"... it gave me the oomph to go and do it ...
or I'd still be sitting in the house 24/7"

COMMUNITY CONNECTIONS PROGRAM

Evaluation report

Prepared by CSI Flinders

August 2022

CENTRE for SOCIAL IMPACT
Flinders UNIVERSITY

Acknowledgements

The authors would like to acknowledge all of the Community Connections Program clients and partners who volunteered their time to contribute to this study. The authors would also like to thank the Department of Human Services project team members who partnered with us to undertake this evaluation.

Acknowledgement of Country

Flinders University was established on the lands of the Kaurna nation. Flinders University acknowledges the Traditional Owners and Custodians, both past and present, of the various locations the University operates on, and recognises their continued relationship and responsibility to these lands and waters.

For further information

Professor Svetlana Bogomolova
Deputy Director, CSI Flinders University
T: +61 8 83012527
E: Svetlana.Bogomolova@flinders.edu.au

Suggested citation

Bogomolova S, Eyers-White D, Tan PJ, Jardine B, Mackenzie C, and Goodwin-Smith I (2022). "… it gave me the oomph to go and do it … or I'd still be sitting in the house 24/7." Community Connections Program. Evaluation Report. Centre for Social Impact, Flinders University. Adelaide.

DOI: https://doi.org/10.25957/erhg-k132

Executive summary

This report presents an independent evaluation of The Community Connections Program (CCP) administered by the Department of Human Services (DHS) South Australia. CCP funds 34 government and non-government partner organisations in 12 State Government Regions to deliver short-term programs and services to support people to increase independence by building connections with communities, social networks, and services.

The objective of this evaluation is to assess the effectiveness and outcomes of the early stages of implementation of CCP (nine months into the program) to inform improvements and recommissioning of CCP post June 2023. The evaluation covers data from partners' quarterly reports (covering the period from the 1st of July 2021 to the 31st of March 2022), qualitative data from focus groups with partners and participants (separately), and R2D2 quantitative data as of the 3rd of June 2022 from 1013 program participants (195 finished the program) and 1740 referral experiences.

The following summary and recommendations were developed by the CSI Flinders research team based on the primary and secondary data collected for the purposes of this evaluation, and broader observations of the sector response to the CCP model in the context of other DHS reform processes.

Program outcomes

CCP achieved significant positive client outcomes in the first 9 months of operation. Pre-post data comparisons showed substantial improvements in participants' quality of life, independence, social engagement, mental health and other client outcomes. Loneliness significantly reduced, and participants reported that the program made a significant positive impact on their lives. Three quarters of participants made progress in achieving their goals and, of those, one quarter fully achieved their goals.

Overall, participants were highly satisfied with CCP and how the program (and staff) assisted them to connect to services, systems, and other people. Participants noted that CCP staff were empathetic and offered immediate emotional support, guided them on their journeys, and listened to their needs.

Recommendation 1: We recommend continuing the program and extending the funding, ideally for 3+3+3 years. This funding will provide stability for partners to build long-term collaborations within CCP, recruit, train and retain good staff and volunteers and build awareness and trust amongst their communities (which takes time and consistent presence).

A shift towards collaboration and outcomes

CCP has led the way as the first program to pioneer the implementation of the DHS Social Impact Framework (SIF), focussing on client outcomes and collaboration between service providers.

Nine months into the new program, there was variability in how CCP partners viewed the program. Some service providers embraced opportunities to find creative and collaborative solutions to each client's challenge, leveraging each other's strength, knowledge, and resources through warm referrals. The broader sector now refers to the 'CCP way of doing things' to describe innovative client-centred solutions, and 'CCP graduates' for CCP staff who gained new skills through CCP Capacity Building trainings and collaborative program practice. These trainings, Communities of Practice and the Partner Forum have been cited as the most successful and instrumental elements of the program. On the other hand, some partners reported struggling with some aspects of the program. Below, we outline where work is needed on specific aspects of CCP to either finetune the program design or to bring all CCP partners on board with the possibilities built into the program.

Variability in complexity of CCP participants' circumstances – the data and partner feedback indicated a great amount of variability in the level of complexity in CCP participants' circumstances (from a very simple case of someone who just needed a little nudge to re-engage with existing social networks, to a very complex set of circumstances including severe and acute life events such as suicide attempts, death in the family, or palliative care). This variability is the result of the 'no wrong door' policy and very wide eligibility criteria, which on the one the hand performed a unique and important social function of not leaving anyone on the street, picking up all people who would otherwise fall through the cracks of all other services. On the other hand, it presented challenges to CCP staff who were often not trained accordingly and therefore at higher risk of burnout or vicarious trauma.

Recommendation 2: We recommend exploring variability in participant complexity to identify ways to effectively and efficiently separate out participants with complex needs from participants with simpler needs. It is possible that there are cohorts of participants with complex medical needs for whom a completely different pathway, or even program, is needed. The idea of a very brief triage at the entry point (without the need to do a full entry questionnaire) was suggested by some partners as a potential solution. An important aspect here is establishing effective referral pathways for complex participant cases – non-responsiveness and lack of capacity of internal and external health and disability providers have been cited as 'bottle necks' in participants' pathways.

Collaboration structure and clarity of roles – CCP presents a new form of working within the human services sector through collaboration and sharing, rather than competition. Naturally, only nine months on, there were examples of very successful partnerships and alliances in some regions, while other regions struggled with understanding each other's roles and responsibilities. The role of Regional Coordinating Partner was discussed as being critical for CCP, yet there were varying views about its hierarchical position. The role of the Care Partner was also quite different to the rest of the partners, with unique challenges associated with complexity and the case management approach to their participants.

Recommendation 3: We recommend revisiting the structure of CCP in close consultation with all CCP partners to collectively agree on hierarchical or flat structure, a delineation of roles, responsibilities (particularly the roles of the Regional Coordinating and Care Partners), and resource allocation that best suits the CCP and South Australian context. The academic literature and practice around the world point to a continuum of possibilities about how program governance could be structured – from the informal leadership role of a backbone coordinator, while maintaining flat organisational structure, to a more hierarchical facilitating partner model where some resource allocation and management responsibility is delegated to facilitating partners.

Program flexibility – while a lot of flexibility (compared to past human services programs) had already been built into CCP, some partners continued to call for more flexibility to meet unique participant needs. A lot of partner comments focused on the nominal 12 weeks length of the program. While the CCP guidelines allow program extension, and indeed some partners used that option (the average length of the program was 18 weeks as shown in this report), some partners still needed reinforcement of this message and possibility. Another comment, coming from participants and partners, was that the abrupt end of the service stirred some negative emotions and separation anxiety once participants' interaction with CCP staff ceased. Some staff took the private initiative to make follow up calls to clients. Another aspect of CCP, the flexible funding, also received mixed feedback. Some partners embraced the opportunity, while others struggled with the lack of guidance. The amount of staff time and effort required to secure the small amount of funds was highlighted as a challenge by some partners.

Recommendation 4: We recommend developing clearer communication to partners and participants (to set their expectations) around the program length flexibility. Furthermore, explore how a gentler phasing out could be built into the program. Similarly, regarding flexible funding, we recommend engaging with partners to find mutual agreement around appropriate funding allocations for flexible funding that would justify the

effort of applying for it. There is also an opportunity through communities of practice or trainings to share successful and creative examples of flexible funding use.

Data collection, analysis, sharing and reporting – in partner focus groups and quarterly data, we observed a degree of confusion among CCP staff about guidelines for data collection. Many partners complained about the excessive burden that the entry and exit questionnaires put on staff and on participants, especially those with complex needs and compromised socio-cognitive skills. Reviewing these data against the CCP guidelines and CCP management commentary, it was evident that not all CCP partner staff understood the built-in flexibility in data collection and room for their judgement call for the level of data collection appropriate for each client and their circumstances. Additional challenges were expressed by some partners around unnecessary duplication of data entry. Some partners had to enter information about the same client three times – for their own data management system, for the DHS/R2D2, and for the DSS system. Care Partners struggled with the lack of a case management function which would suit the nature of their services and participants.

Recommendation 5: We recommend developing clearer communication to all partner staff around the guidelines for data collection, and client-centred flexibility built into these processes. Consider doing a refresher of a specialised training through capacity building partners to assist in dissemination of that information and help upskill staff, particularly new staff – data can be a challenging topic for many. We also recommend revisiting the data collection tools to ensure only essential data are being collected. The same suggestion applies to quarterly reports – some partners suggested replacing open-ended data collection (which takes time and effort), with closed-form questions and shorter specific narratives.

Recruitment and marketing – attracting participants, especially from CaLD and Aboriginal communities, was a challenge for some partners. Low program awareness, lack of program marketing and clarity about its main messages were cited as the main barriers. Furthermore, partners discussed challenges around working with CaLD and Aboriginal communities (separately), for whom mainstream marketing was unlikely to work. Partners suggested that other recruitment and communication strategies were needed, including building relationships with leaders in those communities and finding culturally appropriate messages, ways to engage with those participants, and potentially even different ways of delivering the program (to cater for collective vs individualistic cultures in the local communities, and ways they approach the issues of social exclusion and loneliness).

Recommendation 6: We recommend exploring CCP partners' needs for more participant recruitment support and offering additional training on how to adapt CCP design and messaging to the needs and circumstances of local communities. A particular attention has to be given to developing strategies for engaging and delivering the program to CaLD and Aboriginal participants in culturally appropriate and localised ways. Existing and new (e.g. Aboriginal Partner) Capacity Building Partners could facilitate the development of stronger cultural competencies for CCP partners at multiple levels: from tailoring program design to specific cultural conventions, to ensuring that program recruitment, messaging and delivery is culturally appropriate.

Collaboration between CCP and external programs – partners cited a lack of harmonisation and collaboration between CCP and many 'external' (state and federally funded) programs and providers, where participants 'fell through the cracks' of different programs and different eligibility criteria or experienced a 'bottle neck' upon referral from CCP. The most common example was around gaining acceptance into NDIS (some participants were rejected up to eight times). The federal system offered little support during the application process, while demanding a lot from potential clients in terms of their time, cognitive effort, systems knowledge, and even costs (for health assessments, paperwork etc.) – resources that CCP participants typically lacked. CCP partners expressed confusion over what their role was in that process; some partners enquired whether they could help participants with the NDIS application process.

Recommendation 7: We recommend exploring ways to improve collaboration between CCP and external state and federally funded programs, to allow the sector to facilitate more streamlined client journeys, particularly around NDIS and mental health services – the most common challenges for CCP participants. Clearer communication around the role of CCP staff in the NDIS eligibility assessment process is needed.

Unmet needs and under-serviced groups – some partners and participants identified services that they were not able to adequately refer to or access due to the lack of community assets in their regions. The most cited were the needs around specific services for youth, men, CaLD communities, and transport in regional areas.

Recommendation 8: We recommend engaging with CCP partners to identify ways of responding to these unmet needs collectively and creatively. Improved information sharing about services and community assets that already exist, co-development of assets through collaboration with external partners and programs, using flexible funding, or advocating collectively about addressing a gap in the sector are potential solutions. Awareness of, and specific focus on, the under-serviced target groups during Communities of Practice meetings, Partner Forums or training sessions could also assist in building targeted capacity for the whole sector.

Contents

Tables

Figures

Acronyms

AQoL	Assessment of Quality of Life
CaLD	Culturally and linguistically diverse
CCP	Community Connections Program
CSI	Centre for Social Impact
DE	Development Education
DHS	Department of Human Services of South Australia
DSS	Department of Social Services (federal)
FG	Focus group
HACC	Home and Community Care
ID	Identification
KEQ	Key Evaluation Questions
NDIS	National Disability Insurance Scheme
NHMRC	National Health and Medical Research Council
QR	Quarterly report
R2D2	Results reporting data dock
RCP	Regional Coordinating Partner
RDNS	Royal District Nursing Service
SA	South Australia
SPSS	Statistical Product and Service Solutions

Introduction

The objective of this evaluation is to assess the effectiveness, efficiency, outcomes, and sustainability of the early stages of implementation of the new Community Connections Program (CCP).

CCP is administered by the South Australian Department of Human Services (DHS). The program is funded for development phases until 30 June 2023. During this time, the program delivery model is expected to evolve as evidence of emerging needs is collected, feedback from participants and partners is gathered, and understandings of possible issues or limitations in the program are understood, including through this evaluation.

Background to the Community Connections Program

The Community Connections Program (CCP) operates within the context of a broader system of community and health services funded by the Australian Government, State Government, local government, and community-level initiatives.

The introduction of the Commonwealth's National Disability Insurance Scheme (NDIS), My Aged Care, and the Carer Gateway necessitated the reform of the historical Home and Community Care (HACC) program to create a new, more contemporary program that better reflects the current environment and community needs in South Australia.

Providers reported a continuing service gap for people who are not eligible for NDIS or aged care support, with the greatest common risk factor being social isolation and disconnection from support. This finding aligns with research stating that the common thread of social isolation and disconnection from communities cuts across and underpins a range of social and health issues.

There is overwhelming evidence that participation in social activities, belonging to community groups, and making meaningful connections with others beyond the home, all play a critical role in better health outcomes, improved general wellbeing, and an increased sense of purpose (Holt-Lunstad 2018; Mackenzie, Louth & Goodwin-Smith 2019; Milton et al. 2012). For people involved in caring for their loved ones, these connections are vital to enable them to continue in their caring role for as long as possible and to maintain a good quality of life (for example, see Mohanty et al. 2020). Therefore, connecting people to communities, social networks and services is central to the CCP model.

Target population and timeline

CCP supports people aged 18 to 64 years (or up to 49 years for Aboriginal people) living in South Australia, whose independence and quality of life is at risk because they are disconnected from necessary support and face heightened vulnerability due to social isolation.

CCP was launched in July 2021 and is funded for developmental phases until 30 June 2023. The initial stages allow for the establishment of the program delivery model, and for evidence to be collated to estimate the potential future participant base and emerging needs.

The developmental phases include:

1. Establishment of services, including supporting participants transitioning from the previous HACC program.
2. Development of the regional coordinated place-based response.

DHS intends to continue funding CCP beyond these phases, as the program evolves.

Delivery model

CCP supports its target population by funding government and non-government partner organisations in each of the 12 State Government Regions to deliver short-term programs and services. The aim is to achieve the key objective of *"supporting people to increase independence by building connections with communities, social networks and services"*.

CCP is delivered by a range of organisations across three main partner types:

- Regional Coordinating Partners
- Care Partners
- Community Partners

Additionally, the following partners play a unique role in achieving the objectives of the CCP by utilising their specific expertise and community connections:

- Aboriginal Organisation Partners
- Multicultural Coordinating Partner
- Carer Support Partners
- Capacity Building Partner

Program outcomes

CCP has a Theory of Change for each of the two levels at which it operates: participant level and system level. Each level has its own objectives and outcomes, as presented below. The external evaluation assesses the performance of the CCP at both levels.

Participant level Theory of Change

The CCP aims to achieve measurable outcomes for its participants, in line with the Theory of Change illustrated in Figure 1.

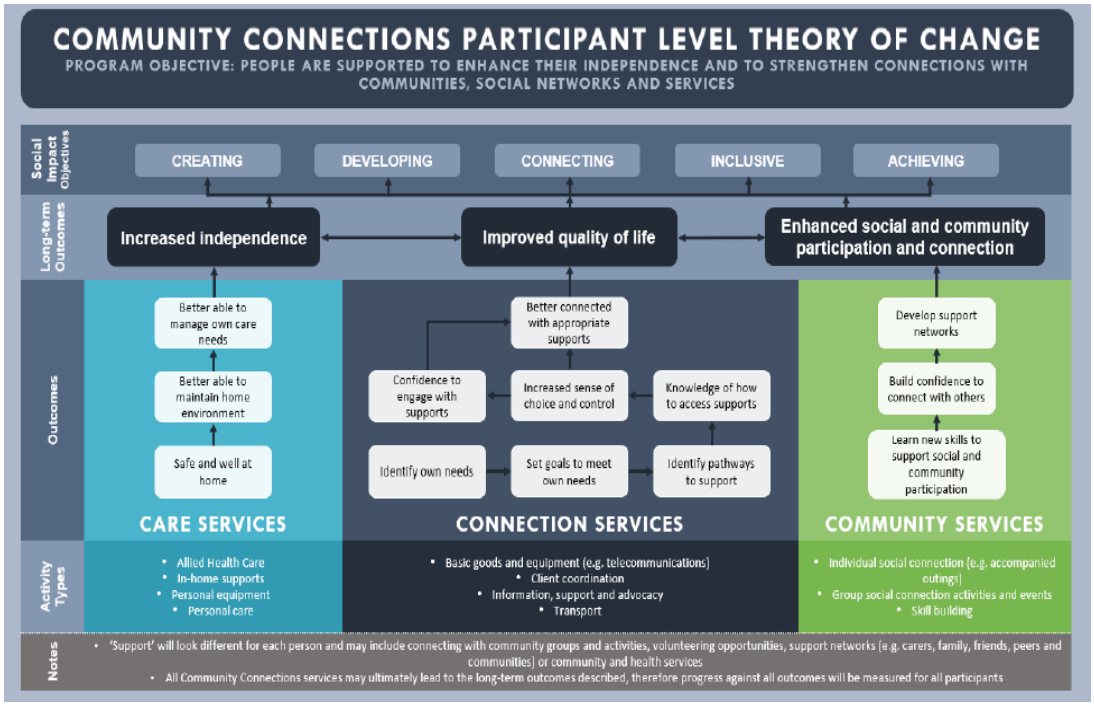

Figure 1. Participant Level Theory of Change

System level Theory of Change

The CCP seeks to accomplish the system level outcomes as outlined in the Theory of Change (Figure 2).

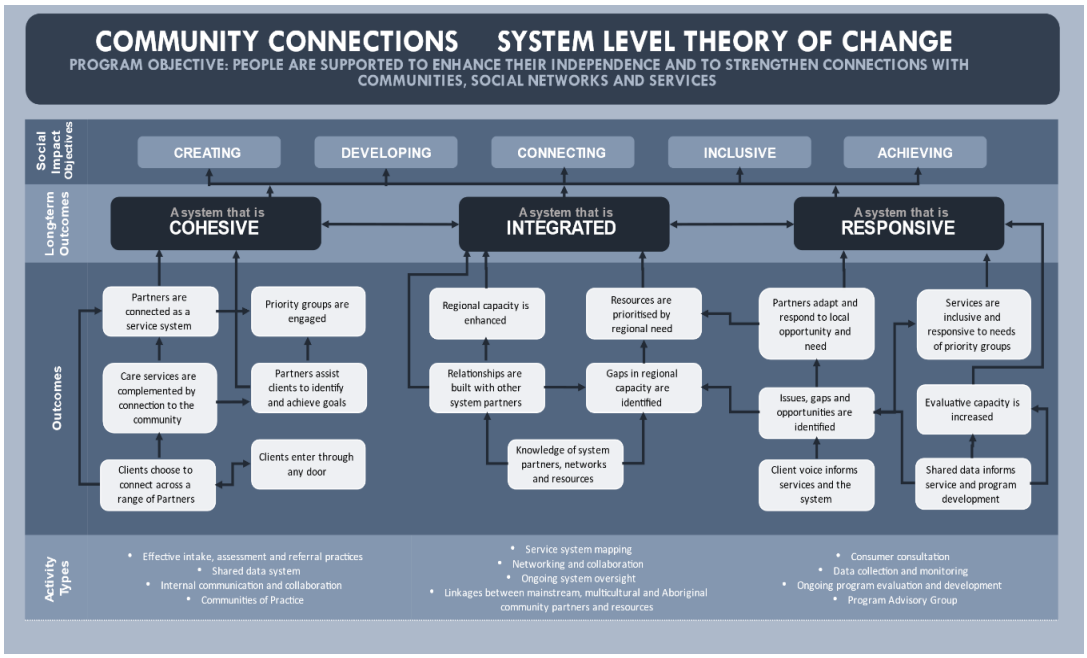

Figure 2: System Level Theory of Change

Background to the evaluation

CCP aims to mitigate the effects of social isolation amongst the South Australian population. During the developmental stages of the program, it was expected that the CCP would require modifications to incorporate emergent needs and respond to feedback from participants and partners. Therefore, a Developmental Evaluation (DE) method is used, because the CCP is a new program being developed over time and with the evaluators as part of the project development team (Patton 1994; 2021). DE is "particularly well suited to evaluating innovative programs in their earliest stages of development and adapting existing programs to complex or changing environments" (Fagen et al. 2011: 645). The DE method is useful for collecting data during the initial phases of the execution of a new program to inform strategic decision making and innovation. Further, DE enables the identification of promising practices or services, allowing space for new and creative designs to emerge, testing a theory of change, and "incrementally improving a system to better serve those in need" (Patton 2021: 31).

The DE of the CCP aims to:

- assess the effectiveness of the CCP implementation;
- evaluate the outcomes of the program;
- seek and analyse feedback provided by participants and partner across the 12 State Government Regions;
- identify challenges, gaps and/or opportunities for improvement.

Evaluation components

There are four components involved in evaluating the CCP. Each component is aligned to one of three Key Evaluation Questions (KEQs). The KEQs are answered by analysing data collected by DHS, and focus group data collected by the external evaluators (outlined above):

KEQ1. How much are we doing?

Component 1: Outputs – analysis of R2D2 data, including the participants' demographics, plus the type, quantity, and quality of activities and services being provided (i.e. number of participants, referrals, and placements).

KEQ2. How well are we doing it?

Component 2: Participant satisfaction – analysis of participant feedback on their experiences of being part of the CCP. This component also assesses the program's capacity to meet the participants' needs and their levels of satisfaction.

Component 3: Systems evaluation – analysis of the ways in which the different components of the program work together to achieve the outcomes outlined in the System Level Theory of Change (Figure 2). This part of the evaluation explores data collected in focus groups, annual performance reviews, quarterly submissions, and participant satisfaction. The aim is to appraise the relationships between partners – the dynamics, limitations, and potential they bring to the program – as well as the mechanisms they use to work together.

KEQ3. Is anyone better off?

Component 4: Outcome evaluation – analysis of data collected from a range of sources including R2D2, Participant Satisfaction, QoL (AQoL-6D), Campaign to End Loneliness Measurement Tool, and Practitioner Completed Post Service reports. This analysis examines the program's outcomes in the three aspects of participants' lives that are expected to change because of their participation in the CCP. Participant outcomes are explored across the following domains: level of independence; quality of life; social and community participation (see Figure 1).

Data collection tools

The following tools provided information on the relationships between the service providers and the participants, and between all the partners of CCP:

DHS tools and data:

- Intake and assessment form (included within the Minimum Dataset document)
- Post-service assessment form (included within the Minimum Dataset document)
- Participant satisfaction questionnaire (included within the Minimum Dataset document)
- Annual performance reviews and regular contract management meetings (recorded)
- Formal feedback, including that provided in quarterly Program Advisory Group meetings

External evaluator:

- Focus groups with partners (two rounds) and participants (one round)

Ethical considerations

The external evaluators sought ethics approval from a NHMRC approved social and behavioural human research ethics committee. Approval was granted to conduct secondary analysis of DHS-collected data, and undertake focus groups with partners and participants.

Analysis

Quantitative data/R2D2

The evaluators used IBM SPSS (Statistical Product and Service Solutions) to analyse the quantitative data using descriptive statistics. SPSS is a data analysis software program that provides a wide range of statistical analyses commonly used in social science research and evaluation (Ho 2017).

Quantitative data came from different data sources, collected at different time points in the program, which resulted in different sample sizes in different sections. Additionally, there were several consent questions which guided the decision of which participant data could or could not be included in the analysis. Full details about consent question responses are in Appendix B.

The data were extracted by the R2D2 supplier on the 3rd of June 2022. The data contained n=1013 unique participants who enrolled in CCP, n=1740 referral experiences (that is, the same participant could be receiving multiple referral services by different providers), and n=195 completed participant placements and all associated 'exit' questionnaires.

A separate dataset completed by partner staff on behalf of participants (placement outcome and goals progress) contained data on n=422 placements. Full partner type split is shown in Appendix C.

These data source details and associated filters and sample sizes are presented in Table 1: Quantitative data scope, filters, and sample sizes.

Client outcomes data (n=195) are based on completed participant placements. Most of these participants (73%) received services from Community Partners, therefore the data might skew towards these types of services. Full partner type split is shown in Appendix C.

The evaluators also noted a small amount of 'missing' eligibility data due to referrals being back-dated to previous reporting periods, and subsequently submitted with no assessments attached. The evaluators recommend a thorough 'clean up' of the data (follow up on missing data) to be included in the next step of in evaluation in June 2023.

Table 1: Quantitative data scope, filters, and sample sizes

	Demographics Program-wide	Demographics Split by Streams	Client outcome	Placement outcome Program-wide	Placement outcome Split by Streams
Sample size	1013	1740	195	422	422
Filter	Global ID: first unique only Consent filter: none Placement filter: none	Global ID: none Consent filter: none Placement filter: none	Consent v1= yes Consent v2= yes Placement filter: none	Q36 Reason for placement closure = all, excluding 'Placement created in error' Placement filter = closed	Q36 Reason for placement closure = all, excluding 'Placement created in error' Placement filter = closed
Split by	Whole sample	Group 1: Care Partner (n=313) **VS.** Group 2: Carer Breaks + Carer Support Partners (n=202) **VS.** Group 3: Community Partner + Regional Coordinating Partner (n=310) **VS.** Group 4: blanks (i.e. External - Non CCP Funded Referral) (n=188)		Whole sample	Group 1: Care Partner (n=128) **VS.** Group 2: Carer Breaks + Carer Support Partners + Community Partner + Regional Coordinating Partner (n=294)
Questions to base results on	Demographics (Page 3 of minimum data set): Q3, Q4, Q9, Q10, Q11 Eligibility and Priority access (Page4): Q14 to Q24	Demographics (Page3): Q3, Q4, Q9, Q10, Q11 Eligibility and Priority access (Page4): Q14 to Q24	Campaign to end loneliness measurement tool (Page9) Quality of Life (Page10) Satisfaction (Page13): Q37 to Q40	Practitioner Assessment of Client Progress (Page14): Q41 to Q46	Practitioner Assessment of Client Progress (Page14): Q41 to Q46

Qualitative data

Qualitative data for the evaluation came from the following sources:

- qualitative data from eight focus groups with all types of CCP partners (n=44 partner staff), conducted in May-June 2022;
- qualitative data from four focus groups/in-depth interviews with CCP participants (n=8, six females, two males, a range of ages, representing southern (4) and northern (4) regions, and broad types of services received), conducted in the same time period;
- qualitative data from all partner type quarterly reports (containing n=741 paragraphs of unstructured text, covering three quarters and a reporting period from the 1st of July of 2021 to the 31st of March of 2022); and
- informal observations during CCP Partner Forum on the 12th of May 2022 (Aboriginal Partner forum is not included).

For the qualitative data analysis, the project team developed a coding framework based on the KEQs, the two Theory of Change models, and emergent themes. The external evaluators used the Framework Method of analysis (outlined above) (Ritchie et al., 2003). Framework entails a process of familiarisation, developing a thematic framework, indexing, charting, mapping, and interpretation. This method offers a useful way to systematically manage and interpret qualitative data, particularly for applied policy research.

Limitations

This evaluation had several limitations and suggestions for future actions:

1. Aboriginal focus was not explored in this evaluation because of the later start of Aboriginal partners –the next round of evaluation will focus on the needs of Aboriginal participants and partners specifically, in partnership with Aboriginal partner organisations.
2. There were eight CCP participants who attended focus groups/interviews. This sample size was due to challenges with recruitment, which relied on CCP partners to encourage participation. The next step of the evaluation should explore a different recruitment strategy to encourage stronger participant contribution.
3. Most of participants (73%) who completed the program and provided the outcome data received services from Community Partners, therefore the overall outcome data might skew towards these types of services.
4. Qualitative analysis of the data was not intended to be representative of the whole CCP population. These data are used to shed light into some aspects of the program and to gain deeper insights into the mechanisms through which the program is (or isn't) having an impact.
5. A small amount of eligibility data is missing due to referrals being backdated to previous reporting periods, and subsequently submitted with no assessments attached. This is what is referred to as “Missing Data” throughout the report.
6. This report, particularly its quantitative part, is a snapshot at particular a time. Since CCP continues, there are new participants joining and completing the program weekly, which means the results, including outcomes data is constantly evolving.

Findings

Key findings are arranged and presented in this section according to the following four evaluation questions:

- *KEQ1. How much are we doing?*
- *KEQ2.1 How well are we doing it? (participant satisfaction)*
- *KEQ2.2 How well are we doing it? (systems evaluation)*
- *KEQ3. Is anyone better off?*

KEQ 1. How much are we doing?

Component 1: from R2D2 data

Referral analysis

As of June 2022, 1013 unique participants had started the program, and 1740 referrals had been activated (some referrals were done more than once for the same participant). Table 2 shows the split of referrals received across types of partners.

Table 2: Number of referrals received per partner type

	Frequency	Percent (%)
Community Partner	458	26
Care Partner	398	23
Carer Breaks	142	8
Carer Support Partner	143	8
Regional Coordinating Partner	113	6
External - Non CCP Funded Referral	486	28
Total	1740	100

No filter, n= 1740 referrals.

The partners that received the most referrals were Community (458 referrals) and Care (398 referrals), as indicated in Table 2.

Most participants (68%) had only one referral within CCP, further 15% had two referrals, and 17% had three or more referrals.

Table 3: Internal and external CCP referrals received

	Internal Funded Referral[a] %	External CCP Funded Referral[b]
Care Partner	36	21
Community Partner	30	55
Carer Breaks	13	7
Carer Support Partner	13	6
Regional Coordinating Partner	8	11
Total	100	100

Total sample size = 1254 (which excludes external non-CCP funded referrals). No filters. a n= 932, b n= 322

Of external Non-CCP funded referrals, the most common were referral to social or community support (17%), mental health (11%), health (8%), financial (8%), and NDIS (7%) services (Table 4).

Table 4: External Non-CCP funded referrals

	Frequency* (n)	Percent (%)
Social or community support**	144	17
Other	106	12
Mental health	98	11
Health	70	8
Financial	66	8
NDIS	64	7
Community Passenger Networks	53	6
Housing	48	6
Educational	48	5
Employment	30	3
Disability non NDIS	30	3
Child and family services	27	3
Legal	24	3
My Aged Care	24	3
Carer Gateway	20	2
Centrelink	14	2
Drug and alcohol	4	1
Total	870	100

n= 486. Filter: Stream = External Non-CCP Funded Referrals.
**Total frequency is higher than sample size as this is a multiple response question.*
***This response option was not added until Q3*

Placement analysis

This section describes data on placements. As of June 2022, there were a total of 422 closed and completed placements (Table 5).

Table 5: Placement status

	Frequency (n)	Percent (%)
Closed/completed	422	36
Closed due to error	28	2
In Progress	350	30
Expired	233	20
Waitlisted	144	12
Rejected	2	0.2
Total	**1179**	**100**

n=1179, the number of placements does not equal the number of referrals by design. For example, external non-CCP referrals are recorded for reporting purposes only and therefore do not result in a CCP placement.

The completed placements were split across partner types as follows.

Table 6: Partner type split for placement outcomes and goal progress data

Partners	Frequency	Percent (%)
Community Partner	229	54
Care Partner	128	30
Carer Support Partner	34	8.1
Regional Coordinating Partner	27	6.4
Carer Breaks	4	0.9
Total	**422**	**100**

n=422 closed placements

The most prevalent placements were with Community Partners (54%), followed by Care Partners (30%).

In terms of duration, on average, a CCP placement lasted 130 days (Std. Deviation is 64 days), which is about 18 weeks (Table 7).

Table 7: Duration of placement

Partners	Average duration (days)	Std. Deviation (days)
Carer Support Partner	192	78
Care Partner	165	76
Regional Coordinating Partner	115	53
Community Partner	105	50
Carer Breaks	102	9
Total	**130**	**64**

n=422 closed placements

The duration varied across partner types, with Carer Support Partner placements being the longest (on average 192 days), while Carer Breaks and Community Partner had the shortest placement duration (on average 102 and 105 days respectively).

Comparing connection, community, and care services

Another way that CCP services data were collected in R2D2 data was through three service categories, being connection, community, and care services, shown in Table 8. Connection Services are delivered by all CCP Partners, whereas Care Services are only delivered by Care Partners and Community Services may be delivered by Community Partners and Carer Support Partners.

The data show services received, not just requested, by participants who have completed their placements.

Table 8: Number of services delivered by service category

	Frequency* (n)	Percent (%)
Connection Services	626	40
Community Services	559	35
Care Services	399	25

n=422 completed placements; the total is higher because of muti-service use

Connection services were most popular (40%), followed by Community services (35%) and Care services (25%), as indicated in Table 8.

Overall, 12% of the participants used only one service, 33% used two services, 34% used three services and 21% used more than four services.

Looking at specific sub-services within each of the three types of services, Table 9 shows the percentage of all completed placements that received specific Care sub-services.

Table 9: Specific Care services

	Percent (%)		
	Yes	No	Total
In-home support	25	75	100
Allied Health Care (home)	24	76	100
Personal equipment for increased independence	19	81	100
Allied Health Care (centre)	12	88	100
Home modifications	9	91	100
Personal care	5	95	100

n=422 completed placements

The most common **care** services were: in-home support (25% of all completed placements), allied health care at home (24%), personal equipment to increase independence (19%), followed by allied health care in the centre (12%), home modifications (9%), and personal care (5%).

The percentage of all completed placements that received specific sub-services for Community services were as follows (Table 10).

Table 10: Specific Community services

	Percent (%)		
	Yes	No	Total
Social connection (individual)	51	49	100
Social connection (group)	41	59	100
Skill building	41	59	100

n=422 completed placements

The most common **community** sub-services were at the individual level (51%), followed by social connection in a group (41%) and skill building (41%).

The percentage of all completed placements that received specific sub-services for Connection services were as follows (Table 11).

Table 11: Specific Connection services

	Percent (%)		
	Yes	No	Total
Information and connection to support	70	30	100
Client coordination	50	50	100
Transport	19	81	100
Basic personal equipment for increased connection	9	91	100

n=422 completed placements

The most popular Connection services were information and connection to support (70%), followed by client coordination (50%), transport (19%), and basic personal equipment of connection (9%).

Participant profile – whole program

This section presents the demographics profile of all participants who were assessed for eligibility and then received a referral (including external non CCP funded referrals, including those who were assessed as ineligible for CCP). For the demographics profile split by partner stream, see Appendix A.

The age profile of participants was spread, with the majority (65%) being in the age group 45-64 year olds, as shown in Figure 3.

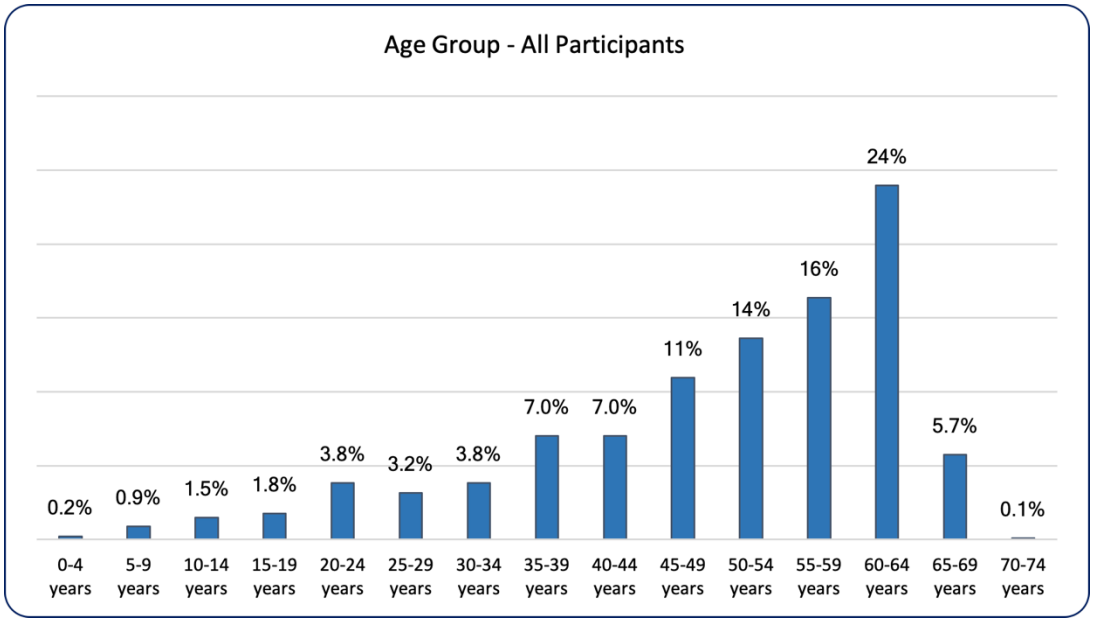

Figure 3: Age profile of all persons assessed

The gender profile (Figure 4) shows that 63% of participants were female, 35% male, and 0.7% gender diverse.

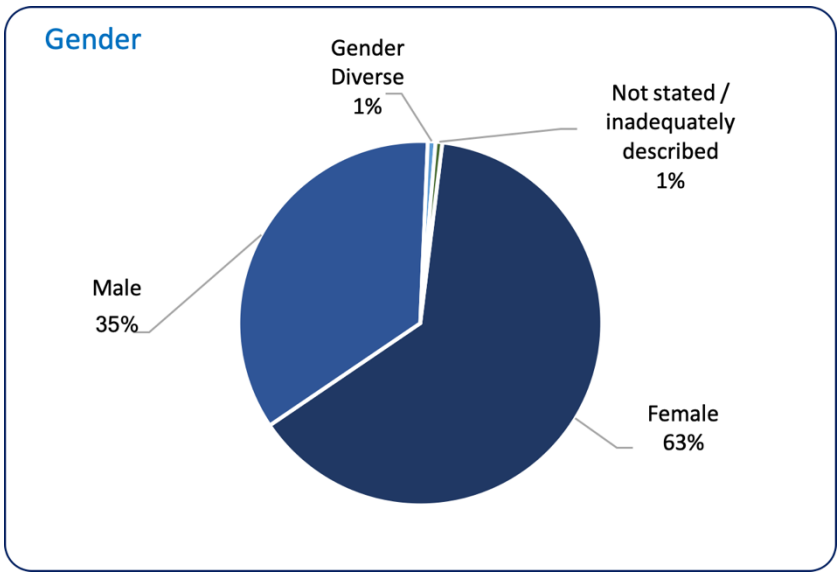

Figure 4: Gender profile of all persons assessed

Looking at Aboriginal status, 5.4% identified as Aboriginal and/or Torres Strait Islanders (Figure 5)

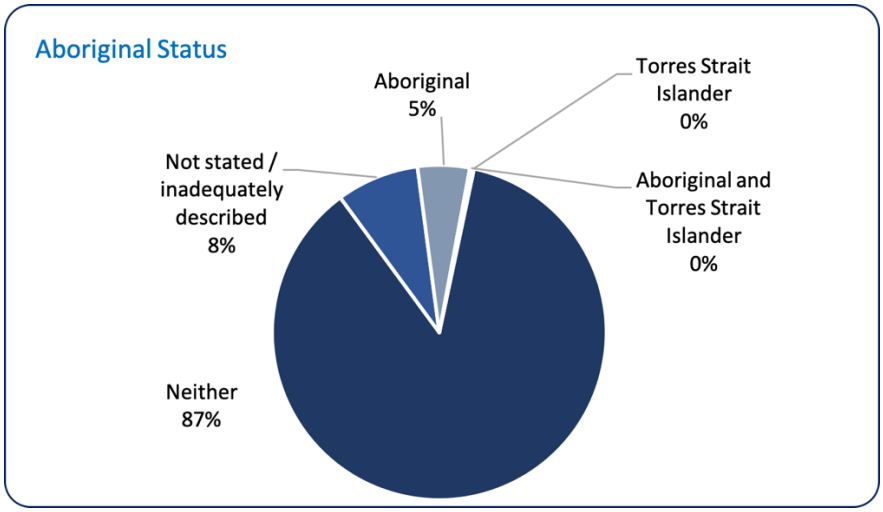

Figure 5: Aboriginal status of all persons assessed

In addition, 10% of participants identified as having a CaLD status, as shown in Figure 6. Of those, half arrived at Australia in the last ten years.

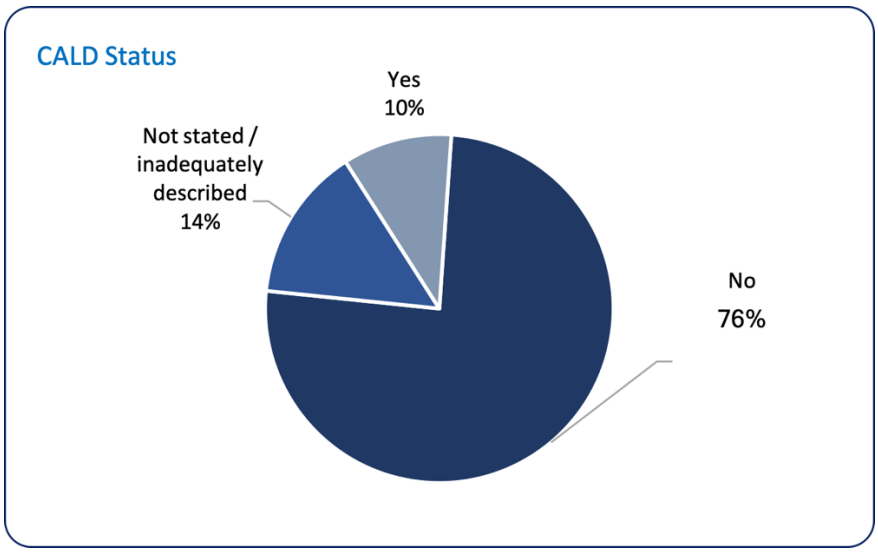

Figure 6: CaLD status of all persons assessed

Regarding disability status, 29% had diagnosed disability, 7% undiagnosed, and 11% both (diagnosed and undiagnosed); so the total proportion of people with any form of disability was 47%. 29% did not have a disability, 24% did not state (Figure 7). While 60% were not eligible for NDIS, the rest were in different stages of NDIS eligibility progress or investigation.

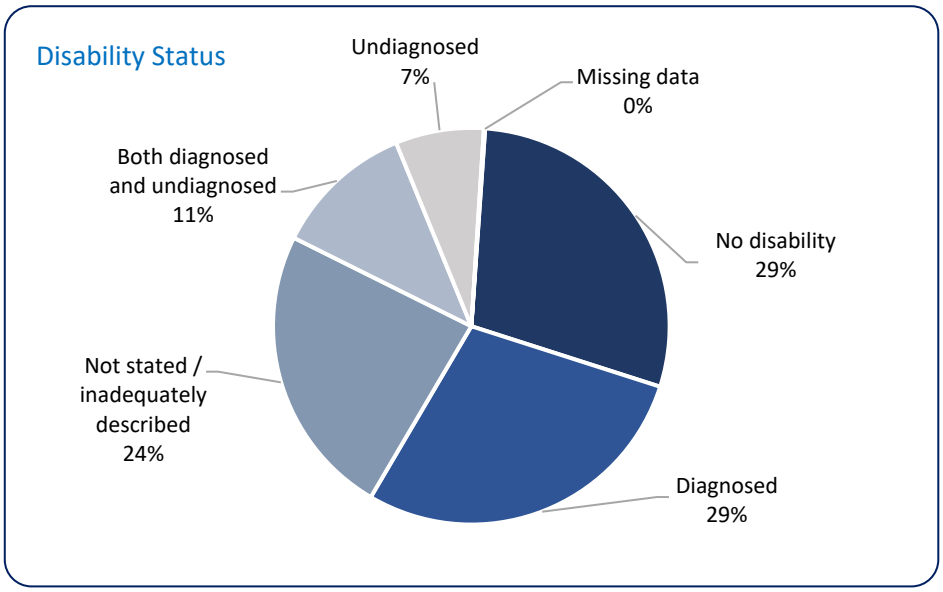

Figure 7: Disability status of all persons assessed

Diagnosed chronic illness was reported by 33%, a further 4% reported undiagnosed chronic illness, and 11% had both (diagnosed and non-diagnosed), so the total proportion of people with any form of chronic illness was 48%, as shown in Figure 8.

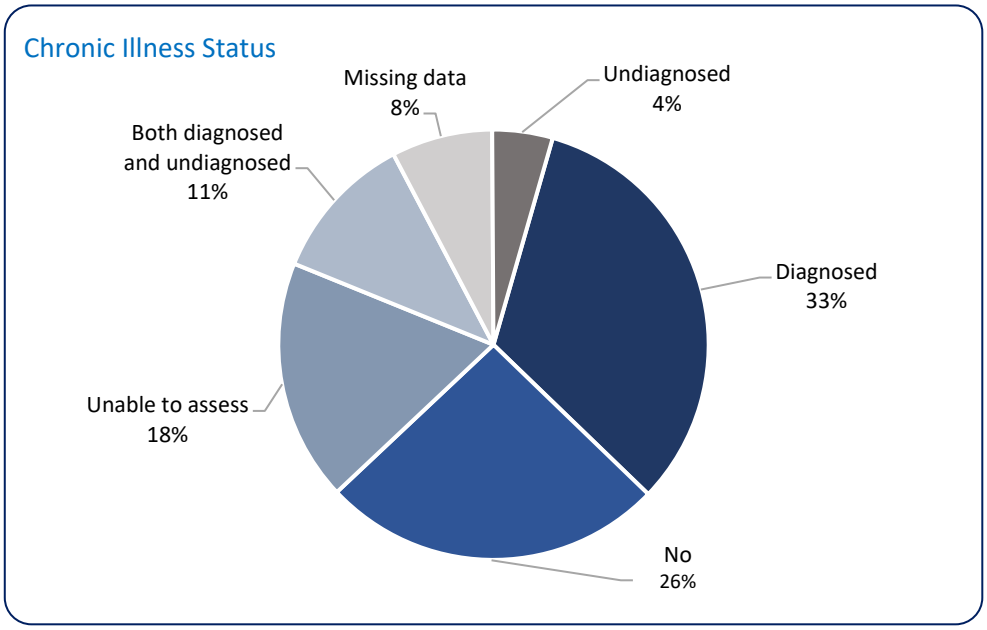

Figure 8: Chronic illness status of all persons assessed

Further, mental illness was reported by 33% (diagnosed), a further 11% reported undiagnosed mental illness, and 9% had both (diagnosed and undiagnosed), so the total proportion of people with any form of mental illness was 53% (Figure 9).

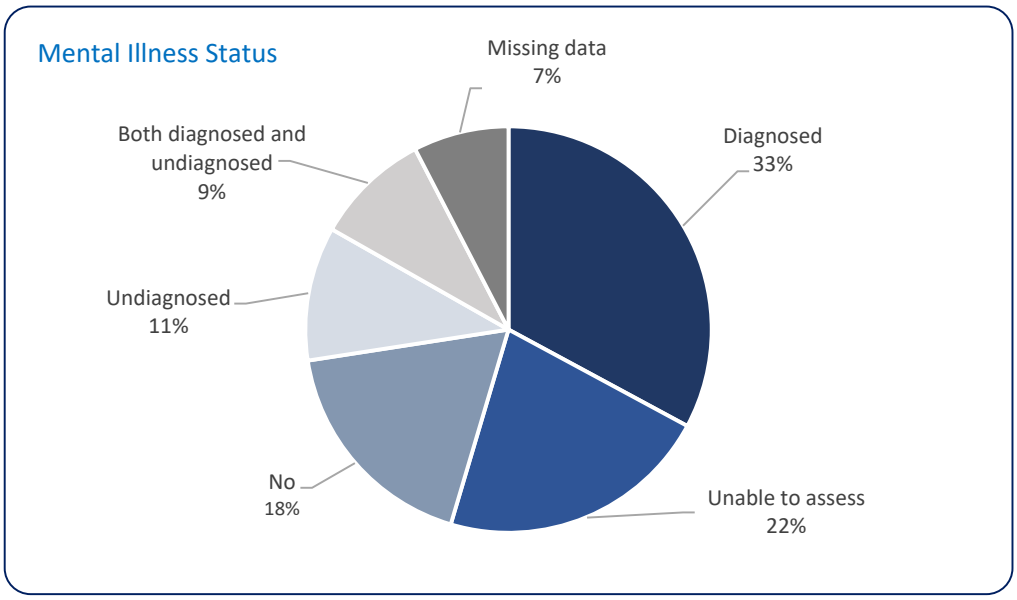

Figure 9: Mental illness status of all persons assessed

Regarding carer status, 27% of participants were carers providing unpaid care and assistance to a person with disability, chronic illness, or mental illness; of those 62% were connected with Carer Gateway. Further 12% reported that they had a carer.

Most participants experienced some form of financial disadvantage. The most common circumstances were unemployment (31%), healthcare card (28%), mortgage/rental stress or at risk (8%).

Table 12: Is the client experiencing financial disadvantage?

	Frequency* (n)	Percent (%)
Unemployed	395	31
Has a healthcare card	354	28
Mortgage and or rental stress	103	8
Accommodation at risk	82	7
Issues with utilities or essential services	79	6
Personal financial crisis	76	6
Debt	75	6
Spending behaviour or money management issues	51	4
Underemployed	39	3
Gambling	7	1
Total	1261	100

n=1013 participants; the total count is higher than the sample size as this was a multiple-response question (non-mandatory)

Additional demographic data revealed that predominant living arrangements were living with others (50%) and living alone (29%). People who had formally transitioned to CCP from the former HACC program formed 16% of CCP participants.

Participant profile – split by partner types

A more detailed analysis was conducted to compare participant profile data across different types of partners. Due to small sample sizes, some partner types were combined. The full results are in Appendix A. This section of the report presents a high-level narrative summary of key differences.

Generally, Community and Regional Coordinating Partner participants were similar to the external non-CCP funded referral participants. Care and Carer Breaks/Support Partner participants had notable differences.

The age profile was broadly similar across all partners, except for Care Partners who had more older participants (65% in the age 55-69).

Gender profile was similar across most partners. However, Carer Breaks/Support had a lot more females with 73% vs 60% in Community and 65% in Care Partners. Gender diverse participants formed just under 1% across all CCP partners, and slightly more (1.6%) in external non-CCP referrals.

Aboriginal and Torres Strait Islander participants were more diverse across partners. The highest proportion was in Carer Breaks/Support at 8.4%, followed by 6.2% in Community, and 2.3% in Care. External non-CCP funded referrals were at 6.5%.

CaLD status was much higher in Community at 14% and external referrals at 13%, compared to Care with 6.3% and Carer Breaks/Support at 6.7%.

As expected, disability status was quite diverse across different types of partners. Carer Breaks/Support had the highest proportion of participants *without* disability (51% compared to 24% in external referrals, 27% in Community, and only 13% in Care). Importantly, the high proportion of not stated/inadequately described responses in disability, NDIS and some other questions, plus 'missing data', calls for the need to verify and clean the data as much as possible at the individual participant level. Table 13 shows disability status by partner types.

Table 13: Disability status by partner types

	Care Partner (%)	Carer Breaks, Support Partner (%)	Community Partner, RCP (%)	External Non-CCP Funded Referrals (%)
Disability (diagnosed + undiagnosed + both)	48	34	60	63
Not stated / inadequately described	39	15	12	12
No disability	13	51	27	24
Missing data	0	0	1	1
Total	100	100	100	100

NDIS eligibility was diverse across partners, with more Care Partner participants being at different stages of NDIS eligibility journeys, as demonstrated in Table 14.

Table 14: Is the participant eligible for NDIS?

	Care Partner (%)	Carer Breaks, Support Partner (%)	Community Partner, RCP (%)	External Non-CCP Funded Referrals (%)
No	43	80	57	56
Unable to assess	20	5	9	7
Missing data	15	4	1	1
NDIS eligibility to be explored	13	9	26	31
NDIS application in progress	9	1	7	4
Currently receiving NDIS support	0	1	0	1
Total	100	100	100	100

Eligibility for Community Connections was very similar across Carer, Community, and external non-CPP funded partners (~95%), yet only 68% in Care Partner participants.

Chronic illness status was quite diverse across partners. In addition, a very high proportion of 'missing data' and 'unable to assess' responses were reported, as shown in Table 15.

Table 15: Does the participant have a chronic illness?

	Care Partner (%)	Carer Breaks, Support Partner (%)	Community Partner, RCP (%)	External Non-CCP Funded Referrals (%)
Chronic illness (diagnosed + undiagnosed + both)	48	44	61	62
No chronic illness	6	45	28	29
Unable to assess	31	7	10	7
Missing data	15	4	1	2
Total	100	100	100	100

Table 16 shows that Community Partners and external non-CCP funded referrals reported a higher proportion of participants with diagnosed mental health conditions (nearly half of participants). Care Partners had reported a lower proportion of diagnosed mental health, yet a very high amount of missing data ('unable to assess') at 41%.

Table 16: Does the client experience mental illness?

	Care Partner (%)	Carer Breaks, Support Partner (%)	Community Partner, RCP (%)	External Non-CCP Funded Referrals (%)
Mental illness (diagnosed + undiagnosed + both)	30	48	78	78
No mental illness	14	38	10	13
Unable to assess	41	10	10	7
Missing data	15	4	2	2
Total	100	100	100	100

Regarding carer status, expectedly, Carer Breaks/Support Partner had the highest percentage of participants who were unpaid carers (90%), compared with other partners. 64% of Carer Breaks/Support participants were connected to Carer Gateway.

Table 17: Is the client a carer providing unpaid care?

	Care Partner (%)	Carer Breaks, Support Partner (%)	Community Partner, RCP (%)	External Non-CCP Funded Referrals (%)
No	48	4.9	73	79
Unable to assess	32	1.8	7.9	4.5
Missing data	15	3.5	1.4	1.6
Yes	4.5	90	18	15
Total	100	100	100	100

No filter

Conversely, Care participants had the highest percentage of participants who received support from a carer (15%), compared to 2-3% in all other groups.

Table 18 demonstrates most prevalent forms of financial disadvantage, being unemployment, healthcare card, mortgage/rent stress and debt.

Table 18: Is the client experiencing financial disadvantage?

	Care Partner (%)	Carer Breaks, Support Partner (%)	Community Partner, RCP (%)	External Non-CCP Funded Referrals (%)
Unemployed	35	21	32	33
Has a healthcare card	32	27	28	29
Mortgage and or rental stress	8	13	7	7
Debt	6	6	6	7
Personal financial crisis	6	6	7	6
Accommodation at risk	4	6	8	7
Issues with utilities or essential services	4	11	4	5
Spending behaviour or money	3	3	5	4
Underemployed	1	8	2	2
Gambling	0	0	1	0
Total	100	100	100	100

Table 19 shows that living arrangements varied across partners. Within Care Partner, the distribution was evenly spread among options. Community/RCP and externally funded referrals had the highest proportion of participants that live alone (46% and 48% respectively). As expected, Carer Breaks/Support had the highest proportion of participants that live with others (89%).

Table 19: What is the client's usual living arrangement?

	Care Partner (%)	Carer Breaks, Support Partner (%)	Community Partner, RCP (%)	External Non-CCP Funded Referrals (%)
Lives with others	29	89	48	45
Unable to assess	29	3	4	5
Lives alone	27	4	46	48
Missing data	15	4	2	2
Total	100	100	100	100

HACC transition status was the highest at Care Partners (34%), compared to about 10% in all other partners.

Summary KEQ1. How much are we doing?

As of June 2022, 1013 participants engaged with the program, and 1740 referrals had been activated. Most participants (68%) had only one referral within CCP, further 15% had two referrals, and 17% had three or more referrals.

The two partner types that received the most referrals were Community and Care Partners. For external non-CCP funded referrals, the most common referrals were for services related to social or community support (17%), mental health (11%), health (8%), financial (8%), and NDIS (7%) services.

The most common **care** services delivered were in-home support, allied health care at home, and personal equipment to increase independence. The most common **community** services were individual social connection support, followed by group social connection, and skill building. The most popular **connection** services were information and connection support, followed by client coordination. Average program duration was approximately 18 weeks (130 days).

Participant profile

The **age** profile of participants was spread, with the majority (65%) in the age group 45-64 years old; 63% of participants were females, 35% males, and 0.7% **gender** diverse. Looking at **Aboriginal** status, 5.4% identified as Aboriginal and/or Torres Strait Islander. 10% identified as having a CaLD status (of those, half had arrived in Australia in the last ten years). Importantly, it is acknowledged that the Aboriginal component of the CCP service ecosystem is still largely under development and was not the focus on this evaluation. A separate evaluation of the Aboriginal component will be undertaken in partnership with Aboriginal Partner organisations.

For **disability** status, a total of 47% program participants had some form of disability (29% had diagnosed disability, 7% undiagnosed, and 11% reported both (diagnosed and undiagnosed disabilities). Further, 29% of participants did not have a disability, and 24% did not state their status. Regarding **NDIS**, 60% of participants were not eligible for NDIS and the remainder were in various stages of eligibility progress or investigation. Some form of **chronic illness** was reported by a total of 48% of participants (33% diagnosed, 4% undiagnosed, and 11% reported both). **Mental health** conditions were reported by a total of 53% of participants (33% diagnosed), 11% undiagnosed, and 9% reported both).

For **carer** status, 27% of participants were carers providing unpaid care and assistance to a person with disability, chronic illness, or a mental health condition, with 62% of those connected with the Commonwealth Carer Gateway. 12% of CCP participants had a carer.

Most participants experienced some form of **financial** disadvantage. Common examples/indicators were unemployment, healthcare card, mortgage/rental stress or at risk, utility bill stress, and issues with debt. Participants who had transitioned from the former Home and Community Care (**HACC)** program formed 16% of CCP participants.

KEQ 2.1 How well are we doing it? (participant satisfaction)

Component 2: from participant satisfaction survey and participant focus groups/interviews

The data from participant focus groups showed that CCP had a unique role. CCP was able to help people who would otherwise "*fall through the cracks*" of all other programs due to its very broad eligibility criteria and the 'no wrong door' policy. The flexibility of entry criteria resulted in a very diverse profile of CCP participants. Some cases were very complex, with multiple needs (including chronic or acute mental and physical health needs, or even palliative care). These participants were often not ready for social connection. Other participants presented simpler cases and worked well within the program's current scope.

Connecting people to community

CCP's main function was of wayfinding – connecting participants to services, programs, and communities in a supportive and empathetic manner, and immediately improving their social connection through relationships with partner staff – "*someone cares about what happens to me*".

Participants reported that partner staff helped explore opportunities and activities of interest, looking for the right fit. Many participants reported not being able to find or think of activities that suited them on their own, or not being in the right headspace to start looking for them. CCP was beneficial in helping participants find these activities.

> *"CCP has given me direction and avenues to go. I want to volunteer. When you've been isolated for a long time, you think up lots of reasons not to go out." (FG11)*

One participant was not interested in any of the activities suggested by his support worker, until the worker introduced him to a men's group which he then started attending each fortnight. The involvement with this group encouraged him to connect with his neighbour, and they started attending the group together.

Building self-esteem was important for participants, which was often boosted by having someone (CCP staff) to talk to in a supportive environment – this was valuable in itself, beyond any other CCP functions.

> *"[a staff member] just was a nice person and happy to listen to me and I don't recall the last time I remember that happening." (FG10)*

> *"When you've had such a trauma, it is very hard to get back into a community type setting, so having someone to hold your hand is important." (FG1)*

Connecting people to services

Some participants had severe health issues and CCP staff helped to link them to the services they needed, such as physiotherapy or home modifications (e.g., wheelchair access and safety devices installed, decluttering), or transportation to activities/services. CCP also helped bridge the gap between services, for example after exiting a mental health facility and not knowing where to get help next. Some participants knew what they needed in terms of services, but had trouble connecting, especially after being isolated for long periods.

> *"He's shown me different things and who to go and see [RDNS]. I now have physio help. If it wasn't for CCP, I'd still be sitting in the house 24/7 without any help whatsoever." (FG10, care participant)*

However, some participants still required more care after the program ended yet could not access services or transportation needed to attend or participate.

> *"I am not able to continue what I've just gone through, which was amazing. It was an eye opener but until I get on NDIS, I have no way of continuing." (FG11)*

> *"I went to all these places which was lovely, but I can't go back, because I can't get there. So, I've seen the light but can't go any further with it." (FG11)*

Relational, 'human', dimension of the service

The relational, 'human', dimension of the service was critical. Participants reported that partner staff were empathetic and that they greatly appreciated them. Participants felt supported, cared about, and had real connections with their partner staff. Relationships were built quickly. Common themes were that participants felt they mattered, were listened to. For most participants, relationship building and 'being listened to' was an important, and rare, occurrence.

> *"It's been a long time since I'd been listened to properly or even sat and thought about myself or my needs for a long time before that." (FG10, carer participant)*

> *"It has extended my life. I was feeling very low, and not much to live for, so that's given me more purpose." (FG11)*

Hand holding support/person-centred support

Partner staff offered tools for self-support, empowerment, confidence building, and encouragement to make contacts for themselves (i.e. 'social muscle building').

> *"She held my hand and helped me get out of my comfort zone. She found events, and was there to support me, pre-and post. Now I can go to events for the first time which I haven't been able to do over the past year." (FG5)*

> *"The support worker helped me create an online support group. I now know I want to be an advocate for women who are housebound. CCP gave me confidence to do that." (FG11)*

Partner staff brainstormed possible ideas for social connections or activities the participant might be interested in (e.g., hobbies) and accompanied them or gave them reassurance to participate – particularly those participants with social anxiety. Being the 'plus one' person until participants felt they were emotionally strong enough to engage on their own was valuable, as was the follow-up/debrief after events. The social connection to community was a useful addition to one participant's life, which she felt had been missing in the mental health landscape.

> *"I want to get back in the same program [computing], because I was enjoying it. And if I didn't do it, we wouldn't be talking now because they taught me how to do video chats and stuff like that". (FG1)*

Length of program and post-program reconnection/sense of loss

Focus group data shows that not all partners and participants were aware of the opportunities built into the program to extend its duration based on participants' needs. As a result, the data captured a lot of dissatisfaction with the 12-week length of the program, and its abrupt stopping.

Participants experienced feelings of loss at the end of the program, after having built such close relationships with staff. Some partner staff followed up with participants after the program ended, although this was done on an ad hoc basis.

> *"There's a relationship built that then abruptly comes to an end. It's short, it just stops, and it's rushed." (FG10)*

> *"You're left in a bit of a limbo. OK I had help, so where do I go from here?" (FG11)*

> *Your carer stops coming to see you. It's like a void. You need something that's continuous. Not every day of the week but another person to talk to." (FG10)*

Disruptions such as COVID, Christmas and illness cut into participants' program time, often leaving them half-finished or the goals they set for themselves at the commencement of the program were not achieved. One participant was uncomfortable leaving the house during a COVID scare because her health would have been compromised. Consequently, the program finished before she could participate.

> *"COVID really ate into my time, in the end I didn't get to do anything. It should have been suspended." (FG11)*

Many of the life stories that participants shared were very personal. Participants felt they would not have revealed their stories so early, however because of the limited timeframe, people opened up very quickly and were left vulnerable at the end of the program.

> *"It can be difficult to open up to people constantly. You see a professional, then they change or something else changes. You share with them and then that connection is gone. It makes you feel like not opening up so much." (FG10)*

Participants enjoyed the social inclusion and activities experienced during CCP. However, because there was no continuing support after completing the program, some felt they reverted to the same state they had been in prior to the program. Indeed sustaining new behaviours is one of the most challenging aspects of programs.

> *"CCP helped me so much, but because of my disabilities, after the program I went from Yay to Nay, because I couldn't continue due to health restrictions." (FG11)*

> *"It was an eye opener but until I get on NDIS, I have no way of continuing with what I have just done." (FG11)*

Gaps in services: a lack of programs in local area, and for younger people

Participants identified several gaps in services that they were not able to connect to, even with the help of CCP partner staff. This was a unique outcome of CCP, that highlighted to participants and their support staff what services are lacking in the sector and their regions. For example, there was a lack of services suitable for the 18-30 age bracket. Participants and staff also reported a lack of programs in local areas to connect to the community, particularly those from minority groups such as LGBTIQA+ communities and people with autism. For these reasons, participants and partner staff needed to look outside their local area to find peers and social connections.

> *"My support staff has been great. She has used all her resources, knowledge etc. to find out definitively that there is nothing. Without a doubt, there is nothing". (FG5)*

Transport to activities/services was also reported as an issue. Some activities/services were far out of the local region and meant that travel to these areas was difficult. Furthermore, it was harder for participants to form connections with peers when they lived in other regions.

> *"Sadly, there's not really a lot around my area. So consequently, I had to travel, which is hard sitting for long periods with my physical health issues." (FG1)*

> *"It was wonderful while it lasted, being connected to social things to get you out of the house, but now that it's finished, because of transport I can't continue." (FG11)*

The cost of transport – either public options or the price of fuel – was problematic and stopped participants continuing social activities after CCP finished.

> *"I achieved my goals but once it stopped a lot of them are not achievable because the outcome is that I can't get to a lot of these places when it was over." (FG11)*

NDIS

An important theme that emerged during CCP evaluation were the challenges with external to CCP services, that participants had difficulties accessing, often even with the help of CCP staff. One of those major challenges was access to NDIS.

The NDIS application process was considered very difficult; participants struggled with paperwork and the process in general. Many participants had been rejected by NDIS, although clearly required support from NDIS. CCP could help for a finite time, yet participants needed longer term care and financial support after the CCP program ended.

> *"They keep saying, go to the NDIS, but it's so hard to get into. 100 bits of paper you've got to deal with just for one doctor, then paperwork for the pain clinic, and all the other specialists. Just to get funding to go to a pool for my physio." (FG1)*

> *"I was supposed to get help to apply for the NDIS again, and basically all they wanted me to do was print out the form." (FG11)*

Awareness of the program/marketing

This theme was mainly discussed by partners (see the next section), as they were the ones who understood the mechanisms and challenges with participant recruitment.

Nevertheless, many participants who took part in focus groups confirmed that they were not aware of CCP services and found the program by accident. Some mentioned other people they knew who could have benefitted from the program, if only they knew about it. This led some to suggest that the program could benefit from better marketing and/or some outreach activities.

> *"It's really hard when you don't know about the services that are available for you. People don't go to a service provider because they don't know they can get help." (FG11)*

Participant satisfaction – scale questions

Data from R2D2 showed that participants who completed the program (n=195) reported high levels of satisfaction with CCP:

- 87% agreed the service listened and understood their issues;
- 84% agreed they were satisfied with the services received;
- 78% reported being involved in choosing the service they received;
- 57% agreed they were now better able to deal with issues they had sought help with, and a further 24% said they 'tend to agree'.

Almost none of the participants 'disagreed' or 'tended to disagree' with these statements, as indicated in Figure 10.

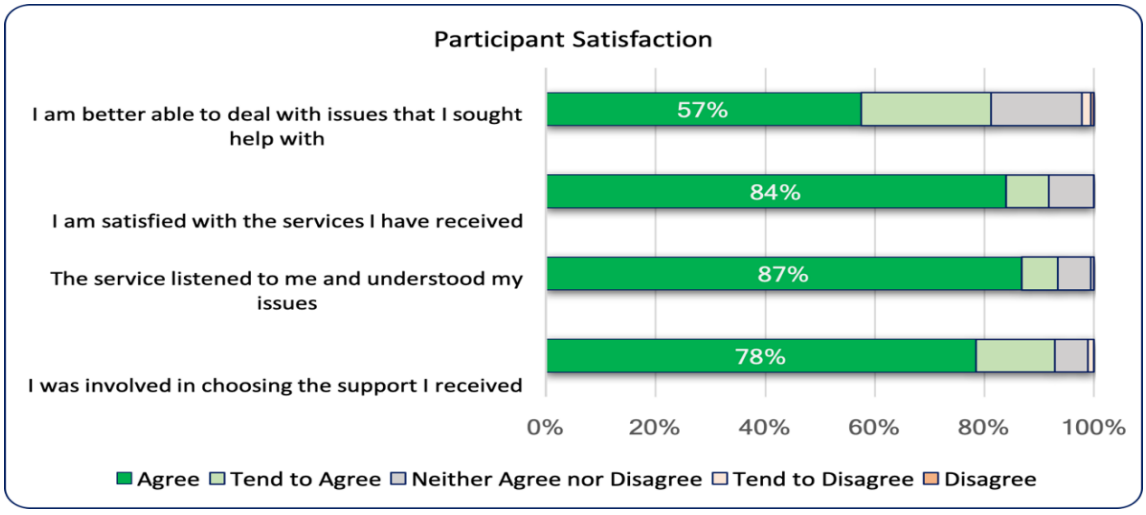

Figure 10: Participant satisfaction with CCP (n=195)

Summary KEQ 2.1 How well are we doing it? (participant satisfaction)

Overall, participants were highly satisfied with CCP and how the program (and staff) assisted them to connect to services, systems, and other people. Participants noted that CCP staff were empathetic and offered immediate emotional support, guided them on their own journey, and listened to their needs.

KEQ 2.2 How well are we doing it? (systems evaluation)

This section covers data from CCP partners, collected in focus groups, qualitative quarterly reports and during DHS CCP forum observations. This systems evaluation section is organised according to three focus areas, investigating CCP's effectiveness as **a cohesive system**, **an integrated system**, and **a responsive system**, plus an evaluation of **data collection**.

Component 3: from partner focus groups, partner quarterly submissions, and scale questions

A cohesive system

Overall, in line with the System Level Theory of Change, most partners reported being able to work as a coherent CCP eco-system. Some partners noted that this was one of the first, if not the only, government program that encouraged collaboration rather than competition across the sector – *"it is not OK to not work together"*. This was an important and very positive aspect of the CCP design according to partners.

Overall, partners were satisfied with the program. The program was flexible enough to really meet client's needs. There were aspects of the program that needed improvement (see below).

Collaboration

CCP was viewed by partners as innovative in that it encouraged collaboration rather than competition between agencies (across regions and across partner types, especially Care vs Community). In doing so, CCP was facilitating a major cultural shift in the whole human services sector. CCP acted as a role model for effectively working together across partners and regions – this was viewed as a unique and major strength of CCP. Partners reported a feeling of a cultural shift of working together, being part of a wider team, and knowing that there was a wealth of knowledge amongst those teams.

> *"Working with our partners has been a phenomenal experience, sharing and not being precious about funding. Quite rare from other programs I have been in." (FG4)*

> *"In this program, what's not tolerated is not working together. It wouldn't be OK to not work together, and people get that sense really quickly." (FG3)*

> *"The potential that we see is that this program has the potential to initiate a systemic change. I think it's quite innovative. I think it's a program that challenges the way we deliver our services." (FG3)*

Some regions began the program with an already collaborative system (either due to pre-CCP established relationships or a purposeful activity to map-out region's resources from the start of CCP). These regions reported positive feedback from Quarter 1 through to Quarter 3. Other regions experienced and reported early challenges, but also improvement over time.

> *"The challenge is that there are no rules and therefore, we're quite isolated from the other regions that we're not funded in. We don't really know how other people are doing it." (FG9)*

Some partners noted the CCP and DHS team's responsiveness and ability to listen and make changes in real time were unusual, and very welcome, aspects of a government program:

> *"I'm very grateful to the DHS that they gave us the space to explore alternatives, and I believe that's why I'm so passionate about it, that we can initiate this change." (FG3)*

> *"I came to this program because I saw potentially what it was going to do. And now I'm in the middle of it. It's like, wow, it's actually happening. You know, it's a real jolt." (FG3)*

> *"It's pretty amazing to see how we've all evolved over these past 11 months." (FG9)*

The Quarter 3 partner reporting tool contained a short quantitative component asking partners to indicate their responses to three questions, including in relation to their collaboration. The results showed that 24% of partners judged partner connection within CCP in their region as 'excellent', and a further 43% as 'good'.

CCP structure

Many partners were confused regarding 'who did what' within the program. Furthermore, information sharing was lacking in some regions. Some partners reported that there was no clear understanding of responsibilities plus there was a lack of transparency for every partner with DHS, particularly for RCPs. For some partners there was a feeling that information was filtered to one partner and not to all, leaving others in the dark. Some partners would like to see RCPs empowered with more authority and resources to enable their role.

> *"The RCP has no power whatsoever. It's like being a toothless watchdog." (FG2)*

> *"Bring some hierarchy, there will be a leadership role and somebody must take responsibility. It would be good to have some clarity." (FG7)*

Interestingly, there was frustration regarding the relationship, involvement, lack of communication, and connection between RCPs and partners in some regions. Some of this frustration was explained by the lack of resources given to RCPs.

> *"The need to coordinate with three different areas [three RCPs and three Community Partners] is onerous and time-consuming. Not enough funding to maintain those partnerships well." (FG4)*

> *"We want RCPs to come and sit with us regularly and just talk... what the issues are and find some solutions. Keep connection open." (FG6)*

Participant profile and eligibility criteria

The criteria for program eligibility were very broad. A key advantage of this circumstance was that it allowed the program to pick up people who had 'fallen through the cracks' of all other programs. Therefore, it was considered by partners as a unique and important strength of CCP.

> *"Ongoing tension between the 'no wrong door' policy and the fact that there is no other door for a lot of these people. (FG9)*

> *"So many gaps in services that even when we escalate particularly complex cases to DHS, they say 'we have a no wrong door policy'. The responsibility falls on us to help." (FG9)*

Due to the broad nature of eligibility criteria, the profile of CCP participants was extremely diverse, especially in relation to the sheer complexity of participants' needs. Partners overwhelmingly reported that complex cases presented challenges such as dealing with acute emergency situations (homelessness, financial struggles, severe mental health challenges, and significant physical challenges including palliative care). Many Community Partners stated they were not well equipped to assist with such cases.

> *"I was meeting this lady. Hours later, the stuff that I heard from her, I felt shell shocked. It was DV, prison, child abuse. I thought we were going to be researching craft groups...". (FG2)*

> *"They [clients] don't have capacity to meet or maybe even set goals appropriately or accordingly to the program, the complexities are massive." (FG9)*

Furthermore, the complexity of participants, coupled with a discrepancy between HACC expectations and what was offered through CCP, presented another challenge for partners. However, overtime, this challenge appeared to reduce in severity.

> *"Individuals with complex needs previously in HACC are unable to have their needs met due to the short timeframe of CCP and complex needs not being included within CCP parameters" (QR1).*

Capacity building

The role of Capacity Building Partners was paramount in facilitating a collaborative culture and teaching the skills of working together. Multicultural Coordinating Partner and Capacity Building Partner training received very positive reviews in terms of opportunities to acquire needed skills, as well as a forum for building collaborations, getting peer support, and learning best practice. Training worked best when group sessions had partners from different organisations, types, and regions. Capacity Building Partners were also a valuable ongoing feedback loop for DHS CCP management, because they heard how the program was progressing during the training sessions.

The CCP forum was very highly praised. The forum provided a great opportunity to hear examples of how the program worked in other areas, to find out what other partners were doing, and to interact with partners in other regions.

> *"This program has removed barriers [competition]. Some of us have seen it a lot sooner than others and it's bringing everybody else on that journey with us." (FG3)*

> *"People have not had the skill or lost the skill of networking. They forgot how to do it because the competition between organisations and funding has siloed everyone dramatically." (FG3)*

Additional training that some staff found or suggested as being useful were:

- Emergency mental health
- Financial resilience/money basics
- Community capacity building
- Multicultural training
- Aboriginal cultural safety
- Accidental counselling
- Personal wellbeing (how to avoid staff burnout, vicarious trauma)

An integrated system

Collaborations outside CCP

Partners reported that CCP participants needed assistance and referrals outside CCP to both NDIS and mental health services, plus to other services. The NDIS eligibility and application process was particularly challenging for many participants. The significant organisational and administrative burdens of the process, plus a lack of participants' psycho-social skills or financial resources (e.g., for medical specialist appointments) were key barriers for participants. Furthermore, some CCP partners believed they were not allowed to assist participants to apply for NDIS or lacked knowledge of the process themselves.

Partners reported a very high prevalence of mental health conditions, often acute and emergency (e.g., suicide attempt, grief over family member loss). Some partners did not have the skills to address the needs of such participants, and referrals were often delayed due to long waiting lists.

> *"The on-going trend is the enormity of challenging mental health issues. The health system is completely inundated and incredibly short staffed. Referring a participant can be weeks and weeks until they can get an appointment and sadly at times this is simply too late." (QR3)*

The prevalence of mental health issues was partly due to external providers referring to CCP simply because they did not know where else to refer people they discharged.

> *"[External] mental health providers exit people because they've done their period and needing to find something for them, but the client is not at that point for CCP." (FG2)*

In the Quarter 3 partner reports, connection with systems outside of CCP was judged as 'excellent' by 4%, and as 'good' by 65% of partners (65% was a lower score compared to collaborations within CCP – refer to collaboration within CCP section above).

Some service providers at capacity

Many referral organisations, such as RDNS, mental health, and other were reported being at capacity. Therefore, they were limited in their capacity to take on more cases. Importantly, it was noted that those organisations had multiple streams to cover (e.g., old HACC clients and external referrals) when they were already at capacity. Therefore, there were long waiting lists experienced across regions. Partners reported that they experienced immense frustration in trying to find alternative providers/programs.

Marketing of CCP

Some partners had successfully marketed CCP themselves.

> *"We've done a lot of promotion and networking as an organisation. Going out into regional communities to promote the program, being a presence in the region." (FG4)*

While other partners struggled with participant recruitment, citing lack of awareness in the community and lack of marketing of the program – '*there is no wrong door, but where is that door?*'. Many partners lacked skills in marketing the program and requested training and support. Equally, it was not clear whose responsibility it was to do marketing – DHS or partners?

> *"How do you access invisible populations?... would be better off going to the local pub and grabbing people who could make it to the office easily" (FG2)*

> *"We are really struggling getting participants. We've done a lot of advertising across the region, whether it's newspapers or Facebook pages." (FG4)*

> *"We're struggling to find where the isolated people are. There hasn't been much support promoting the program to our regions – getting it out there." (FG4)*

Similarly, many partners did not know what was locally available and/or what other CCP partners were offering both within and outside the program.

There was also no agreement on key messaging about the CCP that could be used in local marketing, although there was a desire for a common 'elevator pitch' and for a common understanding.

> *"When I talk to some community centres or other organisations, someone may have already spoken to them about CCP. But it's a very different message from what's delivering in the south rather than in the north etc." (FG3)*

> *"My first thing was OK, elevator pitch, what does it do? And everyone was 'it's kind of this thing' and it was never a clear answer." (FG3)*

> *"We made our own flyer. The DHS flyer is about helping support you in your home. Whereas for a Community Partner, we are supporting you outside your home." (FG4)*

Specific gaps in services

The following is a list of target groups for whom partner staff struggled to find suitable services:

- Young people
- Men
- People who can only attend after hours
- Aboriginal people
- CaLD groups in some regions.

A responsive system

The Quarter 3 partner reporting tool contained a short quantitative component asking partners to indicate their responses to three questions, including the extent to which issues, gaps, and opportunities are identified and responded to. The results showed that 7% believed that gaps and opportunities were identified and responded to 'excellently', 30% 'good', while 63% saw that as a 'developing' opportunity.

Length of the program

Length of the program attracted a lot of discussions. It was also evident that not many partners were aware that they could extend the length of the program to suit participants' needs.

Many partner staff suggested in focus groups that the 12-week timeframe was very restrictive for some participants. Some participants did not need that long, whereas others needed a lot longer than 12 weeks – especially those with chronic conditions.

> *"We service 89% CaLD communities. These people don't speak English and we need to do warm referrals. 12 weeks doesn't fit." (FG9)*

> *"There is going to be the cohort of individuals that are never going to be able to meet the goals of a short-term restorative reablement program. They will continue to fall through the gaps." (FG9)*

Partners reported that participants with complex needs often took time to build trust and share the extent of their problems with partners. These participants initially presented with simpler challenges, only to reveal underlying complex challenges weeks later once the trust was established.

> *"I can't in good conscience tell my staff to close, when someone is in the deepest dark part of their life." (FG9)*

Referrals, especially for care services, had long wait lists which did not fit within the 12-week timeframe:

> *"If there is a three month wait list or longer, then ethically you're in a position to support this person while they're on a wait list." (FG9)*

Flexible funding

The flexible funding was generally well received as it allowed creativity to solve 'wicked problems'. Some partners used flexible funding to fill the gaps they had identified in current services, especially for transport or in-home care.

> *"It is amazing to have that money there in the background because we can support those individual service gaps. Finding what those gaps are is beneficial to what we can offer." (FG4)*

However, other partners did not know how to use flexible funding or what was expected of them. The broadness was overwhelming to some partners who were unfamiliar with such an unstructured approach.

> *"We are used to being told this is what you must do and suddenly there was this 'do anything' style. Coming up with gaps was broad and easy to leap off in a wrong direction". (FG7)."*

Overall, the funding amounts were considered too small for the administrative burden needed to acquire the approval. Partners felt that often that burden did not justify the sums awarded. Another major barrier reported was the short timeframe for both the application and use of funds.

> *"When flexible funding is so limited, it almost isn't worth having." (FG4)*

> *"We've got to climb mountains for $300." (FG4)*

Data collection

R2D2 and data collection

The process of data collection and using the R2D2 system raised a lot of concerns from partners. As mentioned before, not many partner staff were aware of the flexibility they had to make a call about how to collect participant data. Without understanding this flexibility, many partner staff felt obliged to follow the longest most extensive route, which resulted in tension around the data collection.

In that longest route, the sheer volume of data that were typically collected from participants during on-boarding (52 questions) was seen as excessive and an unnecessary burden on participants. The entry survey was six pages for initial assessment, it took up to an hour to complete, and many participants needed talking through the process.

> *"It's not appropriate to be asking that level of questions before you can even have a conversation with someone about their care goals or what they might need." (FG4)*

> *"System process is too ordered. Cannot do referral to a Care Partner until in-home assessment done, then can be two weeks wait. But this person needs the referral right now." (FG8)*

> *"This program is the most administratively burdensome program I've ever overseen in my 20 plus years career in delivering community care." (FG8)*

Similarly, instructions to not turn anyone away without a referral was understood by some partners that even if a participant only needed a five-minute referral outside the CCP, they had to be on-boarded first. Some partners reported that only a portion of referrals received were entered in R2D2, as there was no way to enter participants who did not qualify for CCP yet were referred elsewhere straightaway.

> *"What a referrer might refer a person in for, may not be what the person themselves is looking for. There's work we do prior to anything else just to ensure an actual fit." (FG7)*

The exit interview process was also unclear to some partners. Notably, if a participant had several partner referrals, they had to complete several exit interviews (the length of data collection was also seen as excessive).

Some partners mentioned that R2D2 was not capturing soft data. They referred to the extensive workload of partners e.g., phone calls, transportation and extended visits, administration – the outputs/workload required to achieve outcomes. The system did not allow for segregation in servicing

complex vs simpler cases, yet the workload was dramatically different for complex cases. Overall, the system did not allow partners to effectively demonstrate the effort that went into resolving participants' issues. While the outputs were explicitly not focused on in the program to allow the program to focus on client outcomes, partners felt that capturing the output data (which is routinely being collected for their internal purposes, such as timesheet and staff management), will allow CCP management to understand instances of a mismatch between the workload and the payment offered by the program. This was particularly relevant for management of complex cases.

> *"The effort that goes into resolving complex issues is not recorded in a meaningful way in the system." (FG2)*

> *"Why did you only see three people? And the answer is because those three people had super complex needs and none of that is recognised [in the system]." (FG2)*

The structure of the database did not work well for a case management style, where all partners can see the full history of a participant to help them. A case management style reported by partners as needed, especially for participants with complex needs (particularly medical needs). Care Partners struggled to work within the CCP data management. These partners felt that the system inhibited a case management approach because it was designed in a non-person-centred way (i.e., a system-centred design), with the primary purpose of data collection on a system, rather than case management, level.

> *"R2D2 has been set up as a data collection for DHS. It doesn't work as the case management tool." (FG8)*

> *"If we cannot see other's information on each other's clients, how can we work together?" (FG8)*

> *"A high volume of palliative people come through and we don't have anywhere to say this person has deceased. It just says we didn't meet the goals or unable to answer." (FG8)*

Partners also noted a range of other challenges, for example, that duplicated participant data cannot be deleted from R2D2. This issue began at the data entry stage. When another service provider added a client for their CCP, it was not seen by other providers when entering new client details until the placement section was reached. A commentary by the CCP management suggested that this issue is being addressed at a system level.

Other elements noted by the partners were that there was no simple, efficient way to retrieve statistics and information from R2D2. The system had no filter tools, which was particularly problematic for partners that operated in multiple regions. Partners were unable to filter their data by region, other than by doing it manually.

Further, partners noted that quarterly reports (qualitative open-ended data) were time consuming, and they did not understand clear expectations for the level of detail required. The resulting data was extremely large and unstructured, which would be challenging for timely management decision-making. Some partners suggested to create a close-ended shorter tool for quarterly data collection.

Summary KEQ 2.2 How well are we doing it? (systems evaluation)

Participants' perspectives

Guided by the Participant Level Theory of Change, this developmental evaluation observed substantial improvements in participants' lives following their participation in CCP. Participants reported improved independence, significant improvements in most aspects of quality of life, and increased social connections.

Participants reported high levels of satisfaction with CCP: 84% agreed they were satisfied with the services received, 87% agreed that they were listened to and had their issues understood, 78% reported being involved in choosing the service they received, and 57% agreed they were now better able to deal with issues they sought help with. Almost no one 'disagreed' or 'tended to disagree' with these statements.

CCP had a unique role – it could help all people ineligible for other major service systems (i.e. NDIS, My Aged Care) who would otherwise *"fall through the cracks"* of all other programs, due to its very broad eligibility criteria and the 'no wrong door' policy. The program's main function was wayfinding – connecting participants to services, programs, and communities in a supportive and empathetic manner, immediately improving their social connection through the relationships with partner staff – *"someone cares about what happens to me".*

The wide entry criteria resulted in a very diverse profile of CCP participants. Some participant circumstances were very complex, with multiple needs (including chronic or acute mental and physical health needs, including palliative care). Partners reported that these participants were often not ready for social connection (the main focus of CCP logic), and required a lot more intensive and longer support. Other participants had simpler circumstances and worked well within the program's current scope.

Most commonly, the needs that were not able to be met even with CCP staff help were in the areas of youth connections, transport (especially regionally), men's connections, and CaLD community connections.

Partners or system perspective

A cohesive system

Guided by the System Level Theory of Change, this evaluation discovered that most partners worked collaboratively, noting that CCP was possibly the first government program that encouraged collaboration rather than competition – *"it is not OK to not work together [in CCP]".* This unique aspect appealed to most partners and was strongly facilitated by training delivered by the Capacity Building Partners. CCP training and Communities of Practice (by Community Centres SA and Multicultural Communities Council of SA), and the CCP Partner Forums, received very positive feedback as vehicles for building connections between regions and partner types, as well as an opportunity to share good practice examples.

However, the partnership structure of CCP was not clear to all partners. The role of the Regional Coordinating Partner was particularly challenging, with some partners feeling that they should lead other partners in the region, yet the current structure did not empower them with appropriate authority and resources.

Evaluating partner connections as a system, the scale questions used in the Quarter 3 partner reports showed that, 24% of partners judged partner connection within CCP in their region as 'excellent', and a further 43% as 'good'.

Some staff needed extra training, particularly in dealing with more complex participant circumstances, e.g. emergency mental health, vicarious trauma, accidental counselling, and financial resilience.

An integrated system

There was an uneven level of marketing activities and program promotion, whereby some regions reported struggling to raise program awareness and attracting participants, while other regions ran strong marketing campaigns and were at capacity. This was often driven by the initiative and skill set of partners within the region. The most challenging was attracting participants from CaLD and Aboriginal communities, which would often require engagement and communication approaches beyond just program marketing – a skill set lacking in some partners.

The relationship between the CCP ecosystem and external systems remained challenging, especially with NDIS and mental health providers. Non-responsiveness and lack of capacity of the latter, according to the partners, presented real challenges for CCP participant progress and caused frustration to CCP partner staff.

Reflecting these comments, in the Quarter 3 partner reports, connection with systems outside of CCP was judged as 'excellent' by 4%, and as 'good' by 65%. Furthermore, 7% of partners believed that gaps and opportunities were identified 'excellently', 30% 'good', while 63% saw that as a 'developing' opportunity.

A responsive system

The 'no wrong door policy' allowed partners to *"not say 'no'"* and help anyone who reached out. This approach served a unique and very important social function according to partners, who felt they could achieve stronger participant outcomes and higher job satisfaction as a result.

The 12-week length of the program was often noted by partners and participants as limiting to meet the needs of a very diverse participant profile – some needed less time, some a lot longer, and some needed breaks. While the program guidelines offered some flexibility in program duration, partner feedback indicated that not all partners were aware of such options or took advantage them.

Flexible funding was viewed by partners as a good initiative that encouraged creativity in approaching wicked social isolation challenges. However, partners noted that flexible funding needed less administration and larger funds allocated to justify staff time costs required to obtain this funding.

Data collection

Data collection through R2D2 was frequently reported by partners as unnecessarily burdensome for participants who often lacked psycho-social capabilities to complete the entry and exit questionnaires, which were considered too long. The R2D2 database did not support the case management function that Care and some other partners reported that they required. Reconciliation of these data with program guidelines and management responses suggested that not all partners and their staff were aware of the flexibility and opportunity for making a call about the appropriate level of data collection for each participant circumstances.

KEQ 3. Is anyone better off?

Component 4: QoL (AQoL-6D), Campaign to End Loneliness Measurement Tool, Practitioner Completed Post Service goal progress reports, and focus groups with participants

Participants who completed the program (n=195) were asked a series of questions that described different aspects of their quality of life and social connection/loneliness. Overall, in line with the Participant Level Theory of Change, there were substantial positive improvements for CCP participants, as a result of their participation. Most measures showed improvement between pre- and post-service points.

Independence and quality of life

The Assessment of Quality of Life Tool was used pre- and post-services to determine changes as a result of the program. The tool (AQoL-6D) comprised of 20 questions covering various aspects of participants' situations during the previous week. This tool was repeated at the end of the program. During analysis, the 20 questions were aggregated into seven dimensions:

Physical super-dimension:

1) Independent Living – household tasks, mobility outside the home, walking and self-care
2) Pain – the frequency of pain, the degree of pain, and the interference with usual activities caused by pain
3) Senses – seeing, hearing and communication

Psycho-social or 'mental' super-dimension:

4) Mental Health – feelings of despair, worry, sadness, tranquillity/agitation
5) Coping – covering having enough energy, being in control and coping with problems
6) Relationships - friendships, family, and community role

Overall

7) An aggregated total score for AQoL=6D

Each dimension has a maximum of 13-16, which was then converted to a score out of 100% for easier comparison across the dimensions. The aggregated score is a sum of all items. The results are presented in Table 20.

Table 20: Assessment of Quality of Life Tool (comparison pre- and post-service)

	Pre-Service			Post-Service		
	Mean	Std. Error	Std. Deviation	Mean	Std. Error	Std. Deviation
AQoL-6D	57	1.2	16	66	1.0	13
Independent Living	64	1.7	23	68	1.5	22
Relationships	56	1.7	23	68	1.2	17
Mental Health	44	1.6	22	60	1.3	18
Coping	46	1.6	23	58	1.2	17
Pain	53	2.3	33	61	2.0	28
Senses	78	0.8	12	82	0.7	10

The mean results of AQoL are presented in Figure 11 below.

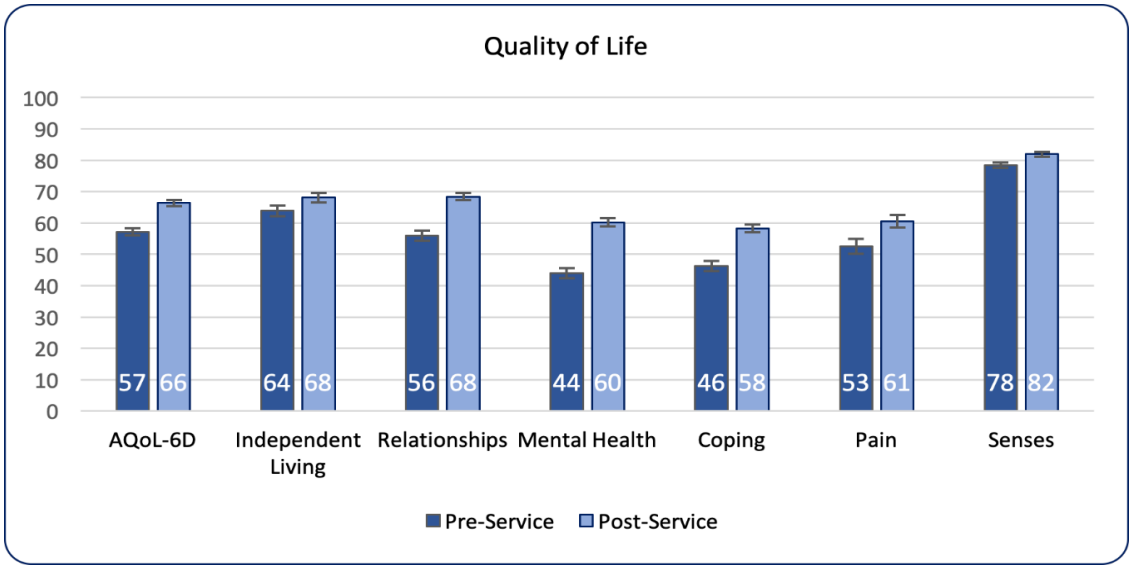

Figure 11: Assessment of Quality of Life Tool (comparison pre- and post-service)

All metrics of the Assessment of Quality of Life significantly improved, on average, by nine points. The AQoL-6D improved from 57 to 66. The largest improvements were in 'mental health' from 44 to 60, 'relationship' from 56 to 68, and 'coping' from 46 to 58, followed by 'pain' from 53 to 61, 'senses' from 78 to 82, and 'independent living' from 64 to 68.

All changes were statistically significant at p<.001, with paired sample t-test results being as follows:

- AQoL-6D: $t(194) = -9.73$, $p < .001$
- Independent Living: $t(194) = -3.54$, $p < .001$
- Relationships: $t(194) = -7.93$, $p < .001$
- Mental Health: $t(194) = -10.61$, $p < .001$
- Coping: $t(194) = -8.68$, $p < .001$
- Pain: $t(194) = -4.87$, $p < .001$
- Senses: $t(194) = -4.52$, $p < .001$

Social and community connection, loneliness

The Campaign to End Loneliness Measurement Tool was used, comprising three statements to which participants needed to indicate their level of agreement on a scale of 0 'strongly agree' to 4 'strongly disagree'. The results for each statement are reported below in Table 21.

Participants completed these questions twice – pre-service and post-service. A lower score post-service means a reduction in loneliness. Paired sample *t*-test was conducted to compare pre- and post-scores. The test shows that all observed differences were statistically significant at p<0.001. The overall measurement was the sum of scores for all three statements.

Table 21: Campaign to End Loneliness Measurement Tool – individual statements

		N	Mean	Std. Error	Std. Deviation
Pre-Service	I am content with my friendships and relationships	194	2.1	0.09	1.21
	I have enough people I feel comfortable asking for help at any time	194	2.3	0.09	1.27
	My relationships are as satisfying as I would want them to be	194	2.3	0.09	1.21
Post-Service	I am content with my friendships and relationships	188	1.4	0.06	0.90
	I have enough people I feel comfortable asking for help at any time	187	1.5	0.07	0.99
	My relationships are as satisfying as I would want them to be	188	1.5	0.07	0.89

Responses for all three statements declined between pre- and post- service, indicating a reduction in feelings of loneliness, as shown in Table 22 (sample sizes vary slightly due to missing data for some participants).

Table 22: Campaign to End Loneliness Measurement Tool – overall score

	n	Mean	Std. Error	Std. Deviation
Pre-Service Loneliness Score	194	6.7	0.22	2.99
Post-Service Loneliness Score	188	4.4	0.15	2.00

Participants' overall feelings of loneliness (as measured by the Campaign to End Loneliness Tool) had substantially reduced from an average of 6.7 out of 12 at pre-service measurement, down to 4.4 at post-service measurement (Figure 12). This change was statistically significant at $t(186)=10.50$, $p<0.001$.

Figure 12 shows that participants' overall feelings of loneliness decreased to 4.4. out of 12.

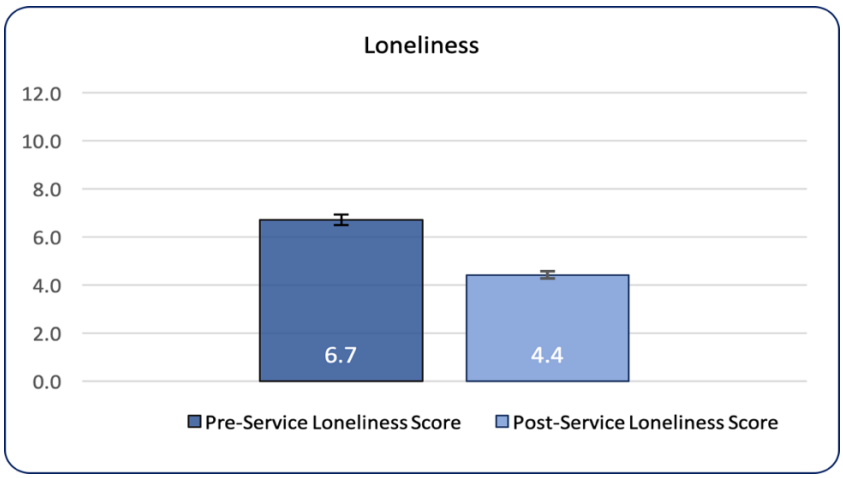

Figure 12: Campaign to End Loneliness Measurement Tool – overall score

(Max=12=Most lonely, Min=0=Least lonely. Value = Mean, Error bars = Std. Error)

Progress on goals (partner reported placement outcomes) – whole program

This section presents partner-reported post-service progress on participants' goals. The analysis uses the data from partner-reported closed placements (n=422).

The results shown in Figure 13 demonstrate that 25% of participants fully achieved their goals, a further 23% achieved moderate progress, and another 23% had limited progress. Further, 9% of participants had no progress in achieving goals, and 19% did not set goals.

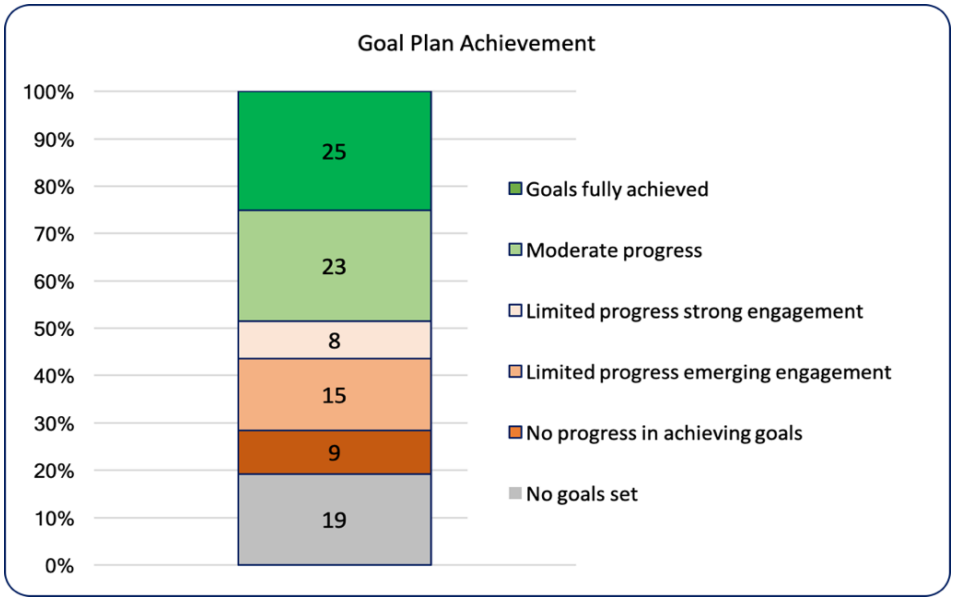

Figure 13: Goal Plan Achievement

Community participation, according to partner staff reporting, improved for 15% of participants who had significant positive change. A further 20% of participants had moderate positive change, and 21% had limited change. 15% had no change, and 29% were unable to assess. These results are presented in Figure 14.

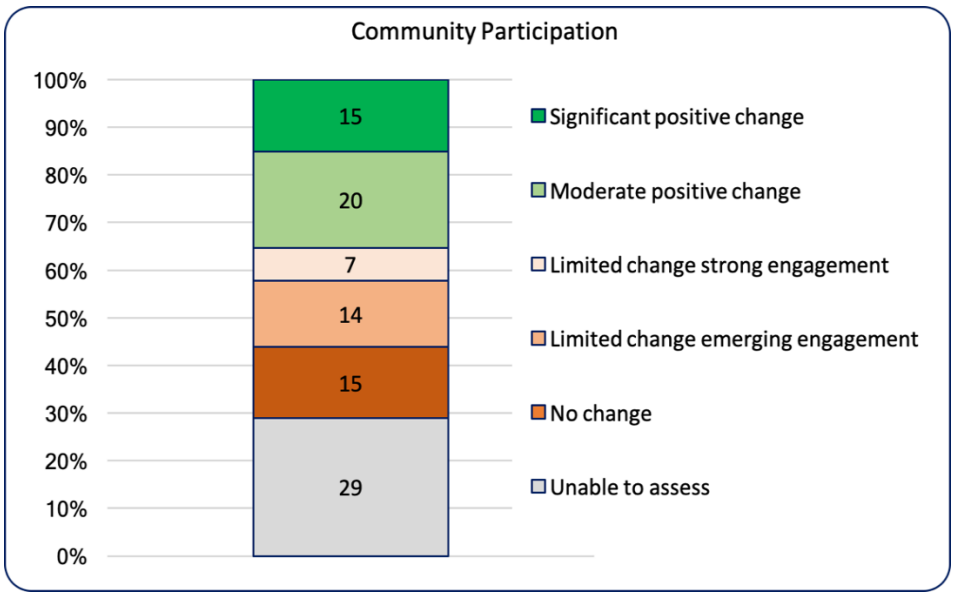

Figure 14: Change in Community Participation

A very similar distribution was reported for participants' changes to their social connections, shown in Figure 15. This question seems to mirror responses to the previous question regarding community participation. Therefore, it is recommended the 'community' question be deleted in future CCP program iterations to reduce participant burden during data collection.

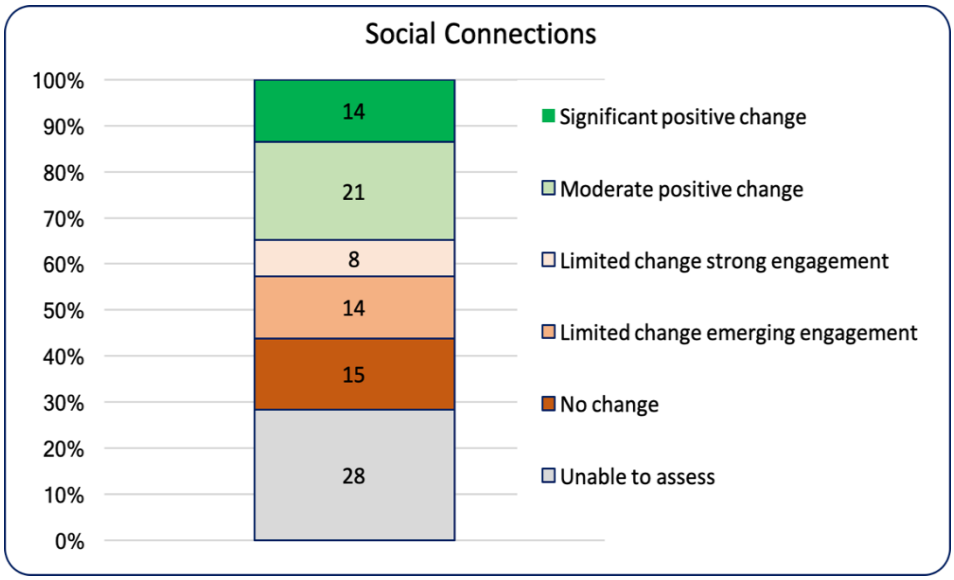

Figure 15: Change in Social Connections

Progress on goals (partner reported placement outcomes) – partner split

Looking at the goals progress split between participants of Care Partners vs all other partners, there are some notable differences, as shown in Table 23.

Table 23: Did the client achieve the goals in their goal plan?

	Care Partner (%)	Carer Breaks, Support Partner, Community Partner, Regional Coordinating Partner (%)
Goals fully achieved	20	27
Moderate progress	20	25
Limited progress strong engagement	4	10
Limited progress emerging engagement	5	20
No progress in achieving goals	4	11
No goals set	47	7
Total	**100**	**100**

Participants of the Care Partners were much more likely to not set goals, with 47% vs 7% in all other partners. This result could reflect a mismatch of the CCP logic model and entry/exit questionnaires with the nature of Care participants. For example, some Care participants were palliative care participants whose goals were completely different, if not irrelevant, to the logic of CCP.

Similarly, the questions about community participation and social connection (see Table 24 and Table 25) were much less relevant to Care participants due to the participants' substantial physical and mental health conditions. This circumstance is reflected in the data that show over half of participant data in Care were not completed, and over 20% did not have any change to their social connection, as shown in Table 24.

Table 24: Describe the change the client has made to their community participation

	Care Partner (%)	Carer Breaks, Support Partner, Community Partner, Regional Coordinating Partner (%)
Significant positive change	4	20
Moderate positive change	7	26
Limited change strong engagement	5	8
Limited change emerging engagement	5	18
No change	23	11
Unable to assess	55	17
Total	**100**	**100**

Table 25: Describe the change the client has made to their social connections

	Care Partner (%)	Carer Breaks, Support Partner, Community Partner, Regional Coordinating Partner (%)
Significant positive change	2	18
Moderate positive change	6	28
Limited change strong engagement	6	9
Limited change emerging engagement	6	17
No change	23	12
Unable to assess	57	16
Total	**100**	**100**

Participants outcomes and stories

This section covers data collected in focus groups with CCP participants, complemented with stories from partner focus groups and their quarterly reports.

Overall program reflections

Most participants in focus groups felt their life had improved after participating in the program. Participants generally voiced positive reflections and felt that CCP connected people to community and services. These connections were seen as valuable because they lead to independence and capacity, which further lead to connection to community. The focus on connection and isolation was also valuable. This all filled a gap in helping people connect to community and be less socially isolated. Lived experiences varied, from social connections because of loneliness, to severe physical or mental health.

CCP was a point of difference for socially isolated participants experiencing mental health issues. By being linked with some services through CCP, they were starting to see the light at the end of the tunnel. CCP has helped bridge the gap in this useful space, which was otherwise left empty.

> *"So consequently, your program stepped in to tell me that yes, there are things that I could be interested in out there, you know, for me to get in contact with these people I saw that I can do these courses." (FG1)*

For many this was the first time they felt that a service or an interaction had that focus. Social interaction was important to the participant. A participant also commented that CCP staff were the only ones that connected them to the community and overcoming isolation.

Support was given in many ways, from ensuring the house was usable and safe for those who were physically unable to leave the house, to finding community groups and activities for social interaction and skill building.

> *"He came around and helped make my home usable for my circumstances and now I feel safe at home. I miss not having him around for a chat though." (FG10)*

> *"Staff did some practical things, but what was most valuable in that process was the humanity, warmth and empathy encountered. She was invested in me." (FG5)*

Examples of specific outcomes for participants:

There were many stories of specific outcomes for participants that increased their independence. For example, one participant joined a walking group which she still regularly goes to. Her goal was to get out of the house, exercise and meet other people. One participant liked that the partner staff booked activities that gave her reasons to physically leave the house:

> *"It gave me the oomph to go and do it." (FG11)*

> *"The Community Connection Program has built my self-esteem and improved my mental health more than the many psychologists I have dealt with in the past" (QR3).*

An example of increased independence:

> *"[Participant] secured private tenancy with support in sorting out the home, arranging RDNS support and supporting to build capacity to take on tasks and how to do them." (QR3).*

An example of improved quality of life and health:

> *"A homeless gentleman… was collecting cans from bins to make ends meet. The CCP worker accompanied the gentleman to the Centrelink office numerous times… connected him with Employment Services and he has an interview with a prospective employer" (QR3).*

Examples of improved social and community participation:

> *"After attending several groups with a CC worker, a participant was able to sit in the group space without the support worker. She made conversations with others in the group and spent time laughing." (QR1).*
>
> *"Client continues to attend the Women's Shed weekly which she feels connected to as though they are 'family'" (QR3).*
>
> *"Participant who has previously studied law, but who has not been well enough to practice due to his mental ill health, was supported by his case manager to connect with a local law firm as a volunteer." (QR3).*
>
> *"Young Carer participant enrolled into Compass School after family's ongoing attempt to ensure this didn't occur due to it compromising government payments." (QR3).*

Summary KEQ3. Is anyone better off?

Overall, in line with the Participant Level Theory of Change, there were substantial positive improvements for CCP participants following their participation in the program. Most measures showed improvement between pre- and post-service points.

Independence and quality of life dimension

All metrics of the Assessment of Quality of Life significantly improved, on average, by nine points. The AQoL-6D improved from 57 to 66. The largest improvements were in 'mental health' from 44 to 60, 'relationship' from 56 to 68, and 'coping' from 46 to 58, followed by 'pain' from 53 to 61, 'senses' from 78 to 82, and 'independent living' from 64 to 68. All changes were statistically significant at $p<0.001$.

Looking at partner-reported post-service progress on goal achievement, 25% of participants fully achieved their goals, a further 23% achieved moderate progress, and another 23% had limited progress; 9% had no progress in achieving goals and 19% did not set goals.

Social and community connection dimension

Participants' feelings of loneliness (as measured by the Campaign to End Loneliness tool) had substantially reduced from an average of 6.7 out of 12 at pre-service measurement, down to 4.4 at post-service. This change was statistically significant at $p<0.001$.

Community participation, according to partner staff reporting, improved for 15% of participants with significant positive change, a further 20% with moderate positive change, and 21% with limited change. 15% had no change, and 29% were unable to be assessed. A very similar distribution was reported for participants' changes to their social connections.

Participants of the Care Partners were much more likely to *not* have set goals, with 47% vs 7% in all other partners missing that data. This finding could reflect a mismatch of the CCP logic model and entry/exit questionnaires, with the nature of Care participants (e.g. some were palliative care participants whose goals were not aligned to the logic of CCP).

Focus group data

Qualitatively, there were stories from participants themselves, plus partners, of specific improvements in participants' lives. These improvements ranged from increased independence in being able to leave the house, engage in a conversation with other people, and join and keep attending a social group, to improvements in self-esteem, mental health, having a reason to live, and continue engaging with a community.

Some participants shared their disappointment with the 12-week duration of the program, and, importantly, what felt for them as an abrupt stop. For participants with complex needs, the time frame of multiple referrals, wait lists etc., required longer program duration. For those with simpler needs, the abruptness of the program ending (and associated emotional separation), plus the need to take holidays/breaks also contributed to the desire for a longer program timeframe. Partner feedback in focus groups and quarterly reports suggested that not all partners were aware of the possibility to extend the program to tailor to participants' needs, suggesting the need to improve communication to partners about this option.

Conclusion

This report presents results of an independent evaluation of the Community Connections Program run by DHS SA. The researchers from the Centre for Social Impact (CSI Flinders) collated and analysed data from multiple sources: quantitative survey data from R2D2, qualitative data from partner quarterly reports, focus groups with partners, and focus groups with participants.

Overall, the results of the evaluation showed the positive impact of the program on participants, especially in supporting their social connectedness and improving their quality of life.

The partners reported that CCP was one of the first programs that encouraged them to collaborate with each other, rather than compete, and there were clear examples where partners were able to work as a system through referrals and information and resource sharing. There were aspects of the program where partners identified opportunities for improvement, of particular note were: data collection and management, partnership structure, program flexibility, and management of complex vs simple cases.

References

Veronica Coram, Selina Tually & Ian Goodwin-Smith (2022): Communities for children: Evaluating an implementation of the facilitating partner model, Community Development, DOI: 10.1080/15575330.2022.2059690

Fagen, M. C., Redman, S. D., Stacks, J., Barrett, V., Thullen, B., Altenor, S., & Neiger, B. L. (2011). Developmental evaluation: Building innovations in complex environments. *Health Promotion Practice* 12(5): 645-650.

Ho, R. (2017). *Understanding Statistics for the Social Sciences with IBM SPSS*, Milton: CRC Press LLC.

Holt-Lunstad, J. (2018). The Potential Public Health Relevance of Social Isolation and Loneliness: Prevalence, Epidemiology, and Risk Factors. *Public Policy & Aging Report* 27(4): 127-130.

Mackenzie, C, Louth, J and Goodwin-Smith, I (2019). *"I feel a sense of belonging here": An investigation into the experiences of Community Centre users in South Australia*. The Australian Alliance for Social Enterprise. University of South Australia. Adelaide

Milton, B., P. Attree, B. French, S. Povall, M. Whitehead and J. Popay (2012). The impact of community engagement on health and social outcomes: a systematic review. *Community Development Journal* 47(3): 316-334.

Mohanty, I., et al. (2020). A multilevel mixed effects analysis of informal carers health in Australia: the role of community participation, social support and trust at small area level. *BMC Public Health* 20(1): 1801.

Patton, M. Q. (1994). Developmental evaluation. *American Journal of Evaluation* 15: 311-319.

Patton, M. Q. (2021). Emergent Developmental Evaluation Developments. *Journal of MultiDisciplinary Evaluation*;17(41): 23-34.

Appendix A - Demographic profile split by partner streams

Q3: Age

	Care Partner	Carer Breaks, Support Partner	Community Partner, Regional Coordinating Partner (RCP)	External Non-CCP Funded Referrals
0-4 years	0.3	0.4	0.2	0.4
5-9 years	0	4.2	0	0
10-14 years	0	5.3	0	0.2
15-19 years	0	6.3	0.5	2.1
20-24 years	0.8	3.2	6.1	3.9
25-29 years	1.5	0.4	4.7	7.4
30-34 years	1.8	2.1	5.6	7.8
35-39 years	3.8	8.4	9.1	7.2
40-44 years	4.8	7.0	8.8	11
45-49 years	7.3	13	15	13
50-54 years	15	16	13	12
55-59 years	20	15	14	12
60-64 years	37	16	20	17
65-69 years	8.0	2.1	3.0	5.6
70-74 years	0	0	0	0.2
Total	100	100	100	100

Q4: Gender

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
Female	65	73	60	60
Male	35	26	37	37
Gender Diverse	0.8	0.7	0.9	1.6
Not stated / inadequately described	0	0.4	1.6	1.0
Total	100	100	100	100

Q9: Aboriginal or Torres Strait Islander status

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
Neither	93	81	85	90
Not stated / inadequately described	5.0	11	9.3	3.7
Aboriginal	2.3	7.0	5.4	4.9
Aboriginal and Torres Strait Islander	0	1.4	0.2	1.2
Torres Strait Islander	0	0	0.4	0.4
Total	100	100	100	100

Q10: CaLD Status

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
No	63	88	82	86
Not stated / inadequately described	31	4.9	4.0	1.9
Yes	6.3	6.7	14	13
Total	100	100	100	100

Q11: Disability status

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
Not stated / inadequately described	38	15	13	12
Diagnosed	34	23	33	35
No disability	13	51	27	24
Both diagnosed and undiagnosed	9.0	6.0	17	19
Undiagnosed	5.3	4.9	9.6	9.3
Missing data	0	0	0.2	0.2
Total	100	100	100	100

Q14: Is the client eligible for NDIS?

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
No	43	80	57	56
Unable to assess	20	4.9	8.6	6.8
Missing data	15	3.5	1.4	1.6
Client NDIS eligibility to be explored	13	9.1	26	31
NDIS application in progress	8.8	1.1	6.5	3.7
Currently receiving NDIS support	0.3	1.1	0.2	0.6
Total	100	100	100	100

Q15: Is the client eligible for Community Connections?

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
Yes	68	95	95	93
No	17	1.4	3.7	5.8
Missing data	15	3.5	1.4	1.6
Total	100	100	100	100

Q16: If born overseas did the client arrive in Australia in the last ten years?

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
Unable to assess	31	0.7	5.3	2.9
No	28	28	47	51
Not applicable	24	64	40	37
Missing data	15	3.5	1.4	1.9
Yes	1.5	3.9	6.8	7.2
Total	100	100	100	100

Q17: Does the client have a chronic illness?

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
Diagnosed	37	35	39	35
Unable to assess	31	7.4	9.8	6.6
Missing data	15	3.5	1.4	1.6
Both diagnosed and undiagnosed	6.8	6.0	16	18
No	6.3	45	28	29
Undiagnosed	3.5	2.8	5.4	8.8
Total	100	100	100	100

Q18: Does the client experience mental illness?

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
Unable to assess	41	9.8	10	7.2
Diagnosed	20	34	49	47
Missing data	15	3.5	1.4	1.6
No	14	38	10	13
Undiagnosed	6.3	8.4	13	16
Both diagnosed and undiagnosed	4.5	6.3	16	15
Total	100	100	100	100

Q19: Does the client have a carer?

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
No	39	82	82	87
Unable to assess	30	2.1	5.1	4.3
Yes	16	12	11	7.4
Missing data	15	3.5	1.4	1.6
Total	100	100	100	100

Q20: Is the client a carer providing unpaid care and assistance to a person with disability, chronic illness or mental illness?

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
No	48	4.9	73	79
Unable to assess	32	1.8	7.9	4.5
Missing data	15	3.5	1.4	1.6
Yes	4.5	90	18	15
Total	100	100	100	100

Q21: Is the client connected with the Carer Gateway?

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
Missing data	60	15	24	9.1
No	26	17	55	76
Unable to assess	7.0	4.2	7.2	3.7
Not applicable	5.3	0	11	5.8
Yes	1.5	64	3.5	5.1
Total	100	100	100	100

Q23: What is the clients usual living arrangement?

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
Lives with others	29	89	48	45
Unable to assess	29	2.8	4.2	5.3
Lives alone	27	4.9	46	48
Missing data	15	3.5	1.4	1.6
Total	100	100	100	100

Q24: Is the client a HACC transition client?

	Care Partner	Carer Breaks, Support Partner	Community Partner, RCP	External Non-CCP Funded Referrals
No	43	75	81	85
Yes	34	11	9.5	7.0
Missing data	15	3.5	1.4	1.9
Unable to assess	8.5	9.8	8.4	6.0
Total	100	100	100	100

Appendix B - Consent questions

Full details about consent questions in R2D2 data.

	Client outcomes assessment consent Pre-Service (consent v1)	Client outcomes assessment consent Post-Service (consent v2)
Client provided consent	988	210
Client did not consent	102	86
Survey not appropriate so client not required to complete	62	78
Client could not be contacted	26	57
Placement created in error	1	29
Total (Valid)	1179	460
System Missing	561	1280
Total	**1740**	**1740**

Appendix C - Partner type split for client outcomes data

Partner type split for client outcomes (n=195, consent v1 and v2 = yes)

	Frequency	Percent (%)
Community Partner	142	73
Regional Coordinating Partner	21	11
Care Partner	16	8.2
Carer Support Partner	10	5.1
Carer Breaks	6	3.1
Total	**195**	**100**