table 4). In contrast, 61.1 per cent of total funding was from non-government sources such as private donations and trusts.

Funding Type	Source	Percentage of Total Funding
1. Government	Federal	25.5
	State	12.8
	Local	0.6
Sub Total		38.9
2. Non-Government	Trusts	23.8
	Donations	20.9
	Court Fund	7.6
	Fundraising	2.6
	Op Shops	2.8
	Other	3.4
Sub Total		61.1
TOTAL		100.0

Table 4. Government and non-government funding sources used by emergency relief providers in Metropolitan Melbourne 2004 (Adapted from Engels, B. 2006 (37))

Recommendations for emergency relief provision

Consistent in the ER literature is the acknowledgement that ER can no longer be seen as a short term “band aid” for people in financial crisis (8,9,24,37,41,44,58). The overwhelming consensus has been that the traditional transactional model of ER is no longer meeting the needs of clients who are increasingly presenting with complex, long term issues and accessing ER services repeatedly. While federal governments still approach ER funding under a paradigm of “poverty” rather than “social exclusion”, service providers are responding to the needs of clients by adopting relational models, with a focus on case management, based on understanding and responding to the underlying causes of financial hardship (5).

The “Time, trust, respect” Salvation Army research report highlights that emerging case management approaches have the potential to respond to client needs, addressing the long term causes of financial hardship, rather than just the symptoms (8). This is mirrored by other research reports on case management models of ER such as the experiences of Anglicare Sydney and the “Ending the stopgap” report in Melbourne (9,44).

These reports have made recommendations to government in relation to ER service provision, including calls for funding to support research and evaluation into new case management models (44) such as:

- A recognition of the complexity and variety of needs across all groups of clients accessing ER and the development of funding models which will enable pilot case management in selected ER services in order to fully evaluate the effectiveness of this approach (44)
- Research into innovative models which provide the best practice for ER service delivery

- Ongoing ER working parties or steering committee of community agencies and government to support development of a holistic ER service delivery model

Other suggestions have focused on consistency across the sector:

- ER agencies should be required to meet service standards to ensure consistency across agencies, especially in the areas of interviewing, assessing, and assisting clients (29).
- Funding to develop a national ER data system to facilitate data sharing between agencies as well as development of key KPIs
- Development of evaluation systems based on client feedback

With the shift in human service provision from the state to non-government providers, especially non-profits, government “purchasers” of services are increasingly requiring reporting on outsourced services (39). A recent article by Tomkinson (62) on performance assessment in the non-profit sector makes two important recommendations which reflect those made by ER providers:

1. Fund non-profits efforts to measure their performance
2. Help non-profits share with other organisations about what they have learned through performance assessments i.e. what does and does not work.

In discussing outcomes-based reporting, Tomkinson comments that the first recommendation offers government a viable pivot for change:

“...good public governance demands government entities reflect carefully on how well their performance data requirements for externalised service providers align with the goals of their service funding agreements and the organisations they fund.” (39).

Government purchasers of services are increasingly expecting funded organisations to report on the outcomes produced for clients, as a way to demonstrate the impact achieved by public policy. Government services were historically judged mainly on broad criteria such as accessibility and availability, however, measures of 'efficiency' have become increasingly important in recent years. These have focused on activities and outputs such as volume of service transactions, number of registered clients, and the number of appointments conducted. However, as Tomkinson argues, if concern for efficiency is unaligned with concern for 'effectiveness', then outcomes may be perverse – because services may be inexpensive on a cost-unit basis but fail to deliver the desired impact.

We have therefore seen a shift towards asking not what services cost per unit of service provided, but to examining whether, and to what extent, government funded services achieve positive outcomes for the people they are assisting. The WACOSS report specifically recognised the need for the ER sector to collect, store, and collate ER data, and highlighted how data plays an important role in not only securing funding but in allowing for analysis of the issues that affect the sector (58). In an era where there is increasing pressure on governments to show public funds are well spent, the above recommendations could help reveal what is working to achieve the best outcomes in the ER sector, and direct government purchasing of services more effectively.

However, while research and evaluation is important, in all reports by far the single largest factor preventing adoption of case management approaches to ER has been lack of direct government funding for these models. As identified by Brackett (8), the problem with the current funding model is that it provides only limited support for emerging models of ER such as case management. ER funds used for case management are no longer able to be used for direct material aid, forcing providers into an either/or scenario rather than providing for a way to build integrated services. ER providers are thus forced to choose between employing case managers to provide assistance for clients with complex needs,

while reducing direct services to others. However, as Brackett argues, supporting case management at the expense of direct ER is difficult as they are complementary models. People need to be able to survive in the short term in order to be able to make long term plans, requiring both the provision of ER alongside case management, rather than one or the other. Government funding needs to be increased to support the development of relational ER while still maintaining basic transactional ER.

Emergency relief provision in the ACT

ER in the ACT is provided via funding from the ACT Government, Commonwealth Government and by charitable organisations which receive community and philanthropic donations. Currently, the ACT Government funds a number of community organisations to provide assistance for people experiencing financial hardship through initiatives such as the Emergency Material and Financial Aid (EMFA) program under the Community Development Program (CDP). In 2016-17 the CDP provided \$10.118 million to 27 community organisations to deliver a range of services with a focus on the needs of individuals and families on low incomes and people experiencing financial crisis (1). Services include information, counselling, advocacy, accommodation and emergency financial and material aid.

EMFA is specifically targeted to provide assistance for people in temporary financial crisis through to short term assistance, including referral to other programs designed to address the underlying long term causes of financial crisis. In 2016-17 the ACT Government provided \$1.123 million to UnitingCare Kippax, Salvation Army, and Society of St. Vincent de Paul. Social Housing and Homelessness Services (SHHS) within the ACT Government reported that in 2015-16 there were a total of 12,590 occasions of EMFA assistance, provided to 4,744 clients. Service providers have also anecdotally reported that they are seeing an increasing demand for ER and assisting new families and individuals who have not previously accessed the service. (1).

Funding for ER in the ACT is also provided by the Commonwealth Government to organisations including: Migrant and Refugee Settlement Services, Society of St. Vincent de Paul, the Salvation Army, the Young Womens Christian Association of Canberra, Anglicare NSW and the ACT, Companion House, Karralika Programs Inc., Foodbank Australia and SecondBite. Many NGOs funded by both the Commonwealth and the ACT Government attract additional resources through fundraising and charitable donations.

Food Assistance

Food assistance in the ACT is provided through a mix of financial support from the EMFA program, food banks/pantries, and charitable organisations. The ACT Government funds the Rotary Club of Canberra to oversee the transportation of food from the NSW Foodbank warehouse to food pantries in the ACT (14).

Financial Management Counselling and Loan Programs

The ACT Government funds a number of financial management services including financial counselling, the No Interest Loan Scheme and the ACT Microcredit Program (15,16). These services are adjunct services to ER which aim to build individuals' financial capacity and resilience in order to help reduce disadvantage and vulnerability. The Commonwealth Government also funds the Commonwealth Financial Counselling (CFC) services through the Financial Management Program, which includes funding for ACT organisations (17).

ACT Government Concessions Programs

A number of targeted assistance and concessions programs are provided by the ACT Government to help with cost of living pressures, in particular for people on low incomes. Concessions programs include affordable housing programs, energy and water efficiency programs, public transport fares and vehicle registration fees (18).

ACT Targeted Assistance Strategy

In 2012 the Targeted Assistance Strategy Panel produced the Targeted Assistance Strategy (TAS) Report (1), which examined the range of ACT programs designed to assist lower income Canberrans and developed a Targeted Assistance Strategy (TAS) for the ACT Government. The TAS report recognised the need for a 'hand up' rather than a 'hand out' approach (19) and included recommendations to assist with financial capacity building for those in financial hardship. By 2014, the ACT Government had adopted a number of recommendations, including:

- Expansion of the No Interest Loan Scheme in the ACT
- Establishment of a Low Interest Loan Scheme in the ACT
- Increasing access to financial counselling and information, particularly at times of change
- Provision of subsidised food to members of the community.
- Funding additional costs to public transport.

In addition, the ACT Government met its commitment under the 8th Legislative Assembly Parliamentary Agreement to establish an ACT Micro-credit Program.

Findings on emergency relief in the ACT

The last review on provision of ER in the ACT was conducted in 2004 for the Department of Disability, Housing and Community Services. While this report reviews the service system, reports on effectiveness and efficiency of the ER sector and provides recommendations, it is currently over a decade old and thus much of the information contained in the review may no longer apply. In particular there have been a number of changes to funding for ER (and adjunct services) at a Federal Level, especially since changes initiated in the 2014-15 Federal Budget. There have also been new ER service providers enter the sector in the ACT as well as the establishment of some new models and services such as no-interest loan schemes. Further, only three services (the Salvation Army, the Society of St Vincent de Paul and the Smith Family) which received funding in excess of \$100,000 were reviewed.

Thus, while some general trends from this review are mentioned below, its findings have not been discussed in detail and it has not been included as one of the key studies of ER discussed in the above section.

The 2012 Targeted Assistance Strategy Report provides recent data on issues of financial hardship and target cohorts for assistance in the ACT and relevant findings from this report are discussed below.

Clients' characteristics in the ACT

A review of ACT Government organisations providing emergency relief in various forms during 2013-15 indicates that around 65% of ER service users in the ACT were female and those aged 25-49 contribute to the majority of the users. Almost 80% of service users were public housing tenants while 11% are in private rental and 5% in refuges or identified as being homeless. Aboriginal and Torres Strait Islander people comprised 16% although they represent only one in fifty of the ACT population. On average, 13% of service users identified as culturally and

linguistically diverse background while the majority (68%) identified neither from Aboriginal and Torres Strait Islander Community nor from culturally and linguistically diverse background. 12% of service users mentioned having some form of disability and the reviews of data reported to the ACT Government also shows that 38% used services once, 39% two occasions and 21% three or more.

Despite the majority of ACT residents having a high standard of living and incomes significantly above the Australian average, (reflected across all income quintiles) some individuals and families still experience disadvantage. The Survey of Income and Housing 2013/14 shows that 8.4 per cent of households in the ACT are classified as low-income with a weekly equivalised disposable income between \$205 and \$511 (64). This income is below the 60% of median income poverty line. Further, this disadvantage is scattered throughout the suburbs of Canberra, thereby reducing its visibility and exacerbating social exclusion. However, the 'Dropping off the Edge 2015' report, commissioned by Jesuit Social Services/Catholic Social Services Australia (65) which examined place based disadvantage across Australia, showed the development of certain geographical "pockets" within the ACT with identifiable disadvantage. Indicators of disadvantage (i.e. long-term unemployment, housing stress, low family income) were used to gauge the degree and location of social disadvantage within jurisdictions, showing a concentration of disadvantage in several ACT locations.

An analysis of data collected from ER service providers funded by the ACT Government from 2011-15 shows that the geographical spread of service user residency is concentrated around Belconnen and the Inner North. This indicates that the ACT may be more amenable to place-based approaches than previous reviews suggested. Figure 6 shows the geographic spread of residency in the ACT

The Gini coefficient for income in the ACT (0.272) is lower than the national Gini figure (0.333) and for states such as Victoria (0.314) and NSW (0.345) (66). The Australian Bureau of

Statistics (ABS) uses the Gini coefficient as an internationally comparable indicator. It is a single statistic with values between 0 and 1, with a coefficient of zero indicating that everyone in a population has the same income. A Gini coefficient closer to 1 represents a larger degree of inequality (66). It is possible that the overall greater degree of income equality in the ACT, compared to other states, may further mask the pockets of disadvantage which are dispersed throughout Canberra.

Many Australian states use place based approaches to ER provision. For example, in Victoria large and well-resourced agencies are located in central and inner areas of Melbourne, with other providers in specific suburbs/ municipalities/shires according to need (37). While the distribution of social disadvantage across Canberra potentially limits the use of a place based approaches, data on areas of greater social disadvantage, such as those mentioned above, can help inform on where ER services are most likely to be needed. Further, the smaller geographical area of the ACT in comparison with other Australian states and the Northern Territory may require that “place-based” be conceptualised differently; for example, programs may be targeted to the whole of Canberra.

The Data Analysis of Costs of Living in Canberra report (1), commissioned by the ACT Targeted Assistance Strategy Panel revealed:

- Although there are high levels of family and community support, 29.5% of those in the lowest income quintile indicated they would be unable to raise \$2000 within a week in case of emergency. This is similar to Australia wide statistics, where the Australian Health Survey 2011-12 reported that nearly 1/3 of people living in low-income households would be unable to raise \$2000 for something important, with similar data for households (67). Single parent families with the adult unemployed faced the largest difficulty in raising emergency funds, with the majority of single parents being women.

- In 2009-10 a significant proportion of ACT households underwent from some form of financial stress, with 28.8 per cent of all households experiencing one or more indicators of financial stress, and nearly 10 per cent of households experiencing four or more indicators.
- Almost 75% of low-income households have a head of the household who is either unemployed or not in the labour force
- The ACT does not have the same range of regional poverty rates as the rest of Australia but does have small pockets of locational disadvantage.

In the ACT, the TAS report also identified a target cohort of individuals and families living in the ACT with different demographic characteristics to those most likely to access ER. This cohort was identified as unique as they are often not receiving any government welfare and may not be eligible for any concessions. They were described as ‘normal, low to middle-income families and individuals’ who live pay to pay but find themselves unable to cope financially if their circumstances change (1). These changes are often sudden (i.e. a medical expense or large utility bill), but may also be cumulative and continuing, with resulting increased financial hardship over time. People may also move in and out of the target group as their situation changes.

The at-risk households were identified as being those in the second income quintile and to the second and third income deciles. These households proportionally expend a higher amount on essential goods and services, with nearly 30% of ACT households in the second income quintile having household expenditures greater than received income. Although they earn more, these second income quintile households were shown to experience more financial stress (57.8%) than households in the second and third deciles (42.6%) who are classified as ‘low-income’. Additionally, when comparing to those in the lowest income quintile, the second income quintile group was less likely to seek assistance from welfare and community organisations.

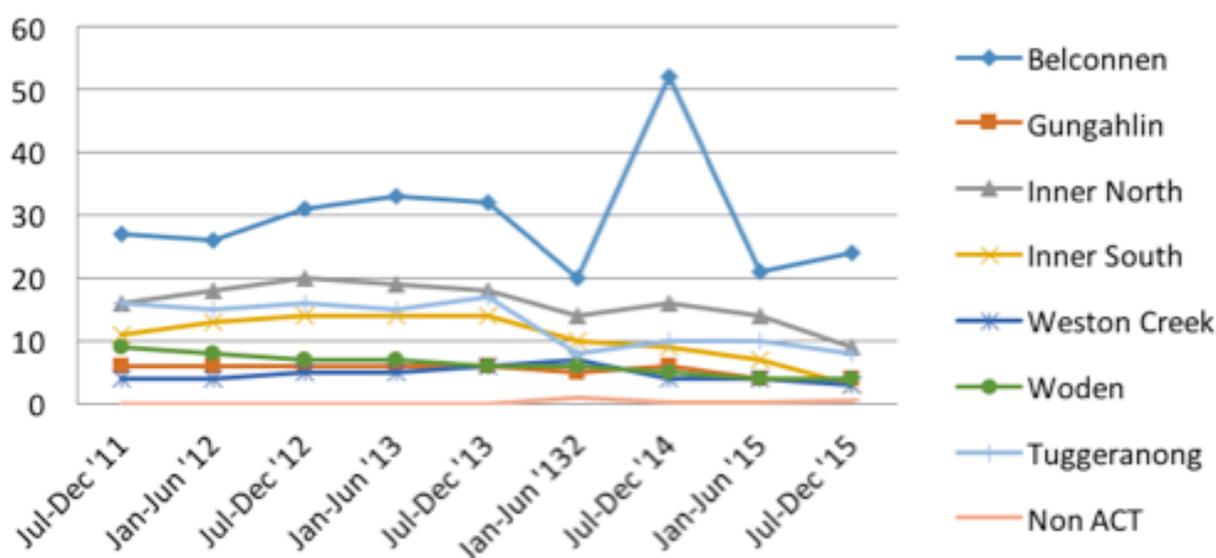


Figure 6. Geographic spread of residency in the ACT over time

Clients' needs in the ACT

Data collected in the 2004 ACT ER review showed that the three services reported on were able to provide some form of assistance people in genuine need on most occasions. However it was also noted that while specific data on exactly how much assistance is provided per contact, qualitative interview data from agencies and clients suggest that it is usually small (less than \$50 - \$100). This was seen as representing a significant shortfall between the resources clients needed to resolve their financial hardship and the resources they currently have. Through qualitative feedback received from clients, it was reported that they often wish not to disclose their real degree of hardship due to a perception of the limited capacity of ER agencies to provide more than help for one bill or one problem. It was also reported that clients could be advised to seek help from multiple agencies in order to gain the full amount of support they needed.

As a result, while clients' immediate basic needs were usually met, they often sought extra assistance from the same agency or another agency within a short time span of weeks or months, suggesting that any help provided was not long-lasting. These experiences are not unique to the ACT and are demonstrated in the ER literature as occurring nationally.

The ACT review notes that this is an important issue for policy makers and service providers. If the model of ER provision provides a 'band-aid' or 'last resort' response focused only on short-term needs, then it should come as no surprise that it will not help address medium or long term issues of financial hardship. In contrast, if the aim of ER is to provide assistance which not only helps resolve people's immediate crises, but also provides support for longer term outcomes, then the volume of repeat visits to ER services shows a failure of effectiveness (63). Again, these findings are not distinctive to the ACT context and have been discussed at length in many reports of Australian ER provision.

Although the needs of people accessing ER in the ACT are similar to those in the rest of Australia, the TAS report identified a target cohort in the ACT which is unique, in that they are often not eligible for any concessions and may be unfamiliar with how to access services. Further, accessing this cohort could be difficult, as they are generally not linked to existing contact points with the Government or community sector. This cohort sees themselves as “normal families doing it tough” and thus may not identify themselves as needing support or assistance (1). The ACT has high housing costs and a large proportion of the population spends a significant amount of their income on housing.

The Household Expenditure Survey 2009-2010 showed that ACT households in the lowest income quintile spent around 20% more of their average weekly expenditure on housing costs (\$162.79) compared with the national average (\$133.91), and the proportion of goods and services expenditure on housing in the lowest income quintile was also nearly 10% higher than the national average (68). The cost of living in the ACT has also been identified as an issue for a significant percentage of people living in the ACT (69), with the ACT Government acknowledging that not all households are always able to share equally in prosperity created by a good economy (19). Changes in the 2014-15 Federal Budget (discussed below) have also had impacts on low-income households in the ACT, with a 2014 ACT Government Issues Paper indicating that these changes would have the flow on effect of increasing demand for Government concessions programs (19). Although ER is not specifically mentioned in the above statistics, it is likely that the increasing cost of living and housing pressures will in turn increase demand for ER services, as more ACT households risk experiencing financial hardship.

Challenges within the ACT context

As identified in the TAS report, there exists in the ACT a target cohort of families and individuals who may be experiencing financial hardship and crisis, but who may not identify with needing ER or know how to access help. As a result, the report made a number of short, medium, and long term recommendations to better focus on the target cohort in areas such as building financial capacity, health, housing, utilities, school education and job training. While many of these recommendations do not relate to direct ER service provision, they suggest the need to provide not just basic ER, but to address some of the longer term structural issues which lead people to ER.

TAS recommendations related to ER more directly included:

- Building financial capacity (medium term)
- Expansion of the No Interest Loan Scheme
- Establish a low interest loan scheme
- Provide increased access to financial counselling and information
- Provide training for additional 6-10 financial counsellors in the ACT
- Community service providers continue to provide subsidised food
- Payment incentive schemes to be implemented for those experiencing financial hardship, by both eth ACT government and business
- The ACT government use debt waiver and partial debt waiver as a form of assistance if people have no or little capacity to pay

The TAS report did not report on models of ER service delivery within the ACT. However, some of the recommendations above suggest a need to target funding towards services providing more relational rather than basic ER, such as offering advocacy, counselling, and referrals.

In April 2017, the ACT Government Community Services Directorate held a forum and called for submissions from service providers and advocacy organisations. Participants discussed a range of issues, which are listed below:

- 1) A transactional model that operates at crisis time only is unable to meet clients' needs holistically. ER provision needs to shift towards a relational approach, which is based on a foundation of trust and dignity and which recognises clients' strength and capacity to cope and develop. In this model, transactional and immediate needs are met and underlying causes are also addressed over time, once a relationship and trust is built.
- 2) Diversity in service users' needs demands diversity in service provision

Forum participants discussed that clients seeking ER often experience multiple forms of disadvantage, which adds to the complexity of accessing emergency relief at time of hardship.

The circumstances of Aboriginal and Torres Strait Islander peoples, people living in less advantaged areas or those with limited access to digital tools, older people, people who are part of culturally and linguistically diverse communities, lesbian, gay, bisexual, transgender

and intersex people, people with disabilities, young people, single mothers, Canberrans experiencing mental health issues, and those escaping all forms of family violence (including financial abuse) make their experience of poverty and social exclusion different to that of other members of the Canberra community.

People within these communities can face multiple and intersecting barriers to seeking assistance, as well as in finding appropriate help and support, regardless of their background, identity or membership of a particular community.

- 3) Continuum of response: a crisis focused response is unable to shift to a stable financial status

Some individuals move constantly between crisis stage and short term recovery, at different points along their journey to financial stability. One contributing reason is the crisis nature of this funding, in which needs are not met holistically.

While services to enhance financial capability are needed at the prevention and early intervention stage, it is often at a crisis point where clients are referred to or access financial capability advice and training. In the spectrum of clients' financial needs, ER and financial counselling are accessible through a range of services such as food bank, utility vouchers and counselling offered by Care Inc in the ACT. However, in order to break the cycle of financial distress, from crisis point to recovery, current allocation of material and financial aid is not able to sufficiently meet the needs of clients with complex ongoing issues.

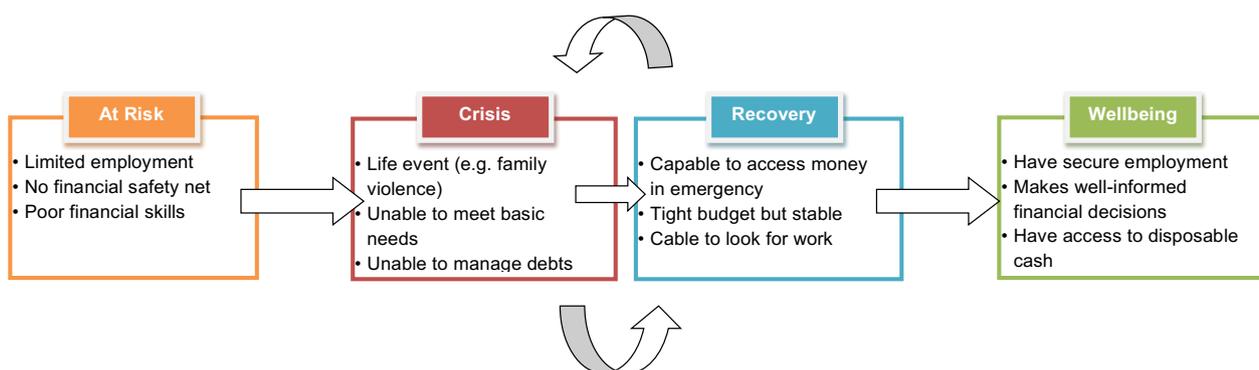


Figure 7. Continuum of crisis

The Human Services Blueprint suggests a number of service principles, including a viable and sustainable response, which leverage resources across the system to respond to current, emerging and future demands. Forum participants acknowledged that the existing EMFA funding needs to keep its focus on emergency response to support families and individuals, who access emergency relief as their last resort.

Due the complexity of issues faced by families and individuals, they may access different specialist services at different points of time. However, having ER located separately from early intervention case management services can be a barrier to access at times of hardship.

Forum attendees and submissions collectively recommended that there needs to be better collaboration and coordination between services. In this collaborative approach, partners would put their resources into a pool for a common purpose while they remain separate entities. Partners share common goals and philosophy and have agreed plans, governance and administrative arrangements.

4) Lack of information sharing and collaboration

There is currently little integration across providers to know when clients are accessing support from more than one provider. Sharing information can add value in identifying clients' needs and trends of issues experienced in a bigger scale. However, in the current service system it is impossible to capture how often and for what occasions someone accesses ER and what other specialist services the person is connected with.

The 2015 OECD report suggests that providers with an integrated service model are better able to achieve improved outcomes for their clients. The report also indicates that improved service integration is better equipped to address multiple underlying issues of vulnerable populations, while at the same time improving access to services, reducing cost burdens and facilitating information and knowledge sharing between professionals.

Adjunct services to emergency relief

In addition to ER services there are a number of adjunct services, provided to similar groups that are in receipt of ER. These services have the potential to operate as extensions of ER or as a way of supporting individuals so that they do not have to draw on ER.

Assistance for Aboriginal and Torres Strait Islander people

ER data shows that a significant proportion of clients identify as Aboriginal or Torres Strait Islander (around 15%, although this varies with geographical location) (41). This is significantly greater than their representation in the broader welfare system – on average 4 to 5 per cent of income support recipients were Indigenous between 1995 and 2005 (70). The ACT government does not provide specific ER services for Aboriginal and Torres Strait Islander people however ER agencies report that around 12% of ER clients in the ACT identify as Aboriginal or Torres Strait Islander.

To acknowledge the disadvantage experienced by Indigenous Australians, in December 2007 the Council of Australian Governments (COAG) endorsed a partnership between all government levels to work with Aboriginal and Torres Strait Islander communities to close the gap on Aboriginal and Torres Strait Islander disadvantage. Six targets were set to 'close the gap' in education, health, and economic participation. The 2013-14 Closing the Gap data indicated that nationally targets for life expectancy, literacy and numeracy, and employment were unlikely to be met, but data for young child mortality was on track (71). Within the ACT context there were some statistically significant positive outcomes compared to other jurisdictions, with the ACT being the only jurisdiction on track to closing the employment to population ratios gap and achieve significant progress in literacy, numeracy, and Year 12 attainment indicators (71).

In order to provide an evidence base for how the ACT is meeting commitments to improving outcomes for Aboriginal and Torres Strait Islander people in the ACT, the Minister for Aboriginal and Torres Strait Islander Affairs commissioned the ACT Closing the Gap Report 2015 (71). In addition to the Closing the Gap results this report included progress made against administrative and population data for the ACT. It was acknowledged that while mainstream services such as health, education, housing and community services are predominantly responsible for achieving better outcomes for Aboriginal and Torres Strait Islander people, in order to improve their effectiveness, investment is needed in initiatives which are targeted and responsive to the needs of Aboriginal and Torres Strait Islander people.

In 2014-15 a number of policies, initiatives and funding commitments were implemented and consolidated for Aboriginal and Torres Strait Islander people in the ACT, including development of the ACT Aboriginal and Torres Strait Islander Agreement 2015-18. This agreement acknowledged the need for:

“intense, integrated and coordinated effort across all ACT Government directorates and the community sector to achieve more equitable outcome for Aboriginal and Torres Strait Islander people” (71)

The ER literature shows that services that provide a relational or case management approach are more effective in helping to address the underlying issues of clients with complex needs. While not specifically discussing ER services the ACT Closing the Gap report identified that well targeted, responsive, and welcoming services can help keep people and families connected and foster community participation. In 2014-15 the Community Services Directorate continued to significantly reform the way it partners and worked with the community. The Better Services Human Service Blueprint in particular focused on simplifying how people can get the right support at the right time, particularly when there are various services involved (72).

ACT Government services or funding for Aboriginal and Torres Strait Islander people focusing on early intervention, overcoming barriers to accessing services and intensive support when required have included:

- Funding via the Child, Youth and Family Services Program to Gugan Gulwan Youth Aboriginal Corporation for case management, group programs, youth engagements and therapeutic services. The provision of these services are delivered within an integrated service model targeting vulnerable and in need Aboriginal and Torres Strait Islander children, young people and their families. This service model is for youth and family engagement that is a series of intentional interventions that work together in an integrated way to promote safety, permanency and wellbeing of children, young people and families.
- Funding for the ACT Council of Social Services for the provision of an Aboriginal and Torres Strait Islander Engagement Service (the Gulanga program).
- The Growing Healthy Families program, through three child and family centres using a community development model. This provides culturally responsive services to Aboriginal and Torres Strait Islander communities in the areas of health, early childhood development and parenting. The program also links to universal health and community services.

Housing

National data from surveys of ER recipients show that the majority of people who seek ER live in either private or public rental accommodation. Overall private renters make up around 50% of ER clients and public renters 30 - 40% (41). A 2016 report by the Australian Housing and Urban Research Institute (AHURI) (73) showed that in the last two decades the private rental market has become more important as a means of providing homes for Australians. However, there has been increasing competition in the private market, especially at the low-end where demand has significantly outstripped supply. Governments have also been encouraging renters who are eligible for social housing to instead move into the private rental market. As a result, several assistance measures for private renters have been developed. The best known schemes include Commonwealth Rent Assistance (CRA), and state and territory Private Rent Assistance (PRA), both of which offer bond and rent loans to eligible households. The National Rental Affordability Scheme and private rental brokerage are other assistance measures.

Due to the large number of ER recipients in the private rental market, these types of assistance play a role in addressing some of the underlying structural factors contributing to housing stress in ER clients. A report on private rental brokerage by the AHURI, describes private rental brokerage as a 'third pillar' alongside CRA and PRA (73). Private rental brokerage programs (PRBPs) are found throughout Australia's housing support system. Some brokerage work is tied to the National Affordable Housing Agreement (NAHA) and provided by state government departments. Localised agencies, many in the non-government sector also provide brokerage. Funding is provided through the NAHA, philanthropic donations or by agencies own budgets.

PRBPs aim to assist low income Australians to access and continue to live in private rental accommodation (73). Clients are assisted individually to navigate the private rental market, from application processes to entering accommodation. The service provided is facilitative, with PRBPs acting as brokers, mediators, and sometimes managers in the relationship between rental applicants and property managers. Brokerage aims to locate, secure, and bring together a range of supports to improve the housing outcomes for vulnerable individuals and households seeking accommodation in the private rental market. It may include linking people in with CRA and PRA. In short, the service is not just about finding accommodation "it is a holistic service to support people" (73).

As an adjunct to ER, PRBPs help clients access information and provide practical and material assistance, depending on individual needs. However, agencies reported that while they are successful in assisting 'rental ready' clients to access housing, it was challenging, and often impossible, to assist clients with high or complex needs. Further, many agencies were only funded to assist clients identified as 'rental ready'. PRBPs also identified other barriers which limited their effectiveness including:

- an absence of affordable rental housing
- discrimination, stigma, and stereotyping of clients – especially those who are Indigenous, have a refugee background, survivors of domestic violence, and those with a disability
- Lack of appropriate built form housing, especially for larger families, and those with cultural and disability needs
- The need for clients to be 'rental ready', as agencies did not have the resources to provide a full service and viewed clients with high or complex needs as needing social housing.

PRBPs provide a service with the potential to assist some groups of people who might also be accessing ER services. However, they face several challenges for which the AHURI has identified a number of recommendations:

- The contribution of PRBPs as a third pillar of Australia's private rental program be acknowledged and conceptualised alongside other such supports at a national level
- Dedicated funding to be provided to ensure a skilled workforce is sustained to assist people struggling to access the private rental market
- Data on PRBPs needs to be collected at state and federal level as recognition of its important role
- Structural factors impacting on housing supply need to be addressed to increase affordable housing options
- Funding should be increased to help support clients with complex needs, or clients assured access to social housing
- There is market failure to address the needs of some clients, in particular due to discrimination, stigma, and stereotyping.

Food banks

Foodbanks in Australia supply charitable welfare organisations that provide emergency food via a centralised and co-ordinated service. As such they can be viewed as an extra tier in the provision of ER (74). While food banking has expanded over the last 20 years in Australia, Booth and Whelan comment on the paucity of literature in this area and that much of this literature is dated (74). In response they provide an examination of the food banking industry discussed below.

Food banks in Australia operate as a centralised, coordinated, and efficient service to provide charitable welfare agencies with food for their ER programs. By building strong relationships with operators in the food supply chain they are able to effectively source and distribute the donated food. The foodbank industry acknowledges that the main driver of hunger in Australia is economic issues (75), with the aim being to reduce the main symptom of food insecurity, particularly hunger. Foodbank Australia is the largest hunger relief provider in Australia, and operates in all regions apart from the ACT. Agencies that use food provided by foodbanks include community and welfare organisations such as Anglicare, the Salvation Army, St Vincent de Paul, the Red Cross, homeless outreach services, and some schools and migrant services.

Each week 41% of charitable ER agencies obtain food from food banks, and another 41% obtain food every second week (75). Rotary currently receives an annual amount of \$84,539.49 (ex GST) from the ACT Government to arrange and manage the transportation of chilled, frozen and dry goods from the Foodbank NSW & ACT Food Distribution Centre, Glendenning, NSW directly to 24 welfare agencies in the ACT region. Rotary reports that an average of 8,281 kg of dry and frozen goods on 25 pallets are brought to the ACT each week providing an estimated 15,000 nutritious meals.

Foodbank Voucher Program ACT:

The aim of the vouchers is to reduce fraud and misappropriation of conventional grocery vouchers, to provide access to very low priced nutritious foods and to ensure that ACT Government funded EMFA is applied efficiently. Each voucher allows the holder to “spend” \$10 at an affiliated Foodbank Agency, for which they get \$40+ value of food, plus the social inclusion that all Foodbank Agencies provide. This implies that the value to the community is around \$48,000, delivered at a cost to the ACT Government’s EMFA program and non-EMFA welfare agencies of \$12,000.

The Foodbank Voucher program is managed through a Memorandum of Understanding between the following participants:

Issuers

- Uniting Care Kippax
- St John’s Care, Reid
- Companion House for Victims of Trauma
- St Vincent de Paul Canberra/Goulburn
- Throughcare (ACT Directorate of Corrective Services)
- Migration Support Programs at Australian Red Cross (ACT/SE NSW)

Foodbank Agencies that Redeem Vouchers

- Canberra City Care, Charnwood
- NationsHeart, Belconnen
- Communities@Work, Gungahlin
- Southside Community Service, Narrabundah
- Anglicare, Queanbeyan
- St Paul’s Helping Hand, Spence

- Communities@Work, Tuggeranong
- Holy Cross Anglican, Hackett
- Youth With a Mission, Watson

While providing food is a vital service for ER organisations, and the advent of food banks has provided a dependable and efficient food source, as Foodbank Australia point out, it has also created a culture of dependence and another tier in the emergency food provision service (75). Further, Booth and Whelan argue that this tier is not reducing food insecurity or meeting the increasing demand for food relief, which raises the question of why food banks continue to persist in an economically prosperous country like Australia. However, as they point out, the food bank industry is firmly entrenched and it is unlikely to see a reduction in growth in the near future. While food banks are meritorious in that they provide food for people in need, they contribute little to actually solving the problem of long term food poverty.

However, Booth and Whelan discuss that food banks are uniquely situated to play an important advocacy role in communicating to governments about the need to address the structural issues underlying people seeking emergency food relief. In recent reports Foodbank Australia has indeed taken a central role in calling on government to address food poverty via extra funding, partnerships with transport industries, tax law reform and policy actions around food insecurity (75,76). Future advocacy roles could adopt approaches using the United Nations human rights framework, for example development of a Federal Charter of Rights or a national right to food policy. These type of rights based approaches can help uphold people’s personal dignity and provide legal entitlements, as well as holding governments to account (74). They can also help shift public discourses which punitively stereotype people in poverty as lazy, fraudulent and personally responsible for their own downfall (77).

Recommendations for the ACT

A spectrum of response is needed to meet diverse needs at different times of clients' journey in accessing human services this includes in the areas of:

Service Provision

- Adoption of flexible eligibility criteria
- Flexibility in working with clients, to ensure equity in outcome not equality in provision
- Providing place-based interventions in locations where needed the most
- Providing culturally and linguistically appropriate response to enhance building rapport and transitioning to a relational model
- Providing female specific response to ER provision to ensure equity in outcome

Training and Upskilling

- Provide training or up skilling opportunities for staff and volunteers in order to ensure quality outcome in transitioning to relational models.
- In an ideal system, respondents are expected to be well informed of services available to clients, have advocacy, active listening, non-judgmental and holistic approach.

Collaboration and Information Sharing

- Formal collaboration amongst service providers and advocacy organisations is a crucial part of providing response to users facing multiple issues at time of crisis and isolation.
- Facilitating information sharing in line with the Privacy Act 1988 to capture the whole story of a family struggling with poverty and social exclusion.

Social Inclusion

- Designing socially inclusive activities to encourage service users with appropriate capacity to contribute to their communities and be treated as a part of the solution not a burden.

Financial Allocation

- Increase financial allocation to clients with complex needs.
- In order to provide a holistic response, it is important to allocate financial resources that facilitates clients' journey to financial wellbeing and stability. This is in line with recommendations from the literature reviews that suggest micro-finance programs along with ER and case management can work together as part of a holistic response to financial hardship.

Summary

As the history of ER funding in Australia shows, governments have long viewed ER as a form of residual welfare, and have generally been reluctant to provide funding for anything more than the provision of basic transactional ER (i.e. provision of immediate needs such as food and utility payments). In the past this funding model has viewed ER under a paradigm of poverty relief whereby assistance is provided because of distribution issues – households or individuals lack resources. This contrasts with the concept of social exclusion which focuses on relational issues such as lack of social integration and inadequate social participation.

The literature indicates that demand for ER has continued to increase in Australia, with people presenting to ER services on numerous occasions over extended periods of time. Given that the majority of ER recipients already receive some form of government welfare, ER has become for many, a way to top up inadequate benefits. As a result, many ER service providers have recognised the need to provide not just basic transactional ER, but services which help address the underlying causes of financial hardship. These relational ER models use the concept of social exclusion rather than poverty, and include services such as individual case management, advocacy, counselling, and referral as well as basic ER. Key reports such as from the Salvation Army, Anglicare, and on ER provision have shown that relational ER models can better target the causes rather than just the symptoms

of financial hardship. Consequently, many service providers are calling on governments to provide funding which allows for the provision of relational ER models. It has also been suggested that funding ER agencies to measure their performance and share data with other agencies would be beneficial to improving both the efficiency and effectiveness of service delivery.

Within the context of the ACT there are a number of challenges to ER provision. The ACT TAS report identified a unique cohort of ACT residents who are often not eligible for government concessions and may be unfamiliar with accessing services. Accessing this cohort could be challenging as they are generally not linked to any existing points of contact with the Government or community sector given they often do not identify as needing help. Housing and living costs in the ACT are high necessitating that a large percentage of the population spend a significant amount of their income on these costs. This impact is greater for those in the lower income quintiles who may be more in need of ER. Changes in the 2014-15 Federal Budget were also shown to have negatively affected low-income households potentially increasing the demand for ER.

A number of issues for ER in the ACT were raised by advocacy and service provision organisations at the 2017 ACT Government Community Services Directorate forum. Echoing what has been stated in the literature, there was an awareness of the need for ACT ER providers to shift to a more relational model of ER in which underlying causes of clients' financial hardship are addressed. A diversity of service users were identified which requires a diversity in service provision. Increasing collaboration, coordination, and information sharing between services was also recognised as important in being able to identify clients' needs and larger scale trends in how and why people access ER.

Recommendations for ER provision in the ACT have shown there needs to be a range of responses to meet the diverse needs of clients at different time points. These include flexibility in service provision to ensure equity in outcomes not equality in provision, including adoption of place based interventions in areas of most need, provision of culturally and linguistically appropriate responses, socially inclusive programs, and female specific responses which take into account the gendered nature of poverty. A shift towards more relational models of service provision is recommended to help address the complex and diverse needs of clients. This transition will require training and up-skilling for staff and volunteers. Formal Information sharing and collaboration between ER organisations has been identified as vital to being able to provide an effective response to clients who are experiencing a multitude of issues and times of crisis. Finally, there needs to be adequate allocation of financial resources so that ER providers are able to offer a holistic response.

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Appendix A

Methodology used to identify key reports

In order to identify key studies and reports on ER in Australia in the last decade a two-stage search was performed.

The results of the searches below yielded 13 reports on ER provision in Australia which met the eligibility criteria to be included as a key report:

- The report as a whole had a specific focus on ER provision in Australia
- Publications released between 2006 – 2016

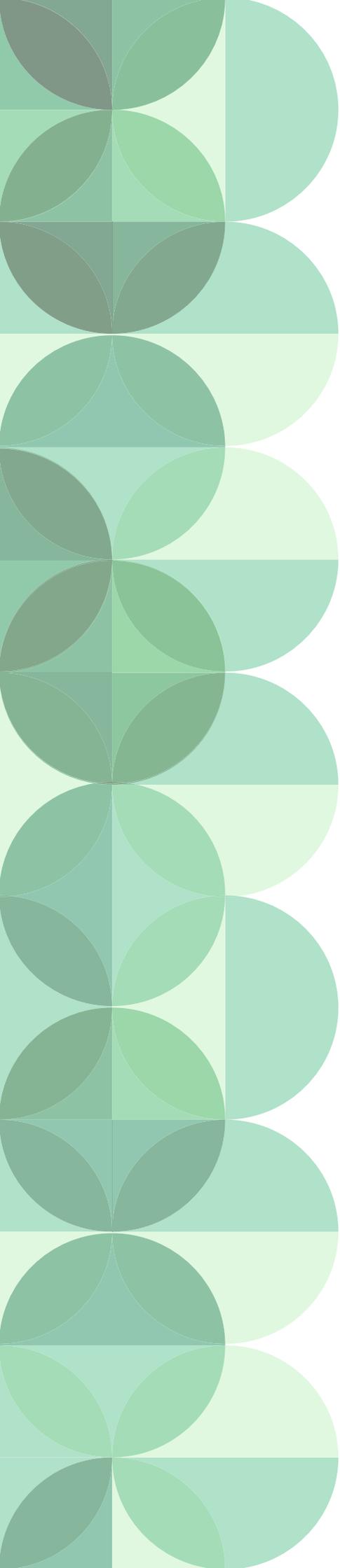
Noting that the reports which included sections on ER (i.e. paragraphs or a chapter) but the focus of the report was not ER were excluded.

1. Peer-reviewed literature

A review of the peer-reviewed literature around the provision of emergency material and financial aid was conducted. This review included English language literature published between 2006 and 2016. Five arts and social sciences databases (JSOR, ProQuest, SCOPUS, EBSCOHost) and the Australian National University library super search function were searched using the key words “emergency relief” in the title/abstract. Given “emergency relief” is a uniquely Australian term, these key words were chosen to identify journal articles pertaining to Australian research on ER provision. The titles/abstracts of returned searches were scanned for inclusion. Papers were excluded if they were not primarily concerned with provision of emergency material and financial aid in Australia. Three papers were identified as meeting criteria for inclusion (12,24,29). One paper (24) was not included as a final key report as it was a summary of another included report (24).

2. Grey literature

In order to identify reports on ER provision in Australia not included in the peer-reviewed literature a Google search was conducted using the search terms “emergency relief report Australia”. The first 20 pages returned by the search were scanned for any reports with a specific focus on ER provision in Australia. Four reports were identified from this search (3,8,41,58). The reference lists of these reports were then scanned to identify any further reports which had not been identified in the Google search. The ACT targeted assistance strategy report (1) was provided to the research team by the ACT government. A total of 11 reports were included as key resources to inform this research.



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