

Final Report

Data partnership with TaskForce

15 June 2020

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1 Summary

In this report, we analyse client data in TaskForce's service record system (SRS), including:

- Client demographics;
- Frequency & method of contact;
- Principle drug of concern;
- Exit reason;
- Forensic status; and
- Outcome measures.

We also outline how data was extracted and provide an indication of data completeness, review the project's lessons, challenges and coverage, and suggest ways for TaskForce to extend the findings of this report.

This report is accompanied by a supplementary HTML file with interactive versions of several visualisations. However, each static view is reproduced in this PDF file for ease of reference.

Key findings

- The initial effects of the COVID-19 crisis played out with a near-complete reduction of in-person contacts and a dramatic rise in telephone contacts.
- The recorded number of contacts in the youth service doubled between February (~400) and March (~800), and has remained at this high frequency.
- In the adult service, males were much more likely to be referred by ACSO-COATS (particularly ages 26–45), while self-referral in youth was more likely.
- In the adult service, methamphetamine was the most common drug of concern for adults (33% of all courses of care), closely followed by cannabis (31%). This was flipped in youth: cannabis was most common (29%) followed by methamphetamine (24%).
- Youth clients reported a wider range of principal drugs of concern than adults, with the most common "other drug" being non-prescribed opioids.
- In both adults and youth, forensic-referred methamphetamine users were significantly more likely to complete treatment than self-referred users, with the latter more likely to cease without notice.
- In adults, self-report measures of psychological health and quality of life showed statistically significant improvements over time.
- However, these improvements may not be experienced equally, with significant increases in some measures for male clients but not females.

2 Project background

Our Community's founding aim was to build stronger communities through stronger community organisations. In 2019, the Our Community Innovation Lab — supported by Equity Trustees — began working with social sector organisations to trial and refine new methods for managing and learning from data, and disseminate tools and lessons to the social sector to amplify its impact.

TaskForce has provided specialist support for young people, adults and families in serious need in Victoria since 1973. Its services focus on addressing social issues of alcohol and other drugs (AOD) addiction, unemployment, mental health and high risk taking behaviours, supporting clients to transition back into "mainstream" services and supports.

The current project arose when Mike Davis (Head of Strategy) identified an opportunity to use TaskForce's data to improve strategic decisions and optimise service provision, cross-referrals, and so on. Ray Blessing (CEO) has endorsed the partnership with Our Community, recognising that better, connected information can facilitate TaskForce's growth.

For more information refer to <20190624 Our Community - TaskForce - Project Brief>.

3 Data analysis

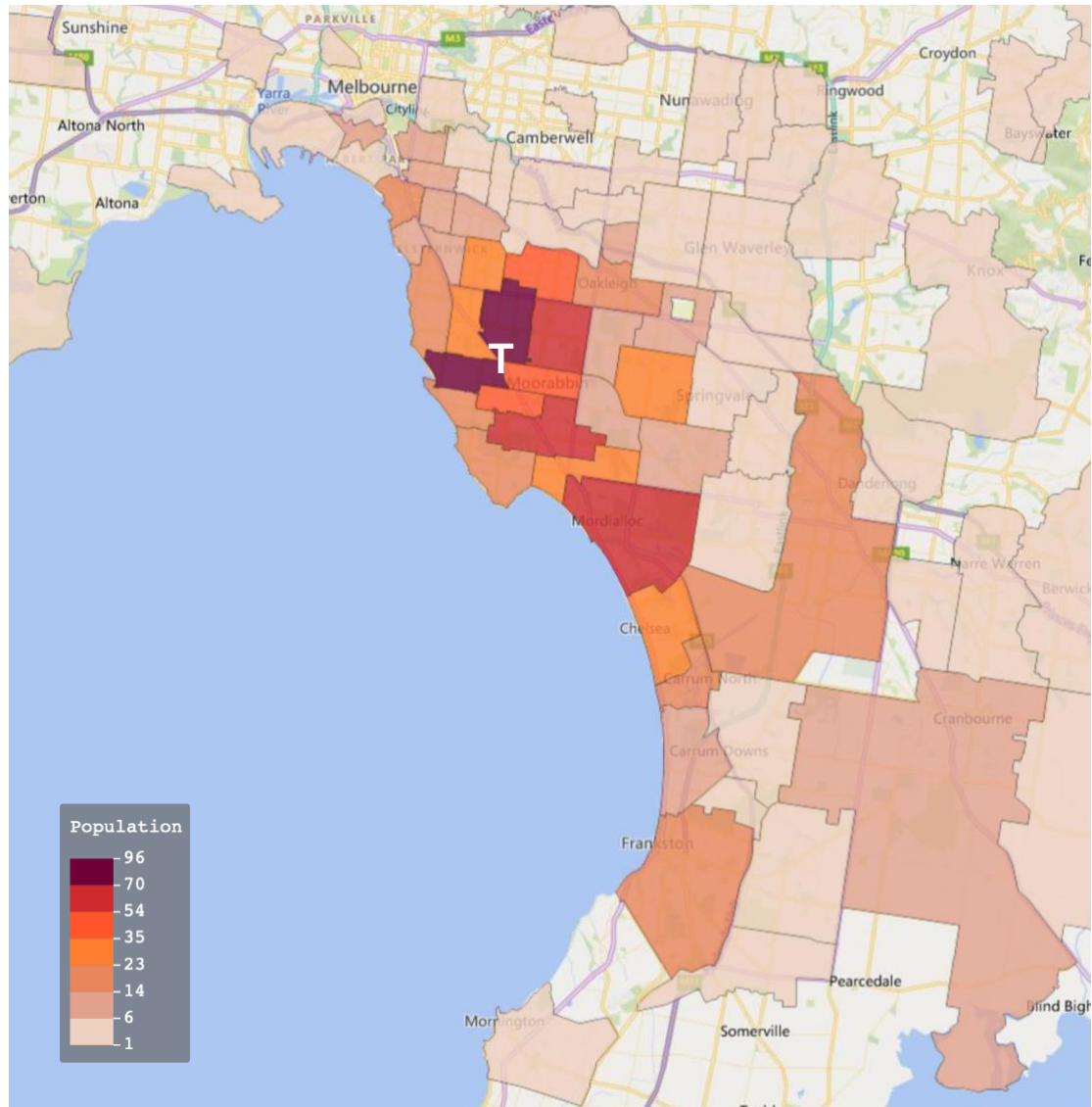
3.1 Improvements from interim reports

This section has been updated from the interim reports in several ways:

- **Adult and youth analyses appear together** rather than in separate reports.
- The complex ribbon diagrams known as “**Sankey diagrams**” **have been replaced** with more easily interpreted alternatives.
- **New visualisations using referral data** highlight patterns in service use based on whether a client entered voluntarily or via the forensic system.
- The interim visualisations used 12-month windows of analysis, whereas this final report uses a **wider 20-month dataset (1 October 2018 to 31 May 2020)** that begins from the first month of regular service record system (SRS) use to allow a more complete view of TaskForce's past and current clients.
- **Substantial extra commentary** has been included to guide interpretations and initiate expert discussion of each visualisation.

3.2 Visualisations

Fig 1 Distribution of all clients by postcode



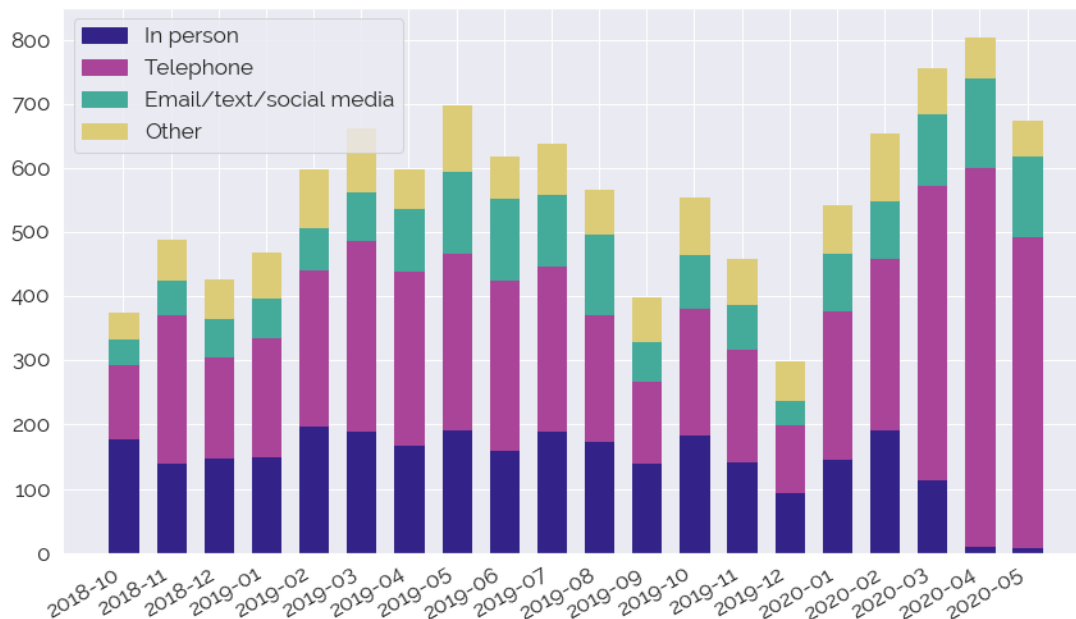
How to interpret the figure:

- Darker reds and purples are more common sources for clients. Some suburbs with 6 clients or fewer are not visible in the depicted area.
- TaskForce Bentleigh & Moorabbin (Youth Hub) are marked by a white "T".

Findings:

- The **most common postcodes** were 3188 (Hampton, Hampton East, Hampton North) and 3204 (Bentleigh, McKinnon, Ormond, Patterson).

Fig 2 Number of contacts per month — Adult



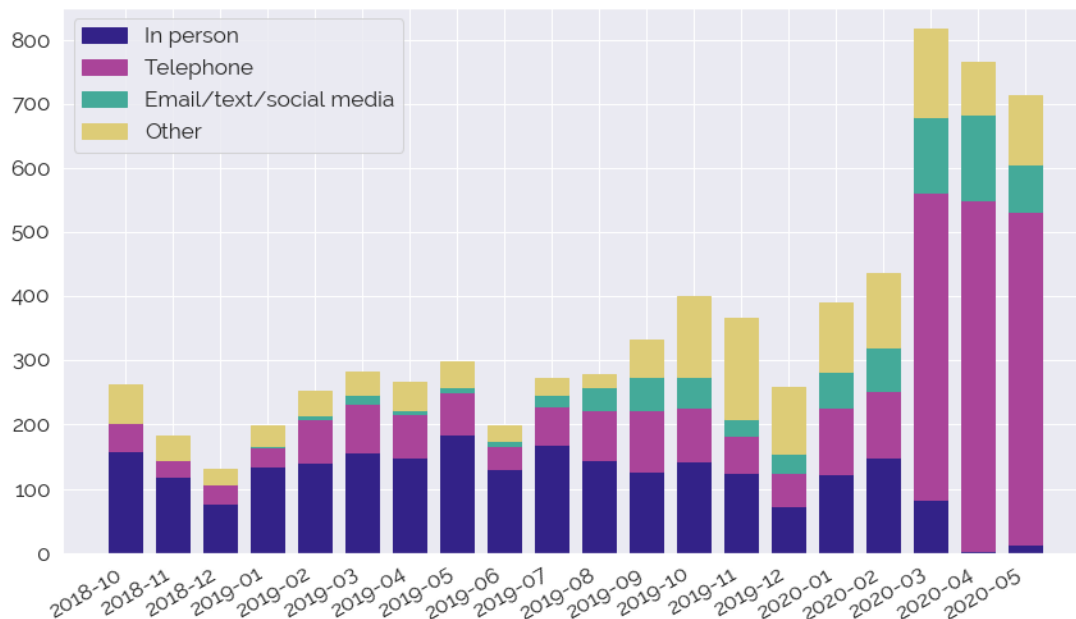
How to interpret the figure:

- Taller bars represent a greater number of total contacts made in that month (refer to the vertical axis). The method of contact is represented by coloured segments.

Findings:

- Reflecting the **initial effect of the COVID-19 crisis** (i.e. restrictions in client movement and clinicians moving off-site in late March), there was a **sudden decrease in in-person contacts** (dark blue segments) in April and May 2020.
- Simultaneously, and even in March before clinicians moved off site, there was a **notable increase in the number of telephone contacts** (purple segments).
- Prior to the unusual March–May 2020 period, there was not a clear trend in the number of contacts, but there were **notable dips in September 2019 and December 2019** and a general increase in the first few months of the platform being used (October 2018–February 2019).
- Generally, **the total number of contacts to adult clients of the clinical service tends to be stable around ~600 contacts per month**. The decrease in total contacts in May indicates a possible return to this baseline.
- Similarly, the **proportions of contact methods remained stable** pre-COVID-19, with **in-person and telephone more frequent** than email/text/social media. (However, note that this is based on data entered into the system, and cannot account for, e.g. a clinician “grouping” multiple texts into one database entry.)

Fig 3 Number of contacts per month — Youth



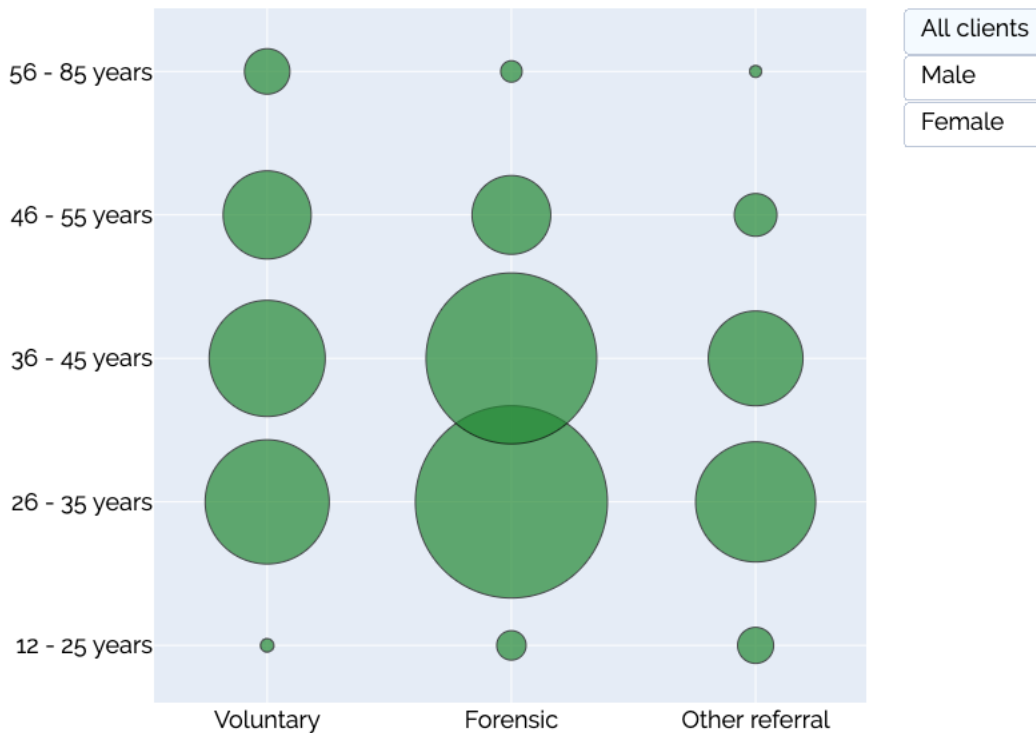
How to interpret the figure:

- Taller bars represent a greater number of total contacts made in that month (refer to the vertical axis). The method of contact is represented by coloured segments.

Findings:

- As expected, **the COVID-19 crisis led to near-complete reduction in in-person contacts** (dark blue segments) to youth clients during March–May 2020 and a **dramatic increase in telephone contacts** (purple segments).
- Whereas the changes to adult contacts was mostly a matter of proportion (i.e. in-person contacts were replaced by telephone contacts, with only minor increases in total contacts over previous busy months), the **total number of youth contacts doubled between February and March from ~400 to ~800 contacts/month and remained constant since then**.
- More specifically, before March, the average number of youth contacts was lower compared to adults (in line with there being fewer clients), but over the past three months, both services have recorded a similar total number of contacts. Possible reasons for such a dramatic increase in youth clients will be best ascertained by staff, but it may reflect: (1) a change in the way the system has been used from March onwards; (2) existing differences in how adult and youth clinicians record contacts; and/or (3) differences in client follow-up needs during the pandemic.
- Prior to March, **in-person contacts were the most frequent recorded method**.

Fig 4.1 All clients — Adult



How to interpret the figure:

- Larger circles indicate that more clients are in that age/referral group (for exact numbers, hover over the bubble in the interactive version).
- Due to the relatively small number of clients younger than 26 and older than 55, multiple age ranges were merged at each end of the scale. (Note that 6 clients aged 12–17 appeared in the adult workgroup, which indicates a data quality issue.)
- See section 3.3.1 for more information about referral categorisation.

Findings:

- In the 20-month period between 1 Oct 2018 – 30 May 2020, there were a **total of 888 adult clients** with a recorded contact (after 88 removed due to missing data).
- The **largest group was forensic (ACSO-COATS) referrals aged 26-35** — 144 clients, of whom 113 were male.
- **Males were much more likely to be referred by ACSO-COATS**, particularly ages 26–45 (see next page).
- In contrast, **females were more likely to be self-referred** or enter through other pathways, mostly **child protection agencies** (see section 3.3.1).

Fig 4.2 Male clients — Adult

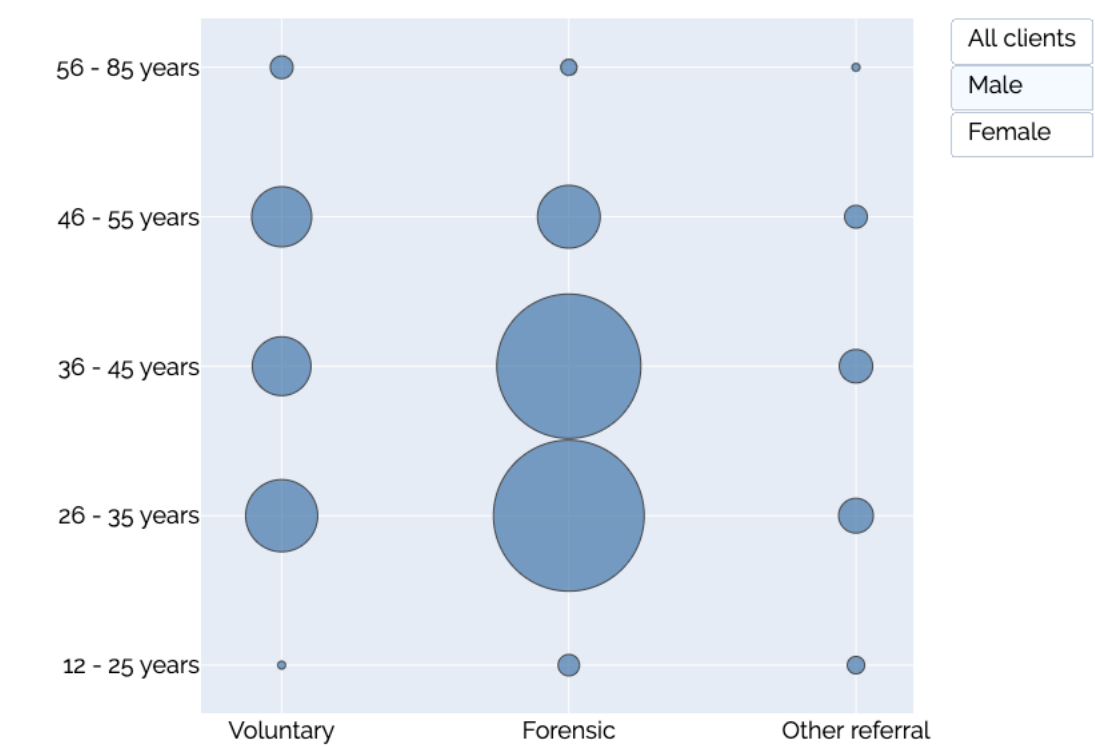


Fig 4.3 Female clients — Adult

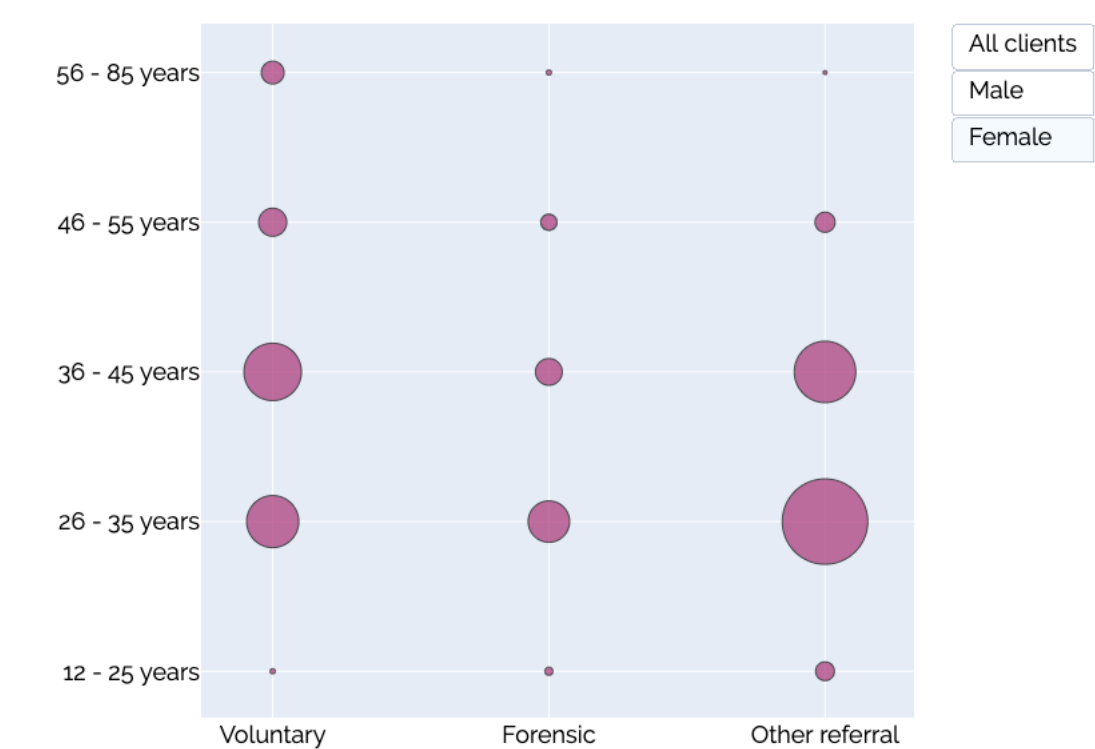


Fig 5.1 All clients — Youth



How to interpret the figure:

- Larger circles indicate that more clients are in that age/referral group.
- Note that of the 32 clients aged 26-45, 29 were born in either 1993 or 1994. (The years of birth for the remaining three clients were 1992, 1991 and 1977.) That is, although 26 or older at time of data extraction, most were 25 or younger at time of service entry.

Findings:

- In the 20-month period between 1 Oct 2018 – 30 May 2020, there were a **total of 529 youth clients** with a recorded contact (after 32 removed due to missing data).
- Unlike the adult service, **self-referrals were the most common pathway for youth** (43% of all clients) for both males and females.
- As for adult clients, males were more likely than females to be a forensic (ACSO-COATS) referral. However, **under-25 males were more likely to self-refer than over-25 males** (compare Figures 4.2 and 5.2). This may reflect a difference in the programs or model of care targeting these respective age groups; for example, young males may be engaged during Youth Hub activities.

Fig 5.2 Male clients — Youth

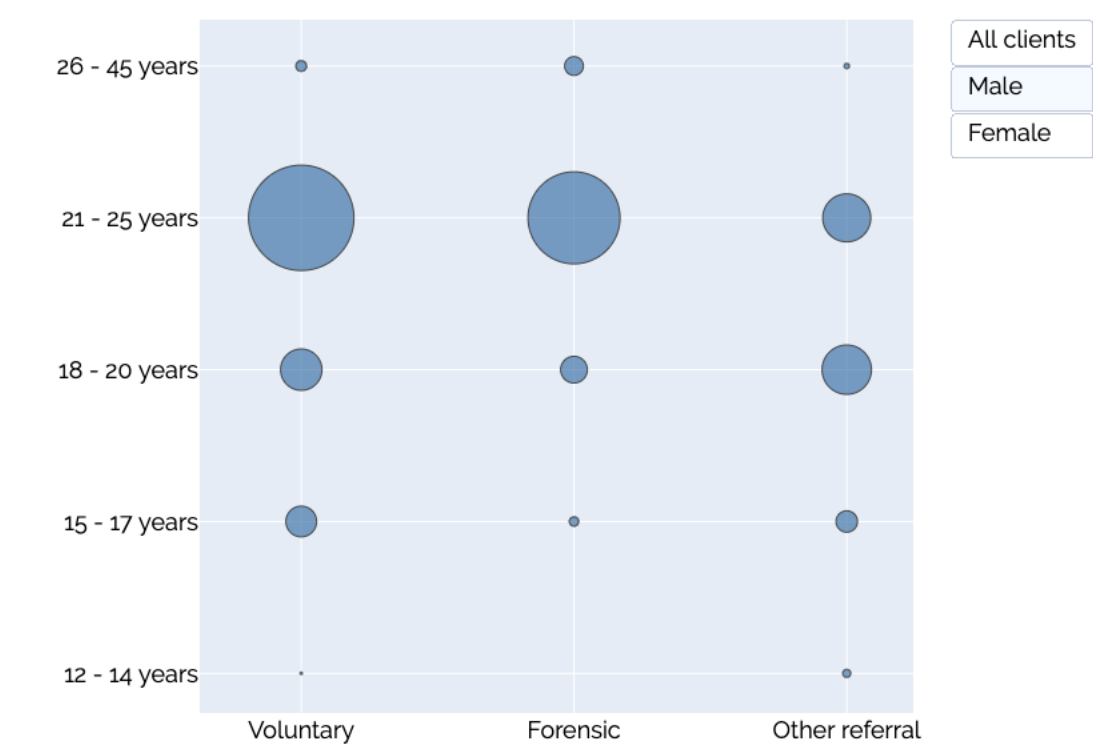


Fig 5.3 Female clients — Youth



Fig 6.1 All clients — Adult



How to interpret the figure:

- Larger circles indicate that more *profiles* (courses of care) are in that drug/exit reason group. Note that clients can have multiple profiles.
- Other drugs included prescribed and non-prescribed opioids, heroin, cocaine, nicotine and GHB. A minority were not stated or inadequately described.
- Other exit reasons were many, among them: ceased to participate against advice, at expiation or by mutual agreement; changes in main treatment type or the delivery setting; and transferred to another service provider.

Findings:

- In the 20-month period between 1 Oct 2018 – 30 May 2020, there were a **total of 1339 adult courses of care** (after 225 were removed due to missing data).

- **Overall, methamphetamine was the most common drug of concern for adults** (33% of all courses of care), closely followed by cannabis (31%).
- Overall, in terms of exit reasons, **completed treatment was the most likely outcome for both alcohol and cannabis adult users**, whereas a greater proportion of methamphetamine users ceased to participate without notice.
- As shown in Fig 6.2 below, **most self-referrals (44%) were cannabis users**, and the **majority (58%) of self-referred cannabis users completed treatment**. This was not the case for forensic and other referred cannabis users (Fig 6.3 and 6.4).
- As shown in Fig 6.3 on the next page, **most forensic referrals (48%) were methamphetamine users**, and while completed treatment was the most common outcome, they were almost as likely to cease without notice.
- However, **forensic-referred methamphetamine users were significantly more likely to complete treatment than self-referred users**, as the latter tended to cease without notice in most cases.
- **Forensic-referred alcohol users were likely to complete treatment**, and at a much **better rate than self-referred alcohol users**.

Fig 6.2 Voluntary (self-referred) clients — Adult

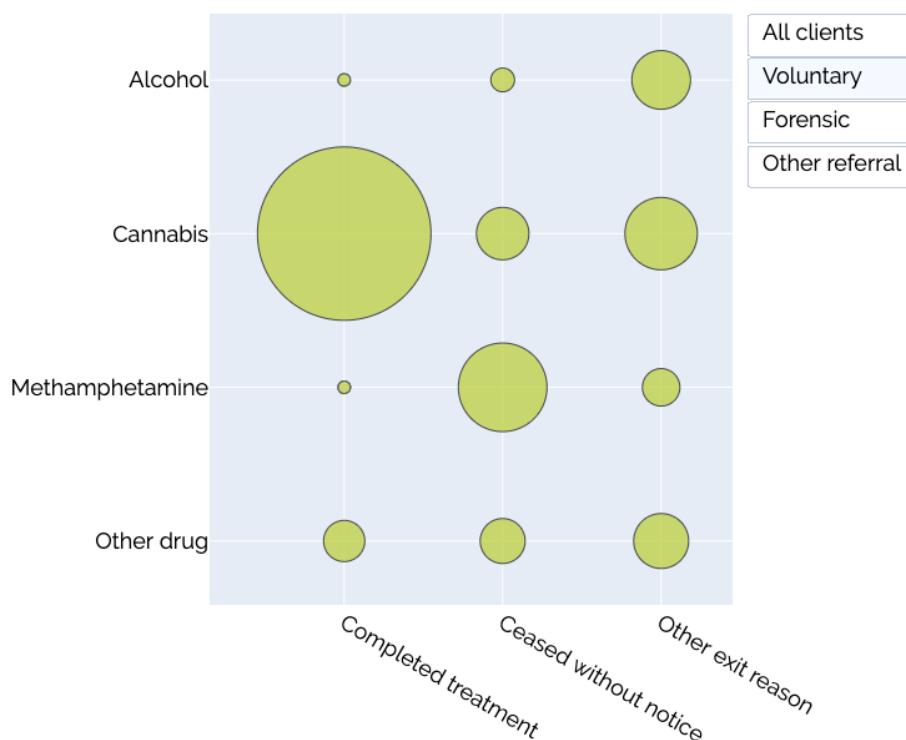


Fig 6.3 Forensic (ACSO-COATS) clients — Adult

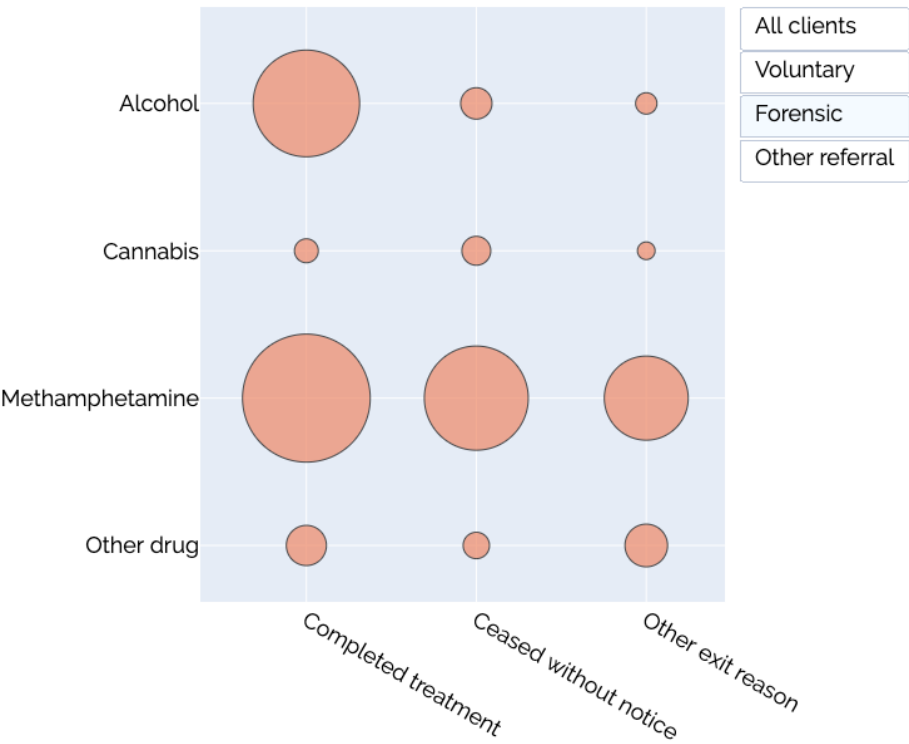


Fig 6.4 Other referrals — Adult

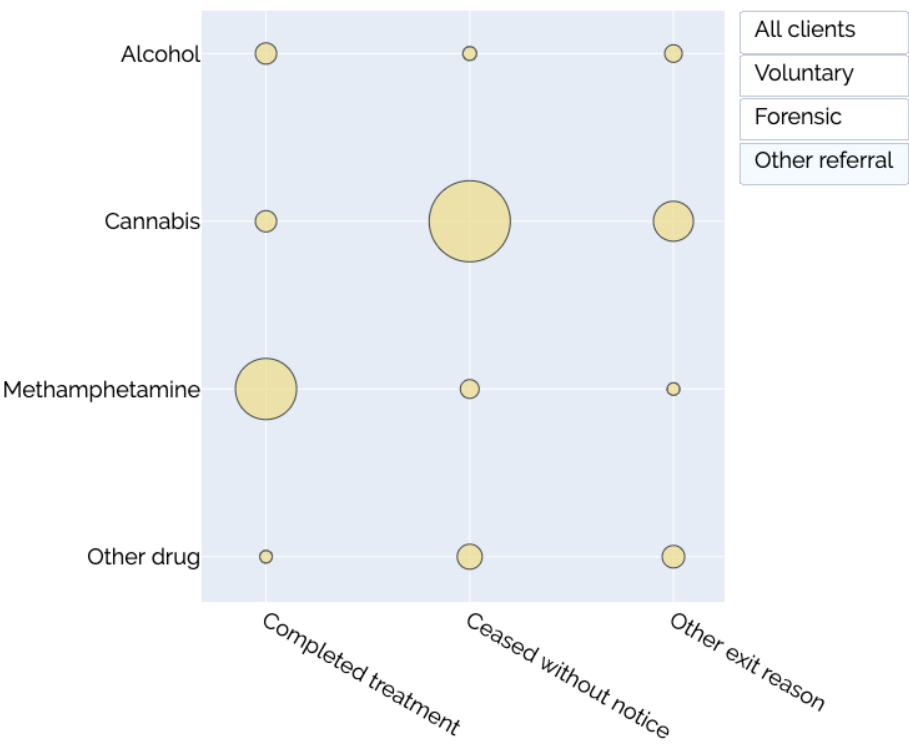
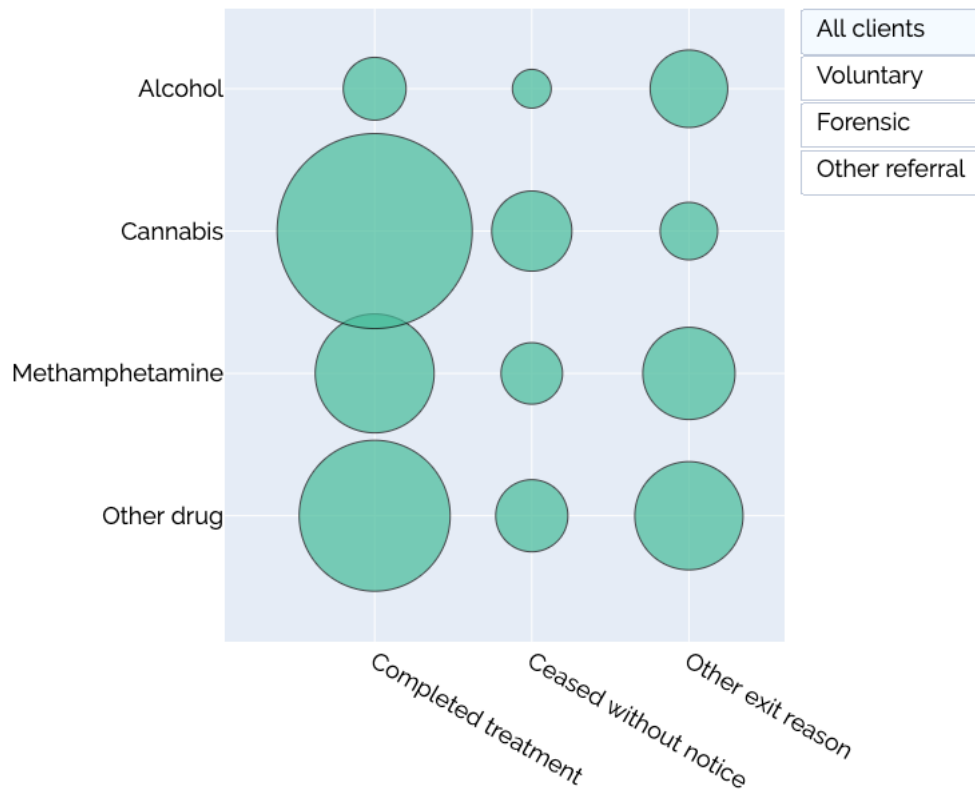


Fig 7.1 All clients — Youth



How to interpret the figure:

- Larger circles indicate that more *profiles* (courses of care) are in that drug/exit reason group. Note that clients can have multiple profiles.

Findings:

- In the 20-month period between 1 Oct 2018 – 30 May 2020, there were a **total of 853 youth courses of care** (after 117 were removed due to missing data).
- **Overall, cannabis was the most common principal drug of concern for youth** (29% of all courses of care), followed by methamphetamine (24%).
- Youth clients reported a **wider range of principal drugs of concern than adults**, with the most common "other drug" being non-prescribed opioids.
- **Completed treatment was the most likely outcome for youth users of cannabis and methamphetamine**, but not alcohol.

Fig 7.2 Voluntary (self-referred) clients — Youth

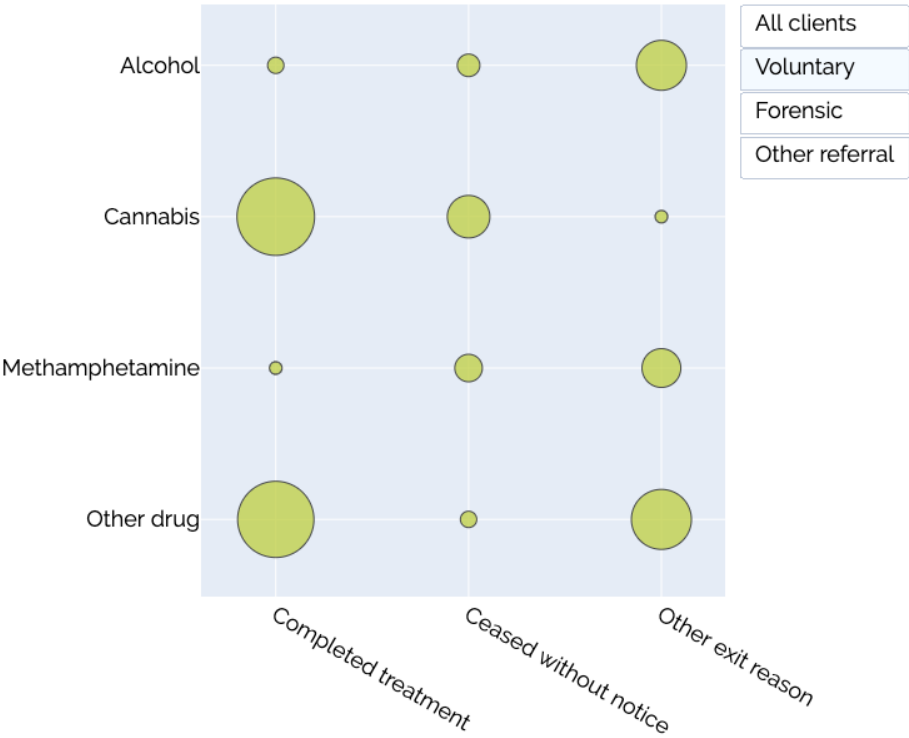


Fig 7.3 Forensic (ACSO-COATS) clients — Youth



Fig 7.4 Other referrals — Youth



Further findings:

- The breakdown by referral source showed that **youth users of cannabis were referred from a range of sources** (whereas adults were largely self-referred).
- Methamphetamine was the most common primary drug of concern for forensic referrals, but this pattern was less significant than for adult clients.
- Similar to adults, **a greater proportion of forensic-referred methamphetamine users completed treatment than self-referrals**.

Fig 8 Outcomes — Adult

Fig 8.1 All clients



How to interpret the figure:

- Some clients were asked to rate (from 0 to 10) their psychological health, physical health and quality of life. A *difference value* was calculated by subtracting the first rating from the last rating; a positive difference value thus represents a subjective improvement over time.
- **Each dot above represents the difference value (change between ratings) for a single adult client** — a total of 227 (after removing 40 due to missing ratings) between 1 October 2018 – 30 May 2020.
- Each line represents the estimated relationship between the difference value and days between each rating, with a steeper slope indicating greater improvement.

Findings:

- **Each adult outcome measure increased over time**, on average, with roughly 2-point expected increases (after 20 months) for psychological health and quality of life, and 1-point expected increases for physical health.
- In particular, **improvements in self-reported psychological health and quality of life were statistically significant** (see section 3.3.2 for more information about statistical significance).
- However, given the **substantial fluctuation in data points**, it is important to note that it was still common for some individual clients to report worsened outcomes.

Fig 8.2 Outcomes — Adult — Gender analysis



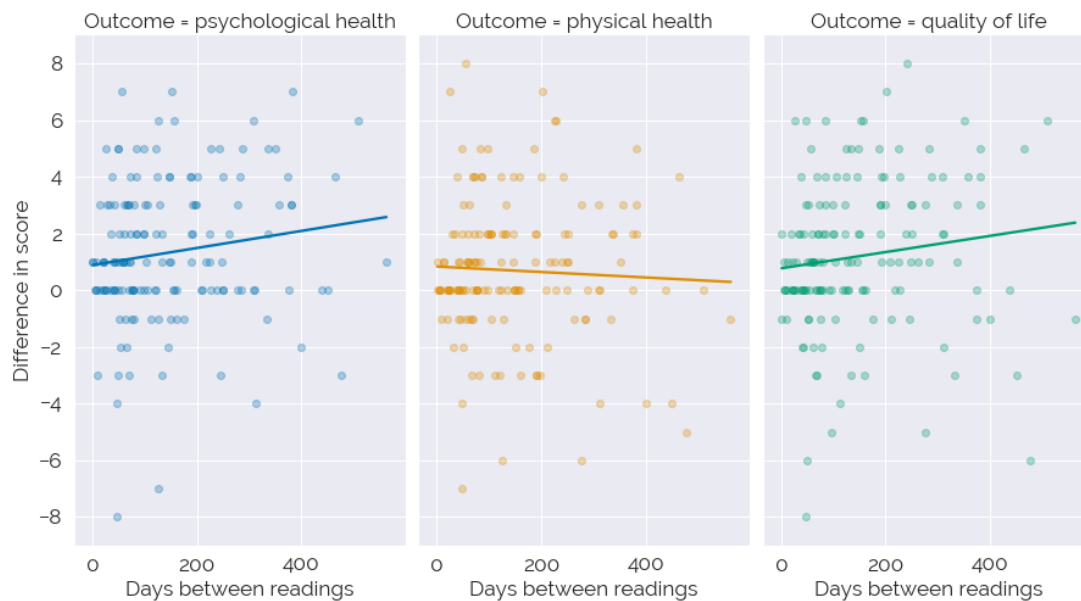
How to interpret the figure:

- **Blue** = male; **Purple** = female. No clients reported non-binary gender.
- This figure represents the 148 clients for whom gender identity was reported. An identical analysis using sex at birth data (available for all 227 adult clients) showed the same trends (with higher levels of statistical significance).

Findings:

- On average, **adult males experienced statistically significant improvements in self-reported psychological health and quality of life.**
- However, **this was not the case for adult females on any measure.**
- It should be noted that the above statements are relative to baseline (i.e. "Was average improvement for males/females better than zero?"). When the groups were directly compared (i.e. "Was average male improvement better than average female improvement?") there were not significant differences in any outcomes. This suggests that gender differences were of intermediate size.
- There are several possible contributing factors to explain these differences. For example, if the same clinical program is used across genders, and was designed without applying a gender lens, this may indicate that it is more efficacious for males. It could also relate to differences in comorbid issues and/or self-reporting tendencies. In any case, it suggests that this area deserves further attention.

Fig 9 Outcomes — Youth



How to interpret the figure:

- Each dot above represents the difference value (change between ratings) for a **single youth client** — a total of 154 (after removing 70 due to missing ratings) between 1 October 2018 – 30 May 2020.
- Each line represents the estimated relationship between the difference value and days between each rating.

Findings:

- **Self-reported psychological health and quality of life improved over time**, on average, with roughly 2.5-point expected increases (after 20 months), though unlike the adult improvements, these were not statistically significant trends.
- There was **no average improvement over time in physical health**. Taken together with the adult finding for physical health, this suggests that physical health should possibly be an area of increased clinical focus going forward.
- No significant differences were identified when broken down by sex/gender nor by voluntary/forensic referral.

3.3 Methodology notes

3.3.1 Referral categorisation

Where referral source was included, referrals from ACSO-COATS (Australian Community Support Organisation – Community Offender Assessment & Treatment) were used as a proxy for forensic clients. Hence, for ease of interpretation, **ACSO-COATS referrals are the source of the category labelled “Forensic” in the figures above.**

However, note that the “Other” category included referral pathways that may involve the forensic system. Specifically, while the “Other” category was primarily “Alcohol and other drug treatment service”, and especially for females, “Child protection agency”, it included a range of less common sources including “Correctional service”, “Court diversion”, “Hospital”, “Other community/health care service” and “Police diversion”.

3.3.2 Statistical techniques

Statistical hypothesis testing was conducted for outcomes data using a conventional cut-off of $p = .05$. In other words, a “statistically significant” finding indicates that the likelihood that an observed difference was due to chance (rather than being a real-world effect) is no more than 1-in-20. This raises the idea of *replication*, that is, to be more confident about findings, it is advisable to repeat analyses in the future using a new set of data (e.g. FY 2019–20 could be compared to FY 2020–21; if both sets of data show the same effects, we can be more confident that they are real).

It worth mentioning two further caveats:

- Statistical significance does not imply *practical* or *clinical* significance. The latter requires a different research approach and evaluation of the TaskForce clinical program.
- The linear regression to compute the trend lines seen in Figures 8 and 9 was used to estimate *average* differences over time, but the real impact of clinical programs is, of course, not necessarily linear.

3.3.3 Ambiguous sex data

Of the 529 youth clients in the 20-month window, the Sex variable of 1 client was reported as “Other”. It is not clear whether this category was intersex, non-binary gender or both (and therefore represents an area of improvement for data collection).

We acknowledge the presence of non-binary responses as consequential and relevant. Nonetheless, to prevent the identification of an individual's clinical information (such as principal drug of concern) we chose to remove the “Other” category, so that the figures can be interpreted in aggregate.

4 Data extraction & completeness

4.1 SRS Lists

We now outline the extraction process and completeness of SRS data.

TaskForce stores client and case management information in a service record system (SRS) developed by Infoxchange. Access was first granted to Our Community staff (Nathan Mifsud and Sarah Barker) on 25 July 2019.

The provided access was read-only, restricting menu items and tabs to those visible here:

"Reports" are aggregate reports of "lists" of data. Hence, to retrieve unprocessed data for the completeness evaluation, we exported all available lists using common parameters:

- Workgroup: *Adult*
To constrain the scope of interim analysis, the workgroup that represented the larger dataset was explored.
- Include in report: *Persons with recorded contact (Note) in report period*
This option was selected under the assumption that the main clients of interest were those that had received at least one contact.
- Period of interest: *1 Nov 2018 – 31 Oct 2019*
This option was selected to provide a 12-month window ending with the most recent full month (at time of analysis). It therefore omits the initial two months of TaskForce's use of SRS, which based on available contact records appears to have started on 27 August 2018, though three isolated records exist for 9 July, 6 August and 20 August. **Note that section 4 is unmodified since the interim report, i.e. it uses a shorter time-frame than the updated analysis presented in section 3.**

Here is an example of those parameters selected for the "Demographic Details" list type:

The screenshot shows the 'Lists' tab with the following settings:

- Workgroup:** Adult (highlighted with a red box)
- List type:** Demographic Details
- Include in report:** Persons with recorded contact (Note) in report period (highlighted with a red box)
- Exclude File notes:** ☒
- Period of Interest:** Select range from list or enter start and end dates
- Start date:** 01/11/2018 (highlighted with a red box)
- End date:** 31/10/2019 (highlighted with a red box)
- Buttons:** Export List, View List

The following table shows the list types available and the number of records (rows) present in each for the time period specified above:

List type	Number of records
Demographic List	531
Profile Details (by person)	See below
Profile Details (by profile)	See below
Contact Details (by person)	531
Contact Details (by contact)	6643
Contact Totals (by person)	531
Family List (using relationships)	535
Outcomes	7
Payments List	131
Payments (by family)	45
Plan List	9
Enquiry List	0
Contact Summary	6643
Activity Data Collection List (TaskForce 2018-19)	834
TaskForce Outcomes list (1.1)	144
TF – Interim VADC Report – DTAU (1.0)	See section 4.2
TF – Interim VADC Report – EOC (1.0)	See section 4.2

This shows that some lists contain no or very few rows of data, indicating that end-users enter data into SRS in a manner that does not match its design. It also highlights that the "TaskForce Outcomes" list contains roughly a quarter of the full client list (144/531 = 27%).

Upon selecting a "Profile Details" list, another dropdown option appears offering different profile types. Using the common parameters specified above, we again investigated each available list permutation:

Profile type	Completeness
TF Assessment	Good
TF Case	Good
TF Self Completion Form	Good
TF Treatment	Good
TF ATOP	Poor
TF Discharge Plan	Poor
TF Presentation	Poor
TF Support	Poor
TF Behaviour Management Plan	Empty
TF Client Dependant	Empty
TF Review	Empty
TF Service Waitlist	Empty

This indicates that SRS is not being used as intended during its setup, given that most profile lists are empty or nearly empty of data. Clinicians appear to primarily use "Case", "Self Completion Form", "Assessment" and "Treatment".

Returning to the other list types, lists that contain a full set of records (rows) may still have missing variables (columns). As an example, we present below an analysis of each variable in the "Demographic List". Some variables (shaded red) have no data at all, indicating that they are not in use. Many other variables (shaded yellow) also have a large portion missing.

Variable	Completeness
Code	100%
Number of Contacts	100%
Person ID	100%
Proficiency in Spoken English	100%
Stays	100%
Case Work Time	100% (33.9% are "0")
Contact Time	100% (9.7% are "0")
Total Time	100% (2.8% are "0")
Travel Time	100% (84.2% are "0")
Age	99.8%

Age Range	99.8%
Date of Birth	99.8%
Sex	99.8%
Post Code	90.3%
Locality	89.7%
Identifies as [ATSI question]	88.7%
Country of Birth	64.3%
Main language at home	64.3%
Interpreter required	37.1%
CALD	11.4%
Year of Arrival	3%
Open Plan	0.2%
Ancestry	0%
Australian South Sea Islander	0%
Centrelink CRN	0%
Other language spoken at home	0%
Coverage across entire dataset	63%

Some of these cases could be resolved by examining the data input user interface (which was not possible given the permissions available to Our Community). For example, in the case of CALD, there are only "Yes" and blank values in the dataset. It may not be a safe assumption to assume missing values simply mean "No", as this would potentially mask clients whose CALD status was not recorded.

For other variables, such as Country of Birth, the plurality of options means that it is simply not sensible to assume missing values are the most common option (Australia); that is, rather than possibly due to the user interface, this is an issue related to user input. For instance, recording a full set of demographics for every client may not be clinically feasible.

4.2 Standardised extract (VADC)

We were interested in the Victorian Alcohol and Drug Collection (VADC) extract provided by TaskForce to the Victorian Government, as its standardised nature means that any data analysis conducted could potentially be extended to other AOD service providers in Victoria.

The VADC extract represents the same data as SRS, but its structure is based on an XML schema definition released and updated by the Department of Health and Human Services (DHHS). Service providers submit their extracts to DHHS via an online portal for retrieval and file validation.

Some difficulties were encountered in providing access to the VADC extract:

1. The user account provided to Nathan Mifsud did not have the ability to generate VADC extracts.
2. Only one extract can be generated at a time; thus, even if user access was granted, it would interfere with TaskForce reporting requirements.
3. The DHHS upload portal was not designed for third parties or downloading extracts.

An ad hoc solution trialled was that once TaskForce generated extracts, they shared them with Our Community via a secure document sharing platform. Some VADC files were made available using this method (Mar–Jun 2019 reporting periods).

An initial look at the XML files suggested that the data could be processed in the provided format. This approach would make it easier to generate reports where desired data fields span across two or more of the various reports currently available to end-users in SRS (e.g. Demographics and Treatment). In addition, these reports would be generalisable to other organisations who submit VADC extracts. However, at an interim meeting on 13 Feb 2020, it was agreed that this work was out of scope for the current project.

5 Project review

5.1 Lessons learned

We hope the insights and visualisations provided in this final report are useful. In a more general sense, one of the project aims was for Our Community to glean and disseminate lessons that can provide benefit to other organisations. In brief, some of those lessons:

- Gaining permission to access data was straightforward, but transforming it into a format for processing was more difficult and takes time.
- It is a good idea to do a “project reset” if subject matter experts exit or enter, to review the background, purpose and scope of the project.
- It is important to involve subject matter experts (such as clinicians) wherever possible, both to validate the priorities of analysis and to interpret visualisations.
- Even with a relatively small dataset, it is possible to identify trends of statistical significance; these results are not conclusive, but suggest where further attention may be warranted.

5.2 Challenges

The project brief called for TaskForce to provide subject matter expertise (i.e. insight into problems and opportunities faced by the organisation). Initially, this was provided by Anna Murru (ex-Executive Manager Clinical Services), who held the primary organisational knowledge of SRS, and had expressed interest in exploring new techniques to interrogate the data. With her departure, and after discussion with senior staff (Tony Johannsen, Sarah Darley and Sarah Dobbie), several issues emerged:

1. **Limits to data.** TaskForce delivers a “wraparound” model of care where a client’s journey may begin with counselling but may involve many other contacts (e.g. transition to work, healthy eating and living, disability services). However, SRS only includes data for clinical services. Outcomes data is also limited because many clients exit without informing TaskForce.
2. **Clinical priorities.** There may be a disjunct between the questions proposed in the original project brief and the questions that matter to clinical staff. For example, a pathway analysis may hold limited value when there is relatively low services thoroughfare and staff are already familiar with the patterns (that said, it is often worth testing such assumptions).
3. **Lack of documentation.** Anna Murru made data collection and reporting decisions that are now fixed in the system; however, the rationale behind these decisions is not apparent. Sarah Darley has taken on the SRS aspect of Anna’s responsibilities, but further time investment is required for her to evaluate the system logic and use of particular data categories and reports.

4. **Data quality.** A lack of documentation can cause flow-on effects. Without a clear understanding of the intended SRS workflow, clinicians may use the system in unexpected ways. (This seems likely to be the case based on issues reported in section 4.1.) As a result, data quality may be adversely affected, particularly in terms of Accuracy ("Does the data reflect reality?") and Validity ("Does the data measure what it was intended to?"). That is, if a clinician's understanding of a particular data field differs from the rationale that underpins its inclusion in the system, this could lead to inaccurate or invalid entries that cause misinterpretation at the aggregate data analysis stage.

5.3 Scope coverage

A set of initial questions was developed prior to examining the data and outlined in the Project Brief. Following interim meetings, extra questions were developed and some initial questions discarded. We now evaluate these questions based on the analysis in section 3.

Addressed

Who are TaskForce's typical clients for services and cross-referrals between services?

Clients were considered in terms of geographic location (Figure 1), age and sex (Figures 4 and 5) and principal drug of concern (Figures 6 and 7). In addition, Figures 4–7 specifically include referral source breakdowns. Cross-referrals cannot be evaluated on the basis of SRS data as it only includes clinical services.

What are the main service referral pathways and how frequent are these?

See Figures 4–7. These could be further explored across time and other variables.

Partially addressed

When and why do clients stop using TaskForce's services? Do clients stop using the services for good reasons, or bad reasons, and what can be done to address this if needed?

These questions have been partially addressed by Figures 6 and 7, which captured exit reason. It is possible to extend this analysis to show when in the course of treatment the exits occur; however, given that the majority of clients either complete treatment or cease without notice, nuanced data is lacking. This kind of question may require a new data collection strategy or qualitative techniques.

What factors are correlated to early exit/incomplete treatment? What factors are correlated to the reporting of positive outcomes?

These questions were partially addressed by Figures 6 and 7, specifically by looking at referral type as a factor, as well as Figures 8 and 9, which additionally considered gender and referral factor in conjunction with outcomes.

The amended brief initially referred to age, homelessness, mental health diagnosis, CALD and Indigenous factors; however, these were omitted due to the current small pool of data (exacerbated by the incompleteness of some variables identified in section 4.1).

Agreed out of scope

Which client demographics or community groups are TaskForce not adequately serving or catering for?

This may have to be evaluated using external sources of data (e.g. ABS). It would also be helped by having more complete data for a wider range of characteristics.

How long do clients stay with TaskForce and what happens or changes to their profile (them) during this time?

It may be possible to perform an analysis based on duration but requires further work (and decisions to make: e.g. what to do about clients with multiple profiles). As mentioned earlier, there are the constraints of not having access to non-clinical referral pathways.

What services are TaskForce not providing that they should be given their demographics and client profile mix?
What services are TaskForce providing that are probably not relevant or effective given the demographics and client profile mix?

These last two questions require further discussion with clinicians. In a conversation supported by the patterns shown in section 3, their domain expertise may surface relevant directions for future data collection and analysis.

6 Future directions

The findings and challenges identified by this report represent opportunities for future work that TaskForce could undertake.

Some examples of possible projects include:

- Any of the ideas listed as out-of-scope in section 5.3;
- Further statistical analysis of relationships between age, gender, drug of concern and exit reasons;
- Further outcomes analysis, e.g. to determine whether outcomes are better for clients who complete treatment;
- Evaluation of SRS logic to improve its fitness-for-purpose in conjunction with clinical staff (end-users of the SRS system).

After a suitable period (i.e. 12-18 months) and/or after changes in policy, it may be worth:

- Replicating key findings, e.g. the gender differences identified in Figure 8.2;
- Re-evaluating data completeness to determine whether collection has improved.