Police and Court Diversion

Telephone Trial Final Report
March 2019

(Not Government Policy)

Police and Court Diversion: Telephone Trial Final Report

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Introduction

A trial of telephone delivery for the Police Drug Diversion Program (PDDP) and Illicit Drugs Court Diversion Program (IDCDP) was conducted from 14 August 2018 to 2 November 2018 in response to legislative amendments made to the *Police Powers and Responsibilities Act 2000* and *Penalties and Sentences Act 1992* enabling greater flexibility in the way Information and Education sessions (sessions) for the PDDP and IDCDP (formerly QIDDI) are delivered

Queensland Health (QH), Department of Justice and Attorney-General (DJAG) and Queensland Police Service (QPS) partnered to test a new approach to delivering the sessions. A mix of State-funded Hospital and Health Services (HHS) alcohol and other drug (AOD) services and non-government organisation (NGO) AOD services across three HHS catchments conducted telephone sessions in addition to standard face-to-face (F2F) sessions over twelve weeks, commencing 14 August 2018.

Participants chose the modality (F2F or telephone) at the point of being diverted either by police or the courts. An appointment to complete the session via the chosen modality was booked via the Diversion Coordination Service (DCS) who are responsible coordinating the diversion of eligible individuals to a network of authorized service providers including Hospital and Health Services and Non-government organisations. The trial was intended to test whether offering telephone sessions would improve accessibility to the diversion programs particularly where completing appointments in person is challenging. Providing the option to complete the session by telephone was expected to reduce wait times for appointments and increase completion rates.

This report provides the results of the trial for the period: 14 August 2018 to 2 November 2018. End of trial data was compared with pre-trial baseline (14 May 2018 to 13 August 2018) and mid-point data (14 August 2018 to 30 September 2018) to allow comparisons in accessibility, wait times and appointment completion.

A mix of quantitative and qualitative data was collected and analysed to determine:

- The impact on program completion
- The uptake of telephone appointments compared to F2F
- Identification of process refinements for scheduling and completing telephone sessions
- Revision requirements to the Service Provider Manual about telephone delivery
- Any potential unintended impacts on service delivery
- Improvements in client accessibility for program participants
- The impact of telephone sessions on service providers

Summary of Findings

Data and service provider/participant feedback suggest that offering telephone appointments has potential to improve program accessibility, availability and completion for some clients particularly for young people, Aboriginal and Torres Strait Islander people, people who reside or work in locations where access to services is challenging, or have other commitments such as child care. However, it was acknowledged that F2F appointments may have greater clinical benefits for some clients, particularly those with complex issues, and some clients will prefer to participate F2F.

Program completion was higher during the trial period compared to the baseline period. While overall completion did not differ substantially between F2F appointments and telephone appointments, telephone appointments improved program completion for Aboriginal and Torres Strait Islander people and people under 18 years of age and between 46 and 55 years of age.

The number and proportion of appointments that were rescheduled was higher during the telephone trial period than baseline period for both modalities. Of rescheduled appointments during the trial period, telephone appointments were less likely to be completed (83%) than F2F (89%). Participants may perceive it as easier to reschedule a telephone appointment than face-to-face appointment. Further consideration will need to be given to this issue should the option of telephone delivery be expanded state-wide.

Telephone appointments may have had a positive impact on wait times, as the appointment wait times during the trial were less than at the baseline period. This was particularly the case in in Darling Downs HHS and South West HHS where telephone appointment wait times were shorter than F2F. However, there was no difference in wait times between modalities in Cairns and Hinterland HHS. Reduced wait times may be due to more appointments being offered, the ratio between F2F and telephone appointments (with telephone offering more scheduling flexibility), staff availability and unpredictable fluctuations in demand due to police and court activity and promotion and education about diversion programs.

Offering telephone appointments may result in cost and time efficiencies for service providers as clinician's travel time is reduced. However, the DCS reported a considerable increase in the time spent communicating with service providers about appointment schedules to optimize the flexibility and potential benefits of telephone delivery. The time and effort required to work with services would increase, at least in the short term, should telephone delivery be expanded state-wide under the current model or reduced if a single provider of telephone sessions was considered.

Services also noted that telephone delivery improves the capacity of the services to backfill staff for appointments during staff shortages and periods of unplanned staff leave. Telephone appointments during the trial period became an effective modality to respond to staffing shortages. For example, although not part of the trial, during the trial period Central Queensland HHS experienced significant staffing issues and as a result was unable to offer any diversion appointments. Appointments for these clients were offered by telephone through other providers until staffing issues could be resolved. Telephone appointments in this situation have enabled access to the diversion program to continue, however, had this not been an option, clients in these areas would have been sent to court.

A few participants provided feedback about the diversion programs (not specific to modality). Specifically, providing the option of a follow up session, providing appointments within two weeks and being able to participate after hours would be helpful. Given that diversion programs are an opportunity for early intervention, reduced wait times are known to improve completion rates and many participants reported working and being responsible for childcare, these are important considerations for the diversion programs and expansion of statewide telephone delivery.

Finally, all areas received telephone appointments and the proportion of telephone appointment scheduled increased throughout the trial period. Additionally, the DCS advised that numerous police officers outside of the trial locations expressed interest in scheduling a telephone appointment. This reflects ongoing promotion and education about the diversion programs and together with the feedback from service providers and participants, is a positive indication of support for telephone appointments. Refining the model for telephone delivery may optimize the benefits of this modality.

Trial Approach

People diverted to participate and complete a session in the following areas were offered the option to participate F2F or by telephone:

- Cairns and HHS
- Darling Downs HHS
- South West HHS

There were three key elements to determine the impact of the trial.

1. The DCS collected data on program accessibility, appointment availability and program completion.
2. Clients who completed a telephone session also answered a few short questions with the service provider at the end of the session. Feedback was sought from participants on the accessibility of the telephone session and some demographic information. The information was collected for the purposes of the trial only (to inform process and quality improvement) and responses were de-identified. Information was used internally by partner agencies and not published in any form.
3. Qualitative feedback about the trial was collected from participating service providers. Feedback was sought on processes, information provided in the service provider manual, and perspectives on further rollout of telephone sessions. QPS are undertaking further evaluation with their participating staff.

N.B Not all police stations within the three HHS catchments participated in the trial.

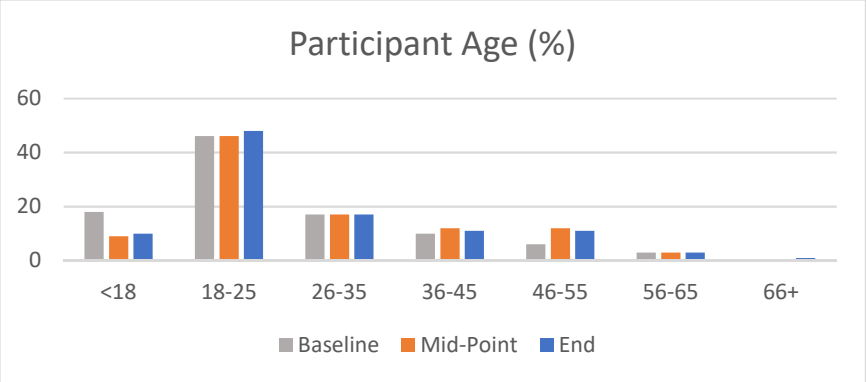
NB: Results for South West HHS must be treated with caution due to low referral and appointment numbers.

Detailed Results

Participants

Between 14 August and 2 November 2018, 361 appointments were scheduled across the trial locations. The majority of participants were male (68%) which is similar to the twelve weeks prior to the trial (71%). Most participants were between 18 and 35 years of age (67%), which is similar to the baseline period (62%). However, there were fewer participants under 18 years of age and more participants between 46 and 55 years of age during the trial period (see Figure 1). The proportion of clients during the trial who identified as of Aboriginal or Torres Strait Islander origin was the same as at baseline (22%).

Figure 1.



Appointments

During the baseline three-month period, 349 appointments were scheduled in the trial locations (either completed or not completed). At the end of the three-month trial, 361 appointments had been scheduled in the trial locations (either completed, not completed or pending). The number of appointments scheduled during the trial is 3% greater than the number of appointments scheduled during the baseline period.

The majority of appointments scheduled were for the PDDP (70%). This is slightly less than baseline (74%). The proportion of appointments scheduled for the IDCDP increased between the mid-point of the trial (23%) and the end of the trial (30%). The increase in court referrals was greatest in Darling Downs HHS. There were no appointments scheduled for the IDCDP in South West HHS during the trial (See Table 1).

Table 1. Number of appointments scheduled by mode of delivery, program type and location

	Court			Police		
	Baseline	Mid-Point	End	Baseline	Mid-Point	End
SWHHS						
F2F	3	0	0	8	4 (66%)	6 (55%)
Telephone	NA	0	0	NA	2 (33%)	5 (45%)
Total	3	0	0	8	6	11
DDHHS						
F2F	38 (100%)	6 (40%)	19 (42%)	107 (100%)	46 (68%)	55 (48%)
Telephone	NA	9 (60%)	26 (58%)	NA	22 (32%)	59 (52%)
Total	38	15	45	107	68	114
CHHHS						
F2F	34 (100%)	24 (86%)	52 (83%)	159 (100%)	51 (74%)	99 (77%)
Telephone	NA	4 (16%)	11 (17%)	NA	18 (26%)	29 (23%)
Total	34	28	63	159	69	128
Grand Total	**75**	**43**	**108**	**274**	**143**	**253**

All HHS areas and service providers received appointments for telephone and F2F sessions. Telephone appointments comprised 36% of all appointments scheduled by police and court.

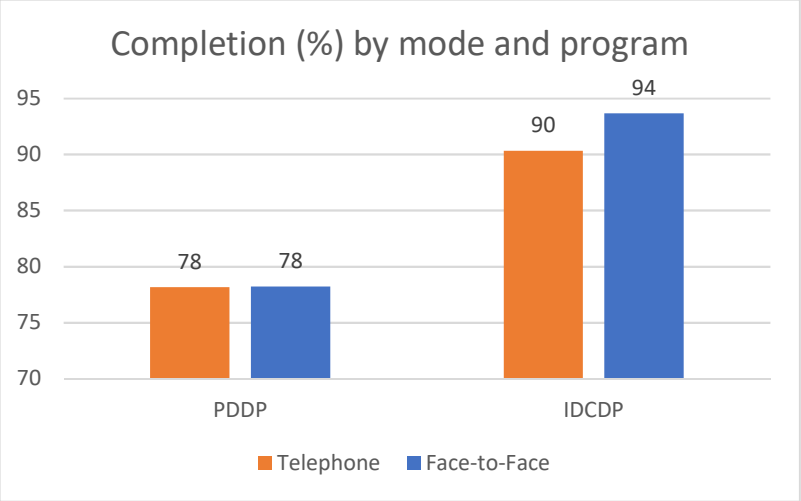
Sex and Mode

Most telephone and F2F appointments were scheduled for males (62% and 72% respectively) which aligns with participant demographics for diversion. However, a larger proportion of females were scheduled for a telephone appointment (43%) than males (33%).

Program Completion

- Program completion was higher during the trial period (82%) compared to baseline (77%).
- Program completion did not differ substantially between F2F appointments (83%) and telephone appointments (81%).
- Program completion did not differ for clients of the PDDP (between telephone or F2F), but was slightly higher for F2F appointments than telephone for clients of the IDCDP (see Figure 2) *.

Figure 2.



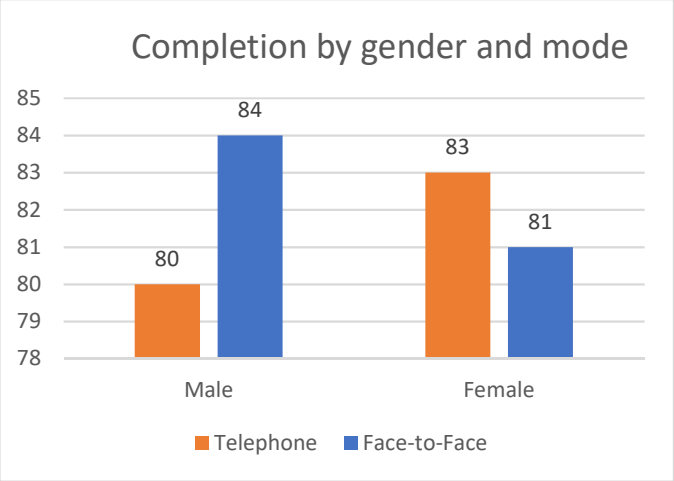
*The result for the IDCDP should be interpreted with caution due to low referral numbers.

Sex

Program completion during the trial was similar for males (83%) and females at (82%) and higher compared to the baseline period where 71% of males and 75% of females completed the program.

Program completion by telephone was slightly higher than F2F for females, whereas program completion by F2F was slightly higher for males than telephone (see Figure 3).

Figure 3.

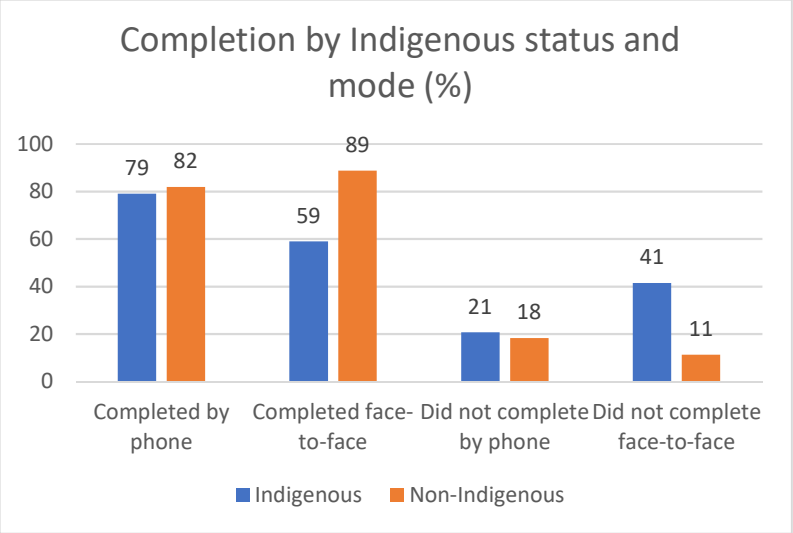


Aboriginal and Torres Strait Islander Status

Across both modalities program completion was higher among non-Indigenous people (86%), compared to Aboriginal and Torres Strait Islander people (67%).

Program completion was higher by telephone (79%) than F2F (59%) for Aboriginal and Torres Strait Islander people. Whereas, completion was higher for F2F appointments (89%) than telephone appointments (82%) for non-Indigenous people (see Figure 4).

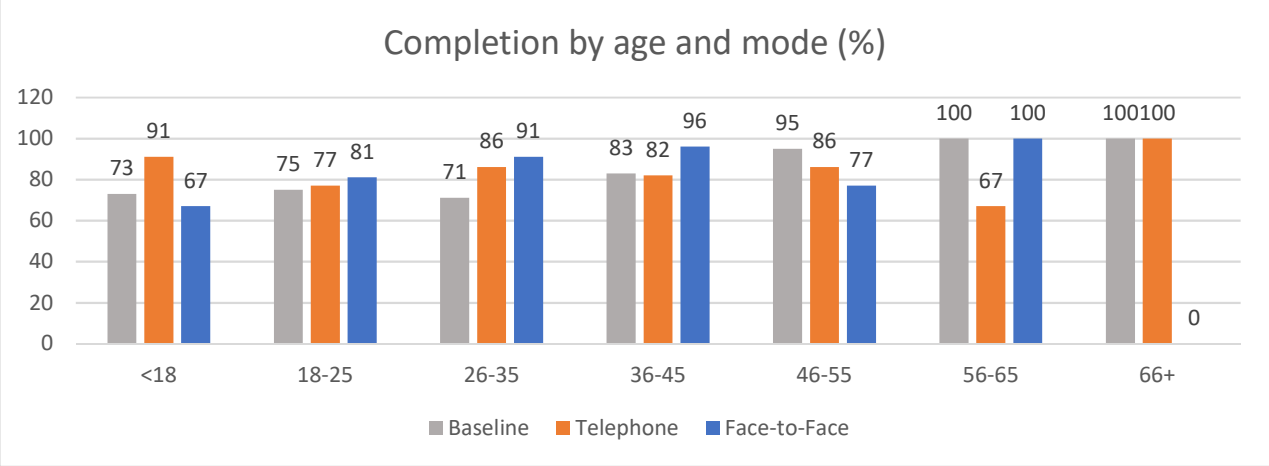
Figure 4.



Age

Completion was higher for F2F appointments compared to telephone for people aged between 18 and 45 years. However, telephone completion was higher for people under 18 years of age and between 46 and 55 years of age (see Figure 5).

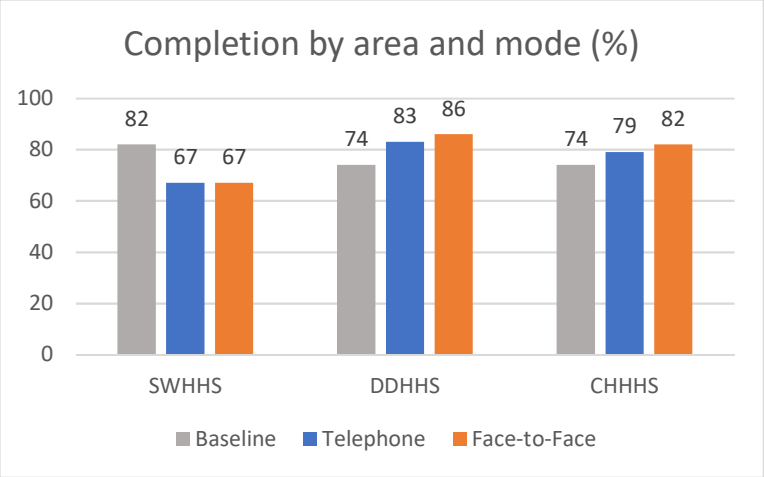
Figure 5.



Location

Program completion was higher in Cairns and Hinterland HHS and Darling Downs HHS t compared to baseline but lower in South West HHS. Program completion was similar between modes across all locations. (see Figure 6).

Figure 6.



Appointment Availability

Appointments Offered

The total number of appointments offered (appointment slots available for the DCS to schedule a session) at the commencement, mid-point and end of the trial was greater than baseline for Darling Downs HHS and Cairns and Hinterland HHS. Due to staffing issues, South West HHS offered less appointments at the commencement, mid-point and end of the trial compared to baseline (see Table 2).

Due to staffing vacancies at Darling Downs HHS, no appointments were offered in Murgon, Kingaroy and Nanango from 11 September 2018 onwards. These vacancies have since been filled.

Table 2. Appointments Offered by HHS catchment (point in time)

	South West	Cairns and Hinterland	Darling Downs
Baseline	134	518	185
Trial Commencement	121	836	228
Mid-point	121	767	233
End of Trial	115	760	266

N.B This number is not the number of appointments that were filled, only appointment spots offered.

Wait time

Between baseline and the end of the trial, the average appointment wait time (combined modality) differed between locations. Specifically, there was no difference in average combined wait time for Cairns and Hinterland HHS, an increase of one day in South West HHS and a decrease of six days in Darling Downs HHS area (see figures 7,8 and 9).

At the end of the trial, the wait time between a telephone and F2F appointment did not differ for Cairns

and Hinterland HHS, was one day less in Darling Downs HHS and three days less in South West HHS. This may have been impacted by the amount of appointments offered.

Rescheduled Appointments

During the baseline period 11% of scheduled appointments were rescheduled within the following twelve weeks. Of those appointments that were rescheduled, 79% were completed.

The reschedule rate was higher during the telephone trial period at 17%. The reschedule rate for telephone appointments was higher F2F appointments at 24% and 14% respectively. Of appointments that were rescheduled, the completion rate for F2F appointments (89%) was higher than telephone appointments (83%).

Feedback

Participant Feedback

Of 130 participants who completed a telephone session, 87 also answered a small number of questions at the end of the session (67%). Most respondents were male (58%) non-Indigenous (78%) and between 18 and 35 years of age (62%).

Most respondents reported that the option of a telephone appointment made it easier for them to complete the session rather than attending a F2F appointment (95%). The most common reasons were that telephone reduced the barrier of distance and transport (n=43), assisted with work/life balance including child care (n=32), made them feel more comfortable and was less confronting (n=19) and was cheaper (n=17). Mental health conditions (anxiety) (n=6), greater privacy and less embarrassment and stigma (n=5) were also cited. Two respondents reported that telephone did not make it easier to complete as they were happy to complete in either modality or were not given the choice of F2F participation.

Most participants reported they would not change anything about the telephone trial process (n=82). Of the five respondents who stated they would change the process of completing a telephone session, one participant indicated there was a lack of flexibility with phoning to confirm the appointment time. Specifically, this participant reported that they contacted the service provider too early (17 minutes prior to commencement of the session instead of 10 minutes prior to the session) and was told to call back 10 minutes prior to the session to confirm their contact number. The other participant was not given the option of a F2F appointment by the referrer despite living in a location near service providers. This indicates that further communication to police and court officers is required to ensure that both options are provided (subject to state-wide rollout). Additionally, where a decision is made not to offer F2F or telephone appointments, the reason should be communicated and discussed with the client.

Three participants provided feedback on the diversion program and process as a whole. This included offering appointments outside business hours, providing follow-up sessions, and offering appointments within a two-week timeframe.

Almost all respondents would recommend telephone participation to others (99%).

Service Provider Feedback

Service providers were supportive of the telephone sessions being offered in addition to F2F sessions. Telephone delivery was identified as a good option for clients who have difficulty accessing services due to transport issues, mental health issues or work and life demands, and for clients who live or work in other areas of Queensland, interstate or internationally. Telephone delivery was acknowledged as more cost and time efficient for services who are required to travel long distances to deliver F2F sessions.

Services also reported that it was easier to schedule staff to telephone appointments as the counsellor is not required to be in the same location as the client. This is particularly beneficial in regional areas where staff recruitment and retention is more difficult.

Service providers reflected on their experiences delivering telephone and F2F sessions. Generally, services thought some clients engaged better and disclosed more over the phone as it was less confronting, while other clients could have been more distracted on the telephone and may perceive telephone intervention as less serious than an intervention delivered F2F, however client's perspectives on this were not sought.

Clinicians who had more experience with delivering telephone interventions (separate to the trial) were more supportive of telephone delivery. Some clinicians thought F2F interventions were more effective as it is easier to establish rapport and identify areas for further exploration through non-verbal communication. It was also reported that telephone sessions were sometimes shorter in duration than F2F sessions and this may be due to the lack of non-verbal communication cues.

All services indicated that telephone delivery is not suitable for complex clients and clients with moderate-to-severe dependence. A couple of services thought that telephone delivery was less beneficial than F2F delivery for young clients as engaging young people effectively in early intervention programs is important in changing their behaviour before potential progression to more problematic use.

Although service providers found the process of telephone delivery mostly seamless, some issues were identified. Specifically, one AOD service was not allocated any telephone appointments in the first half of the trial despite referrals for telephone appointments in this HHS area. This was due to clients being scheduled to the next available appointment within the catchment (to another provider). To mitigate this a business rule was implemented whereby, appointments were scheduled to the nearest provider involved in the trial, unless there is greater than a 14-day appointment wait time. This process aligns with the scheduling processes for F2F appointments. After implementing the business rule, the impacted service provider received telephone appointments.

Further, although telephone reception was not recorded as an issue on the Advice of Attendance forms, this was reported by one provider for some participants. All other services reported there were no issues with reception. One service noted the need for a dedicated telephone line to ensure clients calling to confirm their diversion appointments would be able to reach the service. These issues will need to be considered further should the option of telephone delivery be expanded state wide.

Service providers found the information contained in the Police and Court Diversion Service Provider Manual useful and adequately provided information on the processes, some clinicians suggested it would be helpful to include tips on delivering phone based interventions.

The DSC reported spending considerable time communicating with service providers about their appointment schedules. Specifically, exploring whether services could offer additional telephone appointments to maximize the benefits of less travel or offering an appointment in either mode. The DCS also reported that police officers from areas in the state that were not part of the trail had been inquiring about scheduling telephone appointments.

All services were supportive of expanding the option of telephone delivery state-wide, however, a variety of issues were identified for further consideration. Specifically, one service had provided the DCS with a phone line that was also utilised by other clients of their service. This service stated if this option was to expand state-wide and if the service was expected to continue to deliver telephone based sessions, a dedicated phone line would be required. This would ensure all clients calling to confirm their session are able to reach the service. A few services suggested that specific training for counsellors would be helpful in supporting services to delivery telephone sessions. A couple of services expressed that it is difficult to make referrals to services outside of their area and that a database of service providers

across the state would be helpful.

Finally, some services suggested that a centralised state-wide model for telephone delivery would have some benefits. For example, a centralised model would remove the need to upskill staff across multiple services and would streamline appointment scheduling, data and reporting for telephone appointments.