Final Report

Western Victoria AOD Service Development Coordination Project

Researched and written by VAADA

Western Victoria Primary Health Network and VAADA

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phn WESTERN VICTORIA

An Australian Government Initiative

Together with our partners and communities, Western Victoria PHN identifies priority health care needs, improves access through government funding, and co-designs localised solutions to improve health care systems across western Victoria.

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1 Executive Summary

The Western Victoria Primary Health Network (PHN) is responsible for increasing the efficiency, effectiveness and coordination of health services for patients, particularly those at risk of poor health outcomes. Working together with community and health industry partners, Western Victoria PHN aims to strengthen the primary health care system based on local need. The PHN focuses on improving access to AOD services, and augmenting system integration and coordination of services across four regional centres: Ballarat, Geelong, Horsham and Warrnambool.

In line with their objectives, the Western Vic PHN commissioned AOD treatment providers to deliver AOD Brief Intervention programs across the four sub-regions to reduce AOD harm and prevent or delay onset of regular or problematic AOD use.

To support this project, the PHN engaged VAADA to provide coordination support to assist four commissioned agencies to integrate regional referral pathways across State and Commonwealth-funded programs and assist in the promotion and establishment of relationships with Primary Care, Community and Emergency Service in each sub-region. The project also supported the design and implementation of an evaluation framework across all regions. VAADA has collaboratively supported services through model development and articulation and workforce development. Participating agencies included:

- Western Region Alcohol and Other Drug Centre (WRAD) in consortia
  - Self Help Addiction Resource Centre (SHARC)
  - Portland District Health
  - Brophy Youth and Family Service
- Grampians Community Health
- Uniting Ballarat
- Barwon Child Youth and Family in consortia
  - Colac Area Health
  - Stepping Up

Objectives for the Service Development Coordination Project were achieved via a combination of strategies, including network meetings, questionnaires, qualitative interviews, guided reflection and stakeholder identification activities.

The aim of the project was to yield benefits for both the Western Victoria PHN and the commissioned agencies. It was anticipated the PHN would benefit from understanding key factors required for successful model implementation in regional areas and assurance that its commissioning investment yielded its intended benefits and deeper insights into the needs and experience of commissioned agencies.

Agencies themselves stood to benefit from collaboration and shared learnings, articulating region specific rationales for service targets and by reflecting on and capturing on-going service design. See project aims matrix in section five of this report for more detail. Overall, the project delivered successfully on all objectives, and through that process, captured many of the successes and challenges faced by agencies in implementing the Brief Intervention service.

Successes of the Brief Intervention programs for agencies included:

- Demonstrated resourcefulness and commitment of agencies to implement service as intended and maintain a real belief in its value and future potential
- Offering service to clients (many of whom had complex needs) who would otherwise have not accessed mainstream AOD programs
- Brief intervention integrated well into already existing service environment

Challenges faced during the implementation of the Brief Intervention programs included:

- Delays in recruiting suitably skilled and qualified staff
- Underestimation of time and resource required for consolidating referral pathways
- Overcoming barriers caused by stigma to engage with and refer to the service
- Systemic barriers to accessing GPs and enabling referrals

Regarding outcomes for the PHN, this report details some of the key factors required for successful model implementation in regional areas and offers insights into the needs and experience of commissioned agencies. Observation of the implementation of the Brief Intervention indicates it is meeting its objectives and servicing regional clients effectively.

2 Project domains and Methodology

This section describes what VAADA did against each of the five project domains, which were:

- Service development coordination
- Model development and articulation
- Working collaboratively with development of shared reporting framework
- Work with Evaluation
- Workforce Development

The project domains were primarily centred around offering support to commissioned services to integrate regional referral pathways and focus on establishing relationships with primary care, community health and emergency services within each sub-region. Further to that, attention was also brought to a shared evaluation framework for the brief intervention programs, model articulation and refinement, and the workforce development needs of a successful brief intervention service.

2.1 Service development coordination

Objective: Provide predominantly face-to-face coordination meetings with commissioned agencies across the Western Victoria PHN region

What we did:

Service development coordination was primarily achieved by way of face to face network meetings, and through using an integrated approach, this modality also acted as a method to address elements of stakeholder identification, shared learnings, service targets, support with evaluation and workforce development needs.

Network meetings provided an opportunity for agencies to share learnings, discuss service targets, clarify questions regarding evaluation, build relationships and access learning and

development. They also provided a unique platform for a regional community of practice where participants could discuss challenges, identify possible solutions, reflect on progress, offer support and to build a sense of connectedness and shared goals across the region.

How we did it:

Four face-to-face network meetings were held with representatives from commissioned agencies. As Ballarat was identified as most centrally located, by consensus all meetings were held at the Ballarat Primary Health Network. Commencing in November 2017, meetings were held approximately every two months and to allow reasonable travel time, were held from 11am to 3pm.

Key management representatives and practitioners from each of the commissioned agencies (including consortia representatives) were invited to attend either in person or via teleconference.

Agendas were guided by project domains, feedback from participants and matters topical to the brief intervention services such as pharmacotherapy and the rescheduling of codeine. Full agendas for each meeting available on request.

Evaluations were undertaken with responses indicating the sessions were valuable as opportunities for professional development, networking and clarification regarding ASPEX evaluations.

2.2 Model development and articulation

Objective: Support services to articulate a model of brief intervention
Objective: Support commissioned services in the development of referral pathways

What we did:

Model development and articulation was achieved via the development of a service design template (see appendices), written questionnaire (see appendices), and qualitative interviews. Further to this, agencies were supported in developing referral pathways via activities focused on identifying and mapping stakeholders within their particular regional context.

How we did it:

The service design template provided a consistent architecture for agencies to articulate their service aims, objectives, targets, stakeholders, referral pathways, screening and assessment, intervention, evaluation and to capture a narrative of learnings and on-going service design. Agencies were encouraged to showcase work undertaken in building partnerships, engaging with the community and stakeholders and other achievements not easily extrapolated from reporting data.

Agencies were introduced to this template at a network meeting, where the purpose and function of the document was explained. They were also given an opportunity to provide feedback on both the structure and usefulness of the template. Anecdotal feedback about the template was positive, with agencies appreciating the structured reflection its completion afforded.

Recognising the necessary shifts required to translate a service from theory to practice, VAADA helped agencies to identify new opportunities and learnings that arose through the implementation process and those which may have necessitated on-going service design. The agencies were provided with a questionnaire covering topics such as success and challenges of the implementation, stakeholder engagement, on-going service design and key skills and competencies used by staff. Following this, interviews were held with each agency to discuss these questions, and obtain qualitative feedback. During this reflection, agencies were also asked to explain what changes were introduced, to what end, challenges or barriers faced, and any subsequent impact on stakeholder engagement or meeting service targets.

During an early network meeting, VAADA facilitated a stakeholder identification and mapping exercise. The purpose was for agencies to consider the broader impacts of their projects, to identify potential allies or resistors, to develop a more sophisticated understanding of stakeholder perspectives and assess the quality of stakeholder relationships. Agencies identified additional stakeholders as potential sources of referral, particularly when most faced systemic barriers in engaging with GPs. Agencies explored methods of effective communication and engagement based on their knowledge of stakeholder perspectives, interests and motivations.

2.3 Working collaboratively with development of a shared reporting framework

Objective: Support agencies to develop service targets

What we did:

Working collaboratively with development of a shared reporting framework was realised via structured conversations and questionnaires supporting agencies to identify program efficacy and give focus to regional context.

How we did it

When VAADA commenced working on this project, the WVPHN had already facilitated ground work with agencies to develop a shared reporting framework. As a result, VAADA then focused on assisting agencies to articulate a narrative with regard to meeting service targets and identify learnings associated with implementation.

As outlined in 2.2, VAADA included sections relating to service targets, service scope and staffing levels. Agencies were asked to reflect on proposed targets against implementation learnings and indicate more accurate service targets moving forward. Further discussions were also had during agency interviews and network meetings.

2.4 Work with Evaluation

Objective: Support external evaluation of AOD models of brief intervention

What we did:

Work with evaluation was undertaken via acting as a conduit between ASPEX evaluators and agencies, to provide guidance or answer questions. In particular, ASPEX had direct access to agencies by running sessions at two network meetings.

How we did it:

VAADA supported ASPEX to undertake an evaluation of the AOD models of brief intervention, by acting as a conduit between ASPEX and the agencies, particularly in following up intermittent questions or need for clarification. ASPEX was invited to attend two out of the four network meetings, providing an opportunity to discuss process of data collection, input of data and appraisal collection. Agencies were also afforded a mid-evaluation overview of trends in data, of most importance being the clear effectiveness of their interventions in improving quality of life for participants.

2.5 Workforce Development

Objective: Assess training support needs in delivering the model

What we did:

Workforce Development needs were assessed initially via a targeted activity during a network meeting and further clarified via questionnaire and qualitative interview. VAADA is also working to gain access to workforce survey data, to mine and extract information relevant to the Western Victoria region.

How we did it:

This process was informed by a number of activities, the first being a session at a network meeting, and the second being through questionnaire and interview.

During the network meeting, participants were broken up into two groups – clinicians and supervisors/managers. Each group was asked to create two lists, one to identify already existing skills used in implementing their models, and the second to outline a skills gap. Once these lists were completed, participants were then asked to focus on the 'skills to develop' and to place a mark against what they saw as the top two priorities. The 'votes' column in the below table show how many marks were placed against each priority:

Group	Skills Used	Skills to Develop	Votes
Managers	Networking Community Development Coordination Recruitment Service System Knowledge Supervision	Clinical Governance Increased funds Referral Systems Cert IV core units AOD/MH (for staff) Funding Availabilities Supervision Training Youth recommissioning How to talk to GPs and Police Family Therapy Increased contact from PHN	4 4 4 2 1 1 1 1

Clinicians	Communication Networking Single session approach MFT/CBT Adaption Harm minimisation Holistic Systems Relapse Prevention	Clinical Risk Research Trends Trauma Spectrum Pharmacotherapy Networking Different types of approaches	4 3 3 3 2

Workforce skills

During questionnaire and interview, agencies were asked to identify the key skills and competencies needed to successfully implement the brief intervention program. Culminated results are found in the below table:

Competencies	Skills	Clinical skills/knowledge
Stakeholder engagement Community engagement Networking Partnership development Collaborative practice Planning, coordination and evaluation of outreach services	Perseverance Influencing skills Flexibility Advocacy skills Interpersonal skills	Family inclusive practice AOD treatment knowledge Referral sources Trauma informed practice Motivational interviewing Education and training skills (making presentations) Single session therapy Youth engagement Neuro-psychotherapy Alternative modalities Internal Family Systems

Key Workforce Competencies

Network meetings were also used as a vehicle for professional development workshops, with agencies being upskilled in the following –

- Identifying and managing stakeholders, inter-agency mapping
- Service implications regarding –
  - Pharmacotherapy in Western Victoria
  - Impact of Real Time Prescription Monitoring
  - Rescheduling of opioids
- Reflective practice through sharing of case studies
- Working with families and carers (SHARC, Family Drug Help)

3 Findings from the implementation of the Brief Intervention Programs

This section outlines the positives, or successes the agencies experienced in implementing the Brief Intervention services, and following that, the challenges and barriers they faced as well.

3.1 Positives

A significant positive has been the agencies' commitment to make the brief intervention services a success. Staff have shown exceptional perseverance, persistence and optimism, particularly in the face of many challenges, in establishing stakeholder relationships and developing stable referral pathways. There is a real belief that brief intervention is an effective and valuable service, which has a lot of potential to expand.

Each agency achieved success in accessing a client group that would otherwise have not utilised a mainstream AOD service. It is interesting to note, that many of these clients have presented with complex and multiple needs, so the brief intervention has in many instances been an entry into the state-funded system and to other community services such as homelessness, mental health, family support and financial. In this way, the brief intervention model has integrated well into the already existing AOD and community services environment, and collaboration with other services has seen clients receiving wrap-around support where needed. It is also interesting that this service has seen many families and carers engage, not just looking for advice and guidance for their loved one, but also in seeking out support themselves.

Agencies have shown great resourcefulness in responding to the challenges and unexpected outcomes of the implementation of the brief intervention service. Specific challenges will be discussed in the next section of the report, however agencies transformed them into opportunities and armed with shared learnings from their counterparts in other sub-regions, made inroads with new client groups and stakeholders. For example, success with the emergency department at the local hospital in one sub-region has led to other regions exploring similar options. Agencies have also tailored service offerings to respond to regional needs such as extended hours for farmers or other professionals who would not be able to access support during traditional work hours, and connecting with industry and corporations whose long hours and difficult working conditions have seen increased problematic substance use in employees.

Given one of the regions is experiencing a service gap for youth, local schools were targeted and found some success with providing outreach to students. The brief intervention model has been seen as a good option for youth, as it is a less confronting entry point and can lead to further supports as required.

In another region, already existing relationships and strong partnerships with schools has seen the youth focused brief intervention element have early and continued success. As an already trusted and proven service, the brief intervention model simply became another service offering and existing referral pathways and processes were utilised. Stigma of AOD use was overcome by running a program called 'Healthy Choices' and encouraged participation by having an opt-out consent option. This meant that young people could maintain anonymity as it was a general focus rather than a targeted one, and the 'Healthy Choices' perspective was further de-stigmatising for young people, parents and schools. The group focus also incorporated the peer support element so important to young people, whilst still acting as an entry point if further individual support was required.

Another positive has been developing an improved understanding of the service environment in each region, and promoting and educating stakeholders about AOD services available. In most instances general practitioners (GPs) have been genuinely interested in

co-locating the service, however the recognised clinical benefits of this were outweighed by room availability particularly in light of the income generated by room rentals. Success has been achieved with co-location in a few clinics or community health services, however this has not been consistent. It has also been noted that trusted relationships with referral sources are far more important than co-location. Referral net has had some success in providing GPs and allied health with an option for a quick and easy referral, and some practice nurses have offered strong and effective support, however this is not consistent across medical clinics or sub-regions. GPs have valued feedback as to the outcome of the referral.

The brief intervention network meetings which provided opportunities for shared learnings, relationship building, problem solving, reflection, support and a sense of connectedness, where identified as a positive through the implementation phase and on-going.

3.2 Challenges

A major challenge for agencies was recruiting specialised and appropriately qualified staff in time limited positions. For those agencies who needed to employ additional staff to run the brief intervention, their commencement was significantly delayed due to recruitment processes and other agencies were negatively impacted when staff resigned in preference of more secure and stable employment.

Another challenge for the brief intervention agencies, was engaging with GPs. Although in most instances GPs were receptive of the service, albeit sceptical of its durability given the short-term funding, the business model applied in running clinics presented a systemic barrier that has proven very difficult to overcome. Some agencies spoke of practice managers acting as ‘gatekeepers’ and having to find alternative methods of seeking out GPs at network events, and where others had unfettered access to GPs, found that a lack of Medicare item number meant there was no financial incentive for GPs to refer. Some agencies found success in (free) co-location with GPs where the visibility of the service, supportive nurse practitioners and immediate access to secondary consult saw an increase in referrals. Most agencies struggled to access rooms or facilities at GP clinics as the business model promoted renting rooms to allied health care practitioners and as agencies had no funding for this, there was no financial incentive for clinics to make rooms available.

The issue of stigma surrounding AOD use also proved to be a significant challenge for the service implementation. Ironically, one of the rationale for the brief intervention model was to access clients who due to a range of reasons, stigma being one of them, would not normally access mainstream AOD services. This very same stigma remained a fairly hefty obstacle for agencies to overcome, particularly in relation to setting up a family and carer’s service in Portland and Camperdown. Although the peer support model had been very successful in Colac, and despite active and targeted promotion, SHARC struggled to gain a foothold and lacking any real champions or advocates from within the community instead shifted their focus to deliver individual telephone counselling providing support as well as anonymity. Further to this, GPs themselves may have shown some internalised stigma, via a lack of confidence or propensity to ask their clients questions about AOD use, and for some clients, disclosing to a GP with whom they have an on-going relationship could also have been affected by stigma. In one clinic setting, nurse practitioners included AOD questionnaires with initial paperwork for new clients, however were often met with incredulity and indignation from people who clearly took offence at somehow feeling ‘targeted’. Agencies who reached out to schools as a referral source, would often be met with resistance and

claims that there was no AOD 'problem' in their school, as fear of reputational damage and parental outrage outweighed the possible benefits for their students.
Agencies also underestimated the amount of time and resource required to establish a new service in a new service environment. The extent of outreach and promotion required to consolidate a new service was misjudged, and made more difficult for some agencies as they attempted this across multiple sites simultaneously. The need for committed and trusted relationships was evident, highlighted by the experience of one agency, who having spoken with key stakeholders across the region chose three sites specifically based on stated stakeholder support. When those stakeholders moved on, so too did all support for the service and the agency was left effectively starting from scratch. When queried about a lack of referrals, sources cited confusion about the state-funded system, reluctance to change internal processes for a short-term pilot program, or due to other pressures, the service was simply overlooked. This experience highlights the need for on-going promotion, education and advocacy about the service, which can be compounded by staff turnover. In other instances, stakeholders saw the brief intervention as 'competition' for clients and were not only reluctant to refer but were obstructive in blocking access to the service.

Other challenges for agencies included the large geographical area that the brief intervention was servicing. Client isolation (and increased vulnerability), lack of access to public and private transport, unreliable telecommunications and black spots all speak to the need for an assertive outreach capacity when servicing a vast geographic area

4 Conclusion

The commissioning of a brief intervention service in each of the four sub-regions of Western Victoria PHN was undertaken with an aim to engage two distinct cohorts who to date, where not engaging with the mainstream AOD service system. One of these cohorts were people using substances who traditionally were not accessing specialised AOD services, and the other cohort was the primary care system who were seen as an important and as yet untapped source of referrals.

Each of the commissioned agencies had proven ability to provide a quality treatment intervention to people using substances, or impacted by another's problematic use of substances. However, it appears as though both the agencies and the WVPHN underestimated the amount of time and resources that would be required to embed a new service option within an already existing service environment, particularly when the service was targeting a new and very broadly defined target audience and relying upon a referral pathway that required establishment.

In hindsight it is clear that the agencies would have benefitted from time to undertake an in-depth stakeholder identification and analysis, along with more time and resource to build and consolidate trusted relationships and flexible referral pathways with targeted stakeholders. Although many stakeholders gave in-principle endorsement of the service, a lot of internal procedural change needs to occur for this superficial support to translate into referrals.

The many systemic barriers in accessing and working with GPs further complicated raising awareness and capacity as well as building referral pathways. It has been suggested that incorporating a partnership element into the commissioning process could be helpful in ensuring referral sources are held to account for any commitment they make to refer. A stated support for, and good will towards, a service will not reliably or sustainably translate into referrals, so some form of authorising framework or financial incentive to assuage the

fiscal priorities of the GP clinic business model, may go some way to consolidate any commitments to or interest in the service.
Another key challenge for implementing a new service, particularly in a regional area, is in securing suitably skilled and qualified workers, which has a direct impact on capacity to meet service targets. Building new referral pathways also takes time, so a longer establishment phase with incremental introduction of service targets would be helpful. Where agencies had identified multiple sites to introduce the service, a staggered approach would also allow for focused attention on the needs of one site, provide an opportunity for consolidation and grounded evidence of success.

Overall however, the brief intervention services have been successful at meeting the two key aims of the commissioning, to engage clients who would otherwise not have accessed a mainstream AOD service, and to build referral pathways with primary care. Agencies themselves have shown exceptional perseverance in establishing the service, and have a strong belief in its potential to be an effective entry into the AOD (and associated) service environment. Anecdotal comments from stakeholders also speak to the value of the service. Early findings from the ASPEX evaluation support these positions, and show very promising and positive trends in the efficacy of brief intervention as a viable treatment option in and of itself, as well as a pathway to further support.

5 Appendices

Available on request

- Service Design Template
- Agency Questionnaire
- Network Meeting Agendas
  - November 15 2017
  - February 7 2018
  - April 11 2018
  - June 6 2018