MISSION

Mobile Integrated Social Services Increasing employment Outcomes for people in Need

- Final Report -

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EXECUTIVE SUMMARY

The objective of the MISSION project was to develop, implement and properly evaluate a pilot program aimed at increasing the take up of local employment and social services amongst disadvantaged families in the Belgian city of Kortrijk (76.000 inhabitants). The pilot program consisted of outreaching case managers acting as single points of contact for disadvantaged families in Kortrijk. These outreaching case managers were responsible for the integrated delivery of a wide range of local social services and benefits to these families, based on the method of outreaching case management developed in the project. While the organisation of local social services is usually supply-driven, the MISSION project turned this principle around. Instead of families having to muddle through the fragmented supply of support on offer at the local level, the outreaching case managers basically brought the appropriate amount of support to the families' doorstep. MISSION was multi-dimensional in nature since disadvantaged families often find themselves in a vicious circle of low work-intensity and poverty, which not only stems from but also has an impact on all other life domains, including housing, education, health, and well-being.

The work of five outreaching case managers was supported by a digital tool for the integrated delivery of a wide range of support and services to disadvantaged families, and the creation of a stakeholder platform with 25 social service providers, directly impacting on the accessibility of services and the coordination and cooperation between different service providers. The development of the method of outreaching case management was supported by an extensive action research process. To rigorously test the effectiveness of the method of outreaching case management in increasing take-up rates, a randomized controlled trial (the MISSION trial) was set-up. This enabled us to establish the causal effects of the intervention on the outcomes of families. Moreover, we gathered data at multiple levels: the families, the case managers carrying out the intervention, and the local services and organisations being responsible for local service delivery. Triangulation of these different data sources enabled us to test whether the intervention worked and for whom, and to shed light on the specifics of the daily practice of outreaching case management. In interpreting these data, we paid due attention to the transferability of the method to other contexts and countries.

We find that the method of outreaching management has a causal, substantial impact on the take-up and receipt of additional financial support by disadvantaged families with young children after six months. The longer-term results also suggest that there is a positive effect on participation in training and employment programs. However, there are no discernible effects on the take up of forms of non-financial support nor on the take up of social assistance benefits (*leefloon*).

The effectiveness is not driven by family characteristics, but by specific aspects of the method of outreaching case management. Yet, some conditions need to be met for such intervention to be effective: outreaching case management needs to be intensive, families need to be open to receiving support (which means that gaining trust first is an important factor), and outreaching case managers need to have the mandate to act and advocate on behalf of their clients vis-à-vis the local services and organisations. At the same time, local service providers and organisations need to be open to work with outreaching case managers who can be very demanding towards service providers. Effective outreaching case management often requires a change in the organizational culture of the local social services.

However, after six months we cannot discern structural changes in the income, housing and living conditions of the families. This is due to structural shortages in public services, e.g. in the case of childcare or social housing, which cannot be solved by outreaching case managers, or to the fact that entitlement to benefits and services are usually regulated by federal or regional law. If there is not much discretionary room to make decisions on behalf of families, the method of outreaching case management is not necessarily effective.

At the same time, the barriers and thresholds identified by outreaching case managers in their attempt to support families were strong signals that the organisation of local organisations and services was (at least partly) causing non-take up. Having an outreaching case manager in place who has the mandate to signal problems and an organisation willing to change the way it operates is a promising combination to improve the effectiveness

of local social policies. In this report, we cite numerous examples of how the outreaching case managers reported issues with particular services and how this induced change in local social policies. As such, the effectiveness of outreaching case management not only lies in the question what they can achieve for families but also, and perhaps above all, in how their actions led to social professionals and organisations being more aware of the threshold they themselves impose on clients who seek support. In the longer term, this will be to the benefit of all disadvantaged families.

For governments, municipalities or service providers who want to implement the method of outreaching case management in their own organization, we identified 11 'lessons learned' in chapter 6 of this report. These lessons focus on preconditions that need to be met before outreaching case management can be effective, as well as contextual factors that are important to take into consideration and ways to evaluate and monitor the outcomes of the method. Readers interested in the development and actual implementation of the method in Kortrijk find all necessary information in chapter 2 and chapter 3. The details of the randomized controlled trial are reported in chapter 4. A detailed profile of vulnerable families, and the analyses of the outcomes are presented in chapter 5.

INTRODUCTION

In this report the final results of the project M*obile Integrated Social Services Increasing employment Outcomes for people in Need* (MISSION). The MISSION project was subsidized by the European Commission under the Programme for Employment and Social Innovation (EASI) and ran from December 2016 until November 2019. It was coordinated by the Public Centre for Social Welfare in the Belgian city of Kortrijk (*OCMW Kortrijk*) in close collaboration with the Flemish Agency for Child and Family welfare (*Kind en Gezin*). Scientific support was provided by the Herman Deleeck Centre for Social Policy at the University of Antwerp[1], in collaboration with Vives[2] university of applied sciences and Howest[3] university of applied sciences.

MISSION was developed in response to two simultaneous trends: 1) a growing importance being attached to individual counselling and tailor-made support services to encourage employment amongst disadvantaged persons; 2) a trend towards transferring more responsibility to the local level in the organisation of social services. These trends are universally observed across European welfare states. At the local level, however, a growing fragmentation of social service delivery results in numerous actors being involved in providing social and employment support. This presumably leads to high levels of non-take up of these services amongst disadvantaged families, and a high risk of living in poverty and social exclusion. Yet, strong evidence on the extent of non-take up is still lacking, and programmes or initiatives aiming to improve take-up are usually not rigorously evaluated.

The objective of the MISSION project was to develop, implement and properly test a pilot program aimed at increasing the take up of local employment and social services amongst disadvantaged families in Kortrijk. The pilot program consisted of outreaching case managers acting as single points of contact for disadvantaged families in Kortrijk. These outreaching case managers (OCMs) were responsible for the integrated delivery of a wide range of local social services and benefits to these families, based on the method of outreaching case management developed in the project. While the organisation of local social services is usually supply-driven, the MISSION project turned this principle around. Instead of families having to muddle through the fragmented supply of support on offer at the local level, the OCMs basically brought the appropriate amount of support to the families' doorstep. MISSION was multi-dimensional in nature since disadvantaged families often find themselves in a vicious circle of low work-intensity and poverty, which not only stems from but also has an impact on all other life domains, including housing, education, health, and well-being.

A central tenet of the MISSION project was that the scientific evaluation needed to be rigorous with the aim to tease out causal effects of the pilot program. For that reason, a randomized controlled trial was implemented (the MISSION trial) to properly test to what extent the method of outreaching case management led to improved outcomes for disadvantaged families, in particular in terms of the take-up of employment and social services and benefits at the OCMW Kortrijk and the local job centre. In addition, data was gathered at the level of families, OCMs, as well as organizations, and a qualitative action research trajectory was set up to garner more insights into the daily practice of the method of outreaching case management. Triangulation of different methods and data sources allowed us to not only test whether the pilot program was effective, but also to shed light on the why and how of the effect. Ultimately, this led to insights and lessons learned that are transferrable to other contexts and European member states.

The report is structured as follows. In chapter 1, we describe in detail the context in which the MISSION project was implemented and highlight some of the central actors in the organisation of local social and employment policies in Kortrijk and in Belgium. In chapter 2, an overview of the three actions developed in the project is provided, including a theoretical and conceptual discussion of the method of outreaching case management, and a description of how supportive actions such as a newly developed smartphone application and a multi-dimensional multi- actor stakeholder network have been implemented to support the daily practice of

[1] http://www.centrumvoorsociaalbeleid.be
[2] https://www.vives.be/en
[3] https://www.howest.be/en/university-college

outreaching case management. Chapter 3 describes how the method outreaching case management took shape in daily practice, and how and to what extent outreaching case managers supported families. Chapter 4, then, describes the MISSION trial, the experimental setup to test the causal impact of the method of outreaching case management on the take-up of employment and social services and benefits of disadvantaged families with young children. The results, including a detailed sketch of the income and living conditions of families with young children is presented in chapter 5. Chapter 6 summarizes the lessons learned, with a focus on the transferability of the method to other contexts and countries. Chapter 7 concludes.

1. LOCAL SOCIAL AND EMPLOYMENT SERVICES IN KORTRIJK

Kortrijk is located in the Flemish region of Belgium, which classifies as a 'more developed region' according to EU regional policy. Flanders scores relatively high on a number of indicators relating to regional development, social protection, education and innovation. Kortrijk has 76.000 inhabitants, and it is often regarded a prosperous city in a prosperous region of 300.000 inhabitants. At the same time, however, Kortrijk is confronted with poverty and social exclusion as well as with typical urban problems and complexities. To give one example, in 2014 the number of births in disadvantaged families was estimated to be 15.4% compared to 11.4% in Flanders. In 2017, the number has risen to 18.6% versus 13.7% in Flanders.

In the framework of the active inclusion strategy of the EU, the provision of accessible and qualitative social services is considered essential to support measures in the field of adequate income protection and active labour markets. This include access to decent housing, education, care, health and social services. Local authorities play an important role here: the local level is the level closest to the citizens, it is the level where poverty and social exclusion manifest themselves and where risks become visible and tangible. It also is the level where supportive systems and services are being deployed and organized, and where people seek information and support.

In Kortrijk as well as in other cities and regions, the demand for social services is becoming more and more complex and diverse, as well as the need to identify, combat and prevent new forms of poverty and risks of social exclusion. In Kortrijk, similar to most cities and municipalities in Flanders, people can turn to a large and diverse range of different social services: more than 110 social service providers offer support and services in the areas of income support, employment support, training & education, housing support, health and child (care) support. However, the social services landscape is highly fragmented and categorically organized, and there is a strong focus on supply-driven approaches. Usually providers are specialized in tackling particular problems but fail to adopt a broad-based perspective on the often complex problems families are confronted with. As a consequence, potential beneficiaries but also social professionals do not find their way amongst this multitude of actors. Families which are confronted with problems and exclusion in several spheres of life are often known to different service providers, but coordination is lacking. Non-take up of benefits and services is likely to be a growing problem too: a supply-driven approach combined with a multitude of specialized actors makes it hard for families to seek and find the right amount of support. As such, policymakers expect that many citizens are not even aware of what kind of support is available at the local level. At this point, there is no specific evidence available to back up such claim. For people who do succeed in muddling through, the application process is complex and diffuse. For that reason, the MISSION project tests a novel approach in the context of Kortrijk, and the MISSION trial was set up to evaluate the effects.

To fully understand the operational context in which the trial took place, it is necessary to get a good grasp of some specific actors involved in the delivery of employment services and social services in Kortrijk.

1.1 The Local Job Centre (VDAB)

In Belgium, the National Employment Office (RVA, hereafter) is responsible for the implementation of unemployment insurance schemes and for determining whether or not someone is entitled to unemployment benefits. In contrast, employment services and vocational training are delivered through the Public Employment Services (PES), which are organised at the regional, Flemish, level. The objective of the PES is to integrate jobseekers, trainees and non-active persons into the labour market. They provide counselling, training and labour mediation services. The regional PES for Flanders is VDAB (*Vlaamse Dienst voor Arbeidsbemiddeling*), in charge of the initial registration of unemployment and for the monitoring of jobseekers' availability for work. VDAB is also responsible for forwarding formal unemployment benefit applications to the RVA. Other relevant social benefits are paid by the OCMW (see section §1).

The VDAB consists of one central office in Brussels and 19 regional offices in five provinces, including one in Kortrijk. Since 2002, in larger cities and municipalities, so-called Local Job Centres have been established,

centralizing the most important regional and local employment services under the same roof. Arrangements for this are made locally though specific partnership agreements between the VDAB, the OCMW and other local actors. As far as the cooperation between VDAB and the OCMW is concerned, these agreements may include regular permanencies by the VDAB in the offices of the OCMW or vice versa, the organisation of information sessions for the beneficiaries of social assistance benefits (*leefloon*), developing common training or employment projects, a shared use of instruments for screening and indicating jobseekers and beneficiaries of social assistance benefits (*leefloon*).

Every jobseeker claiming unemployment benefits must register with VDAB – for certain categories this is mandatory even without claiming, e.g. school-leavers. The right to unemployment benefits is linked to conditions related to the number of days that someone has been employed during a specific period prior to the application (called the reference period). People who do not qualify for these conditions are not eligible; they can to turn to the OCMW to apply for the right to social integration (*het recht op maatschappelijke integratie*) and/or the right to social services (*het recht op maatschappelijke dienstverlening*). Registration as a job seeker with VDAB comes with a number of obligations and consequences: jobseekers have to respond to vacancies send by VDAB, they have to prove they are actively looking for work, and they have to respond when they are summoned by VDAB. VDAB monitors the different actions related to employment taken both by the jobseeker and the VDAB job counsellors through *'mijn loopbaan*' ('my career'). This online platform enables jobseekers to consult job suggestions and job vacancies, to upload and publish CVs and job application letters, to access different assignments supporting the search for a job, et cetera. Public and private partners of VDAB offering employment support to jobseekers can access 'mijn loopbaan' to register, consult and follow-up the different actions that were taken for their clients. Therefore, 'mijn loopbaan' is an important source of information on people's employment trajectories. The available information includes chronological overviews of registrations with VDAB, employment status, insight in the different pathways followed by a certain jobseeker, and – if applicable – an overview of 'transmissions', being any sanctions that were imposed if the person concerned did not comply with actions imposed by VDAB or one of its formal partners. This is one of the data sources that will be used in the MISSION trial (see section §4).

1.2 The public centre for social welfare (OCMW)

The Belgian Social Security system is primarily intended to offer social insurance against loss of income when social risks occur, such as illness, job loss, disability, or old age. The social insurance system is mainly financed through social contributions from employers and employees, complemented with specific grants from the federal government and general tax revenues. People who are not eligible for social insurance benefits or do not qualify for its requirements, can turn to the public centre for social welfare (*OCMW*) to seek support. The mission of the OCMW is defined in article 1 of the federal law of 8 July 1976: "Every person has the right to social services. The objective is to guarantee everybody the possibility to live a life in human dignity. There are OCMWs established which, under certain conditions, have the task to ensure these services." Every municipality in Belgium has an OCMW. The contact between OCMW and applicants occurs through trained social professions called 'social assistants'. This particular part of the social security system is of residual nature and has to be seen as a social safety net of last resort.

Role and tasks

In order to properly understand the different roles and tasks assigned to the OCMW, a distinction must be made between the 'right to social integration' (*het recht op maatschappelijke integratie*) and the 'right to social services' (*het recht op maatschappelijke dienstverlening*). Both can be complementary, but they should be considered as separate tasks assigned to OCMW. The right to social integration is a pathway to employment and/or the provision of a guaranteed minimum income, i.e. social assistance benefits (*leefloon*). It is a legal right that can be effectively claimed, but potential beneficiaries must qualify for a number of conditions to be effectively entitled.

The right to social services *(het recht op maatschappelijke dienstverlening)* encompasses a wide variety of services ranging from additional financial support, to medical assistance, energy assistance, debt mediation and housing facilities. It includes various forms of support or social aid from the OCMW, including additional cash benefits (*aanvullende steun*) for citizens with insufficient financial means or beneficiaries of social assistance benefits (*leefloon)*. The legal framework for this support is limited; OCMW has discretionary competence in the provision of social services. In other words, this right consists of a wide variety of instruments to alleviate poverty and social exclusion, but the procedures to implement these instruments are not explicitly framed, at least not at the national and regional level. There is much leeway at the local level to be more (or less) generous.

The right to social integration

The right to social integration is primarily regulated by the Law of 26 May 2002 on the right to social integration (RMI), and the Royal Decree of 11 July 2002 on the general regulation regarding the right to social integration. As mentioned before, this right is of residual nature and is to be seen as a social safety net of last resort. Legislation regarding the right to social integration falls within federal jurisdiction but is executed by OCMW. The OCMW of each municipality has been tasked to guarantee the right to social integration for those who have an income below a certain threshold and comply with a number of conditions regarding nationality, age, place of residence, lack of sufficient (other) resources and willingness to work. With regard to the willingness to work, since 15 February 2014, OCMW are obliged to verify if beneficiaries of social assistance benefits (*leefloon)* are registered at VDAB, with an exception for those who are exempted because of health or equity reasons.

The ultimate objective is to achieve maximum integration and participation in social life. An OCMW has three instruments at its disposal for this: (1) employment trajectories; (2) social assistancebenefits or *leefloon*; and (3) individualised social integration projects, or a combination of these three. These three tools can be tailored towards a particular individual, in combination or as separate elements.

Any person meeting the general conditions of eligibility for the right to social integration may be granted this in the form of employment. There are two types of subsidized employment schemes within the OCMW framework that are intended for this. The first entails an employment opportunity in which the OCMW acts as the employer, or in which it provides support for the actual training of the employee with external employers. The second is employment in a well-defined project in which the OCMW provides financial support with regard to the employer's wage costs.

Persons entitled to social integration for which employment is not (immediately) possible may have an individualised project for social integration designed for them with the ultimate aim of obtaining an employment contract. This project, which shall be established following a joint consultation between the OCMW and the individual eligible for social integration, represents both a path to employment for the applicant as well as a commitment made by both parties - the OCMW and the person eligible - to ensuring that this path culminates in success. Depending on the needs of the person concerned, the focus of the project is either on professional mobilisation or social integration.

Leefloon is a minimum income guarantee that – in principle – should enable the beneficiary to lead a life in dignity. The granting and retention of leefloon can be linked to an individualised project for social integration, either at the request of the person concerned or the OCMW. Beneficiaries are divided into three categories: cohabitants (category 1), single persons or homeless people with whom an individualized social integration project has been established (category 2), or persons with dependents (category 3). The category to which the applicant belongs will be based on the findings of a social inquiry conducted by the OCMW. The basic purpose of this social inquiry is to determine the actual situation, even if it differs from the individual's administrative situation.

In all cases, the individual receives an income from which to live: be it an income resulting from employment, an income in the form of *leefloon* or a combination of the two. The Federal Government subsidises a minimum of 55% of the *leefloon* granted by the OCMW in accordance with the Law of 26 May 2002. OCMW that serve an average of at least 500 beneficiaries every month over the course of the year before the previous year receive

a 65% subsidy. Those with at least 1000 beneficiaries receive 70%. The remaining amount is paid by the OCMW and therefore indirectly by the municipality.

In general, the right to social integration is granted to the applicant by the OCMW of the municipality in which the applicant claims habitual residence, as established by conducting a social inquiry. As being said, potential beneficiaries of social integration must comply with all conditions of this law. All of these conditions must be met simultaneously. The OCMW task is to investigate who is entitled to social integration and to decide how it will be implemented (who is ready for work, what kind of job, which labour market integration measure, et cetera). If all of the conditions regarding the right to social integration have been met, then it becomes a right that must be granted. If an applicant does not meet one of these conditions, he/she may apply for the right to social services.

The right to social services

The way OCMWs have to guarantee the right to social services *(het recht op maatschappelijke dienstverlening*) is not specified by law. It rises from the core duty to enable every citizen to lead a life that meets the standards of human dignity, as stated in article 1 of the federal law of 8 July 1976. This means that, in general, every person can request support or help from the OCMW. Every OCMW can fill this in in autonomy, depending on the local needs. OCMW can decide to organize this itself, refer a person to other services or initiatives, or rely on the cooperation with others. The free choice of the client is always central. Consequently, practice differs widely in this field. Since the (legal) framework for this support is limited, OCMW have more discretionary competence in the provision of social services. The discretionary competence guarantees that OCMW can intervene differently depending on the specific social conditions and social needs (that differ between municipalities and from person to person). Here, a distinction can be made between individual and collective services. In terms of collective services, OCMWs can set up and exploit hospitals, nursery homes, childcare facilities, cleaning and home care services for families and the elderly, social restaurants, social groceries, … In terms of individual aid and support, OCMW can provide persons with information and advice, material support (such as clothing, meals), psychosocial support, budgeting, amongst others.

A specific form of individual support is the possibility to grant **additional cash benefits**. As described above, OCMWs receive from the federal government the task and subsidies to grant social assistance benefits (*leefloon)* to everybody who is entitled to it. Additionally, OCMW can provide supplementary support to beneficiaries of *leefloon* (as well as to recipients of other social benefits), in the form of additional cash benefits. This falls under the right to social services (*het recht op maatschappelijke dienstverlening*), and not under the right to social integration (*het recht op maatschappelijke integratie*). This supplementary support is intended to adjust the amount of support to both the individual needs of the client and the local (budgetary) conditions and possibilities. This supplementary support is not regulated by law. Also here, OCMWs enjoy considerable discretion. Supplementary support can consist of, for example, the reimbursement of costs related to rent, heating and/or energy consumption, or allowances for health care costs, day care costs, school costs or other costs. This supplementary support is financed through the local budget. Social assistants have an advisory role here. They conduct a social and financial inquiry, carry out a rights exploration and compile a social report with advice for the Special Social Services Committee (see below). This can be a positive advice (awarding) or a negative one (rejection, suspension or a sanction).

OCMW Kortrijk developed so called ‘basic principles’ according to which social assistants should act when judging requests for supplementary support. These basic principles are not a comprehensive step-by-step plan leading to a final decision; they were developed to help the social assistant to formulate this advice as clearly, neutrally and objectively as possible. However, these basic principles are just a guideline and deviations are possible. This to allow tailored advice by every social assistant and for every client situation. Deviation from the basic principles is possible as long as this is done within the existing legal framework. Provided that there is good motivation, an advice from the social assistant can be approved by the Special Social Services Committee, even if this deviates from the basic principles.

The final decision for rejecting, granting, suspending and sanctioning lies with the Special Social Services Committee of each OCMW. This is legally determined. The Special Social Services Committee is chaired by a

chairman, represented in the city council, and consists of a political representation of the city council. Furthermore, the Special Social Services Committee can be supplemented with independent experts (e.g. external experts on specific themes or target groups). The Special Social Services Committee can follow the advice of the social assistant and approve or reject it, as long as this is done within the legal framework. If the Special Social Services Committee does not follow the advice of the social assistant, then the social assistant can adjust or additionally argue the advice and resubmit it to the Special Social Services Committee. The social assistant can also personally explain his or her advice to the Special Social Services Committee, and OCMW-clients can be invited to provide extra information on their situation and request.

To sum up, as far as the supplementary support is concerned, there are no general formalized standards on who is eligible, for what kind of support or how to determine the level of support; it is up to the social assistant to investigate to what extent a request is admissible, reasonable and justified, and up to the Special Social Services Committee to decide.

1.3 The Flemish agency for Child and Family welfare (Kind en Gezin)

The Flemish agency for Child and Family welfare (Kind en Gezin, K&G) is a Flemish governmental agency with responsibility for young children and families in Flanders. Its main task is to implement and coordinate government policies for young children and families with young children, in particular in the fields of preventive care, the regulation of childcare services, family support and adoption. Since 1 January 2019, Child and Family is also responsible for coordinating the new Flemish child benefit system. Its aim is to enable children to achieve their full developmental potential, physically, mentally, emotionally and socially, with respect for diversity and children's rights. One of its main policy areas is preventative care: K&G organises and provides free preventative care for all children between 0 and 3 years old with special attention for disadvantaged children. A specific feature of K&G is its comprehensive service of parenting support, including home visits to infants and a network of socio-medical consultation centres. K&G offers a unique, universal service to all families with new-born children on Flemish territory. All of these families are entitled to at least two home visits by a district nurse, the first one shortly after the childbirth and the second visit about 6 weeks postpartum. More visits can be planned in joint agreement between the nurse and the parent.

In addition to these home visits, K&G developed a compound deprivation indicator for identifying children being born in a disadvantaged household. During the home visit, the district nurse collects multidimensional information on the level of deprivation of the household on the following 6 dimensions: monthly household income, parental educational level, child development, parental employment, housing situation, and health status. A child is depicted as being born in disadvantaged circumstances if the households have a negative score on three or more of these dimensions. The result is a fine-grained indicator on the social situation of young children in Flanders that is being used to monitor yearly 'child poverty trends' among very young children.

K&G organizes its parenting support service through 57 'local teams', covering several communities in Flanders and Brussels. The district nurses of those teams mainly offer preventive medical assistance to families with new-borns, hereby assisted by a family coach when working with disadvantaged families. The family coach can assist vulnerable families with their contacts with the district nurses. Close cooperation with the local K&G team in Kortrijk was crucial for the set-up and success of the MISSION project (see section §4.2).

In order to respond more effectively and flexibly to families and their needs, the local K&G teams were reorganized in January 2019. The teams were complemented with a social worker to support the participation of vulnerable families, a pedagogical worker to support the educational process of the children, and a contact person responsible for liaising with the local authority and other relevant partners. The purpose is for K&G to broaden the scope of its parenting support services to the whole context in which children grow up. These changes to the local teams happened at the end of the MISSION trial; its potential is discussed in section §6. The local team in Kortrijk consists of 11 district nurses (six of whom who work in Kortrijk and five who work in the boroughs), one family coach, one social worker, one pedagogical worker and one contact person. The district

nurses meet every week to discuss their work with the families. The whole team meets every two weeks to discuss planning and specific family cases.

1.4 The Centre for General Social Work (CAW)

The Centres for General Social Work (CAW, Centra voor Algemeen Welzijnswerk) are not-for-profit organisations regulated through the Flemish Department of Welfare, Health and Family. Their general mission is to help people with all their questions and problems related to well-being. They fulfil three key functions: general prevention, providing information & advice, and providing psychosocial support. They help people with welfare questions and problems such as difficult relationships, personal problems, financial, administrative, legal or physical problems and family problems. They also offer assistance to victims of violence and abuse, and to detainees and their families. There are 11 different CAWs spread across Flanders, each with a specific regional working area and offering a variety of services which differ from region to region. Some CAWs provide assistance to people living in precarious housing conditions, run different kinds of shelters (e.g. men's shelters, women's shelters) or provide temporary housing options for families in crisis. Although they differ in terms of legislative framework, scope and organizational structure, there is in numerous ways an overlap in service provision with the OCMW. People assisted by CAW are often referred to OCMW for certain services or assistance, and vice versa. However, the concrete way in which CAW and OCMW cooperate is very much depending on the local situation. This can vary from a very close cooperation (e.g. the joint organisation of services for the benefit of specific target groups, or agreements regarding the range of services on offer) to almost no cooperation at all. In Kortrijk, OCMW and CAW work very closely together in the areas of housing, debt mediation and homelessness.

2. THE MISSION PROJECT: DESCRIPTION OF THE ACTIONS

In the MISSION project, three interrelated actions were developed. First, we developed a specific method of 'outreaching case management' in order to improve the social situation of disadvantaged families with young children. Second, we developed and disseminated a digital app called *Sien Online* to support the method of outreaching case management but also to help social professionals and citizens to efficiently find the right support for their needs and questions. Third, we organized a multi-disciplinary and multi-actor (MDMA) network including all of the social organisations and relevant partners active in the local context of Kortrijk. The purpose of this network was to capture bottom-up signals on the accessibility of services from within the MISSION project and use that information to streamline and improve upon the local delivery of social services. In the next section, we discuss in detail how these three axes of the MISSION project were developed.

2.1 Outreaching case management

Case management and outreach work are two well-known methods to support people in multi-problematic living conditions and to counter their social exclusion. Both methods have the same objective: to improve the quality of life. Case management focuses on coordinating the fragmented services in care and welfare. Outreach work focuses more on reaching people and building a positive working relationship. In some cases, the two methods are combined but there exists a great deal of variation as to how this is given concrete form in practice[4]. Outreaching case management as it is applied in the MISSION project, goes beyond case management at home. We first describe the specific characteristics of both methods. Subsequently, we explain the methodological principles of outreaching case management within MISSION, as well as the role of OCMW Kortrijk.

2.1.1 Case management

Case management as a form of counselling has its origins in the United States in the 1970s. It was developed specifically with regard to chronic psychiatric patients and drug users. By the late 1980s, projects were also started in the Netherlands for people with serious and long-term psychological problems. In Flanders, care mediators arose mainly in the field of home health care[5], in geriatrics, with people suffering from mental disabilities and in care for people with addictions.[6]

The scientific literature adopts various definitions of case management. It is a collective term for various practices with similar goals and approaches. Moxley, one of the pioneers in case management, defines case management as "a client-level strategy for promoting the coordination of human services, opportunities, or benefits. The major outcomes of case management are: (1) the integration of services across a cluster of organizations; and (2) achieving continuity of care"[7]. Here, the case manager is a designated person or team who/that organizes, coordinates and supports a formal and informal network of care providers, and organizes activities to optimise the functioning and well-being of clients with complex needs. According to Payne, case management is "a way of organizing social provision that emphasizes the co-ordination of services so that they appear to clients to be delivered as an integrated whole."[8] The NASW (2013) describes case management as "a process to plan, seek, advocate for, and monitor services from different social services or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different

[4] Macan et al., 2008.
[5] Vandenbempt, 2001.
[6] Vanderplasschen, Rapp, Wolf & Broeckaert, 2004.
[7] Moxley, 1989, p.11.
[8] Payne, 2000: 82.

organizations, to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered."[9]

Although there is no consensus on the exact definition of case management, one can find a number of basic principles that distinguish case management as a method from other forms of social work.

First, it is a matter of *coordination and alignment of support and assistance by one person* ('one stop shop'). The case manager has an overview of the total situation of the client and is the central point of contact throughout the entire process.

Second, *case management starts from the client's needs or the client's request for help, not from supply-driven assistance*. He or she puts together a 'package' of services from a range of possible options, adapted to the client's needs. This 'package' will be different for each client and takes into account the client's strengths and possibilities, involving their network, as much as possible.

Third, continuity of care is central. Regular assessment ensures that the selected package of care and assistance stays in line with the actual situation of the client.

Models of case management

The literature distinguishes between various models of case management, according to whether the client is involved in the counselling and the extent to which a certain number of the aforementioned basic functions are included.

First, there is the mediator model. In this model, the case manager mediates between the client and the care and assistance organizations. He or she does not actively participate in the actual implementation of the assistance. In this model, the case manager is merely a 'regulator' who gives clients access to the form of assistance they need.

A second model of case management is the individual coaching model. In this model, too, the case manager is a link between the client and the assistance organizations, but she or he also maintains daily contact with the client. The case manager teaches a client certain skills and keeps an eye on the development and maintenance of a client's social network. The case manager's main activities in this model are coaching, support and advice in the counselling process towards other assistance services.

Finally, there is the therapeutic model. In this model, no distinction is made between case management and treatment. The case manager is both the author and the implementer of the assistance plan. The relationship of trust plays an extremely important role here.

The relation between case manager and client

In most models of case management, the relation between the case manager and the client should rather be described as a collaborative relation than as a relation of trust. Building trust and providing security is considered an means to promote client involvement and to ensure that the client is willing to cooperate with the case manager. The following aspects are of particular importance:

- Describing the positions (rights and obligations, division of tasks) of both the client and the case manager;
- Identifying the conditions on the basis of which the two parties want to work together, such as: location of the assistance, frequency of contact, time, duration;
- Identifying the content of the cooperation, such as the objectives and the planned working method to achieve them.

The relation between case manager and organizations

Van Riet & Wouters state that, if the client is the point of departure, the case manager has to adopt an organization-independent position[10]. If he or she fails to do so, there is a risk that the case manager might

[9] NASW, 2013: 13.
[10] Van Riet and Wouters, 1996.

(in)directly become the person who implements the programmes and/or protocols as laid down by the organization. The case manager is the one who, based on the identified needs of the client, must be able to signal whether or not the assistance offered meets the target group's needs or requests for help.

Building a network

Wolf describes a number of things that need to be taken into account in the implementation of case management.[11] Among other things, he emphasizes building a network, which includes consultation, good cooperation and the exchange of information between all parties involved. Formal cooperation is important in the development of case management. However, collaboration between services is not that easy. Conflicts may arise as a result of different values, goals and objectives, unrealistic expectations about the effects of case management, too much consultation, the division of available resources, etc. Open communication and regular meetings between the various parties involved are therefore put forward as a good alternative.

Case management client ratio

The number of clients for whom the case manager is responsible has a major impact on the effectiveness of the services he or she provides. A higher number of clients means less time available per client. A high case load also influences the nature and quality of the contact with the clients. For example, the case manager might start working in a rather reactive way as opposed to anticipating problems in a proactive way.

2.1.2 Outreach work

Outreach work is a second, specific method used within the MISSION project. In this section we describe some of its basic characteristics and models. In Flanders, the 'Reach out!' project has gathered all knowledge and experience in the field of outreach work. The expertise with regard to outreach work is now being further supported by SAM vzw (*Steunpunt mens en samenleving*)[12]. A thorough analysis of outreach practices has led to the following broad definition:

"Outreach work is a method based on an active approach and aimed at promoting well-being. The outreach worker starts from a participatory basic attitude and focuses on people in socially vulnerable situations, who are not or insufficiently reached by the current providers of services, care and assistance. The outreach worker does so by entering their environment with respect for the values and norms that apply there. Outreach work strives for mutual coordination between the target group, its network, the existing offer of social services and the broader society."[13]

(Pro)active approach

Some practitioners limit outreach work to a "let's look them up" approach – they want to reach those who are hard to reach or cannot be reached at all: without any rules or specialties, they want to be present amongst people who are otherwise not reached. This active approach is very characteristic of outreach work.[14] It goes against supply-and-demand-driven work in which clients are supposed to go to the right services and be able to formulate a request for help themselves. There are various reasons why this might be too demanding for some. In Flanders, various policy texts mention the principle of working pro-actively at the local level in order to protect vulnerable people. This means that the provision of care and assistance must be approached differently so that those people face fewer barriers in making their requests for help and, moreover, that one should not wait until there is a request for help. Outreach implies actively and deliberately turning to individuals or groups in their immediate surroundings. This active approach should lead to reaching people in vulnerable situations who are otherwise not (or do not want to be) reached.

[11] Wolf, 1995, mentioned in Vanderplasschen et al., 2001.
[12] https://www.samvzw.be/
[13] Beelen et al., 2014, p. 97
[14] Beelen et al., 2014; Olmo, 2017; van Doorn et al., 2019; van der Lans, 2010.

Such contact starts in the living environment of those involved, i.e. within the environment that is known to them, with respect for the values and norms that apply there. The outreaching professional, therefore, is a guest and tries to understand the motives of the people involved, without judging. People and groups can be reached in different ways. This can be done through registration by formal and informal network partners, unasked or on demand, announced or not, at home, with a focus on the place where problems are encountered, through preventive neighbourhood actions et cetera. There are big differences with regard to the intensity with which initial contacts are turned into positive working relations in which the living conditions can be improved.

Alignment

As with case management, alignment is an important activity for the outreaching professional. It involves the alignment of the needs of an individual or target group with the existing professional assistance, informal carers or the neighbourhood. What does the person want and what can be the role of others in that story? An outreacher will take on the role of advocate and explain the perspective of the person or target group to service providers and the network. Conversely, the outreaching professional will provide further information to the person or target group about the possibilities and approach of other service providers or the informal network, but he or she chooses the side of the individual or target group. The outreacher will act as a 'bridge' or intermediary, just like experience experts in disadvantaged situations or mental health care occasionally do.

The outreaching professional will not only do her best to establish connections, but also to restore relationships or facilitate new relationships, so that those involved feel they belong somewhere. Think for example of neighbourhood help projects, in which a connection is made between a support request and a local resident (cf. connecting model) or a neighbourhood location (cf. "kwartiermakersmodel"). In addition to these connections at the level of the person or target group, outreach work can focus on the level of organizations or local social policy in order to reverse the structural inaccessibility to rights and services based on the needs of the various target groups.

Promoting well-being and a dignified existence

The focus of this active approach is always to promote well-being, aiming at a dignified existence. In that, a balance is sought between on the one hand a person's individual ethics of existence and self-control and on the other hand fundamental social rights like the right to an income, social security, health care, decent housing, cultural and social self-development. An outreaching professional initiates the processes to facilitate access to social protection. She or he does this by bringing people in touch with those rights and the associated services and by taking action to make those rights more accessible.

Positive working relationship

To reach both those who miss out on care as well as those who avoid care in their lives is a first step. As soon as a person or a target group has been reached, a professional can start building a positive working relationship. The relationship starts in the person's familiar environment and the professional has to adapt to this environment, not the other way around. Outreaching is based on 'professional proximity'. Professional knowledge and attitude is important, but it is the relationship between client and professional that determines how things will proceed, not a predefined goal or plan. As a result, outreaching support is less planned and sometimes organic. Since Baart (2001) published his book '*Een theorie van presentie*' (*A theory of being attentive*), attentiveness has been put forward as a working principle in order to build a positive working relationship and to be able to start working in an outreaching way, i.e. getting and taking the time to meet the other person in an unhurried way and unconditionally, with respect for his/her values and norms, and with bottom-up understanding of the circumstances in which someone lives. Just like in case management, the other

is a subject in the relationship, not an object. A partner with whom to make contact and work in dialogue. The one who practices presence hears what the other is saying and gives meaning to it.[15]

Participatory basic attitude

Apart from the ability to build a positive working relationship, outreaching work requires a participatory basic attitude in which the person's freedom of choice remains the starting point. This means that the outreaching professional continues to explore, formulate objectives and generate solutions together with the person(s) involved. This happens in a dialogue and in a demand-driven way, even if the person in question initially does not have any formulated request for help and therefore can't be all that motivated to get support or assistance. It is quite a challenge for the outreacher to motivate the person(s) in a realistic way. She or he will do so first of all by remaining very authentic, acknowledging the person and accept them as who they are, regardless of the circumstances.

Normative action

Even in the absence of a request for help, the outreaching professional tries to make contact. She or he does not give up easily if no direct contact seems possible or if the person in question sees little hope of changing anything at all to their living conditions. This approach is not self-evident and may raise ethical questions about how far one can go. In the literature, this is called 'normative professionalism'.[16] How can one do well? Social professionals face though choices between one's living environment and the system, between justice, solidarity and private interests. In these choices, they must be supported by their organizations. In addition to the team, the leader and a clear view with the organization, room for self-reflection, team consultation, intervision and supervision also play an important role.

Models of outreach work

There is a great diversity of outreach practices. In the Netherlands, six models were distinguished[17]:

- Help model: solicited or unsolicited support for people in worrisome conditions;
- Presence model: faithful presence in the neighbourhood, not limited by any term, e.g. street work;
- Connecting model: mobilising resources in a neighbourhood; the request for support is linked to a neighbour or neighbourhood organization;
- Persuasion and coercion model: preventing and combating trouble on the basis of signals from the environment. Mainly used for domestic violence, abuse, maltreatment, psychiatric problems;
- "Kwartiermakersmodel": strengthening the acceptance and appreciation of differences, stimulating hospitality, through adjustments if need be, so that those who are otherwise socially excluded can also participate;
- Politicizing model: improving the living conditions and resilience of target groups by working together and removing structural causes.

The models provide frameworks for how to act in certain situations but cannot be used as strict methods. "Some circumstances very clearly require a specific outreaching working method. Think for example of crisis situations involving child abuse. In such situations it is not appropriate to apply (only) patient interventions aimed at connection, self-reliance or hospitality. Such situations first of all require the professional to act quickly and decisively. In other situations, it may be better at an early stage to address people's social networks or new networks (as in the connecting model) instead of offering direct assistance (as in the help model)."[18]

[15] Beurskens, van der Linde and Baart, 2019.
[16] Driessens and Geldof, 2008.
[17] van Doorn et al., 2019; Omlo, 2017
[18] van Doorn et al., 2019, p. 57.

Within the 'Reach out!' project a practical framework has been elaborated for making conscious choices in dialogue with various people involved. This practical framework is a tool for offering transparency to external partners, for giving support to the outreach workers in need of discretionary space or room for action, and it provides clarity within the organization that wants to use the resources as effectively as possible in order to achieve certain goals. The following factors are important for giving concrete shape to a practice[19]:

- The outreacher's position to act. Is it a non-binding, accosting, conditional or forced working relationship?
- The way the client is registered. How does the outreacher know that a person or group could use some support? Is it based on his own observation or has the support been solicited by the target group or person, or maybe via a professional or informal network?
- The place where contact is made. This can be at home, but also in the public domain, e.g. a small square, or in a semi-public way by being present in other organizations. The target audience determines the most suitable place.
- The target group. Is it known or not? Is this group defined by common characteristics such as age, addiction, intellectual disabilities or psychosocial vulnerabilities? Do you work in a group or is it better to work on an individual basis?
- The activities of the outreacher. Is the emphasis on participating in the living environment in order to gain insight in a situation, on direct assistance to and with the person(s) involved or on indirect assistance like coordinating care and advocacy? In structural work, attention is paid to sharing feedback on signals with the organization, the broader field of work or policy makers.
- The duration and intensity of the contacts. Is the support limited in time or not?
- The main objective. Is it rather socially oriented, aimed at improving coexistence, or is it rather aimed at improving the living conditions of the target group?
- The way the assistance is directed. Is the approach supply-driven or demand-driven?
- The focus of the assistance. Is the approach rather specific or integrated, and rather categorical or territorial?

2.1 3 Outreaching case management within MISSION

The outreaching case management within MISSION is closest to the outreaching help model described above and to the individual case management model, with regular (be it not daily) contact with the family. People in difficult living conditions are proactively contacted at home, even though they have not submitted any request themselves. It is the outreaching case managers' (*OCM*) task to start up, coordinate and integrate help and assistance at the family level. The case manager connects the requests for help with the correct service provision and ensures that all information is available for the family to move in the right direction as quickly as possible.

In other words, outreaching case management in this project goes beyond the minimum model and shows more resemblance to the coordination model or even the extensive model. The target group of vulnerable families on which this intervention focuses, requires more from the OCM than just assessment/planning/referrals. The OCM may also have to provide direct care and assistance. n addition, advocacy is an important task of the OCM on two levels: the client and the system. First of all, the OCM mediates, negotiates and aligns between different services in various areas of life on behalf of the families. Secondly, OCMs will discover gaps in the counselling offer in the course of the process. In other words, the assistance system to which the OCMs try to link their client/family may be incomplete, the necessary services may not be available. One cannot expect the OCMs to solve the incompleteness, inadequateness and inaccessibility of the assistance and service system all by themselves. The role of the OCM is to document these gaps and report them to the team. The problem can then be tackled further within the MDMA stakeholder consultation process (see section §5.5).

[19] Beelen et al., 2014 , p. 78-93.

If we look at the different parameters to describe outreach practices, the following choices have been made in MISSION:

- **The working relation**: a choice was made in favour of a non-binding but accosting working relation.
- **Registration**: work is done only on the basis of referral.
- **Location:** the first contact is made through an unannounced home visit with a small present for the new-born (diaper package).
- **The target group:** the work is carried out with individual families.
- **The activities**: the approach is relation-oriented and task-oriented, in dialogue with the family. The emphasis is on the take-up of rights, starting up services, care alignment and advocacy. The *Sien online* app is used as a support tool. The MDMA is used to realize structural changes in the region
- **The duration and intensity of the contacts**: the objective is for the OCM to work intensively with the families. A period of 12 months is set, with an intensive period and a phase out period.
- **The main objective**: to improve the living conditions of the families concerned in a sustainable manner in various areas of life.
- **The way the assistance is directed**: the approach is demand-driven.
- **The focus of the assistance**: the approach is integrated within the Kortrijk region.
- **The duration and intensity of the contacts:** the research evaluates the added value of a short but intensive intervention. At the start of the project, a guidance period of six months was set. The OCM soon found out that they could not yet stop the support after six months, as gaining the client's trust in itself takes time. Eventually, a 12-month intervention was decided, with an intensive period and a phase out period, to achieve the goals (Table 1).

TABLE 1. GUIDELINES FOR THE FREQUENCY OF CONTACTS BY OUTREACHING CASE MANAGERS

Intensive period 6 to 8 months	Minimum	2 home visits per month
		1 contact per week
	Maximum	10 home visits per month
		3 contacts per week
Phase out period 4 to 6 months	Minimum	0 home visits per month
		1 contact per month
	Maximum	2 home visits per month
		1 contact per week

As this concerns families with multiple, complex problems, the assistance may have to continue a bit longer. OCM who act as central contact persons should be easily accessible and, conversely, should themselves be able to contact the people involved in different various ways. To meet this requirement, they have tablets and smartphones. No guidelines have been drawn up with regard to the location of the assistance, the time or the duration of the contact.

Basic functions of the intervention

Assessment

Within MISSION, the outreaching case managers (*OCM*) make an assessment of the specific problems and needs of vulnerable families, as well as the capabilities and resources of the client and his/her network to meet these needs. For that purpose, OCM can use the newly developed SIEN Online application (see section §2.2). This ensures that the diagnostic process can be performed accurately and repeatedly. The assessment within MISSION focuses on the following areas of life: income, housing, employment, health, education in the event of families with children, training, formal and informal network.

Based on the specific profile of the family as entered in the application, an adapted overview of the available services and assistance channels is automatically generated. The OCM examines which services and measures are already applicable to the family. Furthermore, he or she actively searches for services, rights and measures to which the family does not yet have access or which the family are not yet making use of.

Planning

The newly developed application not only makes it possible to make a detailed assessment, the system also has an action component. Within that part of the application, the OCM will draw up an action plan together with the client and then follow up on it. The concrete objectives and related actions differ per family. Within this project, the action plan is not linked to any statement of acceptance. The assistance therefore remains non-binding; families can leave the assistance without consequences whenever they want. However, permission is requested for the exchange of information if necessary. The clients themselves do not have access to the application but can always ask to consult their files if they wish to do so.

Intervention/linking

The outreaching case managers within MISSION support families in their contacts with various organizations and services. The OCM adapts the client's efforts to his or her capacities. The idea is that the case manager should strengthen the client's ability to take certain steps him/herself.

Monitoring

The OCM within MISSION are alert to changes in the living conditions of the families and to any changes that, as a result, may need to be made to the action plan. The OCM uses himself or herself, as it were, as a monitoring tool: he or she visits the families, checks whether there are any problems or remarks and is on stand-by in case of problems. The same goes with regard to monitoring the functioning of the client's social network and critically monitoring the professional assistance.

Evaluation

The quality of the interventions is monitored by means of peer-to-peer learning moments and fortnightly team meetings. Since the intervention is linked to an investigation, the OCMs were instructed to keep track of their method in logbooks. This weekly and monthly registration contributes to a reflection on one's own actions. This was discussed between times in focus groups, in order to gain more insight into their actions and into that which, in their opinion, contributes to changes in the living situations.

The relation between outreaching case manager and client

From the start, the OCM has to create a positive working relationship and take on a positive and participative basic attitude. Because of the limited time frame and the objectives of the MISSION project, the relation with the client is more a collaborative one than a relation of trust. The project is not a buddy system in which the trust relationship is central, but aims at a targeted, intensive collaboration to realize fundamental social rights.

The relation between outreaching case manager and organizations

In the framework of the intervention within the MISSION project, the OCM is the single point of contact or 'one stop shop' for the family and coordinates all the care and assistance needed. He or she thus actively intervenes in and responds to the problems of accessibility and non-take up that people in poverty tend to experience. It follows that OCMs need to have an independent position towards service providers and social organizations in Kortrijk. OCMs in the MISSION project are formally attached to Kortrijk's Public Centre for Social Welfare (OCMW Kortrijk), but in everyday practice they work under the umbrella of the MISSION pilot project, which allows them to act more independently from the OCMW. This is important, because they sometimes need to contest decisions taken by the OCMW on behalf of the families. Such actions require a position of independence. Moreover, social workers working for the OCMW usually have a twofold objective: while they need to uphold

the social rights of clients, they are also responsible for controlling whether clients adhere to the conditions imposed by law. OCMs are explicitly exempted from this duty to control.

Selection and training of outreaching case managers

The job description for outreaching case managers in MISSION mentioned the following general skills:

- Professional skill: to be enthusiastic to know one's profession and to keep learning
- Focus on result: to have the drive to achieve one's goals in time
- Innovation and creativity: to be motivated to improve and innovate
- Collaboration: to be motivated to achieve the team's objectives
- Commitment and motivation: to be motivated and do one's best to do the job as well as possible
- Focus on client: to have the drive to help the client
- Quality work: to have the drive to deliver work that meets the required standards
- Commitment to the organization: to have the drive to defend the interests of the organization towards others and feel connected to the organization, task and function
- Communication: to have the drive to convey and receive information
- Working independently: to have the drive to operate as well as possible and without supervision or control

These general skills were combined with a number of competencies that are specific to outreaching case management:

- Taking initiative: you see opportunities and take action on your own initiative. Yours is not a wait-and-see attitude.
- Contact skills: you easily approach people whom you do not know and you easily mingle among other people. You can explain facts, ideas or opinions to others and adapt your way of communication to the conversation partner.
- Involvement: empathy and commitment to the organization.
- Work connectively: building bridges with the target group, structural work and collaboration.
- Self-reflection and dealing with feedback: you dare and are able to question yourself and you think about your strengths and points of attention.
- Independence: you are able to start up and settle actions with minimal support from others
- Flexibility: you can adapt to a changing environment, changing circumstances, tasks, changing working hours, changes within the target group.
- Perseverance: you persevere when you have started something, even if you are very busy or even if you experience setbacks.
- Responsibility and accountability: you feel and demonstrate responsibility for your professional actions and their consequences.
- Eagerness to learn and ability to learn: you have the desire and the motivation to learn.

Five outreaching case managers with a degree in Social Work were selected from a group of more than 70 candidates. They were all women. Supervised by a coordinator, they formed a team equalling 4.8 full-time equivalents for the implementation of the OCM method and for their contribution to the scientific inquiry. The workload of the latter activity (including registration) is estimated to be 1 day per week per person. Irrespective of their knowledge, skills or experience, the case managers were given a two-months lead-in period. This not only gave them a better idea of what their role as outreaching case managers would be within the setting of a scientific investigation, but also prepared them for the actual work with families. During this lead-in period, they received a three-day training from 'Reach out!' to further strengthen their competencies for developing a positive working relation with clients and a participatory basic attitude. The lead-in period allowed to give all case managers a good grasp of the target group, the variety of social organizations and service providers in Kortrijk, and how these organisations functioned in practice. This was done through compulsory

reading of the literature and by means of an observing assignment in many welfare organizations such as various services within the OCMW, CAW, VDAB, K&G et cetera (see section §1). During these assignments, they not only learned how the various services work, but they also got to know the specific care providers (social workers) with whom they might be working together in the future.

2.2 Sien Online: A digital tool supporting the integrated delivery of local social services

The outreaching case managers (OCMs) were responsible for the integrated delivery of a wide range of local social services to disadvantaged families. The type of services to be delivered was not predetermined; the OCM had to assess the individual families' needs and activate all appropriate rights, benefits and services in favour of the particular families. Consequently, the type of services to be provided or activated could vary from family to family. This created a dual challenge: on the one hand, the OCMs had to have a full and comprehensive understanding of all services available at the local level. This includes knowledge on all the application procedures and eligibility conditions and awareness of potential changes or adjustments to services and procedures. Given the fragmented landscape of local social services, often governed or regulated by the supra-local level, this presented the project with a major challenge to facilitate this part of the case managers' work. On the other hand, the way service providers provide information on their services does not always correspond with the way potential beneficiaries formulate their needs and their questions; information is often peppered with professional jargon and not tailored to the way people search for information and support. Moreover, if people are not aware of certain rights or services or the specific terminology used for it, they will not be able to identify it as a potential answer to their needs. This presented us with the challenge to facilitate the potential end user's search for information in a way tailored to its search behaviour.

A comprehensive rights explorer

The MISSION response to this challenge was the development of a new smartphone application, called 'Sien Online', which is built upon some of the key principles of the MISSION project. Sien Online informs people about rights, benefits and services they might be eligible for or might turn to for support in the areas of income, employment and employability, training and education, (social) housing, health, child care and leisure. It is a digital tool, developed to support social professionals to have a quick and complete overview of all rights, benefits and services that are available for their clients at the local level. Sien Online is publicly accessible, meaning that all citizens can use Sien Online without registration to identify applicable rights, benefits and services in the listed areas. The products are listed by theme, not by provider; people looking for information and support are primarily interested in what is available and where/how to access it - whoever provides the service is at that time of secondary importance. Sien Online not only informs people; it actually guides them to the most appropriate information and provider able to assist to effectively apply for the right, service or benefit.

Sien Online has a search function, designed to generate a comprehensive overview of all possible rights, benefits and services in a certain category (e.g. income, leisure, employment support, …) based on simple key words. Secondly, Sien Online allows a personalized search, based on a person's family profile. After entering some general data on the specific family situation or needs, Sien Online generates a personalized list of products possibly applicable for the family concerned.

All information provided by Sien Online has been re-translated on the basis of a user's perspective, meaning that all information is linked to the way people ask questions, regardless of whether they know what the name of a certain benefit, right or service is, or what products might be available. By way of example: after entering 'money problems' in the search function or in the family profile, an overview of all local possibilities in the area of financial support pops up: information and guidance on social assistance benefits (*leefloon*), debt settlement services, services assisting with budget management, preventative and curative programs for people facing

financial problems. The given information is simple but clear, and the person concerned is guided to the appropriate contact person for the different services.

To keep the information in Sien Online up to date, we established a user group consisting of more than 100 front line social professionals, working for 28 different organisations (e.g. front line workers from the social welfare centre, the OCMW, health insurance companies, neighbourhood centres, …). These frontline social professionals have contact with end users on a daily basis. In addition, they have access to the most current and accurate information about any changes or modifications to the services provided by their organisation. They were involved already in the testing phase of Sien Online, and have been trained to customize and add products to Sien Online, using their daily experiences with end users (how do they ask questions, what are they looking for, how do they search for information), and their knowledge on the services they represent. Their task is to adjust and modify the information in Sien Online as soon as there are changes. Additionally, we screen Sien Online once a year to check for correctness, clarity and accessibility. The public function of Sien Online will remain freely accessible to anyone looking for information and support on the Kortrijk territory.

A secured registration tool

Sien Online also holds a secured registration system specifically designed for the MISSION project to be used by the OCMs. This system has two functions. First, it enables the compilation of a personal portfolio for each of the counselled families, including a comprehensive action plan in which actions were defined and monitored together with the family. This enabled the OCMs to maintain a comprehensive overview on the entire process they undertook with the families assigned to them. This feature also offers the possibility to upload documents, certificates, photos, etc.; in this way the outreaching case managers as well as the families always had various documents at their disposal that could be required to access particular rights, benefits or services. Second, the registration system allowed the research team to monitor and study the outreaching case managers' daily practice. As will be described in section §3, the outreaching casemanagers reported for each of the families on a weekly basis on the form, number, duration and nature of their contacts with the families, the cooperation with service providers, … These data were registered in Sien Online, which allowed the research team to analyse to what extent the outreaching case managers succeeded in working according to the basic principles, and which patterns could be identified to explain the effects of the intervention on the target group (see section §4).

2.3 MDMA: A stakeholder platform

A multi-disciplinary multi-actor (MDMA) network was set up to support the daily practice of the outreaching case managers (OCMs), and to facilitate structural improvements to social services, in particular to their accessibility and alignment with other social services. The OCMs were tasked to identify and expose bottle necks and gaps in social service delivery, experienced by both themselves and their families, and to signal these to the MDMA. The MDMA, in turn, cooperated with the MISSION implementation manager to turn these bottlenecks and gaps into structural improvements in social service delivery, in better alignment of services with both other actors and clients, and in advice for future local and regional social policies and programmes.

The foundations for the MDMA were already laid in the development phase of the MISSION project, submitted in November 2015. In the preparatory year 2015, OCMW Kortrijk organized a stakeholder dialogue with all actors delivering social services potentially impacting the lives of people facing poverty and social exclusion. All providers delivering social services in the fields of housing, employment, health, child support, income, and training and education were consulted about the general project idea, its potential value for them as well as for their clients, and their willingness to engage themselves for the future MDMA. A number of these actors work locally, some of them are governed regionally but organized at the local level (e.g. the health insurance funds). A total of 25 potential stakeholders were consulted.

OCMW Kortrijk invested a significant amount of time in these meetings, during which the initial objectives and the desired structure of the MISSION project were extensively discussed. Particular attention was paid to the

formulation of shared challenges and the way in which these could be included in the MISSION-project. This approach contributed considerably to the successful implementation of the MDMA, which became operational as soon as the MISSION-project was formally approved by the European Commission. Without exception, every consulted stakeholder formally joined the MDMA to work together in the MISSION project. A total of 25 social service providers agreed to cooperate. The composition of the MDMA can be found in annex 9; information on how the MDMA impacted on the delivery of social services can be found in section §5.5.

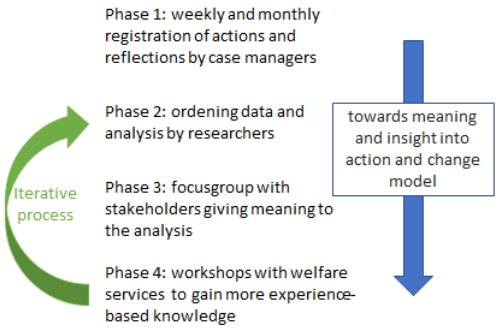
3. OUTREACHING CASE MANAGEMENT IN PRACTICE

This chapter describes the method of outreaching case management and how it was applied in the MISSION trial. How the effects of this intervention were estimated is discussed in section §4 below. First, we present how the intervention took shape and what kind of data we collected to further develop the method of outreaching case management and understand which course of action is associated with improved outcomes for families with young children. Second, we discuss in detail the daily practice of outreaching case managers working with families with young children in the MISSION project.

3.1 Data and research methods

In order to develop the method of outreaching case management (OCM), we created a setting inspired by the technique of action research. As such, the daily practice of case manager was not only a source of information to gain more purchase on the outcomes (discussed in section §4), but also something that was constantly reflected upon. A multi-method approach was developed in which case managers registered their actions into monthly and weekly logbooks for each family, combined with focus groups organized on a six-weekly basis. The insights from the focus groups fed back into the daily practice of the case managers in an iterative process (Figure 1).

FIGURE 1. ITERATIVE RESEARCH PROCESS TO DEVELOP THE METHOD OF OUTREACHING CASE MANAGEMENT



Phase 1: logbook registrations

In **phase 1**, the case managers kept logbooks on a weekly basis to describe their activities at the level of the family. These logbooks were completed in the online tool Sien *Online* (see section §2.2). The registrations were exported from Sien online to an excel table that the researcher converted into a data file. The weekly registrations of the outreaching case managers resulted in the following items:

Variable (group)	Description
Case number	Number of the case
Referrer	K&G (1) or other (2)
Outreaching case manager	Social worker A to E
Period of the case	Intensive period (1), phase out period (2) or terminated (3)
Week	1 to ...
Types and frequency of contact per week	Number of contacts between the client and outreaching case managers in a specific week: • Number of mails • Number of phone calls • Number of text/instant messages • Number of face-to-face semi-public contacts • Number of face-to-face public contacts • Number of house visits
Time spent on a case per week	How long has the outreaching case manager been working on the case in a specific week, split into direct and indirect assistance time in minutes
Topics of intervention per week	Topics discussed with the client in a specific week (1 or 0): trust, parents' training/activation, children, employment, income, housing, leisure, well-being (mental and physical), relationships, autonomy, practical issues, another theme
Cooperation with other (social) services per week	Name of the other service with which there was cooperation in a specific week Topic of cooperation with this service (trust, parents' training/activation, children, employment, income, housing, leisure, well-being, relationships, autonomy, other) The initiator for the contact (outreaching case manager alone, outreaching case manager together with client, client with support of the outreaching case manager or other service contacts the outreach case manager)

The weekly registrations were used to make aggregated variables per case, e.g. duration of the intervention (number of total assistance weeks), total number of contacts for every contact form, total time spent on a case (with/without client), total number of weeks a specific topic was discussed, total number of topics discussed during the intervention, total number of weeks a specific partner was involved, total number of different cooperation partners.

In addition to the weekly registrations, the outreaching case managers also kept monthly logbooks reflecting on three issues: client characteristics, working principles selected by the researchers based on literature about case management and outreach work (see section §2.1), and factors on progress and deterioration per case. In order to easily convert this information into analysable data, the outreaching case managers filled out an online questionnaire via *SurveyMonkey*.

First, the outreaching case managers indicated whether, and if so, which of the following characteristics that presumably hamper the families' opportunities to improve their own living conditions were present in the family: addiction, mental disability, physical disability, psychological vulnerabilities, speaking a foreign language, absence of a supporting network, having a history of positive experiences with professional care and having a

history of negative experiences with professional care. This information was subsequently used to create a '*vulnerability index'*, summing the number of characteristics for each family. It is important to acknowledge that this concerns an assessment of the social worker with regard to the family, not information that the families provided themselves. The outreaching case managers were also asked to monthly register the '*magnitude of problems'* faced by families and the '*accessibility of the family'*. The magnitude of problems was operationalized by the following question: "On a scale from 0 to 10, how heavy do you estimate the problems of the family? This involved an assessment of the following factors: degree of multi-problem situation, degree of a presence of a social network, degree of personal capacity, et cetera." Accessibility was operationalized by the following question: "On a scale from 0 to 10, how accessible do you rate this family? This includes the degree of access and trust you get from the client: to what extent allows the client you in his/her life and is he/she/the family open to support?"

Secondly, the outreaching case managers reflected every month on 10 guiding principles selected by the researchers based on the literature about case management and outreach work. They were also discussed with the team coordinator and outreaching case managers. These principles were:

- integral
- demand-driven
- emancipatory: question clarification
- emancipatory: independent use of services
- proactive
- advocacy
- coordination: main actor
- coordination: bridging problems
- coordination: activation supply
- task- and person-oriented

Each working principle was operationalized into ordinal categories. In some cases the highest category was not always the most desirable; in these cases the variables were recoded to be used in the regression models to understand the intervention (section §4). This will be clarified in the text. In addition to indicating a category, the outreaching case managers also were offered the opportunity to substantiate their score with additional explanations. This made it possible to better understand the evolution of a client case in terms of these guiding principles.

Finally, the outreaching case managers had to reflect in those monthly logbooks on the reasons why they experienced progress or not during the intervention and on the living conditions of the families (keeping in mind the role of the client, social worker, methodology, organization, other organizations/social workers, government, and society). This final question was entirely qualitative and was analysed by using MAXQDA to get more insight into the working and hindering factors within the intervention.

Phase 2 and 3: order, analysing and interpreting data

In phase 2 the researchers ordered the information of the logbooks in SPSS and MAXQDA and made first analyses and draft reports based on discussions in the research team. These initial findings fed back into focus groups, spread over the project period, where exchange, discussion and reflection took place with the aim to achieve common meaning and action (**Phase 3**). The agenda of the focus groups was not only determined by the researchers, but the OCMs regularly asked questions themselves. For example, they were curious whether the logbooks revealed more insight into the working/hindering factors of the intervention. The focus groups included the outreaching case managers, the senior policy officer and the research team often (approximately every three months) complemented by an expert in outreaching work, an expert in case management and an expert-by-experience in poverty and social exclusion. It was decided to expand the focus groups with these three experts to bring an external perspective into the discussions with the MISSION team. The views from these experts challenged the assumptions and beliefs of the outreaching case managers. During those focus groups the method of outreaching case management as it was applied in the MISSION project was further developed.

In total, there were 11 focus groups during the project period:

Date	Topics
15/06/2017	Adjusting logbook registrations + first experiences in practice
06/07/2017	Theory of change in MISSION (experts not present)
07/09/2017	Adjusting logbook registrations + theory of change in MISSION (experts not present)
09/10/2017	Questions regarding first registrations + research approach in analysing focus groups
07/11/2017	Theory of change in MISSION (experts not present)
11/01/2018	Reflection on guiding principles based on first analyses of monthly registrations
04/05/2018	Figures about differences between families K&G and cases referred by others Correlations between client characteristics, accessibility and magnitude of problems Correlations between client characteristics and guiding principles of intervention Discussion about continuity of intervention, coordination and accessibility
19/06/2018	Strategic exercise: what actions to undertake to strengthen MISSION in the coming year so that this project could have a lasting effect on poverty in Kortrijk? (experts not present)
21/09/2018	Feedback and insights from focus group with frontline workers in Kortrijk
25/01/2019	Theory of change: looking back and reflecting on initial exercise Reflection on learning points and success factors in MISSION Discussion on preliminary analysis with regard to working/hindering factors
07/10/2019	Discussion on some final insights from the logbooks (experts not present), focus on correct interpretations and explanations of the data obtained

All focus groups were audio and video recorded and transcribed. The analyses were carried out in the MAXQDA software programme.

Phase 4: Workshops with welfare services to gain more experience-based knowledge

The MISSION-team (researchers and practitioners) regularly presented and discussed preliminary findings to a wider audience of frontline workers and practitioners (**Phase 4**). In addition to presenting the MISSION project, there was always sufficient time planned for discussion with the participants. Valuable insights emerged from these conversations and were considered in the further course of the participatory research.

Date	Participants	Topics
07/05/2018	Study afternoon or extensive focus group with 33 frontline workers in Kortrijk (important stake holders who are sometimes involved in the assistance process of the outreaching case managers)	Presentation of MISSION-project Dialogue tables on the following topics: experience with MISSION as "outreaching case management" issues in MISSION concerning coordination and continuity (what can MISSION learn from others?) frustration in MISSION concerning accessibility of services in Kortrijk
18/11/2019	Study afternoon MISSION	Presentation of MISSION: intervention and research Workshops: 1 – Sien online 2 – Method of outreaching case management 3 – Proximity/Accessibility/Availability: how do you organize that? 4 – Signal function within MISSION
22/03/2019	Study afternoon MISSION (recapture)	
07/05/2019	Study day network child poverty (Brussels)	

The chance that certain issues would remain undiscovered or not discussed, was minimized by this iterative process of inquiry.[20] In doing so, we gained continuous insight into how the intervention took shape, the actions of the outreaching case managers, and the success or hindering factors for supporting families.

[20] Guba and Lincoln, 1989.

Although the experience of clients and their perception of what works and is important to them was relevant to take into consideration, the RCT design (see section §4) did not allow to query the MISSION families about the intervention *during* the intervention. Therefore, in the final months of the project, semi-structured interviews with seven families who were included in the treatment group were carried out at their homes (see annex §9.3). The families were recruited out of the pool of families for which the intervention was finished, follow-up measurement was already carried out and the outreaching case manager was no longer active in the family. The researcher conducting the interviews was not involved in administering the baseline or follow-up questionnaire and had no prior knowledge about the families. The interviews lasted about an hour and were audio recorded. Purpose of the interviews was for the respondent to retrospectively reflect on the various principles of the outreaching case management they were supported with and on what they perceived as being the most important results of the intervention. The data and interpretations described in the section below drew on insights from all these different methods. Quotes from logbooks, focus groups or client interviews were often used as an illustration.

3.2 Method in practice

3.2.1 Caseload

The average caseload per month per outreaching case manager was 12 families. Important to keep in mind is that this number is calculated on the basis of a total sample of 133 cases. The outreaching case managers supported, in addition to K&G families, also clients of the OCMW Kortrijk. Furthermore, this number increased over the years of the project, from 7 cases in 2017, 15 in 2018 and 16 in 2019, reflecting the staggered influx of families in the project (see below).

It is important to consider that the outreaching case managers spent a significant part of their time, 1 day a week, on registrations for the research project. The first phase of the project also consisted out of introductory internships and co-reflection in function of the registrations. Furthermore, one outreach case manager was only 0.8 FTE employed. In short, all the above factors have an influence on the average caseload within MISSION. Given the characteristics of the families included in the project, a caseload of at least 16 cases is certainly feasible, and without a day of registration work even a higher caseload of 20 should perhaps be possible without jeopardizing the time devoted to the families (see below). Yet, the results discussed further down in this report are based on an average caseload of 12.

3.2.2 Contact information

The following description of the daily practice of the OCMs is based on the logbook registration data. In the following analyses, only data up to and including the end of June 2019 are included.

Duration of the intervention

We have full information about 27 families for which the intervention was stopped in June 2019. Table 2 shows that the intervention lasted on average for about a year (53 weeks[21]), which was the prescribed maximum term of the intervention. The intensive period lasted on average 33 weeks (+/- 8 months) while the phase-out period lasted for 20 weeks (+/- 5,5 months). Yet, about half of the cases were closed before one year while more than one third of the cases lasted longer than the period foreseen. Further analyses on the duration of the intervention show a correlation between duration and speaking a foreign language: the average duration of intervention is longer if the client speaks a foreign language.

[21] Weeks in leave were excluded.

TABLE 2. DURATION OF THE INTERVENTION IN WEEKS

	N	Minimum	Maximum	Mean	Std. Deviation
Total weeks	27	9	93	53.3	19.2
Weeks in intensive period	27	9	68	33.0	15.9
Weeks in phase out period	27	0	57	20.3	13.0

TABLE 3. TOTAL WEEKS OF COUNSELLING

	Frequency	Percent	Cumulative Percent
0 – 49	13	48.1	48.1
50 - 54 (about 1 year)	4	14.8	63.0
55=<	10	37.0	100.0
Total	27	100.0	

Contact with the families

The first contact with the families was an unannounced home visit with a small present for the new-born, namely a diaper package. The outreaching case managers introduced themselves as someone from OCMW Kortrijk. The outreaching case managers succeeded in making a first contact with almost all families. Only with two families this was not the case; these families were left out of the sample.

Generally, the outreaching case managers evaluated this first contact as positive in most cases and they said that the small gift came in handy for the families. They did point out, however, that the gift did not make a difference in building a trust-relationship with the family. In contrast, the opinions of the clients give a different perspective on this. All interviewees indicated that they experienced this first contact as weird. One mother dropped out because of the unannounced home-visit. Two clients argued for an appointment by telephone before the first house visit.

> *"A telephone call in advance would have made the difference. You don't go to someone's home without being asked. She stood there. What should I do? I didn't ask that. I let her in anyway and she was friendly, at ease. No problem really, but I don't know that, a case manager. I find that something intrusive. If I want something, I will look into it myself." (Client interviews, client 2)*

Nevertheless, most interviewees pointed out that after some time they gained confidence in the outreaching case managers.

> *"She suddenly stood there with that diaper package. At first it was awkward. What do I have to do with that? There is already a lot of guidance around us and now again someone else. I'm not going to get through with that [...] What a young thing but she made a good impression. She explained that it was a pilot project. And the 2nd time she came again to chat a bit more extensively and I had a click with her. In the end, we were positive about it and we benefited from it more than anything else, other than home based guidance, which is also good. "(Client interviews, client 5)*

The outreaching case managers indicated that also during the intervention contacts with families were critical to the success. They particularly emphasize the importance of spontaneous contacts. By regularly checking how a client is doing, they can quickly pick up new questions, make progress or prevent worse.

> *"On a Friday afternoon I spontaneously call the person concerned: asks when I will come for a home visit because person concerned has many invoices again. That Friday afternoon I went for a home visit (a good thing I did this). During the home visit it turned out that the person concerned had to pay certain*

invoices as a matter of urgency but did not understand which debts these were. This is the added value of spontaneous phone calls." (Logbook registrations, working/hindering factors, A4)

"Keep in touch, often just to hear how it goes. There's always something that occurs that has been questioned in the past period but has not succeeded or to which there has been no response ... where necessary, find out if and what went wrong. Also, often things come up that were previously not necessary but that are now and that were not immediately thought of (e.g. food bank referral, Uitpas application ...). I notice that it is very important to continue to visit, even if it is less intensive. The person concerned would not (always) contact the care provider involved, which can sometimes give the impression that it's OK but, in fact, things are going wrong." (Logbook registrations, working/hindering factors, C1)

A chain of events can make a client (temporarily) less accessible. In such cases, the outreaching case managers continue to work accosting towards the client.

"Mrs. is much more difficult to reach than usual. She does not comply with agreements with the lawyer, it takes a very long time to collect the necessary documents, ... Normally she is very punctual, and she thinks everything is going too slow. So, I think it's strange. She has been through a lot in recent months: her father died, she found her neighbour who committed suicide, and her mother is recently diagnosed with cancer. All heavy things. Due to these events I went to see her a few times, just to see if everything went well and I thought she was taking it relatively well. I now wonder why she is suddenly so difficult to reach and why it is more difficult to fulfil agreements. I will definitely try to visit her next week." (Logbook registrations, working/hindering factors, B7)

"Initially it was difficult to reach Mrs. Other services also indicated that they could not phone her. During the consultation it appeared that she had problems with her mobile phone. After the consultation I saw / called her a few times, but since the middle / end of September this has become more difficult. She does live up to her agreements with other services, which is very good. Maybe there are problems with her mobile phone again?" (Logbook registrations, working/hindering factors, B21)

"Difficult to reach: broken cell phone, no wifi connection, no calling credit." (Logbook registrations, working/hindering factors, A15)

Type and frequency of contacts

Table 4 shows that half of the contacts with families occurred through text messaging or instant messaging.[22] In addition, somewhat more than a quarter of the communication between outreaching case manager and client occurs through telephone. Home visits amount to 12% of communications. This comes down to an average of 3 phone calls, 6 text/instant messages and 1 home visit per month per family.[23] Semi-public visits (accompanying a client to a service provider or meeting in a library, community centre, and so on) are done less frequently with an average of about 1 every 2 months. The number of mails and public meetings with the client (for example, in a pub, on the street, and so on) is limited.

[22] Instant messaging services are apps that allow you to send messages online. The best-known applications are WhatsApp, Messenger (Facebook) and Snapchat. A big advantage is that these apps can be downloaded and used for free.

[23] Contacts were registered per week. To get an overview of the average contacts per week, an average was taken for all contact forms per case, with leave weeks being filtered out. To facilitate interpretation, this data was then converted to months, for which 4 weeks were combined (for example: average number of home visits in a case per week * 4).

TABLE 4. AVERAGE NUMBER OF CONTACTS PER MONTH

	N	Minimum	Maximum	Mean	Std. Deviation
Mail	56	.00	2.67	.29	.56
Phone call	56	.00	13.67	3.19	2.46
Text/instant message	56	.08	37.60	5.73	7.03
Face-to-face semi-public	56	.00	2.22	.43	.45
Face-to-face public	56	.00	.18	.03	.06
Home visit	56	.34	3.43	1.49	.75

The possibility of communicating via text/instant messages appears to be of major value, both according to the outreaching case managers and clients. Various advantages were underlined.

First, this medium lowers the threshold for seeking support. Instant messaging is a very fast form of communication. Families get a much more direct line between themselves and the social service provider which means they will also send out a message more quickly when they have questions or seek help. In turn, the outreaching case manager is able to react quickly as well. Clients do not have to wait until their next face-to-face consultation to have a question answered, which can give them a sense of security.

> *"If the person concerned needs support / contact / has a question, I am available. No procedure must be followed, the person concerned takes contact and receives an answer." (Logbook registrations, working/hindering factors, C5)*

> *"Just the fact that you are available. How many frustrations there are with clients 'oh, I can never reach that social worker'." (Focus group, outreaching case manager)*

Moreover, text/instant messages are cheap or even free, the client does not have to talk and he or she can send a "call me" message to a social service provider to let them know not having any call credit.

> *"At the end of this month it was harder to reach him. The social worker in charge of budget management informed me that he had not come to the appointment to open the accounts for the start-up of budget management. She had called him and left a message on his answering machine. I also tried to call him about this, to check if everything was OK. He didn't answer either. Later it turned out that he no longer had any call credit and could only send "Call me" messages, because they are free. That way he could inform me (= advantage of accessibility via cell phone). This is not possible with the social service department of the OCMW." (Logbook registrations, working/hindering factors, B23)*

Text messages are also used to quickly arrange practicalities. For example, the outreaching case manager can easily send appointment reminders via text/instant messages (for example, "don't forget that you have an appointment at the OCMW at 2 pm") or give information about a letter. This way, they work more efficiently.

> *"There are many clients who send "I have received a letter" and then you can immediately say what it is or go along. Or if it takes too long before you see the client you can say 'send it via WhatsApp and I will already look at it'." (Focus group, outreaching case manager)*

> *"For example, simple proof of an application for study allowance for a daughter. She needed a certificate of her mother's disability. I called the health insurance company, they mailed it to me, and I sent it directly through WhatsApp to the daughter. That is really crazy." (Focus group, outreaching case manager)*

Finally, outreaching case managers like to use this medium themselves to keep in touch with the client, for example to send a text message asking how he or she is doing or how a consultation went (for example: "Success in court", "How did it go at the social housing company?") This generates a sense of belonging and involvement, which keeps the contact "warm" and it allows the outreaching case manager to stay informed of what happened in the time between face-to-face visits.

Although text/instant messaging is the most used medium, outreaching case managers see **home visits** as the most ideal communication form to get in contact with clients. This allows them to enter a dialogue. Additionally, outreaching case managers get a more complete view of the living situation through home visits and they can start a conversation with the client based on things they notice in the home environment. It is also easy for the client that he/she does not have to travel.

> *"By going home, I noticed that the mailbox is not being emptied. She probably misses things because of this. Through our methodology of frequent contacts and home visits, we can notice this and lay this on the table. It is pretty unlikely that this would be noticed anywhere else." (Logbook registrations, working/hindering factors, E13)*

The outreaching case managers furthermore point out the importance of accompanying the client to other social services, which fall under **semi-public visits:**

Firstly, semi-public visits can lower the threshold. It gives clients support in contacting other services. This proves to be very valuable for clients who, for example, experience a lack of confidence or a lot of stress in contacting other services or are suspicious of a service due to negative experiences in the past. This is also often the case when a client has to contact a certain service for the first time:

> *"People often feel safer because someone is sitting next to them. Sometimes you don't have to open your mouth but just the fact that you are sitting there is enough for them to be able to say what they want." (Focus group, outreaching case manager)*

> *"I notice that she often appeals to me to go to a new service. With known services, she goes alone." (Logbook registrations, guiding principle emancipatory: independent use of services, B16)*

Secondly, outreaching case managers note that it can lead to progress in the client situation, for example when the client otherwise does not manage to go to a social service provider or when a service's response has been awaited.

> *"I also have families, even a few, once they are with a service provider, they can say what they want and what they have to say, and they also get what they want. They are assertive enough. But it's just to get there. 'Oh well it's been so busy; I haven't gotten there.' That you really have to say 'look, I'm coming to your house, we're going together'. Simply, purely practical, but those things make sure it keeps dragging on if it doesn't happen." (Focus group, outreaching case manager)*

Thirdly, poor language skills can also be a reason to accompany the client to other services.

> *"The language is an obstacle, so I usually accompany him to services to clarify his situation." (Logbook registrations, guiding principle emancipatory: independent use of services, B9)*

By attending the client to other services, the expectations of other services towards the client become clear to the outreaching case manager. She can also clarify these expectations further if they are not clear to the client.

> *"Being able to come along on an appointment at the immigration department to clarify matters there, to insist on an answer, creates trust with the client involved but ensures also that I hear the message / expectations / 'to do's' for the client immediately and we can continue to work on it." (Logbook registrations, working/hindering factors, C16)*

The outreaching case managers note furthermore that accompanying a client may lead to a different result. For example, there may be more confidence in the information provided by an outreaching case manager resulting in a positive decision in a case.

> *"You also feel that if people got a professional standing next to them to go to another service that it is ... we must also be honest about that. We are also a sworn social worker so to other service providers that ensures that they will sometimes make a different decision because we are accompanying the client." (Focus group, outreaching case manager)*

Attending a client to other services is finally a possible way of defending the interests of clients, either by giving the other social service provider crucial context information, or by mediating between the client and the other service.

> *"If the woman is angry, she needs support to do the right translation of what she wants, otherwise there will be name-calling. At that moment it is good that there is a buffer so that the woman does not burn her bridges." (Logbook registrations, guiding principle emancipatory: independent use of services, D16)*

There are differences in the forms of contact according to client characteristics. A few examples:

For clients without a support network, clients with a mental disability and clients having a history of negative experiences with professional care, more calls are made on average per month (mental disability, r= 0.409; absence of a support network r = 0.294; history of negative experiences, r = 0.402). The outreaching case managers indicate that they are often called by these target groups themselves.

> *"I have some people calling me because they don't really have someone else to call if they have a practical question or if they don't feel well." (Focus group, outreaching case manager)*

> *"In case of a history of negative experiences, it is often the case that they call you because you are the contact person. And because you are also more accessible with a mobile phone than other services. Like 'I can't reach them so I'm calling you'." (Focus group, outreaching case manager)*

For clients speaking a foreign language, on average, less use is made of text/instant messages as communication (r = -0.344).

> *"For clients speaking a foreign language, telephone or texting is difficult. Very short, practical, to make an appointment but you are not really going to ask questions or do an explanation." (Focus group, outreaching case manager)*

The more aggravating client factors are present in a case (vulnerability index), the more phone calls (r= 0.445) and messages (r=0.451) are made (see Table 5). In addition, cases where the magnitude of problems is estimated large by the outreaching case manager, demand more phone calls (r=0.461), text messages (r=0.476) and semi-public visits (r=0.290), while a greater accessibility of a case is associated with more phone calls (r=0.467), semi-public visits (r=0.509) and home visits (r=0.599).

TABLE 5. PEARSON CORRELATIONS BETWEEN AVERAGE NUMBER OF CONTACTS A MONTH AND CLIENT CHARACTERISTICS

	Mail	Phone call	Text/instant message	Face-to-face semi-public	Face-to-face public	Home visit
Addiction	.011	.025	.557**	-.032	.201	-.110
Mental disability	-.015	.409**	.325*	.093	.009	-.010
Psychological vulnerabilities	.307*	-.051	.249	-.023	.060	-.114
Speaking a foreign language	-.214	-.077	-.344*	.203	.095	.166
Absence of a support network	-.106	.294*	.201	.056	.074	.055
Having a history of positive experiences with professional care	.374**	-.093	-.059	-.117	-.109	-.117
Having a history of negative experiences with professional care	.085	.402**	.369**	.174	.062	.196
Vulnerability index	-.007	.445**	.451**	.250	.207	.145
Magnitude of the problems	.151	.461**	.476**	.290*	.030	.161
Accessibility of the family	.142	.467**	.193	.509**	.109	.599**

Time spent on a case

Table 6 shows that, on average, an outreaching case manager works in total for about one hour a week on a case. The ratio between direct (with the client) and indirect (without the client) time spent per case is 60/40: on average about 35 minutes are spent with the client and 24 minutes without the client.

TABLE 6. DESCRIPTIVE STATISTICS OF TIME SPENT IN MINUTES

	N	Minimum	Maximum	Mean	Std. Deviation
Total time spent on a case	56	6.25	172.71	59.86	38.76
Time with client	56	2.30	115.97	35.26	22.56
Time without client	56	2.27	81.97	23.71	19.96

The time spent on a case differs according to the period of intervention: in the intensive period, twice as much time is spent on a case as compared to the phase out period (resp. 76 and 34 minutes). The 60/40 ratio between assistance with and without the client remains constant.

TABLE 7. AVERAGE TIME SPENT ON CASES

		Mean	Std. Deviation
Total time	Intensive period	75.87	86.55
	Phase out period	34.47	63.75
Time with client	Intensive period	44.13	54.98
	Phase out period	20.33	45.24
Time without client	Intensive period	30.70	43.68
	Phase out period	13.33	25.11

Client characteristics largely determine how much time the OCM spends on a case. In families where a mental disability is observed, more work is carried out together with the client (on average 58 minutes/week compared to 34 minutes/week; r = 0.286). Aggravating client factors lead to more time spent on a case (r = 0.386). The table below shows, for example, that on average 21 minutes/week is spent on families where no aggravating client characteristics are present. This increases to an average of 54 minutes/week where one aggravating characteristic is present and even to an average of 113 minutes/week where four characteristics are present. There are also differences in spent time according to the estimated magnitude of the problems or the accessibility of families. The harder a case is considered or the more accessible a family is, the more time-intensive a case is (magnitude of the problems, r = 0.350; accessibility, r = 0.694). In particular accessibility is strongly related to intensity of the intervention.

> *"If they are not accessible then you pass by, but you will be home soon." (Focus group, outreaching case manager)*

TABLE 8. AVERAGE TIME PER WEEK (IN MINUTES) TO NUMBER OF AGGRAVATING CLIENT CHARACTERISTICS

No. of aggravating characteristics	Total time	Time with client	Time without client	N
0	20.84	14.27	6.37	3
1	54.01	31.63	21.45	27
2	68.60	39.66	27.79	21
3	73.82	38.80	35.10	2
4	113.48	77.53	35.50	2

TABLE 9. PEARSON CORRELATIONS BETWEEN CLIENT CHARACTERISTICS AND AVERAGE TIME SPENT PER WEEK

	Total time	Time with client	Time without client
Addiction	-.032	-.006	-.051
Mental disability	.188	.286*	.042
Psychological vulnerabilities	.054	.064	.033
Speaking a foreign language	.006	.032	-.036
Absence of a support network	.159	.169	.113
Having a history of positive experiences with professional care	-.155	-.160	-.115
Having a history of negative experiences with professional care	.423**	.353**	.433**
Vulnerability index	.386**	.415**	.278*
Magnitude of the problems	.350**	.403**	.247
Accessibility of the family	.694**	.670**	.599**

The outreaching case managers point out that a great deal of time is spent on non-case-related activities that are just as important to make progress and which are not included in the logbook registrations. Examples are team meetings, peer-to-peer meetings, informal sessions with colleagues, attending study days, research work on existing services/regulations, signalling structural issues to one's own organization or other organizations, structural consultations, et cetera.

> *"I certainly have not registered team discussions, whether that is ventilation or 'I just looked this up, did you know that?' Those things. And it takes a lot of time." (Focus group, outreaching case manager)*

Topics of the intervention

The outreaching case managers were asked to register every week the topics they discussed with the client. Twelve subjects were proposed:

- Trust
- Parents' training/ Activation
- Children

- Employment
- Income
- Housing
- Leisure
- Well-being (mental and physical)
- Relationships
- Autonomy
- Practical issues (e.g. making an appointment)
- Another theme

During the intervention, the case managers discussed on average ten of the themes with families.[24] This is an underestimation of the effective number of themes, since the 'other' category includes a multitude of themes. Mobility is a theme that was not indicated in the logbook, but according to the outreaching case managers this topic was extremely important. Lacking access to means of transportation hindered progress in various areas.

> *"The family has problems with mobility: the mobility services in Kortrijk have been abolished or just don't exist. Chances to participation decrease due to mobility problems. The family lives at the boarder of a borough. In case of environmental construction works, public busses are redirected, and the situation worsens. The mother of four children has no driver's license and depends on public transport (not possible when busses get redirected because of environmental construction works) or on care providers who transport the family to their appointments…" (Logbook registrations, working/hindering factors, A13)*

The number of topics discussed in a case depends on client characteristics. On average, more themes are dealt with when a case has a high score on the vulnerability index (r = 0.424), the magnitude of problems within a case are estimated as large by the outreaching case manager (r = 0.414) or a case is estimated highly accessible by the outreaching case manager (r = 0.561).

TABLE 10. PEARSON CORRELATIONS BETWEEN NUMBER OF DISCUSSED TOPICS IN AN INTERVENTION AND CLIENT CHARACTERISTICS (N = 26)

Addiction	.182
Mental disability	-.024
Psychological vulnerabilities	.040
Speaking a foreign language	-.038
Absence of a support network	.353
Having a history of positive experience with professional care	.079
Having a history of negative experience with professional care	.243
vulnerability index	.424*
Magnitude of the problems	.414*
Accessibility of the family (N=27)	.561**

The topics discussed can be further investigated by the frequency in which they occur in a case, if worked on. To obtain information about the average frequency of occurrence of a theme within a case, a sum was made of the number of times a theme occurred (1 or 0 every week) and this was then divided by the number of intervention

[24] Only completed cases are included.

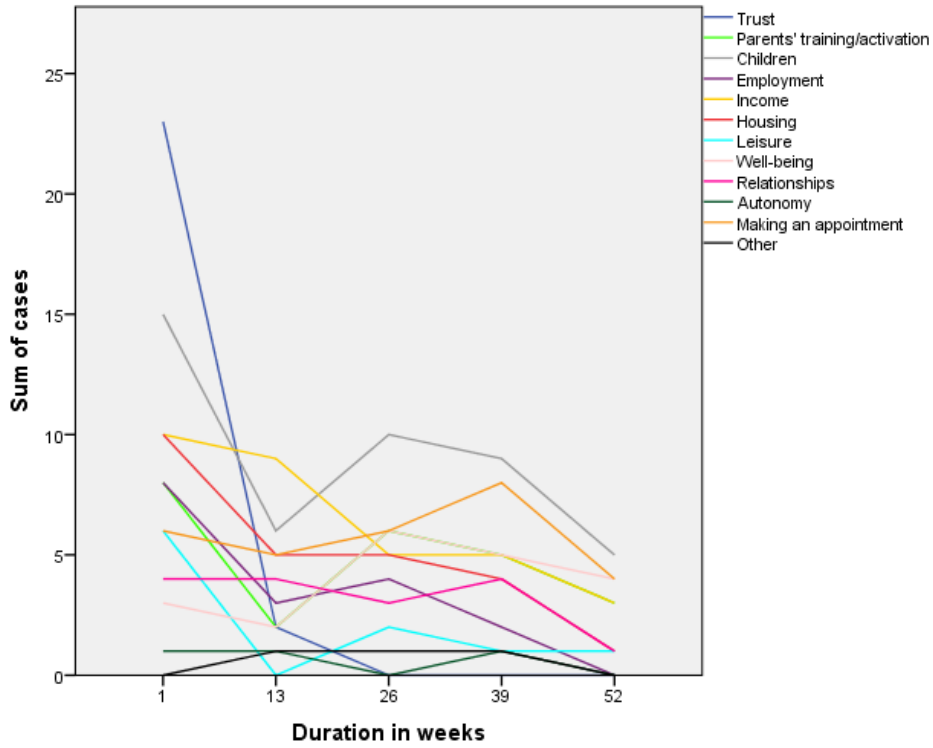
weeks (without leave). The results are displayed in Table 11. In 29% of the total counselling duration in weeks the topic of children is discussed. Income is the theme OCMs second-most often dealt with, with an average of 26% of the counselling weeks. In a quarter of the intervention weeks contact is made in function of making an appointment. Well-being, housing and parents' training/activation are also frequently dealt with, with respectively 22%, 19% and 18% of the total duration. No theme appears every week in a case.

TABLE 11. AVERAGE SHARE OF TOPICS IN THE INTERVENTION

	N	Minimum	Maximum	Mean	Std. Deviation
Trust	27	.03	.33	.13	.08
Children	27	.04	.73	.29	.16
Housing	27	.01	.39	.19	.12
Income	26	0.02	.72	.26	.17
Practical about making an appointment	26	0.02	.59	.25	.16
Relationships	23	0.02	.38	.13	.11
Leisure	21	0.01	.31	.08	.07
Parents' training/activation	20	0.02	.35	.18	.10
Employment	20	0.01	.36	.13	.11
Well-being (mental and physical)	20	0.04	.58	.22	.15
Autonomy	15	0.01	.20	.08	.06

The topic trust is discussed in every case, but only counts for an average share of 13% of the total duration. This topic is especially important at the start of the intervention. Once the outreaching case managers start working on specific themes, the topic trust is less indicated. In addition, the topics children, income and housing are first discussion material in many cases (see Figure 2).

FIGURE 2. TOPICS DISCUSSED OVER TIME



Cooperation with other (social) services

In order to provide the appropriate support and entitlements to families, OCMs established many contacts with local service providers. On the one hand, in approximately one quarter of the cases sixteen or more different local social organisations and partners were involved. On the other, almost 20% of the cases involve two or fewer cooperation partners. The number of services involved in a case depends on client characteristics. On average, more cooperation partners are involved when a supporting network is absent (r = 0.42), a case has a higher score on the vulnerability index (r = 0.49) or a case is estimated more accessible by the outreaching case managers (r = 0.71). It is striking that the estimated magnitude of problems is not related to the number of cooperation partners. The outreaching case managers indicate that clients who score high on the magnitude of problems have often burned their bridges. This complicates the involvement of other services. Other services sometimes claim that these cases do not fit their range of services. A client himself can refuse to work with a service due to negative experiences in the past. Other services may be needed in these cases, but it is blocked either by the other service or by the client.

> *"In the case of a history with negative experiences with professional care it may be that if you say, 'maybe that service can help', they say 'no, I will not go there anymore.' Then you must invest a lot of time in that, so that makes it harder, to get them to come along." (Focus group, outreaching case manager)*

TABLE 12. PEARSON CORRELATIONS BETWEEN NUMBER OF SERVICES INVOLVED AND CLIENT CHARACTERISTICS (N=26)

Addiction	-.174
Mental disability	-.228
Psychological vulnerabilities	.076
Speaking a foreign language	.268
Absence of a support network	.418*
Having a history of positive experience with professional care	-.121
Having a history of negative experience with professional care	.160
vulnerability index	.492*
Magnitude of the problems	.195
Accessibility of the family (N=27)	.705**

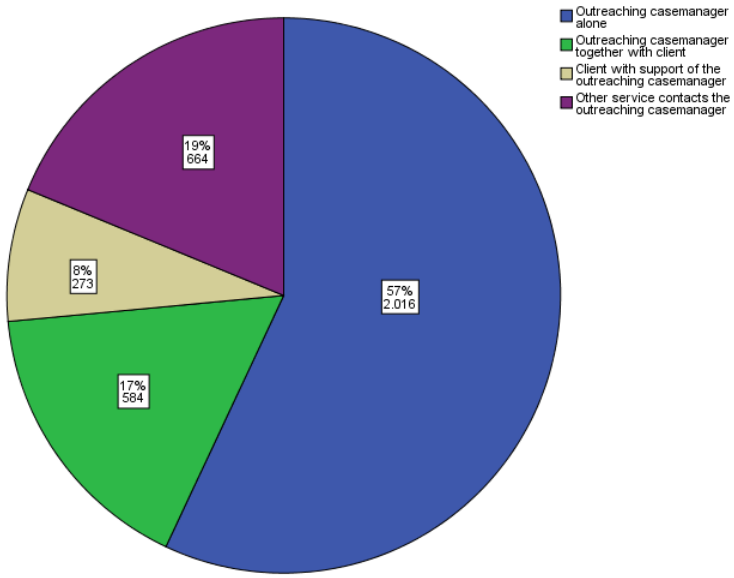
In 77% of the completed cases there was contact with at least one of the OCMW's internal services (for example, social service, activation service, energy service, et cetera) and in almost 70% of the cases there was contact with the municipal services in Kortrijk (69%). In about half of the cases, there was contact with a service that works on health and well-being (for example, general practitioner, physiotherapist, hospital, et cetera) or home care (54%), frontline liaison workers (54%), social housing (50%) or legal system/police (50%). Schools (46%), national health service (42%), day care facilities (39%), K&G (35%) and child benefit funds (35%) are also frequently involved.

Taking the initiative in contacting other (social) services

Ideally, the OCM supports the client in such way they are able to contact social service providers and organisations themselves. In practice however, it often was the OCM who established the contact. The pie chart below (Figure 3) shows the sum of all contacts that have taken place with other services in which the OCM was involved (over outreaching case managers, cases and weeks). More than half of the contacts were made by the OCM alone. In one fourth of the contacts, both the OCM and the client contacted a service (either contact where the client takes the lead or the outreaching case manager). In a little less than one quarter of the cases, the OCM himself is contacted by a service. In such case the OCMs indicate that this is often a second contact after a first, failed contact attempt by the case manager herself. On the other hand, other services sometimes contact the case manager to ask for practical matters or in function of coordination.

"Sometimes it is to coordinate that other services contact me or sometimes it is also 'ah yes you will probably see that client sooner than me, can you ask that or discuss this, or would you please take that with you'." (Focus group, outreaching case manager)

FIGURE 3. SUM OF CONTACTS IN WHICH THE OUTREACHING CASE MANAGER WAS INVOLVED



The fact that the OCMs do a lot on their own can be explained in various ways:

First, it is for practical reasons, such as long queues when calling a service.

"It is often for practical reasons that I call. If you try to call together with the family and you are in that queue, you leave after two minutes and say, 'I'll call back again when I'm at the office'." (Focus group, outreaching case manager)

Second, making contact with other service providers was rather easy for the outreaching case manager because they had already met many of them in person. At the start of the project, the outreaching case managers did an introductory internship in many organizations within the welfare sector (for example, OCMW, CAW, VDAB, social housing company, and so on). They not only got to know the (functioning of) these organizations and their services, but also the specific social workers that they were going to work with in the field. This ensures that the OCMs contact them faster in case they have questions.

Third, the OCMs thought it was important to sort things out for the family. This went faster in some cases when the case manager did it herself.

"A while ago the rent premium was applied for. The family has been on the waiting list for a social home for six years. In principle, they could already receive a rental premium for 2 years. However, they had never heard of this and have unfortunately missed it for 2 years. I had filled in all the documents with them, we only needed the father's signature, but he was at work. Mrs. said she would let him sign it and then send the letter herself. Later I asked her if she succeeded and she indicated that she did. Now it appears that she had not yet sent this letter, as a result the family missed out on the rental premium for an extra couple of months. In this respect, I have a hard time with critics say we pamper families too much. At first, I want people to take up all the rights for which they are eligible. To be sure, I often take control or indeed take over matters. In this case, I did not do this, and it turns out that things go wrong simply by not sending a letter (while all the necessary documents were collected)." (Logbook registrations, working/hindering factors, B18)

“For example, someone who had to call for day care. Then I ask like 'are you going to call?' 'Yes, yes, I'm going to call'. But I already noticed I was going to have to follow up. And you ask every time, for example a few days later, 'and have you already called?' 'Ah no I have not come to it yet.' The week after that again: 'ah no'. And then you will eventually call yourself again. With the client there, but it is me who is holding the phone.” (Focus group, outreaching case manager)

The OCMs noted that the procedures to apply for something in other organizations are often very complicated and people are sent from one to the other. Because of this complexity, services were sometimes contacted in advance to ensure that the client gets on the right track faster. This also prevented the clients from having a negative experience.

“What we often do, is contact services to get information and then take that information back to the family. So that they do not have to call three services to ask: ‘how do you work’, ‘what is your waiting list’, so that you can immediately say we are going to do that or go there together. That are often already five phone calls that you have made and then you make one together with the client." (Focus group, outreaching case manager)

Finally, the OCMs indicated that by contacting services themselves, they provide a family with a little rest or "relieve" them.

During the intervention period the case managers were always seeking a balance between doing things alone, doing things together and having the client do it alone. Client characteristics as well as time and space in the work schedule of the OCM influenced this process.

“You also know your family a bit. If I may speak for myself. It is not by feeling, but from your experience with that family you are going to ask certain things like ‘Are you OK with doing this yourself?’ and with other families you will accompany them faster or call yourself. I do not really see that as if that would impede the emancipatory effect or something, but rather as depending on how you know your family and what they themselves ask for. For example, someone can practically go to the National Employment Office themselves but would rather have some support if he doesn’t succeed articulating himself.” (Focus group, outreaching case manager)

“I think it is also just because we have the time and space that we also do it, especially when they ask.” (Focus group, outreaching case manager)

Despite that "taking over" or “doing things alone” offers advantages, the OCMs stressed the importance of working towards clients being able to arrange matters themselves in the longer term.

With a view on long term progress, the OCMs tried to work as much as possible on the problem-solving capacity of the client. In this context, involvement of the family in the steps taken by the outreaching case manager is important, but an extra push may also be needed to go one step further.

*"I had a French-speaking person and we had to call the French pension service from Paris. And I say, ’You can speak French well, call yourself.’ Then she said, 'No, no.' But in the end, she did. And for her that gave a calmer feeling of ‘I have called, and I actually succeeded.’ A little feeling and as * case manager4 * says: ask the client! I might have pushed a little bit then but still, she succeeded, and she thought that was okay." (Focus group, outreaching case manager)*

For some clients it was possible to strengthen the psychological, economic and social capital in the period of 12 months in such a way that the client could take control of his life again. The OCMs noted that these were usually clients who were more resilient beforehand. However, the OCMs suspect that even if the client was maximally empowered, this still does not guarantee permanent success. The responsibility therefore does not lie solely with the individual. Organizations (and by extension the government) have a major responsibility in making their services more accessible. There are various structural factors in other organizations that hinder even the most strengthened clients in improving their life situation. Examples are long waiting lists, complicated laws and regulations, high expectations/many conditions, lack of a positive basic attitude among employees, the existence of rigid internal agreements, accessibility only within office hours, administrative burden, etc.

“Long waiting lists at the various services, both residential assistance and ambulant assistance. This often makes it more difficult for people not to drop out.” (Logbook registrations, working/hindering factors, C)

“A reference address was requested and approved for her ex-partner. The administrative burden that comes with this is very time-consuming and does unfortunately not lie in my hands.” (Logbook registrations, working/hindering factors, B12)

“The wife of this family has applied for parental benefit from 1/08/2018. She had the necessary documents completed for this by her employer and therefore thought that everything was in order. On a consultation with the debt mediator, the family was given an overview with all the income and expenditure of the year 2018. I then saw that the woman had not received any income for several months. The debt mediator had also not noticed this. I asked the National Office of Employment what was going on: apparently the employer had forgotten to indicate one thing on the document (I.e. whether it is a complete or partial interruption of employment). The National Office of Employment sent a letter to Mrs on 25/09/2018, but never received a response. The family itself indicates that they have never received this letter. I think it is very unfortunate that the National Office of Employment does not take any steps to even call the family or to send a second letter but then registered. They say the responsibility lies with the family to notice if something is out of order with their benefits. This was of course not obvious, since they do not receive their income themselves and this goes directly to the debt mediator! After a number of telephone calls and e-mails, we nevertheless received the necessary documents to complete. I have written a letter with additional explanation and luckily the benefit came in order with retroactively effect. This concerns € 375.17 per month." (Logbook registrations, working/hindering factors, B18)

The expertise and position of the OCMs sometimes opened doors at other organizations that remain closed to a client. For example, OCMs sometimes made it happen that a decision of an organization on the provision of support was reviewed while the client would assume that a 'no' is really a 'no'.

All this leads to the observation that client empowered only brings one so far. Some things can only be arranged at the organizational or policy level. The fear of a relapse of a family into its previous situation due to the structural inaccessibility of services and provisions made it sometimes difficult for the outreaching case managers to let go of the clients when the foreseen intervention period of 12 months was reached. Moreover, there were also clients in need of permanent support; they will never be able to do everything alone. For them, continuity of the assistance must be assured to guarantee that rights are permanently granted.

"The man needs a 'partner for the road', someone who is there for him and supports him, without expectations and time limits.” (Logbook registrations, working/hindering factors, D18)

3.2.3 Progress on the guiding principles in practice

In addition to the weekly contact registration, the outreaching case managers registered their progress on the 10 guiding principles that informed their daily practice for every family on a monthly basis.

We examine the extent to which the outreaching case managers made progress in working according to these principles. In the following bar charts, we explore the evolution over time. It is important to bear in mind that not every case has already been completed and that some months have missing values. Moreover, several cases have not reached the minimum duration of the intervention of 12 months, because these families entered the MISSION trial in the final months of recruitment. For each month, we show the information for the cases available. As a result, every month for every guiding principle has a different sample size. The last two bars illustrate the start and end value of the cases that reached at least the phase-out period and/or are completed and are always based on the same set of 36 cases, of which 27 are closed cases and 9 are in the phase-out period. In the intensive period, outreaching case managers were expected to actively seek and maintain contact with clients, while in the phase-out period they were expected to remain available for questions and needs. Further

explanation is given in the text based on the registered open data in the logbooks, data from the focus groups and the in-depth interviews with the clients. Moreover, we examine whether the client characteristics, the magnitude of the problems/accessibility of the cases and the duration of the intervention play a significant role in the final scores on the principles.

Working integral

Outreaching case managers try to get an integral perspective on the client's situation. They try to gain insight into various life domains such as income, housing, employment, health, education, et cetera. In this way OCMs gain more insight into all problems that play a role in the situation of the client and the relationship between these problems. In addition to the burdens, they also gain insight into the client's strengths.

Figure 4. Working integral over time and first/final score in intensive period

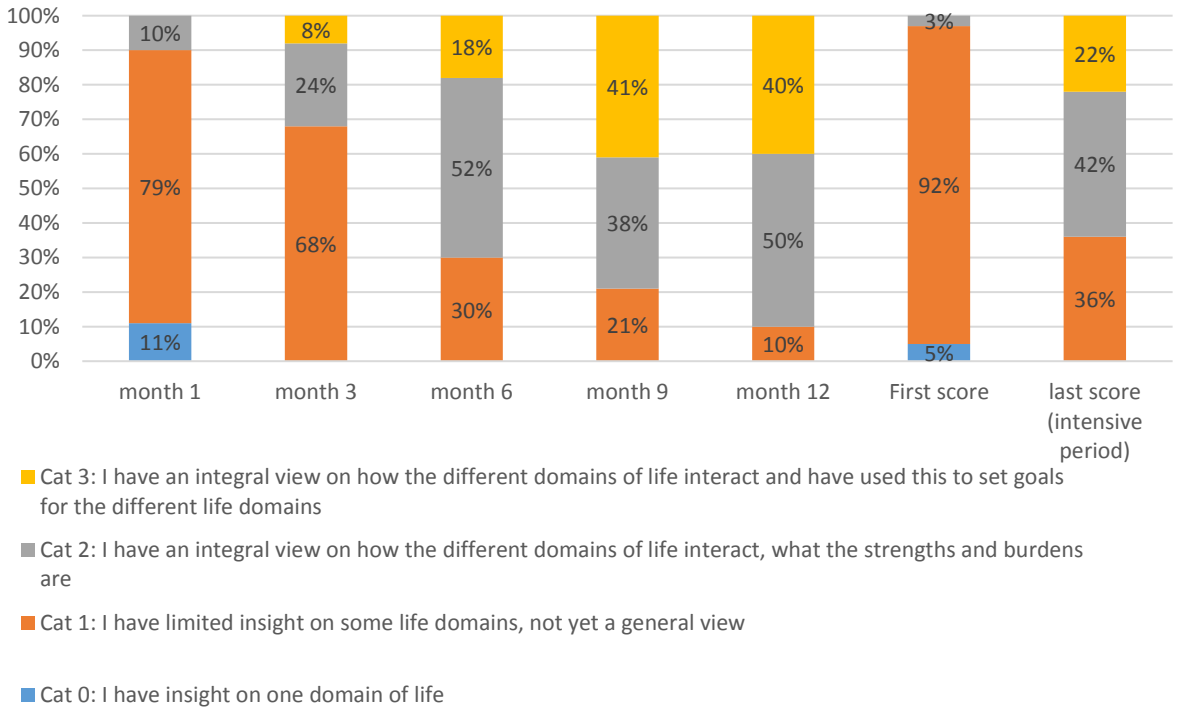


Figure 4 shows a clear evolution in the integral perspective the outreaching case managers acquire over time. In the first month of the intervention they have only limited insight on some life domains in the majority of cases (79%). This can be explained by the limited contact and/or the trust relation that is still in start-up. This score can be perceived as positive in a start phase.

> *"Beginning insight in some life domains. Noticing that there is work to be done on other life domains too, but no openness yet. Less accessible." (Logbook registrations, guiding principle integral, C9, month 1//10, score 1)*

From six months on, there is in more than 70% of the cases an integral perspective on the situation of the client. This continues to rise over time: from nine months on the outreaching case managers have an integral perspective in about 90% of all cases. In half of the cases, this integral perspective is used to set objectives. There

are several factors determining how the outreaching case managers succeeded in obtaining an integral perspective on the situation. First, and most important, as a result of the established trust relationship the client is open about her/his situation. Furthermore, the outreaching case managers emphasized the importance of home visits and face-to-face meetings, client-centred consultation meetings, using the budget planner and going together to other service providers as aspects that allow them to fully grasp the integral situation of the client. A final aspect that helped to obtain an integral perspective, was good communication with the other service providers around the client.

> *"With almost all families, the first questions are mainly about administration or income. Underlying issues, like mental well-being, only come up once you gained their trust." (Logbook registrations, guiding principle integral, B9, month 4/22, score 3)*

> *"This view has been increasingly fed throughout the various house visits and the visits to different services (De Vaart, ACV, …). Now I believe to have a more comprehensive view on the different life domains." (Logbook registrations, guiding principle integral, B16, month 5/17, score 3)*

An important precondition of obtaining an integral view is the time and space the outreaching case managers have for doing their work. Another precondition is a thorough knowledge of the local social organisational map. At the start of the project, due attention was paid to this all-round knowledge through training. Throughout the project that knowledge expanded because of practical experiences with clients, looking things up, discussing with colleagues...

> *"The importance of the amount of information a case manager should have at its disposal or should know: from playgrounds to legislation on the status of residence." (Logbook registrations, working/hindering factors, D13)*

The OCMs, the families as well as the other service providers in the focus group testify to the great added value of working integrally. A social professional who has ample room and time to work in an integral way and who can take up the task of coordinating support is of great help for both clients and service providers.

> *"She helped me with everything I needed from city hall and the OCMW. It is good that you can ask everything and not just one thing. We also talked about participation in a training and a driver's license". (Client interviews, client 6)*

> *"During the preparation of the meeting with the mother, she told me that the amount of times other social professionals refer her with her question to the case manager, is very striking. So, she asks a question for support, and the answer is: isn't your case manager able to support you with this? I found this to be a good example of the tensions 'case managing' sometimes entails. There are six care providers involved in the family, working specifically around the children (…). Yet no one is looking at the full picture here. Mama really experiences this as a shortage and finds it to be burdensome (all the appointments, then). Everyone works starting from one specific context (e.g. school), specific child or limited period. This was discussed during the meeting and there will be an application for contextual guidance. At the same time, to not flood the mam with appointments, other care providers will drop by less. As such this seems a good alternative, but I find it to be a shortage that everyone is sticking to his own limited framework and no one of the involved service providers is able to take on the family in a more intensive way." (Logbook registrations, working/hindering factors, E3)*

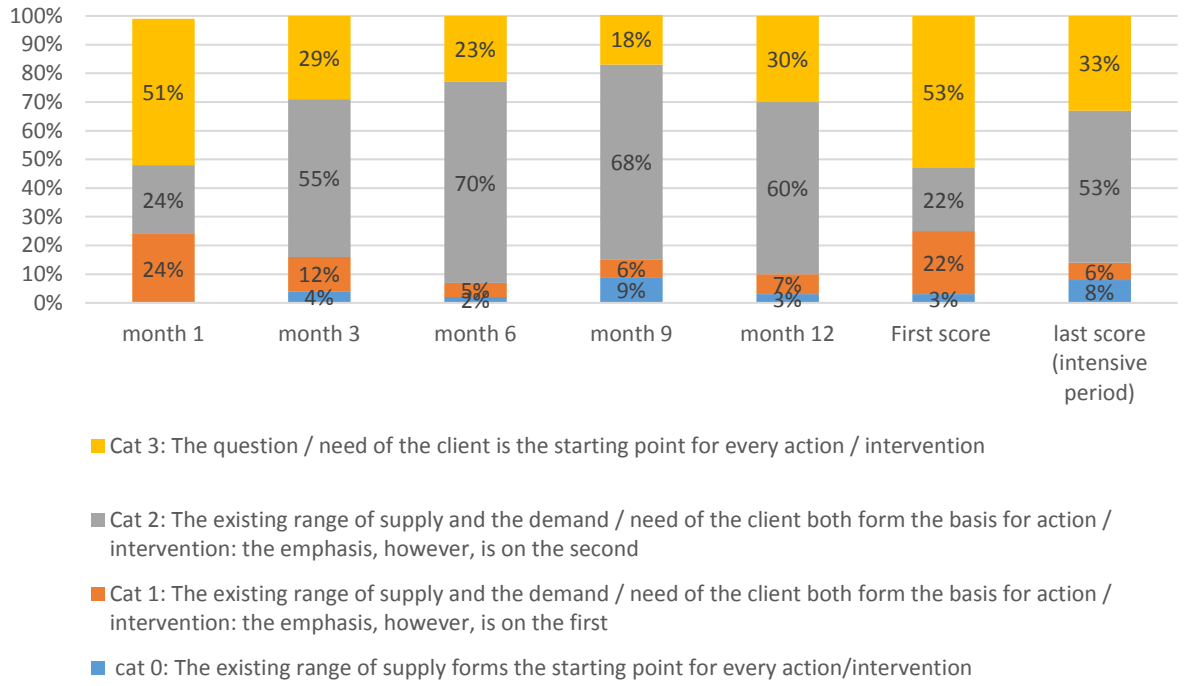
The final value of working integral indicates that in 36% of the cases, it was not possible to end the intervention or go to the phase-out period having obtained an integral perspective. Further analysis shows that the average accessibility of clients is lower among cases that have not been able to end integrally. This means that it was more difficult to gain trust from the client and/or that the client was less open to receiving support. This obviously results in a less integral perspective on the client's situation.

"Certainly not an integral view, permanent suspicion of those involved." (Logbook registrations, guiding principle integral, C13, month 12/13, score 1)

Working demand-driven (versus supply-driven)

This guiding principle summarizes the way in which the outreaching case managers (OCMS) work: do they start working from the demand of the client or the supply of the organization? Within case management, demand-oriented work is one of the basic tenets. This principle is adopted in the MISSION project as well: the outreaching case managers try to support families based on the needs and priorities indicated by the target group itself and not by what the OCMW or other organizations have to offer. The questions, needs or priorities of the family are always the starting point of the OCM as opposed to the specific supply of a service. Based on these needs, the OCM aims to provide the appropriate support.

FIGURE 5. WORKING DEMAND-DRIVEN OVER TIME AND FIRST/FINAL SCORE IN INTENSIVE PERIOD



Working demand-driven seems to be a basic attitude for the OCMs working in the MISSION project. The monthly registrations indicate a demand-driven approach from the start in most cases. In 75% of the cases, the case managers succeeded in acting based on the questions and needs of their clients (category 2 and 3). Within three months, 84% of the cases are handled in a demand-oriented wat, and this increases up to 90% after a year of the intervention.

Supply-driven work occurred when case managers were looking for an entry point to get started with a client without immediate questions/needs. Mostly this happened early in the intervention when clients did not really know what the outreaching case manager could do for them or when they just did not ask any questions. In that case, case managers tried to explore possible needs and rights – often using *Sien online* – to provide a perspective on what the outreaching case manager could do for them.

"(…) Then I proposed to go through the app, that really was an offer that enabled me to start a conversation again and succeeded to visit them again." (Focus group, outreaching case manager)

"Person concerned doesn't indicate a lot herself during the first house visit. Therefore, I mainly try to work demand-driven: increased reimbursement of health care costs? I asked [her] myself whether to

contact the city administration to know the status of residence, … person concerned does not initiate a lot of questions." (Logbook registrations guiding principle demand-driven, A17, month 2/12, score 0).

Nevertheless, this always happened with the greatest respect for the client and sensitivities of the client.

"(…). Start looking for the points that are crucial for clients and what works and what doesn't work, and if you cross that bridge, the door will close. Then look for the points that will open the door again. And do not look for the points that are in our head because we think it should go that way ... because then you definitely have the door closed. " (Focus group, outreaching case manager)

"We really just start from the question and sometimes, indirectly, involve some other issues, but if that does not work for the family, we will not focus on it all the time. We then just continue with the issues the family is up to. Because we really notice, we feel it, as soon as things are being pushed, things go wrong, we lose them." (Focus group, outreaching case manager)

When comparing both demand-driven categories (category 2 and 3), a shift is seen from mainly category 3 at the start of the intervention towards an increased prevalence of category 2 within three months. This category 2, in which the demand driven approach is supplemented with supply-driven opportunities, seems to be the most desirable position: the client is in charge, but the OCM can bring in their expertise to realize more take up of social rights. This is in line with, and thus overlaps with, the fifth principle that outreaching case managers are acting proactively.

"For example, this was someone going for his driver's license and driving lessons are expensive. The OCMW, you know, I know from experience, practically never [financially] intervenes for this. So, we asked for an intervention via De Kier [NGO] to participate in driving lessons. You accompany that person to De Kier, you explain what it is, we are now here for your driver's license, but you can turn to the Kier for this, and that, and other things. So, then they know it." (Focus group, outreaching case manager)

Often this category 2 also indicates that in order to achieve a solution, additional supply is needed. In that case, the outreaching case manager will try to bring in additional expertise from service providers, in order to reach the initial objectives of the client.

"The woman has to continue to prove her motivation to take on an employment to her social assistant and she refers her to Werkpunt. I refer her to the 'liaison worker for employment' because there are still too many preconditions for which no solution has been found yet." (Logbook registrations, guiding principle demand-driven, D20, month 4/12, score 2)

In other cases, the case manager indicated that it was not always possible to work entirely demand-driven, because of the demands of the policy that are conflicting with the needs of the client.

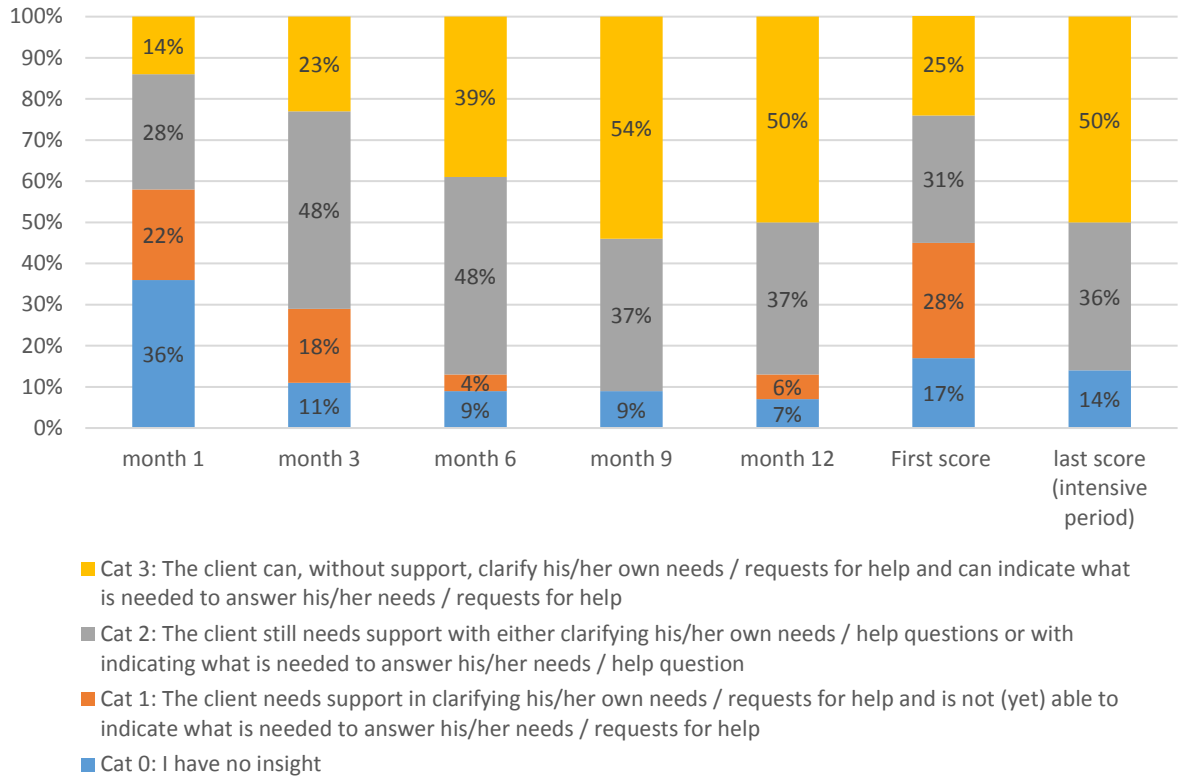
"Although this is not easy: if I were to work in a purely demand-driven way in this case, I would give priority to psychological support and leave the focus on employment out for a bit. Unfortunately, her residence permit is reviewed every 6 months and they really put an incredible amount of pressure on her in terms of gaining an employment. In that sense, it is thus really difficult to work in a client / demand-driven way. She also thinks her residence permit is the most important thing, but I think she is now unable to take up a job in combination with the stress she is experiencing with three young children." (Logbook registrations, guiding principle demand-driven, B22, month 2/7, score 2)

Emancipatory work

The third and fourth principle are based on the emancipatory ideology: the social worker must support the client in order to increase his/her independence and have control over his/her own life. Therefore, It is crucial that the client is actively involved in the process. This focus on emancipatory work has been operationalized using two dimensions, namely 1) to what extent is the family able to clarify their needs and to what extent do they have an idea what kind of help is needed? and 2) the capability of the families to go to social services themselves.

Emancipatory work: question clarification

FIGURE 6. WORKING ON QUESTION CLARIFICATION OVER TIME AND FIRST/FINAL SCORE IN INTENSIVE



At the start of the intervention, 25% of the families were already capable of formulating their needs and possible solutions (first score). This group is increasing toward 50% at the end of the intervention. This implies that the outreaching case managers were increasingly able to work emancipatory in clarifying needs and possible solutions. The qualitative data show that the OCMs play a very supportive role in this and empower the client rather than simply taking over or leaving them to their own judgment.

> *"I think that she is going through a real growth process in terms of assertiveness. Also, she often takes more initiative, e.g. contacting her debt mediator and ask for an update." (Logbook registrations, guiding principle emancipatory: question clarification, B7, month 7/24; score 3)*

> *"This month, I clearly notice that the family (albeit at the end of the month) flourishes and takes some steps again on their own initiative. In some situations, the support of the case manager remains important. In other situations, I see that the family can contact other services independently and on their own initiative. They are able to ask specific questions for support. The person concerned went to OCMW Wevelgem, asking for help: an installation subsidy, a rent guarantee, collective debt settlement, etc. I remember very well - when I first saw the person concerned - it was out of the question to even introduce the possibility to go to OCMW! This is a very good example of what outreach work and intensive counselling can deliver!" (Logbook registrations, guiding principle emancipatory: question clarification, A2, month 8/25 ,score 2)*

However, a substantial group of clients need support in the beginning as well as at the end of the intervention. 37% of the cases remain in category 2, where help is needed in order to clarify the needs or to suggest possible

solutions. The qualitative logbook registrations show that the case managers always tried to improve empowerment of the client, but that they never enforced it. Some clients still needed help or support. The client's language and competences were sometimes a barrier, but also the complexity of the care landscape and the multi-problem situation in some of the families.

> *"The family concerned tries to clarify their needs / requests, but this is sometimes difficult. They need a lot of support: contact with the debt mediator, the father's counsellor at Mentor [a regional training institution]: it is difficult for him to express himself in another language and to formulate his message correctly. Even the contact with his social assistant is sometimes difficult (mainly due to the language barrier)." (Logbook registrations, guiding principle emancipatory: question clarification, A13, month 1/18, score 2).*

> *"Although I have the impression that the person concerned is trying to tackle certain issues independently, e.g. a letter from the bailiff regarding the payment plan - it remains very difficult to achieve results, such as letter sent incorrectly, bailiff's office never received letter." (Logbook registrations, guiding principle emancipatory: question clarification, A8, month 4/19; score 2)*

In half of the cases, the most ideal category was not reached at the end of the intervention. In some cases there was a return to a lower category. Especially in cases where there is a language barrier and a lack of knowledge of the care system, the care managers sometime score a family as 'capable of clarifying their questions without support' in one month to only return to 'needs support in clarifying their question' in the following month. Some other families remain stuck in the 'I have no insight' category - this is usually because there is not enough contact between the OCM and the client, or because the client is mainly in contact with another care provider.

> *"I have too little insight into this. I suppose she can discuss certain things and ask questions to her social assistant, but I don't know to what extent someone supports her with that. I also do not know whether she can indicate what she needs and whether she knows what her options are and what is available." (Logbook registrations, guiding principle emancipatory: question clarification, D6, month 5/21, score 0)*

Emancipatory work: use of services independently

A second aspect of emancipatory work is the objective to strengthen the client's independent use of services and professional support.

FIGURE 7. WORKING ON THE USE OF SERVICES INDEPENDENTLY OVER TIME AND FIRST/FINAL SCORE IN INTENSIVE PERIOD

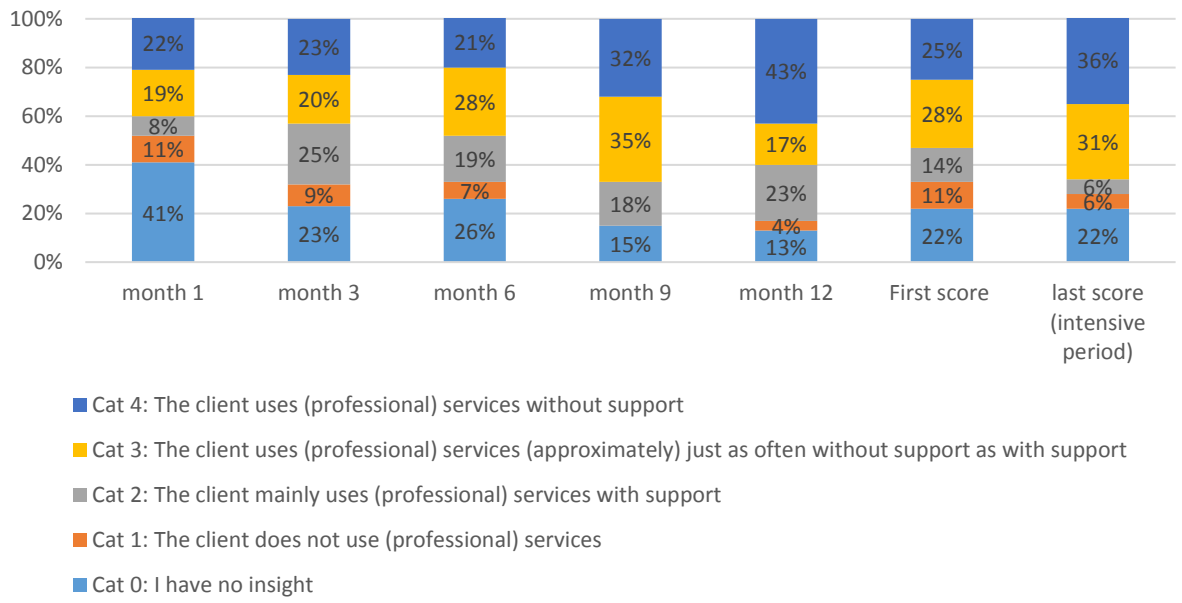


Figure 7 illustrates that there was only a limited evolution on this guiding principle. The group using professional social services (partly) independently increases from 53% to 67%. At the same time, it is striking that in 22% of cases there was no evolution between start and end phase.

In the logbook registrations various reasons are provided as to why the clients need support in using services. First, outreaching case managers (OCMs) offer support because the client's lack of confidence, negative experiences with previous assistance or due to specific characteristics (poor language skills, forgetful, waiting attitude, emotional, physical/mental disability).

> *"The person concerned is able to clarify what she wants and what she doesn't want, and we are finding out together how we can realize this. She has little trust in care provisions, so support remains." (Logbook registrations, guiding principle emancipatory: use of services, C17, month 8/14, score 2)*

> *"Because of the emotional nature of the reactions to situations and the often-explosive character of the reactions, it is important to act as an intermediary and to re-translate." (Logbook registrations, guiding principle emancipatory: use of services, C19, month 4/12, score 2)*

Furthermore, the expertise of the OCMs, the mediator-role and advocacy-role create opportunities and progress the client is not always able to achieve alone.

> *"I have the impression that the family can clarify its needs and questions without my support, and they are able to formulate what needs to be done, but I noticed that the family already experienced that they must go through more trouble if they ask their question without support. Why make it more difficult than it already is? It is easier if I accompany them." (Logbook registrations, guiding principle emancipatory: use of services, C3, month 11/23, score 2).*

> *"If a service has to be contacted that is unknown to her, she prefers I accompany her. This was the case this month when we consulted Kabas, an outpatient service for children with special needs, in this case autism. They also support clients in strengthening their network. I accompanied the mother to this service, I thus made links and built bridges. We secured some agreements, and now this can be continued by the service and the mother. If necessary, of course, they can contact me. I think it is important that I can outline the whole context when I accompany someone. So they know it is not easy to contact the mother during working hours, that they preferably communicate in English, what the strengths and weaknesses of the family are, … (Logbook registrations, guiding principle emancipatory: use of services, B3, month 13/17, score 3).*

Various factors related to the inaccessibility of services resulted in on-going support by the outreaching case managers, as already discussed. The clients relied on the outreaching case managers because of the inflexible opening hours, the limited contact forms, the administrative and bureaucratic burden for clients. Because the case managers are employed by the OCMW, they were able to contact their colleagues quickly. Also, the lack of understanding exhibited by some care providers led to the need of families to get more support to use these services.

> *"Contact with the OCMW social assistant mainly goes through the case manager because person concerned says she cannot reach the social assistant." (Logbook registrations, guiding principle emancipatory: use of services, A7, month 18/25, score 2).*

> *"The family does try to use services without support, but because of the language barrier they are often confronted with impatience and misunderstandings, which is why I notice that they now mainly use the existing (and often already known) services with my support. It seems to be a step backwards because the family should be stronger instead and be able to take steps themselves without support." (Logbook registrations, guiding principle emancipatory: use of services, C3, month 10/26, score 2)*

There are various reasons why clients used services partially with support. The client uses several services alone, however, support was still needed with new or lesser-known services: it enables more confidence of the client in the system, ensures a certain legitimacy, and it allows the OCM to contextualise the situation in first instance to other service providers. Furthermore, it appears that support often remained necessary for administrative

purposes. Finally, support by the OCM was necessary for specific services or professionals with whom the client encountered difficulties with (inaccessibility, negative experiences in the past).

> *"The client had already support from CAW and had contact with a social worker from the juvenile court. This goes smooth. She predominantly needs support in making appointments with other social care providers and in getting her administration in order. This support entails encouragement to make the step. Otherwise, the client herself is perfect capable to do the necessary." (Logbook registrations, guiding principle emancipatory: use of services, E1, month 6/16, score 3)*

> *"The family does a lot alone. Only paperwork and letters are left to the case manager. Accompanying the family never happens." (Logbook registrations, guiding principle emancipatory: use of services, D21 month 5/10, score 4)*

The outreaching case managers tried to work actively on the independent use of services. However, in some cases they made the decision to support families anyway, despite the perception that they could actually do this independently. This way, these clients felt more confident or (important) things were arranged more quickly.

> *"The client would like me to provide always support in contact with other service providers. I talked to her about this and try to encourage her to do this by herself, because I feel she can certainly do this. I will continue to follow this up and discuss it, to see if this works for her." (Logbook registrations guiding principle emancipatory: use of services, E13, month 4/16, score 4)*

> *"yes, some things are super important to get done, for example making sure the allowance is allocated, you won't let this pass in order to make the client stronger in doing this by his self." (Focus group, outreaching case manager)*

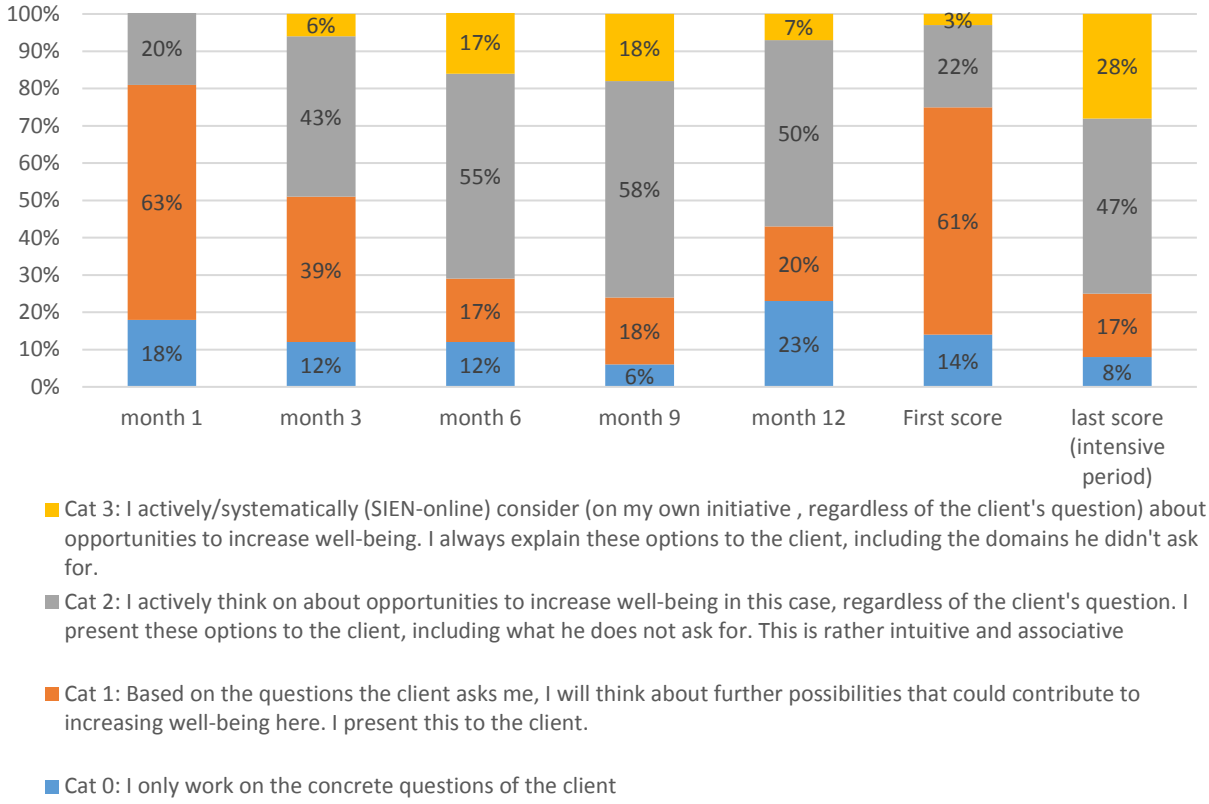
> *"I pay more attention to the division of tasks, that I do not take over too much. Yet this is not always possible. The client indicates that she will try to do something, but often she doesn't get to it, which means that I often take it over again." (Logbook registrations, working/hindering factors, B1)*

Finally, the 'I have no insight' category remains relatively large in the end phase (22%). Further analysis shows that this is category is mainly filled with clients where there was limited contact with and/or where the client was not open for guidance.

Proactive work

The outreaching case manager (OCM) is expected to work in a proactive way, so that take up of social rights in all life domains is guaranteed. This means trying to find a balance between demand-driven and proactive work. Proactive work is operationalised in the monthly logbooks by asking to what extend the case manager succeeded in working proactively last month. Category 0 indicates that proactive work was not possible, desirable or necessary. The second category 1 stands for a proactive attitude, but only related to the concrete demands of the clients. Categories 2 and 3 are about working proactive, regardless of concrete questions, and this in an intuitive (2) or structural way (3).

FIGURE 8. WORKING ON PROACTIVELY OVER TIME AND FIRST/FINAL SCORE IN INTENSIVE PERIOD



Proactive work does evolve quickly. From the beginning, in most cases OCMs worked according to the concrete questions of the client. But in three months' time, proactive work – regardless of the concrete needs – is possible in 49% of the cases; and increasing to 72% and 76% after month 6 and 9 respectively. Most cases begin at category 'proactive work linked to a concrete question' and evolve to category 2 or 3, indicating that proactive work is possible independent of concrete questions and demands from clients.

It was clear that respect for the client's wishes and needs remained central. A proactive role is only adopted when agreed to by the client. When the case manager had the feeling the client did not appreciate it, they didn't go through with it.

> *"At first, I taught more proactively about rights and so on. Now, I opt to leave the initiative with her, because she explicitly requested it. Next week, I will call her to ask how she is doing and to remind her that her son needs to be enrolled in a nursery school. I think it is easier to contact her then, because I have a real reason to contact her." (Logbook registrations, guiding principle proactive, B12, month 6/14; score 0)*

However, in most cases the client agreed to work proactively, and the outreaching case managers were able to take on a proactive role. Nevertheless, the pace of the client was always respected.

> *"I notice with myself that I already have a trajectory in mind about her mental health and her children, but that it is not always adjusted to her situation. The moment she withdraws, the pressure becomes too high for her." (Logbook registrations, guiding principle proactive, D9, month 11/22, score 2)*
>
> *"Be more attentive for non-verbal communication of concerned: [she gives a] resigned impression, emotional conversation about her relationship ex-partner, behavioural problems oldest son, financial*

problems, …. The person concerned would not have addressed these issues if I didn't bring them up in the conversation. What would be an added value in her case? Specific steps in the future might be: a judicial procedure for child support + continuing arrangement for children. Offering structure and support. Alleviate thoughts: sports?" (Logbook registrations, guiding principle proactive, A4, month 13/24, score 2)

In fact, in families that are less accessible, it was more difficult to work proactively.

Furthermore, the last category shows that in 36% of the cases that reached at least the phase-out period and/or are completed, Sien online was used. Particularly in the beginning of the project, the outreaching case managers indicate that Sien online was useful in terms of the take-up of social rights. Mostly they used Sien online in the starting phase as an entrance with the families and/or in the ending phase to double-check whether they have activated all rights (what was almost always the case).

"It was interesting to go through the Sien Online together, because that brought up other topics for discussion and opportunities to exhaust rights." (Logbook registrations, working/hindering factors, E10)

"Going through Sien Online with the family brought up some themes that we hadn't discussed before. It broadens the take-up of rights." (Logbook registrations, working/hindering factors, E6)

However, the percentage of the systematic use of Sien online is relatively small for various reasons. First, they helped constructing the content of the application by offering input of services and benefits. Next, at the beginning of the project they did internships with several services what resulted in a thorough knowledge of these services and their offer. The outreaching case managers point out that after some months they knew (most of) the offer of services in Sien online by heart.

Advocacy role

Outreaching case managers (OCMs) act as attorneys for their clients. There may be barriers inhibiting clients to receive services. The OCM mediates on behalf of the families towards or between different services. This is advocacy at an individual level. Case managers will also identify gaps in the service system and organization. The system can be incomplete, or necessary services can simply not be available. The role of the case manager in this situation is, at z minimum, to document the gap and make their supervisors aware of the situation. The MDMA follows the work of the case managers and receives information about the experienced barriers. So they can take action to overcome them.

This principle is operationalised by monthly registration of the extent of advocacy done in each case. The response categories went from 'no advocacy at all' to 'advocacy work on individual and structural level'.

FIGURE 9. WORKING ON ADVOCACY OVER TIME AND FIRST/FINAL SCORE IN INTENSIVE PERIOD

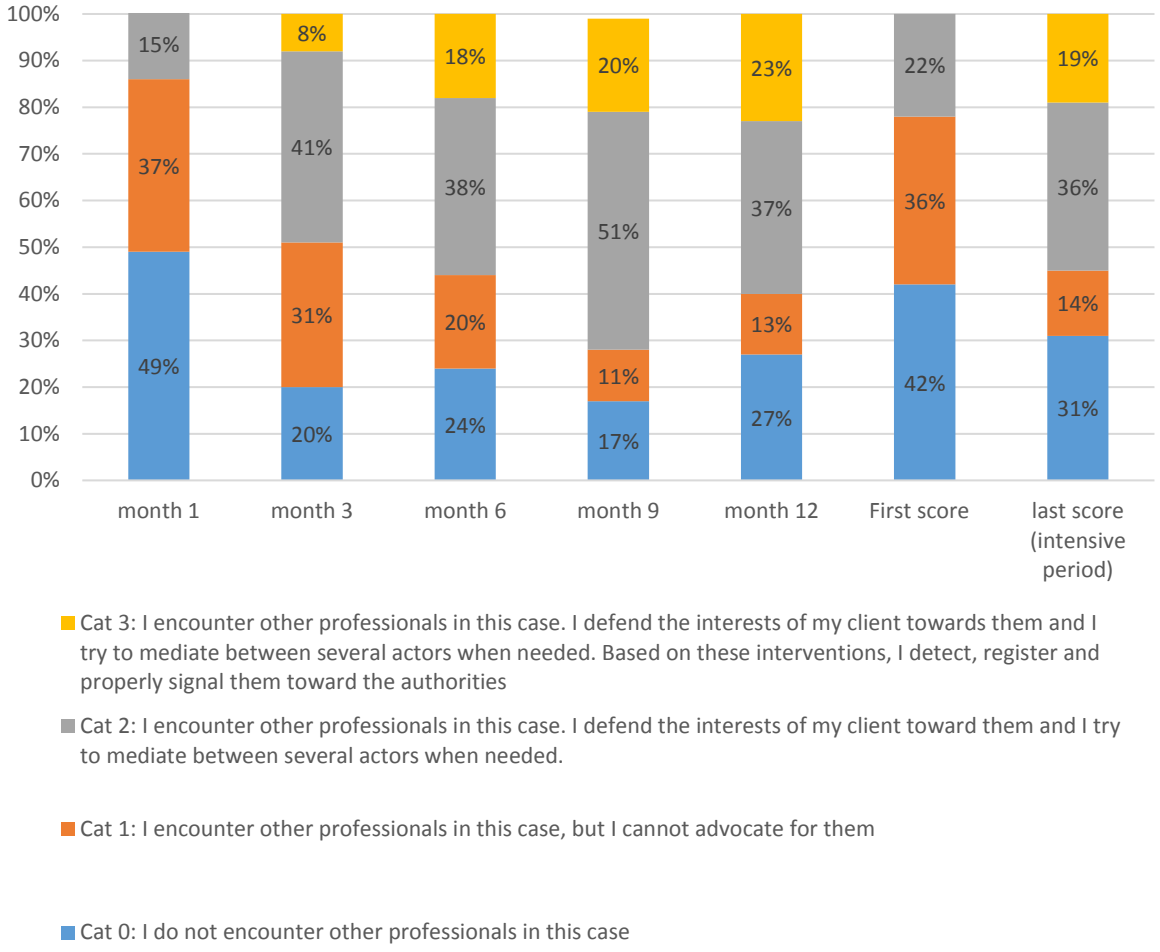


Figure 9 shows that advocacy work is gradually increasing over time. Within 3 months, in 49% of the cases advocacy work is included; after 6 and 9 months these percentages increase to 56% and 71% respectively. Advocacy work entails three functions. First, advocacy is mainly about framing the client's question / perspective so that the other service better understands why there is an effective need for certain assistance or why an exception could be appropriate.

> *"This month, I felt very strongly how important it is to defend her interests. The client could do an interim job for a month. The evening before the start of the job, she had a fall-out with the friend she stayed and unexpectedly, she had to return to Antwerp to her family. She has limited options because she is homeless. So, she could not start the job. Team activation regarded that very negatively. They see it as a refusal to work and consequently, her assistance benefit was questioned. Fortunately, together with her social assistant her situation could be explained: the limited insight, no bad intentions, being homeless, …. now, she gets another chance." (Logbook registrations, guiding principle advocacy, E19, month 8/9, score 3)*

> *"End July, this family got a house through SVK De Poort. They got the offer on July 24. The family had to see the house the same day and the tenancy agreement would begin on August 1 (one week later). Practically, this was unfeasible. Moving in one week time without a car, an agreement for a rental deposit still had to be arranged through the OCMW... I pointed this out to the SVK and as such, we managed to get an extra month." (Logbook registrations, guiding principle advocacy , B16, month 8/17, score 3)*

Some professionals working in other organisations experience some difficulty in believing the client's story. In such case the OCM is often able to repeat the client's story in a more credible way.

"Deliberation between concerned and social assistant budget management. Concerned has asked for the case manager during the deliberation. Both the social assistant budget management and concerned speak out their mind. Contact is rigid. Case manager mediates. Gives some elements in favour of concerned, e.g. the cost of baby milk has gone. The social assistant wants to use this money for budget management. In principle, this money must be used for other nourishment for the baby: bottles, baby food, … This is logical, but the social assistant is only convinced by my opinion and NOT by the opinion of concerned..." (Logbook registrations, guiding principle advocacy, A10, month 10/21, score 2)

A last function is also linked with credibility: many services need the guarantee of another professional to take a decision. This is especially the case in difficult situations in which the client needs 'a second chance' or an exception to the rules.

"Meanwhile, I contacted several services such as the OCMW, the neighbourhood worker and the agency for family care services from the. The agency for family care services does not want to start a cleaning aid because of negative experiences with Mrs. Asked what would be necessary to start the cleaning aid: house must be thoroughly cleaned + all open invoices must be paid. Therefore, I will engage a professional cleaning firm and ask for a financial contribution of the OCMW, and a settlement for the unpaid bills with the agency for family care services. Under these circumstances, they are willing to restart again." (Logbook registrations, guiding principle advocacy, B17, month 1/16; score 2)

After a year, advocacy work is still needed in 60% of the cases. Compared with month 9, this is a decrease of 11%. Still, 60% of the cases, even after 12 months of intervention, need advocacy. In 55% of the cases advocacy is still needed at the end of the intensive period.

During the MISSION project, the importance of advocacy became increasingly clear. A persevering or normative professionalism towards the client is one of the case manager's basic principles. They tried to find a good balance between working accusatory and respecting the client's rejections. If the client really did not want any contact, they tried to reconnect by sending a non-binding message.

"Shortly after the contact broke off, I reached out to her social worker of the OCMW and the nurse of Kind en Gezin. I wanted to reconnect with her. Now that she refuses this, I will stop approaching her (this has also its limits, you can try repeatedly, but at last you must respect the wishes of the family). I know that she respects the appointments of the OCMW and Kind en Gezin. I won't ask behind her back to the social workers what is happening in her life. (Logbook registrations, guiding principle advocacy, B12, month 8/14, score 0)

In other words, this persevering attitude is reflected in being present on behalf of the client and keep fighting for the client's interests. As such, the advocacy focus does not only apply to the client, but mainly to the other service providers. The OCMs did not easily accept a 'no' for an answer, certainly not when they had the feeling this affected the client's living conditions.

Two cases are highlighted below. They provide comments on advocacy work in two cases. It clearly shows what a titanic work advocacy often is, and how successes (by being persistent) are ultimately achieved. Advocacy takes time, patience and persistence.

Casus B7: Advocacy and the time it takes + the effects (intervention period: 24 months)

***"Month 3 (score 1)** As said earlier, I would prefer to defend my client's interests, but this client really does not allow it. She is afraid that, if we discuss the problems between her and her social worker, she won't be able to ask for an extra. I try to convince her, but I will not take an initiative without her consent.*

***Month 4 (score 3)** There is a lack of coordination between the debt mediator and social worker involved in budget management (OCMW). The client does not know for which questions she can contact who, but also the debt mediator and the social worker disagree on this issue. Client find this*

difficult to express, so I see it as my role to clarify this. Personally, I find the language used by the social worker unacceptable and that her social assistance budget (leefloon) is extremely low. So, I have discussed this with the social worker.

Month 5 (score 3) *The collective debt settlement of Mrs. should have finished a long time ago, but now we have discovered that the debt mediator simply has not done her job. I am now looking with the social worker of the OCMW and a lawyer what can be done.*

Month 9 (score 3) *The actions of her debt mediator are not OK to me. The collective debt settlement already lasts almost 8,5 years (while this is limited to maximum 7 years). Together with the lawyer of the OCMW we are looking to take steps to terminate on the one hand the collective debt settlement, but also on the other hand, to report the mistakes the debt mediator has made to the Labour Court.*

Month 10 (score 3) *The debt mediator probably thinks I am stalking her, but I consider it necessary to keep on urging to end the collective debt settlement. With each promise she makes, I call her a few days later to ask her if she has effectively done it. This is the only way to get something realized by her. Finally, there is an outlook of some betterment!*

Month 11 (score 3) *I proactively follow up the case (e.g. debt mediator claims she will submit a petition to end the collective debt settlement. Later I will ask her if she has really done it). This is the only way to get the matter done.*

Month 19 (score 3) *This month I hardly had contact with others. Mrs. seems to find her way on her own, she arranges her own appointments and keeps them. My support is not often required."*

Casus A13: Advocacy and the time it takes + the effects (intervention period: 18 months)

Month 1 (score 2) *During a deliberation which concerned a district nurse from the Child and Family welfare agency and the budget mediator from OCMW, a financial intervention [in the cost for] medication of the children and baby food was discussed. The OCMW put a lot of pressure by making clear that the Special Social Services Committee would demand proof of willingness to take up a job. During this deliberation, it was inevitable that the case manager (and the Child and Family welfare agency) would defend the interests of the family. Applying for a financial intervention for the medication of the children is necessary, because medication amounts to a serious part of the weekly budget of the family and the family members are certainly open to work!!!*

Month 3 (score 2) *I have the impression to have mediated and have advocated for the interests of this family: social worker screens budget- en debt relief. She contacts me to know if there is urgent help in the family needed. The reason for this question is to couple an advice on budget management. The family DOES NOT want budget management but is put to a choice: or budget management or no support from the OCMW, but one of another service. As case manager, I disagreed. I also had a consultation with Fonkel: the family coach focussed too much on the man in the family and put all responsibility with him. I intervened on his behalf: 'if we put the responsibility with the man and if we have expectations towards him and we always discuss him, he should at least be attending these meetings'. - Consultation in Fonkel: family coach does not understand why some agreements cannot be cancelled (e.g. agreement with social assistant that the man can cancel by phone in case of urgencies). I try to contextualize to grow understanding.*

Month 4 (score 2) *Deliberation Mentor (activation husband: Once more, I have tried to get some understanding for the other side. This time, I stressed the well-being of concerned. Deliberation Werkpunt (activation woman): made a clear point that activation is currently not an option.*

Month 5 (score 2) *e.g. calling pharmacy and social worker OCMW to know if the intervention in medical costs is OK for new pharmacy? Applying for a service to do shopping: difficult for family to do their shopping in one time because of limited mobility.*

Month 9 (score 2) *Applied for immediate help because of an emergency!*

Month 10 (score 3) *Discussion with K&G about empowerment! Childcare: mother cancelled last minute. Childcare asked me about this: explained situation. Signalled team coach about differences in visions with K&G concerning support. Contact with debt mediator: mediated with colleague budget management: asked advice to lawyer OCMW.*

Month 12 (score 2) *Contact with several services (childcare), social worker social service: rental deposit for ex-partner. Social worker would not give him the information, so he could fix it with the OCMW on his own. I have informed him that he can apply for a rental deposit for his apartment with the OCMW!*

Month 13 (score 2) *Contacts with K&G: big consultation with a neutral president: does K&G have other intentions here? In contradiction with other services. Discussion between family supporter K&G en case manager. Family supporter threatens to report a disturbing....*

Month 14 (score 2) *Contact en talk with family supporter K&G. Ask for urgent support to social worker OCMW + motivation.*

Month 15 (score 2) *Energy provider, Familiezorg, SVK De Poort*

Month 16 (score 2) *Contacts met SVK DE Poort about visit owner house.*

The examples above show how much time it takes to work on advocacy, but it also shows the position of the outreaching case manager: they are always standing next to the client, defending and explaining the interest and the point of view of the client. The client's situation must be explained again and again so other (specialised) services take this context into account. Consequently, the case managers **work very demandingly** towards other services, they dare to insist and push on until the take up of benefits is guaranteed. Especially within the context of the OCMW, this has led to major tensions.

First, some social workers of the OCMW, for instance, got a feeling of disrespect and distrust; as if the outreaching case managers were superior to them.

> *"Their demands often go too far. They wanted to read the meeting notes of the committee for instance, as we do not defend the rights of the client… so, where is the trust?" (Workshop with frontline workers, participant: social worker from OCMW Kortrijk)*

> *"It is a colleague of mine who said it to me: someone who works in a subsidized employment scheme delivered by OCMW, loses his social tariff on electricity. Apparently, the people who are clients of MISSION keep everything. They get the benefits of people who receive leefloon [a social assistance benefit]. That is not fair to the other clients of the OCMW." (Workshop with frontline workers, participant: social worker from OCMW Kortrijk)*

Secondly, the position of the outreaching case manager is stipulated as 'front office' and consequently, specialized social services are forced into a back-office position, which is more administrative work.

> *"It is mixed. Although it helps to lower the case load, it is also unfortunate that the social assistant cannot do any longer the more gratifying and more intensive forms of support and must outsource them. The house visits, the long talks in which you really get to know people and really can help them and give them the impression that you are there for them, the construction of services, not having time for that. After a while, you become the back office and you only get applications and come on, that is our job, nothing more." (Workshop with frontline workers, participant: social worker from OCMW Kortrijk)*

> *"Now, I often am 'the bad one' of budget management… 'the bad one' because we decide about money and so on. As a result of the division of tasks, we are unable to have a relationship of trust with the client anymore." (Workshop with frontline workers, participant: social worker from OCMW Kortrijk)*

Outreaching case managers are not expected to impose conditional requirements on clients, unlike those who must follow (strict) criteria. Social assistants of the OCMW often have the feeling of being 'the bad cop' without much discretionary room, while the case managers always could play 'the good cop'. This often leads to tensions and misunderstandings.

> *"Sometimes consultation is lacking, e.g. powdered milk. Not everyone is eligible and without consultation, beforehand, they say 'go to the OCMW'. Consequently, we are the bogeyman. That requires means testing (social inquiry), then the trust between client and social worker is broken, not enough contact sometimes." (Workshop with frontline workers, participant: social worker from OCMW Kortrijk)*

Conversely, the OCMs often air frustrations about other, mainly social assistants of the OCMW. Particularly when there seemed to be unwillingness to understand the broader context, or when the vision of the social assistant was not client-centered, when they refused to think proactive,… In one of the focus groups with the case managers these concerns were clearly expressed and linked to specific examples.

> *Researcher: "statement two: I am confident that other care providers defend the rights of the client as strong as I do".*
>
> *Laughter*
>
> *Outreaching case manager: "euh, take the example of a homeless couple living on the street, wandering around in the streets and so on. She has been suspended from leefloon [social assistance benefits] and has to comply with a lot of conditions to become eligible again, but the social assistant refuses to write a letter for them so they can access food, clothing, to do something. So, then I think, well yes, that is not really defending her rights… like we do."*
>
> *Researcher: "how do you react to that?"*
>
> *Outreaching case manager: "well, I act inconspicuously, you know, because she doesn't allow me to do anything anymore. The social assistant doesn't want me to interfere. I can't accompany her anymore, so, … So, I continue my work with her and ignore the social assistant" (focus group with the case managers 21/09/2018 – discussion on the statement: 'I trust other care providers to defend the rights of the clients just as hard as I do').*
>
> *Outreaching case manager: "I think a lot of good happens with certain colleagues, but I am also convinced... You see that sometimes, sometimes it is tilted too much, in my opinion, towards duties and for the rights, they will look for what people ask, but not broader, what else can they apply? Yes, I often lack a broad look by other services."*
>
> *Experience expert in poverty: "Many social professionals work like OK, if people want something, they will ask for it, but they just do not have the necessary information. Half of them do not know their rights, so they cannot ask for them." (focus group, outreaching case manager/researchers - discussion on the statement: 'I trust other care providers to defend the rights of the clients just as hard as I do')*

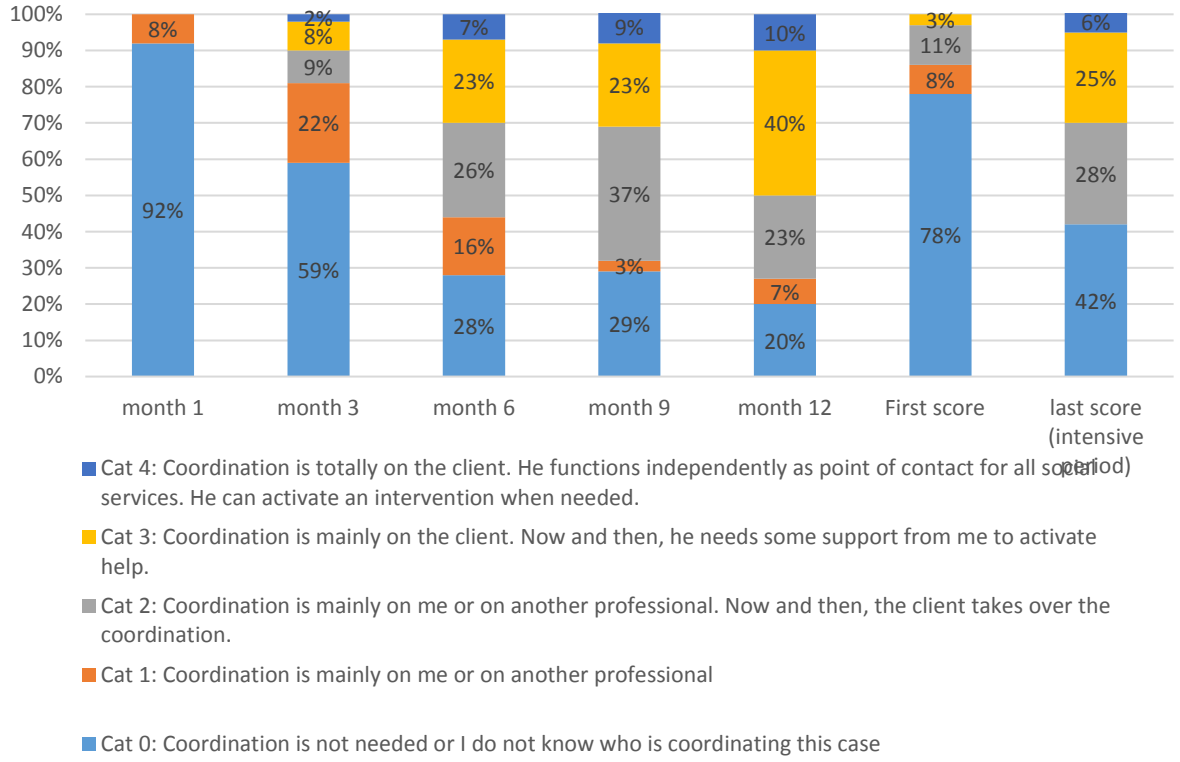
Improving coordination

In the outreaching case management methodology, coordination was incorporated as an important guiding principle. In the monthly logbooks, we distinguished three different dimensions of the principle 'coordination': the main actor in the coordination, bridging coordination problems and the activation of supply.

Coordination: main actor

The first dimension of coordination is related to the 'main actor'. The outreaching case manager (OCM) scores who is taking up coordination: is it mainly the professional (category 1 + 2) or is it mainly the client him/herself (category 3 + 4)?

FIGURE 10. WORKING ON COORDINATION MAIN ACTOR OVER TIME AND FIRST/FINAL SCORE IN INTENSIVE PERIOD



It takes some time to get a view on the case as a whole: who is involved in this case and what are the competences of the family regarding coordination? 92% of the cases start in this category, mainly because the case managers are convinced that you have to give it some time, and you have to work on the relationship between case manager and the client. So they just don't have a clear view on this after one month.

> *"I try to identify which other (professional) actors are active around my client and how they respond to the needs of my client, but so far I have little insight into this." (Logbook registration, guiding principle coordination: main actor, C9, month 1/10; score 0)*

A score of zero later in the intervention means that little assistance is needed, or that the case manager does not have a sufficient mandate to take on the coordination of support for the family. The client does not want the case manager to be involved, yet in many cases other social services refuse to give control to the case manager as well. This makes it hard to get an overview on the case and it puts the client in a difficult situation: other services often have more influence than the case manager since the case manager is never the primary gateway to professional support.

> *"Not enough view on the whole case. The man tries to arrange everything himself, but I notice that this is not going well. His social worker does not coordinate either, since it is already the 4th one. As a case*

manager, I am unable to achieve this / it is difficult because I have to get in first." (Logbook registrations, guiding principle coordination: main actor, D18, month 10/14, score 0)

"There is not really coordination going on, but I do feel a need for it myself. There are various services involved, but I have no idea who actually takes on the coordination. I sense that the social worker keeps the 'strings' tight in her hands and does not communicate with me." (Logbook registrations, coordination: main actor, D20, month 4/12, score 0)

In 41% of the cases, coordination gradually improved within the first three months – in half of the cases, coordination lies **entirely in the hands of a professional**. At the beginning, the OCM takes up this role to manage the case and to enforce a rapid improvement in the situation (as a whole). The qualitative data show that the OCM takes control if and when the impact of not doing this would otherwise be too severe.

"Previously, the client took the initiative to contact other services (e.g. arrange relocation at telenet / contacts with contractors). It now appears that a number of things are going wrong here. That is why I am once again taking control, partly because of the importance that the move could continue shortly." (Logbook registrations, guiding principle coordination: main actor, E10, month 4/21, score 1)

From three months onwards, we observe a positive evolution towards activation of coordination and a cooperation between OCM and client, where in some cases the OCM has the overview, and in other, the client does. This depends on the capabilities of the client: when the client is sufficiently capable she/he takes control. If not, the OCM takes over. A score of 1 means that the case manager estimated that the client was 'not capable of taking over', or was 'not willing'. For the OCM, the client has the right to choose not to function as point of contact. They stimulate this, but they will never force the client to take over control of the coordination. If the client wants or needs the OCM to take over the coordination, she will do so.

"As stated in previous registrations, I think that there is little margin for growth in this area (due to various factors – mobility, age, language barrier)." (Logbook registrations, guiding principle coordination: main actor, B17, month 15/16, score 1)

"Contacts with SVK De Poort and OCMW are taking care of the family itself. Nevertheless, the presence of the case manager remains very important: if only it is that family can use my mobile." (Logbook registrations, guiding principle coordination: main actor, A2, month 8/25, score 2)

Cases in which the families take on the coordination themselves were usually 'stronger' clients, who were able to oversee and keep track of their own situation. These cases already scored higher at the start of the intervention. Support is needed for a number of practical barriers – such as language or because the client is too uncertain / would like additional confirmation from the counsellor.

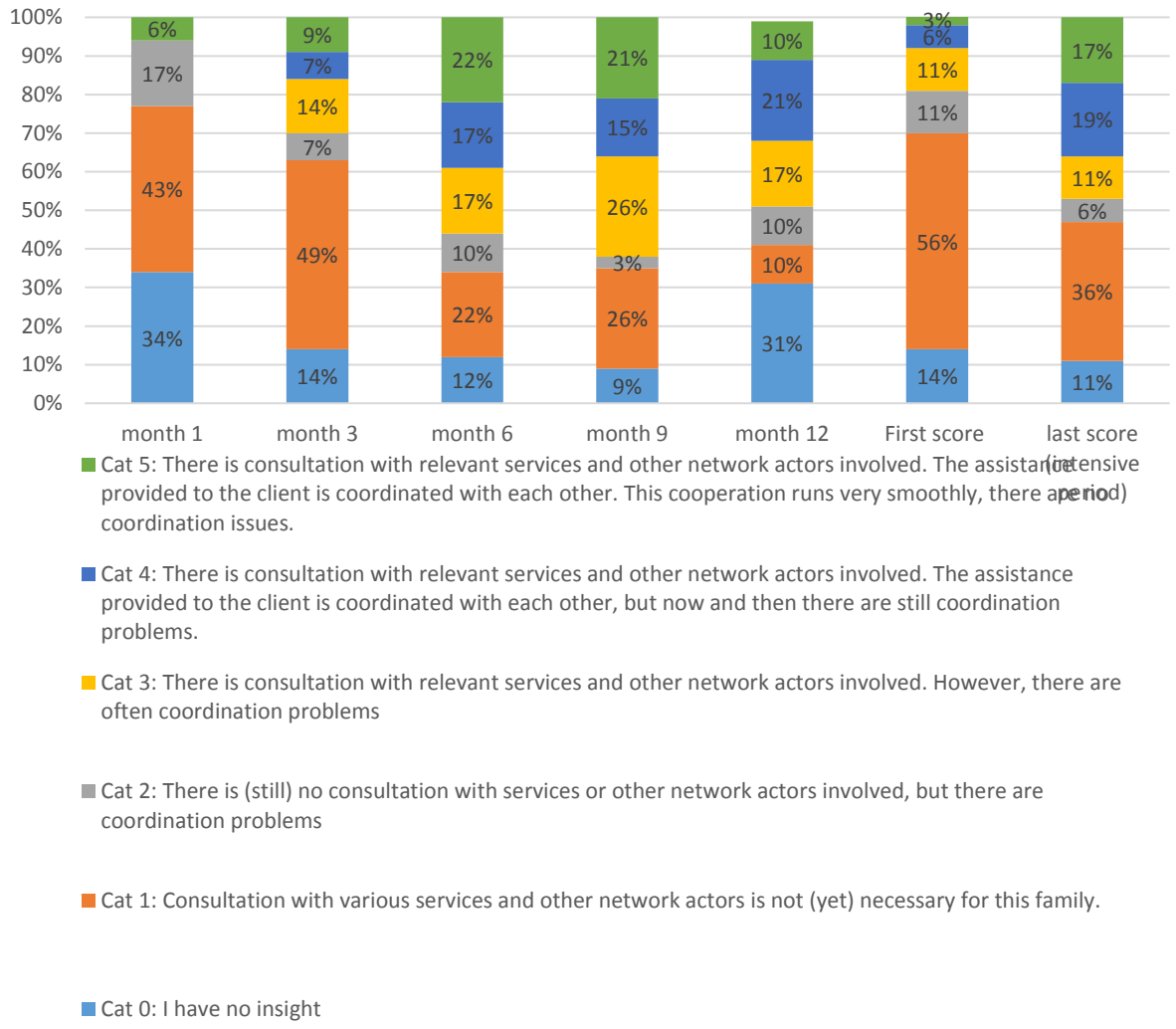
"Initially, the family did not make much use of services, but by going once to all the different agencies that can offer them support, I feel that the family is on track. They find their way and make appointments themselves." (Logbook registrations, guiding principle coordination: main actor, B4, month 2/17, score 3)

Unfortunately, most clients are not capable to take the coordination entirely on themselves without support from the case manager. Only 6% of the cases are scored in this category at the end of the intervention. According to the case managers, this is not due to the capabilities of the client, but due to the inaccessibility of our social services.

Coordination: bridging coordination problems

Other services are often involved to help the client. In the literature it is stated that tensions are inherent to cooperation between organizations or professions. Here we examine the extent to which there are coordination problems between service providers and whether there were consultations between them.

FIGURE 11. WORKING ON COORDINATION BRIDGING COORDINATION PROBLEMS OVER TIME AND FIRST/FINAL SCORE IN INTENSIVE PERIOD



At the onset, the outreaching case managers indicate that in about a third of the cases they do not have insight into this working principle and in 43% of the cases consultation with other services is not (yet) needed. The logbook registrations show that the outreaching case managers often find a consultation too early in the intervention of these cases. For example, in the beginning they do not have a full view of all the services involved - if there are any - and perhaps even after a thorough exploration of the rights of the client additional service providers could be involved. In this exploratory phase, the OCMs indicate that there are already contacts with other service providers, to get acquainted to each other or to coordinate one to one, but a client-centred consultation meeting with all or part of the services involved is not yet possible. Also, it is often unclear at the start of the intervention whether and between which services there are coordination problems. In addition, we see that these categories are also indicated- but to a lesser extent - if the coordination is taken up by another service provider.

"There has already been contact with various care providers, but a consultation is not yet under discussion. They know for sure that I am involved and also contact me to coordinate, but this is 1-on-1; there has been no global consultation yet. I am still busy getting to know the family, as well as mapping the needs and wishes of the family. Once I have an idea of this and also know what else needs to be done (so first do active screening of the rights), then a consultation seems definitely appropriate." (Logbook registrations, guiding principle coordination: bridging coordination problems, B27, month 2/3, score 1)

As the counselling progresses, the OCMs get to know the clients and their situation better, they gain insight into the services already involved and additional service providers are often involved. The "I have no insight into this" category becomes less important over time. This category is usually only relevant if the OCM had little or no contact with the family or if the coordination is done by someone else.

On the other hand, the category 'consultation is not (yet) necessary' remains clearly present with still 31% of the cases at 12 months. In the logbook registrations, the OCMs indicate that in cases where there are few service providers involved or where there is a well-defined problem, one-to-one coordination is sufficient, and a client-centred consultation meeting is therefore not necessary. It can also happen that there are simply no coordination problems or that the coordination problems are mainly situated in cooperation with one particular service, as a result of which the outreach case managers do not consider a general consultation necessary. For some of the cases, the outreach case managers indicate that consultation is (perhaps) necessary, but not yet applicable. For example, the client himself can hold back a consultation.

"The problems are too delineated to do a consultation now. For example the general practitioner + AZ Groeninge are working on the medical part, De Som on integration, ... I don't think it makes much sense to put all the people together around the table." (Logbook registrations, guiding principle coordination: bridging coordination problems, B26, month 4/6, score 1)

"Consultation is more than necessary in itself, but is not possible without the client." (Logbook registrations, guiding principle coordination: bridging coordination problems, B19, month 12/13, score 1)

We also note that in 17% of the cases there are coordination problems from the start. The further the intervention progresses, the more cases there are where this pops up (category 2, 3 or 4). The outreaching case managers indicated various challenges:

First, sometimes there's **insufficient communication** between the services involved, as a result of which the current state of affairs regarding a case can be unclear.

"What about the activation process? A lot of uncertainties: is there daycare? When does the internship start? How to coordinate everything?" (Logbook registrations, guiding principle coordination: bridging coordination problems, A4, problems, month 15/24, score 3)

"If there are coordination problems, this is often because the client actually does not communicate sufficiently. For example, she receives € 80 from her available budget per week if her daughter is not with her, and € 120 per week if her daughter is there. Because of an argument with her father, the daughter was now with my client longer. She then sends angry text messages to me or e-mails to her social worker that it is irresponsible with € 80 to make ends meet, living with a daughter. Then it appears that she had not told anyone about this change, not to me nor to her social worker. We have already mentioned several times that it is only in her advantage to communicate everything properly, only then the assistance can coordinate with this." (Logbook registrations, guiding principle coordination: bridging coordination problems, B15, month 10/18, score 4)

Second, there may be **uncertainties or conflicts regarding one's role**. For example, the OCMs state that other service providers sometimes (too) strictly adhere to their own tasks, which means that the OCMs cannot help but resolve matters themselves. In addition, it also happens that certain tasks are not solved sufficiently or quickly enough, leading to frustration. Furthermore, things can be forgotten because service providers assume that someone else is already working on it. For the client, these role conflicts or ambiguities are reflected, for example, in getting conflicting messages or even a financial setback.

> *"Fact is that because of various service providers involved, who all assume that everything will be okay/ will be followed up or have been handled, there was too much confidence in the good outcome and too little in the actual implementations, so that ultimately months after the date, things arise that can affect the person concerned. (Termination of rental contract not signed by the owner, transfer of meter readings not passed on by the owners ... as a result of which the person involved still receives invoices from a house where he has been away for 2 months ...)" (Logbook registrations, working/hindering factors, C18)*
>
> *"Time shortage OCMW: social worker almost has no time to prepare application for urgent support + application for an imposition on top of the living wage took a long time. Eventually, the case manager requested urgent support through another OCMW colleague and went to the family to hand it over !!! = another lucky thing that the case manager does have / makes time + is flexible to intervene in such crisis situations" (Logbook registrations, working/hindering factors, A13)*
>
> *"At the beginning of this month, a consultation took place with the CAW, client and myself from MISSION. The worker of the intake team was no longer able to take on the assistance of this woman since she is no longer registered for women's care. At that consultation, we agreed (with the client's agreement) that this would be taken over by the housing service from CAW. This social worker was also present at the meeting. It was explained what this housing service exactly means and practical agreements were made. The following week, the housing counsellor calls me with the message that she cannot take this assistance after all, because a social worker is already involved with this client. I explained that it is my job from MISSION to point people to services that can offer permanent assistance; in fact I merely have a bridging function. I also said that the project will end at the end of November. She told me that I can sign up at the end of November if there is no other solution for her. She also could not start because she is convinced that Mrs. needs other help (such as a psychiatric hospitalization). I can agree with this, but Mrs herself does not agree with this at all, but she does want to start housing assistance via CAW. Nevertheless, it cannot be started anyway. I think this is a typical example of supply-driven work and so the pitfalls of it become clear. To Mrs, this also creates a strange picture: first, arrangements are made with regard to housing assistance, the following week she receives a telephone that it will not be started anyway." (Logbook registrations, working/hindering factors, B13)*
>
> *"Registration for social housing: team living follows up but does not run smoothly. I pointed out that the registration nevertheless forms part of the duties of a housing counsellor." (Logbook registrations, working/hindering factors, A19)*

In addition, issues arise regarding **control and a different view/identity**. For example, OCMs sometimes disagree with the expectations that other service providers or professionals have with regard to the client, they experience that other services are taking a dominant role in the support offered to families, or they report differences of opinion about what can be helpful to the person concerned or how the situation should be addressed. In some cases, this tension is exacerbated by a negative perception of each other: where the OCMs state that some specialists do not stand up enough for people in poverty, they in turn blame the OCMs for being too soft on the clients. This has an impact on the communication between services. The perspective/view of other services can also clash with the client and vice versa, in such case the OCM often stuck in the middle.

"Turning the man's request for help to a hospitalization in my eyes: I had drawn up a plan of approach together with the man and passed this on to the social worker when applying for his leefloon [social assistance benefit]. Afterwards she asked if it is not better for the man to go into hospital and I got a list of possibilities from the other social worker to discuss with the man. I don't think it's my job to discuss their (hidden) agenda with the man. The fact is that they are in a dominant position whether or not to apply for a leefloon. Where is the equivalence of social workers who work for the same organization? Do we not all have the same position and 'power'? And why does this power and dependence game continue to last? The couple can't get any further with that. The accusation that I have not discussed the list of hospitalization opportunities with the man and that I do not communicate openly because the social worker did not know that the man had to be appear and did not know the state of affairs about the move out." (Logbook registrations, working/hindering factors, D20)

"Contact with social worker from team budget and debt assistance: she does not want to keep the man's file open if she does not hear from him at the end of the month. Dependence of people who ask for help. For-what-should-what principle of social worker." (Logbook registrations, working/hindering factors, D20)

"It is about searching for the right coordination with the social worker regarding a number of applications. She remains convinced that the family, with their current wage from work, can handle themselves." (Logbook registrations, guiding principal coordination: bridging coordination problems, D17, month 9/14, score 4)

At the start of the intervention, we see that in 17% of the cases where there are coordination problems there's no consultation (yet) between the services involved. This category decreases in time. The OCMs indicate that the reasons it did not yet happen can be various: the OCM is still involved in the organization of a consultation, inaccessibility of services or clients (whether or not due to leave periods), the client does not give permission / is suspicious of (certain) services or the consultation is not considered necessary or even blocked by other care providers.

"The situation remains very complex because it involves various services. The family consists of a mother and daughter with various services involved, namely: budget management OCMW -someone for the daughter and someone for the mother - a legal administrator for the daughter and a debt mediator for the mother. All these parties (including the family) have different interests. Coordination becomes difficult. The administrator did not consider consultation necessary. Mother has never seen the debt mediator: takes a very long time. Communication between different services. Coordination is necessary but continues to drag on." (Logbook registrations, working/hindering factors, A22)

"Fact that there are caregivers who do not want to consult and therefore do not respond to questions asked, which causes a lot of lost time and energy and also ensures a very unprofessional attitude towards the person concerned." (Logbook registrations, working/hindering factors, C3)

"There is quite a lot of consultation between myself and my colleague social worker within the OCMW and also the other service providers. Currently, the daughter is not open to a consultation, although we would like to organize this. She finds it too threatening." (Logbook registrations, guiding principle coordination: bridging coordination problems, E10, month 9/21, score 2)

Over time, coordination problems are increasingly accompanied by consultation (category 3 and 4). The registration shows that "consultation" was interpreted as consultation with one other service as well as a few services (often theme-dependent) or all involved services. Although at the start of the project the OCMs often indicated that they were coordinating one to one and were reluctant to organize a client-centred consultation meeting with all or part of the services involved, we see that this is ultimately done in quite a few cases. In those

cases where a client centred consultation meeting took place, it was experienced as an effective tool in clarifying mutual expectations and roles and informing those involved about the current state of affairs in the client's situation. According to the outreaching case managers, a client-centred consultation meeting can also be useful at the end of the intervention, before closing a case. Clients as well experienced that a client-centred consultation meeting can yield benefits.

> *"We tried to coordinate everything better through a client-oriented consultation meeting. This involves that we cancelled 'unnecessary' assistance (because this involved many practical difficulties). For example, we cancelled the psychological counselling of the son, but this was embedded in the REVA with the necessary transfer. This meant that the family had to drive back and forth less often and this also brought a number of financial savings. A structural consultation meeting was built in between a number of services (e.g. parents, school and rehabilitation centre). All this has ensured that the assistance is better aligned and that the family has hopefully gained more confidence in themselves." (Logbook registrations, working/hindering factors, B14)*
>
> *"The ability to have an external client centred consultation meeting on a regular basis results in clarity for all actors, gives insight in the various steps taken by the family and creates a shared responsibility in the care for the family." (Logbook registrations, working/hindering factors, D19)*
>
> *"We had certainly 10 supportive services and she brought this together in one package. She advocated I couldn't cope with it alone anymore, due to the stress. She then arranged a client-centred consultation meeting. 'She has to drag herself from one place to another. You all expect totally different things of her, and she cannot handle this anymore'. And then she noted down who could arrange what. She balanced it all. And then she followed up on it and if something didn't happen, she said 'Come on, let's send an email to ask why it still didn't happen'. You have to have somebody with knowledge who also can leave the comfort zone. Many agencies tell you 'We are not allowed' and 'We cannot interfere with that'. Then I think it is too strict, too much by the book. But people don't live by the book. Everyone needs something else. You get a bond with them for who they are as a person, not because of what the learned". (Client interviews, client 5)*

The outreaching case managers hereby indicate that organizing client-centred meetings requires a great effort. For example, it can take a long time before it is practically possible to get everyone together, and tempers can flare when certain services refuse to sit around the table with each other.

> *"Already several attempts to meet with the involved actorsbut did not succeed yet." (Logbook registrations, guiding principle coordination: bridging coordination problems, D16, month 4/15, score 3).*
>
> *"When looking at this case more closely – we see that the client centred meeting with all actors has failed to succeed. Communication between case manager and the involved social assistant could only happen by phone. The case manager could however support the client in having a conversation with her OCMW social assistant. The lady had a conversation with her social assistant only about her financial situation and she was satisfied about the contact. The possibility for a new TV-connections has yet to be looked at." (Logbook registrations, guiding principle coordination: bridging coordination problems, D16, month 6/15, score 4).*
>
> *"There is definitely the need for a client centred meeting with all involved partners. I have been indicating this for some months now, but we don't succeed. Now, for example, the family is on vacation and a lot of care providers too." (Logbook registrations, guiding principle coordination: bridging coordination problems, B14, month 7/17, score 3).*

Furthermore, consultation, in whatever form, appears to be no guarantee that coordination problems have been resolved. We see that the proportion in category 3 "there is consultation but there are often coordination problems", is about 14% in month 3 and is still about the same after one year. First of all, this category is indicated if there is an initial consultation but it is not yet clear who will take up which part of the assistance, coordination is still being sought. This may explain why this category increases as time passes, before falling back again at 12 months. In other cases, problems are identified that are more difficult to solve, for example conflicts of interest or visions persist despite consultation, care providers only continue to think from their own expertise which makes it difficult to align them, persistent poor communication or the client refuses to consult between certain services.

> *"Due to a lack of confidence, there is little room for consultations. There is communication to a certain extent but also a lot of coordination problems because person concerned indicates consultations are not allowed." (Logbook registrations, guiding principle coordination: bridging coordination problems, C12, month 10/17, score 3).*
>
> *"One does not see or realize how important it is for person concerned to first work on the addiction problem meaning we have to slow down a bit." (Logbook registrations, guiding principle coordination: bridging coordination problems, C15, month 8/16, score 3)*
>
> *"Not really the feeling that the other services are thinking together with me about solutions for the bigger picture. Own expertise." (Logbook registrations, guiding principle coordination: bridging coordination problems, C13, month 8/13, score 3)*
>
> *"Still problems with coordination. Even after the big meeting of last month, no/little communication between the services and little alignment." (Logbook registrations, guiding principle coordination: bridging coordination problems, A22, month 7/9, score 3)*

It also happens that coordination was achieved during a meeting, but coordination problems nevertheless - and sometimes quickly - arise again. The unavailability of a service or client plays a role in this.

> *"I went quite well after the first meetings, now the impression that it is going down a bit. Could be because person concerned was less available the past period." (Logbook registrations, guiding principle coordination: bridging coordination problems, C10, month 5/20, score 3).*

In addition, after a meeting, there may be a "feeling" of coordination, but afterwards it appears that the services are not yet aligned.

> *"I had asked her social worker to follow-up on her more closely. I can't mean a lot to her anymore, I have administered (in my opinion) all possible rights. There are few services actively working with this family, so I could work little on coordination and alignment. It is a pity that Mrs. waits until the last instance to contact her social assistant from the OCMW (often too late). That is why I agreed with her social assistant he would take the initiative himself. After our talk, he called her and gave her an appointment. This appointment could not go ahead, but he did not make any effort afterwards to call her again. We know that this is precisely the pitfall of her, hence my request to work very closely. I had the impression that the social assistant understood the situation, but in practice it turned out not to work very well. I could discuss this again with him, but of course it is not nice to have the same conversation over and over again." (Logbook registrations, working/hindering factors, B10)*

To prevent a negative evolution, the OCMs indicate that after consultation with other or all service providers it is necessary to follow up on the agreements made. If this is not feasible for the client, a professional must take up this task. A pitfall with the latter is that other services do not feel responsible for the case and, for example, do not take the initiative during the leave of that person to follow up the situation further. Longer periods of absence can thus result in a standstill or even deterioration in the client situation.

> *"We have organized a client-centred meeting this month. I notice how it is important that the agreements made at the meeting are coordinated by 1 specific person. In the best case, this is done by the family itself, but in practice it is usually me who takes this on. I usually make a report or summarize all agreements on e-mail and indicate who is responsible for follow-up. After a few weeks I ask what the state of affairs is and what is possibly difficult / where I can help." (Logbook registrations, working/hindering factors, B16)*
>
> *"During the consultation in November it was agreed that one of the service providers involved would file an application for 'parental and contextual support'. This would happen via Konekti. In the meantime this has still not happened. It is generally speaking really necessary to follow up on agreements with other care providers ..." (Logbook registrations, working/hindering factors, E3)*
>
> *"The fact that it is expected that 1 person coordinates, and if this person no longer is available (despite the fact that this was agreed), then it is ruined. For example: coordination by the outreaching case manager. A handyman working in the house of the person concerned (necessary for future steps) becomes ill. No problem, make a new planning, case manager goes on leave and by return nothing of what was planned has been executed. No one of the involved service providers, despite the fact that it had been agreed to follow up on the situation during leave, took the initiative to search for another solution to solve the problem with the handyman." (Logbook registrations, working/hindering factors, C15)*

At 12 months we see that the share of category 4, "there are consultations but occasionally there are coordination problems", is about 17% while the percent of cases in which there are frequent coordination problems is smaller (10%). Category 4 is mainly indicated when the assistance is in progress, with now and then an intervention because of, for example, different expectations with regard to the client or a different pace. It is a continuous search for balance. Also, coordination concerning the roles, especially during leave periods, starting up a new service or a change in the client situation, often remains applicable in this category if the client does not manage to do the coordination himself.

> *"I have the impression that everything is coming together in a good way. Every 'problem' has a solution or a service provider was mobilized to bring in support. Now budget management has started. In the first month this is still a bit of a search and there is a lot of coordination needed with the family and with the debt mediator." (Logbook registrations, guiding principle coordination: bridging coordination problems, B18, month 8/14, score 4)*
>
> *"Most of the times a good cooperation, sometimes little differences in how things are being approached but this is not problematic." (Logbook registrations, guiding principle coordination: bridging coordination problems, C18, month 8/13, score 4)*

The fact that consultations with services pay off not only appears from the increasing share of cases where there are only occasional coordination problems, but also from the "smooth cooperation" category. We see that the share of cases in which there is a smooth cooperation without problems is small at month one (about 7 %). This is initially only indicated if the coordination is already taken up by someone and a client-centred consultation meeting periodically takes place or there is only one other service involved with whom there is a good contact.

The number of cases in this category increases over time: from 7% in month one to about 20% from 6 months on. Hereby the outreaching case managers note that there must not necessarily be very regular consultations. Once the services are aligned, it can also be maintained through occasional telephone contact. The importance of following up agreements made is also emphasized in this category.

> *"Looking back at the past month, the cooperation between Kitty, renovation coach Jan and Layla (from the team on energy-poverty) went very well. There was a clear communication and everyone knew what to do and what to follow-up on." (Logbook registrations, guiding principle coordination: bridging coordination problems, D7, month 24/24, score 5)*
>
> *"This month a client-centred consultation took place. At this meeting we discussed everything we were still working on and designated a 'responsible person' for every need and made sure that everyone (every caregiver and every family member) was on the same line." (Logbook registrations, guiding principle coordination: bridging coordination problems, B16, month 12/17, score 5)*
>
> *"Consultations took place several times in the past and this is one of the reasons why there are hardly any coordination problems. Now there are no more consultations, but I certainly have the impression that the different service providers find each other in an emergency, and that communication between each other is good." (Logbook registrations, guiding principle coordination: bridging coordination problems, B9, month 15/22, score 5)*

According to the outreaching case manager, when the services are well-aligned, they each do a little more than their set of tasks, they strive together for the best for the client, think together, et cetera, it benefits the client.

> *"The cooperation between the various service providers and the ongoing consultation made it possible that we kept looking in the same direction and that the person concerned has experienced that we want to support the family to get back on track. Because the various service providers applied for a 'crisis home' together, this could be arranged faster (because it was clear that the family was sufficiently supported)." (Logbook registrations, working/hindering factors, C19)*
>
> *"The Child & Family district nurse did more than her duty. I find it very positive to note that fellow service providers are doing everything possible to help families move forward. It makes her an important confidant for the client." (Logbook registrations, working/hindering factors, E17)*

Finally, the outreaching case managers indicate that, even though the assistance is coordinated, and it is clear who does what, the client can still simply choose the most accessible social worker to ask his questions.

> *"Sometimes Mrs. contacts me instead of another more specialist professional more familiar with the nature of her specific question. For example: her ex-partner informed her she still had a debt to settle. She asked me for advice. I gave her my advice but told her that in the future she should consult her social assistant responsible for her budget management because she is more specialized in this matter. Mrs. knows very well who to contact with her questions but I think I am more available, so she contacted me (she wanted a quick answer because she was worried). The single point of contact is a big added value too." (Logbook registrations, guiding principle coordination: bridging coordination problems, B7, month 21/24, score 5)*

Further analysis of the final intervention phase shows that case manager C has considerably more cases where there are still coordination problems. A focus group with the outreaching case managers shows that this case

manager was more often confronted with differences in vision or identity through more frequent cooperation with certain social workers. Differences in vision are a stubborn barrier to achieving good coordination.

Linked to client characteristics, it appears that this method pillar is related to estimated accessibility of the family. Cases where the outreaching case manager failed to start cooperation without problems are estimated to be less accessible. As such, coordination problems cannot always be explained by poorly functioning support, sometimes the client is simply not open to it.

> *"I suggested to him to organize a client-centred meeting because expectations are not very clear to him. It is equally important that he can relate to these expectations; that they are feasible and create an added value for his quality of life. That is why I suggested the client-centred meeting. He initially agreed with it, but now, again, he is very hard to reach. Therefore the meeting could not take place. The other care providers are open to such a meeting." (Logbook registrations, guiding principle coordination: bridging coordination problems, B23, month 3/9, score 2)*
>
> *"We planned a consultation. The client did not show up so we discussed shortly, without her, how we will continue to try to contact her." (Logbook registrations, guiding principle coordination: bridging coordination problems, E17, month 5/10, score 3)*
>
> *"Individual consultation with the other service providers is already in place, now and then together with all the involved service providers together with the person concerned, but it is certainly not going smoothly. The person concerned does not really like a consultation with the various service provider." (Logbook registrations, guiding principle coordination: bridging coordination problems, C1, month 10/27, score 3)*

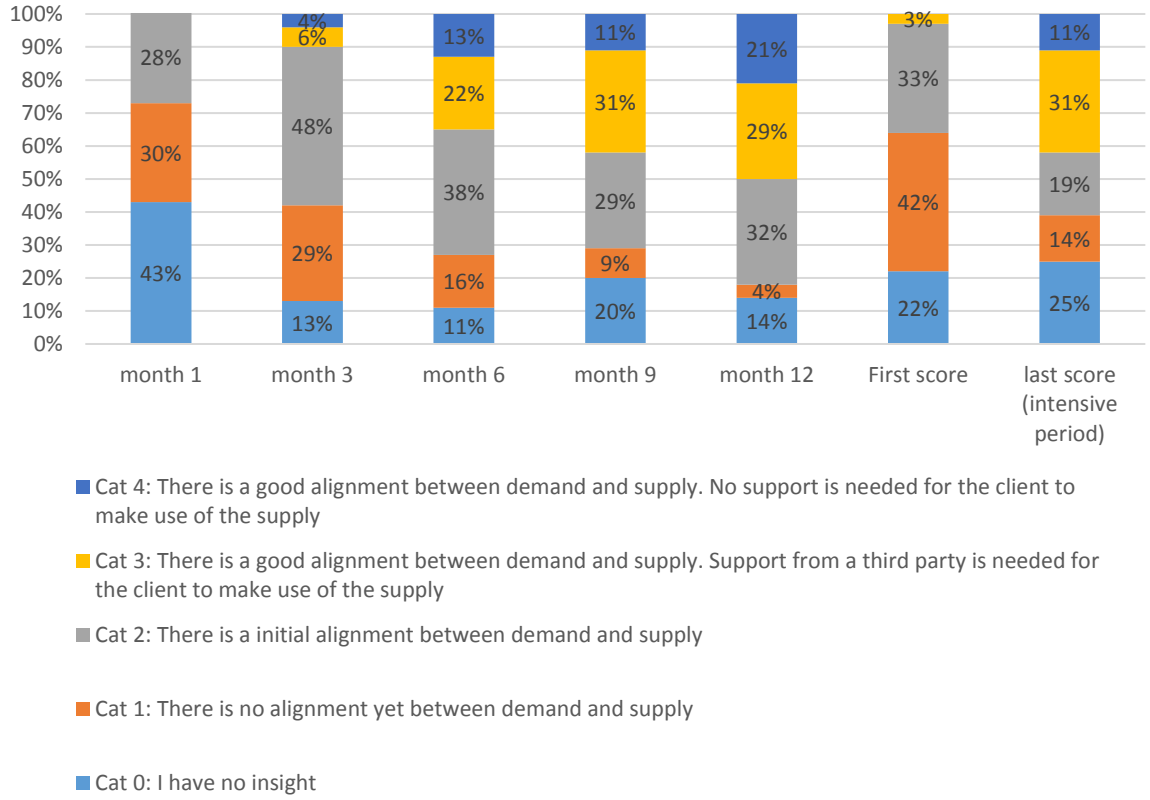
During the focus group with frontline social workers in Kortrijk, it became clear that coordination is seen as a major added value, it makes the OCMs different from other services such as frontline liaison workers. However, a few frontline workers indicate that this coordinating role can be taken up even a bit more by the OCMs. The inaccessibility of a family is one explanation why this is not the case in all families, even if it would be useful in that situation.

> *"For me, the biggest added value is the coordination of the care providing process. We also do a lot of work done by the case managers, meaning outreach work, we can work as far and as intense with the families as we think is necessary. But coordinating the process is a big task because it means contacting people, bringing them together, evaluating, making a report, sending e-mails. This we cannot do, it is not a part of our duties because we are frontline workers and not coordinators. But sometimes we also do it where necessary and where there is no case manager, but then we actually go a bit beyond our range of duties." (Workshop with frontline workers, social worker from OCMW Kortrijk)*
>
> *"It is a gift to take over such a family/guidance. A lot of things had already been taken care of: budget management had already started, for the children etc, a lot of information on the family, close contacts with the care providers around the client, contact with a lot of liaison care providers around her, and if I have questions, she (the case manager) still is available." (Workshop with frontline workers, other service provider)*

Coordination: Activation supply

This guiding principle is about the search for balance between the needs of the client and the activation of the supply of support. Regular consideration of this balance ensures that the support and services used by families are in line with the actual needs of the family. Best case scenario is when needs and supply coincide.

FIGURE 12. WORKING ON COORDINATION ACTIVATION SUPPLY OVER TIME AND FIRST/FINAL SCORE IN INTENSIVE PERIOD



The results in Figure 12 show that outreaching case managers (OCMs) do not start working immediately on the alignment between demand and (activating of) supply. First they take time to get to know the family and to get some mandate to work on a better balance between needs and supply.

> *Some professional actors are already involved, but it is not clear whether this is tailored to the actual needs of the client. I do not have a clear view on this because needs have not yet been clearly identified (Logbook registrations, guiding principle activation supply, C13, month 1/13, score 1)*

This first category further decreases during the intervention, but is still regularly scored when the case manager feels that the offer is not being activated or that it does not adequately match the request for help.

> *The client may have a leefloon [social assistance benefit], but the relationship with her social worker has not changed. The woman wants someone who listens to her and does not say what she can and must not do and increases the pressure. (Logbook registrations, guiding principle activation supply, D20, month 7/12, score 1)*

Nevertheless, we do see that in many cases a quick restart can be made in the coordination between request for help and assistance; The second category rises from 28% after the first month to 48% after three months. The qualitative data show that at the beginning of the intervention this score is mainly given to cases where support was already present from the start. The scores in the following months are more about the lines that are drawn at the beginning of the intervention.

Initially her most 'urgent' problem was the fact that the family did not have an income (both her sickness and unemployment benefits remained under investigation and by the time I got to know the family, they had not received any income for 3 months with the exception of child benefits). I then brought them into contact with the OCMW to apply for a leefloon. In the meantime, we have also taken the necessary steps to make sure the sickness -and unemployment benefits. When it turned out that she also had numerous debts, we also sought the necessary help from the OCMW for this. In addition, we have also established contacts regarding childcare, education and activation. (Logbook registrations, guiding principle activation supply, B16, month 4/17, score 2)

From month 6 onwards, this category drops until 30%. In particular, in cases that continue for a long time (up to 24 months), slower progress is made. When comparing the start of the intervention (first score) and end of the intervention (last registration in intensive period), 33% of the cases are started in this initial phase, and 19% also ends there.

I think the decision to stop debt mediation is a step backwards. The family still needs support in various domains. I am now looking which services can be activated. I already contacted the nurse from KenG and the OCMW. (Logbook registrations, guiding principle activation supply, B16, month 16/17, score 2)

The slow progress in this lack of alignment between demand and supply is sometimes linked to the supply-side, but often we see that the client plays an important role in this. It is not because needs are clear, that the client is immediately ready to take action. It is remarkable that in the qualitative registrations, the OCMs refer several times to the psychological vulnerability of families which makes it difficult to achieve a good match between supply and demand.

"I find it difficult to give a correct answer here. One moment the assistance runs smoothly and there is a good contact between the client and the various actors involved. The other moment she is angry, she wants to stop all guidance and she needs to know nothing more. It remains a constant search for what she wants and what she 'really wants'. Maybe I am too close here, which makes it difficult for me to see it anymore? (Logbook registrations, guiding principle activation supply, D9, month 7/22, score 2)

In a number of cases, the need for strong management ensures that a file remains 'stuck' in a lower score for coordination: as soon as the OCM drops out, the coordination between request for help and assistance quickly diminishes.

"I have been on leave for 5 weeks and I see that the assignment between need and supply can be compromised very quickly, certainly with this client. For example, her address was officially canceled and she therefore no longer received her income replacement benefit. We were able to get all this back in order relatively quickly, but the client would probably never have succeeded on her own (contacting the local police officer and town hall to put the domicile back in order, contacting the FPS SZ to get the benefits in order request from the OCMW to request advances for bridging until the payment is in order again, ...)". (Logbook registrations, guiding principle activation supply, B17, month 13/16, score 2)

The last two categories are indicated when the OCM has the feeling that there is a good match between the demand for help and the activation of the supply. For obvious reasons, these numbers grow during the intervention. From month 6 onwards, these categories cover 35% to 50% of the cases. At the end of the intensive period, 42% of the cases are scored as 'there is a good alignment between need and activation of supply – with or without support of the case manager'.

Every month I see that we are getting closer to a good, structural match of needs and supply. The family indicates that starting up budget assistance and debt mediation makes a world of difference for them. They have more space financially and they have the impression that they are finally getting ahead (the family's own words). (Logbook registrations, guiding principle activation supply, B18, month 9/14, score 3)

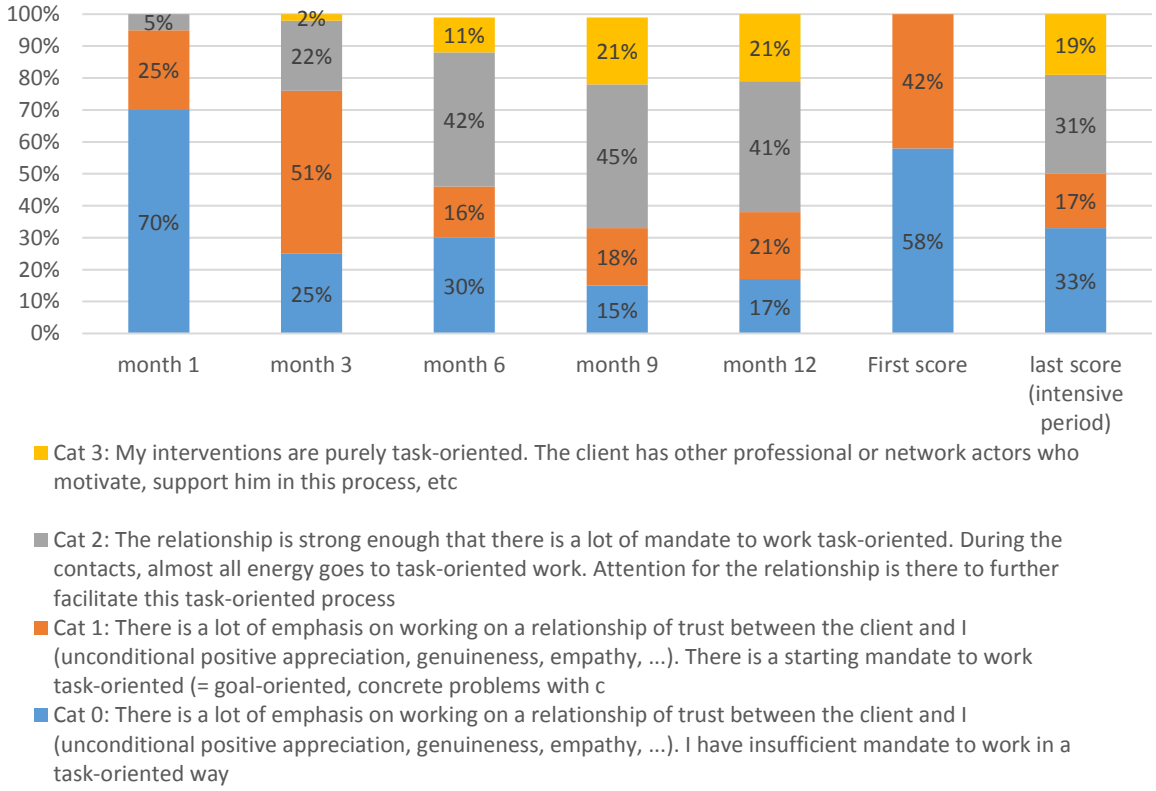
The difference between a good alignment with and without support is mainly due to the capacity of the client. In cases where guidance remains necessary, the OCM plays an important supporting role towards matching needs and supply. When the OCM has the feeling that the client can do it himself - or does not allow control - they indicate the fourth category.

The right services were approached and are active around the client but they do not work together and if the client encounters a question or problem, he always comes to me. (Logbook registrations, guiding principle activation supply, C1, month 12/27,score 3)

Working task and person-oriented

The intervention is aimed at improving social outcomes for the families within a period of 12 months. There is a clear focus on problem solving and taking things forward. However, in order to work properly, it is necessary that the case manager has acquired a sufficient mandate from the family. Although person-oriented work is important and essential, the intention is to set-up a goal-oriented intensive cooperation. Outreaching case management should not be and is not a non-committal 'buddy system'.

FIGURE 13. WORKING TASK AND PERSON-ORIENTED THROUGHOUT TIME AND FIRST/FINAL SCORE IN INTENSIVE PERIOD



In the first phase there is a lot of emphasis on creating an atmosphere of mutual trust between client and the outreaching case manager (OCM). We observe an evolution at 6 months, where in half of the cases there is a

(starting) mandate to work task oriented. As the above data illustrate, categories 0 and 1, with a strong emphasis on the relationship of trust, are primarily indicated in a start-up phase. On the one hand, a relationship of trust is indispensable in order to work in a task-oriented way. On the other hand, the OCMs also point out that for many clients the task-oriented approach in the start-up phase (so-called quick wins) is crucial to build up a relationship of trust.

> *"Especially and almost exclusively working on the relationship of trust, a very cautious and limited mandate to work task oriented" (Logbook registrations, guiding principle task and person oriented, C11, month 2/17, score 0)*

> *"I can submit an application and collect evidence, but I feel that trust is not there yet. It feels more like a "test" to see how far I go with their question." (Logbook registrations, guiding principle task and person oriented, D11, month 1/12, score 1)*

> *"It was not extremely difficult to build up this relationship of trust because of certain interventions by the case managers: listing up their needs and questions for assistance and already taking certain concrete steps such as e.g.: service club, contact with renovation counselling, being able to immediately arrange certain documents in order to receive reimbursements, etc". (Logbook registrations, guiding principle task and person oriented, A7, month 6/25, score 1)*

In building a relationship of trust with the client, the OCMs underline the importance of a participatory basic attitude. For them, a positive basic attitude is more than being empathetic. According to the case managers, it is all about listening, taking time and approaching families with an open mind, without judgment. One must consider the social context of the family, try to understand them in the choices they make. It requires perseverance, having a constant eye for opportunities, to care for the families, and give recognition, even though things have gone wrong several times. This does not mean that the OCMs assume that families always tell the truth or that they approve of everything the families do or say. A relationship of trust basically ensures that even in bad times meaningful contact is still possible. In addition, the OCMs strongly appreciate that they were given sufficient time and space within the MISSION project to invest in this relationship of trust.

Only when there is enough trust, there is room to bring up more sensitive topics. In first instance the "safer" or easier topics are discussed: administrative and financial matters, childcare, school, et cetrea. When there is more confidence in one another, more sensitive topics can be discussed and tackled as well.

> *"I do feel that the client trusts me regarding administrative-financial questions. Yet I have the feeling that a wall has been built around her, that I cannot get through. I feel that there are deeper (personal / relational) difficulties, but I don't get to that yet." (Logbook registrations, guiding principle task and person oriented, B5, month 8/13, score 1)*

The categories with an emphasis on person-oriented work are still present in a later stadium of the intervention (for example after 6 months). Further analysis shows that this mainly regards families with low accessibility and a lower average duration of the intervention. In other words, these are families that are less open for receiving support, which explains the emphasis on building a relationship of trust.

In both category 2 and 3, where there is an emphasis on task-oriented work, it is often indicated that person-centred work is key: one cannot work (purely) task-oriented when there is an absence of trust. Attention to the relationship in function of "facilitating" the task-oriented, as described in the category, is therefore not always regarded an appropriate description by the OCMs. As a result, some OCMs never indicated category 3, while others do: they do similar things, but they registered it differently.

> *"The relationship with the client is good and I receive a lot of mandate, but I still continue to invest in the relationship and not just to be able work task-oriented."(Logbook registrations, guiding principle task and person-oriented, D2, month 3/24, score 2)*

> *"Although my interventions are task oriented, I always try to pay a lot of attention to the relational aspect (this applies to all my clients). Without this, it is impossible/difficult to work in a task-oriented way. For example, she called me this month, just to say she had become a grandmother. These are things*

that almost never appeared in my previous job. When I indicate 'task-oriented', I mainly mean that there is trust; the basis is there." (Logbook registrations, guiding principle task and person oriented, B7, different months, score 3)

However, a few times it is also explicitly stated that the OCMs worked in a purely task-oriented way. First, this was the case when other social professionals were involved in motivating and supporting the client, reducing the need for the OCM to step in as well. Second, this category is also indicated when there was limited trust from the client. Finally, this category is indicated when there are difficulties in building a relationship of trust (for example due to language barriers).

"I reflect on whether the woman is effectively 'in need' of building a relationship, since she is surrounded by a network. Maybe she sees my intervention as task oriented and is this enough for her?" (Logbook registrations, guiding principle task and person oriented, D8, month 10/17, score 3)

"Perhaps a bit weird, but I can't "read" this family. There is so much unclearness for me and it is difficult to work on a relationship of trust, which means that I often work in a task-oriented way." (Logbook registrations, guiding principle task and person oriented, D16, month 13/21, score 3)

4. THE MISSION TRIAL

4.1 Study design

The MISSION trial is a randomized controlled trial (RCT) carried out between March 2017 and November 2019 in the Belgian city of Kortrijk. The effects of the method of outreaching case management are tested on a sample of poor families with young children, comparing the outcomes of the treatment group with treatment as usual (TAU) in the control group. The outcomes in terms of take-up of social and employment services and benefits are tested at 6 months and 1 year after baseline. The outcomes are measured based on register data from OCMW and VDAB. The method of outreaching case management is described in detail in section §3 in this report. The RCT is complemented with a mixed-method approach where all participants in the experiments are surveyed at baseline and at follow-up (after 6 months) to shed light on the determinants of the primary outcomes and to examine the socio-economic characteristics and living conditions, social networks, trust in and satisfaction with local social services. Data is also gathered by the outreaching case managers working with families in the intervention group by means of weekly and monthly registration of their daily practice in logbooks as well as by means of focus groups with outreaching case managers and with families (see section §3). Triangulation of these different data sources will be used to shed light on the 'how' and 'why' of the outcomes of the trial.

The MISSION trial was approved by the University of Antwerp Ethics Committee for the Social Sciences and Humanities (EA SHW), and all data gathering was cleared by the Flemish regulator for data processing (*Vlaamse Toezichtscommissie voor de verwerking van Persoonsgegevens*). The study was also approved for each of the participation organisation transmitting personal data. The MISSION trial was registered at the American Economic Association RCT registry #AEARCTR-0002786 (socialscienceregistry.org/trials/2786). The study and program are funded under the umbrella of the EASI (Employment and Social Innovation) programme (PROGRESS axis) of the European Commission (VS/2016/0203).

4.2 Study population

A significant challenge in setting up the MISSION trial was how to reliably identify the targeted population, *in casu* disadvantaged families who may be eligible for local social and employment services and benefits. The problem is that local governments usually have information on families who have been supported in the past, or who present themselves to the local social and employment services to apply for support. Those who do not find their way or cannot reach out to the local governments for whatever reason, are unknown. This is related to the way social and employment services are organized at the local level (see section §1). In order to reliably identify this hard-to-reach group, the study makes use of home visits of district nurses by the Flemish agency for Child and Family Welfare (*Kind en Gezin*, K&G hereafter). The nurses visit around 96,5 % (in 2014) of all new-borns in Flanders and identify disadvantaged household based on a multidimensional deprivation indicator consisting of 6 dimensions: monthly household income, parental educational level, child development, parental employment, housing situation and health status. Families with new-born children that are identified as living in disadvantaged circumstances by K&G are the target group of the MISSION trial. In 2014, 15,4% of new-borns were perceived to be born in disadvantaged circumstances.

The district nurses introduced the MISSION project to these families. They explained to the mother (or the father if the mother was absent) that the purpose of the research project was to improve the organisation of local social services and support, and that they would be visited by a researcher who would conduct an interview with them. If they agreed, the nurses would provide the research coordinator with the address of the family, the name of the mother, on which of the dimensions the families were disadvantaged, and the nationality of and language spoken by the mother. If not, the nurses only provided the research coordinator with the number of families who refused to take part.

A member of the research team made an appointment with the mothers who agreed to take part and aimed to visit them within two weeks. The first contact with the mother was usually made by means of a phone call, but text messages or WhatsApp messages were also often used. The purpose of this first contact was to explain the purpose of the study, to ask again for consent to participate and to make an appointment for a first visit. During this first visit, the researcher explained the purpose of the study, had any questions answered, and asked to sign a written informed consent. After this, the first interview took place. Many appointments were cancelled at the latest moment and needed to be rescheduled. As a result, the researchers involved in conducting the interviews needed to be very flexible in terms of availability and timing. The interviews conducted were long; they usually lasted for two or three hours. After finishing the interview, mothers were asked if they agreed to be visited again six months later, and they were given a financial incentive of €20 (€30 for the interview at follow-up). In case families agreed to participate but still could not be reached by the researcher, the research coordinator asked the district nurse to again explain the research project to the family during her next home visit. If mothers refused to take part, they were no longer approached.

4.3 Study intervention

Disadvantaged families with a new-born child were randomly assigned to either receive an intervention by outreaching case managers or a control group receiving treatment as usual. The intervention consisted of an outreaching case manager (OCM) who closely counselled the families in order to guide them towards the appropriate services, benefits and organisations that are on offer at the local level. The OCM was mandated to guide the families towards all services and benefits they could be entitled to depending on their needs, including access to employment and training programs, adequate income and cash benefits, housing services, health services, and childcare services. The families in the control group are entitled to the same services and benefits as the families in the treatment group, the one difference being that for the latter group the OCM acts as a go-between.

The period of the intervention was set at 12 months in total with an intensive period of 6 to 8 months, depending on how quickly the case manager could build a relationship with the families and start the intensive support. After the intensive treatment period support continued up to 12 months but gradually diminished with the goal to hand over the family to existing local services and support. During the intensive treatment period OCMs had contact with the family at least once a week and visited the families at least twice a month. The OCMs were trained beforehand to ensure that all families in the treatment group would receive this minimum treatment. Depending on the situation, the case manager could choose to pay more visits to a family or to invest more time in counselling a family. What is constant across all families in the treatment group is the availability of an OCM during 6 to 8 months intensively and for 12 months in total. A detailed description of how the OCMs acted in practice is provided in section §3.

Randomization

The research coordinator at the University of Antwerp randomly assigned families provided by the K&G district nurses into treatment and control groups. Randomization is stratified by nationality of the mother (Belgian versus non-Belgian), because in 67% of families in Kortrijk designated as being disadvantaged the mother does not possess the Belgian nationality. To avoid imbalances of the groups in terms of nationality pose a threat to internal validity, each household was first grouped into Belgian and non-Belgian strata based on the mother ‘s nationality. Within each stratum, individual household were then randomly assigned to treatment or control using a random number generated in Microsoft Excel. Only the research coordinator had access to randomization files. Researchers conducting the interviews and families were blinded to the treatment allocation. Moreover, families were not aware that the intervention measured in the research project was the OCM. Of course, in a real-world situation there is no 100% guarantee that blinding was never breached. For instance, there may be neighbourhood effects, in that some families in the same neighbourhood or street were supported by an OCM and others were not, and that people might talk about this among one another. There is also one known case of a district nurse of K&G unwittingly telling a mother that the OCM who was working with

her was part of the research project. Finally, the MISSION project was also featured in a local newspaper which might have triggered awareness amongst some of the families.

4.4 Study Outcomes

The primary outcomes under study were take up of services and benefits offered by OCMW and VDAB, and the types of services and benefits the families receive including a particular focus on employment services. Measurement of primary outcomes is based on register data of OCMW and VDAB which are linked to the families in both control and treatment group. The advantage of using register data is that we were able to measure the primary outcomes at the household level, i.e. one of the partners (if applicable) received or participated, and to follow-up all families who participated in the baseline survey, even if they did not participate in the endline survey. Take up of services and benefits include (1) receipt of a social assistance benefit (*leefloon*); (2) participation in a training, education or employment program; (3) receipt of additional financial support; and (4) receipt of additional non-financial support. While entitlement to *leefloon* is bound to federal legislation and several conditions with respect to household income, wealth, citizenship, and job seeking behaviour, OCMWs have much more autonomy to grant additional financial and non-financial support to beneficiaries (see section §1). For participation in training, education or employment, it is important to also take the role of VDAB into account since participants can be counselled by OCMW *or* VDAB in terms of employment depending on their social security status. It is thus possible that participants receive financial support from OCMW whilst at the same time being supported by VDAB by means of a training program. For that reason, we jointly analyse VDAB and OCMW data for testing primary outcome (2).

The secondary outcomes were measures of income and living conditions, well-being, trust and assessment of support, measured in the survey conducted with all of the families. This MISSION survey was a questionnaire coded in *Qualtrics* administered by means of personal interviews with all families at baseline and at follow-up measurement 6 months later. Given the time limitations within the project and the staggered inflow of new families into the trial, it was not possible to carry out the same survey again after a year. Next to detailed information on the composition of the household, the nationality and residence status of both partners (if applicable), the employment status and experience of both partners (if applicable), and measures on the income and living conditions of the family, the questionnaire consisted of items gauging current and past experiences of participants with the use of local services, the take-up of benefits and the reasons for (non-)compliance. The interviewer had discretionary room to add relevant information and observational field notes. In 37 of the 112 interviews (33%), the help of professional interpreter was necessary. Interpreters were used for the following languages: Somali, Arabic, Maghrebi, Tigrinya, Berber, Dari, Pashtu, Albanian and Urdu. The researchers always tried to properly estimate during the first contact whether the respondent's command of Dutch, French or English was sufficient to conduct the questionnaire without an interpreter. Understanding the questions was always the primary concern. Interpreters were recruited with the Flemish agency for integration and integration, a public organisation aimed at social integration of newcomers also offering interpreting services for public organisations. The interviews generally lasted between 2 and 3 hours. Missings in the data were not imputed, unless there was information available to reliably impute the values (this was primarily the case in terms of household income and childcare use). In case missing values were imputed, this is discussed in the text.

It is not only important to know whether proactive service delivery through outreaching case managers is effective in improving primary and secondary outcomes of disadvantaged families living in Kortrijk, we also aim to shed more light on the determinants of success or failure, and on the contextual factors that are crucial to make the intervention a success. In particular we incorporate experience-based knowledge of different actors involved in the project: the outreaching case managers, the families, and the local social organisations and services. For that reason, in interpreting the data we draw on additional sources of data collection and research actions we organised within the MISSION project.

An important dimension of knowledge to include was the perspective of the outreaching case managers themselves: what did they do, in what way, and how did they experience this? In section §3 it is described how

they kept logbooks on a weekly and on a monthly basis, including the frequency and type of contact with families and local social services, which topics they were working on, and a reflection on their progress on the 10 guiding principles guiding the daily practice of outreaching case management. Although the experience of clients and their perception of what works and is important for them is important to take into consideration, the RCT design did not allow us to query the MISSION families about the intervention. Therefore, in the final months of the project, semi-structured interviews with seven families who were included in the treatment group were carried out at home (see Annex). The families were recruited out of the pool of families for which the intervention was finished, follow-up measurement was already carried out and the case manager was no longer active in the family. The researcher conducting the interviews was not involved in administering the baseline or follow-up questionnaire and had no prior knowledge about the families. The interviews lasted about an hour and were audio recorder. Purpose of the interviews was for the respondent to retrospectively reflect on the various principles of the outreach case management they were supported with and on what they perceived as being the most important results of the intervention. In interpreting the data and formulate policy recommendations, we draw on insights from all these data sources.

4.5 Sample Size and Statistical Analysis

We estimated before the start of the MISSION trial that a total of 235 participating families would be needed to detect a difference between groups, with a two-tailed α of 0.05 and power (1-β) of 0.80, for a comparison of 2 independent proportions if there was an absolute increase of 11% in the primary outcome measures, assuming a base rate take up of 18% in the control group. Although previous research on the specific issue of improving take-up of local employment services by means of home visits by case managers is absent, experimental research into the effectiveness of job counsellors allowed to estimate a minimum detectable effect (MDE) of the intervention compared with the control group. An overview of studies that examined the effect of 'job counsellor' meetings with participants to get them into an employment trajectory showed substantial effects of a 10% to 30% difference between control and intervention groups.[25] For our power calculations, we relied on the estimation that the average number of children born in disadvantaged circumstances over the period 2014-2017 was 114 per year, taking account of multiple birth rates. This would ensure a sample of sufficient size to estimate an MDE of 11%.

However, the number of births was lower than anticipated, and only 281 families with new-borns met the eligibility criteria (i.e. being regarded as living in disadvantaged circumstances by the district nurses of K&G) between March 2017 and April 2019, when the last group of families entered the MISSION trial. In total, we received information on 202 families who were asked to participate in the study (see Figure 14). This means that 79 families were not asked to participate to the study or that their information was not transmitted properly to the research coordinator. Of the 202 families asked to participate, two families were eligible but could not be reached by the district nurses while one family moved out of Kortrijk soon after giving birth, 69 families declined to participate. 130 families were randomized before baseline interviews were conducted (an initial response rate of 46% (130/281)). Another 18 families did not respond to invitations for baseline interview or could not be reached anymore. Two respondents were excluded from the intervention group because the case managers did not manage to make first contact within a reasonable amount of time. These two families were never in contact with the outreaching case managers and were assigned to the control group post randomization and before the analyses started. The achieved sample size was 112 families (56 in the control group and 56 in the treatment group). Under the same assumptions as our initial power analysis, this sample size allowed us to detect a difference between groups of 24% in the primary outcome measures, which is close to the upper ceiling of the MDE.

We collected register data for all study subjects before and at baseline until 6 months after the intervention started from OCMW and VDAB. We also collected register data for the majority of study subjects 1 year after

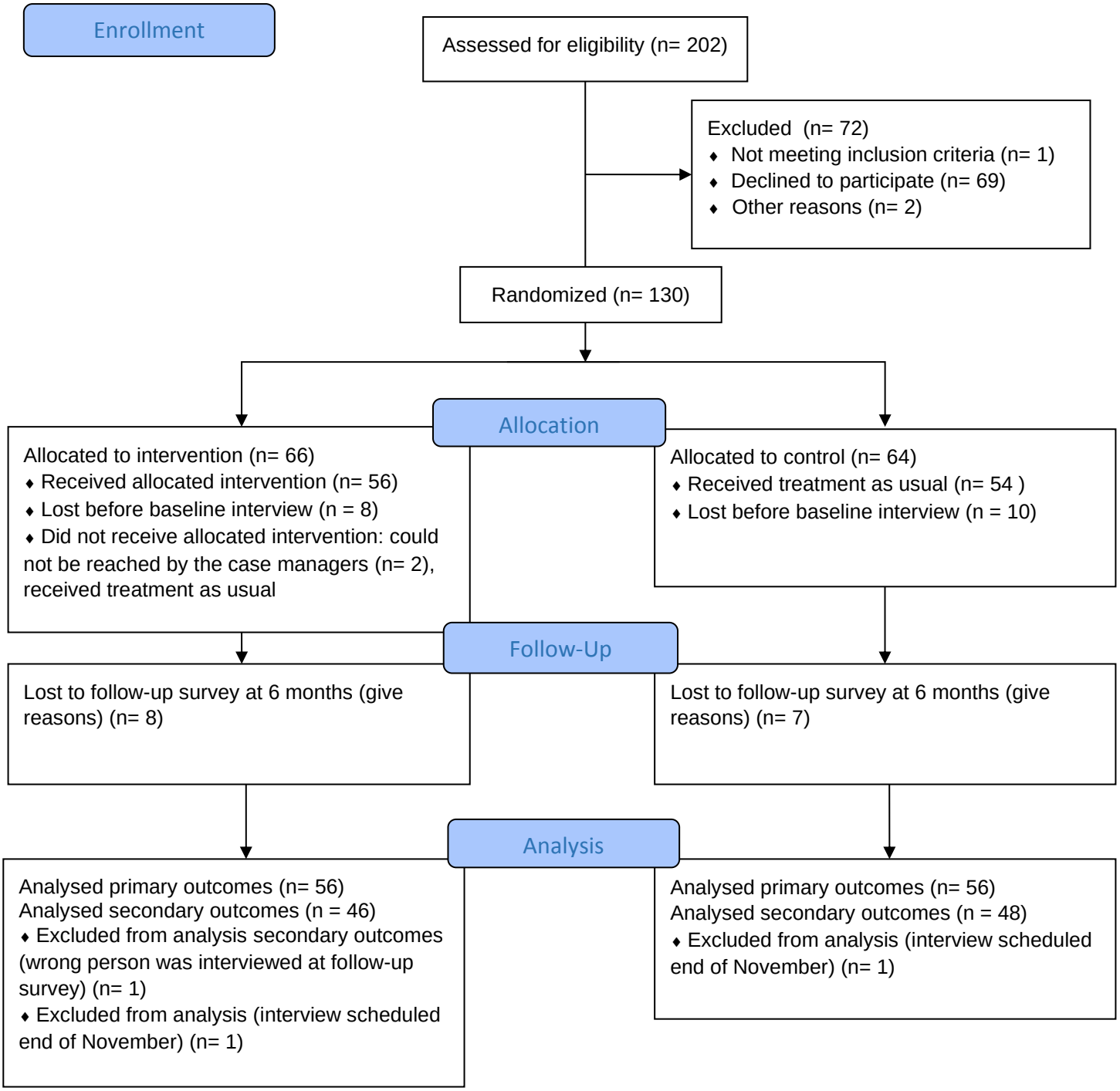
[25] Rosholm 2014.

the intervention started.[26] The use of register data allowed us to analyse primary outcomes using an intent-to-treat approach, including data from participants who did not complete the questionnaire at follow-up or who had missing data points for other reasons.

Analyses were carried out using independent samples t-tests for comparing primary and secondary outcomes by groups at 6 months. Profile plots are used to visualize differences in primary outcomes at baseline, 6 months and after 1 year. Paired sampled t-tests were calculated to assess whether changes over time differ significantly by group. Finally, to further understand the why and how of cases in which the intervention is associated with significantly different primary outcomes, in a next step we linked register data with the MISSION survey data to obtain information on personal and household characteristics, as well as with the diary data collected from the case managers to obtain information on their activities and perceptions about the families. Variables obtained from these various sources are subsequently added to linear probability models to test the association between family characteristics or intervention characteristics and the primary outcome of interest. Although the primary outcome variables are operationalized as binary variables, we follow recent guidelines to estimate linear probability models instead of logistic regression models.[27] All analyses were conducted using Stata version 15.1.

[26] Given the fact that the intervention for some families started only 6 months before the study ended, it was not possible to include measures for all families at 1 year after intervention.
[27] Breen et al. 2018; Mood 2010.

FIGURE 14. CONSOLIDATED STANDARDS OF REPORTING TRIALS (CONSORT) DIAGRAM: SAMPLE RANDOMIZATION AND PROGRAM PARTICIPATION



5. RESULTS

5.1 Baseline descriptives

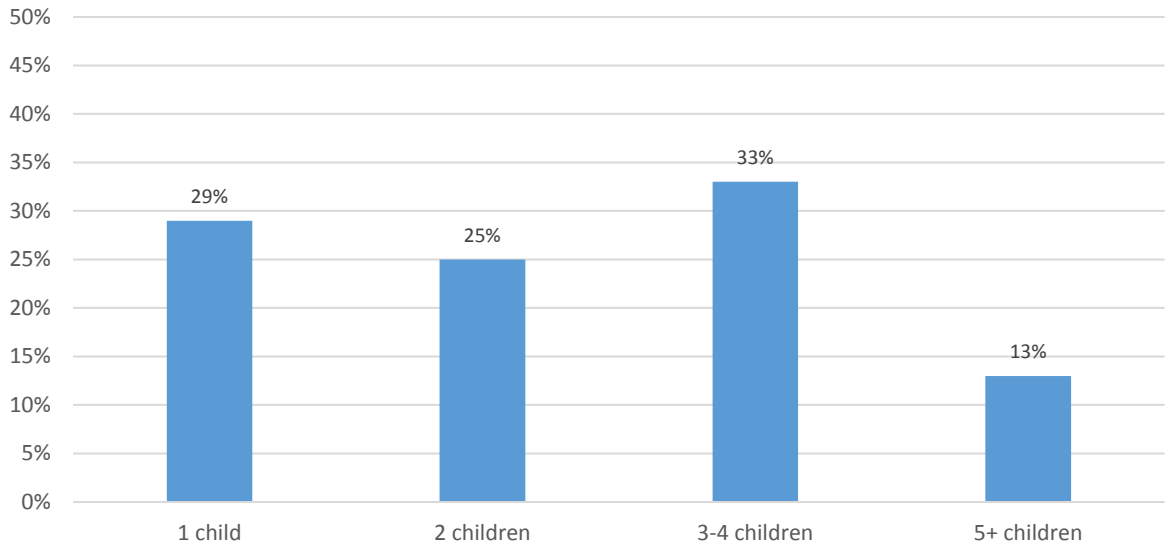
In this section we describe the baseline socio-economic characteristics, living conditions, dimensions of trust and well-being, and assessment of support and social services on offer to the 112 families in our sample. If relevant and possible, we compare these characteristics with survey data representative for Flemish families with young children. For this we draw on the European Union Statistics on Income and Living Conditions (EU-SILC), wave 2017, and on data from the European Social Survey (ESS), waves 2014 and 2016. With regard to EU-SILC, we compare our sample group of families with two groups: Flemish families with at least one child below 3 years old (N = 864), and Flemish families with at least one child below 3 years old at risk of poverty (N = 82)[28]. With regard to ESS, we compare our sample group with Flemish families with children (ESS8 N = 422; ESS6 N = 399). More details are provided in the text. The data presented here are based on the survey carried out at baseline and on the register data from OCMW and VDAB. Missing values are not imputed, unless we had reliable information in the register data to fill in the blanks. We provide more details in the text where appropriate.

Background characteristics of MISSION families

In this section we examine the household composition, nationality and education levels of MISSION respondents and (if applicable) their partners. In 95% of the cases, the respondent was the mother. In 80% of families, respondents live with their partner in one household; 20% of families are single parent households. The marital status of respondents is as follows: 58% is married, 9% is divorced or separated while 33% never married. The average age of respondents is 31 year; the average age of partners is 34 year. The average number of children living in the household is 2,65 (SD = 1.51) with a median number of 2. Figure 15 shows that 29% of families have one, recently born, child, 25% have two children, 33% have 3 or 4 children, and 13% have 5 or more children. On average, the families included in our sample have more children compared with Flemish families with at least one child below 3 (Av. = 1.8), and Flemish families with at least one child below 3 living at risk of poverty (Av. = 2.3).

[28] Poverty is defined in accordance with the European headline indicator at-risk-of-poverty: an individual is considered to be living with a poverty risk if she or he is living in a household with an equivalized net disposable income below the poverty threshold, defined as 60% of median equivalized net disposable household income. See Eurostat, 2019. https://ec.europa.eu/eurostat/statistics-explained/index.php/Glossary:At-risk-of-poverty_rate.

FIGURE 15. NUMBER OF CHILDREN IN THE HOUSEHOLD (N = 112)



Source: MISSION survey at baseline.

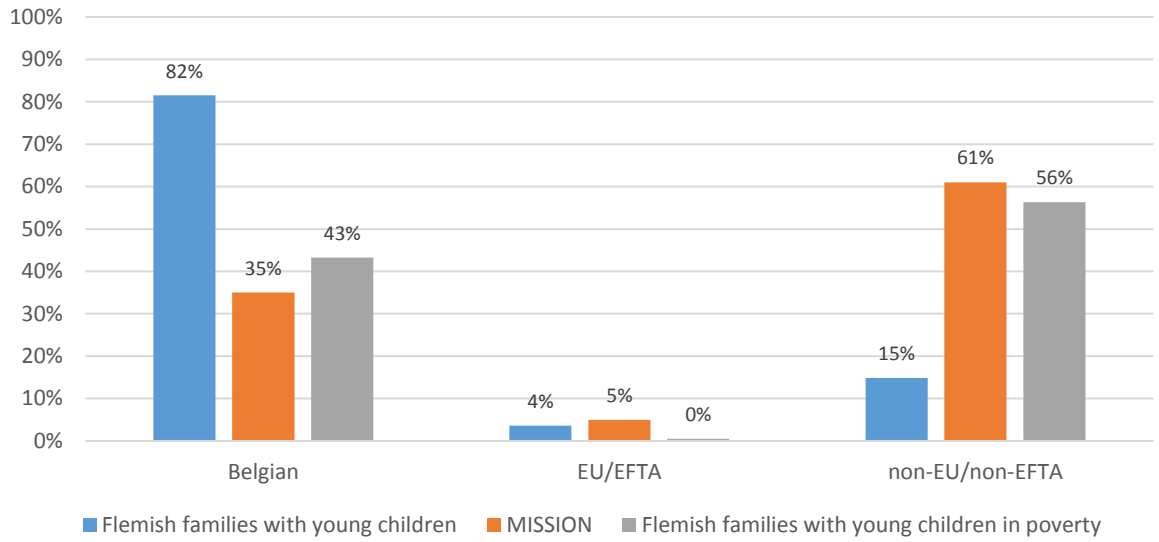
Figure 16 shows that 35% of respondents has the Belgian nationality, 5% is an European Union or EFTA national, while 61% has a non-EU/EFTA nationality[29]. Of the partners, 29% is a Belgian citizen, 16% is an EU/EFTA national, while 56% has a non-EU/non-EFTA nationality. Of the respondents from non-EU countries, 35% comes from Middle Eastern and North African (MENA) countries, 41% from Sub-Saharan Africa, 18% from South and South-East Asia, and 6% from other (non-EU/non-EFTA) European countries. Similar patterns can be discerned amongst respondents: 42% comes from MENA countries, 32% from Sub-Saharan Africa, 22% from South and South-East Asia, and 4% from other European countries. Compared with Flemish families with at least one child below 3, our sample is characterized by a strong overrepresentation of non-EU nationals. Compared with the average poor Flemish family with at least one child below 3, however, our sample composition in terms of broad-based categories of nationality is more similar.

Respondents without the Belgian nationality have a specific residence status. This includes (1) asylum seekers registered in the waiting register (7%), a provisional population register for foreign nationals; (2) foreign nationals with electronic type A or type B residence card or a certificate of immatriculation (54%). These includes recognized refugees, subsidiary protected persons, and foreigners with an indefinite residence permit; (3) foreign nationals with an electronic C, D, E,F or H residence card (29%). These are residence permits for long-term residents or family members of a Union citizen or person with a Belgian nationality.; and (4) respondents without a valid residence permit or respondents who are not registered into the waiting register (10%). The average number of years of residence for respondents with a foreign nationality is 4.5 years. Of the respondents with the Belgian nationality, 60% is born in Belgium with parents who were born in Belgium as well, 10% is born in Belgium with parents born in another country (so-called 'second generation'), while 31% is born abroad and acquired Belgian citizenship ('first generation'). Those who acquired Belgian citizenship have been residing in Belgium for 18 years on average.

A wide variety of languages is spoken in the MISSION sample. Respondents could denote up to 2 languages they speak at home. The main languages spoken at home are Dutch (43% of respondents), French (18%), Arabic (18%), Somali (14%) and Berber (5%). In 25% of the cases, Dutch is the only language spoken at home.

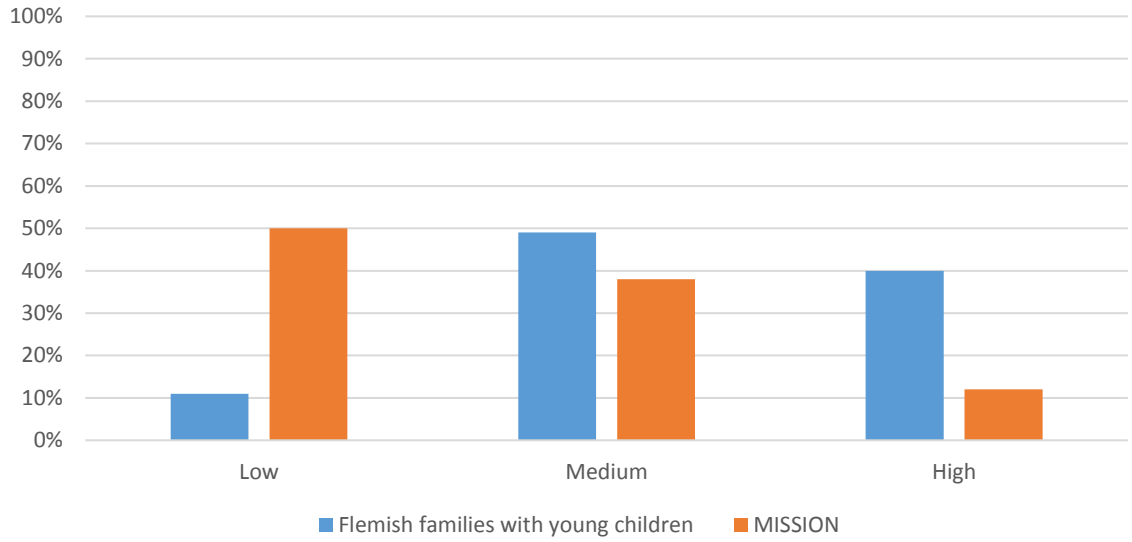
[29] This includes all member states of the European Union (including the United Kingdom) as well as Switzerland, Croatia, Iceland, Liechtenstein, Montenegro, FYR Macedonia, Norway and Turkey.

FIGURE 16. NATIONALITY OF THE RESPONDENT (N = 112)



Source: MISSION survey at baseline, EU-SILC 2017. Note: Flemish families with young children defined as having at least one child below 3 years old. Poverty risk is defined as living in a household with an equivalized disposable net income below the Belgian poverty threshold.

FIGURE 17. EDUCATIONAL LEVEL OF RESPONDENTS (N = 112)



Source: MISSION survey at baseline and EU-SILC 2017. Note: educational level is based on the International Standard Classification of Education (ISCED), UNESCO (2011).

Figure 17 shows the educational level of the MISSION population compared with Flemish families with young children. Half of the respondents are low skilled (operationalized using the ISCED 2011 classification), 38% are medium skilled and only 12% are low skilled. A similar pattern appears for the partners in the household: 52% are low skilled, 39% are medium skilled and 8% are to be considered high skilled. It is quite clear that low skilled persons are overrepresented in the MISSION sample, compared to the distribution of educational levels amongst families with young children in Flanders. About half of low educated respondents live together with a low skilled partner.

Living conditions of MISSION families

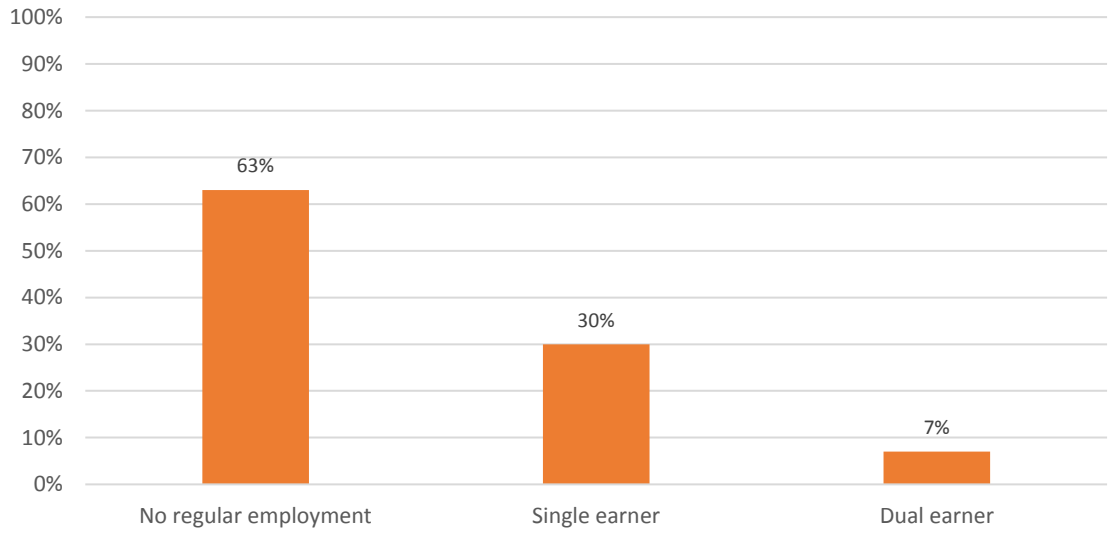
In this section we examine the living conditions of MISSION families, including housing situation, employment status in the household, household financial and material situation and the use of childcare services. Changes in these dimensions will also be tested as secondary outcomes in the MISSION trial (*infra* section §5.3).

Employment

In terms of employment, 13% of respondents and 40% of partners indicate that they are in paid employment (including temporarily absence at the moment of baseline, e.g. maternity leave). Figure 18 shows the pattern of regular paid work (employee or self-employment, including service voucher work) at the household level: 63% of households are households in which mother nor father are engaged in regular paid employment; 30% can be considered single earner households while only 7% are dual earner households. The data also provide detailed information on the self-defined activity status of both respondents and partners. Among the respondents, 33% indicate that they are fulfilling domestic and care tasks, 11% indicate that they are not seeking paid employment, 9% that they are permanently disabled or otherwise unfit for paid employment, and 11% that they are inactive for 'other reasons'. Half of the latter category indicate that they are learning or want to learn Dutch first. This means that 64% of respondents are not readily available for an engagement in the labour market. The share of partners indicating that they are not available for the labour market is much lower, however: 6% are unemployed but not seeking paid employment, 9% are permanently disable or unfit for paid employment, 5% are fulfilling domestic and care tasks, and 8% are inactive for 'other reasons'.
We asked respondents who are not in regular paid employment to assess the most important obstacles they face to work (up to three answers were possible). First of all, a language barrier is perceived to be a major issue for 44% of respondents (56% amongst those who don't speak Dutch as their main language at home). Second, 27% indicate that it is difficult to combine employment with family life. Third, 20% argue that it is difficult to have access to jobs because of lack of (affordable or available) public transportation. Fourth, 13% list health issues as the main obstacle. Finally, 9% list discrimination as an obstacle to obtain paid work.

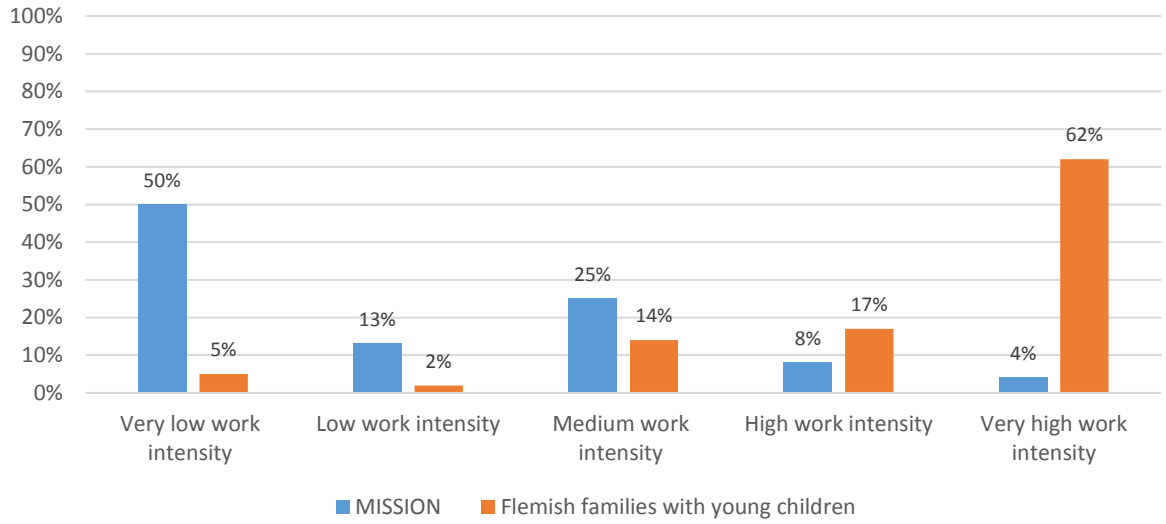
Figure 19 shows a measure of household work intensity, defined as the ratio of number of months worked in the previous year by adult members of the households and the total number of months they could have worked. This measure is comparable to the Eurostat measure of household work intensity. The results show that the MISSION families exhibit the inverse pattern of Flemish families with young children. Half of the MISSION families report a very low work intensity, compared to 62% of Flemish families with young children reporting a very high work intensity. Due to a small number of observations, a full comparison with Flemish families with young children living in poverty is not possible. Yet, calculations on the basis of EU-SILC data do show that 50% of these families report a very low work intensity; similar to the MISSION sample.

FIGURE 18. REGULAR EMPLOYMENT PATTERNS AT THE HOUSEHOLD LEVEL (N = 112)



Source: MISSION survey at baseline. Note: employment includes regular paid work as employee or self-employed.

FIGURE 19. HOUSEHOLD WORK INTENSITY FOR MISSION FAMILIES (N = 112) AND FLEMISH FAMILIES WITH YOUNG CHILDREN (N = 864)



Source: MISSION survey at baseline and EU-SILC 2017. *Note*: The work intensity of a household is the ratio of the total number of months that all working-age household members have worked during the income reference year and the total number of months the same household members theoretically could have worked in the same period. Very low work intensity is a ratio of less than .20; low work intensity .20 <>.45; medium work intensity .45 <>.55; high work intensity .55 <>.85; and very high work intensity > .85.

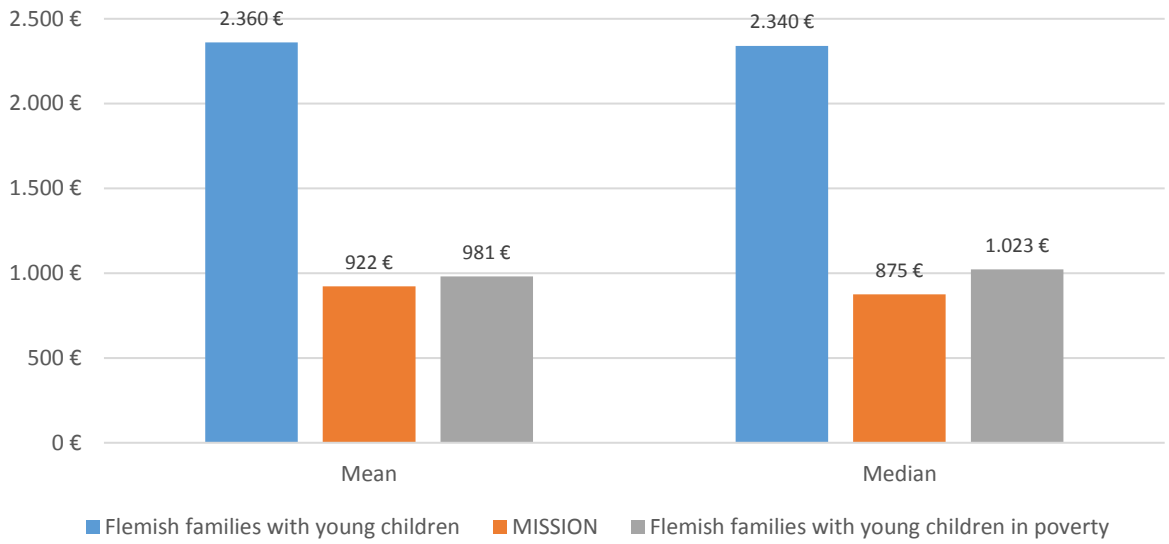
Register data from OCMW and VDAB show that at baseline measurement in 10% of *families* one of the partners is engaged in employment or training programs directly supervised by OCMW and another 15% supervised by VDAB. Whether these shares can go up is one of the primary outcomes tested in the MISSION trial (*infra* section §5.2).

Income and poverty

Let us now turn to the disposable household income of MISSION families. Total disposable household income is based on an assessment by the respondent and her of his partner (if applicable). It includes (1) wages and salaries (including wage premiums) and net operating profits and losses for the self-employed, after deduction of taxes and social contributions; (2) social benefits and cash transfers (including alimony payments and child support); (3) additional sources of income such as income from properties and land, dividends, interest from capital investment et cetera. Income is limited to income from official sources, incomes from working in the grey economy or non-reported incomes are not included (see below). To render incomes comparable across families of different size and to take due account of economies of scale, net disposable household income is equivalized by means of the LIS scale (square root of the number of household members). Although the concept is not exactly similar and EU-SILC includes a more detailed assessment of household income of all household members, in Figure 20 we compare the mean and median equivalized disposable household income levels of the MISSION families and Flemish families with young children (in general and living in poverty). The mean equivalized disposable household income of MISSION families amounts to €922/month. It becomes immediately clear that the income levels of the MISSION families are lower but close to the income levels of Flemish families with young children who are living in poverty. If we apply the Belgian poverty threshold (calculated on the basis of EU-SILC 2017 with the LIS equivalence scale) to the MISSION families, 91% of them would qualify as being income poor.[30]

[30] The 2017 poverty threshold is uprated with 2% for each subsequent survey year to account for inflation.

FIGURE 20. MEAN AND MEDIAN EQUIVALIZED DISPOSABLE HOUSEHOLD INCOME

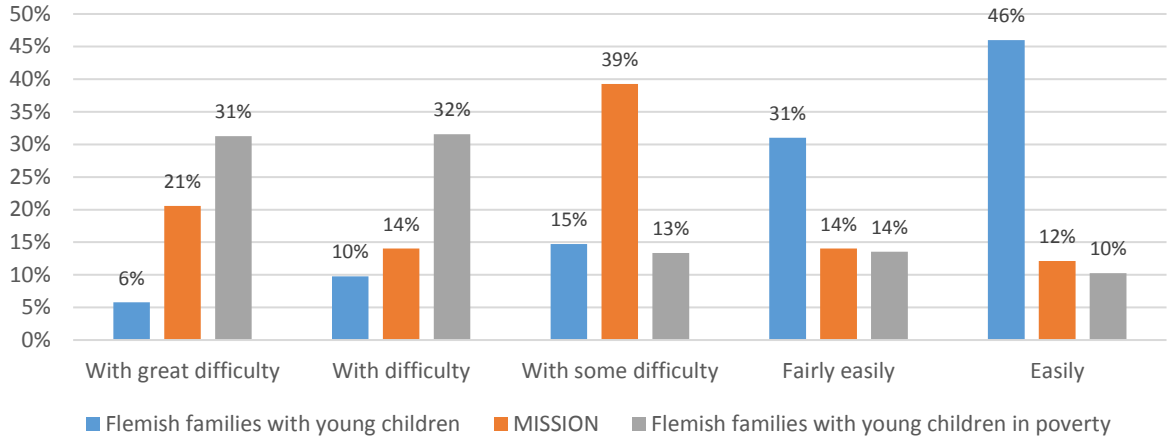


Source: MISSION survey at baseline and EU-SILC 2017.

Apart from a measure of monetary poverty, the data also allow to assess the MISSION families' own subjective assessment of their living standard. First of all, Figure 21 shows the distribution of so-called subjective poverty, based on the question whether households are able to make ends meet to pay for usual necessary expenses. The same question was asked in the SILC survey. The results show that the MISSION families are much more likely to indicate they face difficulties in making ends meets. Still, 26% of families report it is fairly easy or easy to make ends meet. In contrast to poor Flemish families with young children, of which 63% report they have (great) difficulty to make ends meet, MISSION families are more likely to indicate 'some difficulty'. Second, 87% of respondents report that they are not be able to face an unexpected expense of €1.000. In comparison, 20% of Flemish families with young childrfen indicate they cannot face such an unexpected expense; this raises to 65% of poor Flemish families with young children. So, in terms of disposable household income and the capacity to meet unexpected expenses, MISSION families generally fare worse compared to Flemish families with young children living in income poverty, while their subjective assesment of making ends meet is somewhat better. This confirms existing scholarship on the 'relative character' of subjective poverty measures: it depends on one's idea of what is 'necessary' in life, with whom one is comparing with, and perceptions of broader economic circumstances.[31]

[31] Goedemé & Rottiers 2011.

FIGURE 21. PROPORTION OF HOUSEHOLDS, BY DIFFICULTY OF MAKING ENDS MEET



Source: MISSION survey at baseline and EU-SILC 2017.

The data provide a more detailed picture of different income sources from benefits and transfers of the MISSION families.

Table 13 shows the proportion of household in which at least one of the partners received a certain benefit or earnings last month. Receipt of these benefits is not mutually exclusive. Most families receive child benefits (84%), somewhat more than half of families qualify for increased reimbursement of healthcare (*Verhoogde Tegemoetkoming*, 56%), one third of families receive a social assistance benefit (33%), 19% of families receive a sickness or invalidity benefit, and 16% of families receive unemployment benefits. Finally, 38% of families have some income from regular employment, and 9% of families receive alimony with an average monthly amount of €130 (SD = €112). The share of households receiving child benefits is low, since government studies indicate only a minimal level of non-take up of the Belgian child benefit[32]. Upon a closer look, those families who are not receiving child benefit (yet) are families with only one child who are still in the application process, an/or having a residence status which makes it impossible or at least more difficult to apply for child benefits (certificate of immatriculation, electronic A-card or without any valid residence permit). So, while non-take up of child benefit in Belgium is indeed low, in the particular composition of the MISSION sample not all families are entitled to receiving child benefits. The relatively low share of unemployment and sickness or invalidity benefits can be explained by the conditions for entitlement. One has to have performed paid work for a minimal numbers of days and or be available for the labour market (for unemployment benefit) or having a recognized work incapacity status recognized by a medical doctor.

Under the increased reimbursement (IR) for healthcare individuals pay lower or even no co-payments for healthcare visits to the general practitioner, and beneficiaries are entitled to other financial benefits as well. The status is granted by the health insurance organisations (*mutualities*) after an eligibility test that is based on household income and employment status in the previous year. Families entitle to social assistance benefits (*leefloon*) are automatically granted IR status. Since the income thresholds to qualify for IR are high, almost all families should in principle be entitled to IR.[33] This confirms earlier assessments that there is a substantial amount of non-take up of IR status in Belgium.[34] Although IR is not a replacement income or social insurance benefit, it is an important top-up for low income families improving their living standard.

[32] FAMIFED 2017.
[33] The income concepts in het MISSION survey are not readily comparable to the ones used in the eligibility assessment for IR (net disposable household income versus gross taxable household income), but a conservative estimate learns that 9 out of 10 families should qualify for IR.
[34] Van Gestel et al. 2017.

Perhaps more surprising, this does not hold to the same extent for social assistance benefit (*leefloon*) receipt: 33% of MISSION families at baseline receive social assistance benefits. Based on the questionnaire administered to families at baseline we estimate the share of families to be eligible for social assistance benefits (*leefloon*) to be maximum 43%. This takes into account the nationality and social security status requirements. We are not able to simulate the income-test, so this percentage should be regarded an upper ceiling. This means that about 77% of potential beneficiaries (households) actually receive social assistance benefits (*leefloon*); a non-take up of 23%. Although substantial, this is much lower an estimate compared with international studies in which the non-take up of social assistance benefits (*leefloon*) is usually estimated to be in the range of 50 to even 80%.[35]

TABLE 13. INCOME SOURCES

Income source	*Share of households*
Child benefits	86%
Unemployment benefit	16%
Sickness or invalidity benefit	19%
Increased reimbursement for healthcare (*Verhoogde Tegemoetkoming*)	56%
Social assistance benefit (*Leefloon*)	33%
Earnings	38%
Alimony payments	9%

Source: MISSION survey at baseline.

Apart from regular sources of income from employment, transfers or capital, we asked respondents whether they had additional sources of income. First of all, 9% of families report that one of the partners has performed activities in whey they earn money on the side. There is significant difference in disposable household income between families performing these irregular activities and those who do not (t = .257, p = .798). Second, 17% of families indicate that they receive some form of financial help from relatives of other persons outside of the household. The average monthly sum over the last 6 months before baseline amounts to €441 (SD = €1010), with a median value of €150. There is no significant difference in disposable household income between families receiving financial help and those who do not (t = .282, p = .778).

Finally, an important source of non-cash income is so-called 'material assistance' such as food, clothing, diapers, or other forms of support. No less than 48% of families report that they receive such support, often through local organisations such as food banks, NGO's, charity organisations or voluntary citizens' initiatives, often supported by the city of Kortrijk or the OCMW in terms of logistics and communication. Mostly, families receive a package of diapers (59%) through the so-called 'Pamperbank' or food aid (44%). There is a significant difference in the household income of families relying on such material assistance compared with families who do not (t = 2.410, p = .018): families relying on material assistance have on average €151 lower equivalized household income. In sum, the poorest families are the ones relying on such additional support to get by.

Expenses and debt

It is clear the MISSION sample consists of families with low incomes and often precarious living standard. As a corollary, they are often in arrears with their payments, which is often indicated by the outreaching case managers as being one of the first things they aim to tackle. 40% of respondents report that they got into arrears in the past year. About half of these families are in collective debt settlements (which is a legal procedure) or they are in debt mediation or other forms of budget coaching by OCMW or the Centre for General Social Work (CAW, *Centra voor Algemeen Welzijnswerk*). More in particular, 37% of families were in arrears at least once with utility bills, 26% with health expenses, 21% with rent or mortgage payments, and 13% with other expenses such as school bills, internet and telephone bills. Second, many families send remittances to relatives or other persons living outside of the household. In the MISSION sample, 34% of families report they have done so in the

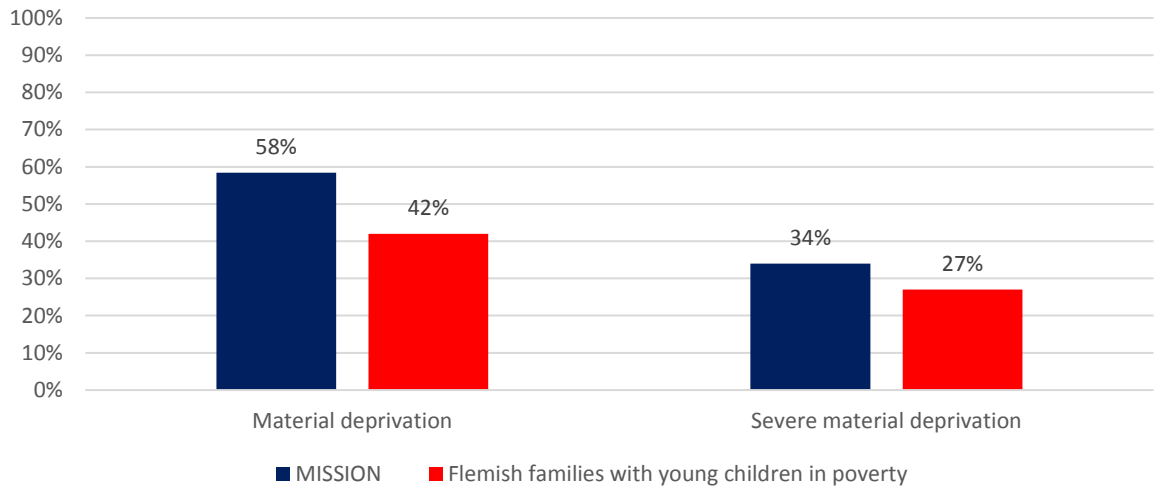
[35] Hernanz et al. 2004.

last 6 months, with an average monthly amount of €128 and a median of €100. Third, in 7% of the MISSION families alimony is paid to a former partner or to children living in another household.

Material deprivation

Finally, the MISSION survey allows to calculate material deprivation rates. The material deprivation rate expresses the share of families who are not able to afford at least four out of the following nine items: mortgage or rent payments, utility bills, hire purchase instalments or other loan payments; one week's holiday away from home; a meal with meat, chicken, fish or vegetarian equivalent every second day; unexpected financial expenses; a telephone (including mobile telephone); a colour TV; a washing machine; a car; and heating to keep the home adequately warm.[36] People are living in material deprivation when they cannot afford three out of these nine items, and in severe material deprivation when they cannot afford four out nine. Figure 22 shows the result for the MISSION families compared with the results for Flemish families with young children in poverty based on EU-SILC. The results show that 58% of MISSION families can be considered materially deprived while 34% are considered to live in extreme material deprivation. These rates are higher than the rates amongst the average Flemish family with young children living in poverty. When it comes to objective measures of living standards, the MISSION families are in a disadvantaged situation, even compared with 'typical' poor families with young children.

FIGURE 22. MATERIAL DEPRIVATION RATES



Source: MISSION survey at baseline and EU-SILC 2017. Note: material deprivation = household is deprived of at least 3 of 9 items (see list of items in text); severe material deprivation = household is not able to afford 4 of 9 items.

Housing

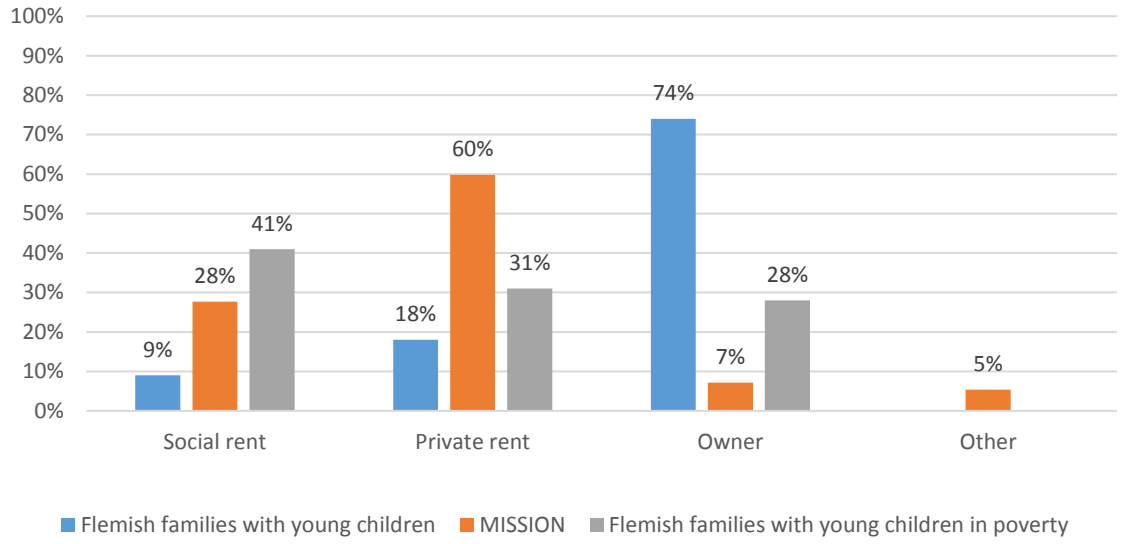
There is a strong link between one's housing situation and financial vulnerability. Housing costs often are a burden for low income families, and living in poor quality dwellings makes life more difficult on several other life domains. For instance, it was reported *supra* that 21% of MISSION families were in arrears with mortgage or rent payments. The MISSION questionnaire includes several questions on the housing situation of families with young children in Kortrijk. Figure 23 shows the type of dwelling the MISSION families are occupying, compared with the housing situation of Flemish families with young children and Flemish families with young children living in poverty. It becomes immediately clear that MISSION families are more likely to rent on the private housing market (60%) and less likely to be in social housing (28%), compared to poor families with young children in Flanders (resp. 31% and 41%). Finally, 7% are owners, and these are families who generally somewhat better off

[36] E.g. Eurostat (2019). Material deprivation statistics - early results. https://ec.europa.eu/eurostat/statistics-explained/index.php/Material_deprivation_statistics_-_early_results.

in terms of disposable income. Owners have a higher disposable household income compared with private (t = 1.89, p = 0.061)) or social renters (t = 2.39, p = .019). It also true that monthly housing costs are higher for private renters (Av. €533; SD = €99) and owners (Av. €594, SD = €205) than for social renters (Av. €390, SD = €125).

The survey included a question on the satisfaction with one's living situation (measured on a scale from 0 to 10, with 0 meaning extremely dissatisfied and 10 extremely satisfied). Mean satisfaction scores differ strongly with the housing situation: homeowners are most satisfied (Av. = 7.13, SE = .61), social renters are less satisfied than homeowners (Av. = 5.2, SE = .48) but more satisfied than private renters (Av. = 4.24, SE = .35). Problematic situations like insufficient heating infrastructure, leaking pipes, mould, lack of space or no access to hot water were regularly reported by the respondents.

FIGURE 23. HOUSING SITUATION



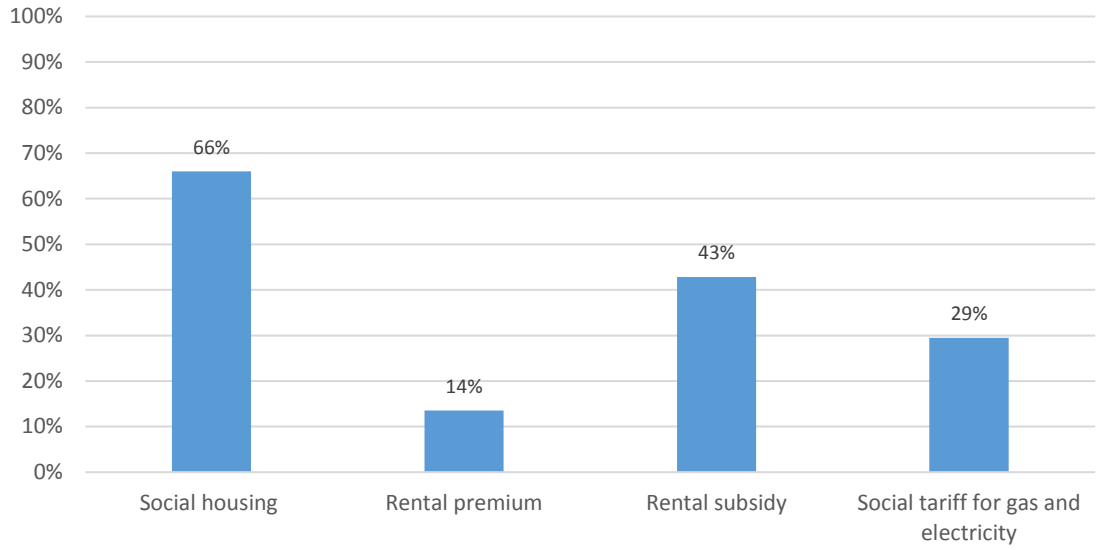
Source: MISSION survey at baseline and EU-SILC 2017. Note: other includes respondents living with other people and respondents residing in local shelter initiatives (LOI, lokaal opvang initatief).

For low income families renting on the private market it is important to apply for social housing or for one of the federal or Flemish allowances that are in place to compensate at least part of the housing and utility costs. In the survey, we asked whether someone in the household had ever applied for social housing (at the social rental agency and/or the social housing association[37]), a rental premium, a rent subsidy, or federal social tariffs for gas and electricity. Figure 24 shows that 66% of households had applied for social housing in the past. This means that there is strong demand for social housing amongst the MISSION families, and corroborates the existence of long waiting periods (up to 4 years) in the social housing application process. Access to social rental housing in Flanders is restricted to low income groups, but the social housing stock is rather low in comparative perspective. Only 14% of families who are not living in social housing have applied for the Flemish rental premium, a very specific allowance for households who have been on the waiting list for social housing for more than five years. A share of 43% of MISSION families have applied for a rent subsidy, which is an allowances for families on a very low income that moved from a poor quality to a good quality rental dwelling, on the private market or provided by social rental agencies. Finally, 29% of MISSION families applied for social tariffs for gas and electricity, a

[37] In Flanders, social housing is provided by two actors: Social Housing Associations (SHA) and Social Rental Agencies (SRA). While SHAs build and rent houses, SRAs rent houses on the private market to let them out to low income families. See Winters (2019). Flemish housing policy and outcomes: new directions after the reform of the Belgian State? Housing Finance International, pp. 36-42.

federal measure applicable to specific categories of persons on low income, including recipients of social assistance benefits

FIGURE 24. SHARE OF HOUSEHOLDS EVER APPLIED FOR HOUSING ALLOWANCES AND FINANCIAL SUPPORT



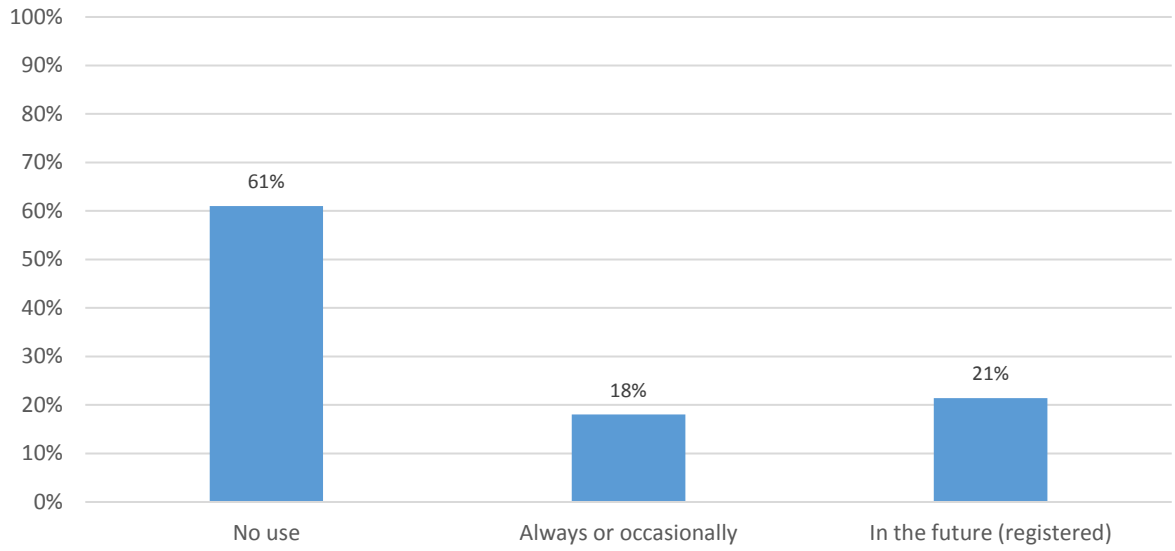
Source: MISSION survey at baseline. Note: Application for social housing and rental premium only asked to those respondents currently not living in social housing.

Childcare

For families with young children, the availability, usability and affordability of formal childcare services is an important prerequisite to work. There is also a strong evidence base that the use of formal childcare services of high quality has beneficial effect for the cognitive and non-cognitive development of young children, in particular for children growing up in poverty.[38] Still, it is well documented that the use of childcare services is socially stratified, with poor families having less access to affordable childcare compared with their higher income counterparts.[39] Figure 25 shows that in the MISSION sample, 61% of respondents indicate that they do not use childcare now or plan to use childcare in the future. Because respondents are usually on maternity leave at the moment of the baseline interview, we explicitly made a distinction between current and future use: 18% of families report current childcare use (always or occasionally), while 21% indicate they are registered to use childcare in the future. Of those currently using childcare, almost half of them (45%) do this on a fulltime basis (all days of the week). Importantly, amongst families not using childcare, 70% indicate that they would like to use it either now or in the future.

[38] Kulic et al. 2019.
[39] Pavolini & Van Lancker 2018.

FIGURE 25. CHILDCARE USE



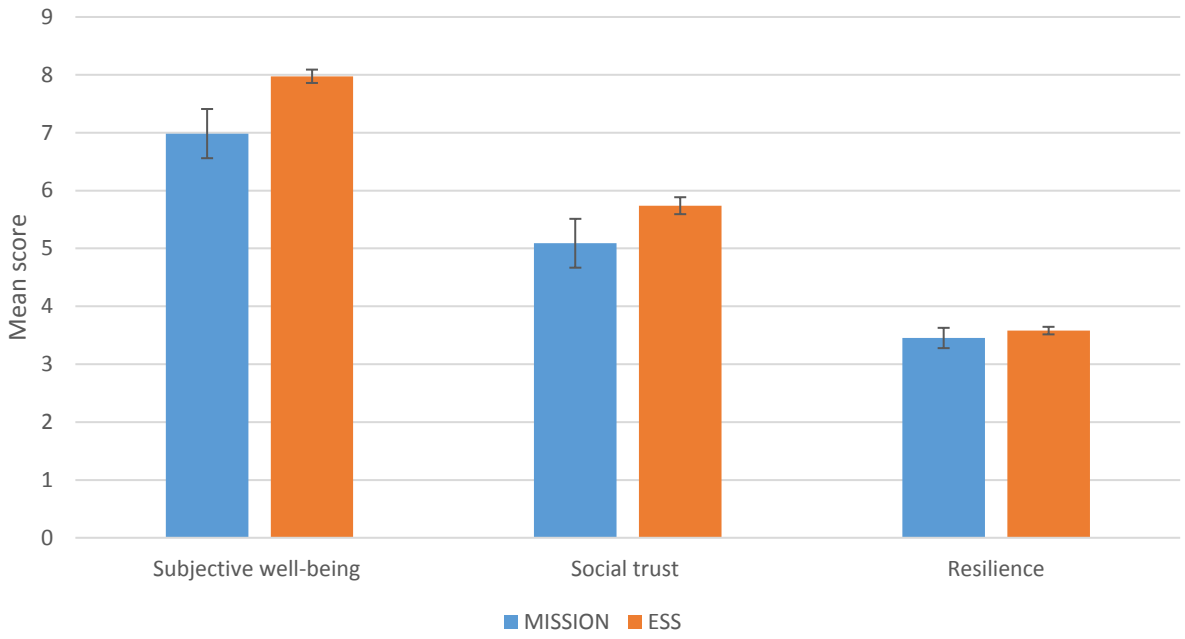
Source: MISSION survey at baseline.

Well-being

The MISSION survey includes a number of questions gauging different dimensions of well-being of the respondents. These questions are comparable with the questions included in the European Social Survey, round 8 and round 6 (which includes a module on personal and social well-being). The ESS allows to identify Flemish families with children, and in Figure 26 the results for MISSION families and Flemish families with children are compared. First of all, we constructed a measure of subjective well-being comprising of two items, self-declared life satisfaction and self-declared happiness (Cronbach's alpha 0.82 for the MISSION survey). Both items are measured on a 10-point scale (with 0 meaning extremely unhappy or dissatisfied and 10 extremely happy or satisfied) and the mean score is presented. The results show that MISSION families have a substantial lower level of well-being compared to the average Flemish family with children (a 1-point difference on the scale, 6.99 versus 7.98). Second, social trust is an index comprising of three items (all measured on a 10-point scale): whether people can be trusted, whether people try to take advantage of you, and whether people are helpful (Cronbach's alpha 0.78). Again, the results show that the MISSION families exhibit lower levels of social trust compared with Flemish families with children. Finally, we present a measure of resilience, which refers to one's ability to function well during a time of adversity, which is what life in poverty often is, and the ability to bounce back. It is regularly seen as an important factor in the probability of families to climb out of poverty and improve their well-being.[40] Resilience is the mean score of four items, all measured on a 5-point scale (Cronbach's alpha 0.70): "In general I feel very positive about myself", "At times I feel as if I am a failure", "I'm always optimistic about my future", and "When things go wrong in my life, it generally takes me a long time to set back to normal". The items are recoded so that higher numbers reflect greater resilience. The results show that there is virtually no difference in levels of resilience between MISSION families and Flemish families with children. Finally, the questionnaire included a question on the number of persons respondents can discuss personal matters with. In the MISSION sample, 12% of respondents indicate they have no one. According to the ESS data (round 6), this amounts to 0.01% of Flemish families with children. In sum, MISSION families report lower levels of subjective well-being and social trust, and they have fewer persons they can rely on, but they are no less resilient than others.

[40] Seccombe 2002

FIGURE 26. MEAN SCORES ON DIFFERENT DIMENSIONS OF WELL-BEING



Source: MISSION survey at baseline and European Social Survey.

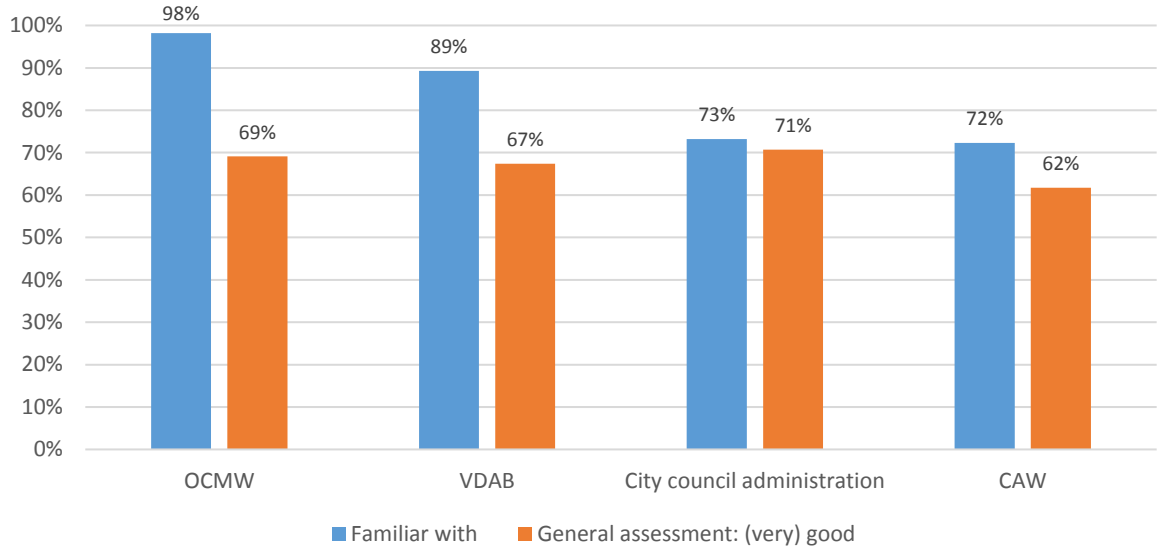
Professional assistance and local social welfare organisations

One of the assumptions at the start of the MISSION experiment was that many low income families would be unknown to local organisations in general and the public centre for social welfare (OCMW) in particular. Our approach to link register data with both control and intervention group allows to shed light on this issue, since we not only collect data at baseline, after 6 months and if applicable after 1 year, but also check which of the families in our sample have had *any* contact with the OCMW in Kortrijk before baseline measurement. The data show that 89% of families in our sample have had contact with OCMW before baseline. This means that they are registered with, applied for and potentially received any form of support from OCMW Kortrijk. There is no significant difference between intervention and control group in having had contact with OCMW before ($t = -0.7407$, $p = 0.47$). The idea that many families in our sample would be unknown to the OCMW is clearly wrong. Of those families that are unknown by the OCMW, in 75% of the cases the respondent is a non-EU immigrant being 5 years or less in the country, usually in a family reunification procedure. For VDAB, we find that 53% of the families in our sample have had contact with VDAB at any time before baseline. There is no significant difference between intervention and control group in having had contact with VDAB before ($t = 0.188$, $p = 0.852$). In our sample, 93% of families have had contact with either OCMW or VDAB. As a corollary, only a small fraction of 4% of poor families in Kortrijk had contact with VDAB without having had contact with OCMW. This confirms that while OCMW and VDAB work closely together, the main point of contact for low income families is the OCMW.

As a matter of fact, when we ask the respondents whether they are familiar with local services and organisations, OCMW comes out on top. Figure 27 shows the proportion of respondents who indicate that they know three local welfare services and organisations and are familiar with its purpose. For comparison, we also asked whether they were familiar with the city administration where they have to register to live in Kortrijk, for instance, request a residence permit or renew a visa or identity card. While 73% of respondents indicate that they are familiar with the city administration and its purposes, almost everyone (98%) is familiar with OCMW. Still nine out of ten respondents (89%) are familiar with VDAB while a lower share of respondents are familiar with CAW. We also asked respondents for their general assessment of these services. The share of respondents

whose assessment of OCMW (69%), VDAB (67%) and the city administration (71%) was (very) good is similar, while a lower share assessed CAW as being (very) good (62)%.

FIGURE 27. FAMILIARITY WITH AND GENERAL ASSESSMENT OF LOCAL SERVICES AND ORGANISATIONS



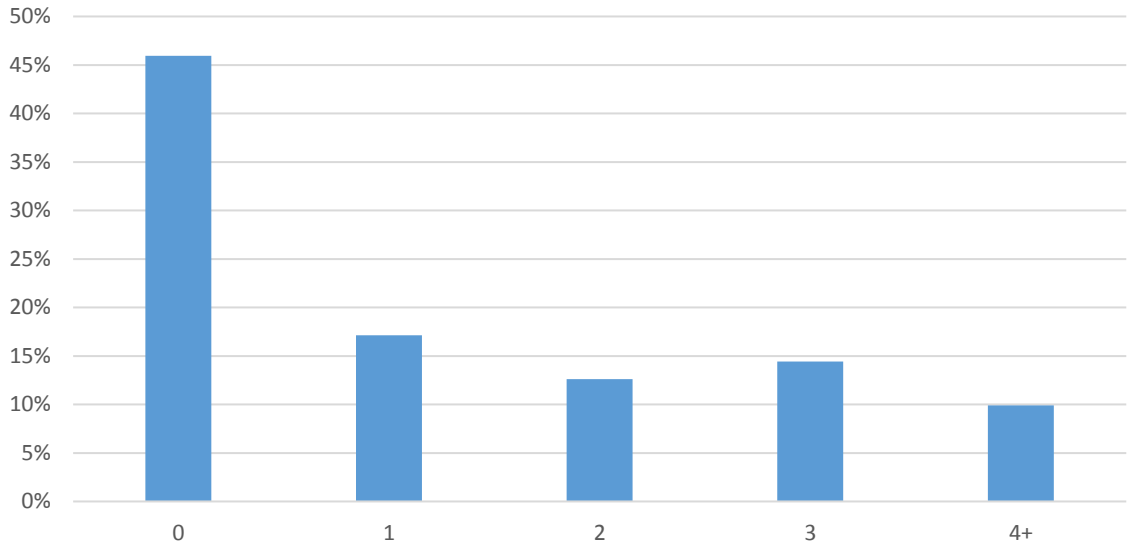
Source: MISSION survey at baseline. Note: general assessment is based on respondents who are familiar with the organisations.

Finally, we asked respondents about their personal experience with professional assistance provided by local social services. One of the assumptions underlying the MISSION trial is that some families may not receive the support they need while others may experience too many professionals at the same time working with them. To get a sense of this, we asked respondents to provide an indication how many professionals are operating in the households of respondents. Figure 28 shows the results. Despite the fact that all of these families have been visited by nurses of Kind en Gezin (K&G), and several of these families continue to receive support by these nurses or by other members of the regional team of K&G, 46% of respondents report that there are no professionals or services active working in the household. Moreover, 17% of respondents report that one professional is providing support, 13% indicate that two professionals are providing support at the same time, 15% experience the help and support of three professionals, and 11% report that four or more professionals are providing support in the households. It will be interesting to observe how the assessment of respondents changes when a outreaching case manager is active in the family with the explicit objective to become a 'one stop shop', mediating between the family and other professionals and services.

Second, we asked respondents to assess to what extent they feel that the professionals working in their household are working in a harmonized way and that different organizations are providing support aligned to the respondents needs. These questions are expected to tap into (part of) the daily practice of outreaching case managers (see section §3). Respondents answered four questions on a 4 point scale ('completely true', 'true', 'not true', 'completely not true'): (1) There is a service provider who has an overview of my situation; (2) I have to tell my story too often; (3) I have to provide my personal details too often to different agencies; (4) I feel that the social services for my situation are not coordinated with each other. We recoded the first question so that higher scores mean more favourable outcomes. Figure 29 shows the share of respondents agreeing (scores 1 and 2) with the statements. Amongst the respondents who experience professional help at baseline, almost half (44%) indicate that they have to tell their story too often, which is an indication that there is not sufficient transmission of information between different organizations or social professionals. Similarly, 42% of them agree that social services are not always coordinated with one another. 37% feel they have to provide personal

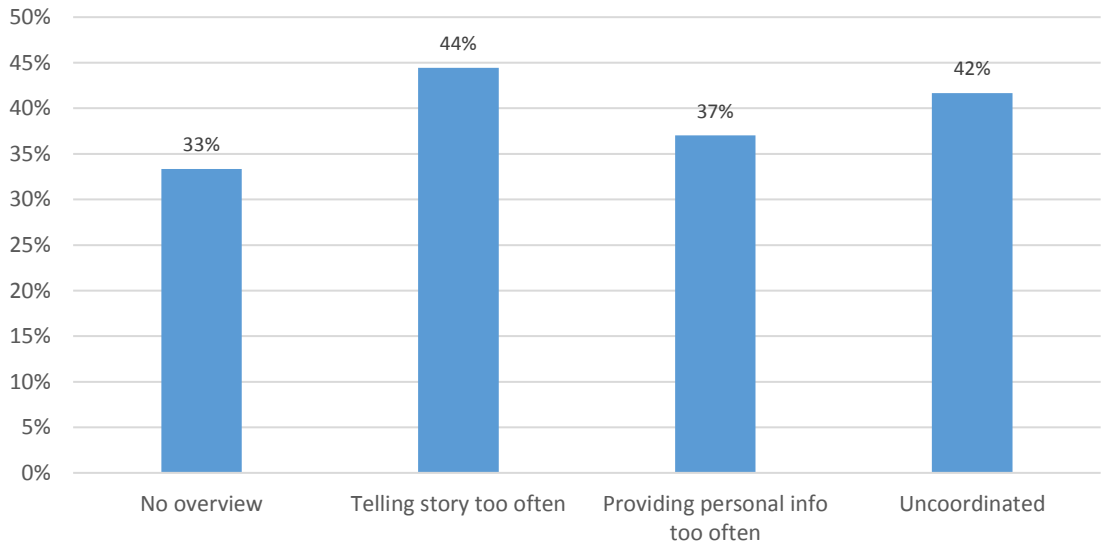
information too often, and finally 33% feel that social professional(s) do not have a proper overview of the problems they face.

FIGURE 28. SELF-ASSESSMENT OF THE NUMBER OF PROFESSIONALS WORKING IN THE HOUSEHOLD



Source: MISSION survey at baseline. N = 112.

FIGURE 29. SELF-ASSESSMENT OF HARMONIZATION OF SOCIAL PROFESSIONALS

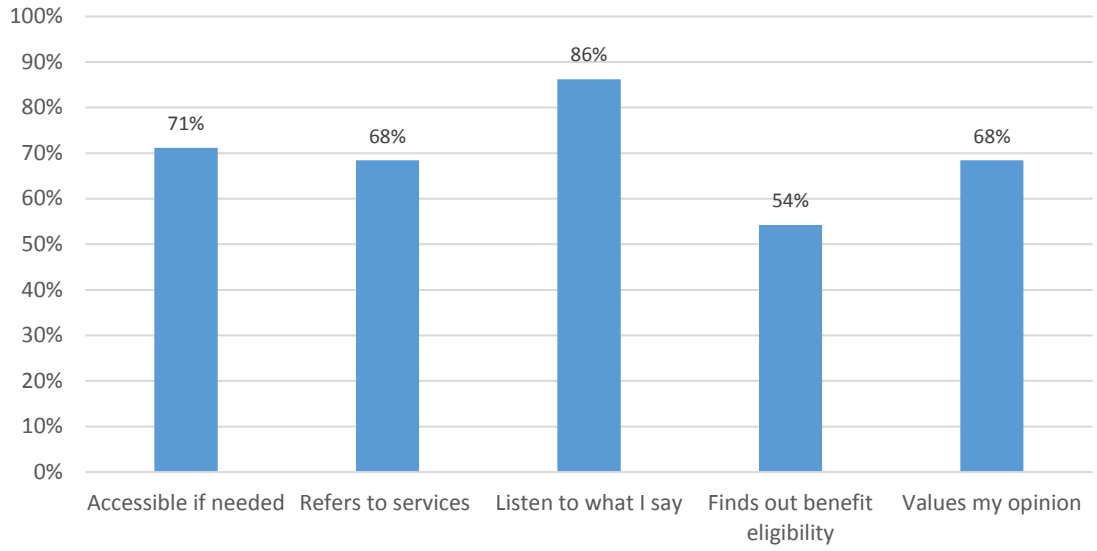


Source: MISSION survey at baseline. The items are only asked to respondents who indicate that there is at least one professional working with the family.

Finally, we asked several questions which all gauge one dimension of the quality of the professional support these families are getting. Respondents answered 5 questions with 5-point scales ('Completely disagree', 'Disagree', 'Neither disagree or agree', 'Agree', 'Completely agree'): (1) There is a service provider who is accessible if I need one; (2) There is a service provider who finds and refers me to services and assistance that could be useful to me; (3) There is a service provider who listens to what I have to say; (4) There is a service

provider who finds out which benefits and allowances I am eligible for; and (5) There is a service provider who takes my opinion into account. Again, these questions are tapping into the methodology guiding the daily practice of the outreaching case managers. Figure 30 shows the share of respondents agreeing or strongly agreeing with the statements. Respondents agree most with the statement that social professional(s) listen to what they have to say (86%), they agree least with the statement that professionals are helping them finding out their benefit eligibility (54%). This is one particular domain in which outreaching case management should be able to make a difference. The majority of respondents agree that their opinion is valued, that social professionals are accessible if needed and that they refer to the proper services and assistance.

FIGURE 30. SELF-ASSESSED QUALITY OF PROFESSIONAL SUPPORT



Source: MISSION survey at baseline. The items are only asked to respondents who indicate that there is at least one professional working with the family.

5.2 Primary outcomes

To check the balance of treatment and control groups, we perform a t-test of the differences in the sample means of the primary outcomes variables between control and treatment group at baseline.

Table 14 shows that there are no significant differences between the groups at baseline. Since our sample size is smaller than anticipated, we also provide the normalized difference in primary outcome values by treatment status, i.e. differences in means of the covariates normalized by the standard deviation of these covariates.[41] This allows to asses not only the statistical significance of difference but also the substantial significance. As a rule of thumb, a normalized difference in means larger than 0.25 standard deviations is regarded substantial, and might pose a threat to internal validity of the experiment. The results show that nowhere the normalized difference between treatment and control is substantial. Only for participation in training or employment programs the normalized difference between treatment and control amounts to 0.12 standard deviations.

[41] Imbens and Woolridge 2009.

TABLE 14. PRIMARY OUTCOMES AT BASELINE

	Primary outcome	Treatment	Control	Diff.	T value	P-value	Nor-diff
(1)	Take-up of OCMW services or benefits	.429	.446	.018	.189	.851	.025
(2)	Participation in training or employment program (OCMW or VDAB)	.214	.286	.071	.868	.387	.120
(3)	Receipt of social assistance benefit (*leefloon*)	.321	.339	.018	.199	.842	.026
(4)	Receipt of additional financial support	.196	.179	-.018	-.240	0.811	-.032
(5)	Receipt of additional non-financial support	.054	.071	.018	.387	0.699	.052
	N observations	*56*	*56*				

Let us now turn to the effect of the intervention on the primary outcomes after six months. Table 15 shows differences between groups at follow-up after 6 months. We discuss the results after 1 year (for a more limited sample) further below. We observe no significant or substantial difference in terms of take-up of OCMW services or benefits. There are no differences between treatment and control in terms of participation in training program or receipt of social assistance benefits (*leefloon*) as well, although the differences here are bit more substantial in favour of the control group for social assistance benefits (*leefloon*) while the difference is smaller for participation in training and employment programs. We do observe a significant as well as substantial difference in receipt of additional financial support. After 6 months of the treatment, families in the treatment group are much more likely to receive additional financial support compared with families in the control group (difference of 20 percentage points). The normalized difference shows that this is a substantial effect (amounting to 1/3rd of a standard deviation). Finally, there are no significant differences between treatment and control in terms of receiving non-financial support by the OCMW.

TABLE 15. PRIMARY OUTCOMES AT FOLLOW-UP AFTER 6 MONTHS

	Primary outcome	Treatment	Control	Diff.	T-value	P-value	Nor-diff
(1)	Take-up of OCMW services or benefits	.536	.518	-.018	-0.188	0.852	-.025
(2)	Participation in training or employment program (OCMW or VDAB)	.304	.357	.054	0.598	0.551	.080
(3)	Receipt of social assistance benefit (*leefloon*)	.321	.393	.071	0.784	0.435	.105
(4)	Receipt of additional financial support	.375	.179	-.196	-2.360	0.02	-.315
(5)	Receipt of additional non-financial support	.089	.125	.036	0.607	0.545	.081
	N observations	*56*	*56*				

In sum, the results show that the outreaching case managers manage to substantially increase the receipt of financial support apart from social assistance benefits (*leefloon*) amongst poor families with young children. This kind of support includes a reduced rate for childcare fees (in 61% of the cases), financial support for medical expenses (19%), paying energy bills (16%), a top-up of the family income (16%) and financial support for paying rent or rental deposits (6%). In sum, these are costs or allowances that directly relate to the living conditions of families with young children. Rates of non-financial support increased in both treatment and control groups.

Such type of support includes inter alia debt mediation and budget management assistance, and assistance in the search for appropriate housing.

Obviously, 6 months is a short period of time for close counselling of families which are usually confronted with a multitude of issues in different spheres of life. The outreaching case managers for instance sometimes indicate that they first try to work on basic needs, and only afterwards focus more on training and employment trajectories. For that reason, we also collected register data from OCMW and VDAB at one year after baseline. For about half of the families in the treatment group (48%), the treatment was effectively stopped at that point. The following results are based on a complete-case analysis, meaning that we only take account of cases for which we have full information. We do not have data at one year after baseline for 10 families who entered the MISSION trial after November 2018; for 4 families we only have partial data[42]. These missings are not imputed.

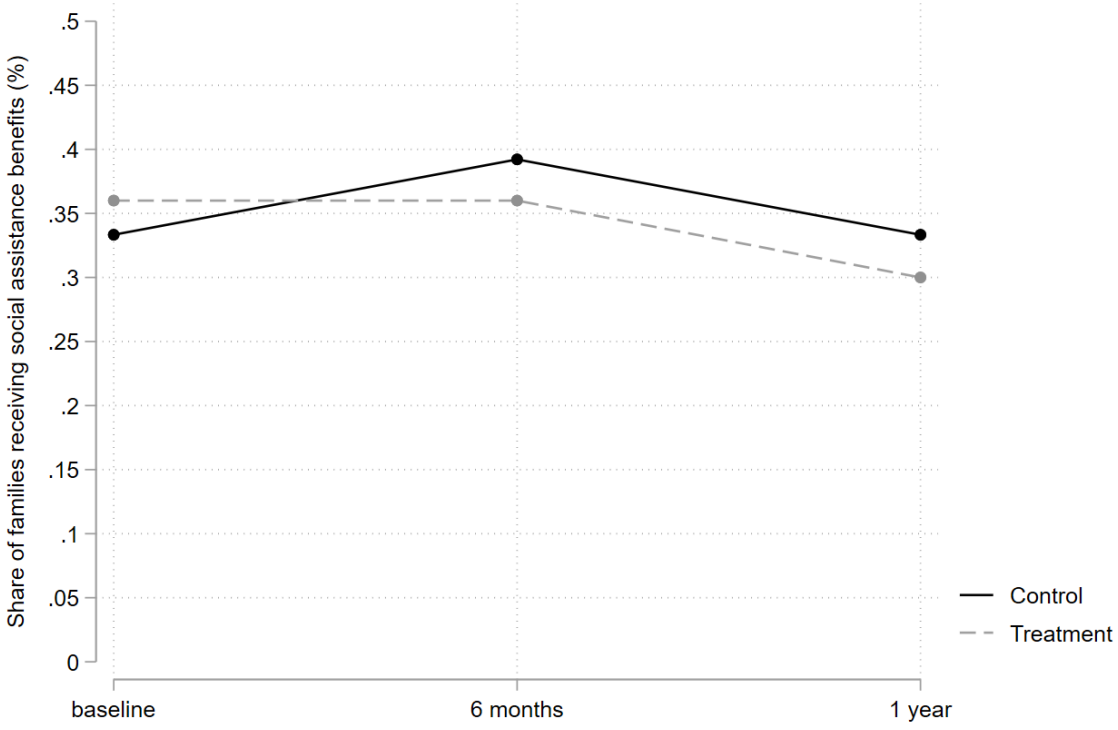
Figure 31 shows the evolution of social assistance benefit receipt over the course of one year by group. It becomes immediately clear that the share of families (in which one of the members is) receiving social assistance benefits (*leefloon*) weakly declines over time, and that there are no discernible differences between control and treatment groups. Figure 32 shows the evolution of the share of families in training or employment programs. These programs are organised by either OCMW or VDAB, and often in close cooperation with one another. The share of families (in which at least one of the members is) taking part in these programs is increasing strongly over time. As was already apparent from Table 15 showing the results after 6 months, the increase was stronger in the treatment group. After one year, 42% of the treatment group is participating in employment or training programs versus 36% of the control group. The increase between baseline and 1 year is significant in the treatment group (t = -2.646, p = .011) while it is not significant in the control group (t = -1.429, p = .159). This means that the average gain in participation in employment or training programs was stronger in the treatment group.

Figure 33 shows the evolution of the receipt of additional financial support over the course of one year by group. Here we see a substantial and significant increase between baseline and 6 months for the treatment group (t = -2.858; p = 0.006), while the evolution flatlines for the control group. Although the number of families receiving additional financial support declines somewhat after one year (t = 1.4289; p = 0.159), there is still a difference of 12 percentage points between treatment and control (t = -1.397; p = 0.166; norm. diff. = -.199). Since additional financial support is awarded often temporary and on an *ad hoc* basis to cover for specific needs, it is not surprising that the share of families receiving such support declines over time. At the same time it can be a sign of improving living standards. E.g. if families have a higher income, or are entitled to social tariffs for gas and electricity, it is usually less needed to ask the OCMW to intervene.

Finally, Figure 34 shows the evolution of the receipt of additional non-financial support over the course of one year by group. Similar to the findings after 6 months, there are no significant difference between treatment and control group one year after baseline (t = -.786, p = .434).

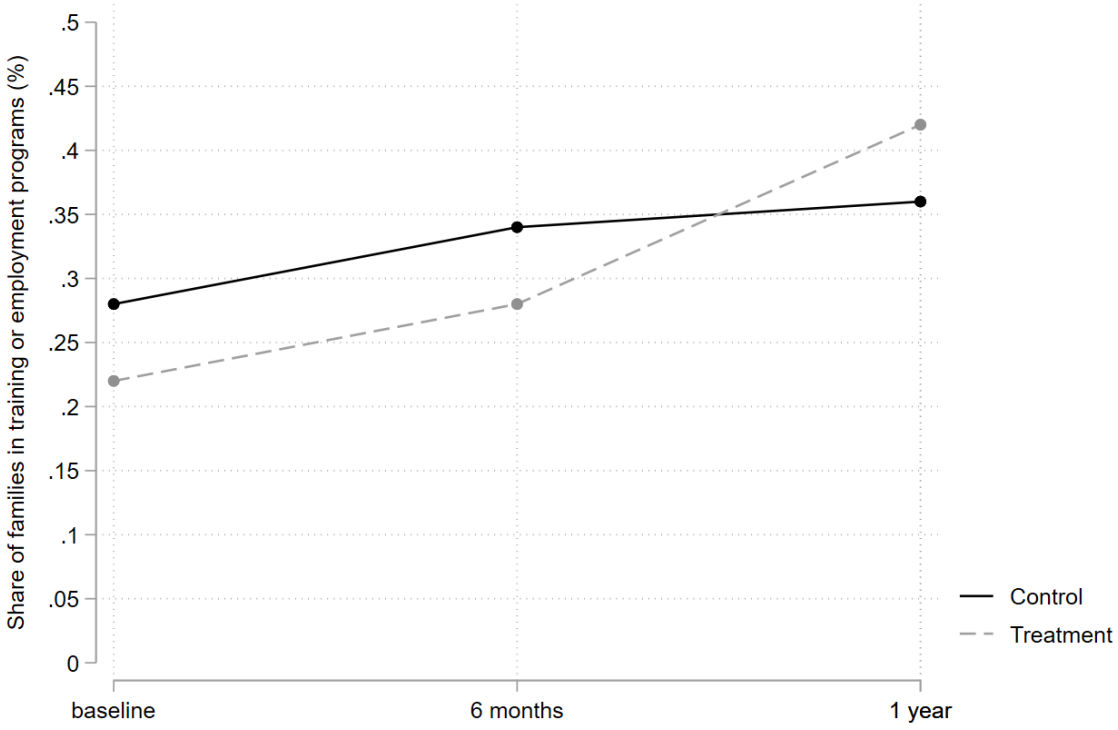
[42] Because social assistance benefits are usually granted for a longer period of time, for 3 families we do have information on the receipt of social assistance benefits after 1 year even though information on the other primary outcomes is missing. For one family we have information on the long-term receipt of reduced childcare fees while data is missing on the other primary outcomes. For two families we have information on employment and training programs.

FIGURE 31. EVOLUTION OF SOCIAL ASSISTANCE BENEFIT (LEEFLOON) RECEIPT BY GROUP



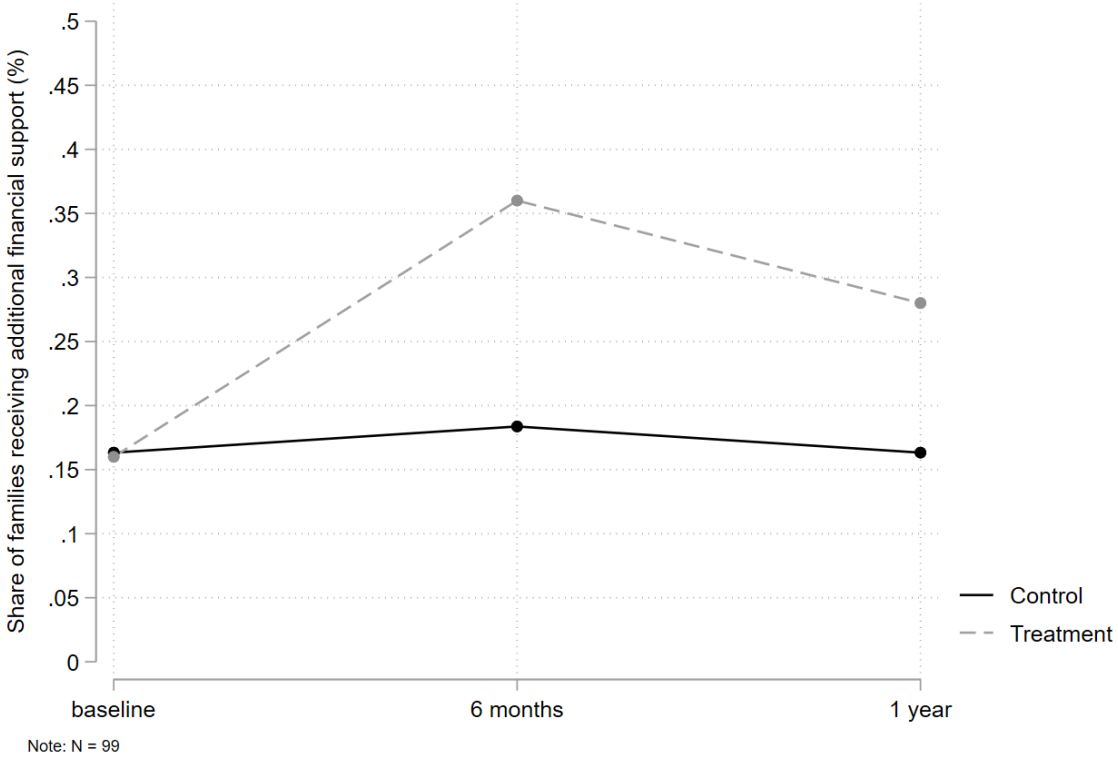
Note: N = 101

FIGURE 32. EVOLUTION OF THE SHARE OF FAMILIES IN TRAINING OR EMPLOYMENT PROGRAMS BY GROUP



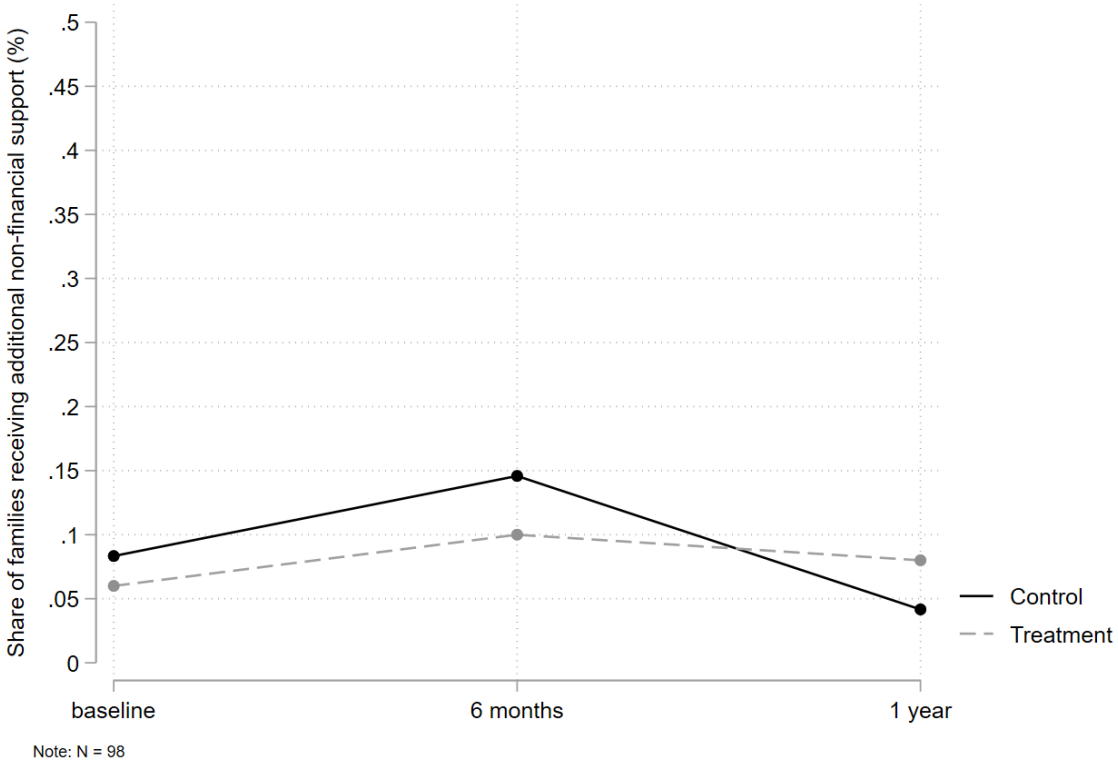
Note: N = 100

FIGURE 33. EVOLUTION OF THE RECEIPT OF ADDITIONAL FINANCIAL SUPPORT BY GROUP.



Note: N = 99

FIGURE 34. EVOLUTION OF RECEIPT OF ADDITIONAL NON-FINANCIAL SUPPORT BY GROUP



Note: N = 98

Let us now try to get better purchase on the why and how of the treatment effect. In Table 16, we model linear probability models to investigate to what extent the receipt of additional financial support in treatment and control groups is associated with family characteristics. In Table 17 and Table 18 we test which kind of intervention characteristics and actions taken by the outreaching case managers are associated with a higher probability to receive additional financial support.

The first model of Table 16 shows that there are no significant baseline differences in the receipt of additional financial support by family characteristics such as single parenthood, number of children or nationality of the respondent. As expected, there is also no difference by group. After six months, however, being a single parent is significantly associated with a higher probability to receive additional financial support (Model 2). This however does not explain the treatment effect. To shed more light on this, we add an interaction between single parenthood and treatment in Model 3 to test whether the effectiveness of the intervention differs by household composition. The interaction effect is not significant which suggests that this is not the case. To illustrate this, 31% of single parents in the treatment group receive additional financial support at baseline versus 62% at follow-up (after six months). In the control group this is 33% and 22% resp. At the same time, the share of couples receiving additional financial support increases from 16% at baseline to 30% at follow-up in the treatment group versus 15% at baseline and 17% at follow-up in the control group. In sum, these results suggest that the effect of the intervention is not contingent on specific family characteristics. Although single parents are more likely to receive additional financial support, the intervention benefits both couples and single parent households.

TABLE 16. OLS REGRESSIONS PREDICTING THE RECEIPT OF ADDITIONAL FINANCIAL SUPPORT AT BASELINE AND AFTER 6 MONTHS

	Model 1	**Model 2**	**Model 3**
	Baseline	*Follow-up*	*Follow-up*
Treatment	.001 (.074)	.**173** (.083) *	.**405** (.189) *
Having a partner (ref. = being single parent)	-.182 (.096)	-.**222** (.107) *	-.060 (.159)
Treatment x Partner			-.288 (.211)
Number of children	.021 (.025)	.025 (.028)	.028 (.028)
Nationality of the respondent (ref. = Foreigner)	-.098 (.078)	.036 (.110)	.044 (.087)
Constant	.311 (.107) **	.289 (.120) *	.143 (.161)
R^2	*0.05*	*0.09*	*0.10*
N	*112*	*112*	*112*

Note: standard errors in parentheses. Significance levels: * p < 0.05; ** p < 0.01; *** p < 0.001.

In order to get more insights into the mechanisms of effectiveness, in Table 17 and Table 18 we test which characteristics of the intervention are associated with higher levels of receipt of additional financial support. In section §3 we discussed in detail how case managers modelled their interventions in the MISSION trial, here we examine which of their actions mattered most. We focus on differences by case managers, the duration of the intervention and time spent with clients, client characteristics as perceived by the outreaching case managers, and finally the principles of outreaching case management that informed the daily practice of the case managers in working with the families. We have to be aware that we are dealing with small numbers here, because we can only use the information of families in the treatment group. For that reason, we will test only a limited number

of variables at once to establish associations. All models are controlled for being a single partner, the household characteristic that is significantly related to the receipt of additional financial support (Table 16 *supra*). The objective is not to establish causality like we did before, but to uncover which elements of the daily practice of 'outreaching case management' are likely to be most effective in increasing take-up of financial support at the local level.

Model 1 shows differences between the five case managers in the take up of additional financial support given by the OCMW at follow-up. The results show that there are no significant differences between case managers. This means that the results are not driven by one particularly effective case handler nor that personal characteristics of case managers determine the outcomes. It does suggest that the parameters within which the case managers work in daily practice (described in section §3 on outreaching case management) ensures a certain uniformity in the outcome of the treatment. In Model 2 we focus on the duration of the intervention and time spent with clients. Although the intervention consisted of an intensive period of counselling lasting 6 to 8 months followed by a phase out period of about 4 to 6 months. In reality, this turned out to be difficult, and less than half of the files were closed within the foreseen duration of the intervention (42% of all cases for which we have data up until 1 year). To test whether this makes a difference in understanding the effect of the treatment on the primary outcome variable receipt of additional financial support, we add a variable measuring the total duration of the intervention measured in months (Av. = 12,77; SD = 6.39). We also add a variable measuring the average amount of time spent on counselling a family in the first six months of the intervention, expressed in minutes per week (Av. = 67.80; SD = 42.40). The more time spent on a case, the more intensive the intervention was. The results show that the duration of the intervention is not related to a higher probability to be granted additional financial support. Both shorter and longer forms of counselling provide opportunities to improve this outcome. The time dimension is important, however. On average, each additional 10 minutes per week spent on a client case is related to a 3 percentage point increase in the probability to receive additional financial support. This suggests that outreaching case management is an intensive, time-consuming practice. This has obvious implications for the transferability of this method to other contexts (see section §6).

Model 3 tests the association of client characteristics (as perceived by the case handler) with primary outcome (4). We add three variables: First, a variable depicting the 'magnitude of the problem', i.e. the perception of the case handler to what extent the family is faced with a multitude of problems. This variable is measured on a scale from 0 to 10, with 0 meaning the family faces a low burden of problems and 10 that the family is confronted with a heavy burden of problems (Av. = 6.18; SD = .214)[43]. Second, 'accessibility of the family', i.e. the perception of the outreaching case manager to what extent it is easy to make contact and support the family. This variable too is measured on a scale from 0 to 10, with 0 meaning not accessible at all and 10 totally accessible (Av. = 6.33; SD = .272). Finally, we add a 'vulnerability index', calculated as the sum of factors that are associated with an increased vulnerability of families ranging from 0 to 4 (Av. = 1.51; SD = .11).[44] The results show that there is no significant association between the magnitude of the problem or the vulnerability index on the one hand and the primary outcome on the other. There is however a significant association with the accessibility of the family: the more open the family is to outside help, the better the primary outcomes are. This means that gaining trust of the families is an important part of the preliminary work with the families.

Finally, in Table 18 model 4 we test which of the principles that informed the daily practice of the case managers, based on theoretical insights from the literature on outreaching and case management (see section §2.1 *supra*), is associated with improved outcomes. We add variables related to the 10 different principles guiding the daily practice of outreaching case management: (1) working integrally; (2) working demand-driven; (3) emancipatory work: increasing the capability of the client to ask for help independently; (4) emancipatory work: increasing the capability to go to social services independently; (5) pro-active work; (6) advocacy work; (7) the main actor involved in improving coordination; (8) improving coordination by bridging coordination problems between services; (9) improving coordination by aligning client demand and service supply; and (10) working task- and

[43] For one client case, the case handler could not determine the magnitude of the problems faced by the family.
[44] These factors are: addiction, physical or mental disabilities, psychological vulnerabilities, speaking a foreign language, absence of a support network, and having a history of negative experiences with professional care.

person-oriented. These guiding principles are described in detail in section §3.2.3. All of these variables were measured on an ordinal scale with higher scores indicating that the case handler is working more according to the principle with a particular family. The variables used here are based on the measurement at 6 months of the intervention (or the final score in case the intervention lasted less than 6 month). Given the small sample size, the variables are entered separately into the model, controlled for being a single parent.

The results show that working according to four particular principles is significantly associated with better primary outcomes: working emancipatory by increasing the capability to go to social services independently, doing advocacy work, the main actor involved in improving coordination, and improving coordination by aligning client demand and service supply. Emancipatory work consists of strengthening families' capability to seek support from professional services on their own. This means that outreaching case managers work with families to e.g. improve their self-confidence by helping them to make contact with services and showing them how these services operate and what they can expect. The results show that the probability to receive additional financial support is higher when families are actively involved in the process of seeking support. Advocacy, then, should be understood as any activity undertaken by the case handler to obtain something for the client or to get something done. The more case managers were able to advocate on behalf of their clients towards other social professionals or organisations, the better they succeeded in securing additional financial support for the family. In practice, this usually involves case managers mediating between different professionals. Several examples of the advocacy approach are listed in section §3.2.3. The two dimensions of coordination yielding significant associations means that take up is associated with the family coordinating support themselves. Moreover, the more professional support is tailored to the needs of families, the better the primary outcomes turn out to be. The other principles followed by case managers in their daily practice do not yield significant associations.

In sum, we identify following factors of success: supporting families in their capability of seeking and coordinating their own support, professional support that is tailored to the actual needs of families, and an outreaching case managers who takes serious her advocacy role.

TABLE 17. OLS REGRESSIONS PREDICTING THE RECEIPT OF ADDITIONAL FINANCIAL SUPPORT AT FOLLOW-UP FOR THE INTERVENTION GROUP

	Model 1	**Model 2**	**Model 3**
Case handler (ref. = A)			
B	.083 (.206)		
C	-.008 (.206)		
D	-.277 (.210)		
E	.108 (.200)		
Intensity of the intervention			
Duration of the intervention (in months)		-.002 (.010)	
Average time spent on a family (in minutes per week)		**.003** (.002) *	
Client characteristics			
Magnitude of the problems			.039 (.045)
Accessibility of the family			**.071** (.032) *
Vulnerability index			.023 (.091)
Constant	.620 (.116) ***	.482 (.197) *	-.064 (.091)
R^2	*.15*	*.15*	*.18.*
N	*56*	*56*	*55*

Note: all models are controlled for being a single parent. Standard errors in parentheses. Significance levels: * p < 0.05; ** p < 0.01; *** p < 0.001.

TABLE 18. OLS REGRESSIONS PREDICTING THE RECEIPT OF ADDITIONAL FINANCIAL SUPPORT AT FOLLOW-UP FOR THE INTERVENTION GROUP

	Model 4			
Principles of outreaching case management	b (se)	Constant	R^2	N
Integral	.105 (.076)	.340 (.239)	.11	*56*
Demand driven	-.020 .(119)	.693 (.477)	.08	56
Emancipatory: independent use of services	**.077** (.038) *	.556 (.131)***	.14	56
Emancipatory: asking for help independently	.070 (.054)	.562 (.137) ***	.10	56
Proactive	.089 (.085)	.370 (.270)	.09	56
Advocacy	**.189** (.069) **	.370 (.215) **	.19	56
Coordination: one stop shop	**.094** (.044) *	.421 (.157) *	.15	56
Coordination: bridging coordination problems between services	.046 (.033)	.544 (.140) ***	.11	56
Coordination: alignment between client demand and service supply	.**113** (.043) *	.503 (.132) ***	.18	56
Task and Person-oriented	.082 (.067)	.440 (.194) *	.10	56

Note: all models are controlled for being a single parent. Each principle is tested in a separate model. Standard errors in parentheses. Significance levels: * p < 0.05; ** p < 0.01; *** p < 0.001.

Discussion

The outcomes of the trial are clear. The method of outreaching case management does have a causal, substantial effect on the take up of additional financial support amongst poor families in the Belgian city of Kortrijk. The longer-term results also suggest that there is a positive effect on participation in training and employment programs. However, there are no discernible effects on the take up of forms of non-financial support nor on the take up of social assistance benefits (*leefloon*).

These results are probably related to the nature of the outcome. As mentioned *supra* the additional financial support is granted ad hoc on the basis of need. Outreaching case managers (OCMs) are in an ideal position to quickly spot those direct needs (e.g. unpaid bills or struggles to pay the rent or childcare fees), make contact with the appropriate case worker at the OCMW, and finally advocate on behalf of the client with these case workers to get things done. This is a time-intensive process, in which they support families to coordinate the support they get, and advocate on behalf of their clients. As a matter of fact, data from the OCMs weekly registration indicates that 26% of total time of the intervention was spent on dealing with issues relating to income, and in 77% of the cases, OCMs worked together with OCMW. However, case managers need to be mandated by the families to achieve success. The more case managers indicated that families were accessible, the better they were able to coordinate support and to advocate on their behalf (section §3). After 6 months, still, in 7% of families in the treatment group it was not possible to advocate on their behalf (calculations for the principle advocacy work after 6 months). For families who are not accessible, the first course of action is to gain their trust, and it might take (much) longer than 6 months to see results.

When it comes to the receipt of social assistance benefits *(leefloon)*, an important source of income for many vulnerable families in Belgium, the situation is different. Before baseline, almost anyone was already in contact with OCMW. While not everyone is aware of the availability of different smaller-scale and ad hoc financial support, a large majority of families is acquainted with social assistance benefits (*leefloon*) in Belgium. Case in point: 83% of respondents indicated at baseline measurement that they had active knowledge of *leefloon*. Moreover, the right to social assistance benefits is bound by legal conditions (see section §1). Even if OCMs were

successful in supporting families in the application process, they were less able to play their advocacy role. If families don't qualify, they will be denied the benefit. This also means that if case managers would be able to structurally improve the income situation of families (e.g. they engage in paid employment, or they receive other benefits in the social security system), this would affect the social benefit entitlement of these families. One OCM notes:

> *"Although the man is now doing a job via article 60 [subsidized employment scheme, OCMW] and in general the family experiences a raise in income, there also drawbacks. They have lost their social assistance benefit (leefloon) entitlements because the man is now an employee. This means that a whole bunch of social support measures that are tied to the statute of receiving social assistance benefits (leefloon), such as social tariffs for gas and electricity and supplemental child benefits. He also has to bear additional costs to get to work (such as gasoline)." (Logbook registrations, working/hindering factors, B9)*

Finally, it should be noted that the five outreaching case managers working for the MISSION project have their own style and approach in working with a variety of families with different socio-economic characteristics. Still, there is no evidence that the treatment effect is explained by family characteristics or specific case managers. This suggests that the methodology of outreaching case management *in itself* has the potential to improve the outcomes of families. That being said, there are some conditions for such intervention to be effective: outreaching case management needs to be intensive, families need to be open to receiving support (which means that gaining trust first is an important factor), and outreaching case managers need to have the mandate to act and advocate on behalf of their clients vis-à-vis the local services and organisations. At the same time, local service providers and organisations need to be open to work with outreaching case managers who can be very demanding towards service providers. Effective outreaching case management often requires a change in the organizational culture of the local social services (see section §6).

5.3 Secondary outcomes

In what follows we discuss the effect of the intervention on the secondary outcomes. These analyses are based on the MISSION survey data collected at baseline and at follow-up after six months. As per our trial registration, we focus on outcomes in terms of employment, income and living conditions, housing, childcare, well-being and personal assessment of professional support. We present complete case-analysis, meaning that we only take account of observations that have both baseline and follow-up measurements. Because this might induce bias and pose a threat to internal validity, we estimate treatment effects using an analysis of covariance in case there are significant differences between groups at baseline. In analysis of covariance, a linear regression analyses is conducted estimating the effect of the treatment on the follow-up measure, including the baseline measure as a covariate. This also means that the baseline measurement and number of observations differs with the results presented in section §5.1 on the baseline descriptives where we used the full sample. We discuss the results in the same order as before.

Employment

First we examine to what extent changes in household employment patterns differ across groups. We focus on two measures: (1) the share of households reporting a 'very low work intensity'. A change in this variable means that more people entered paid employment or that people increased working hours; (2) the share of households in which at least one person was at work (employees, self-employed, and working under the service voucher system). Table 19 shows that there was no significant difference between groups in the share of households with a very low work intensity. At baseline, there was a 11 percentage point difference between groups ($t = 1.031$, $p = .305$) which was reduced at follow-up. Table 20 shows similar results for the share of households in which at least one person was at work: a difference of 10 percentage points between groups ($t = -1.006$, $p = .317$) which was reduced at follow-up.

TABLE 19. SHARE OF HOUSEHOLDS IN VERY LOW WORK INTENSITY AT BASELINE AND FOLLOW-UP BY GROUP

(1)	Treatment	Control	Diff.	T-value	P value	Nor-diff
Baseline	.435	. 542	.107	1.031	.305	.150
Follow-up	.500	.521	.021	.199	.842	.029
N observations	*46*	*48*				

TABLE 20. SHARE OF HOUSEHOLDS IN WHICH AT LEAST ONE PERSON WAS AT WORK AT BASELINE AND FOLLOW-UP BY GROUP

(2)	Treatment	Control	Diff.	T-value	P value	Nor-diff
Baseline	.435	.333	-.101	-1.006	.317	-.147
Follow-up	.413	.396	-.017	-.168	.867	-.024
N observations	*46*	*48*				

There was no effect of outreaching case management on getting more people into (more) regular work. This is not surprising, since the primary outcomes already showed that an increase in the participation in training and employment programs only surfaced after 6 months, and such participation in training does not necessarily lead to gainful employment afterwards. Moreover, at baseline a substantial share of respondents (64%) and their partners (28%) were not readily available for the labour market. The outreaching case managers observed many obstacles for the MISSION families in getting a job, including health, language and practical issues such as lack of childcare or public transportation. These obstacles are in line with the obstacles respondents themselves reported as being important barriers to work (language, family life, public transportation, and health).

> *"It is not easy to find an employment. Since recently she gets assistance for this via 't Werkt [an ESF-project under the coordination of the OCMW]. Mobility is a factor here. The client does everything on foot and by bus. It is not easy to bring a baby to day care in the morning, one to school and at the same time being on time for work. (Or, like now, for Dutch lessons)." (Logbook registrations, working/hindering factors, E4)*

> *"The man's activation pathway does not automatically lead to a job. He has no driver's license, speaks French and has too little work experience in certain sectors to find a suitable job." (Logbook registrations, working/hindering factors, A8)*

Not finding or refusing an employment or activation trajectory implies losing all sorts benefits and support. This pressure often prevents OCMs working primarily on other issues, such as the mental well-being of clients.

> *"During the consultation the activation pathway that the mother should take up was discussed again. I agree with an activation pathway, but the mother needs rest first. I think it is not appropriate to bring it up immediately. Mama is a single mother of two small children, pregnant with a third child and has just been homeless for a month." (Logbook registrations, working/hindering factors, E12)*

> "*Because the person concerned has no room left to take on or follow up other matters because of the training program, causes the situation to deteriorate in other areas (mainly financially).*" *(Logbook registrations, working/hindering factors, C11)*

Although finding a job in some cases causes a significant improvement in the financial situation, in other cases it does not. Having a job does not always guarantee progress. For example, having a job often leads to extra costs for, e.g., childcare or transportation, not being entitled anymore to certain social benefits or neglect other matters that need to be sorted out. It is also obvious that the target group in itself poses a challenge for the method of outreaching case management with respect to employment outcomes. In families with a new-born child, the likelihood that mothers will be up and ready to join employment or training programs is presumably limited to begin with.

Income and living conditions

Analysis of the primary outcomes demonstrated causal evidence of the method of outreaching case management to increase the take-up of additional financial help at follow-up. As a secondary outcome, we analysed whether the intervention had a more general effect on disposable household income or other general indicators of living conditions. Household income is influenced by many factors, and receiving temporary additional financial support might relieve families from an immediate need (e.g. pay for heating) or lowering the cost of using services (e.g. lower childcare fees) but does not necessarily raise living standards. Particularly so since the intervention did not affect employment in the short run.

Table 21 shows differences between groups in equivalized disposable household income at baseline and at follow-up. For three families with missings who completed the follow-up questionnaire we were able to impute incomes based on the OCMW register data (in which disposable household income is often reported as part of the means-test). There was a substantial difference between groups at baseline: equivalized income was €121 higher in the treatment group (t = -1.830, p = .071, norm. diff. = -.267). For that reason, we use analysis of covariance (ANCOVA) to conduct between-group comparisons at follow-up after adjusting for baseline values. In the table, the adjusted t- and p-values are shown. The results show that there are no significant differences in disposable equivalized household income between groups.

TABLE 21. MEAN EQUIVALIZED DISPOSABLE HOUSEHOLD INCOME AT BASELINE AND FOLLOW-UP BETWEEN GROUP

	Treatment	Control	Difference	T-value	P-value	Norm. diff.
Baseline	995.80	874.83	-120.97	-1.830	.071	-.267
Follow-up	1032.25	918.59	-113.66	0.893[x]	.374[x]	-.272
N observations	*46*	*48*				

[x] *Values based on ANCOVA*

Outreaching case managers regularly recorded in the logbooks that they were unable to make immediate headway in the income situation of families, despite their efforts to do so:

> *"Income cannot be increased spectacularly. Only interventions for small costs (day care and school invoices). It remains difficult to arrange this for the person concerned. Leading to: no child benefits, no study allowance, no registration with social housing company, …" (Logbook registrations, working/hindering factors, A4)*

Often, progress was limited to quick wins in terms of ad hoc support for relieving direct needs. While such form of support is of primordial importance, it is unlikely to lead to a structural improvement of the living standards of families.

> *"I personally found this to be a very productive month with this family! Many steps were taken in the right direction. 2 important issues: the accessibility / availability of the family has improved considerably and we are fully engaged in finding out their rights, advocacy, and an activation of the appropriate services:*
> *- Creating an overview of the current financial situation. This opens up opportunities for substantiated dialogue with the debt mediator. Due to their very limited means, the family has again made € 18,000 estate debts after entering the collective debt settlement. We have requested a follow-up consultation to see how we can structurally settle these debts and how we can avoid further debts.*
> *- A request for budget management through OCMW Kortrijk (at the request of the family and with the agreement of a debt mediator).*
> *- Rental subsidy: this was already applied for in May, but now it came to the surface that the family had not posted the letter. Now I have done this and this rental subsidy was dealt with and approved in less than 1 week: € 287 per month! Too bad they were entitled to this already for 2 years.*
> *- Regularization requested from the health insurance company: Mrs did not comply with the health insurance regulations, but now this is also OK.*

- Applied for study allowance (did not know that they were entitled to it; they thought this only was for children in secondary and higher education). Meanwhile, this has already been dealt with, approved and paid.
- Searched for sport opportunities for the 3 oldest children.
All this does create trust for the people. They get the feeling that things are moving forward. By screening their possible rights, a lot of financial benefits could be secured." (Logbook registrations, working/hindering factors, B18)

An example of such quick win is material assistance. At baseline it was noted that almost half of families relied upon support for basic items such as food, clothing or diapers. In the follow-up questionnaire, we again asked respondent whether they relied upon such material assistance. Table 22 shows the share of households receiving material assistance at baseline and follow-up between groups. The results show that there is a difference of 16 percentage points in favour of the control group, a difference of almost a quarter of standard deviation. For that reason, we use ANCOVA to estimate differences at follow-up. At follow-up the difference was 6 percentage points in favour of the treatment group, but that difference was not significant. A paired sampled t-test showed, however, that there was a substantial and significant increase of 25 percentage points (norm. diff. = .353) in the share of households receiving material assistance in the treatment group (t = 3.387, p = .002). Such increase failed to materialize in the control group (t = .275, p = .785). This is in line with the experiences of OCMs that they were able to improve these forms of material help in the short run.

TABLE 22. SHARE OF FAMILIES USING MATERIAL ASSISTANCE AT BASELINE AND FOLLOW-UP BY GROUP

	Treatment	Control	Diff.	T-value	P value	Nor-diff
Baseline	.400	.562	.163	1.571	.120	.231
Endline	.644	.583	-.061	1.508[x]	.135[x]	-.088
N observations	45	48				

Note: there was one missing in the treatment group. [x] *Values based on ANCOVA*

Although the financial situation did not improve, it might be the case that the subjective experience of poverty changed. Table 23 shows the share of families in subjective poverty, indicating that they are only able to make ends meet 'with (great) difficulty'. At baseline, about one third of families live in subjective poverty with no differences between groups. If anything, the feeling of subjective poverty increased in both groups but the within-group changes are not significant.

TABLE 23. SHARE OF FAMILIES IN SUBJECTIVE POVERTY AT BASELINE AND FOLLOW-UP BY GROUP

	Treatment	Control	Difference	T-value	P-value	Norm. diff.
Baseline	.326	.313	-.014	-.140	.889	-.020
Follow-up	.391	.396	.005	.044	.965	.007
N observations	*46*	*48*				

A final measure of living standards is the share of families being materially deprived. Families are materially deprived or severely materially deprived if they feel they cannot afford three resp. four out of nine items that are deemed necessary to uphold a decent living standard (section §5.1). Table 24 shows the share of families in (severe) material deprivation at baseline and at follow-up by group. At baseline there is a 9 percentage point difference between treatment and control, but that difference is not significant. At follow-up, there is no significant difference between groups.

TABLE 24. SHARE OF FAMILIES LIVING IN (SEVERE) MATERIAL DEPRIVATION AT BASELINE AND FOLLOW-UP BY GROUP

		Treatment	Control	Diff.	T-value	P-value	Nor-diff
Material deprivation	Baseline	.630	.542	-.089	-.867	.388	-.127
Severe material deprivation	Baseline	.304	.354	.050	.509	.612	.074
Material deprivation	Follow-up	.717	.583	-.134	-1.360	.177	-.199
Severe material deprivation	Follow-up	.391	.333	-.058	-.579	.564	-.084
	N observations	*46*	*48*				

Housing

At baseline measurement 28% of the MISSION families were living in a social housing unit. Table 25 shows that there were no significant differences between groups at baseline. At follow-up, six months later, the difference between groups increased from 3 percentage points to 6 percentage points, but this difference was significant nor substantial. Although the housing situation of the MISSION sample is often problematic, it turned out to be hard to improve this on such short notice. Particularly problematic was the lack of social housing and the long waiting lists once families applied for social housing.

> *"The lack of good and affordable housing is causing a decline. Despite the many initiatives, there are still long waiting lists making the person concerned rather despondent." (Logbook registrations, working/hindering factors,* C18)

The outreaching case managers also indicated that the supply of social housing is very fragmented, and that the admission procedures are devious and unclear.

> *"It took me a long time to register madam in all kinds of housing associations. This is mainly due to her psychosocial problems, but it would have helped me if there had existed one central point of application for (social) housing. For example, someone registers with team living of OCMW and would automatically (with consent of course) also be registered at SVK De Poort [social rental agency], Wonen Regio Kortrijk [social housing association], Kracht.Wonen [a regional registration centre], and is proactive contacted by the Woonclub [part of the regional registration centre, offers assistance with housing]. This is not the case today en very fragmented; you have to sign up at each association separately and deliver the necessary documents. This is very time-consuming! To get an appointment at SVK De Poort [social rental agency]] is not easy, you have to call first to see when you can call to make an actual appointment! "(Logbook registrations, working/hindering factors, B13)*

Given the shortage of affordable and qualitative dwellings on the private rental market, one thing the OCMs could do was to raise awareness of social housing policies and help families to register for the waiting list. Table 26 shows the difference between groups in the share of respondents being aware of social housing and its application procedures for both Social Rental Agencies (SRA) and Social Housing Associations (SHA), as well as the share of families who actually applied in the first six months for social housing. Unfortunately these items cannot be compared with baseline measurement. In the baseline survey the question was asked whether there has been *any* application for social housing while in the follow-up survey the question was whether there was an application or a request for information in the past six months. Moreover, in the baseline survey the knowledge items were asked only to respondents indicating they were living in social housing while at follow-up these items were asked to all respondents. For that reason, we only show the difference between groups at follow-up. The results show that knowledge of both social housing organisations was higher in the treatment group than in the control group at follow-up. Although the results are not significant, they are substantial with more than a quarter of a standard deviation difference. Similarly, the share of households who applied or asked

for information at both SRA and SHA was higher in treatment groups at follow-up, but the differences were not significant. These substantial differences in terms of awareness and knowledge corroborate the experience of the outreaching case managers:

> *"Their wishes mainly are finding decent and affordable housing and a sustainable employment. The necessary steps have been taken for both these issues and we worked on preconditions. For instance housing: registered with SVK De Poort [social rental agency] and Wonen Regio Kortrijk [social housing association]. Explained to them that they entitle to a rental subsidy after being on a waiting list for four years. If they want another house now they will have to turn to the private rental market. The biggest problem is that this is too expensive, but something more affordable is difficult. We contacted the house owner for the necessary improvements to the property, which he is now taking care of. Hence all services have been contacted but no final results have been achieved…. Unfortunately there is no other option than going through the waiting time." (Logbook registrations, working/hindering factors, B9)*

TABLE 25. SHARE OF HOUSEHOLDS LIVING IN SOCIAL HOUSING AT BASELINE AND FOLLOW-UP BY GROUP

	Treatment	Control	Diff.	T-value	P value	Nor-diff
Baseline	.304	.271	-.034	-.355	.723	-.052
Follow-up	.348	.292	-.056	-.579	.564	-.084
N observations	46	48				

TABLE 26. SHARE OF HOUSEHOLDS REPORTING KNOWLEDGE ABOUT AND APPLIED FOR SOCIAL HOUSING AT FOLLOW-UP BY GROUP

		Treatment	Control	Diff.	T-value	P value	Nor-diff
Knowledge of social rental agency (SRA)	Follow-up	.978	.896	-.082	-1.640	.104	-.241
Knowledge of social housing association (SHA)	Follow-up	.478	.291	-.187	-1.875	.064	-.273
Application for or information about social housing at SRA	Follow-up	.457	.313	-.144	-1.436	.154	-.209
Application for or information about social housing at SHA	Follow-up	.109	.063	-.046	-1.007	.317	-.147
	N observations	*46*	*48*				

Childcare

Childcare is an important policy instrument for disadvantaged families with young children, both in terms of supporting paid employment and improving children's school readiness. Table 27 shows the share of families using or being registered in formal childcare services at baseline and follow-up by group. Based on the OCMW register data, we were able to impute these values for 8 additional families, increasing the sample size for this item to 102. The results show that there was a baseline difference of 13 percentage points between groups in favour of the treatment group, but that this difference was not significant. At follow-up, the difference has increased to 20 percentage point, a substantial and significant difference between treatment and control. Paired sample t-tests showed, however, that the changes within both treatment and control groups were not significant.

The OCMs indeed recorded in the logbook how difficult the search for a slot in childcare often was. They signalled long waiting lists (of six months to even a year) for few available places. When families were able to secure a childcare slot, the practical hassle sometimes prolonged the process of actual using childcare.

> *"It is a shame that the practical aspect – in particular for vulnerable families – has such a big influence. That makes sense, of course (they don't own a car and are depending on public transport, or they must go on foot)." (Logbook registrations, working/hindering factors, B27)*

> *"Arrange the registration. I notice that childcare initiatives are really satisfied if you accompany the client, that you are taking care of the creation of the child registration code. There is much to be done. If you have to take care of this, alone as a family, it is really very complicated. Initially, they always put the responsibility for this with the families, but it must be done digital, you must have an email address, the threshold is high. It is not always easy to create this code, half of the times, the website doesn't even work." (Focus group, outreaching case manager)*

Despite a structural shortage, the OCMs persevered in finding families a place in childcare, often with results. But the experiences of the OCMs revealed some structural problems with how the local and Flemish childcare registration system worked.

> *"In search for childcare, I contacted the local childcare liaison officer. The answer was that there are no available places until January 2020 at the earliest. However, I contacted various child care initiatives and was able to find several (!) places for the desired date. The client could even choose between a daycare centre and a child minder." (Focus group, outreaching case manager)*

> *"We have a local 'childcare portal' in which available child care places must be entered, but it is a very static system. We have no instruments to oblige child care initiatives to keep it up to date." (Focus group, team coordinator)*

> *"The system really doesn't make any sense because childcare initiatives themselves tell us that at times they are really overwhelmed with questions. Every individual social worker or mother sounds the alarm bell: is there a place available? They [the child care initiatives] constantly receive e-mails, the system is not working properly." (Focus group, outreaching case manager)*

TABLE 27. SHARE OF FAMILIES USING CHILDCARE (NOW OR IN THE FUTURE) AT BASELINE AND FOLLOW-UP BY GROUP

	Treatment	Control	Diff.	T-value	P value	Nor-diff
Baseline	.473	.339	-.133	-1.432	.155	-.192
Follow-up	.653	.453	-.200	-2.052	.043	-.288
N observations	*49*	*53*				

Well-being

The MISSION survey at baseline indicated that MISSION families exhibited poorer subjective well-being, social trust and social networks compared with Flemish families with children, but also that they were no less resilient. Table 28 shows the difference in the measure of subjective well-being (see section §5.1 for the operationalization of this measure) at baseline and follow-up by group. The other items gauging dimensions of well-being could not be tested, because there were strong imbalances in the number of missing observations by group. As usual, we show complete case analyses. The results show that there are no differences in the level of subjective well-being at baseline between group, and this did not change at follow-up. There is no improvement in the subjective well-being score for the treatment group compared with control.

TABLE 28. SUBJECTIVE WELL-BEING SCORE OF RESPONDENTS AT BASELINE AND FOLLOW-UP BY GROUP

	Treatment	Control	Diff.	T-value	P value	Nor-diff
Baseline	6.963	6.882	.081	-.153	.879	-.025
Follow-up	7.000	6.882	-.118	-.234	.815	-.038
N observations	*41*	*34*				

Professional assistance and assessment of local social organisations

Finally, it is important to examine the perceptions of respondents with respect to professional support and their assessment of local social organisations. Families in the intervention group were confronted with a new way of providing close and intensive support while families in the control group received treatment as usual. How does this affect perceptions about professional support?

First of all, we asked respondents to give an estimate of the number of professionals working with them or supporting them in the household. Table 29 shows the share of respondents indicating they have no professional support in the household. At baseline, there no differences in the share of households reporting no help or support. At follow-up, however, there is substantial and significant difference between the two groups of about half a standard deviation. While 58% of families in the treatment group indicate they receive no support, this drops to 26% in the treatment group. While this is not an unexpected result, it is noteworthy that still a quarter of families do not seem to experience the support provided by OCMs as professional support. The logbook registration files of the OCMs indeed indicate that the OCMs perceived these families as less problematic, and total time spent with these families was lower than for the other families.

TABLE 29. SHARE OF RESPONDENTS INDICATING THEY RECEIVE NO PROFESSIONAL SUPPORT

	Treatment	Control	Diff.	T-value	P value	Nor-diff
Baseline	. 435	.479	.044	.428	.670	.062
Follow-up	.261	.583	.323	3.308	.001	.483
N observations	*46*	*48*				

At follow-up, respondents were again asked whether they experienced that the professionals working in their household were working in a harmonized way and the support provided was aligned to different needs. Unfortunately, these questions were only asked to respondents who reported there was at least one social professional present in the household. Given the strong differences in this variable between baseline and treatment, we cannot test changes over time. For that reason, Table 30 shows the difference between groups at follow-up only for the following questions: (1) There is a service provider who has an overview of my situation; (2) I have to tell my story too often; (3) I have to provide my personal details too often to different agencies; (4) I feel that the social services for my situation are not coordinated with each other. Although the sample sizes are limited, we observe substantial differences by group in the assessment of professional support at follow-up. In particular, there is a significant and substantial lower share of respondents in the treatment group who agree that they have to tell their story too often. There are also substantially lower shares of respondents in the treatment group indicating that they have to provide personal info too often, and agreeing that social services are not always coordinated with one another. These items were indeed central to the daily practice of OCMs (section §3).

TABLE 30. SELF-ASSESSMENT OF HARMONISATION OF PROFESSIONAL SUPPORT AT FOLLOW-UP BY GROUP

		Treatment	Control	Diff.	T-value	P value	Nor-diff
No overview	Follow-up	.030	.050	.020	.358	.722	.069
N observations		*33*	*20*				
Telling story too often	Follow-up	.206	.526	.320	2.490	.016	.488
N observations		*34*	*19*				
Providing personal info too often	Follow-up	.364	.556	.192	1.319	.193	.271
N observations		*33*	*18*				
Uncoordinated	Follow-up	.242	.50	.259	1.714	.094	.382
N observations		*29*	*14*				

TABLE 31. SELF-ASSESSMENT OF THE QUALITY OF PROFESSIONAL SUPPORT AT FOLLOW-UP BY GROUP

		Treatment	Control	Diff.	T-value	P value	Nor-diff
Accessible	Follow-up	.794	.65	-.144	-1.160	.251	-.226
N observations		*34*	*20*				
Eligibility	Follow-up	.758	.722	-.035	-0.272	.787	-.056
N observations		*33*	*18*				
Listen	Follow-up	.912	.900	-.012	-0.141	.888	-.023
N observations		*34*	*20*				
Refer to services	Follow-up	.818	.90	.082	0.796	.430	.164
N observations		*33*	*20*				
Opinion	Follow-up	.903	.765	-.138	-1.296	.201	-.261
N observations		*31*	*17*				

Finally, several dimensions of the quality of the professional support families are receiving were queried at follow-up. Again, we cannot compare changes over time within groups. Table 31 shows differences in the assessment of different dimensions of quality of support by group at follow-up. There is only one substantial difference between treatment and control groups with respect to respondents' feeling that their opinion is taken into account. On the other dimensions of support, there are no substantial or significant difference between treatment and control. Yet again, sample sizes are small and there are many missing observations. These results should serve as an indication but should not be taken at face value.

Discussion

The analyses of secondary outcomes reveal much about the potential as well as the limitations of the method of outreaching case management (OCM) to improve the lives of disadvantaged families at the local level. The results suggest that after six months at follow-up, families in the treatment group were better informed, were more likely to apply for support, were more likely to receive material assistance, and were more likely to use childcare. Moreover, their perception of the professional support they received changed: a higher share experienced support in the household, and they experienced this support as being more harmonized and tailored to their demands.

Yet, at the same time, when it comes to the effect on the actual living conditions of families, the results showed no effects. There were no differences between treatment and control group in terms of household income, subjective poverty, material deprivation, employment patterns, social housing, and subjective well-being. This means that a similar pattern as with the primary outcomes arises: OCMs can make the difference when it comes to achieving quick wins in domains they have room to actually influence decision-making. They too, however, are limited by structural barriers towards a better life that are imposed upon disadvantaged families. Case in point: more families in the treatment group applied for social housing, but having to wait for years on a waiting lists does nothing to solve the housing problems families are facing. One cannot expect the case managers to solve the incompleteness, inadequateness and inaccessibility of the welfare state all by themselves. While such inadequacies at the local level were tackled within the MDMA network, structural inadequacies stemming from federal or Flemish policies are out of reach. In that sense, OCMs can only do so much, however effective the method promises to be.

5.4 The added value of an online tool

Sien Online is an application, developed to support the integrated delivery of a wide range of rights, benefits and services to disadvantaged families (see section §2.2). It was conceived as a diagnostic tool for the outreaching case managers, enabling them to carry out a quick screening of all rights, benefits and services their families entitle to, and if applicable, activate these for the benefit of the families. Sien Online is also a registration tool, used for the follow up of the MISSION-families and as a data-source for the action research.

Building information capacity

Sien Online includes information and access to 337 different rights, benefits and services (*products*) in seven categories: income, children, housing, education, health, employment, leisure. In order to keep the information up to date and modify where necessary, a user group was created consisting of 100 frontline social professionals working for 28 different organisations. Apart from that, every year, Sien Online is screened on accuracy, clarity and accessibility.

To avoid outdated information as much as possible, the conditions to obtain a certain right or benefit are not described in the app but are directly linked to the websites of the responsible organizations. Although all frontline professionals have clearance to change information, a yearly update is not enough to keep the information reliable. It is a big challenge to keep the information up to date and to form a self-correcting community amongst the social professionals.

Use of Sien Online

Sien Online is implemented in Kortrijk since November 11, 2018. A year later, users statistics showed that Sien Online was consulted by 6.733 unique users, with an average of 1.7 consultations per user and an average of 7 minutes and 40 seconds per consultation. These users are social professionals as well as citizens. The total of consulted pages amounts to 54.419. Use is regularly spread over the year, with peaks related to MISSION information and dissemination events. Social professionals use Sien Online to screen which rights, benefits and services should or could possibly be activated for the benefit of their clients. Citizens use Sien Online to screen whether there are services they could benefit from or to look up information on certain rights, benefits and services.

The outreaching case managers (OCMs) have not used Sien online systematically. None of the clients interviewed could remember the use of an online tool or website to go through rights and benefits. This is confirmed by the OCMs. They were hired based on their knowledge of rights and benefits and have contributed to the initial database of Sien Online. By doing so they internalized a large part of the information. They believe they do not need to consult Sien online anymore to detect possibilities and to enable procedures. They use Sien

online solely to prepare themselves before a meeting with a client, to generate questions if the family has none, and as a checklist, especially for domains they are not an expert in.

> *"If you have families and you think 'OK there are no questions, I'm going to look myself.' And if you are really going to try to do everything to the max, then I'll try this through Sien online. But then it might be in advance, without the client, that you do it alone. Have a good look 'would she there or there …' or to enter keywords. … And this is not always the case, in fact no." (Focusgroup, outreaching casemanager)*

> *"Yes, I have to say that if you do the latter, you notice that everything has been taken up. But it is important for yourself to do so. Then you know for certain, 'OK I haven't overlooked anything'. More a check, yes." (Focusgroup, outreaching case manager)*

One OCM uses Sien online systematically.

> *"I'll try to do it but it depends a little. With some families I do it when I really don't know how to start. Then it might be that after 2 or 3 times I have met the people, I do it because things come out you can start with and you get to know them by inquiring all those specific life domains. Or I would do it even more because I have been counselling for a year and to conclude, to properly control whether everything is taken up. Thus, it depends but I'll try to do it with everyone." (Focusgroup, outreaching casemanager)*

The OCMs have the impression that the use of Sien online by clients without professional support might be difficult. Too much information appears and not everything is relevant. When one fills out a profile in Sien Online, for instance, not only tailored information appears but also general information on benefits. In this way users get long lists of possibilities which sometimes need extra explanation or need to be screened by relevance on that moment for that profile. The most important benefits or rights for that specific situation might not be seen by the users. For social professionals the appearance of the information on the screen might be a reason to talk about the local centre in the neighbourhood.

The OCM are not all convinced of the added value of a registration tool to reflect on their daily actions. In fact, they have mixed feelings towards registration no matter which tool is used.

> *"I had the same feelings working as a street corner worker. Yes, if there is one thing you skip it is registration because you hardly see the effect of that act of registration. First, people underestimate what registrations do with your mind: reflect on the chaos of the environment you are trying to register. But if social workers have to admit that registration is helpful they'll have to do it. Secondly, what he said before, you can use that information to give a signal about a particular situation but one sees the effects of that even less. Structural work takes long and is complicated and is annoying. But those data help you. But it is so annoying to do so. I too had that feeling, I felt sick about it." (Focusgroup, expert outreach)*

Sustainability

Sien Online was presented and discussed at several local and regional platforms and during MISSION information and dissemination events. This generated a lot of interest from other social service providers and local and regional administrations, in particular from the Flemish OCMWs. We were contacted separately by different organizations and OCMW, but also by the Flemish Association of Cities and Municipalities (VVSG) and the former Association of Flemish OCMW directors (VVOS), meanwhile merged into the consultation platform of Directors of Flemish Centre Cities. We were also contacted by Information Flanders, an institution of the Flemish government that supports authorities in Flanders with marketing, digitalization and improving services. At the moment of writing, discussions are on-going on the further development of Sien Online and the potential for upscaling to all Flemish OCMWs. As far as the further development is concerned, it is being investigated to what extent Sien Online can be linked to the Crossroads Bank for Social Security, how E-ID possibilities can be built in (in the context of automatic allocation of particular rights), and how Sien Online can serve as a lever to move towards an 'integrated social file' for clients of social services.

For now, pending further supra-local developments, arrangements have been made with the software developer that allow individual OCMWs or social service providers to freely implement Sien Online (the public function) on their territory. The software is available for free; it is up to the service provider or OCMW to upload products and keep it up to date. If technical adaptations are requested, the concerned organization has to contact the software developer and make specific arrangements for this.

5.5 Impact on the local organisation of social services

In this section we discuss how the work of the outreaching case managers (OCMs) affected the way local services were organized and how it resonated within the multidisciplinary multi-actor (MDMA) network (see section §2.3).

The initial idea was to structure all MDMA-work around collective meetings with the full MDMA four times a year, in order to discuss the OCMs experiences and elaborate on actions for improvement on accessibility and availability of the involved service providers and organizations. Already after the kick-off meeting it became clear this was not an ideal setting: gathering four times a year with *all* actors involved, certainly because many local organisations were not always involved in the actions of the OCMs. On the other hand, four times a year was not enough to elaborate on all of the barriers and bottlenecks experienced and documented by the OCMs. This was extensively discussed during the first MDMA-meeting which led to a new framework in which the MDMA would meet once a year with the whole group to discuss progress and monitor the main actions. Apart from that, a large number of bilateral consultations were organized with the various stakeholders, based on specific signals or problems reported by the OCMs. The MISSION implementation manager was appointed as MDMA-manager who acted as liaison between the OCMs and MDMA-participants, capturing all reported barriers to effective service delivery to or by the MDMA and elaborating on the appropriate actions for improvement together with all involved actors. The great advantage was that OCMs are professionals looking from the outside to the on-the-ground functioning of service providers. This led to unique insights into barriers inhibiting the take up of social rights at the organisational level. This approach led to changes in four dimensions of service delivery, always starting from specific client situations.

Specific client situations as a driver for improved services

The OCMs were asked to identify and expose bottlenecks and gaps in social service delivery, experienced by themselves and/or the MISSION families. The nature of their task, specifically the integrated approach, the mandate to be the attorney of families, and the time at their disposal to closely counsel families, made it not only possible to expose barriers but also to identify the underlying causes. Such findings were signalled to the MDMA-manager who in turn organized consultations with the relevant actors to work out actions for improvement. The objective was to clarify the situation for the specific family while at the same time ensuring that the necessary adjustments were made to avoid future clients or social professionals experiencing the same problem.

A concrete example:

> *Three food aid centres (food banks) are active in Kortrijk, each with a wide reach but with their own specific eligibility conditions, procedures, and application conditions. Since quite some time it had become very unclear who could go to which centre and under what conditions: in some cases potential beneficiaries could register spontaneously, in other cases food aid centres worked only on referral by certain social services with whom they had an (informal) agreement, some people were sent to the OCMW for support, others weren't. Attempts had been made in the past to structure these different approaches according to some basic principles. These included the agreement that every social service provider could refer people though a specific application form for material assistance (in this case food aid) to the appropriate food aid centre for a fixed period of three months. If the three-month period had expired, the food aid centres had to refer their beneficiaries to OCMW Kortrijk who could, after a social*

inquiry indicating that no other options (e.g. structural measures) were possible in the given situation, extend the eligibility for food aid with another 6 months.

Already from the start of the project, the outreaching case managers signalled that these basic principles were not properly implemented: social service providers had designed their own application forms, resulting in the circulation of different types of application forms. The initial three-months term was not respected, the food aid centres themselves granted extensions to beneficiaries without referring them to OCMW Kortrijk for the social inquiry, and OCMW Kortrijk was not consistent in executing the social inquiry before extending the eligibility with another six months. This caused ambiguity and confusion for both the food aid centres, the referrers and the beneficiaries.

The MDMA-manager called upon the food aid centres and the involved social service providers to create a clear and formal framework in which granting food aid had to be considered as an emergency measure pending a structural solution for the concerned families instead of an ad hoc approach. Clarity and transparency were created in the eligibility criteria of the different food aid centres, the duration and the frequency of the initial notification (twice a month during a three-month period), and the referral to the OCMW for the 6-months extension – only in case the social inquiry proved other structural solutions were not possible. Food aid is now much more considered an emergency intervention yet focused on structural solutions for its beneficiaries in the longer term. It is now clear who is entitled to what kind of aid. As far as OCMW Kortrijk is concerned, formal agreements are in place ensuring that every request for food aid is always accompanied by a thorough social *and* financial inquiry exploring sustainable solution for the precarious living conditions of the applicant. Finally, the MDMA-work in this area resulted in an agreement to organize biannual meetings with all the involved actors to structural improve and align procedures to the beneficiaries' needs.

Specific client situations as a driver for organizational change

At this level, general findings reported by the OCMs and their families were contextualized, and improvements were sought at the level of an entire organization. The objective was again to prevent future clients encountering the same problem, and secondly, to increase the accessibility of a certain social service provider in a more general way.

Concrete example:

The outreaching and integrated approach of the MISSION case managers demonstrated that, in addition to solid knowledge and expertise in the field of legislation, poverty and the general social landscape, the way in which assistance and services are provided and the way in which clients are approached are crucial for a successful counselling process. Driven by the field experiences of the outreaching case managers, OCMW Kortrijk rethought its policy for the recruitment and training of new social assistants. Where the prevailing recruitment policy primarily focussed on knowledge and theoretical expertise, selection procedures have now been adjusted in such a way that a positive approach, the motivation to work with vulnerable clients and a participatory basic attitude of potential employees are more thoroughly screened and are decisive to whether or not to recruit. The new recruitment policy also includes a number of objectives to align training modules for new employees with an outreaching way of thinking and acting.

Specific client situations as a driver for inter-sectoral cooperation and knowledge transfer

Social service provision is today still highly fragmented and diffuse, and social professionals specialize in very specific areas covered by the organisation they work for, which leaves them with little or no opportunity to address client situations in a more holistic way. Consequently, solutions to problems are not always sought where they can be found, for example in the cooperation with other service providers. MDMA-work in this area focussed on improving coordination between different service providers, with a strong focus on knowledge

transfer between different service providers and their employees. The objective was to increase efficiency and accessibility of different social services across different sectors.

Concrete example:

> *The RVA (the National Employment Office) is responsible for the implementation of unemployment insurance schemes and determining whether or not someone is entitled to unemployment benefits. Consequently, many OCMW-clients have to file an application with RVA. The MISSION outreaching case managers reported to the MDMA that procedures weren't very accessible and delays occurred due to waiting times. RVA, in turn, as a member of the MDMA, reported that many OCMW-clients are not well prepared when referred to the RVA by the OCMW, which indeed caused delays. In addition, it turned out that RVA can administer applications from OCMW clients with priority, but this possibility was unknown to many social assistants and outreaching case managers.*

MDMA work in this area led to the creation of a cooperation protocol between RVA and OCMW with targeted actions on both sides; clients referred to RVA are now well-prepared by their social assistant (e.g. in the possession of the necessary documents and information to file the application) based on a manual drawn up by RVA. Also new communication procedures are in place to ensure applications coming from OCMW-clients are treated with priority by RVA.

Specific client situations as a driver for policy change

The outreaching case managers exposed many bottlenecks and gaps in social service delivery, which were turned into different improvement actions under the umbrella of the MDMA at the above defined various levels. This in turn enabled the identification of opportunities for policy improvements, meanwhile translated into policy planning for the upcoming period 2020-2025 and included in the new administrative agreement of the city of Kortrijk and the corresponding anti-poverty plan:

First of all, the entire anti-poverty plan is based on three basic principles, two of which directly occur from the MISSION-experiment:

> "Focus on early detection: we will actively invest in an early detection of poverty risks, and identify and help people in and at risk of poverty as early as possible. The earlier we intervene, the better we can prevent people from falling into deep poverty."
>
> "Focus on outreach work: we will draw on the positive experiences with both the frontline liaison workers and the [MISSION] case managers by organizing our services as close as we can in the living environment of our citizens".

The administrative agreement 2020-2025 also includes a major reorganization of the entire social services department, in which the above cited basic principles will be implemented throughout the entire OCMW:

> Under the heading '1 family, 1 plan', the MISSION single point of contact principle will be implemented in the whole social services department, with social assistants in the role of central points of contact for families and social service providers, taking on a coordinating role and working in the living environment of their clients.

The use of technology has proven to be very efficient for increasing the availability and accessibility of individual social service provision and support. Building on these experiences, OCMW Kortrijk is currently investigating how to mainstream the use of smartphones and instant messaging into regular policy.

Second, in addition to the implementation of these rather general principles, specific bottlenecks have been translated into structural policy measures. We highlight two specific examples:

The availability and accessibility of childcare: the outreaching case managers exposed bottlenecks in both the availability and accessibility of child care provision in Kortrijk. A lot of the MDMA-work was dedicated to this specific topic, which has eventually led to targeted measures listed in the anti-poverty plan for 2020-2025:

Accessibility: in principle, low-income families are entitled to subsidized income-related childcare, but in practice the number of available places is limited. Supply does not cover the demand. Hence, families have to turn to private childcare initiatives charging an average price of €24/day. The OCMW can provide financial support based on the individual situation of the applicant and within the framework of the right to social services *(het recht op maatschappelijke dienstverlening*). This is one of the primary outcomes tested supra (§0). Initiated by the MDMA, financial means and actions have been secured in the anti-poverty plan 2020-2025 with the objective to increase the efficiency of this system and to implement it on a broader scale.

Availability: The administrative agreement 2020-2025 includes the development of a new system consisting of financial incentives to stimulate the start-up of new child care initiatives (both group care and childminders), and to guarantee the continuity of existing initiatives. Extra incentives will be provided to cover blind spots in the city (neighbourhoods with little coverage) and for starting up new initiatives in vulnerable neighbourhoods. Kortrijk will also invest in additional places.

The OCMW will provide for extra occasional childcare places, intended for last minute requests for childcare for a short period of time, for example for people who enter a training course, apply for jobs or enter a temporary work experience program.

The availability of qualitative and affordable housing opportunities: due to a structural shortage in social housing, the MISSION families often have no other option than to turn to the private rental market. However, houses here are often too expensive or too high conditions are set. Tenants tend to make a selection by setting income requirements, which denies many families living on, for example, social assistance benefits (*leefloon*) or unemployment benefits, accessing a decent housing opportunity. Also the quality and comfort of the houses MISSION families live in are below standards. The outreaching case managers dedicated a lot of their time to this theme by introducing existing local instruments such as renovation support, the rental guarantee, the housing club, the rental guarantee fund, et cetera to the MISSION families. However, limited progress could be made here and the progress actually made did not fundamentally improve the housing situation of the MISSION families. This can to a certain extent be explained by the fact that the most important instruments for social housing policies belong to the regions – the local level has fewer tools for this (see section §6).

Nevertheless, based on the experiences of the outreaching case managers and the MISSION-families, the MDMA could help shape some important new policy measures for 2020 – 2025 in this area:

In collaboration with all local social housing actors, an integrated housing policy is now being developed, containing specific actions to optimize the take-up of all possible measures in the field of housing. One of the actions is the alignment of existing instruments which are currently spread among various actors in the city.

Kortrijk has formulated the ambition to provide for 750 extra social housing units. Existing but vacant houses will be upgraded to contemporary standards, and investments will be made in new social housing units.

In order to tackle the problem of 'energy poverty', it will be investigated to what extent disadvantaged owners of bad quality houses can be supported in improving the quality of their houses. One of the concrete actions here is the implementation of a 'roof insulation plan', specifically targeting this group of house owners.

Kortrijk will invest in a Housing First programme to provide the homeless as soon as possible with a housing opportunity, creating stability as a lever for further support.

6. LESSONS LEARNED

What if other governments, municipalities want to introduce the method of outreaching case management in their local context? In this section we highlight some of the key lessons learned from the MISSION project, drawing on the various data sources we gathered throughout the project and our own interpretation of the results.

Lesson 1: identifying the target group is a major issue

One of the most important issues is to identify the target group: who is potentially in need of the support offered by outreaching case managers? The MISSION project hugely benefited from the collaboration with the Flemish government agency Kind en Gezin (K&G) for two reasons: 1) they have a quasi-universal reach of families with new-born children; 2) they assess the vulnerability of families on multiple dimensions through a so-called local deprivation index (see section §4.2). These two features enabled us to set up the whole project, but at the same time limited the target group to families with young children. For reaching out to vulnerable families with older children, without children, pensioners, rough sleepers et cetera, other ways of entry need to be found. If there are no services in place with a universal reach, it might become difficult to achieve better outcomes for the hard-to-reach through outreaching case management.

Lesson 2: outreaching case management might be more effective with other target groups

The cooperation with K&G was partly prompted by the availability of the local deprivation index, which enabled the identification of a solid target group that could benefit from the intervention but at the same time was suitable as a study object. Obviously, this also means that all families in the trial had just welcomed a new baby, and employment was not an immediate priority on their personal agenda. The MISSION baseline survey confirms that 64% of mothers and 28% of their partners were not readily available for the labour market. This suggests that the effectiveness of outreaching case management in terms of employment might be higher when it is applied to a target group that is more fit to enter employment and training trajectories.

Lesson 3: the local welfare organisation needs to be open to a change of doing things

In the MISSION project, outreaching case managers had the explicit mandate to act on behalf of families, and to even seek to overturn decisions taken within their own organisation. This inevitably leads to tensions between outreaching case managers and 'regular' social professionals, in particular social assistance working for the Public Centre for Social Welfare (OCMW). This is in particular the case in Kortrijk (and Flanders and Belgium) in general, because of the supply-oriented history of organizing local social welfare. Taking outreaching case management seriously requires the willingness and openness to allow members of an organisation to pinpoint the things that go wrong. It also requires a perspective that starts from the needs of the client. In practice, this means that outreaching case managers need to be 'generalists', having knowledge of services and benefits that may potentially be useful for their clients, who are able to refer the particular needs of clients to 'specialists' such as social professionals with detailed knowledge of the legislation of a specific benefit. Finally, outreaching case management is an intensive counselling process, which means it requires a serious investment of time and resources. The case load of OCMs in the MISSION project was low at 16 cases per OCM in the final year, taking account time spent on registration for the scientific inquiry. In contrast, the regular case load of social professionals in OCMW Kortrijk is estimated to be at 40 to 50 cases per person. Outreaching case managers need to be able to be in a modus of constant availability for families or clients which is not possible in the context of regular case load and task assignment.

For organisations or local authorities that are not considering a change in their organisation along these lines, it might make less sense to implement a method such as outreaching case management.

Lesson 4: clear boundaries need to be drawn and cooperation agreements need to be agreed upon

Although it was the objective that the OCM would be the sole point of contact for a family, in reality many other local and Flemish social services were active in the same households. One obvious example is that Child & Family has a wide range of services on offer, including nursery, doctor visits, vaccinations, but also close counselling of families by social workers or persons with poverty experience working with the Child & Family regional team. They too are mandated to support families in a multitude of different domains. It was revealed in the focus groups with the OCMs that this sometimes led to problematic situations, in which multiple social professionals were working in the home of the same family and gave contradictory advice. For a method such as outreaching case management, such territory drift needs to be avoided. Clear communication and arrangements need to be made on which social professional from which organisation is mandated to act on behalf of families (with families permission). It is necessary to constantly strive for coordination between social professionals for providing effective support.

Lesson 5: outreaching case management is a longer-term process

In the MISSION trial we assessed outcomes of the intervention after six months for most of the outcomes. Six months is a short period of time for an intensive counselling intervention with families who are often confronted with complex problems in different spheres of life. The primary outcomes suggest that its effectiveness in, e.g., increasing participation in training and employment programs, only start to manifest after one year. As a matter of fact, outreaching case managers themselves noted that in the first months they usually focused on building trust and achieving so-called quick wins, e.g. additional financial support or material assistance. Usually, only afterwards they felt there was enough trust and openness to start working on a broader set of themes on the longer term. For the same reason, in half of the cases the intervention succeeded the intervention period we agreed upon before the start of the MISSION trial. In particular for vulnerable families, OCMs experienced the 6-8 months intensive counselling and 4-6 months phase-out period to be too limited. In terms of evaluation, it is wise to take a longer timeframe into account (see lesson 9).

Lesson 6: collaboration with families should happen on the basis of trust and presence

Usually, a social professional enters the picture to handle a problematic situation; first contacts with social services and service providers start on a negative footing. In the MISSION project, the first contact was grafted on a positive event: the birth of a child. This positive entrance was highly effective to enter the homes of families, after which a trajectory of building mutual trust could begin. The logbook data demonstrated that all OCMs started with gaining trust and just being present. This was possible since there was no specific agenda to work on. The OCM could take the time to invest in building a relationship with the family and to obtain an integral view on the case. In most cases, task-oriented work was possible within three months. Once the outreaching case managers started working on specific themes, the topic trust was less emphasized, but never neglected. For other target groups, similar ways of searching for a positive entrance and getting the time to invest in the relationship as such need be reflected upon. Finally, text messaging and instant messing were efficient ways to be present around families, and to keep in touch, complemented with home visits.

Lesson 7: take due account of the local context

A local context with ample leeway to grant additional financial and non-financial support to families is an important part of the story. Outreaching case managers can achieve a lot (if they have the mandate to advocate on behalf of their clients and other conditions are fulfilled) if the support on offer is not bounded by conditions set by law. As far as the Belgian OCMWs are concerned, legislation regarding the right to social integration (*het recht op maatschappelijke integratie*) falls within federal jurisdiction; it covers all aspects, from eligibility conditions to governance arrangements. Eligibility conditions relate to age, nationality, residence, lack of financial resources, willingness to work, and enforcement of other social rights. The law also specifies the rules for implementation to which an OCMW is bound, which can take the form of employment, social assistance benefit (*leefloon*), or an individualized social integration project. These three tools can be customized for the individual, in combination or as separate tools, provided that all conditions of the law are met. This leaves the OCMW with limited leeway.

The right to social services *(het recht op maatschappelijke dienstverlening*), however, is much less bound to supra-local regulations. As described in section §1, OCMWs have to guarantee this right to enable every citizen to lead a life that meets the standards of human dignity. The way in which OCMW have to guarantee this right is however not specified; the legal framework for this support is limited which means that OCMWs do this autonomously depending on the local social conditions and local social needs. This discretionary competence applies to the organisation of collective as well as individual services by each OCMW, but it also applies to individual social assistants working for the OCMW. Social assistants process requests for support such as additional financial support or non-financial support, and have an advisory role in whether or not such requests are admissible, reasonable and justified. Since no general formalized standards exist on who is eligible, for what kind of support or how to determine the level of support, amply leeway exists to tailor the delivery of this right to social services to local social needs and contexts, and to individuals seeking for support. This is a context in which outreaching case management is a particularly suitable method to achieve higher levels of take-up of these additional forms of support. This is exemplified by our empirical results (see section §5.2).

Lesson 8: the effectiveness of outreaching case management is limited due to the national context

What an outreaching case manager can achieve is determined by the limits imposed by broader welfare state and social policies. Take the example of social housing. The MISSION survey indicates that families are struggling with housing of poor quality at high costs. The outreaching case managers working in Kortrijk have reported several times that they can help and support families to reach out to the proper local organisation responsible for allocating social housing, but that nothing changes in the end because there is a shortage of dwellings. In our case, target-setting and financing social housing is a prerogative of the Flemish government, and as long as such shortages persist, the problem will not be solved, despite an outreaching case manager being effective in helping families to find the right service for their problems.

More in general, an approach involving outreaching case management cannot be expected to solve structural social problems in social security, the tax system, housing, labour markets, and education to name only a few. Preferably, the OCM approach is embedded in a broader poverty-reduction strategy involving all levels of policymaking.

Lesson 9: evaluation is important but is not necessarily costly

In the MISSION project, we implemented a randomized controlled trial to establish the causal effects of the method of outreaching case management on the outcomes of families. This required a research team of 2.6 FTE researchers from three higher education institutions (see annex §9.4), a scientific coordinator, several privacy agreements, multiple meetings with local organizations, the collection of data at various levels and from various sources including over 200 intensive and time-consuming interviews with disadvantaged families, the capacity to analyse the data at hand, and three years of time. Moreover, a research team external to the implementing

organisation is necessary, to ensure that data collection is not biased. It is unrealistic for each and every municipality to implement such an extensive research program in order to test whether outreaching case management might be effective in their particular local context.

In the MISSION trial, we combined register data with survey data and registration data from the case managers. One way forward for municipalities and organisations to evaluate a method of outreaching case management is to collect some (register) data from the chosen target group (see lesson 1) and to link this with register data from the organisation. Usually these data are already available, and (usually) only a privacy clearance and an informed consent is needed to link these data. For example, suppose a municipality wants to target vulnerable elderly to increase the take-up of financial support they have on offer at the local level. If existing organisations are already offering support to the elderly (perhaps in a scattered and uncoordinated way, as is often the case), these organisations are used as a point of entry to identify the target group. The data they already register on their clients can be matched to data registered by the organisation for which take-up needs to be increased. This allows to estimate the scope of non-take up, and to track to what extent outreaching case managers are able to support these people over time. Each and every local context and data situation might be different, of course, but thinking about evaluation in terms of linking existing datasets usually allows to shed more light on the outcomes of newly implemented policies without having to register and collect all kinds of new data.

Lesson 10: taking structural work seriously requires organizational support

Signalling is considered one of the main tasks of social workers. The MISSION project shows that the organization can play a major role in facilitating this task. A good problem analysis of bottle necks and gaps in the social service delivery requires insight and time. It is therefore first and foremost important that the organization offers time and space to the social workers to do such case-transcending work. In some situations the individual social worker can try to intervene by one-to-one consultation with another social worker. Other problems require action at the meso and the macro level. The role of the MDMA, or a similar coordination structure between different local actors in the field of social services was instrumental in the MISSION project. Section §5.5 lists different examples of how the signals from the OCMs have changed the local social welfare organisation. Also the MISSION implementation manager, appointed as go-between between OCM's and MDMA-participants, had a crucial role in translating the signals from the OCMs to useful changes at the organizational level. In that way, changes on the level of the organisation, inter-sectoral cooperation and policy were achieved. It is crucial that signalling is encouraged and taken seriously at the organizational level.

Lesson 11: should everyone start implementing this method?

Not necessarily, or at least not for every purpose. The strong evidence that OCM is an effective strategy to increase additional financial support in the short term and seems to have a longer-term impact on employment opportunities through participation in training programs and an increased use of childcare services offers a window of opportunity to rethink the local organisation of social and welfare services. If it requires someone with full knowledge of the local context, the time and the mandate to act on behalf of families to uphold their social rights, even for ad hoc financial help, there might be something wrong with the procedure to claim these rights.

Changing the system towards (1) a more automatic delivery of welfare benefits and services; (2) shorter and easy to understand application procedures; (3) safe transmission of information about clients so that they don't have to prove or explain their situation time and again; (4) and avoiding that people need to apply for different benefits and services in different places with different eligibility conditions, might go a long way in making the method of outreaching case management redundant. In doing so, due account should be taken of the particular problems associated with language barriers in claiming benefits and services.

Still, irrespective of the context, it is unlikely that all barriers can be dissolved in the short time, and there will always be families who will need support to muddle through the social services on offer. It might be a good strategy to start working according to the OCM principles, take the signals from the on-the-ground practice

seriously, and adapt the way the local social welfare organisations and services function accordingly. This might diminish the need for the OCM method which can then be scaled down or targeted to the hardest-to-reach families.

7. SUMMARY AND CONCLUSION

The objective of the MISSION project was to implement a pilot program to increase the take up of local employment and social services and benefits amongst disadvantaged families with young children in the Belgian city of Kortrijk. In doing so, a method of outreaching case management was developed, supported by a digital tool for the integrated delivery of a wide range of support and services to disadvantaged families, and the creation of a stakeholder platform with 25 social service providers, directly impacting on the accessibility of services and the coordination and cooperation between different service providers. The development of the method of outreaching case management was supported by an extensive action research process. To rigorously test the effectiveness of the method of outreaching case management in increasing take-up rates, a randomized controlled trial (the MISSION trial) was set-up. This enabled us to establish the causal effects of the intervention on the outcomes of families. Moreover, we gathered data at multiple levels: the families, the case managers carrying out the intervention, and the local services and organisations being responsible for local service delivery. Triangulation of these different data sources enabled us to test whether the intervention worked and for whom, and to shed light on the specifics of the daily practice of outreaching case management. In interpreting these data, we paid due attention to the transferability of the method to other contexts and countries.

We find that the method of outreaching management has a causal impact on the take-up and receipt of additional financial support by disadvantaged families with young children after six months. The results also suggest (but the data are not yet conclusive) that the method is effective in increasing the share of families taking part in employment and training programs after one year. The effectiveness is not driven by family characteristics, but by specific aspects of the method of outreaching case management. The more outreaching case managers can work intensively with families, advocate on the behalf of families, and support families in their capability to seek and coordinate their own support, and the better professional support at the local level is tailored to the actual needs of families, the more effective they are in increasing the take-up of public support. However, after six months we cannot discern structural changes in the income, housing and living conditions of the families. This is due to structural shortages in public services, e.g. in the case of childcare or social housing, which cannot be solved by outreaching case managers, or to the fact that entitlement to benefits and services are usually regulated by federal or regional law. If there is not much discretionary room to make decisions on behalf of families, the method of outreaching case management is not necessarily effective.

At the same time, the barriers and thresholds identified by outreaching case managers in their attempt to support families were strong signals that the organisation of local organisations and services was causing non-take up. Having an outreaching case manager in place who has the mandate to signal problems and an organisation willing to change the way it operates is a promising combination to improve the effectiveness of local social policies. In this report, we cite numerous example of how case managers reported issues with particular services and how this induced change in local social policies. As such, the effectiveness of outreaching case management not only lies in the question what they can achieve for families but also, and perhaps above all, in how their actions led to social professionals and organisations being more aware of the threshold they themselves impose on clients who seek support. In the longer term, this will be to the benefit of all disadvantaged families.

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9. ANNEXES

The composition of the MDMA

- Department of Services, Social Policy and Work, city of Kortrijk
- Social services and welfare unit
- Community work unit
- Child care unit
- Work and activation unit
- Economy and education unit
- Public employment service, Kortrijk
- Local Job Centre, Kortrijk
- LOP, Local Consultation Platform primary and secondary education, Kortrijk
- Social Rental Agency SVK De Poort
- Social Housing Company
- Local Union for tenant's rights
- Social Housing Club
- Public Housing Services OCMW Kortrijk
- Department of social services, general hospital AZ Groeninge
- Social services department, OCMW Kortrijk
- Local Program Manager 'poverty and social progress', city of Kortrijk
- Local Program Manager 'integration and diversity', city of Kortrijk
- Local Program manager 'child-and youth friendly city', city of Kortrijk
- ABVV, General Belgian trade union, local unit
- Outreach work Flanders
- SEL, Regional Cooperation Platform Primary Care
- Huis van het Kind, cooperation platform family support services
- Kind en Gezin, Flemish agency for child and family welfare, local unit
- Intermutualistisch overleg, Umbrella organisationsof health insurance organisations (mutualities)
- Logo Leieland, local health platform
- CGG Mandel en Leie, mental health centre
- RVA, National Employment Office, local unit
- CAW Zuid-West-Vlaanderen, Regional Centre for Social Work
- W13, regional association (south of West-Flanders) of 14 Public Centres for Social Welfare (OCMW) and the regional Centre for Social Work (CAW)
- Konekti, regional association for youth care

Weekly registrations

Date:

With which family members?

Method of contact (enter number of times)

Phone call:

Text message:

E-mail:

Face to face home visit:

Face to face semi-public:

Face to face public:

Duration of the contact

All included (e.g. travel time, administration, research): Hours – Minutes
Spent together with the client: Hours – Minutes

Effective Topics

- Trust
- Parents' training/activation
- Children
- Employment
- Income
- Housing
- Leisure
- Well-being (mental and physical)
- Relationships
- Autonomy
- Practical issues
- Another theme

Cooperation with other (social) services

Service:

Name service provider:

Topic of cooperation

- Trust
- Parents' training/activation
- Children
- Employment
- Income
- Housing
- Leisure

- Well-being (psychosocial guidance)
- Relationships
- Autonomy
- Other

The initiative in contact

- Outreaching case manager alone
- Outreaching case manager together with the client
- Client with support of the outreaching case manager
- Client alone or someone of the family
- Service alone

Extra info : …

Remarks : ….

Monthly registrations

The questionnaire starts with a number of general questions about the family and the family's strengths and pitfalls. This is always an assessment of the outreaching case manager and not information provided by the families. The outreaching case manager is asked to make an assessment of the magnitude of problems and the accessibility of the case. In addition, we also ask about family characteristics that can influence the intervention.

"On a scale from 0 to 10, how heavy do you estimate the problems of the family? The problems involve an assessment of the following factors: degree of multi-problem situation, degree of a presence of a social network, degree of personal capacity, et cetera."

"On a scale from 0 to 10, how accessible do you rate this family? This includes the degree of access and trust you get from the client, to what extent allows the client you in his/her life and is he/she/the family open to your support?"

Is there one of the following factors in this family? (multiple answers possible). You only have to fill in this question after month 1, then you can skip it - unless something has changed / you have additional information.

- *Addiction (drinking, drugs)*
- *Mental disability*
- *Physical disability*
- *Psychological vulnerabilities*
- *Speaking a foreign language*
- *Absence of a supporting network*
- *Having a history of positive experiences with professional care*
- *Having a history of negative experiences with professional care*
- *Already knowing the family from previous experiences*
- *Another characteristic, namely:…*

Integral: the outreaching case manager focuses on different areas of life such as income, housing, employment, health, education, training and network.

Indicate which description is currently most applicable:

- *I have insight on one domain of life*
- *I have limited insight on some life domains, not yet a general view*
- *I have an integral view on how the different domains of life interact, what the strengths and burdens are*
- *I have an integral view on how the different domains of life interact and have used this to set goals for the different life domains*

Demand-driven: the outreaching case managers support families based on the needs and priorities indicated by the target group themselves, not on what the OCMW has to offer. The questions, needs or needs of the family are always the starting point of the case manager. Every action is discussed with the family.

Indicate which description is currently most applicable:

- *The existing range of supply forms the starting point for every action/intervention*
- *The existing range of supply and the demand / need of the client both form the basis for action / intervention: the emphasis, however, is on the first*
- *The existing range of supply and the demand / need of the client both form the basis for action / intervention: the emphasis, however, is on the second*
- *The question / need of the client is the starting point for every action / intervention*

Emancipatory/Participative: the emphasis is on helping the client to help himself and, in this way, increasing independence and the own grip on the life of the client. After initial testing of this guiding principles, it turned

out that two dimensions were intertwined here, namely the need for support / clarification of demands on the one hand, and the (independent) use of services on the other.

Emancipatory: question clarification

Indicate which description is currently most applicable:

- *I have no insight*
- *The client needs support in clarifying his/her own needs / requests for help and is not (yet) able to indicate what is needed to answer his/her needs / requests for help*
- *The client still needs support with either clarifying his/her own needs / help questions or with indicating what is needed to answer his/her needs / help question*
- *The client can, without support, clarify his/her own needs / requests for help and can indicate what is needed to answer his/her needs / requests for help*

Emancipatory: independent use of services

Indicate which description is currently most applicable:

- *I have no insight*
- *The client does not use (professional) services*
- *The client mainly uses (professional) services with support*
- *The client uses (professional) services (approximately) just as often without support as with support*
- *The client uses (professional) services without support*

Proactive: the outreaching case managers approach the families proactively and together with those families they ensure that all applicable rights and services are brought into that family.

Indicate which description is currently most applicable:

- *I only work on the concrete questions of the client*
- *Based on the questions the client asks me, I will think about further possibilities that could contribute to increasing well-being here. I present this to the client.*
- *I actively think on about opportunities to increase well-being in this case, regardless of the client's question. I present these options to the client, including what he does not ask for. This is rather intuitive and associative*
- *I actively and systematically (SIEN-online) consider (on my own initiative , regardless of the client's question) about opportunities to increase well-being in this case. I always explain these options to the client, including the domains he did not ask for.*

Advocacy:

At client level: the outreaching case manager coordinates, mediates and negotiates on behalf of the families between different services in various fields.

At the system level: outreaching case managers will be confronted with gaps in the assistance- and service system. These gaps are at minimum documented and reported to the team. The "Multidisciplinary multi-actor network" (MDMA) or the Flemish / Federal policy can look into this further.

Indicate which description is currently most applicable:

- *I do not encounter other professionals in this case*
- *I encounter other professionals in this case, but I cannot advocate for them*
- *I encounter other professionals in this case. I defend the interests of my client toward them and I try to mediate between several actors when needed.*

- *I encounter other professionals in this case. I defend the interests of my client towards them and I try to mediate between several actors when needed. Based on these interventions, I detect, register and properly signal them toward the authorities.*

Coordinated:

At client level: the outreaching case manager has a view of the client's overall situation. He / she is the central point of contact throughout the entire process (one-stop shop) and takes care of the coordination of all necessary help and services (both through the family's own network and professional bodies).

At the level of assistance and services involved: the outreaching case manager is the central point of contact for all involved service providers. He / she connects the family's requests for help with the right service and ensures that all information is available so that this service can help the family as quickly as possible.

At system level: all local actors and stakeholders who provide social assistance and services will actively cooperate within the MDMA (multi-disciplinary multi-actor network). The MDMA follows the work of the outreaching case managers and also serves as a back office. The network receives feedback and signals from the outreaching case managers regarding the perceived obstacles or barriers in integrated working between and within different organizations. In addition to this consultation function, the MDMA also has a policy-forming function.

After initial testing of this guiding principles, it turned out that there are three dimensions of coordination.

Coordination: main actor

Indicate which description is currently most applicable:

- *Coordination is not needed or I do not know who is coordinating this case*
- *Coordination is mainly on me or on another professional*
- *Coordination is mainly on me or on another professional. Now and then, the client takes over the coordination.*
- *Coordination is mainly on the client. Now and then, he needs some support from me to activate help.*
- *Coordination is totally on the client. He functions independently as point of contact for all social services. He can activate an intervention when needed.*

Coordination: bridging coordination problems

Indicate which description is currently most applicable:

- *I have no insight*
- *Consultation with various services and other network actors is not (yet) necessary for this family.*
- *There is (still) no consultation with services or other network actors involved, but there are coordination problems*
- *There is consultation with relevant services and other network actors involved. However, there are often coordination problems*
- *There is consultation with relevant services and other network actors involved. The assistance provided to the client is coordinated with each other, but now and then there are still coordination problems.*
- *There is consultation with relevant services and other network actors involved. The assistance provided to the client is coordinated with each other. This cooperation runs very smoothly, there are no coordination issues.*

Coordination: activation of supply

Indicate which description is currently most applicable:

- *I have no insight*
- *There is no alignment yet between demand and supply*

- *There is a initial alignment between demand and supply*
- *There is a good alignment between demand and supply. Support from a third party is needed for the client to make use of the supply*
- *There is a good alignment between demand and supply. No support is needed for the client to make use of the supply*

Task and person-oriented: The intervention is aimed at improving social outcomes for the families within a period of 12 months. There is a clear focus on problem solving and taking steps forward. However, in order to work properly, it is necessary that the case manager has acquired a sufficient mandate from the family. Although person-oriented work is important and essential, a goal-oriented intensive cooperation is intended rather than a buddy system.

Indicate which description is currently most applicable:

- *There is a lot of emphasis on working on a relationship of trust between the client and I (unconditional positive appreciation, genuineness, empathy, ...). I have insufficient mandate to work in a task-oriented way*
- *There is a lot of emphasis on working on a relationship of trust between the client and I (unconditional positive appreciation, genuineness, empathy, ...). There is a starting mandate to work task-oriented (= goal-oriented, concrete problems with concrete solutions, focused on action, etc.)*
- *The relationship is strong enough that there is a lot of mandate to work task-oriented. During the contacts, almost all energy goes to task-oriented work. Attention for the relationship is there to further facilitate this task-oriented process*
- *My interventions are purely task-oriented. The client has other professional or network actors who motivate, support him in this process, etc*

What works for whom in which circumstances: factors that cause progress and decline.

A final question within the monthly registration is entirely qualitative: the outreaching case manager reflects every month on the question of what are the working and hindering factors within the intervention of every case. We systematically insert this data into MAXQDA and the star model from Hermans (2014) forms the framework for analysing this data. Hence, we keep in mind the role of the client, the social worker, the methodology, organization, other organizations/social workers, the government and society (Hermans, 2014).

When you think about this specific case, what made you advance this month? (think of the role of the client, you as a social worker, methodology, organization, other organizations / social workers, government, society)

If you think about this specific case, what made it more difficult or even worse this month? (think of the role of the client, you as a social worker, methodology, organization, other organizations / social workers, government, society)

Semi-structured questionnaire conducted with families after intervention

To start …

A case manager came by. We would like to know how you experienced that. If you now look back on the period that the case manager came by, can you indicate how satisfied you were with that service?

Why do you give positive, neutral, negative? Is that service different from other services? What is the same, what is different? What did you find strong? What can be done better?

First contact

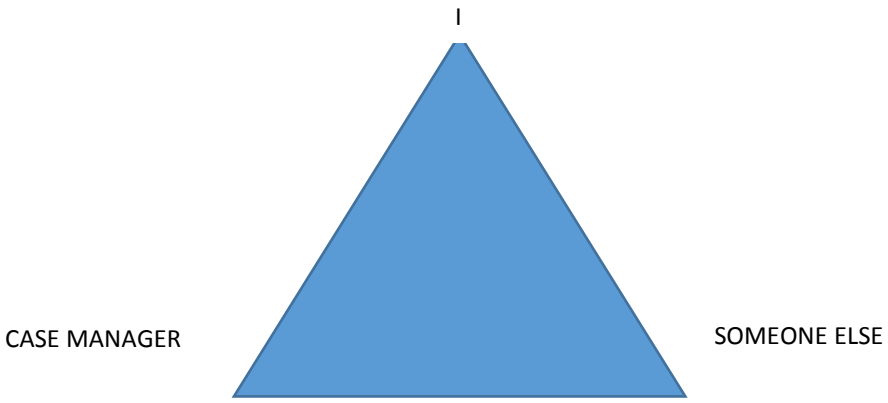
Do you remember the first contact with the case manager? Can you describe how that first contact went? How did you experience that?

Task oriented/person oriented

Do you remember what was discussed during the counseling? What did you do during such a home visit? What were you mainly talking about? Did that change over time?

Demand oriented

Who determined what was discussed during the counseling?



Explain. Why do you put a dot there? Is it important for you to keep the lead with you? Who took the initiative? Has that changed over time? Have you reviewed all rights on the iPad / Sien online? How did you experience that?

Integral

Could you go to the case manager with all your questions?

Do you find that important? What benefits do you experience with that?

Is that different from other care providers? Did you feel that the case manager was too interfering?

Advocacy

Do you feel that the case manager has fought to gain rights and benefits for your family?

Can you give examples? What did you notice? Do you expect this from a social worker?

Confidence

Did you trust the case manager?

What made you have (no) confidence? How is that built up?

Availability

Did you think the case manager was easily available?

Do you find that important? Have you also called / sent a message yourself?

Understandable

Was the explanation you received from the case managers clear?

Was the case manager important to understand information from other services?

Reliable

Could you count on the case manager?

Were agreements fulfilled by her?

Continuity

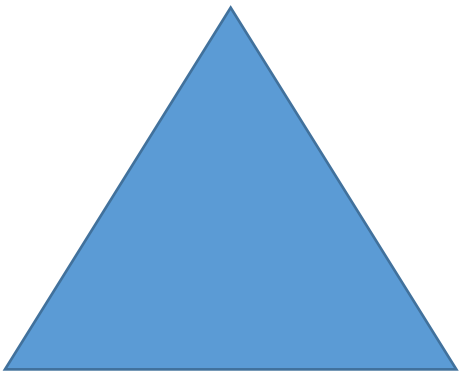
Who has decided to stop the support? What was the reason?

Did you think you needed further support? Who does that now? Did the transition go well?

Results

Something has changed for you / your family through the counseling?

The living conditions of our family have improved.



I have more hope and confidence

I now know better the different services and rights and I can request this myself.

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