

EVALUATION REPORT

Assertive Case Management Team Pilot
Dublin City Centre 2016



Author & Date

Emer Dolphin, April 2016

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FOREWORD

Dublin is a wonderful city - vibrant, full of life and culture and loved by many - both residents and visitors. However, like all urban centres, the city has its difficulties. Drug use and associated anti-social behaviour are two of those difficulties

In 2011, and building on work previously done in the area, an independently chaired Strategic Response Group (SRG) of stakeholders was formed, with the objective of developing ways to build sustainable street-level drug services and address related public nuisance.

Arising from the work of this group, and its report - 'A Better City for All' - an Assertive Case Management Team (ACMT) was established in September 2014. Run by the Ana Liffey Drug Project (ALDP) and supported by a Higher Level Group (HLG) of senior stakeholders, it is tasked with identifying, approaching, engaging with and assisting those individuals with complex and multiple needs.

This is not easy work; the people the ACMT work with can be isolated and marginalised from mainstream services. They typically have many needs: housing issues; family issues; health issues; and criminal justice issues - and they are not always able to access mainstream services as well as we might hope.

It is, however, work that is both important and effective, as I believe this independent report shows. That is the case because this project is an example of interagency work that is genuine and places the client at the heart of the service. In turn, this is due to the commitment of the agencies and people involved, and to them I express my sincere thanks and support.

The difficulties that Dublin faces in terms of drug use and antisocial behaviour are not discrete problems to be solved, they will always exist in some form in any large urban centre. We can, however, manage such issues in a humane, person centred, efficient and effective way. The work of the ACMT is an example of this, and I look forward to it being supported and developed.

Brendan Kenny
Chairperson, HLG



BACKGROUND

The Assertive Case Management Team (ACMT) is a multi-agency project, stemming from the 'Better City for All' report which was published in October 2012 by key stakeholders in the city centre who had been tasked by the Lord Mayor to investigate issues of public drug use and perceived anti-social behaviour in Dublin.

Origins

The project was established in September 2014 based on a Memorandum of Understanding (MOU) between: the Health Service Executive (HSE); Dublin City Council (DCC); An Garda Síochána (Garda); and the Ana Liffey Drug Project (ALDP). The project overview states that the parties will work together to provide a multi-agency team focused on addressing the needs of a cohort of people with complex and multiple needs in Dublin City Centre. The team provides intensive case management support to people identified as members of the target cohort.

Resources

Core funding for the team is provided by the HSE, with management and employment responsibilities taken on by the ALDP.

The ALDP employ a team leader and a project worker using the HSE funding, and provides management and volunteer support from existing resources. The two paid ALDP staff are the only members of the team who carry cases. They receive regular supervision from the ALDP head of services.

The Garda have two members, one from each side of the city, allocated to working with the team. They give up roughly a quarter of their time each to the project, amounting to half a full-time input. DCC provide the team with rent-free office and meeting space and resources.

Structure

The HLG is made up of senior management from: HSE; DCC; Garda; and Dublin Region Homeless Executive (DRHE). The HLG meets every four-six weeks with the ALDP director in attendance to give an update on the project.

An interagency case management team meeting takes place every week with the ALDP team leader and project worker, the Garda members and a Housing First representative. This meeting updates information and reviews all cases and identifies actions to progress cases.

The team also has regular informal and/or structured communication with a range of other statutory agencies and community/voluntary charity/non-governmental organisations (NGOs) providing services in the homeless and addiction sectors (see Appendix 1).

Target group

The team focuses on conducting assertive case management in the city centre area by identifying, approaching, engaging with, and assisting those individuals with complex and multiple needs. The needs of the target group spans four key areas: addiction and public injecting; homelessness and rough sleeping; anti-social behaviour, begging and criminal behaviour; and mental health.

The total target group is estimated to be somewhere between 100 - 150 people. Exact figures are difficult to quantify due to transience and the changing make-up of the group, which also includes some migrants, particularly from Eastern European countries. Many of the target group are well known to the Garda and justice systems as well as statutory and NGO services.



Outreach

The team takes a proactive approach to outreach, supporting clients at locations and times that are suitable to them. The team works to either supplement existing case management structures for these individuals, where such is in place, or will take on the case management role where none exists.

Case Management

In order for a person to be case managed under the ACMT, they must first sign a Consent Protocol - agreeing that information on their case can be shared across key agencies - including the Garda. An individual may receive an incentive in the form of a mobile phone top-up if they agree to case management. When an individual agrees to be case managed, they benefit from having direct access to a range of supports from a variety of agencies.

There is a case load of 20 per project worker, totalling 40 by both ACMT workers at any one time. Where Housing First take on a lead role in managing certain cases through the weekly interagency meetings, the ACMT worker may adopt a key working role and the case load may increase beyond 40, e.g. in October 2015 it was at 47.

METHODOLOGY & TERMS OF REFERENCE

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This evaluation was commissioned by the HSE in December 2015. Data collection and interviews were conducted in the early part of 2016. Early drafts of the report were circulated to the HLG for feedback prior to publication.

Aim

The aim was to carry out an evaluation of the first year of the ACMT Pilot in Dublin city and make recommendations regarding its future.

Methodology

The approach was action-research and based on data collection from primary and secondary project sources, including consultative meetings/interviews with key stakeholders, project workers and clients.

Interviews were consultative and based on open ended discussion relating to the following semi-structured questions:

What's working well in the ACMT project?
What's not working or could be improved?
What is the key learning?

Most interviews were face-to-face for 30-45 minutes in length. Due to time constraints and circumstances, three took place by telephone and one by email. There were only two identified stakeholders who could not be reached before the first draft of the report was completed and their perspective was covered by an interview with someone of a similar rank in the same organisation.

Schedule

The schedule of work included: initial briefing meetings with HSE manager and ALDP director; a review of project documentation e.g. MOU, HLG reports and the 12-month report; three consultative meetings; and one telephone interview with members of the HLG from HSE, DCC, DRHE and Garda.

Consultative meetings were held with: the ALDP head of services, project team leader and project worker; the Garda; the service manager in Housing First; a counsellor in City Clinic; and the senior outreach nurse in the National Drug Treatment Centre.

In addition, consultative meetings were held with two ACMT clients and one telephone interview with another client. An outreach walk about for 90 minutes was conducted with the project team leader, during which eight of the target group were met.

A discussion in relation to data management was conducted with the ALDP director and head of services and telephone interviews were conducted with a former inter-agency case management team member from Housing First and the outreach and the contact services coordinator in Merchants Quay.

Email exchanges with GP and Methadone Clinic were conducted and internet research on low threshold services in London and Glasgow was explored.

Finally, a first draft of the report was written and circulated for feedback during a feedback meeting with the HLG. A more detailed list of personnel interviewed is contained in Appendix 2.



The findings present information on what is working in the project and what is not working well, or needs improvement.

Outline

What is working well is documented through a synthesis of points and themes raised in interviews and direct quotes from a range of stakeholders under the following headings:

- 3.1 Interagency relationships
- 3.2 Assertive Case Management model
- 3.3 Engagement of target group
- 3.4 Impact on target group
- 3.5 Skills and mindset of staff
- 3.6 Overall management, scale and focus of the project

What is not working well or needs improvement is covered at the end of the findings.



3.1 INTERAGENCY RELATIONSHIPS

There was a very strong consensus that the interagency partnership in this pilot project is working exceptionally well and has succeeded in establishing a very high level of trust, teamwork, and good communication between outreach workers, Garda and other statutory and NGO agencies involved.

Sharing

Combined with the Consent Protocol agreed by clients, this means that there is excellent information and intelligence sharing to support and progress case management in practical ways.

This approach supports the work with the target group by both statutory and NGO services, e.g. sharing of information in relation to medical treatment and legal issues means the case workers can support clients to keep those dates and even accompany them to court and appointments, which in turn builds trust with the client at a very practical level. Also, if statutory staff (e.g. HSE or Garda) are looking to get a message to someone who is rough sleeping, they can 'put the word out' through the outreach staff to look out for them and pass on the information. This is a win-win situation for everyone.

Ethos

There is a realistic and mature ethos that acknowledges that the various agencies, including Garda and HSE, have specific functions. Therefore, the roles of the different players are clear and statutory bodies are more receptive to the project and the traditional suspicion that often permeates interagency partnerships between statutory and NGO sectors is not an issue.

This trust between partners allows complex cases to be managed through a culture of straight, open and honest discussion at weekly case management and other meetings.

Garda

The Garda are very engaged and supportive and have regular (sometimes daily) phone and text contact with the ACMT, as well as attending the weekly case management team meeting. As a result of being involved, the Garda have a much better understanding of the community and voluntary organisations in the inner city and the process clients go through when being supported to deal with addiction and homelessness.

Links

There are very good links with City Clinic and the Drug Treatment Centre Board. Both acknowledged the benefit of regular communication and interagency planning with the ACMT, to support and progress common clients and that they are very happy to use the ACMT.

Knowledge

There is a good cross-fertilisation of knowledge and expertise among all players, particularly across the areas of homelessness and addiction. This has resulted in increased cooperation to streamline which agency is best placed to take the lead role in case management.

Quotations: Interagency Relationships

“everyone knows what they’re meant to be doing - there are no grey areas.”

“everyone is straight up.”

“there’s good trust, we’re all on the same level. We speak openly, we talk straight and don’t sugarcoat.”

“the staff on street understand what Garda are facing. They know the job we have to do.”

“great example of agencies working well with focus on target.”

“the project has increased the culture of accountability and problem-solving among all front-line agencies involved.”

“Garda are more trained in dealing with addiction.”



3.2 ASSERTIVE CASE MANAGEMENT MODEL

A cornerstone of the ACMT model is the Consent Protocol which clients are encouraged to sign up to before being taken on as full cases. This allows for exchange of information between different agencies, including Garda, to progress case management.

Model

There was strong and significant positive feedback from many interviews on the model of assertive case management being used in this project. In several interviews, participants said they saw the ACMT model as a distinct improvement on other models and practice in the sector. Therefore, it is worth distinguishing clearly between this ACMT model and other practices/models to clarify how this ACMT model is different and the factors that make it successful with this particular target group.

The matrix on the following pages focuses on distinguishing success factors in the ACMT model. Points listed under ‘Other Practices/Models’ are a generalised synthesis of comments by a number of those interviewed and are in no way meant to refer to any specific services. Some of the points under ‘ACMT Model’ may already operate in other services and there is no intention here to assert otherwise. The intention is to distinguish as many of the success factors as possible that underlie the AMCT model, given how positively it is viewed.



Table 1: Comparison of ACMT Model and Other Practices/Models

Success Factors	Other Practices/Models	ACMT Model
Single focus job	Key-working is used widely but often has a low impact as staff involved have many other roles and do not have time to build a relationship with the client or offer practical, but time-consuming support when it matters most.	Project staff are 100% focused on the one job of case management, allowing them time to build trust with clients and consolidate the engagement through demonstrating very practical support e.g. emotional support through 'tea and chat', accompaniment to legal and medical appointments, form filling and follow up on advocacy in relation to housing and other needs. There is an acknowledgment that assertive case management with this target group is very time-intensive.
Focus on street outreach	Some models focus less on outreach, primarily working with clients in drop-in centres or other premises. This may work very well for clients who are willing to engage, but is less successful with the target group of this project, who can be suspicious of, resistant to, excluded from, or negative about engaging with services.	Outreach work on the street is a major part of the ACMT project staff's role and a deliberate strategy to bring services to the clients wherever they are at. The team are flexible in their working hours to identify peak times of engagement with the target group, sometimes going out as early as 7am and as late as 8.30pm. Outreach work is done in pairs. Sometimes the project worker is supported by an intern or volunteer allowing for the maximisation of human resources. This allows for the essential role of a second person to witness and corroborate staff interactions. It also provides the opportunity of work experience and development of a skilled workforce. One-to-one meetings are also held once a client is known to staff, this can happen in partner agencies and/or cafes, without a second staff member required.
Protocol for consent from clients	While multi-agency communication exists, this may vary in its focus. Where there is no protocol for consent by clients, this limits interagency partnership and may even create a closed culture between organisations. It can result in duplication where several organisations are working with the same clients, sometimes giving levels of low support with overall low impact.	The consent protocol by clients allows the ACMT to build a very strong foundation for interagency partnership in the case management of clients who have agreed to it. This gives great flexibility to the project workers, as they have a remit to engage with any service relevant to the needs of the client and progressing their support plan.
Structure of regular positive interagency case management meetings	The absence of consent to share information means no structures for an interagency partnership to track and progress client support plans.	The structure of the small weekly interagency case management meetings, particularly involving the Garda, allows case management to be streamlined and support plans to be pro-actively progressed and tracked. This also means that no major new decisions on cases are taken in isolation or by only one person.

Success Factors	Other Practices/Models	ACMT Model
Tracking and accountability mechanisms	In crisis work, and particularly where there is a lack of simple and accountable tracking mechanisms, it is easy for slippage to occur and the culture to gravitate towards excuses, negativity and blame for inaction.	The consistent tracking mechanism builds a culture of accountability that is forward looking and solution-focused, so that actions are identified to progress every support plan at case management meetings. This leaves very little room for slippage.
Quality, skills, experience and mindset of staff	The qualifications, skills and experience/mindset of personnel (staff and/or volunteers) may vary significantly across projects and organisations.	Project staff are qualified, skilled and experienced in low threshold addiction work. They have a range of key skills that are identified in more detail in section 3.5, including a leadership mindset.
Good reflective practice re boundaries in caring and challenging	The fine line between the need to challenge clients as well as care for them is not always clear or understood. It can lead to doing too much for the client ('mollycoddling'), sometimes based on a misguided need to demonstrate caring. Without good reflective practice, this can result in unclear boundaries and blurred thinking about what is actually the best action for the client.	The ethos of ACMT includes building an empathetic and compassionate relationship with clients, as well as clarity about how to motivate and challenge them for their own benefit. Project workers are skilled in both these aspects of psychological support/emotional intelligence skills. This is supported by discussion on care plan actions at the case management team meetings and backed by a supervision structure that puts high value on reflective practice and ongoing learning.

Quotations: Assertive Case Management Model

“this is clear assertive case management - not watery key-working.”

“this is a strategy for those who don't go to services - bring services out to them.”

“it's very time intensive.”

“this is a change from old case management which was softer, more watery, often blaming with slippage and excuses.”

“consent is huge - has made life a lot easier - joint agency care plan is brilliant.”

“the project workers know when to challenge and when not to - there's no mollycoddling.”

“Paul and Ross push me to be on time for appointments - wouldn't be where I am but for them. They tell me the truth. Help me to be more honest with myself... They wouldn't buy me cigs because it's not good for me. They're on the button for good advice. They don't take any bullying, don't tolerate it at all... They work so closely together, it's all about the clients. The care plan works.”

“can decide at case management where to draw the line - even if difficult and client may get angry.”

“weekly case meetings are very important.”

“work very closely with clients and agencies - have access to all information.”

“every case has to be left with an action to be progressed.”

“you can't hide when each case is reviewed every week.”

“there's no slippage.”



“this is a change from old case management which was softer, more watery, often blaming with slippage and excuses.”

3.3 ENGAGEMENT OF TARGET GROUP

Interviews with the stakeholders, including clients, reflected a very positive view of the level of engagement achieved to date by the pilot.

Target group

The target group of this project have multiple and complex needs ranging across addiction, homelessness, rough sleeping, mental health, begging, and criminal/anti-social behaviour. In addition, they have been targeted particularly because they have a low level of engagement with other services, or that engagement did not work, or they are excluded from services because they do not meet criteria.

It is estimated that the total target group in the inner city is somewhere between 100 - 150 at any one time, with a certain level of transience.

Relationship building

Given the needs and history of the target group, the process of engaging them to sign up to the Consent Protocol to begin case management is slow and challenging and requires significant investment of time in building relationships and trust by the outreach staff.

This positive view of the rate of engagement is backed by statistical data from the project. The report submitted to the HLG at the end of November 2015 highlights that 59 individuals (44 Male, 15 Female) had signed up to be case managed by the end of October that year, of which:

- 47 were still engaging with the team. These are either being case managed directly by the ACMT ($n=40$); or are being case managed by the Housing First team, with key working input from the ACMT ($n=7$).
- 5 individuals were successfully moved on to a case manager in other agencies and their cases with the ACMT were closed.
- 1 individual passed away during the pilot.
- 6 individuals have disengaged and are uncontactable.

Crucially, 35 of the 59 (almost 60%) individuals stated during assessment that they had not previously engaged with a case management system in adult services.

Estimating a mid-point (between 100-150) figure of 125 for the total target group, based on the above figures, the following can be deducted:

- 47% of the target group were successfully engaged to sign up to consent and case management in the first year of the pilot
- Only 10% of those signed up either disengaged or are uncontactable (e.g. due to transience)
- 90% of those who signed up have stayed engaged or progressed to other options (excluding one person who passed away)

These figures are impressive given the extremely challenging and complex needs of the target group, many of whom have a history of exclusion or resistance to services.

Case load

It should also be noted that the success rate for engagement is limited by the case load of 20 per project worker. As the case load is currently full, it is reasonable to conclude that the success rate would be higher if there were more workers on the project.

These figures do not take account of ongoing interaction by the ACMT staff with a much wider number of the target group who have not engaged, are not yet ready to engage, or who are waiting to be taken on for case management.

Quotations: Engagement of Target Group

“clients are open to it and signing up.”

“going to client’s territory - they are not so threatened. Sometimes it’s one step forward, two steps back - need to be flexible.”

“it’s very intensive.”

“had tried another outreach team - had one meeting with them and nothing more... it’s easier when it’s one-to-one”

“it’s about building trust with client through understanding and empathy.”

“it’s getting those hard to follow up e.g. rough sleepers to engage.”



3.4 IMPACT ON TARGET GROUP

The desired impact and overall outcomes can be grouped under three major areas: improved health outcomes for clients, particularly in relation to addiction and polydrug use; reduction in homelessness and rough sleeping; reduction in begging and anti-social/criminal behaviour.

Impact

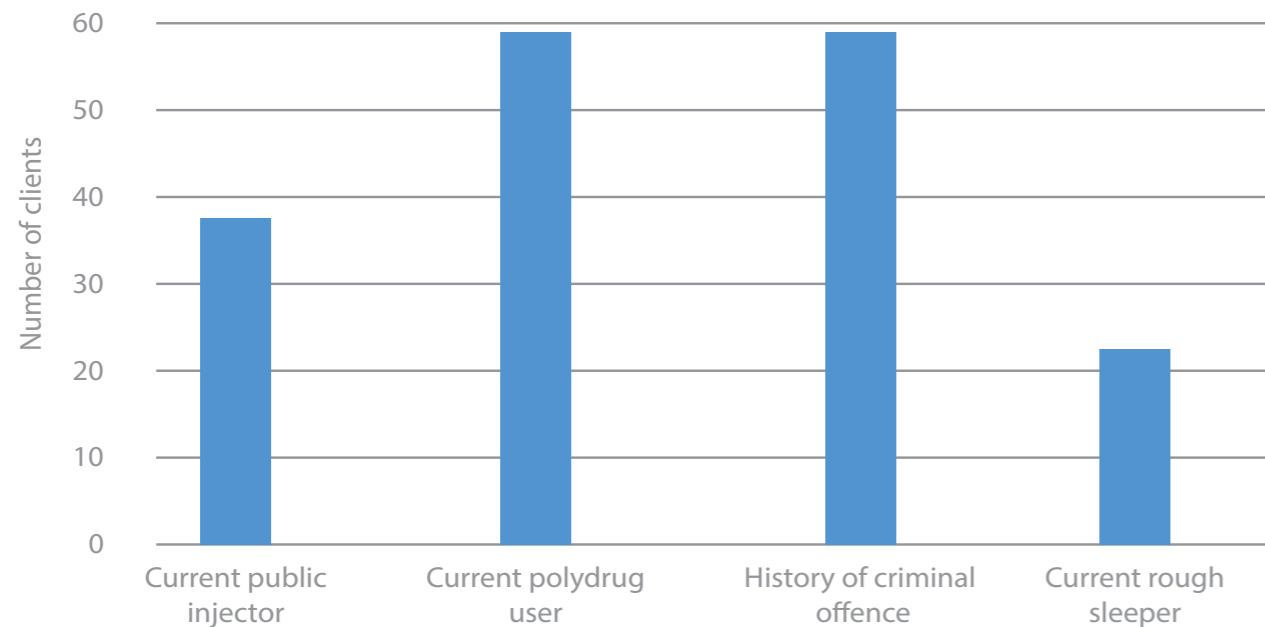
Given the complexity of need and chaotic lifestyle of many of the target group, measuring and tracking impact and outcomes is a major challenge. For example, the initial intention in the MOU to use the self-reported progression measured by an outcomes measurement tool proved unworkable.

Detailed tracking is mostly done through case management notes and care plans which are logged on Salesforce. A summary (anonymised) of the progression of each person being case managed is contained in some reports to the HLG under the following headings:

- Referral
- Area of origin
- Anti-social issues
- Personal health
- Outcomes
- Status
- Unmet needs

This gives a very useful narrative of the key issues and how they are being dealt with. The following two graphs contain an overview and analysis of the core issues and outcomes among the 59 clients.

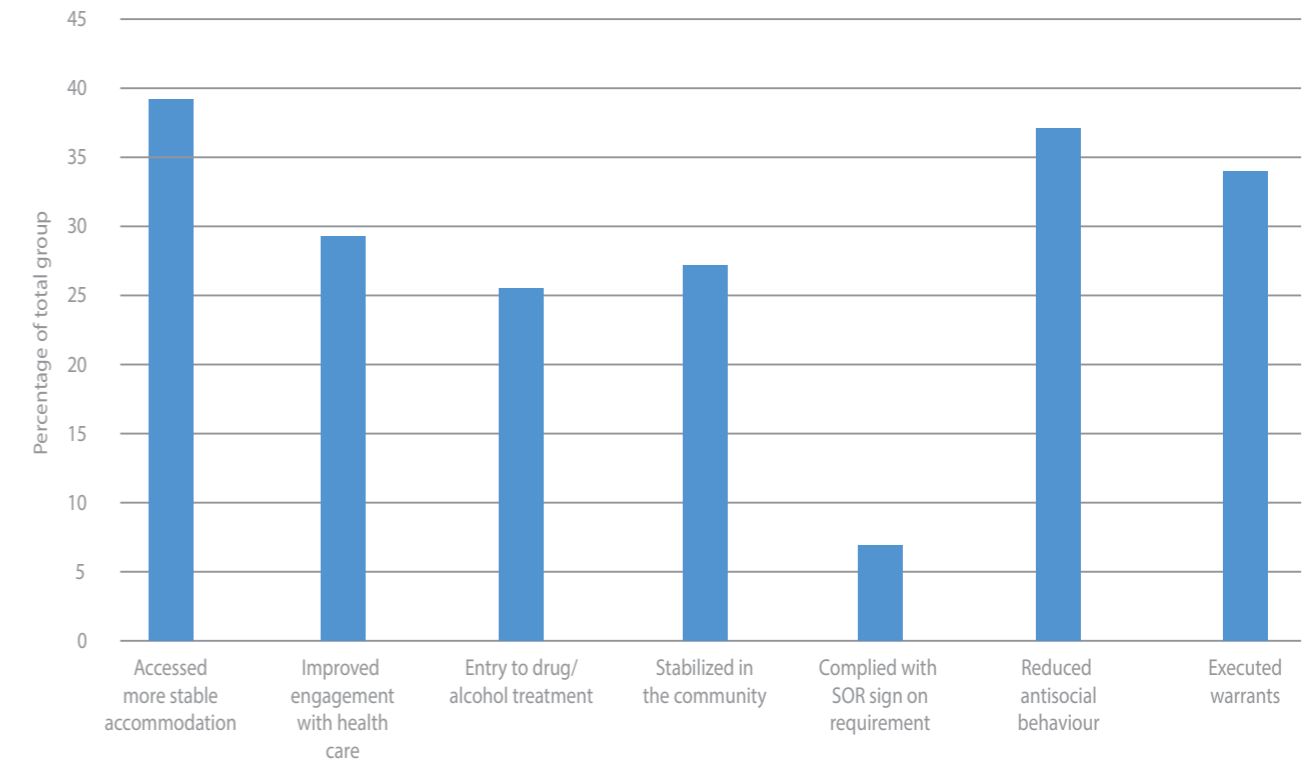
Core issues:



The previous graph reflects that all 59 clients presented as polydrug users with a history of criminal offences. 36 individuals (61%) presented as current public injectors. 22 individuals (37%) presented as rough sleepers - with an important note that most of the total cohort of 59 individuals identified as homeless and as resident in emergency or other unstable accommodation. Outcomes in relation to the above issues were tracked and analysed according to the following categories:

- accessed more stable accommodation;
- improved engagement with health care;
- entry to drug/alcohol treatment;
- stabilised in the community;
- complied with Sex Offender's Register (SOR) sign on requirements;
- reduced anti-social behaviour;
- executed warrants.

Outcomes:



This graph is accompanied by a narrative that gives a very detailed breakdown of the interventions carried out to support and achieve the above categories of outcomes and to show the level of hand-holding and the number of small but significant steps needed to progress outcome based care plans for this target group. These are: accommodation; entry to treatment and compliance with signing on requirements; and execution of warrants.

Accommodation

- supporting the clients to get photographic identification and birth certificates to allow for registration with homeless services;
- accompanying the clients to their local authority to register;
- liaising with the Central Placement Unit and/or the Housing First intake team to assess suitability for housing, helping them move and creating a plan with the client for sustainment of their accommodation.

Entry to treatment

- completing drug and alcohol diaries with the clients prior to referral to assess suitability for treatment;
- facilitating the clients to access photographic identification and birth certificates to allow for registration with methadone clinics;
- supporting clients to complete counselling and urinalysis screening to access treatment, transporting individuals to treatment;
- co-case managing clients during treatment to support success of care plan and planning aftercare options with clients.

Compliance with signing on requirements and execution of warrants

- liaising with the Garda case manager in relation to signing on requirements;
- coordinating with the client and their Garda case manager to continuously feedback their whereabouts (especially relevant with homeless clients);
- accompanying clients to the appropriate Garda station to sign on, to register and communicate with Garda if the client is not contacting the team and is in breach of their obligations;
- liaising with the Garda to identify outstanding warrants;
- building trust with the clients to take them to the Garda station;
- accompanying the client to Garda station;
- managing upcoming court appointments with clients to avoid missed appearances and further bench warrants.

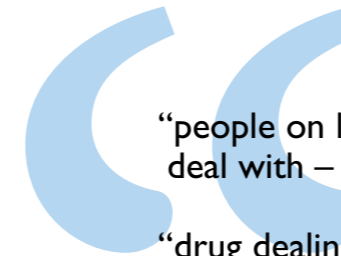
There was a strong consensus among those interviewed that the ACMT project is making a difference to clients and to the reduction of anti-social behaviour in the city. It was acknowledged that the progress of outcomes with the target group happen through slow, small steps, during which persistent trust building and case management support can make a significant impact over time.

The following soft and hard outcomes were particularly highlighted during interviews:

- emotional support to clients;
- giving hope to clients, positive thinking and problem-solving through care plans;
- doing hand-holding e.g. paperwork, accompaniment, advocating in relation to other services, which solves practical problems for the client and therefore reinforces trust and engagement;
- more rounded and informed assessment of client needs through interagency case management, leading to more comprehensive treatment plans;
- clients supported to access services previously unavailable to them or excluded from;
- better coordination of two specialisations - addiction and housing - to meet needs of clients;
- more clients keeping medical and legal appointments;
- clinics using the ACMT to follow-up on clients who drop out of medical treatment;
- significant improvement in the relationship between many clients and the Garda, leading to increased communication, trust and compliance with the law, warrants and court appearances;
- reduction in drug-dealing, begging and anti-social behaviour.



Quotations: Impact on Target Group



“people on list are not causing as much trouble – they’re easier to deal with – will talk to Garda now.”

“drug dealing and anti-social behaviour has gone down among participants - afraid they will lose the support. Assistance with keeping appointments at clinics, more comprehensive treatment plan and we (clinics) know what’s going on outside.”

“people don’t fall through the gaps as much.”

“there’s better progress.”

“if people have dropped out of treatment - we (clinics) put them on Paul & Ross’s radar or arrange for them to see them here – we complement each other.”

“the clients are more open speaking to us (Garda) – makes it easier to deal with some of legal issues.”

“a few people there is a definite improvement in – come to less Garda attention. It has softened people towards garda - we (Garda) have a different relationship with clients.”

“Paul is fighting for me – felt he was always there for me.”

“they opened doors for me.”

“I hadn’t worked with other services before – they got me into housing and helped me move.”

“they give you a lot of hope when you’re negative - they give you positive thinking.”

“they work so closely together – all about the clients.”

“I tried other services – they (ACMT) help you more with your stuff - the Care plan works.”





3.5 SKILLS & MINDSET OF STAFF

There was huge acknowledgement by those interviewed of the skills and commitment of the project staff. Given the intensive relationship-based nature of the work, it is important to identify this as a key success factor.

Skills

It is useful to distinguish the skills and mindset involved to ensure their continuity in the future of the project should there be a change or expansion of staff.

The skills can be identified under four key areas:

- Professional qualifications and experience
- Sectoral and systemic knowledge
- Emotional intelligence skills
- Leadership mindset

Professional qualifications and experience

Staff are professionally trained and qualified to third-level, with specialist knowledge and experience of addiction and homelessness. They possess hands on experience on the ground with the target group and an understanding of low threshold work and the psychology of addiction. In addition, they have a knowledge and appreciation of the full continuum of care, the contribution of both clinical and social models in dealing with addiction and insight into the criminal system.

Sectoral and systemic knowledge

Staff have a significant practical knowledge of 'the system' and how 'to work it' i.e. the large number of statutory and NGO services relevant to the needs of the target group, their function, culture, personnel, and the often complex formal and informal interrelationships between them. There is also an acknowledgement of, and ability to negotiate, the different roles and agendas of the statutory and NGO sectors and work so that they can complement each other.

Emotional intelligence skills

There is a good understanding of human psychology and compassion/empathy with the target group among the team. An ability to motivate and inspire trust with clients using open and honest communication was evident. Clarity about when to challenge clients (if needed) and a professional understanding of boundary issues was also

evident. Staff also demonstrated the ability to network and generate trust with a range of agencies through mature, clear and diplomatic interactions.

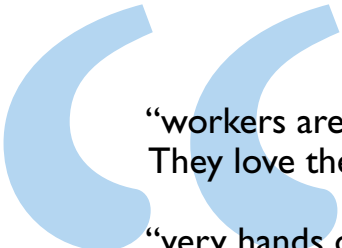
Leadership mindset

Staff are passionate about making a positive difference in clients' lives. They have a commitment to problem solving, with the ability to keep moving issues forward, to ensure outcomes and progress for the client. They are courageous in having conversations to make a difference, with and on behalf of the client. They also have the ability to generate a culture of accountability and follow-through on actions.

Garda

The skills and commitment of the two Garda members was also commented on very positively, in particular their clarity in relation to their own role and understanding of a community policing approach. They were found to have excellent communication skills, a willingness to learn about addiction and homeless issues and positive and open engagement with the clients. They gave time, hard work and input into the case management team, were accessible outside of case meetings and were accountable and reliable.

Quotations: Skills and Mindset of Staff



“workers are someone I look up to - they are loving and caring. They love their work and enjoy it – they enjoy our happiness.”

“very hands on engagement and very skilled.”

“new generation of staff – about client not the organisation.”

“have commitment to making a difference – to stick with them no matter what.”

“good knowledge of clinical and social models.”

“not coming with baggage.”

“don’t have to challenge certain things – challenge in regard to what’s best for clients.”

“very good dynamic between two workers.”

“very clear understanding of system – official and unofficial.”

“ethos is to progress people.”

“have knowledge of disadvantage.”

“leads team to outcomes.”

“can work the system.”


“Not afraid to ask – very easy to work with.”

“Garda have softer people skills.”

“Not authoritarian.”

“Insight and maturity and awareness of macros agendas.”

“Huge knowledge of players and people.”



3.6 OVERALL MANAGEMENT, SCALE & FOCUS OF PROJECT

Success factors

One of the success factors identified by many stakeholders is that the project is working well because it is small and ‘tight’. This can be seen in terms of target group, geographic spread, ethos, purpose and number of players involved. The project has a clear focus on a small identifiable number of the most entrenched and vulnerable people living with addiction and homelessness in Dublin city centre. It has a clear, pragmatic ethos and purpose, successfully combining a focus on individual health with wider economic and social well-being for the city. There is a small number of players directly involved in the two main structures - the weekly interagency case management and the HLG.

HLG & Ana Liffey

The HLG provides an external oversight structure and works very well giving important senior management endorsement to the project by the three key statutory agencies: HSE, Garda and DCC. The HLG meets every four-six weeks ensuring that senior management are informed, engaged, and can identify issues to be addressed at their level.

The direct management of the project by the ALDP was seen to be working well and several stakeholders commented positively on their competency and credibility. It was also commented that it was important that the project remain outside of mainstream HSE services.

It was also stated that it was important that the project is separate under ALDP management - rather than being mainstreamed into it - as the culture of the ACMT model was seen by some stakeholders to be different to other services in the organisation.

There is good line management, support and supervision for the project within the ALDP and the positive lessons from the ACMT culture and model are being used to inform and improve other ALDP services, in line with a continuous improvement approach.

At least one service not involved in the weekly interagency meeting expressed a wish to be involved more directly in the project, and there is a sense that this view may be echoed among other NGOs who were not interviewed as part of the evaluation. The excellent working relationship with the Garda was named specifically as an element other

groups might envy. However, caution was also expressed about expanding the project to include more players in the main structures as this could dilute its focus.

Statutory and NGO stakeholders commented that the project potentially saves the state substantial funds through avoiding delays in legal procedures and reducing anti-social behaviour.

Issues

When asked what was not working well or needed improvement, those interviewed primarily identified issues outside the control of the project, for example, the current housing crisis that is making it more difficult to get clients into stable accommodation.

The lack of treatment options for clients was also an issue, in particular the gap in crisis or low threshold stabilisation/detox/rehab treatment services, such as those existing in other cities, e.g. London and Glasgow.

Improvements

The following is a synthesis of points and suggestions for improvements made during interviews.

It was suggested to have case meetings less often than weekly, e.g. fortnightly or every three weeks and deal first with those cases with Garda input.

Current outreach workers are overworked, constantly busy, spread too thinly and the case load is full. There is a need to bring in an additional outreach worker(s) to ease this and allow the case load to be increased. One possibility is to add a current HSE outreach worker to the project team as this would increase links with the HSE and be more economically viable.

There could be more involvement from the clinics and other NGOs and there may need to be more involvement from the Garda, especially if there is an increase in the case load. It would also be useful for the front-line managers of the services that link in with the ACMT to meet up twice a year to be updated on the project. In addition, there needs to be more focus on the measurement of hard and soft outcomes and it would be useful to look at international practice, e.g. Amsterdam, where the police have a different role.

Quotations: Overall Management, Scale & Focus of Project

“HLG is important - it’s a big thing.”

“There’s good senior management engagement.”

“HLG structure can be used to get things done.”

“don’t bring more players into the project – lots of organisations want to be part of it.”

“It’s good value for money.”

Quotations: What is Not Working or Needs Improvement

“The project workers are overworked - it’s very intense and personal. They are constantly busy.”

“We could meet more needs with more case workers.”

“Need harder outcomes - not sure how much of an impact its having, but some slow progress is being made re reducing rough sleeping, homeless and begging.”

“Arresting and locking up is not working.”

“There’s no service (i.e. treatment options) for the really chaotic.”

“Client can’t get into many of the current treatment options as they don’t meet entry criteria.”



CONCLUSIONS

4

Outcomes

The ACMT pilot is working well and demonstrates a strong model for outcomes focused low threshold work. It is making a difference through achieving significant engagement and case management outcomes with the identified target group.

Teamwork and partnership

There is great teamwork and interagency partnership in this project. This is a result of the skills and mindset of the staff involved and not some accident of personality.

Workload

The small and focused nature of the pilot is a key element in its success and it should not be majorly or suddenly upscaled. However, given the workload on project workers and the current full case load, an additional one or more outreach workers should be considered. Particular attention should be paid to ensure that any new outreach workers have the skills and leadership mindset required by the project and demonstrated by its current staff.

Data collection

While significant individualised tracking takes place through the case management and care plan system there needs to be a more tailored, in-depth approach to data collection, data analysis and data visualisation that allows the overall trends and outcomes of this complex work to be identified and extracted for wider learning and policy development.

Changes and implementation

Changes could be tried to a small number of operational issues highlighted and reviewed as required.

There is a need for significant change at systemic level to support the work of the project and some contributors have suggested that implementation of the following may address some of the challenges: (a) the establishment of a crisis stabilisation/detox service for low threshold clients; (b) the establishment of protocols and practice

for fast tracking those engaged in ACMT into housing and treatment options; and (c) implementation of government policy on injecting rooms. The HLG could play a role in advocating for these.



RECOMMENDATIONS



Funding and management

The ACMT pilot should continue to be funded for the next three years. There should be a mid-point review and a final evaluation towards the end of the three years, with recommendations for the future of the service on a permanent basis.

Staffing

An additional project worker, with the required skills and mindset, should be added to the outreach team within the next few months to increase the case load.

Funding should be sought from a variety of sources in addition to HSE, including local businesses, for additional project workers to be added to the ACMT team over the next three years to increase the case load up to at least 100 clients, provided this is paced and managed in a way that ensures the integrity of the project model and ethos.

Operational changes

Review the regularity and format of case management team meetings to maximise the time of the Garda and change as required.

Discuss with the Garda at the HLG level their increased involvement, particularly as the case load gets bigger.

Create an induction procedure for any new Garda involved in the project, including some training on addiction issues.

Systemic issues

The HLG to work together to discuss current and emerging systemic issues and work with government and senior statutory representatives to lobby for change.

Data tracking and analysis

Allocate a small budget for specialised technical support to significantly improve data gathering, data analysis, data

visualisation and to explore the potential of Salesforce. Data analysis should focus on mapping the impact of the project, particularly the progress - or reversal of progress - of clients in relation to key indicators, so that evidence based trends and learning can be extracted.

The Higher Level Group



Jack Nolan, An Garda Síochána; Frank Clerkin, An Garda Síochána; Ruth Treacy, Dublin City Council; Brendan Kenny, Dublin City Council; Brian Kirwan, HSE; Vincent Norton, Dublin City Council

APPENDIX 1

List of key agencies and NGOs with which ACMT has structured or informal contact*

- Access Mental Health Team
- An Garda Síochána
- Arnott's Department Store
- CASP (Clondalkin)
- Coolmine Therapeutic Community
- DCC (Central Placement Unit)
- DROP (Dun Laoghaire)
- Drug Courts
- Dublin Region Homeless Executive
- Dublin Simon RCOS
- Dublin Simon Respite Unit
- Dublin Town
- Exchange House
- Focus Ireland Coffee Shop
- Housing First
- HSE (Soilse)
- HSE Outreach Worker (City Clinic)
- HSE Outreach Worker (National Drug Treatment Centre)
- Labour Inclusion Programme
- Merchants Quay Ireland
- Mountjoy Family Practice
- North West Inner City Training and Development Project
- Park Rangers, Phoenix Park
- Peter McVerry Stabilisation
- Probation Service (Homeless Section)
- SAOL Project
- Sisters of Charity
- Tiglin treatment centre

*This list is representative of the many agencies the ACMT engages with.

APPENDIX 2

List of stakeholders consulted during evaluation process

HSE	<ul style="list-style-type: none"> • Tom O'Brien • Brian Kirwan
Dublin City Council	<ul style="list-style-type: none"> • Brendan Kenny
ALDP	<ul style="list-style-type: none"> • Tony Duffin • Dawn Russell • Paul Duff • Ross McNulty
Clients	<ul style="list-style-type: none"> • G (male) • S (female) • B (female - by telephone) • 7 other clients met on street walk-about with project staff
An Garda Síochána	<ul style="list-style-type: none"> • Karl Colgan • Mark Eccles • Frank Clerkin (telephone)
City Clinic	<ul style="list-style-type: none"> • Ciaran Howley
National Drugs Treatment Centre	<ul style="list-style-type: none"> • Joe Merry
Dublin Region Homeless Executive	<ul style="list-style-type: none"> • Cathal Morgan
Housing First	<ul style="list-style-type: none"> • Adrian Quinn • Paul Kelly (telephone)
Mountjoy Family Practice	<ul style="list-style-type: none"> • Austin O'Carroll (email)
Merchants Quay Ireland	<ul style="list-style-type: none"> • Andrea O'Reilly (telephone)

