Karralika Non-Residential Withdrawal *Support* Service

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Final evaluation report

360edge.

phn ACT
An Australian Government Initiative

Capital Health Network
Partnering for better health

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In the spirit of reconciliation, 360Edge acknowledges the Ngunnawal people as traditional custodians of the country upon which we work and live and their connection to land, sea and community.

We pay our deep respects to elders past, present and future, and to all Aboriginal and Torres Strait Islander peoples today.

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Executive summary

The aim of this evaluation was to provide an independent assessment of the operations, performance, and impact of the Non-Residential Withdrawal Support Service (NRWSS) program of Karralika.

Karralika is a non government organisation that provides alcohol and other drugs services to people in Canberra and surrounding regions. The evaluation focussed on evaluating the effectiveness of the program in delivering community based withdrawal support, assessed service user outcomes, and identified barriers and enablers to achieving positive experiences and long term recovery. The evaluation also aimed to generate recommendations for service improvement, ensuring that the NRWSS remains aligned with best practice, well monitored, and sustainable into the future.

NRWSS is supported by funding from the ACT PHN through the Australian Government's PHN Program.

EVALUATION APPROACH

We used a collaborative design methodology involving Karralika and NRWSS staff, the funder, and external experts. The approach included qualitative consultations with nurses, referrers, and management, alongside quantitative analysis of 12 months of service data.

A three month feasibility trial was conducted before full implementation to ensure data quality and practical evaluation processes. The evaluation explored service fidelity, effectiveness, and outcomes, identifying strengths, barriers, and opportunities for program enhancement.

KEY FINDINGS

The evaluation shows that the NRWSS is a highly valued and essential nurse led program that provides flexible, community based withdrawal management for people in the ACT and regional NSW. Since its establishment in 2018, the program has filled a critical gap in the alcohol and other drug treatment landscape, offering a person centred, evidence based alternative to residential withdrawal services.

This evaluation highlights the program's strong governance, effective service delivery, and positive service user outcomes, reinforcing its critical role in the ACT's healthcare system.

WHO ACCESSES THE SERVICE?

The NRWSS caters to a diverse group of service users, with high representation from priority populations and individuals with complex needs. Between January and December 2024, 95 episodes of care were provided to 85 unique service users.

Nearly half of the service users were female (48.4%), a higher proportion than the national average of females accessing alcohol and other drug treatment (35%). One in five (20.7%) service users identified as Aboriginal and/or Torres Strait Islander, exceeding the national withdrawal service access average of 13%.

Many service users presented with complex health concerns, with 31.4% reporting a co-occurring physical health condition and 72.7% experiencing a co-occurring mental health condition.

Methamphetamine (40%) and alcohol (38.9%) were the most common primary substances of concern, followed by cannabis (13.7%), with 36.8% of service users engaging in polydrug use, most commonly with cannabis (17.9%).

These figures highlight the complex social and health challenges faced by service users and reinforce the importance of a flexible, accessible withdrawal service that can provide support in home and community settings.

STRENGTHS OF THE PROGRAM

The evaluation confirms that the NRWSS is operating as designed, with high fidelity between its documented processes and actual service delivery. Governance mechanisms are well established, with clinical oversight, regular reviews, and ongoing quality improvements that enhance service effectiveness. The program's flexibility, responsiveness, and person centred approach have been identified as key factors in successful service user engagement and positive outcomes.

Key strengths of the program include:

- **Highly responsive service:** Most service users reported being able to access the program quickly, sometimes within 24 hours of making contact
- **Strong service user outcomes:** NRWSS successfully assists service users to cease or reduce their alcohol and other drug use, reduces psychological distress, and improves the quality of life of their service users
- **Strong self referral pathway:** 54.7% of service users entered the program through self referral, demonstrating its accessibility and reputation in the community
- **High service user satisfaction:** 87.5% of service users rated the program's overall quality as 'very good' and 12.5% found it 'good,' with many describing the service as 'life changing'
- **Dedicated and highly skilled workforce:** Service users consistently praised the professionalism, responsiveness, and compassion of the nursing staff, who play a critical dual role in clinical and therapeutic support
- **Well integrated referral network:** The program maintains strong relationships with external services, ensuring effective pathways into treatment and aftercare
- **Flexible service delivery:** The program's ability to provide home based withdrawal support allows service users to maintain their routines and access care in familiar environments

CHALLENGES AND AREAS FOR IMPROVEMENT

Despite its many strengths, the program faces some challenges that impact its ability to optimise service delivery.

Key challenges include:

- **Limited engagement from GPs:** Many GPs are reluctant to engage with people who experience alcohol and other drug use issues, often due to stigma and limited knowledge and skills, leading to challenges in securing prescriptions for withdrawal medications and care transitions
- **Difficulty accessing mental health services:** Many service users require coordinated mental health and withdrawal support, but long waiting lists and service gaps in the ACT create barriers to timely care
- **Weekend service limitations:** The program operates Monday to Friday, meaning some service users may disengage if they require withdrawal support over the weekend
- **Workforce sustainability challenges:** Attracting, retaining, and developing the capacity of skilled alcohol and other drug nurses remains an ongoing challenge, as does advocating for alcohol and other drug nurse practitioner roles to enhance clinical capacity

RECOMMENDATIONS

The NRWSS is an exceptional, high impact nurse led program that is meeting a critical need in the ACT, supporting service users with compassion, flexibility, and evidence based care. The evaluation reaffirms the importance of continued investment to ensure the program remains accessible, sustainable, and responsive to emerging challenges.

The evaluation provides targeted recommendations aimed at enhancing and refining service delivery, ensuring the program remains adaptable, well resourced, and positioned for long term sustainability. These include:

- Strengthening engagement with GPs through ongoing education programs to reduce stigma, structured engagement strategies, and exploring funding for a dedicated GP liaison role
- Strengthening partnerships with mental health services for service users with co-occurring mental health needs to enhance coordinated care
- Exploring extended service hours, particularly weekend availability, to reduce service user drop off and improve accessibility
- Advocacy for greater representation of nurse practitioners, and participation in sector wide strategies for increased funding, workforce retention, and workforce development
- Increasing program awareness through targeted community outreach and potential rebranding, ensuring the service is more widely recognised and accessible
- Incorporating ongoing collection of additional data items to inform service improvement and quality assurance processes and retain survey data collection strategies to improve response rates

Introduction

For more than 45 years, Karralika Programs has provided specialist alcohol and other drug treatment services in the ACT and regional NSW to adults, families, children and young people. Karralika delivers a comprehensive range of alcohol and other drug treatment and support services, including residential rehabilitation, non residential withdrawal, day programs, counselling and aftercare services.

The establishment of the Non-Residential Withdrawal Support Service (NRWSS) in 2018 followed extensive sector consultation and a comprehensive report that identified the critical need for a non residential alternative to the existing ACT limited residential withdrawal capacity.

Capital Health Network (CHN), ACT's Primary Health Network initially funded a one year pilot of the NRWSS. The pilot was based on existing outpatient withdrawal models from Victoria, Queensland, and NSW. The ACT government also provided funding support for the NRWSS program until 2021, when CHN secured four year funding from the Commonwealth.

This funding expanded and enhanced the program from a pilot model to a program embedded in the community and included funding for an evaluation of the support service that corresponds with the funding cycle ending 30 June 2025.

The NRWSS supports people living in ACT and the surrounding NSW areas to reduce or withdraw from alcohol and other drug use while they remain in the community.

The service employs nurses to provide evidence based medicated and non medicated care where low to mild withdrawal syndrome is anticipated. The nurse led program is delivered collaboratively with community based general practitioners (GPs) and pharmacists when medication is required to manage withdrawal symptoms and stabilise co-occurring conditions.

The NRWSS's objectives are to:

- Assist a person to cease or reduce alcohol and other drug use to a level that restores a person's health and wellbeing in the short term
- Provide a step up or step down response for service users requiring withdrawal and/or stabilisation, including bed based withdrawal services
- Form part of an integrated and coordinated care pathway by connecting service users with aftercare alcohol and other drug services and community health and wellbeing services

To achieve the program objectives, the service also collaborates with a range of external service providers as well as other programs within Karralika. This collaboration allows for treatment matching at the point of intake and assessment to the most suitable type and intensity of service and allows for flexible adjustment of care should a service user's needs, circumstances, or goals change.

EVALUATION AIMS

CHN commissioned 360Edge to undertake this evaluation of the NRWSS. The evaluation will provide CHN and Karralika with an independent assessment of the program's operations and performance and inform ongoing service improvement and recommissioning planning.

The evaluation will determine the impacts of the NRWSS's activities and provide guidance to ensure that future delivery is consistent with best practice approaches and is effective, well monitored, and sustainable.

Evaluation approach

We applied a collaborative design methodology to develop a framework for the evaluation of the NRWSS. This collaboration included representation from Karralika, CHN (as funder), and an external evaluation subject matter expert. Our methodology included consultations to collect qualitative data and an examination of available quantitative program data. Combining both of these elements allowed us to explore key evaluation questions relating to the impacts and benefits of the service, as well as barriers and enablers to NRWSS achieving its intended outcomes.

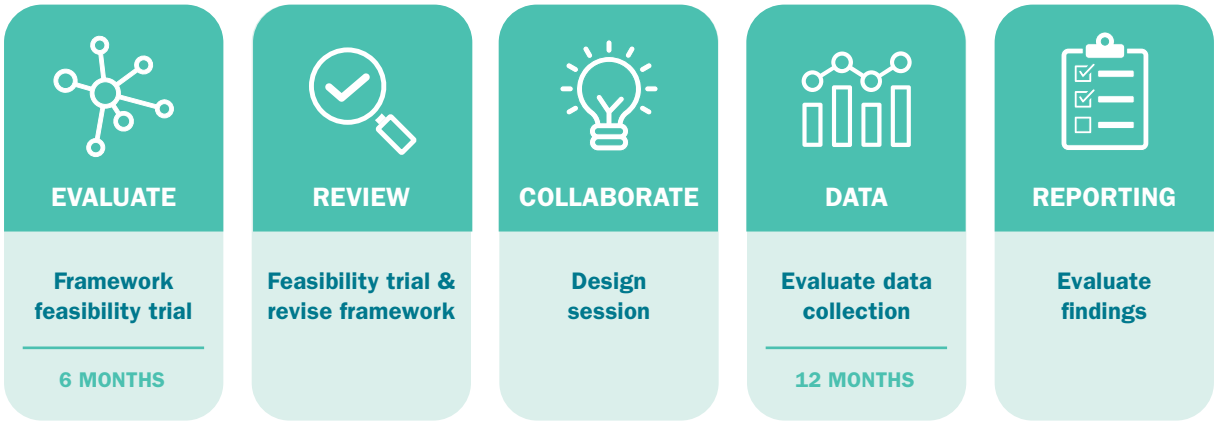


Figure 1 provides an overview of the evaluation process, including framework design, the initial feasibility trial, the review and revision of the framework through collaborative design, and the implementation of the 12 month evaluation.

DEVELOPMENT OF THE EVALUATION FRAMEWORK

Our method for developing the evaluation framework was informed by an initial scoping of the program (consisting of consultation with the steering group, data source mapping, and a review of available program documentation).

The evaluation steering group members participated in three collaborative design sessions to develop, test, and refine the evaluation methodology.

These workshops helped to identify the expected outcomes of the program for service users and the most appropriate methods of assessing how well the program facilitates these outcomes. Collaborative design was chosen to ensure that the evaluation methodology would be appropriate and the final report would deliver relevant insights for the program, Karralika leadership, and the funder.

Karralika Programs has an established Consumer Advisory Body providing high level advice and insights to the Board and Executive across a range of issues, bringing their perspectives as a past client or family member of a past client. We hosted a session with the Consumer Advisory Body to receive feedback on the evaluation methodology. In particular, we explored the service user survey to ensure the language and approach were appropriate.

The resulting evaluation framework described the approach to the evaluation and provided more in depth details about our methodology.

It included:

- A program logic model describing the theory of change for the program
- Key evaluation questions
- Evaluation data sources
- Data collection methods
- Analysis and reporting considerations

We also developed a program logic model for the evaluation framework, which outlined the key program elements and the expected cause and effect relationships between these elements.

It provided the basis for the development of the evaluation questions and the identification of key data sources. The program logic also helped to identify the assumptions that underpin the program's activities and identify the expected impacts and outcomes.

The program logic can be found in appendix 1.

FRAMEWORK FEASIBILITY TRIAL

The evaluation included an initial three month feasibility trial. The aim of the trial was to test the practical workability of the framework to capture the right data at the right timepoints and allow exploration of the effectiveness of key program elements. Karralika were closely involved in planning data collection and management and were supported by 360Edge for the duration of the trial.

The feasibility trial found that the data collection and handover methods were acceptable and would support the 12 month evaluation. Minor revisions to data management were made based on the feasibility trial (for example, renaming items for clarity purposes) to streamline processes for the main evaluation.

FORMAL EVALUATION

The finalised evaluation framework was used to undertake the 12 month evaluation. 360Edge worked with Karralika to plan and schedule key evaluation tasks, including the engagement of internal and external stakeholders for consultations. We maintained close engagement with Karralika and provided support to ensure consistent data collection and facilitate the handover of data for analysis.

Consultations

We facilitated three focus group consultations with NRWSS nurses (N=5), internal and external referrers (N=3), and Karralika management (N=3). These consultations provided qualitative insights about the value and impacts of the NRWSS and the enablers and barriers to delivering services. They also provided insights into service user profiles and needs and the ways in which the NRWSS is integrated with other health and social services.

Data handling, analysis, and synthesis

Program data provided the evaluation with quantitative information about program activity, fidelity of delivery, service outputs, and impacts. These data included deidentified service user demographic information, primary and secondary drugs of concern, number of admissions, number of completed episodes, and outcome data based on validated measures.

Karralika provided 360Edge with 12 months (January to December 2024) of deidentified client data in an Excel file. All quantitative data was collated, cleaned, and analysed by 360Edge. The evaluators did not have access to identifying program or service user information and used a statistical linkage key to analyse the data.

At six months, 360Edge received interim data to allow us to test the mechanisms for data handling and assess the quality of the data. Based on this early examination, some changes were made to how the service user feedback survey was collected to improve completion rates. A QR code and a paper form option were added for service users. An envelope was provided so service users could seal it for confidentiality and hand it back to the worker on their last NRWSS appointment.

The consultations were reviewed and thematically analysed in alignment with the key evaluation questions. All data was then collated and synthesised and informed the evaluation findings in the next section of this report.

ANALYSIS AND REPORTING

A snapshot report was developed to provide an update on the progress of the evaluation and an overview of the early findings as of February 2025.

In the final evaluation report, we describe overall service activity and explore service user profiles and main service user outcomes. We also identify the enablers and barriers to effective and efficient service delivery and the achievement of positive service user experiences and outcomes. We also provide recommendations to further strengthen service accessibility, coordination and sustainability.

Further analysis of quantitative and qualitative data was used to fully interrogate the key evaluation questions and generate recommendations for potential service delivery enhancements. We also engaged with the project steering group and Karralika staff to reflect on the co-designed evaluation framework used throughout the NRWSS project to better understand whether adjustments for ongoing monitoring and reporting were needed.

Evaluation findings

This report provides an overview of the findings of the NRWSS evaluation, describing the fidelity of the program's operations to documented processes, program governance systems, and the effectiveness of program processes such as referral pathways.

The report describes the service delivery model and characteristics of service users. It explores service user outcomes, drawing on validated measures of alcohol and other drug use, psychological distress, and quality of life. Drawing on our analysis of program data and feedback from service users, Karralika and NRWSS staff and external partners, we identify key strengths of the program, best practice alignment and potential areas for strengthening the program.

EFFECTIVE GOVERNANCE

We explored governance arrangements by reviewing governance documentation and consulting with NRWSS nurses, internal and external referrers, and Karralika management. The program's management structure is well defined, with clear demarcation of roles and responsibilities within the program. Systems for operational and clinical administration of the program are well documented, found to be in routine operation, and were assessed to be highly effective in maintaining operational effectiveness and efficiency.

The program is able to identify and address emerging service user needs, as well as modify processes for efficiency and quality purposes.

At a program level, processes for clinical governance include annual reviews of the program by Karralika's Quality Improvement and Compliance Committee, including a regular assessment of the program against national and local guidelines for withdrawal services. At a service user level, monthly care team meetings review progress, quality of care, and management of risk. Quality of care and adherence to processes is also governed via provision of regular supervision, practitioner support, and professional development, as well as audits of clinical records to ensure compliance with treatment and discharge protocols.

We found evidence that iterative changes are made based on these quality assurance processes. A recent review considered a feedback mechanism from nurses and refining treatment plans to ensure uniformity across programs. Similarly, an organisational quality improvement to the administration of consent forms was undertaken to streamline intake as the program enhanced their clinical guidelines regarding the withdrawal protocol for GHB (gamma hydroxybutyrate).

FIDELITY OF OPERATIONS

We explored the fidelity of the program's operations by comparing documented processes to actual practices. We assessed current practices through consultations with program leadership, staff, and external stakeholders, as well as by exploring intended service user experiences through our quantitative analysis.

We found a high degree of agreement between current operations and the policies and processes documented in operational manuals, meaning the program is operating as designed.

Where any changes were made in operations over the period of the evaluation, these followed a systematic process informed by continual quality improvement and benefiting from consultation with staff, program leadership, and Karralika senior leadership.

NRWSS SERVICE DELIVERY APPROACH

The NRWSS uses a flexible, client centred approach, combining the specialist expertise of the nursing staff with community based GPs and pharmacists. As a community based program, service users can be seen in a variety of locations, including Karralika offices, the service user's home, or an alternative safe location.

Flexibility applies across a number of domains. Withdrawal support is tailored to service user goals — from achieving abstinence completely, with or without medical support, to supporting a tapering or reduction in the quantities of alcohol or other drugs used. NRWSS service users can be seen as often as required, including multiple contacts per day, for as long as required. Staff balance this flexibility with structured plans to achieve drug use change goals within agreed timeframes.

The NRWSS can be medicated or non medicated and can involve the GP of the service user. For 39.8% of the service users, a GP was involved in the client's reduction or withdrawal.

Having a GP involved significantly adds to the caseload of nurses (for example, due to additional correspondence). Management noted that the capacity to manage withdrawal without GP input also demonstrates the autonomy, skills, and experience required for the NRWSS nurse role.

The NRWSS works closely with Karralika's other programs and external partners to ensure service users receive coordinated care that best meets their needs. As an example, service users with complex care needs can receive initial short term medicated residential withdrawal via Canberra Health Service's inpatient unit, then receive community based support for withdrawal via the NRWSS.

Alternatively, where inpatient withdrawal services are unable to cater to certain drug types or amounts (for example, Canberra Health Service has limitations on their ability to assist GHB withdrawal), the NRWSS has been able to either assist service users to reduce their use to make them eligible for admission to the residential withdrawal unit, or achieve a referral from their GP for a hospital admission prior to stepping down to the residential withdrawal unit. This ability to coordinate care delivery is based on formal systems of communication and information sharing and effective working relationships between the services.

NRWSS SERVICE USER PROFILE

Service user profile

In the 12 month period from January to December 2024, 95 episodes of care were provided to 85 unique service users. Nurses noted in the consultations that there seems to be a predominance of a low socioeconomic status among program participants, as well as participants who lack access to Medicare or permanent residency in Australia.

Most service users lived in cities (86.3%), were born in Australia (90.5%), and were non Indigenous (79.3%). About half of service users were male (51.6%) and 48.4% were female.

The number of female service users is higher compared to national averages of this population accessing alcohol and other drug treatment services (which is around 35%).[1] The average age of service users was 39 years.

One in five (20.7%) service users identified as Aboriginal and/or Torres Strait Islander, which is higher compared to national averages of this population accessing a withdrawal management service (which is 13%).[1]

Nearly a third (31.4%) of service users reported having a co-occurring physical health condition and 72.7% a co-occurring mental health condition, with 27.3% reporting to have both. Almost one in ten (9.5%) service users were culturally and linguistically diverse.

Most service users had not been arrested in the last three months before entering the NRWSS program (91.9%), while 17.6% of service users reported having been the victim of violence (for example, domestic violence) at admission.

More than a third (35.5%) of service users reported being employed at admission, with almost a quarter (22.6%) reporting to have full time work for more than 36 hours a week.

A similar rate of service users (35.5%) also reported to be unemployed at admission.

The usual accommodation of most service users was a rented house or flat (45.2%), a private residence (33.9%), or a privately owned house or flat (11.3%). A small percentage (3.2%) were in a shelter or refuge or were in an alcohol and drug treatment setting (3.2%).

More than a third (35.5%) of service users lived alone, with some living with children and no partner (6.5%). Almost one in five (19.4%) service users lived with their partner and children, with some living with just a partner (14.5%). Some service users reported to also be living with their parents (14.5%), with service users generally not living with friends (1.1%).

Alcohol and other drug use

Methamphetamine was the main drug of concern (40%), followed by alcohol (38.9%) and cannabis (13.7%). Polydrug use was high, with 36.8% of service users reporting a secondary drug of concern, the main one being cannabis (17.9%).

TABLE 1: Primary drug of concern (N=95)	%
Methamphetamine	40.0
Alcohol	38.9
Cannabis	13.7
Cocaine	2.1
Amphetamines	2.1
Heroin	1.1
Benzodiazepines	1.1
Tobacco	1.1

Most service users consume their alcohol and other drugs orally (42.1%), followed by smoking (32.6%) and injecting (12.6%). Most service users had never injected in their lifetime (67.4%).

1 *AIHW. Alcohol and other drug treatment services in Australia annual report. Canberra: Australian Institute of Health and Welfare; 2024.*

TABLE 2: Method of use (N=95)	%
Eats/drinks	42.1
Smokes	32.6
Injects	12.6
Inhales (vapour)	9.5
Sniffs (powder)	3.2

Referrals

Referral sources

Self referrals made up 54.7% of new episodes of care over the 12 month period. Other referrals were mainly received from residential alcohol and other drug treatment services (22.1%).

TABLE 3: Referral source (N=95)	%
Self	54.7
Residential alcohol & other drug treatment service	22.1
Other services	9.5
Child protection	5.3
Mental health care service	3.2
Non residential alcohol & other drugs treatment service	3.2
Correctional service	1.1
Medical practitioner	1.1

Referral processes

Timely communication with referrers, including people who self refer, is an important best practice benchmark. Responsiveness at the point of referral or first contact with service users allows engagement and support, including needs assessments and risk management, to commence. It also allows referrals to be made to more suitable supports if the NRWSS is not the best fit.

The program prioritises initial engagement and a 'no wrong door' approach, meaning service users are responded to quickly (within 48 hours of initial contact), receive a warm welcoming approach, and are supported to access alternative services via a warm referral if the NRWSS is not the most appropriate service type or location. Referrals can also be directly made to the nurses (a separate email address exists to support this pathway into the program).

We found evidence from our consultations that the NRWSS is highly responsive to referrals. Communication about referrals with the NRWSS team was described as 'frequent, responsive, and high quality.' The program is able to action incoming referrals rapidly, undertake comprehensive needs assessments, and determine suitability for the withdrawal service, as well as consider alternative options. Referrers spoke positively about the collaborative efforts by Karralika to ensure service users' needs are met. The NRWSS referral form is also seen as simple and user friendly.

The service maintains close relationships with referring and shared care partners (both within Karralika and externally), reinforcing eligibility and suitability criteria to ensure service users are matched with the most appropriate care.

However, the NRWSS team noted that engaging and communicating with community based GPs remains challenging. This difficulty can limit referrals, or lead to inappropriate referrals, and may impact on handover at the conclusion of a withdrawal episode of care.

Difficulties with engaging with community GPs is a persistent issue across the alcohol and other drug sector, and commonly stated barriers such as lack of specialist alcohol and other drug expertise or unwillingness to engage with treatment needs were echoed by Karralika staff during our consultations.

PROGRAM DELIVERY

Intake, assessment, and treatment planning

Many service users highlighted the speed of access, with some noting they were able to start the program after a single phone call or within 24 hours. The intake and admission process was described as efficient and well organised, despite service users sometimes finding the administrative process a burden due to a perception that intake involved duplication of questions.

Internal and external referrers noted that the requirement for multiple assessment touch points can create delays and frustrations, which can lead to service user disengagement. This tends to occur when a service user requires assessments for multiple drug types. It was suggested to streamline assessments between NRWSS and external services more to improve service user transitions — for example, handing over information from the referring service to lessen the information gathering burden at the NRWSS. This information sharing reflects current practice across other alcohol and other drug services in the area and occurs only following the service obtaining written permission from clients.

Nursing staff consulted during the evaluation also described initial assessment processes being potentially overwhelming for service users, especially when they are experiencing withdrawal symptoms. The nurses nominated a reduction in paperwork and/or simplifying assessments as potential ways to improve service user experiences at intake.

External referrers and service users noted that a particular strength of the service is that the nurses are highly responsive to referral requests from new service users. We heard from multiple informants that NRWSS staff initiate support prior to the service user undergoing a comprehensive assessment and formally entering the NRWSS program.

Most service users have a treatment plan in place (88.2%). The main reason that some service users did not have a treatment plan in place was the service user disengaged before the development of their plan.

Treatment delivery

Withdrawal management is the core business of the NRWSS program.

The average length of stay in the program is 24 days. This duration is calculated from when the first assessment is conducted through the provision of withdrawal management support to the closure of that service user's episode of care.

Most withdrawal management support is provided at home (62.1%). Some receive support at a non residential treatment service (24.2%) or a residential treatment service (13.7%).

The NRWSS program combines clinical work with motivational interviewing, brief counselling interventions, and case management support for service user goals. Treatment plans are tailored and include harm reduction; relapse prevention; and aftercare planning for counselling, residential rehabilitation, and other community resources and supports.

Karralika's model of care prioritises early engagement, thereby preventing and reducing alcohol and other drug related harms. There is a strong focus on 'no wrong door' access, ensuring warm referrals and continuous care pathways are considered throughout the episode of care.

The nurses play a critical dual role in clinical and therapeutic domains and this combination of skills is seen as contributing significantly to engagement, retention in care, and achieving positive service user outcomes. As noted in the NRWSS service delivery approach section (page 14), where a client does not have an external GP involved in their care, program nurses must lead the clinical component of care autonomously.

Similarly, when the client does not have a designated support person (who does not use alcohol or other drugs) in the community to assist, the additional support and risk management responsibilities fall to the program's nursing staff.

As is the case across most Australian alcohol and other drug services, workforce retention and development were identified as an ongoing challenge for the NRWSS, including hiring and training nurses with the required specialised skills. Informants noted that there are broader structural factors impacting the alcohol and other drug nursing workforce, including limited funding support for the advancement and professional development of nurse practitioners in the ACT compared to other jurisdictions.

Caseloads

The funding agreement states that there should be evidence of 60 clients assessed or treated per full time equivalent (FTE) registered nurse. Variations in workload associated with individual clients can be attributed to several client factors. If the client has a GP involved in their care, there will be additional correspondence involved, and if the client has no designated support person, nurses will be required to plan for and provide additional support.

In addition to direct service provision, the NRWSS provides secondary consultations to other health professionals where the client is not willing to engage with alcohol and other drug treatment services and education sessions from other service providers.

Currently the NRWSS program staffs 3.6 FTE nurses. The episodes of care of 95 for the year ending December 2024 translates into individual caseloads of approximately 27 service users allocated to each nurse. Caseloads are made up of a combination of service users with higher and lower needs to balance workloads across the team.

A total of 1472 direct clients contacts occurred during the evaluation period, averaging 15.5 direct client contacts per episode of care.

This means that, on average, 491 direct client contacts were provided per nurse within 12 months. This statistic does not include communication with other service providers and stakeholders such as GPs, other service providers, and family members.

Shared care

The NRWSS program collaborates effectively with external partner services in terms of management of service user needs (for example, determining suitability and best fit responses), coordinating shared care, and operational coordination like sharing information about eligibility and coordinating communication pathways.

One external referrer did express the desire for more formal shared initial case management between Karralika and the external service to improve alignment on service user needs. They suggested formalising communications by having dedicated email addresses for the different service providers to better track service user movements and updates.

The NRWSS team noted that two local external alcohol and other drug services were less well engaged with referrals to and shared care with the NRWSS.

These two services had expectations of medication prescribing that were unable to be met by the scope of practice of the NRWSS.

Continuing care

Continuing care and support after withdrawal includes a spectrum of services, from a tapering off of direct support from the NRWSS nurses to warm referrals and coordinated care with treatment programs such as residential rehabilitation. This capacity of the service to maintain engagement and/or facilitate handover to other services was highly valued by service users who provided feedback for the evaluation. Service users noted that they felt cared for, particularly after the immediate withdrawal phase.

The NRWSS team noted the importance of consistent communication with referring doctors and external stakeholders.

Program completion rate

Most service users (76.9%) who enter the NRWSS program have a successful outcome. Program success includes a successful program completion and a change in delivery setting or treatment type to better meet the needs of the service user.

TABLE 4: Reasons for leaving the program (N=95)	%
Completed program successfully	67.4
Change in main treatment type	7.4
Did not complete program	5.3
Ceased to participate against advice	5.3
Ceased to participate without notice	4.2
Ceased to participate involuntarily (non compliance)	4.3
Ceased to participate by mutual agreement	3.2
Change in the delivery setting	2.1
Referred to a more suitable service	0.0

NRWSS DEMONSTRATES POSITIVE SERVICE USER OUTCOMES

The NRWSS program shows positive aggregate service user outcomes across all main outcome measures included in this evaluation, including the Australian Treatment Outcomes Profile (ATOP), the Kessler-10 (K10) which measures psychological distress, and the EUROHIS-QOL 8-item which is a quality of life measure.

Alcohol and other drug use

The ATOP is a brief, 22 item instrument designed to assess alcohol and other drug use and general health and wellbeing over the preceding four weeks. It is a service user reported outcome measure and clinical risk screening tool, facilitating its integration into routine clinical care within alcohol and other drug treatment settings.

Forty percent of service users completed the instrument at admission and program completion.

The NRWSS program demonstrates that it successfully assists service users to cease or reduce their alcohol and other drug use. The number of days of using show downward trends for all substances, the exception being heroin and benzodiazepines. However, there was only one person who used heroin in the last four weeks, and service users could have been prescribed benzodiazepines to assist with withdrawal symptoms.

During our consultations, we explored outcomes for different drug use profiles. The nurses reported that reduction as a goal is more challenging for some service users, particularly those who are using cannabis and methamphetamines, who anecdotally appear to relapse more frequently. Nurses identified the importance of setting concrete reduction goals and timeframes for these user groups to enable sustained positive changes. In addition, the reduction plan and timeline are client led to be achievable and motivational interviewing techniques are used to increase client motivation.

TABLE 5: Number of days of using an alcohol or other drug in the past four weeks	**Using days**	
	Admission	Completion
Alcohol (N=24)*	**19**	**10.4**
Cannabis (N=13)	**16.5**	**10.5**
Amphetamine type substances (N=14)	**13.6**	**8**
Benzodiazepines (prescribed and illicit) (N=11)	**2.8**	**7**
Heroin (N=1)	**1**	**1**
Other opioids (N=0)	**-**	**-**
Cocaine (N=1)	**28**	**0**

**The N reflects the number of service users who have reported using that particular substance in the past four weeks. Each substance is analysed separately but please note that some service users reported using multiple substances in the past four weeks.*

Psychological distress

The K10 is a psychological distress scale measuring symptoms of anxiety and depression over the past four weeks. It consists of 10 items rated on a five point Likert scale (1 = none of the time, 5 = all of the time), with total scores ranging from 10 to 50. Higher scores indicate greater distress, with a score of 30 or more suggesting a very high level of psychological distress.

Forty percent of service users completed the instrument at admission and program completion.

On average, service users went from a very high level of psychological distress (average score of 31) to a high level of psychological distress (average score of 24).

Quality of life

The EUROHIS-QOL 8-item index is a brief measure of quality of life across key domains such as health, relationships, and financial security. Each item is rated on a five point Likert scale, and the total score is obtained by summing responses. Higher scores indicate better overall quality of life.

Almost one third (32.6%) of service users completed the instrument at admission and program completion.

On average, service users went from a moderate quality of life at admission (average score of 22.5) to a good quality of life at completion (average score of 27.3).

THE PROGRAM IS VALUED BY SERVICE USERS

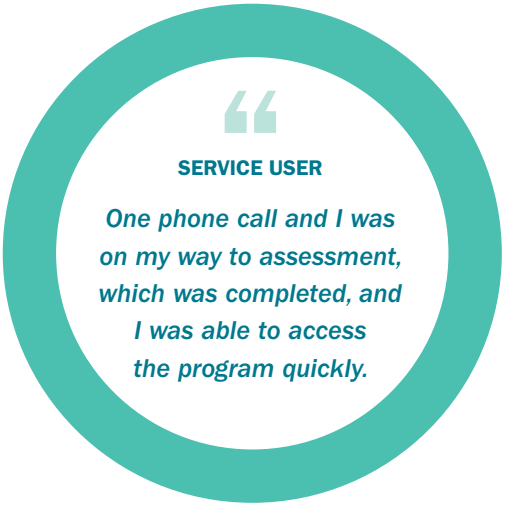
In total, 28.2% of service users completed the feedback survey. Almost all aspects of the NRWSS program are rated good or very good.

The program is meeting the needs of service users

The majority (87.5%) of service users found the overall quality of the NRWSS program very good and 12.5% found it good. The feedback (open comments in the survey) is overwhelmingly positive, with high praise for staff, accessibility, speed of service, and effectiveness.

The program is described as ‘life changing,’ with 87.5% of service users reporting they would definitely recommend the service to others and 12.5% reporting they would probably recommend it. Many service users have already recommended it to others.

Most (91.7%) service users had their treatment needs fully met, with 8.3% reporting that the program met their needs a little. A high proportion (70.8%) of service users reported that they received support from a different service while attending NRWSS.



CASE STUDY 1

Stan (pseudonym), a 36 year old male, had successfully completed a non residential withdrawal a year prior but had recently relapsed and contacted the program again.

The non residential withdrawal nurses completed a comprehensive nursing assessment at his home where he disclosed that he was consuming 25 to 35 standard drinks of alcohol daily and was smoking tobacco. He reported no other substance use. Stan reported some comorbid medical and mental health diagnoses, including chronic leg pain due to a vehicle accident, difficulty hearing due to a previously damaged inner ear, major depressive disorder, and PTSD, and reported that he was prescribed medication that is effective in managing his moods. Stan stated that he wanted to do an eight week residential rehabilitation program following his withdrawal from alcohol and nicotine.

The non residential withdrawal nurse developed an alcohol reduction plan with Stan as he experiences withdrawal symptoms when attempting reduction at home himself. Reducing his alcohol intake over two to three weeks before commencing a withdrawal phase provided a safer and more manageable withdrawal for Stan. Stan also engaged with alcohol and other drug counselling and SMART Recovery groups during his time in the non residential withdrawal program.

Unfortunately, during the non residential withdrawal program, Stan experienced some relationship issues which changed his stable home environment to one less stable. The non residential withdrawal team reassessed the environment, decided that two nurse visits were the safer option, and kept Stan in the non residential withdrawal program.

Stan also experienced some difficulties obtaining medication to support his reduction and withdrawal from his local GP, so the non residential withdrawal program referred him to an alcohol and other drug nurse practitioner where he was well supported throughout his reduction and withdrawal.

Throughout the withdrawal process, the non residential withdrawal nurse monitored Stan's vital signs, blood alcohol concentration (breathalyser), and completed withdrawal scales and random urine drug screens. The nurse worked with Stan to develop a withdrawal treatment and relapse prevention plan, helping him identify coping strategies to manage cravings and achieve his treatment goals. Motivational interviewing techniques were used to explore strategies for managing cravings and anxiety. The nurse also administered treatment outcome questionnaires (ATOP) at both admission and discharge to evaluate Stan's psychological health, quality of life, and substance use.

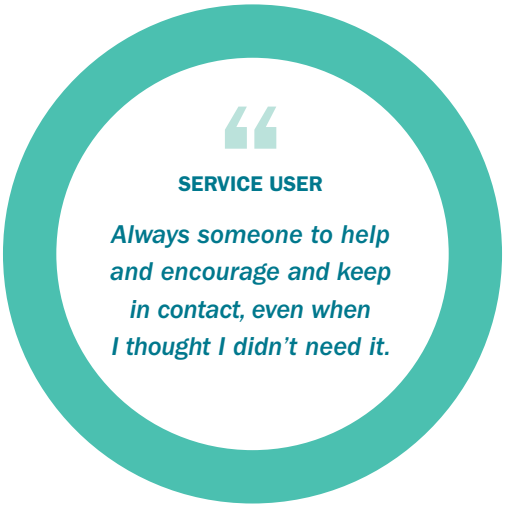
Stan was discharged from the non residential withdrawal program after completing his reduction and withdrawal and was 10 days abstinent from alcohol. Stan was prescribed pharmacotherapy to assist with alcohol cravings, commenced an alcohol and other drug day program instead of the residential rehabilitation program to learn relapse prevention skills, and continued with the alcohol and other drug counselling and SMART Recovery groups. Stan decided to delay his withdrawal from nicotine until he was secure in maintaining abstinence from alcohol. The non residential withdrawal nurses provided access to nicotine replacement therapy and Quit support services and apps to employ when he was ready.

Exceptional staff and personalised care

Service users strongly agreed (87.5%) or agreed (12.5%) that staff understood their needs. Service users also strongly agreed (83.3%) or agreed (16.7%) with program staff having the skills to support service users.

Service users strongly agreed (87.5%) or agreed (12.5%) with program staff having a professional approach to working with service users. Service users consistently praised the professionalism, empathy and dedication of staff. Many described staff as 'amazing,' 'highly professional,' 'caring,' and 'supportive.' Specific staff members were highlighted for their communication, attentiveness and ability to provide tailored support.

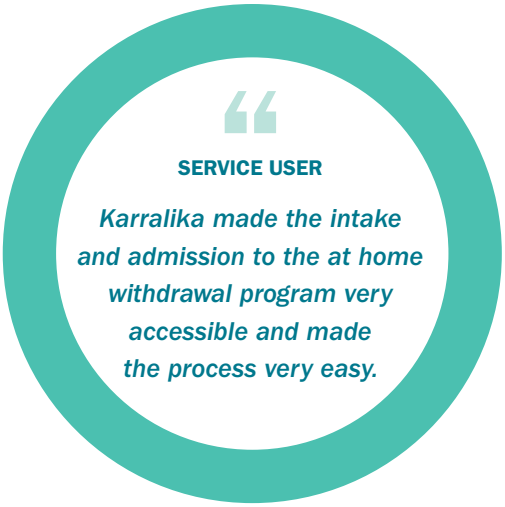
Service users strongly agreed (87.5%) or agreed (12.5%) with program staff respecting and accepting service users. Service users highly valued that the NRWSS nurses are nonjudgemental and proactive, always working to link a service user to alternative services when necessary.



Flexible and accessible service

Service users found it very easy (87.5%) or easy (12.5%) to get into the NRWSS program. Service users value the ability to self refer and the responsiveness of staff. The nurses noted that they try to accommodate the service users as much as possible, including providing home visits, meeting the service user wherever is convenient (for example, a park or near workplaces), and visiting a service user multiple times a day when needed. The service user feedback is reflective of the individualised care and the flexible approach service users receive.

Service users strongly agreed (87.5%) or agreed (12.5%) with feeling supported during their time in the program. Service users appreciated being able to remain at home, maintain their routine, and continue working while receiving support. Regular home visits and daily contact helped them stay on track. They valued structured support, check ins, and ongoing encouragement.



Access to other Karralika services

Half (50%) of service users discussed referral to a different service with a nurse. Easy access to a diverse range of services through Karralika's broader service offerings is an enabler to positive outcomes for service users. In addition to the NRWSS program, Karralika offers residential rehabilitation, community based programs such as day programs, and alcohol and other drug programs for young people. NRWSS service users are supported to access step up (for example, residential withdrawal) or step down services (for example, outreach support or outpatient counselling) as required.

This internal referral capability helps to facilitate continuity of care within the one organisation and limits the need for service users to advocate for themselves when they need support from other services.

THE PROGRAM IS EVIDENCE BASED

NRWSS delivers services that are aligned with the best practice evidence base. These include withdrawal management under specialist clinical supervision via nurses, harm reduction approaches, a biopsychosocial focus on needs, addressing motivation and readiness for change through motivational interviewing, person centred practice, use of brief interventions, relapse prevention, and provision for or planning aftercare.

The program is culturally responsive and uses validated screening tools, including the ATOP, K10, and EUROHIS-QOL 8-item.

Improving completion rates of these outcome measures could strengthen the evidence base of the program. For example, only 40% of the service users completed the K10 at admission and at program completion.

Responding to the GHB issue (described below in the Barriers to achieving positive outcomes for service users section, page 26) is an example of Karralika's commitment to using evidence based approaches and having effective governance processes in place. The Karralika team consulted national and international guidelines. Discussions with addiction medicine and other specialists led to the establishment of clear thresholds for community versus residential or hospital based care. This led to improved coordination between non residential, and hospital based services. The clear articulation of processes ensured that service users above a certain risk threshold could seamlessly transition to hospital care, then potentially step down to residential or non residential services. The process involved close communication between clinical teams, including clear referral pathways and risk sharing agreements.

Through these adjustments, the program successfully managed cases of GHB reduction and withdrawal and enhanced its ability to address complex alcohol and other drug use patterns. The example highlighted the program's capacity to adapt and respond to emerging substance trends, ensuring client safety and continuity of care. However, external referrers were not consistently informed that Karralika had updated their protocols to better support this cohort.

THE PROGRAM IS VALUED BY LOCAL SERVICE PARTNERS

External service partners and internal referrers were asked about the role the program plays in the ACT alcohol and other drug, health, and social services sectors.

NRWSS fills a treatment gap in the ACT

Karralika's strength lies in its integration within the alcohol and other drugs sector, offering diverse treatment pathways and maintaining strong relationships with stakeholders. Both the external and internal referrers report having positive experiences with the NRWSS program and team. There is a strong collaboration between the services and NRWSS, ensuring effective pathways for service users.

The NRWSS fills a critical gap for service users who require withdrawal support but do not meet eligibility criteria elsewhere (for example, clients who require support for GHB withdrawal). It fills a critical gap for nonmedicated withdrawal management in the ACT by providing an alternative for service users who do not require medicated withdrawal management or who cannot attend a residential program. Through these mechanisms, the NRWSS is reducing reliance on the ACT's hospital based withdrawal management programs.

Informants also found it helpful that service users can access external services while accessing the NRWSS and that service users can move between services (step up and down).

CASE STUDY 2

Kay (pseudonym) is a 51 year old with a history of drinking alcohol since the age of 13. She has had periods of sobriety which lasted for two to six years. She is engaged in the workforce full time and has kept the same job for many years despite her alcohol use issues.

Her father and siblings are supportive and she also has some good friends on whom she can rely.

She has previously attended residential rehabilitation and two different day programs. She is currently engaged in counselling and is prescribed antidepressant medication.

Kay reported that her drinking has caused problems by exacerbating her depressive episodes and mood swings. She says that she also gains weight, suffers from insomnia, and loses focus when drinking. She has had episodes of self harm and on at least two occasions has attempted suicide, for which she had an emergency admission to the hospital and mental health unit.

She reported to be consuming 14 to 20 standard drinks per day. She has never had a seizure while withdrawing but admits to long bouts of insomnia which often encourage her to drink again. The insomnia is problematic both when she drinks and when she is withdrawing. Her frequent hangovers have led to a lot of absenteeism at work.

Kay and the non residential withdrawal nurse decided that she would commence a withdrawal at home and a treatment plan was developed in collaboration with her GP. Unfortunately, Kay was provided with a full box of diazepam (50 tablets) for her withdrawal period, which can lead to a dependence on diazepam, which Kay is already at a higher risk of with her reported insomnia.

Kay's family agreed to keep the medication and dispense it as per the Karralika clinical guidelines for alcohol withdrawal.

The non residential withdrawal nurse saw Kay every day for that first week and monitored her vital signs, blood alcohol concentration (breathalyser), and completed withdrawal scales and random urine drug screens. The nurse ensured she was using the medication as advised. In the second week, the non residential withdrawal nurse had three home visits and phoned her on alternate days. The medication was not needed during this second week and was ceased, with any remaining diazepam tablets returned to the pharmacy.

The non residential withdrawal program worked with Kay for two weeks following the withdrawal period while she re-established alcohol and other drug counselling and Alcoholics Anonymous meetings. Kay did not want to attend residential rehabilitation or day programs at this time as she did not want to cause any more disruption to her workplace. Kay continued with abstinence from alcohol and her insomnia quickly resolved with some sleep hygiene techniques provided by the non residential withdrawal nurses.

Positive feedback from service users

Both external and internal referrers reported receiving positive feedback from service users. Service users report a comfortable, supportive experience and feel that they can discuss any issues (for example, concerns over relapse) with the nurses honestly and without judgement.

Communication and coordination is excellent

The NRWSS team is highly responsive, with no significant issues identified in our examination of program data or informant reports regarding barriers to admission or timeliness of referrals.

The service has never failed to accept a service user on the requested date. While the NRWSS team is good at informing external referrers about service user acceptance and completion of the program, there is room for improvement in communication around service user dropouts. External referrers reported a perception that handover of service user information at the end of the program is sometimes ad hoc. This may reflect a misunderstanding as to when a discharge letter was issued (for example, no letter would be issued if the person has been transferred to another Karralika Program).

BARRIERS TO ACHIEVING POSITIVE OUTCOMES FOR SERVICE USERS

Program awareness

Some service users indicated that they were surprised that they had not heard of NRWSS earlier and suggested increasing awareness, particularly around self referral options. Nurses likewise noted that increased promotion (and possibly a name change) of the program is needed, as NRWSS remains underutilised despite being the only service of its kind in Canberra.

Availability of community support persons

It is preferred that NRWSS service users have a designated support person who is able to support the person during the critical time of their reduction or withdrawal. This sometimes involves assisting with managing the medication (if involved). The support person is required to be free of alcohol and other drug use while in the support person role. Most service users do not have a support person that can provide this type of support (79.6%). The requirement to fill this gap places an additional burden on the nurses as the treatment plan needs to be altered to allow for additional support and potentially the management of additional risk.

Complex needs

A high number of service users experience co-occurring mental health issues (see the Service user profile section, page 14). Mental health issues exacerbate challenges for service users, as withdrawal management without proper mental health support can worsen risks such as self harm.

During our consultations, nursing staff noted that over time the program has adapted its eligibility criteria to cater to people who were not readily catered to by residential withdrawal programs, such as those using methamphetamine and cannabis and who had co-occurring mental health needs.

Coordinated care for service users with complex needs is complicated by external service factors. Mental health services are limited or have a long waiting list in the ACT. Support for mental health issues should ideally already be in place before a service user enters the NRWSS program. NRWSS does not have the capacity to manage complex mental health or risk presentations as a flexible, outreach based service with a primary mandate to support alcohol and other drug behaviour change.

Lack of accessible GPs

A particular barrier that was noted in the consultations was an overall unwillingness of some GPs to prescribe or work with service users with alcohol and other drug issues. Additionally, GPs sometimes fail to prescribe withdrawal medications, causing delays and difficulties for service users. Gaps in medication support are especially problematic for high risk service users.

GPs who bulk bill are particularly hard to find, leaving many service users without the necessary medical support. This is problematic considering many service users have co-occurring physical health conditions.

A prescriber on site or accessible GPs would significantly improve the support provided by the NRWSS nurses.

Karralika is engaged in outreach to GPs to improve engagement and educate GPs on alcohol and other drugs, improve capabilities, increase willingness to work with this cohort, and contribute to lower stigma for service users.

Practice consistency

On the whole, internal and external consultations reflected a high degree of practice consistency across the delivery of the NRWSS. One of the external referrers noted some inconsistency in practice among team members, with this referrer noting that some nurses were more flexible and accommodating than other nurses at intake. The example given was variability in the requirement for medication to be arranged for a service user prior to entering the NRWSS. This reported inconsistency appears to have only impacted one external referral service.

Reduced capacity in weekend

NRWSS operates from Monday to Friday, which sometimes makes referrals hard for service users whose withdrawal management should ideally start on the weekend. Some informants noted that this could potentially lead to service users dropping out.

Responding to service users who use GHB

Informants noted that not being able to refer service users who are using GHB to NRWSS, regardless of whether GHB is their primary drug of concern or part of polydrug use, was a significant barrier. One external service has stopped referring individuals with GHB use to the NRWSS program. Karralika has however made changes to their clinical guidelines to be able to assist this group.

The GHB issue is however not unique to Karralika and is an issue within the ACT more broadly. For example, this group is often also ineligible for residential withdrawal management services. A particular issue for supporting service users who use GHB are the potentially life threatening complications that may occur during withdrawal. Multiple clinical guidelines across many Australian states and territories identify that 24 hour nursing observation is required to safely manage a withdrawal from high use or dependent use of GHB, and resources only available at hospitals would be needed if any of the complications were to occur.

Karralika has taken steps to assist people who want to undergo a withdrawal from GHB that are beyond recommended safe care in the community. It however seems that external services are not aware of this change. See the program is evidence based section, page 24.

CASE STUDY 3

Alex (pseudonym) is a 58 year old male referred to the non residential withdrawal program by a local residential rehabilitation service.

The referral was coordinated with the non residential withdrawal program prior to Alex's admission to the residential rehabilitation program, as Alex was homeless at the time and was unable to access residential withdrawal. The residential rehabilitation program was willing to provide Alex the safe and supportive environment to undergo withdrawal prior to participating in their program.

A non residential withdrawal nurse completed the assessment where Alex reported injecting two points of methamphetamine daily and three to four points at his worst. Alex reported he first used methamphetamine at the age of 48 and had previously been to a different rehabilitation service and relapsed recently after maintaining abstinence for one month. Alex indicated he was diagnosed with depression, which is well managed with antidepressant medication, and has no other medical diagnoses.

During the non residential withdrawal program, the nurses provided visits at the residential rehabilitation site to monitor his vital signs, complete the withdrawal scale, and conduct urine drug screening and random breathalysers for alcohol. On the first nursing appointment, Alex's baseline urine drug screen was positive for methamphetamine and amphetamine and negative for all other substances. His breathalyser results also showed he was negative for alcohol.

The non residential withdrawal nurses also examined Alex's injection sites for infection and checked if he had recently had testing for blood borne viruses and sexually transmitted diseases. The nurse also took the opportunity to provide harm minimisation education to Alex and offered repeat testing with a GP or sexual health clinic.

As part of the non residential withdrawal program, the nurses worked with Alex to develop a withdrawal treatment plan and identified coping strategies to ease his cravings and reach his treatment goals with short interventions. The NRW nurses implemented motivation interviewing tools to assist Alex and explore strategies to cope with cravings and anxiety. Non residential withdrawal nurses also completed the treatment outcome questionnaire tools (ATOP) at admission and discharge to explore Alex's psychological health, quality of life, and reduction in substance use.

Alex experienced common methamphetamine withdrawal symptoms such as irritability, anxiousness, tiredness, sleeping a lot, and sweating. On day four, Alex reported feeling restless, anxious, and having nightmares. Alex reported he was unable to calm himself down with distraction strategies and was really struggling with the withdrawal.

The non residential withdrawal nurse collaborated with his GP over the phone and arranged a telehealth appointment for Alex with his GP. The GP provided him with an e-prescription for medication to assist with his withdrawal symptoms. Alex's anxiety, restlessness, and nightmares were resolved with two doses of the medication. On day six, Alex confirmed he was not experiencing any withdrawal symptoms, including anxiety and nightmares. He reported having a better sleep and appetite and more energy to do daily activities. On day nine of his withdrawal, he started participating in the rehabilitation program.

Alex successfully completed his withdrawal and after 10 days of detox he provided three consecutive urine drug screens that were negative for methamphetamine, amphetamine, and other drugs. Alex continued in the residential rehabilitation program after completing the non residential withdrawal program.

Recommendations

NRWSS is an exceptional and much needed nurse led program that provides vital, evidence based withdrawal support to people in the ACT. The program's high level of responsiveness, flexibility, and person centred approach ensures that individuals can access withdrawal support while remaining in their community, filling a critical service gap.

The evaluation findings demonstrate strong governance, effective service delivery, and positive outcomes for service users, reinforcing the program's value and success. Service users and external stakeholders consistently praise the dedication, professionalism, and compassion of the program staff and the high completion rates and improved wellbeing outcomes highlight the program's impact.

While the program is already delivering high quality care, there are opportunities to further strengthen service accessibility, coordination, and sustainability. The following recommendations do not suggest fundamental changes but rather focus on enhancing and refining existing service strengths, ensuring that the program remains adaptable, well resourced, and equipped to meet the growing needs of the community.

These recommendations align with the program's commitment to continuous improvement and reflect the dedication of the NRWSS team to providing the best possible care for service users in the ACT and regional NSW.

STRENGTHENING ENGAGEMENT WITH GPS

The NRWSS program has demonstrated strong adaptability in responding to emerging needs and maintaining evidence based practice.

However, challenges in GP engagement remain a sector wide issue, including for the NRWSS program. Many GPs lack confidence, knowledge, and skills in working with people who experience alcohol and other drug use problems. GPs are also often less willing to engage with alcohol and other drug services due to stigma, limited understanding of withdrawal management and other interventions, and concerns about the complexity of alcohol and other drug related health issues. This reluctance has resulted in difficulties for the NRWSS nurses in terms of having GPs prescribe withdrawal medications, managing co-occurring conditions, and ensuring effective care transitions.

Targeted GP education and training programs should be funded to reduce stigma and increase awareness of evidence based withdrawal management. Education could focus on challenging misconceptions about alcohol and other drug service users and providing practical guidance on managing withdrawal. In addition, exploring funding opportunities for a dedicated GP liaison position would enhance service coordination and engagement at NRWSS. This role could facilitate better communication between GPs and the NRWSS nurses, improve referral pathways, and provide direct education to GP clinics.

ADDRESSING GAPS IN MENTAL HEALTH SUPPORT

The high prevalence of co-occurring mental health conditions among service users presents an ongoing challenge, particularly given the difficulty in engaging mental health services. NRWSS has shown adaptability in adjusting eligibility criteria to better support people with complex needs, but further collaboration is needed. Strengthening partnerships with mental health services for service users with co-occurring mental health needs would enhance coordinated care. Some options to consider for improving shared care processes between the NRWSS and mental health services include negotiating agreements for closer collaboration that allow for expedited referral, shared multidisciplinary meetings, streamlined information sharing, and worker co-location or staff exchange.

IMPROVING SERVICE ACCESSIBILITY AND CAPACITY

Service accessibility remains a core strength of NRWSS, with fast intake processes and flexible service delivery, including home based withdrawal support. However, the program currently operates Monday to Friday, and some service users may require withdrawal support outside of these hours. This limited availability could lead to a drop off in engagement, particularly for individuals who experience withdrawal symptoms over the weekend and are unable to access immediate support.

To improve accessibility, NRWSS could consider extending service hours to ensure service users receive timely care when they need it most. While additional funding would be required to achieve this, exploring options for limited weekend availability or after hours check ins could enhance retention and reduce the risk of disengagement. Given the program's strong commitment to flexibility and person centred care, adjusting service hours could further strengthen its ability to meet the needs of service users and improve overall outcomes.

WORKFORCE DEVELOPMENT AND RETENTION

The dual clinical and therapeutic role of NRWSS nurses is a key factor in the program's success, but workforce retention remains a challenge. To address this, advocacy for increased funding to support alcohol and other drug nurse practitioner roles should be prioritised, ensuring specialist nursing pathways are strengthened. Karralika could explore opportunities with the funder for nurse practitioner training positions, creating a sustainable workforce pipeline.

INFORMING EXTERNAL PROVIDERS ABOUT PRACTICE CHANGES

The program's ability to adapt to emerging alcohol and other drug use trends has been demonstrated through its evolving approach to GHB withdrawal management. However, better external communication regarding recent clinical protocol changes could help to ensure referrers understand the program's capabilities. Continued collaboration with hospital based withdrawal services is essential to ensure seamless transitions for service users requiring inpatient level care. Given that other services in the ACT and nationwide face similar challenges, leveraging sector wide forums to advocate for improved clinical guidance on community based GHB withdrawal could be considered.

INCREASING PROGRAM AWARENESS AND PROMOTION

Despite the program's strong reputation and high service user satisfaction, service users and nurses indicated that service users are often unaware of the NRWSS program before engaging with the program.

Increasing targeted community outreach would help improve accessibility and encourage self referrals. In addition, a review of the program's branding or name could be considered to ensure the service is easily understood by the broader community and to encourage self referrals.

We also recommend promoting the role of this program in reducing the burden on the public health system. We found that this unique nurse led program provides high level clinical support in the community and reduces demand for alcohol and other drugs support in hospital emergency departments, hospital based withdrawal units and inpatient alcohol and other drugs programs. The value of this program's role in providing clinical care 'at home', cannot be underestimated. However, currently there is limited data to support this program's impact on the broader health system. We recommend identifying existing data sources that will contribute to validating this value and telling the story of how the program helps to reduce the burden on the local public health system.

MONITORING AND EVALUATION

The program has a collaboratively designed evaluation framework in place that includes validated tools to measure service user outcomes and overall program effectiveness. For this evaluation, data collection was undertaken by NRWSS staff, while 360Edge conducted the analysis.

Karralika already collects a robust set of data as part of their routine quality assurance and reporting processes. Karralika also regularly analyses this type of data to inform service planning and meet funding key performance indicators and reporting requirements. However, for the purpose of this evaluation additional data was collected (for example, GP involvement in withdrawal support) which went beyond standard data collection.

The use of an Excel file to collect the additional evaluation specific data was not viewed as burdensome by the NRWSS nurses, and has provided additional insights for program fidelity and quality monitoring.

We recommend Karralika consider ongoing collection of these additional data items to inform service improvement and quality assurance processes, to allow the program to demonstrate service delivery impact, and to strengthen advocacy for funding and policy change.

Increasing client response rates for the post treatment feedback surveys proved challenging. Despite the adoption of several strategies to improve response rates (for example, offering hardcopy forms, providing QR codes, and nurse administered options), the response rate remained relatively low. This is a sector wide issue and not unique to this program. Nevertheless, it does limit the breadth of service user perspectives that can be captured. We recommend that Karralika maintain the processes put in place during the evaluation to encourage higher response rates. We also recommend regular audits of completion rates and consideration that service user experience and satisfaction data response rates should be a key internal KPI for this program.

Finally, while Karralika has demonstrated strong capacity to manage and analyse data internally, evaluations of this scale and complexity require significant time, expertise, and resources.

If the evaluation framework is to be used on an ongoing basis or for future evaluations of similar depth, additional funding to reduce the burden placed on Karralika to collect and analyse the data is essential. Karralika may wish to strategically deploy comprehensive evaluations like this at key intervals to maximise insight and impact without overburdening service delivery staff.

Appendix 1

NRWSS PROGRAM LOGIC MODEL

OBJECTIVES	INPUTS	ACTIVITIES	OUTPUTS	IMPACTS	OUTCOMES
To assist a person to cease or reduce substance use to a level that restores a person's health and wellbeing in the short-term	Effective governance, quality assurance, administration infrastructure	Line management, clinical supervision and quality assurance	Program effectively managed, staff supervised, program accredited	Program maintains high quality and consistent service provision	Improved service user health, wellbeing and quality of life outcomes
	Service users	Stakeholder relationship management, service promotion	Appropriate staff recruited and retained, required skills provided	Program is delivered with high fidelity and is sustainable	
	Funding/resources	Service users engaged and provided with evidence based care as per program documentation	Service users receive screening, assessment, treatment planning, withdrawal services and aftercare/referral	Improved service user health, wellbeing and quality of life outcomes demonstrated. Reduction in harms to service users and the ACT community	
To provide a step-up or step-down response for clients requiring withdrawal and/or stabilisation, including bed-based withdrawal services	Evidence based program content	Suitable staff profile maintained	Outcomes monitored with validated measures, KPIs tracked and reported	Program quality assurance, accountability for individual and cohort positive outcomes	Reduction in harms associated with alcohol and other drug use amongst ACT community
	Stakeholder engagement and referrers	Secondary consultation for external providers	Referral and shared care providers well informed and engaged with service	Secondary consultation for external providers	
To form part of an integrated and coordinated care pathway by connecting clients with aftercare alcohol and other drug services and community health and wellbeing services	Collaborating care stakeholders	Facilitate linkages to external services	External providers receive clinical advice services	Overall capacity of sector to provide response services improved	Improved sector alcohol and other drug responsivity
	Client record management system	Program monitoring and reporting	Service users engaged with specialist external service providers	Service users are supported to access suitable shared care, aftercare and step-up or step-down treatment outcomes	
	Qualified and supported workforce				

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