

Analysis of MERIT Residential Rehabilitation Survey



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Background

All non-government agencies (NGOs) funded to provide treatment services for clients of the Magistrates Early Referral Into Treatment (MERIT) program, and all Area Health Service (AHS) MERIT staff were asked to complete a survey to:

- inform the next residential rehabilitation EOI round
- assist in reviewing and appraising the delivery of residential rehabilitation services.

A total of 40 responses were received. This represents 91% of NGO and AHS MERIT service providers.

Report overview

The report summarises and analyses the survey results in the light of the bed utilisation data. The results and the issues that arise are presented under the following headings.

	<i>Page</i>
1. Patterns of service use.....	3
2. Extent of the need for residential rehabilitation services	5
3. Entry criteria.....	6
4. Interagency systems	8
5. Suggestions to improve service utilisation.....	10
6. Other information	11
7. Summary of recommendations.....	12
Appendix 1: Reasons for current utilisation	13
Appendix 2: Entry criteria	15
Appendix 3: How to improve service access and usage.....	16

Charts

- Chart 1: Usage of MERIT beds: April 02–March 04
- Chart 2: Bed usage: 20 providers and 17 most used providers: 1st year, 2nd year and over two years
- Chart 3: Bed usage at each NGO, 1st year, 2nd year and both years
- Chart 4: MERIT views about the percentage of clients suited to residential rehabilitation
- Chart 5: How often MERIT refer to residential rehabilitation
- Chart 6: Frequency of meetings between AHSs and NGOs
- Chart 7: Joint case conferencing
- Chart 8: Formal communication channels for case management
- Chart 9: Would Joint training be useful?

Patterns of service use

1

Bed usage rates

See:

Chart 1: *Usage of MERIT beds: April 02-March 04*

Chart 2: *Bed usage: 20 providers and 17 most used providers; 1st year, 2nd year and over two years*

Chart 3: *Bed usage at each NGO: 1st year, 2nd year and both years*

The use of MERIT residential beds has changed significantly over time. The first funding quarter showed 11% usage which rose steadily to 52% usage in late 2003, when it fell back to 24% for the first quarter of 2004.

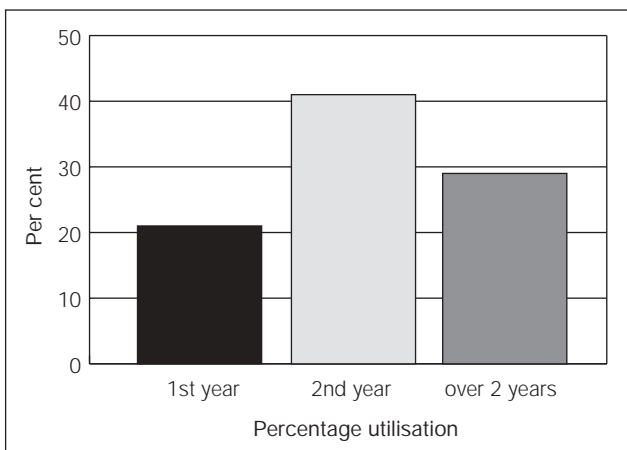


Chart 1: Usage of MERIT rehabilitation beds April 2002-March 2004

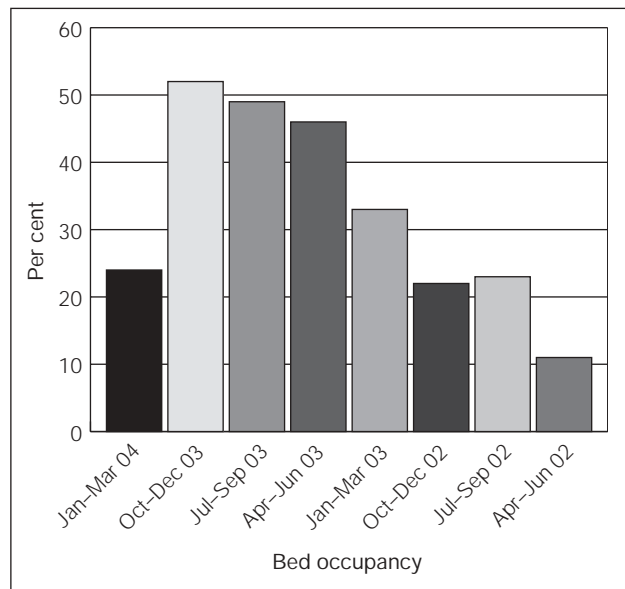
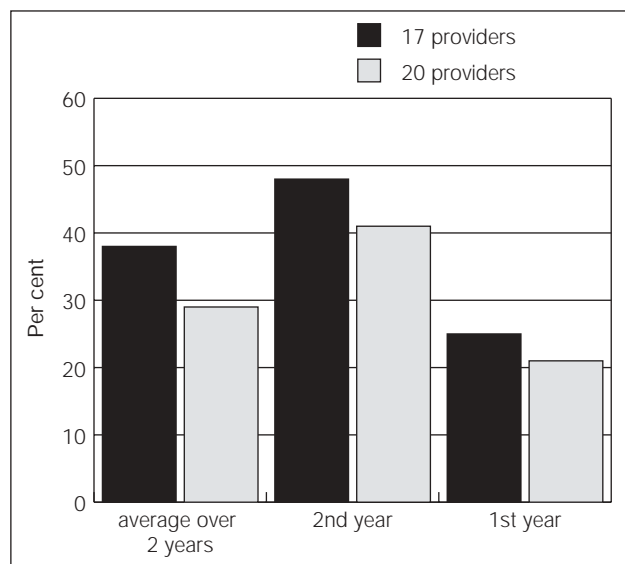


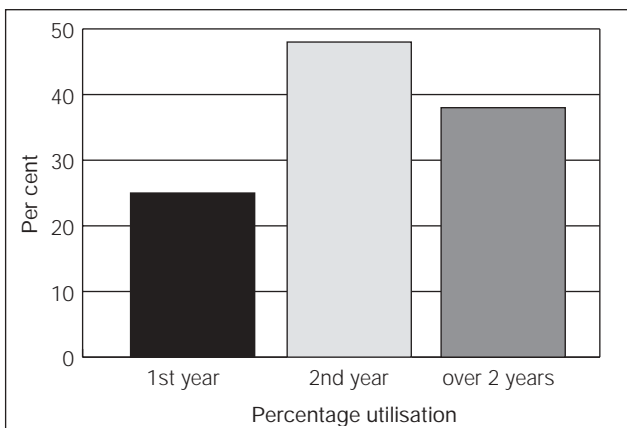
Chart 2: Bed usage: 20 providers and 17 most used providers; 1st year, 2nd year and over two years



There is wide variation in the use of different agencies. The highest annual rate was at Adele House (103%) while Cyrenian House recorded 0% usage for its first year and 1.2% for its second year.

The statewide bed utilisation rate improves when the three most poorly used services are removed from the calculations:

17 best used services



Comments on the low level of use of residential rehabilitation

(Question 1.1)

See Appendix 1: *Reasons for the current level of utilisation*

NGOs and AHS/MERIT have very different views about the low average rate of service utilisation. NGOs most commonly attributed it to:

- insufficient referrals from MERIT/AHS
- MERIT teams' conflict of interest leading them to support their own AHS-based service providers in preference to NGOs.

MERIT teams most commonly attributed low utilisation to:

- exclusion of people on pharmacotherapy
- client unwillingness
- exclusion of people with mental health problems
- exclusion of people remanded in custody or with histories of violence.

Areas where MERIT teams and NGOs held the same views were:

- MERIT doesn't have enough information about what RR can offer.

- Funding uncertainties had impacted on service outcomes.

In Appendix 1: *Reasons for the current rate of utilisation* (page 13) responses are summarised as:

- reasons related to MERIT teams
- reasons related to residential rehabilitation services
- issues related to client needs
- structural reasons
- gaps in services.

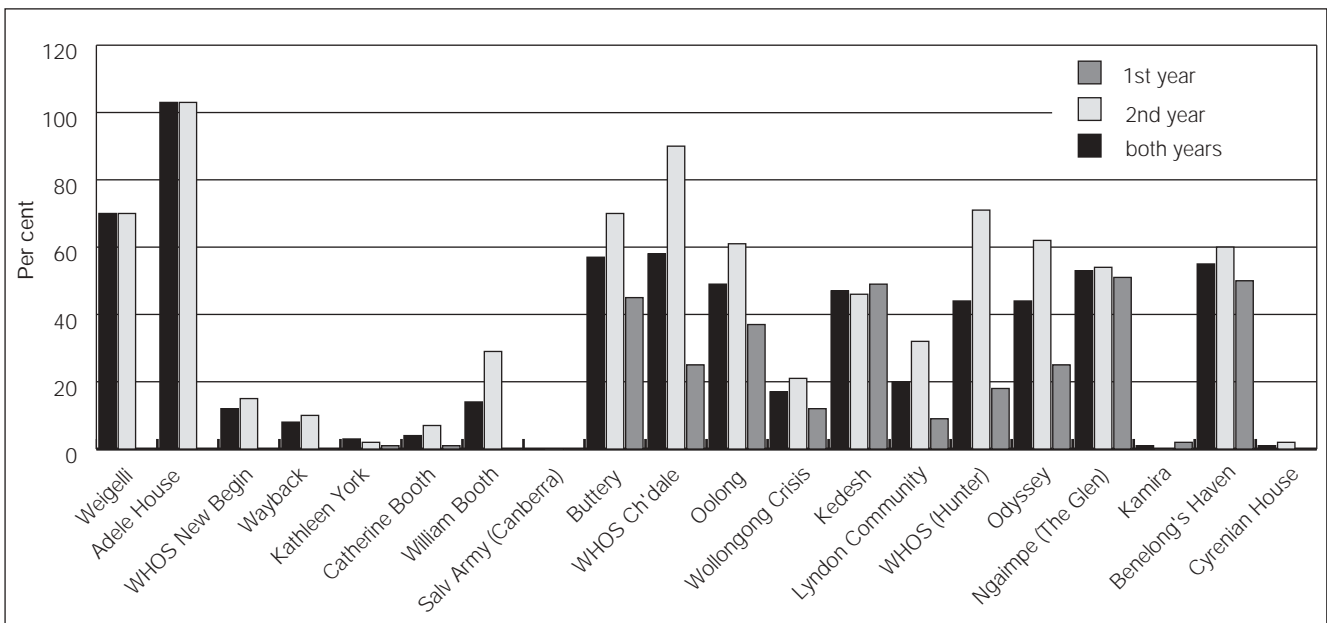
NGOs' view on bed utilisation rates

(Question 2.1)

Many rehabilitation services (40%) report being very concerned about low referral rates from MERIT and a further 40% believe they are under-utilised. Some individuals commented on the lack of support from the AHS, and the negative impact of funding uncertainty.

'We cannot further reduce or remove assessment criteria to allow in inappropriate clients.'

Chart 3: Bed usage at each NGO: 1st year, 2nd year and both years



Extent of the need for residential rehabilitation services

2

Need for residential rehabilitation identified by MERIT

(Question 3.2)

See Chart 4: *Proportion of clients suited to residential rehabilitation*

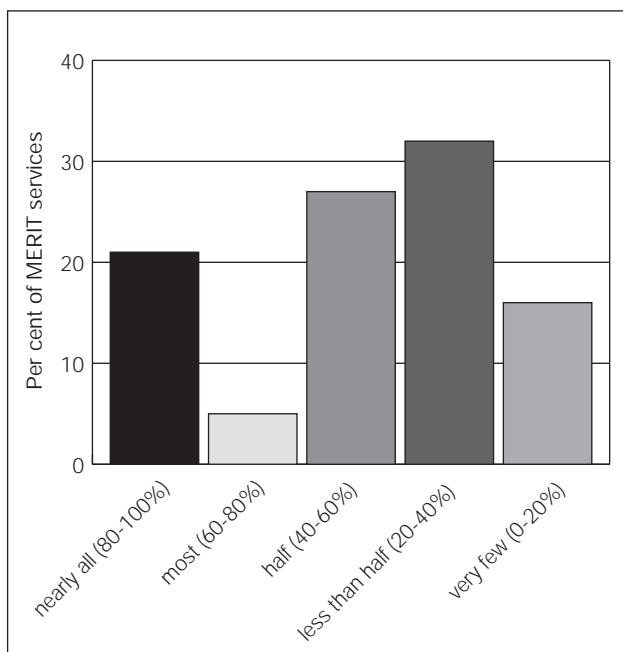
There was a full spectrum of views about the need for residential treatment amongst MERIT clients.

Almost the same number of MERIT services state that **very few** (0-20%) of their clients are suitable for residential treatment as said that **nearly all** (80-100%) are suitable for residential treatment.

The result should be treated with caution since the question appears to have been interpreted in several ways: 'a client is suitable for referral even though he is unlikely to go', or alternatively, 'a client is suitable and will be referred'.

'Most clients suitable for res rehab, approx 30% will go.'

Chart 4: MERIT views about the percentage of clients suited to residential rehabilitation



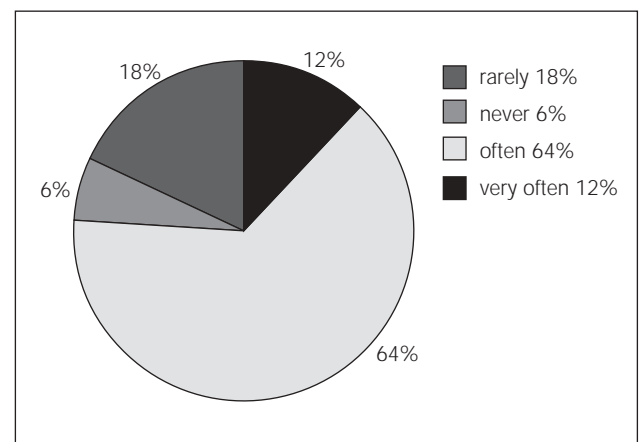
Frequency of MERIT recommendation for residential rehabilitation

(Question 3.3)

See Chart 5: *How often MERIT refer to residential rehabilitation*

Two thirds of MERIT services say they make referrals to residential rehabilitation 'very often', but this was not quantified as a proportion of clients. It is not clear whether this amounted to a concrete referral or was just a general recommendation.

Chart 5: How often MERIT refer to residential rehabilitation



3 Entry criteria

Criteria used for recommending referral or accepting a referral

(Question 1.3)

See Appendix 2: *Entry criteria*

There are interesting differences in the criteria used by NGOs and MERIT staff when they decide whether to refer/accept a client into residential treatment.

The most commonly mentioned reasons that MERIT staff gave for referring clients to rehabilitation were:

- client has unsuitable living environment (71%)
- client homeless (29%)
- client chaotic (24%).

None of these issues were mentioned by NGOs, who most commonly made general comments about 'meeting agency assessment criteria' (47%).

Areas of agreement

Similar proportions of NGO and MERIT staff said that their criteria included:

- the severity of the clients' problems (21% of NGOs and 33% of MERIT)
- client choice
- client stage of change (21% of NGOs and 14% of MERIT)
- client failure with other treatment approaches.

Variations in NGOs' entry criteria

(Question 1.5)

Three-quarters of all respondents agreed that there were differences in the criteria for entry into different residential rehabilitation services. The remainder considered the differences were minimal. Differences related to different target groups, and whether or not the client had mental health problems or was involved in pharmacotherapy.

MERIT procedures for determining suitability

(Question 3.5)

MERIT workers use a range of individual client assessment techniques to determine suitability for residential rehabilitation. Very little useful detail was provided in answer to this question.

MERIT's out-of-area referrals

(Question 3.1)

The vast bulk of MERIT services (88%) refer to residential treatment services outside of their Area. Most commonly given reasons include 'meeting client needs' and Aboriginality of clients.

Experiences in seeking access

(Question 2.4)

A quarter of MERIT workers reported they had no problems accessing residential rehabilitation services for their clients. Others reported difficulties with:

- waiting lists
- phone calls that are not returned
- access to detox prior to admission
- transport problems
- problems placing particular groups of clients: parents with children, people currently taking (or not taking) pharmacotherapy, people with mental health problems or a history of violence.

Several MERIT services also mentioned exclusion due to a client's previous failure in a program and negative staff attitudes towards coerced clients.

Retention

(Question 2.3)

The results from this question were insufficient to make meaningful comment since:

- it is not possible to compare the length of stay in different programs as the standard program length varies between services
- only service providers were asked to comment
- referrals to some agencies have been limited.

A separate, coherent process will be required to address this question, drawing on existing data collection systems, annual reports and QMS processes.

4 Interagency systems

Knowledge of MERIT RR services available in their Area

(Question 1.2)

Most MERIT services (80%) and half of the NGOs (53%) could name between 1 and 5 NGOs that provide residential rehabilitation for MERIT in their Area.

The question was ambiguous, as some people believed they were being asked to list only the NGOs located in their Area.

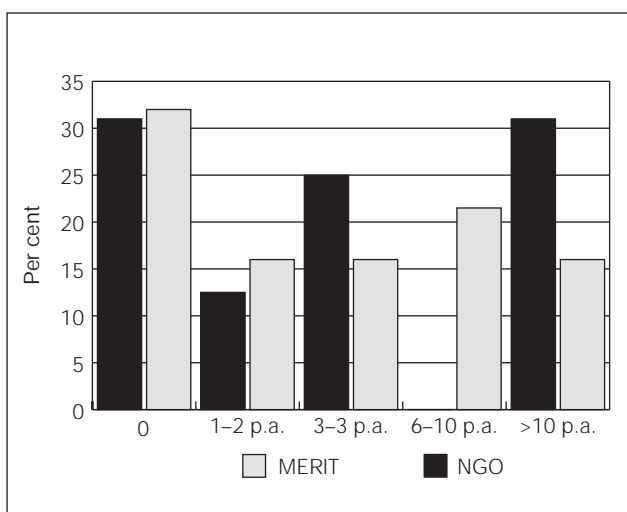
Meetings between AHSs and NGOs

(Question 1.7)

See Chart 6: *Frequency of meetings between AHSs and NGOs*

There are wide differences in the frequency of meetings between NGOs and AHSs. Roughly a third of services have no meetings at all, while a quarter have more than 10 meetings per annum.

Chart 6: Frequency of meetings between AHSs and NGOs



NGOs were more likely to attend joint meetings than MERIT services.

'Regular meetings between senior clinical and management D&A staff with NGO personnel regarding data, clinical supervision, performance agreement development and monitoring.' Mid Western AHS

Joint case conferencing

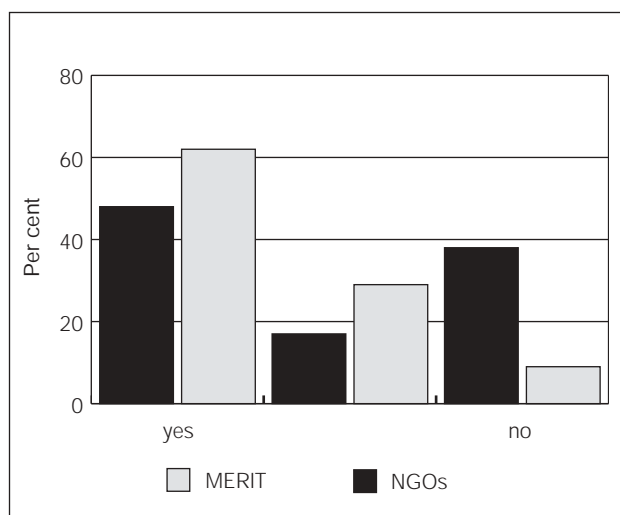
(Question 1.8)

See Chart 7: Joint case conferencing

Less than half of NGOs and two-thirds of MERIT services say that joint case conferencing occurs.

'RRs reluctant to share case management.'
'Case management tends to run parallel.'
'MERIT staff have focussed on building relationships with the courts, legal professions and police and limited time with NGOs.'

Chart 7: Joint case conferencing



Formal case management communication channels

(Question 1.9)

See Chart 8: *Formal communication channels for case management*

A small number (a quarter of NGOs and a sixth of MERIT programs) have formalised systems for shared case management:

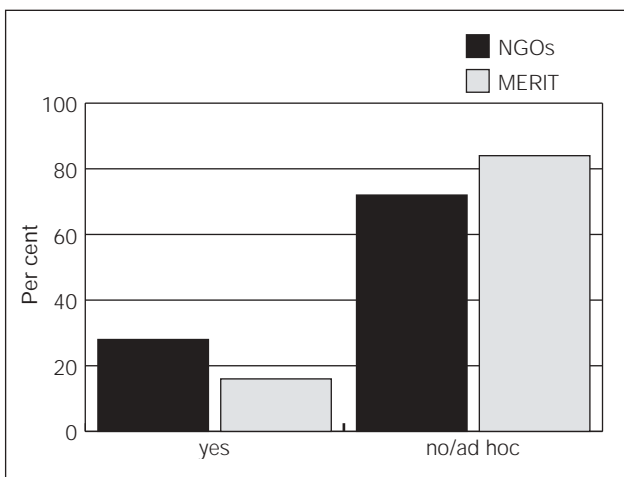
'Assessment criteria are routinely monitored.'

However some respondents showed little understanding of the process of shared case management:

'RRs rarely contact MERIT to discuss clients.'

'The rehab can phone MERIT.'

Chart 8: Formal communication channels for case management



NGOs' satisfaction with MERIT referrals

(Question 2.2)

More than half of the NGOs (60%) were satisfied with the types of referrals made from MERIT. The remainder were satisfied 'sometimes' or not satisfied because MERIT assessments had not identified unmanaged mental health problems or there was conflict or misunderstanding about the treatment program's entry criteria.

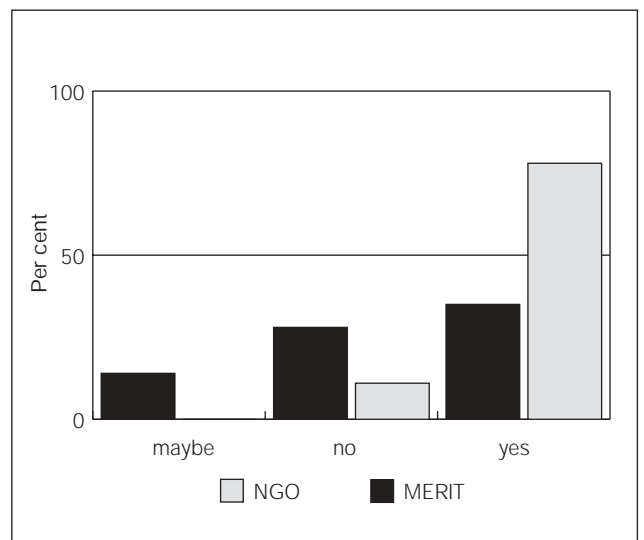
Usefulness of joint-training

(Question 1.10)

See Chart 9: *Joint training*

NGOs were nearly twice as likely to say that they were interested in opportunities for shared training than MERIT programs. A significant minority felt that partnership development activities rather than training would be useful, where the focus would be on role clarification, interagency networks and the development of local MOUs.

Chart 9: Would joint training be useful?



5 Suggestions to improve service utilisation

Ways to improve access to beds and service utilisation

(Questions 1.4 and 1.6)

See Appendix 3: *How to improve service access and usage*

Suggestions shared by both MERIT teams and NGOs:

- Provide statewide MERIT database with clear information about entry criteria, fees and services provided (eg via RR website).
- Streamline assessment systems.
- Establish partnerships, role clarity and communication systems between MERIT and NGOs.
- Provide in-house detox (or close links between RR and detox).
- RRs should provide MERIT with assessment tools and information about programs and fees.

In addition, MERIT teams commonly suggested:

- Provide family accommodation, especially for women and children.
- Relax entry criteria.
- Reduce delays for assessment.
- Provide 12-week programs tailored for MERIT clients.
- Increase RR staff knowledge of MERIT program and MERIT clients' needs.

NGOs mostly suggested:

- Provide more information at assessment, including mental health.
- Educate MERIT about evidence of RR treatment outcomes.
- Run statewide MERIT-RR conference.
- Match clients' needs to RR program.

Other information

6

Beds brokered by the Area

(Question 3.6)

Only 3 of 17 MERIT respondents said that their Area 'brokered' beds outside the programs funded by MERIT. These were at Namatjira Haven, Karralika Therapeutic Community and Jarrah House.

Other suitable NGOs

(Question 3.7)

MERIT staff identified NGOs that could provide residential rehabilitation for their clients, including:

GROW	2
WHOS MTAR	2
Karralika TC, ACT	2
Namatjira Haven	2
Endeavour Community	2
Miracle Haven	2
Richmond Fellowship	1
Lake Macquarie Recovery (dual diagnosis)	1
Arcadia House, ACT	1
Selah Farm	1
Phoebe House (methadone, children)	1
Peppers	1
O'Connor House	1
The Lodge (children)	1

Staff suggested increasing MERIT beds at:

Adele House	2
Odyssey Family Unit	1
Kamira Farm	1
Bridge Program	1

7 Summary of recommendations

MERIT website

Establish a regularly updated MERIT Residential Rehabilitation database with clear information about:

1. Details on each MERIT-funded residential program, including:

- entry and exclusion criteria
- assessment tools
- detoxification arrangements
- fees
- current vacancies
- details of services provided for MERIT clients
- transport costs and arrangements
- any special target group, focus or area of expertise that apply to the program
- program accreditation status (QMS).

2. How MERIT teams can access residential AOD treatment services suited to:

- clients with co-existing mental health problems
- clients with dependent children
- clients on pharmacotherapy
- clients requiring detoxification.

3. Research on outcomes achieved by residential treatment programs in comparison to other treatment approaches.

Partnerships and MOUs

Undertake both Area-based and statewide action to stimulate and support the development of partnerships between MERIT and NGOs, with specific goals to:

- improve role clarity and articulate mutual expectations
- activate shared case management systems
- define performance agreements.

Capacity building

Develop the capacity of Residential Rehabilitation services to provide 12-week programs alongside or within their core programs. Create opportunities for MERIT-funded residential treatment services to share information, tools and problem solving strategies.

Budgets

Allocate funds to enable MERIT services to deal with the financial barriers that may prevent clients from accessing residential services (ie initial fees, transport costs, detoxification costs).

Evaluation data

Establish a coherent evaluation process that traces :

- patterns of MERIT team referrals
- program retention
- re-offending.

Appendix 1

Reasons for current utilisation

Question 1.1: Residential rehabilitation bed utilisation has averaged out to approximately 40%. What is your understanding of the issues around the rate of utilisation?

Most common explanations provided

from NGOs

Low referral from MERIT/AHS	7
MERIT teams' conflict of interest: support AHS-based service providers in preference to NGOs	5

from MERIT teams

Exclusion of people on pharmacotherapy	7
Clients unwilling (NB family, work)	5
Exclusion of people with mental health problems	5
Exclusion of people remanded in custody or with violent histories	4

Views shared by both MERIT teams and NGOs

	NGO	MERIT	total
MERIT doesn't know what RR can offer	2	2	4
Funding uncertainties	2	2	4
Clients unwilling (NB family, work)	2	5	7

All reasons given

Reasons related to MERIT teams

	NGO	MERIT	total
Low referral from MERIT /AHS	7	-	7
MERIT teams' conflict of interest support AHS-based service providers in preference to NGOs	5	1	6
MERIT doesn't know what RR can offer	2	2	4
Negative views of RR by local AHS	2	1	3
MERIT does not match clients to treatment	1	1	2
RR is more work for MERIT staff than outpatient referral	1	-	1
MERIT have limited knowledge of RR	1	-	1

Reasons related to rehabilitation services

	NGO	MERIT	total
RRs expect long stays	1	4	5
Uncoordinated and inconsistent entry processes	-	4	4
RRs reluctant to work with MERIT clients	-	2	2
Lack of professional staff at some RRs	-	2	2
Lack of alternatives to 12-step programs	-	1	1
RRs provide poor aftercare	-	1	1
City RRs are poorly located so clients abscond	-	1	1
RR have lower expectations of MERIT clients' capacity to complete the program	-	1	1
RR has little respect for MERIT expertise	-	1	1
Lack of knowledge of MERIT in RR services	-	1	1

Appendix 1 Reasons for current utilisation

Issues related to client needs

	NGO	MERIT	total
Clients unwilling (NB family, work)	2	5	7
Programs suit only a % of clients	1	2	3
Outpatients is the easy option for clients	2	-	2
Indigenous people need indigenous services	1	-	1
Rehabilitation clientele perceived as too rough	-	1	1

'We have not received funds from AHS for 03-04 financial year.'

'Some rehabs like the \$ but not the MERIT clients.'

'Residential rehabs should come into the modern treatment arena, embrace change and client choice: ie reinvent themselves to be more useful.'

'RR have little respect for expertise of MERIT staff, and the intensive treatment planning that occurs prior to assessment for RR.'

'Potential to be effective, but to date has been left floundering without the strong links between agencies being developed.'

Gaps in services

	NGO	MERIT	total
Exclusion of people on pharmacotherapy	-	7	7
Exclusion of people with mental health problems	-	5	5
Client has to have completed detox, which is costly	-	3	3
No services for parents with children	-	2	2
Restricted entry criteria	-	2	2
Exclusion of people with violent histories	-	2	2
Exclusion of people remanded in custody	-	2	2

Structural reasons

	NGO	MERIT	total
Funding uncertainties	2	2	4
AHS has conflict of interest as funding body and service provider	3	-	3
Poor relationship between MERIT and RRs	1	1	2
Distance problems	-	2	2
Long waiting lists	-	2	2
Oversupply of beds	-	1	1
Improved community-based alternatives means reduced service demand	-	1	1

Appendix 2

Entry criteria

Question 1.3: There are occasions when the extent of some client's needs cannot be met through public sector drug and alcohol treatment services. Often the MERIT program represents the client's first engagement with any drug and alcohol treatment, in what circumstances would you recommend/accept a MERIT client to residential rehabilitation?

NGO perspective

Meets agency entry criteria	9
Client choice	5
Stage of change	4
Severe drug use problem	4
Meets MERIT entry criteria	3
Failed with other approaches	3
Has completed detox	1

MERIT perspective

Client has unsuitable living environment	15
Client choice	10
Failed with other approaches	7
Severe drug use problem	7
Client homeless	6
Client chaotic	5
Stage of change	3
Client has mental health concerns	2
Meets MERIT entry criteria	2
Meets agency entry criteria	2
Has completed detox	2
Previous success with rehabilitation	2
If child protection concerns exist and client wants to regain custody	1
Not done rehabilitation before	1
Pharmacotherapy unavailable or unsuitable	1

Appendix 3

How to improve service access and usage

Question 1.4: What would assist smooth access to residential rehabilitation beds?

and

Question 1.6: Please provide your suggestions for improving res rehabilitation utilisation rates.

Views shared by MERIT teams and NGOs

	NGO	MERIT	Total
Provide statewide MERIT database with clear information about entry criteria, fees and services (eg via RR website)	14	7	21
Streamline assessment systems	2	9	11
Establish partnerships, role clarity and communication systems between MERIT and NGOs	9	2	11
Provide in-house detox (or close links between RR and detox)	2	9	11
RRs provide MERIT with assessment tools and information about programs and fees	3	4	7
Provide MERIT with regularly updated vacancy information, eg weekly email	2	3	5

Additional suggestions from MERIT teams

Provide family accommodation, especially women and children	7
Relax entry criteria	7
Reduce delays for assessment	7
Provide 12-week programs tailored for MERIT clients	4
Increase RR staff knowledge of MERIT program and MERIT clients' needs	4

Additional suggestions from NGOs

Provide more information at assessment, including mental health	6
Educate MERIT about evidence of RR treatment outcomes	4
Run statewide MERIT-RR conference	4
Match clients' needs to RR program	4

