NSW GOVERNMENT Health

Alcohol and Other Drug Continuing Coordinated Care Program

Interim Program Evaluation

EXECUTIVE SUMMARY

July 2020

CRITICAL SUMMARY

The principal aim of the Continuing Coordinated Care Program (CCCP) is to help people stay in alcohol and other drug treatment, especially those with significant and complex needs who require intensive support. CCCP has been delivered by three non-government organisations across the 15 NSW Local Health Districts (LHDs) from July 2018 onwards. This interim evaluation assesses progress in implementation and service delivery over the initial phase of CCCP, to 31 December 2019.

As of 31 December, 2019, all planned CCCP services had been implemented, with services scaling up to support approximately 725 active clients per month across NSW by late 2019. Key challenges to CCCP delivery included: (i) limited available treatment services (residential rehabilitation, services for women/parents and clients with coexisting mental illness), (ii) physical distance and transportation, and (iii) barriers to securing housing (gaps in homelessness support services and lack of temporary, social and affordable housing). Service providers reported they were running at or beyond capacity and that adequate and regular outreach to remote NSW would require service expansion.

LHD staff perceived the CCP as being highly valuable, the majority rating the continuation of this service as 'essential' in their District. More clarity was sought, however, on referral pathways and the scope of services available through the CCCP.

There was a high level of disadvantage among CCCP clients, with high rates of homelessness and very low rates of employment. At entry to CCCP, clients also rated their quality of life/wellbeing well-below the population normative range. Preliminary outcomes data indicate clients who completed the service experienced improvement in quality of life/wellbeing, reduced severity of dependence, reduced rates of homelessness/risk of homelessness and reduced rates of domestic violence.

Based on the CCCP client cohort to date, consideration should be given to revising the 6-month maximum duration of service and to opening referrals to clients who are not currently in AOD treatment. Strategies to engage and support Aboriginal and Torres Strait Islander clients should be an ongoing focus of service providers. Client brokerage funds may support retention of clients through provision of transportation fares and mobile phones. Development of CCCP guidelines would clarify program aims, eligibility criteria, referral pathways, services available and a model of care.

Background and Objectives

In 2016 the NSW Government announced a funding package of $75 million over four years for a suite of alcohol and other drug (AOD) services. The Drug Package aims to reduce service gaps, particularly for clients with complex needs and untreated substance use disorders.

The $12 million Continuing Coordinated Care Program (CCCP) is one component of the Drug Package. The principal aim of CCCP is to help more people stay in AOD treatment. This is achieved by enhancing continuing care pathways for people receiving community-based AOD treatment, especially those with significant and complex needs who require intensive support to maintain their engagement with treatment services.

The CCCP objectives are that:

- Clients maintain engagement with AOD treatment services
- Clients have reduced consumption of alcohol and other drugs of concern
- Clients experience reduced harms associated with AOD use
- Clients have improved physical health and wellbeing
- Clients have improved employment, educational and vocational connections
- Clients have improved social functioning and family and community connectedness
- Clients' housing tenancies are maintained
- Clients experience reduced functional impairment.

Supports delivered under CCCP encompass a wide range of activities that build independence in daily life, minimise harms associated with AOD use, maintain engagement with treatment services and contribute to recovery. Clients receive services in three streams:

1. Clinical linkages: intensively supported access to existing clinical AOD services, primary health, medical services and mental health services;
2. Livings skills support: intensive personal and domestic support, financial, vocational and educational support;
3. Family and community connections: intensive support to maintain or renew connections with family as well as to access community services, housing services or other government / NGO services.

CCCP is delivered by three non-government organisations (NGOs), following a competitive tender process – St Vincent de Paul Society, Mission Australia and The Buttery. Under the CCCP funding package, the Network of Alcohol and Drug Agencies (NADA) was funded to provide overarching support for CCCP providers via a CCC Consultant role. Services were rolled out across the 15 NSW Local Health Districts (LHDs) between July 2018 and February 2019. Services will continue under the current funding agreements until the following dates: St Vincent de Paul – 1 December 2020; Mission Australia – 31 October 2020; The Buttery – 31 October 2020. The CCCP will continue for another 4 years with the current providers, until 2024.

This interim evaluation has been performed to assess progress in the implementation and service delivery over the initial phase of the grant (2018-2019). This interim evaluation looks at:

(i) Whether the CCC program has been implemented as intended
(ii) Whether the service is being delivered to priority populations as intended
(iii) Whether there is demand for the service
(iv) The case mix of clients (principal drug of concern, demographics etc)
(v) Whether the LHDs find the service useful/valuable
(vi) Whether there is preliminary evidence that intended client outcomes are being achieved
(vii) Whether NADA has been successful in its role of addressing systemic barriers and supporting the CCC program providers in advocating for their clients.

A full evaluation of the CCCP, containing more detailed data analyses and informed by the findings reported in this document, is intended in future years.

Evaluation component 1: Evidence for the successful implementation of CCCP

AIMS

1. To determine whether there has been successful implementation and uptake of the services;
2. To determine whether the services are being delivered effectively;
3. To understand the referral needs of the client population;
4. To determine whether linkages have been established between the NGOs and relevant providers, the LHD, and other health and welfare services etc;
5. To identify barriers and challenges to successful service delivery;
6. To make recommendations for future service improvement;
7. To flag problematic performance indicators that will need to be redefined in the next funding round.

METHODS

Information for Evaluation Component 1 was derived from three sources:

1. A review of routine activity and performance reports (submitted every six months as a requirement of CCCP funding agreements);
2. Qualitative interviews with service providers (see Appendix A);
3. Online surveys of Drug and Alcohol Service Directors and relevant staff members from each LHD (surveys were completed anonymously, and responses collected using the Survey Monkey platform; see Appendix B).

Qualitative interviews and survey data were analysed qualitatively using thematic analysis. Transcripts were coded using an inductive sematic approach (i.e. allowing the data to determine the themes and analysing the explicit content of the data as opposed to subtext). After coding, themes were generated based on the pooled responses of the service providers.

KEY FINDINGS

Key referral needs of CCCP clients	Main types of extra support needed by CCCP clients
- Housing organisations and accommodation services - AOD treatment and support services - Mental health treatment and support services - Family support services - Domestic violence specialist support services - Financial support services - Education and training - Employment agencies - Legal support services - Cultural and healing support services	- Transport to and from appointments - Support to find housing or temporary accommodation - Financial support including food vouchers, mobile phones, brokerage, household bill support, advocacy with debtors, and financial counselling - Support with legal issues including support at court and support with FACS meetings - Crisis intervention with suicidal and self-harming clients - Mental health support and trauma counselling - Emergency support with police matters

- Other support for social and community engagement (e.g. Community drop-in centres) - Health and disability services	- Support related to domestic and intimate partner violence - Child protection - Emotional support with informal counselling, after-hours telephone support, and conflict resolution - Health issues including chronic health conditions unrelated to AOD

- As of 31 December, 2019, all planned CCCP services had been implemented, with organisation accreditation and clinical policies/protocols in place.
- The implementation of the CCCP service locations, hours and staffing was in line with CCCP aims; however, all service providers have had to adjust service delivery to some degree in response to local factors, reducing service hours for the CCCP by approximately 1,000 hours/year.
- A key goal of CCCP is to retain clients in AOD treatment. The proportion of clients engaged in AOD treatment at CCCP exit ranged from 17% - 44%, reflecting a combination of (i) diverse client needs, (ii) a lack of treatment options or cost/access issues, (iii) client preferences.
- Gaps in available treatment services located within a reasonable distance – especially lack of residential rehabilitation services, step-down services, services for women and parents and services for clients with coexisting mental health needs – are a key barrier to meeting the treatment needs of CCCP clients.
- Transportation is also a key barrier to meeting the treatment needs of clients. The greater the transportation difficulty/distance/cost, the greater the challenge to retaining clients in AOD treatment.
- Homelessness is a major factor affecting retention in treatment, however multiple barriers exist to clients securing suitable housing, including gaps in homelessness support services, lack of temporary accommodation and lack of social and affordable housing.
- The CCCP eligibility requirement that clients must have been in treatment in the previous month presents a barrier to potentially suitable clients who are experiencing difficulties making initial contact with AOD treatment services.
- Anecdotal reports from providers suggest that CCCP is filling a service gap for clients who have difficulties accessing other AOD services, such as parents with dependent children and clients for whom residential rehabilitation would not be ideal, including Aboriginal and Torres Strait Islander Australians who wish to remain on country.
- The Buttery, delivering services to Northern NSW and the mid-North Coast, reported a high uptake of the CCCP services by Aboriginal and Torres Strait Islander clients. Greater uptake of CCCP services by Indigenous clients in other regions might be enhanced by relationship building with local Aboriginal agencies, the local Land Council and the community, by providing

more expert services targeted towards Aboriginal and Torres Strait Islander clients, and by ensuring Aboriginal-identified positions are filled.

- Several services reported that they are running at or beyond capacity and noted that more staff would assist in meeting demand for CCCP services and existing client needs. In Districts that span a wide geographical area, it is physically impossible for a small number of full-time equivalent (FTE) staff to provide a meaningful service everywhere it is needed.

- The six-month duration of CCCP service delivery is often not enough time for clients to address the issues for which they engaged with the program. Services are dealing with this by opening a new MDS DATS episode of care in some cases, by arranging for the client to step up or step down into other programs offered by the provider, or by transferring the client to a related organisation.

- Formal Memoranda of Understanding (MoUs) and regular meetings with LHDs and other stakeholders were related to stronger stakeholder relationships and greater clarity around referral pathways. Colocation with stakeholder agencies also facilitated stronger relationships.

- More clarity is needed about appropriate referrals into CCCP; specifically, the exact scope of referral criteria and clarification of the services available through CCCP.

- Regular communication and engagement with LHDs are critical to maintaining functional referral processes, and this was identified as a key area from improvement.

- LHDs perceived the CCCP as being highly valuable, the majority rating the continuation of this service as 'essential' for their District. Clinicians noted that many of their clients need the type of intensive case management provided by CCCP, and that this need would otherwise go unmet.

- An unexpected positive outcome of the CCCP has been that clients have been able to connect with and support other clients they have met through the service and develop strong peer-group connections. Peer support networks are particularly relevant for clients located in regional and remote areas where they might not have peers around them for support.

- Opportunities for enhanced service delivery identified by service providers and LHD representatives:

    - More staff needed to deliver adequate regular outreach to remote NSW
    - Develop capacity to run Smart Recovery meetings
    - Client brokerage funds
    - Fill Aboriginal-identified positions
    - Provide expert services designed specifically for Aboriginal and Torres Strait Islander clients
    - More staff training in relation to key issues facing clients
    - Review eligibility criteria to support access for homeless clients and those struggling to make contact with AOD services
    - Review the 6 month limitation on service provision

Evaluation component 2: Service demand and reach

AIMS

1. To determine uptake and ongoing demand for CCCP services since implementation.
2. To determine where referrals are primarily coming from
3. To determine how long clients require support from CCCP services
4. To determine the demographics of those using the service (age, gender and Aboriginal and Torres Strait Islander status)
5. To determine the social and economic circumstances of the clients accessing this service and the nature of their treatment and support needs (i.e. principal drug of concern, source of income, accommodation type, living arrangements).

METHODS

Relevant data were obtained from the NSW Minimum Dataset for Drug and Alcohol Treatment Services (NSW MDS DATS). CCCP providers are required to report this client information and service activity monthly. To capture all CCCP data up to and including 31 December 2019, NSW MDS DATS data were extracted on 1 June 2020.

KEY FINDINGS

- From commencement of services to 31 December 2019, 1269 unique clients had received support through CCCP.
- After an initial scale-up phase, the program reached capacity around October 2019, at which point CCCP services were supporting approximately 725 active clients per month across NSW.
- Six months of support appears to be insufficient for many clients. For one-quarter of CCCP clients, the episode of care was open for longer than 6 months post-intake; 5.8% of clients as of 31 December 2019 had received multiple episodes of care.
- Conversely, retention in the program is also a challenge for many clients. Only 22% of episodes of care were closed due to service completion. It was more common for episodes of care to be closed because the client left without notice.
- Clients were most commonly referred to the CCCP through AOD treatment agencies (22% of referrals), non-health services agencies (18% of referrals), and Community Corrections (Department of Communities and Justice - 18% of referrals).
- The most common principal drug of concern among CCCP clients was methamphetamine/ amphetamine (39%), followed by alcohol (34%), cannabinoids (11%) and heroin (10%). Nearly one-quarter of CCCP clients reported injecting drug use within the past 12 months.
- Some CCCP services reported a higher-than expected proportion of female clients, possibly reflecting local unmet need for women's services.
- There was wide variation across services in the proportion of CCCP clients identifying as Aboriginal or Torres Strait Islander, ranging from 37% to 4%. With the exception of the Northern NSW/Mid-North coast districts, there was no indication that CCCP services were supporting at higher-than-expected proportion of Indigenous clients.
- There was a high level of disadvantage among CCCP clients: 23% of CCCP clients were homeless or living in a shelter/refuge, compared to 9% of clients of AOD NGO services in NSW overall in 2019. Only 3% of CCCP clients had any form of employment.

Evaluation component 3: Impact on client outcomes

AIMS

1. To determine whether measurable improvements in individual client wellbeing occurred as a result of engagement with the CCCP;
2. To determine whether measurable improvements in AOD use and severity of dependence occurred as a result of engagement with the CCCP;
3. To examine the nature and completeness of client outcomes data (i.e. what tools are used and how often outcomes data are being collected).

METHODS

Mission Australia, St Vincent de Paul Society and The Buttery use slightly different tools for assessing client outcomes. All three providers use the Australian Treatment Outcomes Profile (ATOP) tool, as required under CCCP funding agreements.

Mission Australia use the Personal Wellbeing Index (PWI, 5th Edition) to track wellbeing in clients across their journey within a service. For CCCP clients, the PWI is intended to be administered at service entry, at 3-6 month progress, and at service exit. In response to a request from the Ministry, Mission Australia provided aggregated PWI scores for CCCP clients at service entry, progress and exit, by service location. Data were analysed for the period from the time the first survey was completed (10 October 2018) to 31 December 2019. Averaged wellbeing scores across the client population at entry were compared with averaged scores at exit, and the significance of the difference assessed using a two-sample t-test assuming unequal variances (hypothesised difference of the means of 0, significance level of 0.05).

Mission Australia also administer the ATOP survey at service entry, progress and service exit. Aggregated results for each time point were provided on request.

CCCP services run by St Vincent de Paul Society routinely report client outcomes data to NADAbase.[1] NADA generates summary reports for the CCCP and provides these to the Ministry every 6 months or on request. To assess client outcomes data collected by St Vincent de Paul over the duration of the CCCP, a bespoke request was made to NADA for aggregated client outcomes data reported for CCCP services up to 31 December 2019. These data include AOD severity of dependence scores and quality of life scores (EUROHIS-QOL-8) measured at entry, one or more progress points, and exit.

St Vincent de Paul Society also provided deidentified ATOP data for CCCP clients at program entry, progress and exit. These data were available for the Central and Eastern Sydney service sites only.

The Buttery routinely perform ATOP and K10 surveys at service entry, 3-6 month progress and exit. A report on ATOP and K10 outcomes for matched pairs from service commencement to 31 December 2019 was supplied for the purposes of this evaluation.

[1] NADAbase is a comprehensive system for client data collection and reporting, including client outcomes data. NADA provides the database free to members for the National and NSW Minimum Data Sets for Alcohol and Other Drug Treatment Services (N/MDS) and Client Outcomes Measurement System (COMS)

KEY FINDINGS

- Evidence of impact of the CCCP is based on pre/post observational data, with no control group available, and should be interpreted with appropriate caution and consideration of the limitations of these data.
- All CCCP providers use the ATOP survey tool to assess client progress. Mission Australia also measure client well-being according to the Personal Wellbeing Index. St Vincent de Paul routinely measure quality of life according to the EUROHIS-QOL-8 survey and substance dependence using the Severity of Dependence Survey (SDS). Client surveys are administered at intake, 3-6 month progress, and service exit (where possible – see Section 2.4).
- The present analysis is limited by the small number of exit surveys available. Given the large proportion of clients who leave the service without notice or for reasons other than service completion, it is not feasible to conduct an exit survey in many cases. The client sample on which the outcomes assessment is based is therefore likely to be biased to some extent.
- Evidence from quality of life and wellbeing surveys indicate that CCCP clients rated their wellbeing well-below the population normative range at CCCP entry.
- Data from the Mission Australia Personal Wellbeing Index survey indicated that the domains of greatest dissatisfaction for CCCP clients at program entry were 'achieving in life', 'personal relationships', 'community connectedness' and 'standard of living.
- Comparing averaged quality of life and wellbeing scores at entry, progress and exit points, improvement was observed across all CCCP programs, although results should be interpreted with caution due to small numbers and statistical limitations.
- CCCP clients of The Buttery and Mission Australia who completed an ATOP survey at program exit reported an increase in average number days of work and a smaller increase in average days of study. A similar improvement was not observed for St Vincent de Paul clients; however, the small number of exit surveys mean these results should be interpreted with caution.
- Preliminary evidence indicates that risk of homelessness and domestic violence is reduced among CCCP clients from program entry to program exit.
- Among clients who inject drugs, ATOP results indicated a substantial decline in injecting behaviour from CCCP entry to exit.

Evaluation component 4: the role of NADA in supporting the objectives of CCCP

AIMS

1. To review the implementation and the scope of the CCC Consultant role;
2. To review the achievements of the CCC Consultant in supporting the objectives of the CCCP;
3. To review the priorities and key deliverables of the CCC Consultant role going forward.

METHODS

The Directors and CCCP coordinators from St Vincent de Paul, Mission Australia and The Buttery were surveyed for their views regarding the role of the CCC Consultant in supporting the program's objectives.

The NADA CCC Annual Report 2019 and the NADA CCC Clinical Consultant Interim Evaluation (December 2019) were reviewed for information on implementation and achievements.

KEY FINDINGS

- There was a high level of satisfaction with the NADA CCC Consultant expressed by CCCP providers.

- Key areas where the CCC Consultant had contributed to the objectives of the CCCP included:
    - Establishing new relationships between CCCP service providers and relevant organisations/agencies, especially Community Services, LHDs, primary health networks (PHNs) and other AOD services
    - Brokering agreements between CCCP services and stakeholder agencies (e.g. Community Services)
    - Establishing referral pathways
    - Facilitating collaboration across teams through the CCCP Forum
    - Targeted training to up-skill staff quickly in key areas

- A key challenge of the NADA CCC Consultant role has been in relation to facilitating access to suitable housing for CCCP clients. The consultant has been establishing stronger links with housing agencies such as Homelessness NSW, however the shortage of suitable housing in many parts of NSW has limited the ability to secure housing for all CCCP clients who need it.

- Providing equitable support to CCCP services across the state, given distance and limited resources, is another key challenge of this role

- New/ongoing areas for support from the CCC Consultant, as identified byproviders, included:
    - Advice and assistance around referral pathways, in particular for clients with co-occurring mental health concerns
    - Continuing professional development and provision of resources and information (e.g. drug and alcohol fact sheets, information on mental health for clients and staff, a database of other AOD services, information on withdrawal management programs)
    - Training around current practice gaps (identified gaps include motivational interviewing, pharmacology, relapse and harm reduction, grief and loss, mental health, domestic and family violence)
    - Facilitation of greater networking, knowledge sharing and collaboration between CCCP providers
    - Group supervision.

Key Implications

Implications for service delivery

1. Existing resources and the wide geographical area covered by some LHDs limit the ability of the CCCP to deliver adequate and regular outreach to remote NSW;
2. Brokerage funds would support retention of clients in services by addressing challenges related to transportation and communication (i.e. provision of transport fares and mobile phones);
3. Aboriginal-identified positions can support engagement and retention of Aboriginal clients;
4. Provision of services designed specifically for Aboriginal and Torres Strait Islander clients and expanded delivery of CCCP services to Indigenous clients may be warranted for some services;
5. Consideration should be given either to revising the 6 month maximum duration of service, or adopting other flexible approaches to clients who require a longer duration of support;
6. Consideration should be given opening access to CCCP to clients who are not currently in AOD treatment, given that many who are most in need of intensive case support face considerable barriers to accessing AOD treatment in the first place;
7. CCCP guidelines should be developed and made widely available which address program aims, eligibility criteria, referral pathways, services available and a model of care;
8. Ongoing engagement with referring partners is needed to minimize inappropriate referrals (including referral without client agreement or awareness) and to maximise appropriate referrals (especially from primary care physicians and community health);
9. Consider reallocation of unused FTE to address service need in other locations; alternatively, utilise unspent funds to further support the aims of the CCCP, for example for client brokerage;
10. Providers to establish Smart Recovery meetings;
11. A need for more capacity building/training is identified in the following areas:
    - Supporting victims of domestic violence
    - Working with LGBTQI clients
    - Suicide ASIST
    - AOD knowledge (pharmacotherapy and emerging drugs)
    - Working with men who are using violence
    - Working with women engaged in AOD treatment
    - Working with people who use methamphetamine
    - Family inclusive practice
    - Mental health training.

Recommendations for performance monitoring

Having a formal written agreement in (e.g. an MoU) in place was identified as facilitating engagement with, and referrals from, the host LHD. Nearly all LHD representatives stated they lacked clarity regarding appropriate referrals to the CCCP. Regular meetings between CCCP and LHD staff were identified as important for promoting communication, fostering partnership and supporting shared care coordination. LHD representatives suggested that there was a role for more active contract management by the Ministry in this regard. The inclusion of a performance indicator requiring services to have an agreement in place with the LHD that clarifies referral pathways and response protocols, articulates how care coordination functions in practice, and sets out a schedule for regular meetings and committee participation is therefore proposed.

Services are required to report among their key performance indicators the proportion of clients who are engaged in AOD treatment at service exit. Based on routine performance reporting as of 31 December 2019, this proportion is quite low (17-44%). However, this low proportion is less a reflection of service performance issues, and more of a reflection of incoming referral patterns, client needs/preferences and AOD treatment service availability/accessibility. Setting a benchmarking for this performance indicator is not recommended.

While one CCCP service reported a significantly higher than expected proportion of Aboriginal and Torres Strait Islander clients, for other CCCP services there may be scope to increase service delivery to Indigenous clients. Services should report on actions they have taken to reach Indigenous clients. This might include a qualitative indicator requiring a description of engagement with the community and Indigenous organisations and/or a quantitative indicator of number and proportion of CCCP clients in each service identifying as Aboriginal or Torres Strait Islander.

Given various updates to client outcome data capture and reporting that have taken place over the past 12 months, including retrospective data entry of hard copy client files and uptake of new instruments for monitoring client wellbeing by some services, it is recommended that a report on client outcomes data be provided by each service to the Ministry upon completion of the first grant period. While some of these data are captured by NADA's Client Outcomes Measurement System (NADACOMS), not all providers report client data into this system. Previous reports to the Ministry on client outcomes provide this information in different ways, making evaluation difficult. A uniform reporting template should be designed for this purpose by the Ministry, supported with clear written guidance.

Establishing evidence of impact of the CCCP is reliant on the availability of client outcomes data, ideally capturing the majority of clients. Various critical barriers to completing exit surveys were identified during this evaluation; however, it remains important that the completion of client outcomes surveys remains a priority. In addition to reporting the number and proportion of clients for whom an exit survey was conducted, regular performance reports should also provide a narrative of actions taken to improve the rate of survey completion and the impact of these actions. Progress surveys should also be prioritised and included in outcomes data analysis and reporting. Future analysis protocols should utilise progress survey results for those clients who leave prior to completing the program.