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UNSW
AUSTRALIA

**Evaluation of outcomes for people nominated
to the Integrated Services Program
Evaluation plan**

Never Stand Still

Faculty of Arts & Social Sciences

Social Policy Research Centre

REPORT 2/2014

February 2014

Thank you

to the ADHC Integrated Services Program team, the SPRC research team and colleagues for advice and comments.

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ABBREVIATIONS

ADHC	Ageing, Disability and Home Care
CJP	Community Justice Program
HASI	Housing and Accommodation Support Initiative
HREC	UNSW Human Research Ethics Committee
ISP	Integrated Services Program
MACNI	Multiple and Complex Needs Initiative
NDIS	National Disability Insurance Scheme
NDRA	National Disability and Development Research Agenda
NHMRC	National Consumer and Community Participation in Health and Medical Research
NFP	Not-For-Profit
NGO	Non-Government Organisation
NSW	New South Wales
SPRC	Social Policy Research Centre
PWI	Personal Wellbeing Index
UNSW	The University of New South Wales

1 INTRODUCTION

The Integrated Services Program (ISP) commenced in 2005 with dedicated funding from the NSW Government as a demonstration project. The project became a recurrently funded program in 2009–10 following an independent evaluation conducted by the Social Policy Research Centre (SPRC) at The University of New South Wales (UNSW) (McDermott et al., 2010). A further descriptive study was conducted in 2011 and provided a profile of people nominated to the ISP, both those people accepted and not accepted by the Program.

The SPRC is conducting a follow up evaluation that also includes people who have left the program. The evaluation is from September 2013 to June 2014. This evaluation plan explains the evaluation methodology and management. It includes:

- background information (program overview and service delivery context);
- an overview of roles and responsibilities of key program partners;
- conceptual approach to the evaluation and key questions;
- evaluation methodology;
- data analysis process;
- ethical considerations; and
- project management, including deliverables, tasks and timeframes.

1.1 PROGRAM OVERVIEW

The Integrated Service Program (ISP) is a specialist service that coordinates a cross agency response to adults who have been identified from across the NSW government human service agencies as having complex needs and challenging behaviour. The ISP is a time-limited service and is based in the Sydney metropolitan area (ISP Factsheet, ADHC 2012).

The ISP is administered by ADHC in partnership with Mental Health and Drug and Alcohol Office (MHDAO) of NSW Ministry of Health and Housing NSW. The Program is overseen by a Management Committee consisting of officers from the major partner agencies and is advised by a broader Interagency Reference Group.

People in the ISP are over the age of 18 years and identified as having multiple and complex needs which place themselves and or others at high risk. They have had significant barriers accessing coordinated cross-agency responses. These clients may have one or more of the following; intellectual disability, brain injury, mental illness, personality disorder, and/or issues with alcohol and other drugs. Most people using ISP have experienced insecure housing prior to entry into the Program.

Since 2005, 177 people have been referred to the Program, 71 have been accepted, and nearly half of these have exited the Program. The current operating budget of the ISP is \$10.3 million.

ISP TARGET GROUP

Within the ISP people with complex support needs are understood to experience, or be at risk of experiencing, one or more of the following¹:

- have a disability and interrelated conditions (e.g. mental health, substance abuse) and complex support needs;
- high risk challenging behaviours which place themselves and/or others at significant risk of harm;
- local support options exhausted or at risk (e.g. breakdown in carer arrangements);
- challenge the service system's capacity to appropriately respond to their needs.

PROGRAM AIMS

The overarching aim of the ISP is to provide highly targeted, coordinated interagency support to people with complex needs, improve their life outcomes, and reduce the cost of this group to service systems and the wider community. The Program aims are to:

- improve the persons housing stability and social connectedness;
- improve life outcomes in other key areas, including health, mental health and wellbeing;
- decrease the adverse impact of behaviours on the person, other people around them, and the community more broadly;
- improve coordination and capacity of local supports;
- develop a sustainable model with the person, so that they can, as much as possible, regain independence and transition to receive support within the mainstream service system ('service fit'); and
- contribute to evidence base on supporting people with multiple and complex needs.

SERVICE DELIVERY FEATURES

The ISP is designed to provide holistic, integrated, cross-agency services to approximately 30 people with multiple and complex support needs that have not been met within the existing service system. The key features of the ISP are to:

- take a holistic view of the person requiring assistance and their support needs;
- undertake a multi-disciplinary comprehensive assessment;
- provide person-centred case management and planning;
- provide assistance and facilitate access to intensive clinical and non-clinical interventions (incl. disability support, therapeutic rehabilitation);
- provide safe and supported accommodation for people in the program; and
- provide assistance and build local support networks.

Originally the ISP was designed to provide time-limited 18 months intensive support. People referred to the ISP however remain in the Program as long as is required. In most cases they cannot leave the Program (because of guardianship orders) (Shannon McDermott et al., 2010), or be discharged until a sustainable support model has been found for them. Some people remain in the Program because suitable arrangements have not been found yet. The implications of this will be a question for the evaluation.

¹ Reference: internal program documentation, including confidential report (KPMG, 2013)

TYPES OF SERVICES

The ISP provides a range of time limited (18 months) intensive services in the Sydney metropolitan area. Clients or a substitute decision marker are required to consent to the provision of services prior to entry into the ISP. These services may include:

- Multidisciplinary comprehensive assessment
- Individual case planning and case coordination
- A range of accommodation models , including; 24 hour supported group homes to drop in support in either private or subsidized housing
- Access to a range of behavioural, therapeutic, rehabilitative and disability support programs
- Building of support networks
- Identification of a sustainable long term service option
- Planned and systematic withdrawal and handover of support to relevant agencies

ROLES AND RESPONSIBILITIES OF PROJECT STAKEHOLDERS

The evaluation project will define the roles and responsibilities of the project stakeholders.

Project partner agencies:

- ADHC, Corrective Services, Police, Housing NSW and NSW Health.
- Project stakeholders include:
- ISP Managers and staff
- ISP Management Committee
- Interagency Reference Group members and other government, non-government, University sector and private sector partners
- Executive Director, Clinical Innovation and Governance, ADHC
- Executive, ADHC, Family and Community Services
- Mental Health Senior Officers Group
- People in the Program, people likely to use the Program and people who represent them

GOVERNANCE ARRANGEMENTS

The evaluation project will define and analyse the governance arrangements for the Program.

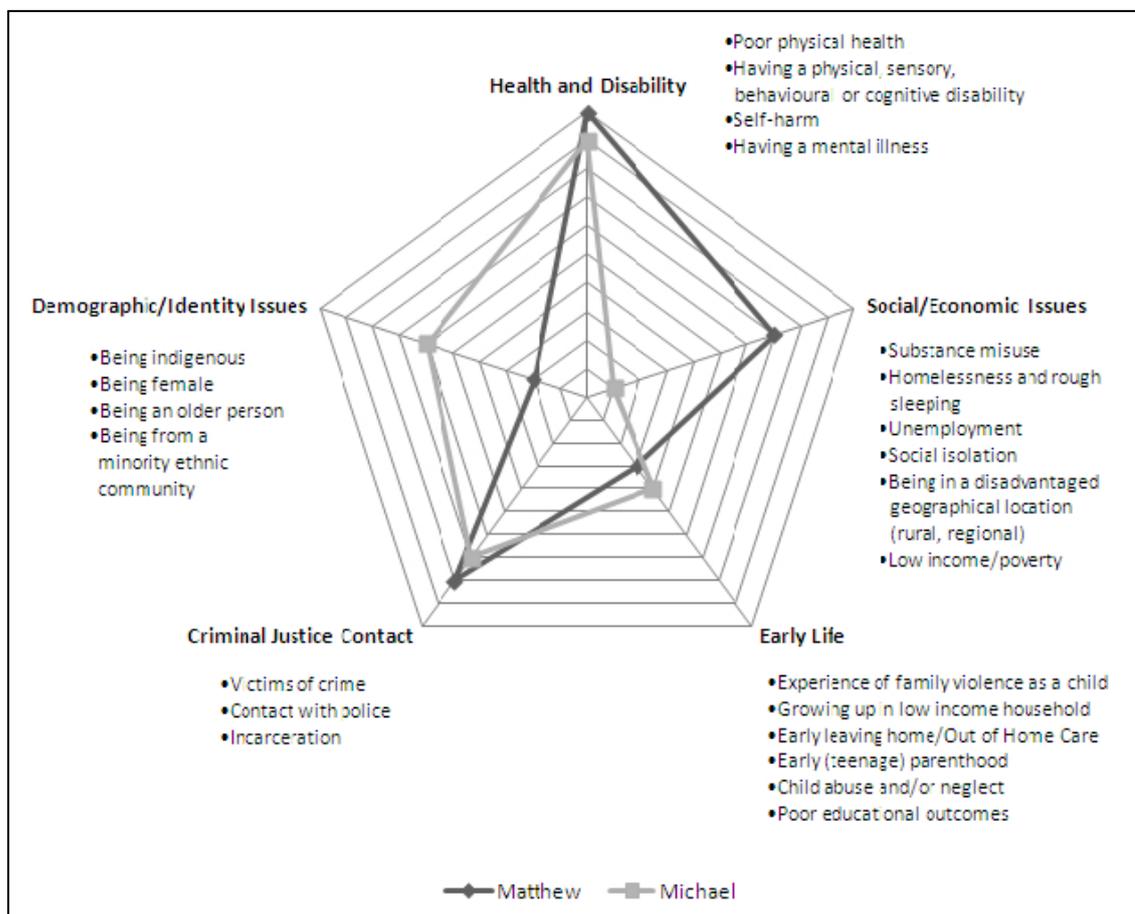
1.2 SERVICE DELIVERY CONTEXT

DEFINING COMPLEX NEEDS

There is little consensus amongst professionals and academics across various fields and disciplines on how to define people experiencing multiple and interrelated needs, which are therefore more complex to meet. Baldry and Dowse (2013) note that much of currently used terminology is based on a primary medical condition (such as co-morbidity), where attributes appear rather static, and often 'problems' are individualised, understating the social and structural factors that have in most cases led to, or aggravated, the circumstances people are experiencing.

Instead Rankin and Regan (2004) have suggested the term *complex needs*. This term encompasses two critical notions: complexity arising from a range of interrelated needs and factors, and the profoundness of these experiences. Although not without ambiguity, it allows us to understand the simultaneousness of people's experience of complex needs, which are multiple and interlocked (Rankin and Regan, 2004) and characterised by a compounding effect (Baldry and Dowse, 2013). Compounding here means that an increase in one area/need is likely to increase the potency of another area or need. This dynamic further contributes to people in this group being subject to greater risk and heightened vulnerability to experiencing further needs. Using two case studies, Baldry and Dowse (2013) illustrate the experience of complex needs as a 'dynamic, interactive and multidimensional concept'. The framework captured in Figure 1 highlights the interplay of individual, social and systemic factors, without reducing people to 'atomised notions of additive individual dysfunction or disability' (p.224).

Figure 1: The complex needs web mapping the case studies of 'Matthew' and 'Michael'²



DEFINING CHALLENGING BEHAVIOURS

Another contested term, which has been frequently used in connection with people experiencing complex needs, is *challenging behaviours*. In disability contexts it was originally used to describe people with a cognitive or learning disability and their interaction with the environment around them (Knapp et al., 2005; Lowe et al., 2007). While the term can be useful, it is frequently used in a way that ignores the social and environmental factors that may have contributed to a specific type of behaviour (Mansell, 2007), furthermore the term has been misused as a 'diagnostic label' (Banks et al., 2007).

²Figure by Han Xu in Baldry and Dowse, 2013, p.224.

Banks et al. (2007) propose a redefinition of the term challenging behaviour, as a behaviour that may significantly impact on the quality of life or physical safety of a person with intellectual disability, people around them, or the community more broadly. The underlying principle when working with people in this group should be 'to improve the quality of life for people whose behaviour challenges others' (Banks et al., 2007, p.9). Within the ISP the term is generally understood in this sense.

1.3 DISABILITY POLICY AND SERVICES LANDSCAPE

Australia is currently undergoing a major transformation in the way that disability services are funded and delivered. The Australian Government is committed to roll out the National Disability Insurance Scheme by 1 July 2018.³ The aim of this policy is to give people with disability greater control over their life and decision making process over the supports they receive. This policy shift is based, among others, on the Productivity Commission's recommendations, to move the disability sector from more 'centralised control to a more market setting' with for-profit and not-for-profit (NFP) providers playing an even greater role; whereas government providers remain the supplier of 'last resort' (Productivity Commission, 2011, p. 526).

NSW has been among the states to spearhead the transformation of its disability sector. Under *Stronger Together* significant changes and investments were made into disability services. The second phase of *Stronger Together* commenced in 2011 and will go until 2016, and it will focus on service expansion and sector reforms (ADHC, 2010b). One of the five key reform areas identified under *Stronger Together* was to expand options for people living in specialist support services (including people with an intellectual disability who have complex support needs) (p. 8).

Until the implementation of *Stronger Together* in NSW very little funded support existed for people with complex needs (Bleasdale, 2006). There was growing recognition that this group was not well served within the existing service system (Shannon McDermott et al., 2010; Philips, 2007). As a consequence a number of targeted programs have been developed, such as the ISP and HASI, and existing ones expanded (CJP), to build and strengthen capacity within and across service systems to meet complex support needs.

RELATED PROGRAMS IN NSW

Housing and Accommodation Support Initiative

The Housing and Accommodation Support Initiative (HASI) was established in 2003 to provide stable housing and accommodation support services as well as clinical mental health services to people with severe mental illness and who also have insecure tenancy (Bruce et al., 2012). The program is a partnership between NSW Health, Housing NSW and the non-government organisation (NGO) sector, and provides packages of low-to-medium, high, and very high levels of support to people with mental ill-health.

The most recent evaluation of the program (Bruce et al., 2012) established that people using HASI experienced a number of positive outcomes, including a reduction of mental health hospital admissions; stable tenancies; increase in independent living skills; and greater social and community participation. Most participants believed that HASI had contributed to

³<http://www.disabilitycareaustralia.gov.au/>

improving their quality of life (ibid. p.9). The annual cost of HASI per person ranged between \$11,000 and \$58,000. The evaluation undertook a cost analysis (expenditure per person), but did not include a cost-benefit analysis or estimation of savings for government and community services if the participant had not been in the program.

Community Justice Program

The Community Justice Program (CJP) is another program that supports people with complex needs, specifically people with intellectual disability, who have been in contact with the criminal justice system. The program was established in 2006 and provides a range of accommodation options, as well as specialist support and clinical services targeted to individual need. One of the residential components is the Intensive Residential Support service model. It provides accommodation and 24 hour specialist support and supervision to people with an intellectual disability with complex needs, high risks, and behaviours that pose a risk to themselves and others. The aim is to develop personal skills and minimise the likelihood of re-offending, eventually allowing the person to re-integrate into the community (ADHC, 2010a).

To date one evaluation of the CJP is publicly available, commissioned by the Queensland government and specifically looking at outcomes for Indigenous people and communities. The main findings relevant for this literature review were that program effectiveness was restrained due to underfunding and under-resourcing; and efficiency of the program could not be assessed due to inadequate financial and performance data (KPMG, 2010). An internal evaluation of the NSW CPJ is underway by NSW Treasury.

RELATED PROGRAMS IN AUSTRALIA AND OVERSEAS

The Multiple and Complex Needs Initiative (MACNI), introduced in 2004 in Victoria, is a time-limited specialist service for people 16 years and older who have been identified as having multiple and complex needs, including intellectual disability, substance abuse, or mental health issues. People in the program are at significant risk of harm to themselves and others. MACNI aims to provide effective and co-ordinated support using a care plan coordination model to develop individualised care plans, and deliver case management and behavioural support services across a range of agencies (Victorian Department of Human Services, 2003). Similar to the ISP, the program has a strong emphasis on inter-agency coordination, here in particular of government and NGO services, which has been identified as a best practice response (McVilly, 2004). The main aim of MACNI is to improve participants' life outcomes, in health, housing, social connectedness and safety.⁴

Different aspects and components of the initiative have been externally evaluated or internally reviewed over the years (Victorian Department of Human Services, 2009). A number of discussion papers looked at the challenges and best practice lessons, for example, in the assessment, care plan development and implementation (Hamilton and Elford, 2009). A small recent review looked at the need to balance risk aversion and client autonomy in the absence of the requirement for informed consent (Victorian Department of Human Services, 2012). None of these evaluations so far have undertaken a cost-benefit analysis.

This current ISP evaluation project will refer to further literature about Intensive Behaviour Support Teams (QLD), Alcohol Related Brain Injury Accommodation Support Service (ARBIAS), secure care and MACNI evaluation in Scotland for people leaving prison.

⁴<http://www.dhs.vic.gov.au/about-the-department/plans.-programs-and-projects/projects-and-initiatives/cross-departmental-projects-and-initiatives/multiple-and-complex-needs-initiative>

METHODOLOGICAL QUESTIONS ARISING FOR THIS EVALUATION

There is growing evidence showing that people experiencing complex needs, including those without stable accommodation, have a much higher use of health and justice services than the population average (Bruce et al., 2012; Flatau et al., 2008). With the increased investment in specialised programs, there has also been a growing interest in measuring the outcomes for service users, and costs and benefits to Government and the community more widely.

Zaretzky et al. (2013) provide a detailed outline on how they will measure the cost-benefits of Australian specialist homelessness programs. In this comprehensive national study the authors attempt to examine the cost of providing specialist services and the net benefits of such programs comparing them to a quasi-experimental comparison group (Zaretzky et al., 2013, p.1, 37-38). Their approach includes:

- to examine the extent to which outcomes for clients of specialist homelessness programs are changed by receiving support, using a longitudinal survey of relevant services;
- to look at the costs of non-homelessness services used by persons at risk of homelessness (mainly across the health, justice and income support domains);
- to examine the cost of providing specialist homelessness programs; and the potential savings in non-homelessness services, which are then netted off against specialist services, to determine the cost to government in providing certain types of assistance; and
- to investigate the use of linked administrative data on homelessness, health, justice, income and wealth support.

A related research project rather than evaluation is Baldry, E., Dowse, L., McCausland, R, and Clarence, M. (2012), Lifecourse Institutional Costs of Homeless for Vulnerable Groups, a Final Report completed under the Homelessness Research Agenda of the Department of Families, Housing, Community Services and Indigenous Affairs, Australian Government, Canberra, ACT.

The methodological implications from this literature are that evaluating interventions for people with complex needs to consider how the Program addresses

- the particular needs and preferences as a whole of each person in the program, rather than attempting to isolate particular causes or generalise between cases;
- as well as focus on the service and system level impact of demonstrated change from new practices that addressed the particular needs of participants in the Program.

2 EVALUATION FRAMEWORK

2.1 EVALUATION FRAMEWORK

A mixed method evaluation design will be used to measure outcomes for adults with multiple and complex needs using specialist ISP services and people referred to, but not accepted into the Program; the Program process; and costs. The methodological approach has been developed to track a sample of clients referred to the ISP with a view to further examination of the longer term client outcomes achieved via the Program. The evaluation framework aims to identify and compare, where possible, outcomes for three groups of service users:

- A. People using ISP services;
- B. People referred to ISP who have exited the Program;
- C. People referred to ISP who have not been accepted into the Program.

The methods in Section 3, and the evaluation framework, have been designed to measure the outcomes of people using ISP services and determine the costs of providing support for people outside the ISP. This approach will allow a better assessment of cost-benefits for Government and the community in providing intensive and specialist ISP services. It will also contribute to on-going debates and policy making in the roll out of the NDIS.

OUTCOMES AND PROCESS EVALUATION

The aim of the evaluation is to measure key outcomes for people using ISP services, those who have used the services in the past and exited the Program, and people referred to ISP who have not been accepted into the Program. The key outcomes to be measured include access to:

- i. ongoing stable accommodation
- ii. case management/care coordination via a clear lead provider
- iii. a comprehensive range of support services based on identified needs (therapeutic, rehabilitative, employment, disability support etc)
- iv. established clinical indicators including number of hospital bed days and number of days in custody.

Costing of supports will also be a focus of this work.

Another part of the evaluation is to look at the processes – for the people using ISP services, service providers and ISP partners involved. The process evaluation, mainly qualitative methods (focus groups with service providers, and ISP representatives), will identify what is working well in the delivery of ISP services, what is not working as well, and how it could be improved. The focus of the process evaluation will be to contribute to the evidence on achieving ISP aims and outcomes for service users. This part of the evaluation will also provide insights into the procedures and governance of the Program and will contribute to on-going program development.

ECONOMIC EVALUATION

The economic analysis will compare the costs of the Program to the outcomes for service users, but also outcomes for people with similar support needs who have not entered the program (Group C.) The aim of this approach is to understand the extent to which costs to

outcomes (e.g. increased personal wellbeing and independence) represent value for money over a longer term (e.g. reduced hospitalisation and imprisonment). The underlying principle of economic analysis is that for the given budget, the government wishes to maximise consumer benefits. The economic analysis will also inform future decisions about the Program and similar support models for people with multiple and complex support needs. The ISP is a highly specialist and intensive support program which has very limited comparison in Australia and other countries.

2.2 EVALUATION QUESTIONS

1 Was the ISP effective for changing outcomes for people using the Program?

Including housing stability (in the longer term), health, mental health, and personal wellbeing (e.g. reduced hospitalisation, incarceration), impact of complex needs, social connectedness (e.g. greater community participation, improved connection and support through informal support networks etc.)

Which people using ISP benefited most/least? Are there any particular characteristics that appear to have contributed to better or less effective outcomes for some?

Did the program adhere to its own criteria and target group? Which group of people is missing out on ISP services that could have benefited? (e.g. people most in need)?

2 What aspects of the service delivery model contributed or were barriers to the operational effectiveness, and how could they be addressed?

Including governance, inter-/cross agency approach, program management and service delivery in partnerships; and what aspects hindered it from running as effectively as it could?

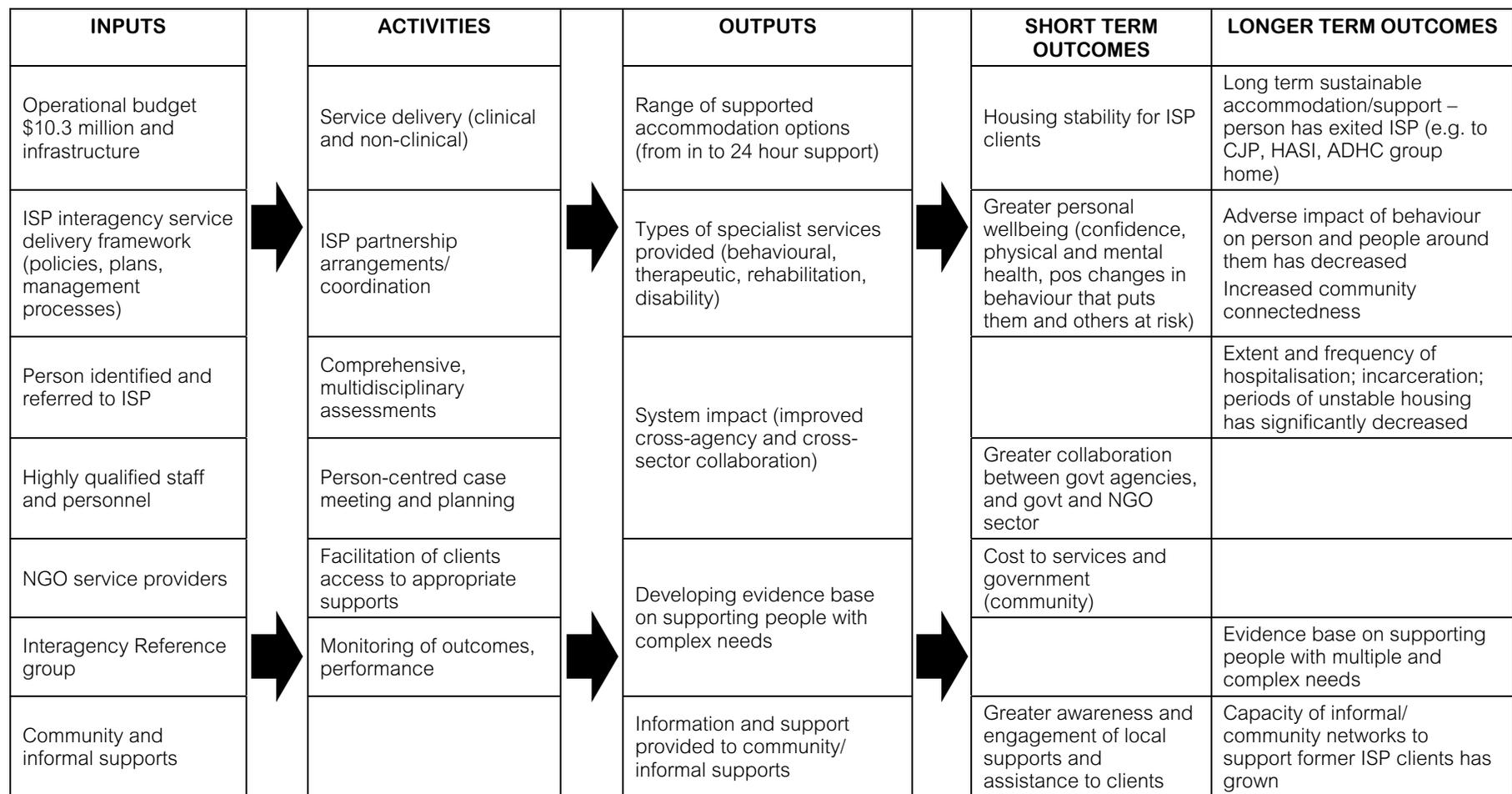
What are the main 'external barriers', including legislative or industrial factors assisting or inhibiting provision of services across the target group?

Are services integrated for the sustainability of support for post-ISP and non-ISP clients, and what improvements could be made?

3 What was the cost of delivering ISP compared to outcomes for clients and the broader service sector?

Is the Program value-for-money and is it a viable service delivery Program?

2.3 ISP PROGRAM LOGIC



2.4 PHASES OF THE EVALUATION

PHASE 1: DESIGN

The evaluation team will work closely with the ADHC project manager and other key stakeholders to develop an agreed evaluation plan. This process will include refinement of evaluation objectives, evaluation questions and research methodology. To maximise resources, the evaluation design has taken into account existing data, secondary data collection tools and methodologies, and issues raised in the previous evaluation of the ISP (Fisher and McDermott, 2008; Shannon McDermott et al., 2010).

For this design phase a short review of available literature and data on outcomes for people with multiple and complex needs who may or may not have had access to integrated services models has been undertaken. The findings informed the design of this plan.

This phase of the evaluation requires close consultation with ADHC and relevant stakeholders to explore the availability of outcomes and cost data related to current, former ISP clients and those referred to the Program. This information, provided by ADHC, will be the main data collected and analysed for this evaluation.

PHASE 2: COLLECTION

The evaluation data—secondary client and financial data, and case studies—will be collected and transferred from ADHC and relevant stakeholders in the Program. ADHC will collect all data from October until December 2013. ADHC will arrange two focus groups with staff and relevant stakeholders involved in the program in November 2013 to be conducted by the SPRC to inform the outcomes and process evaluation.

PHASE 3: ANALYSIS

In Phase 3, the evaluation team will analyse the data provided by ADHC and the information collected in the focus groups. Analysis will be against the evaluation questions, evaluation objectives and client outcomes outlined in the evaluation plan. The SPRC will produce a draft evaluation report and present it to ADHC in a form agreed during the design phase. During the analysis phase, the team will remain in regular contact with ADHC as before and will continue to provide monthly progress reports. The draft report will be delivered in March 2014 if the agreed data are transferred for analysis in 2013.

PHASE 4: REPORTING

The team will finalise the evaluation report according to feedback from ADHC and other key stakeholders in the Program, and present the results by June 2014. A public version of the report will be agreed with ADHC for publication on the SPRC website.

3 METHODOLOGY

3.1 RESEARCH RATIONALE

The evaluation methods have been designed, within budgetary and time considerations, to meet the requirements of ADHC, and taking into account the service delivery framework and aims of the ISP. The methodological approach will examine the longer term client outcomes achieved by the ISP, to inform policy makers about cost and operationally effective models of service provision for people with multiple and complex needs. The research will also contribute to the sparse evidence base on effective service models.

3.2 METHODS

We will use mixed data collection methods as outlined in more detail in this section, including client administrative, secondary and financial data collection, case studies and focus groups.

SAMPLE AND PURPOSE

The methods will collect a range of data – administrative, secondary outcome, financial and case study data – for three groups of service users:

- A. people using ISP services;
- B. people referred to ISP who have exited the Program;
- C. people referred to ISP who have not been accepted into the Program.

Sample sizes are summarised in Table 1. Client data will be collected on all post-ISP clients and a similar number of non-ISP clients. This would be a sample of about 35 people in each group. Based on past experience, the sample size will yield enough information for meaningful outcome analysis and comparison between groups.

The aim of this approach is to compare, where possible, outcomes for the three cohorts. Comparative analysis will provide insights into the extent to which the Program has achieved its key objectives, to improve a range of life outcomes for people using ISP, and reduce cost of this group to the broader service system, but also which groups have benefited the most/ least from the Program.

Table 1 below provides an overview of the data collection methods, both qualitative and quantitative, and sample sizes by each respective method.

Table 1: Data collection by sample sizes

Type of data collection method	Sample size
Client administrative data	All post-ISP, all or similar numbers current ISP and non-ISP
Case studies	At least 12 (6 post-ISP, 6 non-ISP)
Client secondary data	All post-ISP, all or similar numbers current ISP and non-ISP
Financial data (service provision)	All post-ISP, all or similar numbers current ISP and non-ISP
Focus groups (up to 10 people each)	2

The extent of information collected on each client in the sample depends on its availability and ADHC capacity to collect and transfer the data. The qualitative data will be collected on at least 12 people (six post-ISP and 6 non-ISP), to produce in-depth case studies on these clients. This qualitative information is important, as the budgetary and time limitations and ethical considerations in this evaluation do not allow the researchers to conduct face-to-face interviews with people using ISP services.

QUANTITATIVE DATA–CLIENT PROGRAM AND FINANCIAL DATA

Client program and secondary data

Based on the experiences of the previous evaluation of the ISP (Fisher and McDermott, 2008; Shannon McDermott et al., 2010) the quantitative outcome and financial data will be collected by ADHC staff. SPRC designed client information sheets to collect administrative and secondary data about current and former ISP clients, and those who did not enter the Program. The tools have been amended to reflect any changes to the ISP since the last evaluation.

The main areas covered in the administrative and outcome data include questions on demographics, reasons for referral to ISP, and mental health and disability, as well as other client outcomes to be measured by this evaluation: accommodation situation and stability, case management, support services used based on identified need, and established clinical indicators such as number of hospital days and days in custody. Living skills, social and community participation, relationships and economic participation should also be measured.

If ADHC has the evaluation capacity, questions on well-being and community participation will be drawn from a validated instrument so that comparison can be made to other research, such as the Personal Wellbeing Index (PWI)(Cummins, 2005)and other studies about supporting people with challenging behaviour (Kelly et al., 2006; Robertson et al., 2004; Stancliffe et al., 2007). The PWI scale was also used in the previous evaluation of the ISP to measure subjective wellbeing (Shannon McDermott et al., 2010). For study participants who have completed more than one PWI measure, this will enable us to undertake longitudinal analysis and measure change over time.

To allow for a more holistic understanding of the person using ISP and their needs, qualitative questions (fields) have been included in the client information sheet to allow ISP and other services staff to provide descriptive accounts of clients' outcomes.

ADHC will attempt to transfer secondary data on current, former ISP and non-ISP clients from NSW Health, Corrective Services, Housing and other relevant agencies. This data will include the clients' use of services before, during and after Program use and use of services of non-ISP clients before and after referral to the Program.

Cost and financial data

To undertake the cost effectiveness analysis of this evaluation, the researchers rely on the transfer of financial data. Financial data will include service provision to all three groups of people (current ISP, post-ISP and non-ISP). If the financial data are available, specific items of service delivery will be costed and estimated per person/ per year, including accommodation, health, criminal justice, disability support, therapeutic services, rehabilitation and employment services, and case management support, preferably before, during and after ISP.

QUALITATIVE DATA

Case studies and supporting information

Project staff will collect qualitative data. One set of data are written case studies of at least 12 people (6 ISP and 6 non-ISP). SPRC provided ADHC with a manual and template on how to complete these case studies. The key areas of the case studies include the person's service use and experiences in key life areas, e.g. health and housing, before and after referral to ISP (irrespective of whether they entered the Program or did not enter).

To further inform the outcomes evaluation, staff will provide de-identified supporting documentation, along with the data on the information sheet (quantitative). The type and amount of data might include client behaviour and intervention plans, hospital data, criminal record data, guardianship reports, incident reports, and risk assessments. This information will be used to develop a more holistic, in-depth understanding of each client's situation and service use.

Focus groups

In addition to the quantitative data—administrative, secondary and financial—and case studies, the evaluation will conduct focus groups with key stakeholders in the Program. One group will include external representatives from government agencies responsible for project implementation and policy, service providers in other government and non-government organisations and client advocates; and the other group will be staff responsible for service delivery. The focus group participants will be selected by ADHC and other key stakeholders, consultation with the evaluators. SPRC researchers will undertake the focus groups.

Stakeholders in the focus groups may include a range of government and non-government representatives:

- ISP managers and staff
- ISP management committee
- Interagency reference group members and other government, non-government, academic and private sector partners
- Executive ADHC
- Client advocates, community organisations

The range of topics covered during these discussions will further inform and strengthen the outcomes and process evaluation section of this evaluation. A preliminary set of questions has been included in this Plan (refer to Appendix 6.1) to be refined.

4 ANALYSIS

The data analysis will be undertaken comparing the three cohorts in the evaluation study and triangulating data from various sources and research methods, where possible. The main focus of the analysis will be to measure longer term outcomes for people using (or who have used or not used) ISP, and compare Program outcomes to cost of running the ISP and service provision.

Client outcomes and process evaluation and economic analysis will address the evaluation questions (Section 2.2).

5 PROJECT MANAGEMENT

The evaluation will be conducted in the timeframe in the project outline provided by ADHC, as adjusted to the contract start date. The project commenced in September 2013, the draft Final Report will be delivered in March 2014, and the Final Report in June. All deliverables will be completed by June.

The key deliverables are:

- Evaluation plan and progress reports
- Draft and final evaluation reports, and presentations.

In addition, monthly progress reports will be provided to the ADHC project manager. These reports will outline the current status of the project against the agreed project plan, any issues or risks which may impact progress, and any potential variations to the project scope, budget or deliverables.

The evaluation will consist of four phases (Table 2): design, data collection, analysis and reporting. Key activities within these four phases are: meet with stakeholders and finalise/agree to project plan; ethics application; conduct literature and data review; collect and analyse data; produce a report and present to stakeholders.

Table 2: Evaluation deliverables, tasks and project timeframe

	Year	Month
Phase 1: Design	2013	
Contract signed		Sep
Briefing meetings with ADHC and other stakeholders		Sep
Literature and data review		Oct
Ethics approval		Oct
Evaluation Plan		Nov
Phase 2: Data collection		
<i>Qualitative</i>		
Focus groups with key stakeholders and service providers	2014	Feb
Case studies		Feb
<i>Quantitative</i>		
Administrative secondary data to SPRC		Feb
Financial data (service provision) to SPRC		Feb
Progress report		Feb
Phase 3: Data analysis		
Qualitative		Mar
Quantitative		Mar
Phase 4: Reporting		
Final draft		Apr
Final report		May
Presentation of Final Report to stakeholders		Jun
Report submitted, approved and published		Jun

As demonstrated in Table 2, the successful completion of the evaluation project relies on all partners to work collaboratively towards the identified timelines. The SPRC researchers' ability

to undertake the evaluation within the expected timeframes is dependent on ADHC to facilitate and manage the data collection processes and provide evaluation data to the SPRC by the end of December 2013. Other possible risks to the successful completion and quality of the evaluation research are identified below in Table 3.

5.1 EVALUATION TEAM

RESPONSIBILITY	RESEARCHER
Chief Investigator	Karen Fisher
Project management	Christiane Purcal
Research design, data collection instruments, and analysis	Christiane Purcal, Sandra Gendera, Fred Zmudzki Karen Fisher
Reporting	Research team
Disability advice and consultation	Rosemary Kayess

5.2 COMMUNICATION AND RISK MANAGEMENT

COMMUNICATION STRATEGY

SPRC and ADHC have agreed to weekly or fortnightly teleconferences and face-to-face meetings as required (e.g. attend collective meetings). The Department and other relevant key stakeholders (e.g. Interagency Reference Group) will have input into the evaluation at all critical stages: refining of research methods; project description and program logic model; coordination and selection of participants to the focus groups; and providing feedback on the draft report and other outputs. The communication strategy is designed to be flexible and to address the needs of the Department.

We will ensure that our communication and liaising with ADHC staff and other key stakeholders will only occur after discussion with the ADHC project manager and project team. To communicate effectively, a single member of the evaluation team, Karen Fisher (Chief Investigator), will be the primary point of contact for project stakeholders. Christiane Purcal will support her in this role as required.

Another aspect of the communication plan relates to researchers, policy makers and the public. We suggest that, with the permission of ADHC, the evaluation plan and final report be made publicly available to contribute to the evidence base on integrated services models, and that accessible versions also be produced and agreed on with ADHC. The purposes of communication with these groups are: to encourage engagement with the participants in the project; and to broaden engagement with researchers and policy makers in similar programs. In cooperation and agreement with the Department, we will disseminate information to

researchers, policy makers and the public on our website and other relevant forums (e.g. conferences, seminars, publication in academic journals).

RISK MANAGEMENT

Table 3: Risks management

Risk	Likelihood	Severity	Solution
Poor quality client administrative data	Medium	High	Close consultation with Department, service providers and Interagency Reference Group to identify and manage data quality problems. SPRC staff have experience working with Department data and this particular project
Failure of service provider to recruit case study sample and complete quantitative data	Low	High	Work actively with service providers to maximise participatory methodology and commitment to the project
Poor quality data collection (inter-rater reliability)	Medium	High	Use of standardised instruments which have been used in previous evaluations of the ISP. SPRC to provide clear, simple to administer templates and instructions to service providers
Research compromised due to lack of capacity	Low	High	The research centre has a wide range of skills which could be drawn on if needed to enhance capacity of the team
Poor communication between researchers and the Department	Low	High	Karen Fisher and the team have worked very closely with ADHC policy makers; project managers on both sides have been identified to facilitate clear communication pathways and problem solving as required
Research does not adhere to budget	Low	High	Budget is based on previous experience of several projects, all of which have reported on time and within budget
Research design does not meet the policy needs of the Department	Low	High	Design, detailed objectives and dissemination strategy has been developed in collaboration with the Department and can be amended during the project
Evaluation team fails to work effectively	Low	Low	Build on history of collaboration and protocols for accountability and communication
Evaluation team member unavailable	Low	Low	Succession plan within the evaluation team for continuity

5.3 QUALITY MANAGEMENT

UNSW and SPRC are committed to the highest standard of integrity in research. During the design phase, an ethics application for UNSW's Human Research Ethics Committee (HREC) has been approved.

The detailed process of ADHC staff making contact and gaining consent from research participants (both clients and stakeholders) is a key component of Ethics approval. All data will be kept in secure storage at the SPRC, viewed only by the research team for the purpose of the evaluation and destroyed after seven years.

The SPRC is also committed to principles of equal opportunity, cultural diversity and social justice. Of relevance to this project are the principles in the National Disability and Development Research Agenda (NDRA 2011) and the Consumer and Community Participation in Health and Medical Research (NHMRC 2002), which commit researchers and evaluators to recognising the contribution that participants can make and to actively engaging them in the research process.

The Chief Investigator, Karen Fisher, is an active member of the Australasian Evaluation Society and adheres to its Code of Ethics, in addition to the UNSW Codes. She is the SPRC Disability and Mental Health Research Program Leader, which holds regular workshops to continuously inform critical improvement to inclusive disability research methods. The SPRC has an Indigenous Research Strategy and employs Indigenous staff to ensure compliance with sensitivities of research with Indigenous people, families and communities.

UNSW follows standards of quality data management which will be followed in this evaluation to ensure data are stored in a secure, confidential and non-identifiable manner, as required by UNSW codes and ethics requirements.

The SPRC is supported by high quality infrastructure of the UNSW that contributes to the conduct of the evaluation. As part of University, researchers adhere to the various research management guidelines of the University, including the UNSW Code of Conduct for the Responsible Practice of Research and the SPRC Quality Assurance Manual.

The project draws on our existing evaluation experience and instruments from two previous evaluations of the Integrated Services Project (Fisher and McDermott, 2008; Shannon McDermott et al., 2010; S McDermott et al., 2008). This Plan has been carefully designed taking into consideration limitations that have arisen in the past evaluations, and methods described under Section 3 have been developed in consultation with the Department and input from key stakeholders through the program Reference Group.

The ISP Interagency Reference Group consists of representatives of the key partner agencies involved in the delivery of the ISP. The Reference Group will be consulted throughout the implementation of the evaluation, as necessary, either as research participants (in focus groups), or to review and comment on major evaluation outputs. This process will further strengthen and assure that the evaluation meets its requirements and delivers to high research standards.

6 APPENDIX

6.1 TOPIC GUIDE: FOCUS GROUPS WITH ISP STAKEHOLDERS

A smaller selection of these questions will be prioritised following discussion with ADHC and be selected according to the roles of confirmed participants in each focus group.

GOVERNANCE

1. Are all relevant agencies represented at appropriate levels in the current governance arrangements?
2. What are the critical factors or barriers to actively engaging relevant stakeholders?
3. How effective are current processes for meetings, planning, monitoring and reviewing the project? What could be improved?
4. Could any elements of the project's governance be of value if maintained or introduced into the wider service system?

OPERATION/MANAGEMENT OF SUPPORT PROVIDED

5. Do you have any comments about the administration of the ISP? e.g. funding or service design; adequate resources to support clients; referral and assessment processes and support from DHS; other service viability issues?
6. Have you been involved in the development of any protocols on the operation of ISP (e.g. referral process, range of agreements, resource manual)? What are they? What issues have you needed to take into consideration in developing these protocols?
7. Are all relevant agencies represented at appropriate levels of the governance structure?
8. What are the critical factors and barriers to actively engaging relevant stakeholders in the project?
9. Do current arrangements support appropriate leadership, accountability and decision-making?
10. What improvements could be made to current governance arrangements? Could any of these arrangements be of value if introduced into the wider system in the long term?

OUTCOMES

11. Has adequate data been available to monitor progress and results?
12. What are the benefits of ISP for clients? Can you give examples of these?
13. Can these strengths be sustained in the longer term? Can they influence the wider system of service provision?
14. What are the downsides of ISP for clients (prompt: loneliness, isolation, vulnerability, hospitalisations)? Can you give examples of these?
15. Did some clients benefit from this project more than others?

16. What type of accommodation has been provided? Are you happy with the housing you have provided to the ISP clients?
17. How long did it take to house the person after he/she was admitted into the project?
18. Why have clients left the ISP? What happened to the resources – housing, furniture & funding?
19. Are there any legislative or industrial factors assisting or inhibiting provision of services across the target group?
20. Can anything be done to foster earlier intervention in such situations?
21. To what extent did the project garner and maintain active involvement of social services?
22. Has the project acted on capacity building opportunities?
23. How do you see the future for the clients?
24. How do you see the future of the project?
25. Are there any other experiences or issues with the implementation and conduct of ISP that you'd like to be reflected in the evaluation?
26. Do you have any ideas about how ISP could be improved?
27. Do you have any further comments you would like to make about the ISP?

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