

Rural Workforce Innovation Grant Program – synthesis of case studies

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List of abbreviations

Abbreviation	Definition
ABI	acquired brain injury
AHA	Australian Healthcare Associates
AOD	alcohol and other drugs
AWH	Albury Wodonga Health
AWH-NEBMHS	Albury Wodonga Health Northeast Border Mental Health Services
BH PS – RNCT	Bendigo Health Psychiatric Services – Rural North Community Teams
BHS-MHS	Ballarat Health Services Mental Health Services
CAMHS	Child and Adolescent Mental Health Services
CMH	clinical mental health
DBT	dialectical behaviour therapy
DTS	drug treatment services
EOI	expression of interest
FYCS	Family, Youth and Children's Services
GLCH	Gippsland Lakes Community Health
GVAMHS	Goulburn Valley Area Mental Health Service
Hume DDxHECs	Hume Dual Diagnosis Hume Education Collaborative
HuMINS	Hume Motivational Interviewing Network
HWA	Health Workforce Australia
HWRIT	Health Workforce Reform Implementation Taskforce
HYDDI	Homeless Youth and Dual Diagnosis Initiative
I&CMHS	Infant and Child Mental Health Service
Implementation Plan	<i>Victoria's Alcohol and Drug Workforce Framework: Implementation Plan 2012–15</i>
ISI	Improved Services Initiative
LCHS	Latrobe Community Health Service
LMS	Learning Management System (electronic)
MHCSS	Mental Health Community Support Services ¹
MHSRRA	Mental Health Services in Rural and Remote Areas programme

1. The Victorian Psychiatric Disability Rehabilitation and Support Services (PDRSS) program was renamed the Mental Health Community Support Services (MHCSS) program from August 2014.

Abbreviation	Definition
MoU	memorandum of understanding
MRBS	Medical Rural Bonded Scholarship
RAMUS	Rural Australia Medical Undergraduate Scholarship
RRHWIR	National Rural and Remote Health Workforce Innovation and Reform Strategy
RRIG	Rural Relocation Incentive Grant
SDQ	Strengths and Difficulties Questionnaire
Sharc	Self Help Addiction Resource Centre
SMSDGF	Substance Misuse Service Delivery Grants Fund
SWH	Southwest Health
The department	Department of Health and Human Services, Victoria
The Program	The Rural Workforce Innovation Grants Program 2013–14
VDDIRF	Victorian Dual Diagnosis Initiative Rural Forum
Workforce Framework	<i>Victoria's Alcohol and Drug Workforce Framework: Strategic Directions 2012–22</i>
YMHS	Youth Mental Health Service
YSAS	Youth Support and Advocacy Service

1. Executive summary

Background

Healthcare provision in rural Victoria faces considerable challenges because of the geographical, population and socio-demographic profile of its rural population. These challenges are further compounded by a range of rural workforce issues including staff shortages, high levels of staff turnover and difficulties recruiting new staff.

The Rural Workforce Innovation Grants Program 2013–14 was funded by the then Victorian Department of Health (the department) to identify, explore and showcase innovations that improve utility of the workforce while maintaining and improving quality of outcomes for clients, service provision efficiency, and worker satisfaction. Specifically, the program aimed to identify solutions to existing and projected workforce challenges and strategies that could affect positive change and support sustainable health services into the future. The types of projects it sought to support included pilots, research, and the development of tools and models.

Six priority areas were targeted by the Rural Workforce Innovation Grant Program:

- attracting and retaining workers in rural and regional Victoria
- meeting the professional development needs of workers
- access to supervision
- increased collaboration
- use of technology
- redesigning roles for a more flexible workforce.²

In May 2014 Australian Healthcare Associates (AHA) was engaged by the department to produce a synthesis report and case studies of initiatives implemented that demonstrated successful or promising workforce innovations in alcohol and other drugs (AOD), clinical mental health services (CMH) and mental health community support services (MHCSS) sectors.

This report provides a summary of 12 projects across the AOD, CMH and MHCSS sectors that received funding under the Rural Workforce Innovation Grant Program. It highlights the achievements of the projects and the factors that were common to the success of these initiatives. It also identifies the implementation challenges associated with workforce change and how these challenges were addressed.

Methodology

Following a competitive application process, 13 organisations were provided with additional funding to prepare case studies of the projects that were funded under the Rural Workforce Innovation Grant Program.

A structured workbook was developed by AHA to support organisations to develop the case studies. Organisations were also invited to provide additional materials/evidence to support the information provided in these workbooks and they were later contacted by AHA to discuss and/or provide additional information regarding any queries or gaps identified in the workbook content. A summary case study was generated and circulated back to each organisation for review and verification before finalisation.

2. <http://www.health.vic.gov.au/aod/workforce.htm>, accessed 17 February 2014.

A thematic analysis was undertaken of the finalised workbook content using the three phase approach to data analysis advocated by Miles, Huberman and Saldana (2013).³ Through an iterative process, key themes and issues were identified.

The quality of evidence provided by organisations in relation to the outcomes of the initiatives differed significantly, ranging from the anecdotal to more objective sources such as staff employment records, surveys, file audits and so on.

The findings presented in this report are based on the information related to 12 case studies. One organisation was unable to compile their case study and withdrew from the project.

Project activities and outcomes

The analysis undertaken as part of this project sought to identify the key activities that were undertaken to address workforce issues as well as identify the outcomes/achievements that were the result of these initiatives.

Across the projects, there was evidence that the initiatives led to improvements in:

- **Attracting and retaining workers** – by encouraging graduates to join the health sector, increasing placement opportunities, improving the culture of the organisation and improving staff engagement in organisations.
- **Meeting professional development needs** – the introduction of video conferencing capability, new professional development programs, staff scholarships and cross-sector workshops offered staff the opportunity to expand their skill sets and encouraged collaboration across agencies.
- **Access to supervision** – new roles and use of video conferencing facilities enabled staff to access remote supervision and support.
- **Increasing collaboration** – partnerships and collaborative working relationships were established with other local service delivery agencies in the sector and more broadly with other partners, including tertiary institutions (a university and a TAFE). These partnerships expanded organisational capacity through, for example, providing grant recipients with access to additional resources/staff needed for the initiative, training opportunities or improved referral pathways.
- **Use of technology** – increased organisational capability to improve supervision and access to training opportunities for staff, deliver services and enhance communication with clients.
- **Workforce redesign** – expanded workforce capacity through the introduction of new roles and introduction of greater flexibility in existing roles.

In addition to these specific outcomes, some projects also resulted in broader organisational impacts, including:

- **Client service improvements** – some marked client service improvements were reported in terms of increased access to services, improved integration across services and a greater range of services available in the community.
- **Workplace efficiencies** – several organisations reported efficiency improvements and/or cost savings as a result of their initiatives.

3. MB Miles, AM Huberman & J Saldana, *Qualitative Data Analysis: A Methods Sourcebook*, Sage Publications, London, 2013, pp. 12–13.

Implementation challenges

Two main groups of implementation challenges were reported in the case studies: internal challenges and external challenges.

Internal challenges

Internal implementation challenges spanned four areas:

- **Staff** – resistance to change and limitations imposed by the skill set of existing staff were key among the staff challenges cited. Some organisations experienced staff turnover in the early stages of implementation as a result of these challenges.
- **Organisational** – aspects of organisational culture, such as entrenched recruitment strategies and workplace practices, and the extent of organisational readiness for change, impacted implementation.
- **Infrastructure** – for those proposing technology-related changes, implementation was constrained by existing hardware and software infrastructure.
- **Timelines** – often, implementation required more time than anticipated. In some cases, implementation delays generated further challenges for the initiative, particularly where external collaborations were involved.

External challenges

External challenges generally proved to be harder to address than internal challenges. In some cases, policy/funding challenges and procedural challenges led to substantial delays or to the discontinuation of the initiative.

Three themes were evident in the list of external challenges:

- **Partner related** – several initiatives involved collaboration with external partners and challenges arose in formalising collaborative activities through a memorandum of understanding (MoU).
- **Policy/funding** – within organisations, policy/funding changes had positive and negative effects. In some cases, they were instrumental in prompting initiatives, while one grant recipient was unable to commit to the requirements of their MoUs pending the outcome of proposed changes associated with the redevelopment and recommissioning of Victorian Government-funded alcohol and drug services and the Psychiatric Disability Rehabilitation and Support Services in 2014. Policy and funding changes impacted staff and funding availability in partner agencies.
- **Procedural** – for one grant recipient, the process of securing accreditation for a training course proved lengthy and represented a key external procedural challenge for their initiative.

Factors that facilitated implementation

For the majority of challenges encountered, the recipients identified and implemented strategies to ensure that the project could continue to progress. The following implementation strategies that were identified in the case studies are summarised below. The extent to which these solutions proved successful varied and some solutions are still ongoing.

Staff engagement

Open and ongoing consultation, feedback and involvement in the initiative fostered staff engagement and minimised resistance to change.

Persistence, often over a long period, as well as maintaining enthusiasm and commitment to the initiative, were also key to overcoming challenges as well as through building in opportunities to share learning and collaborate across programs and between staff.

The right skills mix

Providing training so staff felt better equipped to manage the changes was identified as a successful strategy in promoting staff buy-in and support for implementation of new practices.

In addition to this, changing recruitment policies and engaging external expertise to overcome skills deficits were identified as responses to implementation issues.

Working with early adopters and appointing staff with the necessary expertise and passion to drive and champion the project over time

Management buy-in and support

This enabled organisations to trial new initiatives.

Strong leadership at executive/senior management level was seen as crucial to the development and implementation of the initiatives. The commitment of middle management was also seen as key, particularly in relation to ensuring good communication across the organisation and providing opportunities for staff to be actively involved.

Support by the leadership team facilitated the growth of partnerships.

Adequate time

Change management was repeatedly cited as a time-consuming activity that required persistence and leadership, acceptance of the long-term nature of change, a focus on incremental progress and the allocation of adequate time for change to be effective.

Allocating adequate time to overcome resistance and to plan and implement initiatives was an essential facilitator. This allowed organisations to adapt to change and address issues as they arose.

Support by champions

Appointing a champion to spearhead the initiative and securing the support of the senior leadership group early in the process were the key mechanisms used in overcoming resistance and other organisational challenges.

Local champions provided the necessary expertise, passion, dedication and determination to drive the project over time. It also meant local leadership and local people involved in developing local solutions.

Change management expertise

Having the expertise to coach colleagues through change, often at peer level, enabled the organisation to use the principles of contagion to advantage in their initiative.

Agents of change management can also explore new opportunities, including engagement and partnerships with external agencies to support implementation.

Precedence

In some cases, initiatives built on prior experiences. This facilitated implementation by increasing stakeholder receptiveness to the changes proposed in the initiative.

Adaptability and responsiveness

Strategies used to address collaboration-related challenges included seeking out new partners in instances where proposed partnerships had failed to become operationalised or diversifying partner relationships to increase collaborative, funding or employment options.

Acknowledgement/recognition of achievements

Internal and external acknowledgment or recognition of achievements served as twofold facilitators. For those involved in the initiative, this recognition was motivational and affirming, adding further incentive to maintain enthusiasm and commitment for the initiative. It also increased awareness of the initiative, internally and externally.

Conclusion

The 12 case studies included in this synthesis report represent a diverse range of initiatives undertaken in different health regions and across three sectors in Victoria (AOD, CMH and MHCSS). While many of these initiatives were not innovative in the sense of being inventive, they represented new solutions for problems experienced within the organisations in question.

A key attribute shared by these initiatives was their focus on addressing specific problems in specific local contexts.

Overall, each of the Rural Workforce Innovation Grant Program priority areas was either directly or indirectly addressed by the mix of projects funded. In some cases, workforce changes/outcomes were generated from initiatives that were not specifically workforce-focused. Rather, workforce improvements were a by-product of other broader service redesign activities.

2. Introduction

In 2013–14 the Victorian Department of Health (now the Victorian Department of Health and Human Services) established the Rural Workforce Innovation Grants Program. The aim of the project was to identify and test solutions to existing and projected workforce challenges and strategies that could effect positive change and support sustainable health services into the future while maintaining and improving quality of outcomes for clients, service provision efficiency, and worker satisfaction. The types of projects it sought to support included pilots, research, and the development of tools and models.

Recognising the importance of sharing the outcomes and learnings of these projects, and providing leadership and insight to other organisations that are looking to implement workforce improvement strategies, organisations delivering mental health (MH) and the alcohol and other drugs (AOD) services that received funding were invited to submit case studies of their initiative.

Based on these case studies, the Australian Healthcare Associates (AHA) was requested to develop a synthesis report to explore and showcase the innovations and the outcomes that had been achieved to improve the utility of the workforce.

This paper represents a summary of the analysis conducted by the AHA.

It is acknowledged that there are a range of other initiatives across other specialties that also implemented strategies that effectively addressed workforce issues. In bringing together those that were implemented in MH and AOD services, the focus is on drawing out the experiences and approaches that were specifically used in this sector to identify some of the challenges to successful implementation, and those factors which contributed to the success of the initiatives.

The reports is also intended to identify how government policy can also support and promote innovation and service design to assist organisations to implement new initiatives aimed at addressing workforce related challenges.

Methodology

Following a competitive expression of interest (EoI) process, 13 services that participated in the Rural Workforce Innovation Grants project were provided with a small amount of additional funding to prepare case studies about the innovations they developed and implemented under the Rural Workforce Innovation Grants Program.

These case studies have formed the basis of an analysis of the different projects to identify the outcomes of the various projects and share the learnings of implementation, in particular, the challenges that were encountered and the factors that contributed towards overcoming these challenges.

Further detail about the project methodology, including how data and information was obtained as well as the issues that have impacted on comparability of information and outcomes is provided at Appendix 1.

The rural service sector

Geographical, population and socio-demographic factors present significant challenges to healthcare provision in Australia, particularly in regional, rural, and remote areas.⁴ These areas are generally characterised by older populations, higher levels of health risk factors and higher rates of chronic disease and injury.⁵

As the world's sixth largest country in terms of landmass,⁶ Australia's low population density (three people per square kilometre),⁷ reflects an inequitable population distribution. While most of the population lives in urban and coastal regions, one-third of Australians (approximately seven million people) live outside major cities.

Residents are more likely to report an acute or chronic injury, to drink alcohol in quantities risking harm in the short term, to be overweight or obese, or to have poorer dental health.⁸ Males in outer regional and remote areas are more likely to show high to very high levels of psychological distress. Furthermore, as remoteness increases, the proportion of the population who are Indigenous also increases, ranging from one per cent in major cities to 45 per cent in very remote areas.⁹ Higher rates of morbidity and mortality in Aboriginal communities partially accounts for health status differences between areas.

The situation is compounded by the fact that there is less access to health services and shortages of almost all health professions and health-related infrastructure outside major regional centres.^{10, 11} Health services in these areas are more dependent on primary health care services, particularly those provided by general practitioners (GPs). Access to GPs in remote areas, for example, is between 45 and 67 per cent of the level of access in metropolitan areas.¹² The ratio of medical specialists to population in major Australian cities is four times higher than the ratio in remote and very remote areas.¹³ Facilities are generally smaller, provide a broad range of services (including community and aged care), have less infrastructure and locally available specialist services. They also provide services to a more dispersed population.

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4. J Wakeman, JS Humphreys, 2011, Sustainable primary health services in rural and remote areas: Innovation and evidence, *Australian Journal of Rural Health*, 9, pp. 118–124.
 5. Australian Institute of Health and Welfare (AIHW), 2008, *Rural, regional and remote health Indicators of health status and determinants of health*.
 6. Department of Foreign Affairs and Trade, 2012, *Australia in brief* <<http://www.dfat.gov.au/aib/overview.html>>.
 7. ABS, 3218.0 – *Regional Population Growth*, Australia, <<http://www.abs.gov.au/ausstats/abs@.nsf/Products/3218.0~2012~Main+Features~Main+Features?OpenDocument#PARALINK2>>, accessed 3 January 2014.
 8. AIHW, Impact of rurality on health status, <http://www.aihw.gov.au/rural-health-impact-of-rurality/>, accessed 2 March 2015.
 9. AIHW, *Demography*, accessed 23 February 2015, <<http://www.aihw.gov.au/rural-health-demography>>.
 10. Healthinsite, Rural and remote health, accessed 24 February 2015, <<http://www.healthdirect.gov.au/#/rural-and-remote-health>>.
 11. J Baxter, A Hayes, M Gray, *Families in regional, rural and remote Australia*, Australian Institute of Family Studies, March 2011, <<http://www.aifs.gov.au/institute/pubs/factsheets/2011/fs201103.html>>, accessed 24 February 2013.
 12. Health Workforce Australia (HWA), *Rural and Remote Health Workforce Innovation and Reform Strategy*, May 2013, <http://www.hwa.gov.au/sites/default/files/HWA13WIR013_Rural-and-Remote-Workforce-Innovation-and-Reform-Strategy_v4-1.pdf>, accessed 6 January 2014.
 13. Health Workforce Australia, *May 2013, Rural and Remote Health Workforce Innovation and Reform Strategy*, <http://www.hwa.gov.au/sites/default/files/HWA13WIR013_Rural-and-Remote-Workforce-Innovation-and-Reform-Strategy_v4-1.pdf>, accessed 6 January 2014.

The situation in Victoria is comparable to Australia as a whole. Victoria has population groups in rural, regional and remote areas that are likely to be disadvantaged, including low-income earners, the aged, those in public housing, people living with a disability, and Aboriginal and Torres Strait Islanders. People living in rural areas of Victoria have lower life expectancy than those living in metropolitan areas.¹⁴

Many rural communities experience a chronic shortage of allied health workers, high levels of staff turnover and challenges in recruiting new staff. This results in longer waiting lists and greater travel distance to services, with people in these areas being four and a half times as likely as those living in major cities to travel over one hour to see a GP.¹⁵

Rural and remote health services in Victoria also face issues relating to staff recruitment and retention in the health sector, with the greatest challenges evident in remote areas.¹⁶

Policy environment

Encouraging workforce innovation is an important component of responding to rapidly changing service delivery models.

The Victorian Government is focused on supporting innovative approaches to expanding service, workforce and system capability as well as increasing the system's financial sustainability and productivity. The department's *Workforce Innovation and Reform Roadmap* (the roadmap)¹⁷ provides a process framework to support idea generation, project execution and wider implementation of proven health workforce initiatives.

In 2012, the department released *Victoria's Alcohol and Drug Workforce Framework: Strategic Directions 2012–22* (Workforce Framework) and *Victoria's Alcohol and Drug Workforce Framework: Implementation Plan 2012–15* (Implementation Plan). These documents are designed to increase efficient work practices and innovative ways of working in rural and regional Victoria.

The Victorian policy approach to addressing workforce challenges aligns with the national approach to workforce development which focuses on capacity and skills development, leadership, workforce policy and planning, workforce funding and regulation, and workforce reform targeted at more effective, efficient and accessible service delivery.

14. Department of Health Victoria, *Victorian Health Priorities Framework 2012–2022: Rural and Regional Health Plan*, <[http://docs.health.vic.gov.au/docs/doc/E9DF1F9EF227FF09CA2579680004BC2B/\\$FILE/1108032_Rural%20and%20Regional%20Health%20Plan%20WEB.pdf](http://docs.health.vic.gov.au/docs/doc/E9DF1F9EF227FF09CA2579680004BC2B/$FILE/1108032_Rural%20and%20Regional%20Health%20Plan%20WEB.pdf)>, accessed 6 January 2014.

15. ABS, *Australian Social Trends March 2011, Health services: Use and patient experience*, Catalogue 4102.0, <[http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/LookupAttach/4102.0Publication23.03.113/\\$File/41020_Healthservices_Mar2011.pdf](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/LookupAttach/4102.0Publication23.03.113/$File/41020_Healthservices_Mar2011.pdf)>, accessed 6 January 2014.

16. J Humphreys, M Chisholm & D Russell, 2010, *Rural allied health workforce retention in Victoria: Modelling the benefits of increased length of stay and reduced staff turnover*, Monash University School of Rural Health Bendigo, Victoria, <[http://docs.health.vic.gov.au/docs/doc/E6C68A907601C280CA257A53001B5409/\\$FILE/Final%20Report%20Department%20of%20Health_FINAL.pdf](http://docs.health.vic.gov.au/docs/doc/E6C68A907601C280CA257A53001B5409/$FILE/Final%20Report%20Department%20of%20Health_FINAL.pdf)>.

17. Department of Health, Victoria, 2012, *Workforce Innovation and Reform Roadmap*, <[http://docs.health.vic.gov.au/docs/doc/4EEC5A9BAA2B7DD3CA257B9E000B84FB/\\$FILE/Workforce%20Innovation%20and%20Reform%20Roadmap.pdf](http://docs.health.vic.gov.au/docs/doc/4EEC5A9BAA2B7DD3CA257B9E000B84FB/$FILE/Workforce%20Innovation%20and%20Reform%20Roadmap.pdf)>, accessed 6 January 2014.

Evidence based interventions to address rural health workforce issues

In 2010 the World Health Organization conducted some analysis of the types of interventions that were crucial in achieving greater retention of health care workers in rural and remote areas. *Increasing access to health workers in remote and rural areas through improved retention – Global policy recommendations*¹⁸ identifies a range of interventions that can be utilised by organisations and policy makers to achieve greater retention of rural health care workers across four main domains:

- education
- regulatory
- financial incentives
- professional and personal support.

Appendix 2 summarises the approaches identified by WHO as successful for building the rural workforce and ensuring the right mix of skills are available. It also draws synergies between these key approaches and Australian workforce development theory and practice. Overwhelmingly, the approaches promoted by the WHO strongly align with policy directions in Australia to attract and retain the workforce required to sustain rural health organisations and meet community health needs.

The literature confirms that there is no single approach that will work in all situations. Strategies need to be appropriate to local contexts and address multiple aspects of personal and professional satisfaction. The particular mix of supports needed by each individual organisation will vary according to the context in which they operate because, as the WHO points out:

Context is a key element that can be responsible for different outcomes or results from the same intervention and thus needs to be better captured in the research on these interventions.¹⁹

This highlights the need for higher quality evidence to assess the effectiveness of different workforce innovations and incentives. At this stage, the quality of the evidence available for assessing the impact of workforce interventions is poor. As noted by WHO:

There are no studies in which bias and confounding are minimised to support any of the interventions that have been implemented to address the inequitable distribution of health care professionals. Well-designed studies are needed to confirm or refute findings of various observational studies regarding educational, financial, regulatory and supportive interventions that may influence health care professionals' choice to practice in underserved areas.²⁰

This is also an issue that impacts on this project.

18. World Health Organization (WHO) 2010, *Increasing access to health workers in remote and rural areas through improved retention*, <<http://www.who.int/hrh/retention/guidelines/en/>>, accessed 24 February 2015.

19. WHO, 2010, p. 11.

20. L Grobler, BJ Marais, SA Mabunda, PN Marindi, H Reuter, J Volmink, 'Interventions for increasing the proportion of health professionals practising in rural and other underserved areas', *Cochrane Database of Systematic Reviews* 2009, Issue 1. Art. No.: CD005314. DOI: 10.1002/14651858.CD005314.pub2.

Role of innovation in addressing rural workforce issues

Innovation is commonly defined as making changes in something established, particularly through the introduction of new methods, ideas, or products. However, for new methods, ideas or products to be innovative, they do not necessarily need be original or ground breaking:

Being innovative does not mean inventing; innovation can mean changing your... [service] model and adapting to changes in your environment to deliver better products or services.²¹

Innovation is required across sectors and at multiple levels to improve rural workforce issues and access to care for those Australians living in rural and remote areas, with appropriate governance, management, leadership and community engagement.^{22, 23}

Ongoing evaluation of innovations is also essential for informing future policy and initiatives.²⁴

The Rural Workforce Innovation Grants Program 2013–14

The Rural Workforce Innovation Grants Program 2013–14 (the program) was developed to identify, explore and showcase innovations that improve utility of the workforce while maintaining and improving quality of outcomes for clients, service provision efficiency, and worker satisfaction. Specifically, this Victorian Government program aims to identify solutions to existing and projected workforce challenges and to identify strategies that could effect positive change and support sustainable health services into the future.

Six priority areas were targeted by the Rural Workforce Innovation Grant Program:

- attracting and retaining workers in rural and regional Victoria
- meeting the professional development needs of workers
- access to supervision
- increased collaboration
- use of technology
- redesigning roles for a more flexible workforce.²⁵

The types of projects it sought to support included pilots, research, and the development of tools and models. Projects were required to include local evaluation strategies aimed to assist in the understanding and measurement of the local impacts of the changes brought about by the projects.

21. Australian Government, *Innovation*, <<http://www.business.gov.au/business-topics/business-planning/innovation/Pages/default.aspx>>, accessed 20 February 2015.

22. J Wakerman, JS Humphreys, R Wells et al. 2009, 'Features of effective primary health care models in rural and remote Australia: a case study analysis', *Med J Aust* 191: 88–91.

23. J Wakerman, JS Humphreys, 2011, 'Sustainable primary health care services in rural and remote areas: innovation and evidence', *Aust J Rural Health* 19: 118–124.

24. J Wakerman, 'Innovative rural and remote primary health care models: what do we know and what are the research priorities?' *Aust J Rural Health* 2009 17: 21–6.

25. <<http://www.health.vic.gov.au/aod/workforce.htm>>, accessed 17 February 2014.

3. Overview and achievements of projects

Summary of participating projects

Table 1 highlights the key characteristic of each of the innovations included in this project. The original case studies prepared by the agencies that participated in the grants program have been provided at Appendix 3.

Table 1: Profile of grant recipients by innovation aim, region, sector, and implementation status

Grant recipient	Workforce issue(s) addressed	Innovation aim	Implementation status (August 2014)
AWH-NEBMHS Region: Hume Sector: CMH	<ul style="list-style-type: none"> • Workforce shortages • Lack of accredited courses for peer roles • Limited placement opportunities 	To expand the capacity of the mental health workforce through creating new roles and functions (peer workers and volunteers) that will improve service users options and embed a recovery approach into the existing service structures	Some planned activities underway
Ballarat HS MHS Region: Grampians Sector: CMH	<ul style="list-style-type: none"> • Need for critical mass of trained mental health clinical staff to provide services for children and young people aged 0–25 years 	To improve access to care, through workforce redesign and partnerships across service delivery agencies, for children and youth aged 0–25 years	All planned activities underway
Barwon Health Region: Barwon-South Western Sector: CMH	<ul style="list-style-type: none"> • Workforce supply issues, particularly in relation to recruiting clinical psychologists to work in public mental health 	To develop a contemporary service provider-focussed training program for clinical psychologists with a view to increasing graduate recruitment and retention in public mental health services in the region	Some planned activities underway
Bendigo Health PS-RNCT Region: Loddon Mallee Sector: CMH	<ul style="list-style-type: none"> • Difficulty recruiting and retaining clinical staff to community mental health teams, and providing supervision • Two sites located 200 km apart 	To use video conferencing and technology in the Rural North Community Mental Health Teams to provide effective management, clinical supervision and improved patient care across two geographically separate sites	Some planned activities underway

Grant recipient	Workforce issue(s) addressed	Innovation aim	Implementation status (August 2014)
DDxHECs* Region: Hume Sector: AOD, CMH, MHCSS	<ul style="list-style-type: none"> Need to further develop staff capacity to recognise and provide effective services for the growing number of people presenting with co-occurring mental health and substance use concerns 	To contribute to better outcomes for people experiencing both mental health and substance use concerns (dual diagnosis) by assisting Hume Region AOD, MHCS and CMH services to develop their capacities to recognise and provide effective services to people presenting with dual diagnosis	All planned activities underway
GLCH Region: Gippsland Sector: AOD	<ul style="list-style-type: none"> Attracting and retaining well-qualified, experienced, staff was a key challenge for the AOD service 	To attract and retain staff and reduce turnover within the AOD program through the development of a new multidisciplinary service delivery model in the Family, Youth and Children's Services (FYCS) unit	All planned activities underway
LCHS DTS Region: Gippsland Sector: AOD	<ul style="list-style-type: none"> Lack of consumer participation in the LCHS drug treatment services (DTS) 	To address a lack of consumer participation in the LCHS drug treatment services (DTS) area by employing a consumer who had received DTS services	All planned activities underway but position is vacant
LCHS FSS Region: Gippsland Sector: AOD	<ul style="list-style-type: none"> Difficulties recruiting and retaining highly skilled employees to deliver high quality, person-centred care Difficulties meeting family support targets 	To develop a highly skilled workforce to deliver client-centred services to clients and families accessing family support services, thus improving service quality	All planned activities underway
Mind Region: State-wide Sector: MHCSS	<ul style="list-style-type: none"> Need to provide high quality student placements to attract and retain new graduates in the rural sector 	To provide a coordinated approach to student placements across Mind and, through providing high-quality placements, attract and retain new graduates in the rural sector	Some planned activities underway
SWH LMS Region: Barwon-South Western Sector: CMH	<ul style="list-style-type: none"> Need for training and professional development programs for the rural and regional workforce High rates of staff turnover 	To establish an online mental health learning management system (LMS) for all staff and develop a standardised two-year training pathway for new staff	All planned activities underway

Grant recipient	Workforce issue(s) addressed	Innovation aim	Implementation status (August 2014)
SWH-workforce Region: Barwon-South Western Sector: CMH	<ul style="list-style-type: none"> High rates of attrition of staff from outside the local area Rigid, inflexible, and unsupportive culture 	To 'grow our own' workforce and also bring about workplace culture change to attract and retain staff	All planned activities underway
VDDIRF* Region: Statewide Sector: AOD, CMH, MHCSS	<ul style="list-style-type: none"> Need to support isolated rural dual diagnosis capacity-building workers 	To provide support and infrastructure to rural dual diagnosis clinicians whose role is to assist AOD and mental health agencies and clinicians to further develop their levels of dual diagnosis capacity	All planned activities underway

Analysis was also conducted on the distribution of the projects included in this project, although this is only based on the specific projects funded for this analysis, not the broader Workforce Innovation Grants Program. See Appendix 4.

Note: The information provided in this report is based on material provided by the grant recipients in August 2014. Details and circumstances may have subsequently changed.

Project drivers

Improving services for clients provided the key underlying impetus for organisations to initiate their workforce projects. In many cases the move towards providing more client-focused and recovery-focused services was a key driver.

Table 2 identifies the various workforce issues that were identified as impacting on the capacity of organisations to provide more responsive and effective services to their populations, synthesised into seven key themes. The most frequently cited issue related to workforce shortages/ difficulties recruiting/retaining staff (n = 7).

Table 2: Workforce issues as drivers to projects included in this project

Workforce issue	Number of citations*
Workforce shortages/ difficulties recruiting/retaining staff	7
Need to increase staff capacity/skills	3
Training-related/lack of accredited courses	2
Limited placement opportunities	2
Need to increase peer involvement	2
Limited supervision/support	2
Negative organisational culture	1

* Some organisations listed multiple issues hence the total number of citations exceeds the number of grant recipients.

Staff changes is an obvious issue that impacts on the capacity of health services to needs of their client group. Table 3 highlights the impact of staff changes on the workforces of the organisations involved in this project. While some variability was evident in the extent of impact, few organisations reported being impact free. The majority of organisations were impacted by staff changes relating to new staff joining the teams, resignations and retirements and role changes.

Table 3: Extent workforce has been impacted by staff changes in previous 12 months

Type of staff change	Level of impact (n=10 organisations)*		
	A lot	A little	None
New staff joining teams	3	5	2
Resignations	3	5	2
Retirements	-	5	5
Staff deployed to other roles	4	4	2
Staff filling in for others**	4	3	2
Unfilled roles	2	5	3

* Refers to count of individual organisations

** Unknown for Hume DDxHECs.

A further issue that the project sought to tease out was the impact of environmental factors had on workforce recruitment and retention. Table 4 identifies what grant recipients perceived as impacting on the potential to attract and retain the workforce.

Table 4: Impact of local/community factors

Local/community level factor	Level of impact (n = 8 organisations)*		
	A lot	A little	None
Availability of local accommodation	-	4	4
Cost of local accommodation	-	3	5
Quality of local accommodation	-	2	6
Social opportunities for partners/families	2	1	5
Employment opportunities for partners	2	2	4
Educational opportunities for children	1	-	7

* Excludes Hume DDxHECs and VDDIRF because these factors were listed as not applicable in each case.

For the grant recipients, accommodation-related factors were generally reported as having a little or no impact on staff attraction or recruitment. Social and employment opportunities for partners were both cited as impacting workforce a lot by two organisations and one organisation rated educational opportunities for children as impacting staff attraction/recruitment a lot.

Activities and outcomes arising from projects

The following discussion provides an overview of the various activities that were undertaken across the different projects to meet the following objectives of the Rural Grants Innovation Program:

- attracting and retaining workers in rural and regional Victoria
- meeting the professional development needs of workers
- access to supervision
- increased collaboration
- use of technology
- redesigning roles for a more flexible workforce.

Table 5 aligns the projects included in this project with the priority areas articulated for the Rural Workforce Innovation Grant Program.

Most projects addressed a number of the areas identified as priorities for the program. This includes instances where initiatives were directly focussed on priority areas as well as those where a more general alignment with the priority areas is evident.

Table 5: Alignment with the Rural Workforce Innovation Grant Program priority areas

Grant recipient	Attracting and retaining workers	Meeting professional development needs	Access to supervision	Increased collaboration	Use of technology	Redesigning roles for a more flexible workforce
AWH-NEBMHS	✓	✓		✓		✓
Ballarat HS-MHS		✓		✓		✓
Barwon Health	✓	✓	✓	✓		✓
Bendigo Health PS-RNCT	✓	✓	✓	✓	✓	✓
GLCH	✓	✓	✓			✓
Hume DDxHECs*		✓		✓		
LCHS--DTS	✓					✓
LCHS-FSS		✓	✓	✓	✓	✓
Mind	✓	✓		✓	✓	
SWH-LMS		✓		✓	✓	
SWH-workforce	✓	✓	✓	✓		✓
VDDIRF*	✓	✓		✓		✓

* Auspice: Albury Wodonga Health.

Attracting and retaining workers

A range of different approaches to attracting new staff and retaining existing staff were embraced across the projects and included:

- Increasing graduate recruitment: AWH held information sessions with local high school students with a view to influencing future educational and career directions at an earlier age. This strategy was augmented by advertising vacancies in local as well as national media in the hope of attracting former locals back to the area.
- Increased placement opportunities to improve graduate retention rates: The Barwon Health initiative increased clinical psychology student placements by 150 per cent and this led to increased graduate retention, with more than 20 graduates from the M. Psych program attaining employment within the Barwon-South West region.
- Improving the culture of the organisation to reverse negative cultural perceptions and promote/enhance positive elements of organisational culture: The AWH initiative resulted in increased optimism among staff regarding the potential of consumer roles in the organisation and also led to the establishment of shared social activities between clinicians, service users and carers.
- Improving staff engagement through the use of regular staff forums, collaborative activities and changed work arrangements: For example, as part of the SWH-workforce initiative, work arrangements were changed so that all staff were supported and provided with professional development opportunities and work life balance strategies were put into place. The SWH workforce initiative achieved a sustained reduction in staff turnover, with the number of resignations reduced from 28 (2006), 20 (2007), 18 (2008) to 14 (2009).

Meeting professional development needs

Training dominated the list of strategies aimed at meeting the professional development needs of workforces. Training and professional development initiatives included:

- Development of online learning management systems (LMS) and standardised training pathways for new staff: The SWH-LMS initiative not only resulted in the expansion of online training across the organisation, but also in the identification of mandatory competencies. Key outcomes of the initiative include increased staff availability for service provision to clients as a result of reductions in travel to offsite training.
- Establishing a video-conferencing capability that provided a conduit to increased professional development opportunities: This initiative also resulted in staff reporting improved team cohesion, a better sense of being connected, increased information sharing, increased peer support and clinical supervision. The number of virtual meeting rooms at Bendigo Health has increased significantly from three prior to the initiative to 30.
- Cross-sector workshops and scholarships: The Hume DDxHECs initiative provided AOD, CMH and MHCSS workers with opportunities to develop their dual diagnosis knowledge/skills. To date, more than 20 training sessions/workshops have been convened (attendance exceeded 500 participants) and 71 workers received scholarships to participate in accredited education courses.
- Education and training program: The LCHS-FSS educational sessions were attended by government departments, not-for-profit agencies, emergency services and other LCHS departments. As a result of this initiative, partnerships were formed with other organisations to deliver the workshops. Anecdotal feedback from staff performance reviews indicates staff now feel supported and valued by LCHS because of the opportunities offered for skills improvement and career advancement.

These strategies increased the skill set of staff and in so doing often increased confidence and diminished resistance to proposed changes. Other initiatives included:

- student placements that offered professional development opportunities for both the mentors and placement students
- onsite training opportunities in a dedicated clinic
- provision of group training at local level
- an interagency workforce development program
- efforts to develop and accredit a training program for peers in mental health

Professional development was also facilitated through a mix of staff scholarships, study leave and conference attendance.

Access to supervision

Strategies to facilitate access to supervision included:

- use of video conferencing facilities to provide remote supervision and support
- development of the psychology clinic to provide supervision for clinical psychology students
- inclusion of staff supervision as a key component of their workforce development and professional development strategy
- regular supervision to clinicians in groups and individually by internal and external experts in AOD counselling and AOD nursing.

The introduction of a new role of LCHS-DTS initiative highlighted the potential of non-supervisory support through peer arrangements as a means of retaining staff in consumer roles. Likewise, support for rural workers is core to the activities of the VFFIRF.

Increased supervision was reported to be instrumental in raising knowledge and skills with the workforce. The Bendigo Health video conferencing and Barwon Health psychology clinics are prime examples in this regard.

Increased collaboration

Some projects funded through the Rural Workforce Innovation Grant were either specifically collaborative in design, while in others, collaboration was a secondary component involving other internal and/or external service providers.

Examples of inherent collaborative projects included:

- development of the Hume DDxHECs (a group with representation from the AOD, CMH and MHCSS sectors)
- establishment of the VDDIRF (whose membership includes 12–14 workers from health services across Victoria).
- Creation of a 16-agency consortium led by Ballarat Health Services to undertake the Grampians Region Child and Youth Mental Health Service Redesign Project.

Several grant recipients aimed to increase staff capacity through partnerships with external agencies. These agencies included tertiary institutions (a university and a TAFE) and collaborative working arrangements with other local service delivery agencies in the sector, including:

- AWH-NEBMHS developed a partnership with Wodonga Senior Secondary College as a strategy to promote future career choices and the donation of a computer by Coles supermarket in Wodonga to the initiative. The organisation also convened a community information session in association with Wodonga TAFE, which prompted three TAFE enrolments. The proposed Certificate IV in Mental Health Peer Support relied on collaborative arrangements with Wodonga TAFE. Collaboration with Charles Sturt University was also part of this initiative.

Such partnerships expanded organisational capacity through, for example, providing grant recipients with access to additional resources/staff needed for the initiative, training opportunities or improved referral pathways.

For some organisations, implementation of their initiative led to increased internal and external collaboration with service providers. For example, the LCHS-FSS initiative has resulted in the DTS staff being involved in meetings with other teams regarding counselling, withdrawal nursing, linkages and support, and forensics. The GLCH initiative facilitated shared learnings across programs in the organisation.

Increased external collaborations were widely reported. Examples included:

- collaboration by LCHS-FSS with other agencies such as the Self Help Addiction Resource Centre (Sharc), Youth Support and Advocacy Service (YSAS), headspace, Community Mental Health (MIND), Child Protection and Child First
- partnering by LCHS-FSS with other organisations to deliver local educational workshops
- development of strong partnerships by SWH with Spectrum and the Victorian Centre for Excellence in Eating Disorders as well as participation in the Western Victorian Mental Health Learning and Development Cluster
- the development of an intersectoral workforce development program which involved training of staff across agencies in collaborative practice was developed and delivered to 890 individuals across more than 34 organisations.

Engaging in collaborative activities has demonstrated increased efficiencies for some health services. For example, the development of resources and materials by the VDDIRF have meant that individual organisations do not have to develop these resources and materials from first principles. At August 2014, the download history for these resource was as follows:

- 5,259 downloads of the *Rural Clinical Supervision Manual*
- 5,404 downloads of the job description template for a specialist dual diagnosis worker position
- 4,308 downloads of the job description template for a dual diagnosis liaison role.

Use of technology

Technology was used for a variety of purposes across the initiatives, including improving access to supervision, delivering services, staff and client communication, and increasing access to training opportunities.

Some initiatives were inherently technology based, while in others technology was part of a broader focus. The key technology reliant initiatives were Bendigo Health's video conferencing initiative, which

contributed to increased uptake of technology, reduced staff resistance to technology and resulted in new uses of video conferencing in the organisation including:

- initial patient consultations
- clinical handover, intake and consultation
- discharge planning
- psychiatric liaison and review with consultant psychiatrists
- CAMHS daily intake meetings
- staff performance reviews
- staff interviews
- ward rounds
- hospital reviews
- GP academic teaching sessions
- management, staff, and other meetings.

The organisation's use of video-conferencing was also been embraced by patients.

Technology was also a component of the following initiatives:

- Hume DDxHECS used technology (emails, video conferencing and telephone) to engage in frequent communication with its members.
- LCHS introduced:
 - a new database to facilitate recording of all family work completed by clinicians in its FSS initiative
 - a new telephone intake system
 - family information packs which were developed in both print and electronic format.
- Mind's student placement project used the Northern Clinical Placement Network's VicPlace system (a web-based information system) to plan and administer clinical placements. Mind also introduced an e-learning platform.

Additionally, the VDDIRF has promoted the use of remote clinical supervision to support capacity building of isolated rural dual diagnosis workers and provided a manual to support rural dual diagnosis specialists in the use of web technologies for clinical supervision.

Workforce redesign

Workforce redesign tended to have one of two objectives: to expand workforce capacity through the introduction of new roles and thus increase its flexibility, or to engender greater flexibility in existing roles.

Examples of role redesign across the projects include:

- The Grampians Region Child and Youth Mental Health Service Redesign Demonstration Project led by Ballarat Health Services involved restructuring its mental health services into two integrated and developmentally appropriate teams and the development of CYMHS child and youth consultant and family/carer consultant positions to support a formalised secondary consultation model, interagency collaboration and increased mental health literacy and capacity across all

sectors in the region. As a result of the redesign, total referrals, assessments and treatments of 0–25 year olds increased by 38 per cent, 64 per cent and 61 per cent respectively (2010–11 and 2013–14 data). Functional improvements were also evident in children participating in the CAST program as demonstrated by pre- and post-intervention Strengths and Difficulties Questionnaire (SDQ) scores.

- Development of a new multidisciplinary service delivery model in the Family, Youth and Children's Services (FYCS) by Gippsland Lakes Community Health.
- The Barwon Health psychology clinic initiative involved making appointments to new profession-specific positions and generated roles in clinical psychology that were previously unavailable within the public mental health service. As a result of this initiative:
 - clients with anxiety and/or depression now have access to individual treatment as an alternative to group treatment
 - disengagement rates are lower than expected (25 per cent), compared to other psychology services such as the Access to Allied Psychological Services (ATAPS), where disengagement figures of 37 percent were reported.
 - referrals for the treatment of anxiety and mood disorders have increased from 58 in 2010 to 239 in 2013 and 153 referrals were received for DBT for borderline personality disorder over 2011–13
 - supportive referral process between services minimised the time spent reassessing individuals' needs for treatment programs thus reducing clinical time in assessment by 50 per cent.
- The AWH-NEBMHS initiative involved developing a new cadre of accredited peer workers to increase the options available to case managers, provide greater flexibility across roles and reduce case managers' workload by redefining and distributing key tasks
- The LCHS-DTS consumer consultant initiative involved employing a casual consumer consultant (CC) to join the Senior Leadership Group in driving the Victorian AOD reforms in the service. This position was newly created and was designed to add to the overall mix of staff. This offered an opportunity for service staff to better appreciate and understand their services from the consumer perspective, thus providing informal professional development as the organisation transitioned to a more recovery-focused service model.

Other initiatives that involved redesign elements included:

- project officers and administrative staff were employed to take on the non-clinical aspects of clinicians' roles as part of the LCHS-FSS initiative
- work arrangements were changed to create positions that are attractive (manageable case loads, good work/life balance, promotional and training opportunities in the SWH workforce project).

Two grant recipients approached the task of increasing staff capacity in their organisations by creating or developing peer roles. These roles were designed not only to increase the diversity of the workforce, but also to increase staff awareness of the contribution peer workers can make to understand the needs of the organisation's client group.

Broader organisational impacts

The discussion above highlights the impacts of individual initiatives on the key areas of focus for the workforce grants. However, it is important to note that the services also reported broader organisational impacts of the various initiatives, including:

- improved client services
- increased efficiencies.

Improved client services

Some marked client service improvements were reported, not only in terms of the number of clients seen, but also the range of services provided.

The Gippsland Lakes Community Health initiative, which resulted in an integrated service model, meant that clients were only required to 'tell their story' once, rather than continuing to present to multiple agencies without information being linked or shared.

The LCHS-FSS initiative, which included the employment of project officers and administrative staff to take on the non-clinical aspects of clinicians' roles, resulted in a 38 per cent increase in the offering of, and implementation of family sessions offered to clients. Partnering and meeting regularly with other regional service providers also enables LCHS to establish good working relationships with other service providers and facilitated more coordinated care for clients.

Hume's DDxHECs initiative led to improvements in clinicians' recognition of co-occurring disorders, evidenced by increased screening. This indicated that clinicians are providing more integrated treatment of co-occurring disorders.

Increased efficiencies

Several organisations reported efficiency improvements and/or cost savings as a result of their initiatives.

For example, Bendigo Health's video conferencing initiative substantially reduced travel time and improved access to clinical supervision and support for staff in rural centres. It also improved discharge planning between health services. The following outcomes have been reported:

- the capacity of the consultant child psychiatrist to provide services to Echuca CAMHS patients has improved from two to three families per month to two families per week, if required
- reduced travel time by staff resulted in savings of approximately \$750 per month in travel costs.

Barwon Health also reported efficiency improvements as a result of their initiative. Group treatment reduced clinical treatment times by 75 per cent and supportive referral process between services minimised the time spent reassessing individuals' needs for treatment programs, thus reducing clinical time in assessment by 50 per cent.

South West Health's introduction of the LMS resulted in more staff accessing more training at substantially lower costs to the organisation. In 2011, 235 staff received 4,552 hours of training at a cost of \$64,054. In contrast, 243 staff received 5,044 hours of training in 2013 at a cost of \$19,965. These cost savings have rendered the training program more sustainable.

4. Learnings from the projects

The following discussion reflects on the experience of the various organisations in rolling out their projects to identify the challenges in implementation, and also the factors that were seen as facilitating implementation and contributing to the success of the individual projects.

Implementation challenges

Implementation challenges reported in the case studies can be categorised into two groups:

- internal challenges:
 - staff
 - organisational issues
 - infrastructure
 - timelines
- external challenges:
 - partnerships with other organisations
 - policy/funding
 - procedural issues.

Internal challenges

There were four themes were evident within the internal implementation challenges reported. These challenges were related to staff resistance and other challenges, organisational cultural issues, technology requirements and adaptations to new processes, and issues relating to time pressures and implementation delays.

Staff-related challenges

Staff resistance to change was grounded in factors such as:

- a sense of inertia where the need for change/changed work practices was not recognised by staff. Some staff had to be convinced of the merits of the proposed changes
- service model changes that in turn generated concerns including the protection of role boundaries within organisations and perceptions of existing services being 'taken over' by the new initiative
- a lack of training
- limited familiarity in working with the particular client groups targeted under the initiative
- lack of confidence in using new equipment/technology
- concerns regarding the changes to established structures and team functions proposed by the initiative
- the additional workload generated by the change.

Skill set limitations among existing staff provided further challenges. Examples include an initiative commencing without suitably qualified and experienced staff because of recruitment issues and an initiative floundering while a project worker was on leave because of a lack of suitably skilled staff to cover during their absence.

Organisational challenges

The key organisational challenges cited related to organisational culture and the level of organisational readiness for change. For some organisations, entrenched recruitment strategies and workplace practices, and existing silos and barriers within the organisational culture were major barriers to change.

The level of organisational readiness for change not only varied between organisations, but also within divisions of the same organisation.

Infrastructure-related challenges

For those proposing technology-related changes, change was constrained by:

- the organisation's existing hardware and software infrastructure, because of the costs involved in replacing any existing infrastructure and the need to retain consistency across the organisation
- software compatibility with systems operated by external partners.

Timeline challenges

Change management and embedding the use of new technology or practices requires time. Often, more time was required than initially anticipated as staff came to terms with changing workload and competing demands. In some cases, implementation delays generated further challenges for the initiative, particularly where external collaborations were involved. In one case, this resulted in a scenario where industry partners had resources to contribute but the initiative was insufficiently developed to draw on the available resources.

External challenges

Three themes were evident in the external challenges reported. These were related to:

Partner-related challenges

Several initiatives involved collaboration with external partners. Formalising collaborative activities through a memorandum of understanding (MoU) posed a number of challenges. This process was time consuming, particularly as organisations sought to:

- collaborate while maintaining control over their own resources and funds
- operate cross-sectorally in a manner that bridged the gap between health provision organisations and tertiary institutions
- meet the requirements of specific MoUs.

Policy/funding-related challenges

Implementation of initiatives occurred in a dynamic environment of policy and funding changes. These changes posed particular challenges to implementation because of the impact they had on partner agencies. Impacts included a reduction in the level of resources and staff available to the collaborative venture, loss of project staff through staff restructuring, and the introduction of a cost-recovery strategy by a partner agency (that is, training fees).

The initiatives themselves were not exempt from policy and funding changes. For some initiatives, policy changes were instrumental. Conversely, policy and funding changes meant that one grant recipient was unable to commit to the requirements of their MoUs pending the outcome of the recommissioning of the Victorian MHCSS and AOD sectors in 2013–14.

Procedural challenges

For one grant recipient, the process of securing accreditation for a training course proved lengthy and represented a key external procedural challenge for their initiative.

Factors that facilitated implementation

For the majority of challenges encountered, steps were identified and implemented to address them. The extent to which these solutions proved successful varied and some solutions are still ongoing. Details of the factors that enabled participants to address key internal and external challenges and progress implementation are discussed below.

A variety of factors were cited as implementation facilitators. These included:

- staff engagement and ownership
- the right skills mix
- management buy-in and support
- adequate time to embed change
- support by initiative champions
- change management expertise
- precedence
- adaptability and responsiveness
- acknowledgement/recognition of achievements.

Staff engagement and ownership

Staff engagement with initiatives was fostered through ongoing consultative opportunities. This not only involved providing staff with repeated input and feedback opportunities during the implementation phase, but also through involving staff in developing solutions for issues that arose. In some cases, staff involvement included representation on working groups.

Building in opportunities to share learning and collaborate across programs and between staff served as a further facilitator of staff engagement.

Ensuring good communication with staff, and providing opportunities for staff to be actively involved in the process and feel that their concerns were being heard and that solutions were being developed further enhanced levels of staff engagement.

Involving staff with the passion to drive and champion the project over time will also promote long-term change.

The right skills mix

Providing training so staff felt better equipped to manage the changes was identified as a successful strategy in promoting staff buy-in and support for implementation of new practices. In some cases, this involved using existing positive relationships with partner agencies to assist in staff training and development provision.

In addition, changing recruitment policies and engaging external expertise to overcome skills deficits were identified as responses to implementation issues.

Working with early adopters and appointing staff with the necessary expertise and passion will ensure momentum for the project over time.

Management buy-in and support

Strong leadership at executive/senior management level was seen as crucial to the development and implementation of the initiatives. Reinforcing the organisational commitment is also seen as key to engender a shared mission with staff.

Support by the leadership team facilitated the growth of partnerships.

In one organisation, the extent of management support for the initiative was illustrated through the formal inclusion of the initiative in the organisation's business plans. In others, this support was demonstrated through funding commitments and the allocation of staff time / staff release for initiative-based activities.

Adequate time

Having adequate time to plan and implement initiatives was an essential facilitator. This allowed organisations to adapt to change and address issues as they arose to embed the initiative.

For some, this involved removal of implementation deadlines with management recognising that it was more important to 'get it right' than meet arbitrary deadlines.

Support from champions

Champions played a major role in supporting the implementation of initiatives. While champions differed in terms of seniority (senior managers, senior clinicians, team managers, and non-managerial staff), their involvement in the initiative ensured:

- local leadership of the initiative
- local people were involved in developing local solutions
- innovation was driven from within the team, rather than being imposed from outside the organisation
- the necessary expertise, passion, dedication, and determination was available to drive the project over time
- well-developed working relationships were fostered with internal providers.

Capacity, expertise and attributes of those involved in change management

Change management was facilitated by the capacity and expertise of those involved. This included staff having the requisite expertise to engage in partnerships with external agencies and to coach colleagues in the use of new technologies or approaches. In the latter case, the merits of change were demonstrated at peer level, thus allowing the organisation to use the principles of contagion to promote change.

Commitment to the vision and strategic intent of the initiative, coupled with a capacity to maintain enthusiasm for change throughout the process, were key facilitating attributes of those involved.

Change management was repeatedly cited as a time consuming activity that required persistence and a focus on incremental progress to support longer-term change.

Precedence

In some cases, initiatives built on prior experiences. Examples included the development of collaborations with external partners where strong partnerships already existed and the expansion of remote supervision beyond those who had prior experience in this mode of supervision.

These experiences provided precedence for the initiatives and facilitated implementation by increasing stakeholder receptiveness to the changes proposed in the initiative.

Acknowledgement/recognition of achievements

Internal and external acknowledgment or recognition of achievements served as twofold facilitators. For those involved in the initiative, this recognition was motivational and affirming, adding further incentive to maintain enthusiasm and commitment for the initiative. It also increased awareness of the initiative, internally and externally. Internally, it showcased the benefits of the initiative to the broader organisation, thus facilitating broader engagement with the initiative. Externally, it showcased the initiative to potential clients and possible partners, thus facilitating service uptake and possible future collaborations respectively.

Adaptability and responsiveness

In situations where collaboration-related factors are challenging a project, strategies used to address these challenges could include:

- seeking out new partners in instances where proposed partnerships had failed to become operationalised
- diversifying partner relationships to increase collaborative, funding, or employment options.

5. Conclusions

The 12 case studies included in this synthesis report represent a diverse range of initiatives undertaken in different health regions and three health sectors (AOD, CMH and MCHSS) in Victoria. A key attribute shared by these initiatives was their focus on addressing specific problems in specific local contexts. While many of these initiatives were not innovative in the sense of being inventive, they represented new solutions for the problems experienced within the organisations in question.

In some cases, workforce changes/outcomes were generated from initiatives that were not specifically workforce focused. Rather, workforce improvements were a by-product of other broader service redesign activities.

Overall, each of the Rural Workforce Innovation Grant Program priority areas was either directly or indirectly addressed by the mix of projects funded.

Strong alignment was also evident with the WHO evidence-based recommendations in the areas of education and personal and professional support. Minimal usage of regulatory or financial incentives was evident – the latter possibly constrained by award-based employment arrangements, levels of funding received by the health service, and access to discretionary funding.

Based on the findings of this synthesis report, for rural organisations to support or replicate similar initiatives they need to:

- develop initiatives that address local problems and are appropriate to the local context
- secure senior management support and buy-in
- appoint champion(s) to spearhead the initiative
- ensure those involved in change management have the appropriate capacity, expertise and personal attributes to drive change, motivate involvement, and sustain the ultimate vision of the initiative
- invest in stakeholder engagement and address any concerns and issues stakeholders may have regarding the changes proposed in the initiative
- foreshadow and implement strategies to address challenges, such as:
 - staff resistance
 - limitations imposed by the skill set of existing staff
 - organisational culture and the level of organisational readiness for change
 - infrastructure issues
- allocate adequate time to the development and implementation of initiatives, recognising that change takes time
- be aware of the dynamic environment in which initiatives operate, recognising that internal and external circumstances can change over time and thus impact the initiative
- build on any precedents for the initiative in the organisation, including earlier pilots and pre-existing relationships with external partners
- work with early adaptors so that they can demonstrate the benefits of the changes to their colleagues
- acknowledge/recognise initiative achievements. This will not only help sustain the motivation of the change managers but will also provide opportunities to showcase the initiative to internal and/or external stakeholders, thus promoting greater stakeholder engagement.

Appendix 1: Research methodology

Overview

Each of the Eols submitted by the grant applicants was reviewed to determine their utility as a data source for this project. Considerable variability was evident in the quality and comprehensiveness of responses provided using the department's original application template. For this reason, a structured case study workbook was developed to support organisations to develop their case studies, and thus optimise the comprehensiveness and consistency of the case study information provided.

The approach used to develop the case study workbook was informed by the case study definition used by Simons (2010):

Case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a 'real life' context. It is research-based, inclusive of different methods and is evidence-led. The primary purpose is to generate in-depth understanding of a specific, topic, programme, policy, institution or system to generate knowledge and/or inform policy development, professional practice and civil or community section.²⁶

To obtain an in-depth understanding of each innovation, the following key areas of information were captured in the case study workbook:

- contextual details related to the setting in which the innovation is taking place
- the background to and rationale for the choice of innovation adopted
- implementation details – stage and progress to date
- consequence and achievements of the innovation to date
- reflections and learnings.

On 16 July 2014 an electronic copy of the case study workbook was sent to the 13 grant recipients. Organisations were allocated a four-week period to complete the workbook and were encouraged to provide evidence to support any achievements or successes cited.

On 26 August 2014 Goulburn Valley AMHS advised that the project worker and lead manager related to their innovation had left the organisation. Because organisational records lacked the level of detail necessary to complete this workbook, Goulburn Valley AMHS withdrew from the project.

The findings presented in this report are based on the information provided in the remaining 12 case study workbooks that were submitted.

26. H Simons, 2010, *Case Study Research in Practice*, Sage Publications, London, p. 23.

Data analysis process

Submitted workbooks were initially reviewed to ensure all sections had been completed and the necessary supporting evidence had been provided. Gaps in content or evidence were followed up.

Following the three-phase data analysis process, organisations were:

- contacted to discuss and/or provide additional information regarding any queries or gaps identified in the workbook content. Additional materials and/or commentary provided at this stage were incorporated in the development of the case study summaries and in the findings presented in this report
- provided with a copy of the AHA-generated summary case study for review. The case study summaries provided in Appendix 4 *include all changes and additional information provided by organisations during their review.*

A thematic analysis was undertaken of the finalised workbook content using the three-phase approach to data analysis advocated by Miles, Huberman and Saldana (2013). In the data condensation phase, grant recipient responses were transformed into thematic areas based on the key questions being addressed and illustrative quotations highlighted. The data display phase involved displaying the condensed data in a matrix with case details (grant recipients) on one axis and theme areas on the other. Phase 3, the conclusion drawing/verification phase, involved identifying patterns, explanations, and causal flows from the display matrix.²⁷

This iterative thematic analysis was synthesised to identify key themes and issues and to:

- identify key learnings and innovation themes with particular regard to the quality of evidence to substantiate claims of success of outcomes
- establish how innovative workforce solutions can be further developed and promulgated in Victoria.

Particular emphasis was placed on unpacking the contextual factors at play in each innovation so that replicability can be assessed in terms of ‘what works for whom in what circumstances, in what respects, and how’.²⁸

27. MB Miles, AM Huberman & J Saldana, 2013, *Qualitative Data Analysis: A Methods Sourcebook*, London: Sage Publications, pp. 12–13.

28. R Pawson & N Tilley, 2011, *Realistic Evaluation*, London: Sage Publications.

Evaluability issues

A number of evaluability issues were identified regarding the case study workbook information provided. These include:

- **Time lapse between implementation, EOI submission, and circulation of case study workbooks.** The call for Eols to write up case studies was issued in May 2013. The circulation of the case study workbooks did not occur until July 2014, by which time the timeframes since initiative inception ranged from 18 months to those dating back to 2003. In the intervening time periods, organisations experienced staff and structural changes (see below for implications thereof), policy changes occurred (the Mental Health Community Support Services reforms, 2014), and a state election was pending (November 2014). These events highlight the dynamic environment in which the innovations were operating or attempting to operate and in which case study material was being written up.
- **Loss of corporate knowledge.** In a number of cases, key personnel involved in an innovation had left the organisation and this resulted in a loss of corporate knowledge, particularly in relation to the development and implementation phases. While organisational records were used to reconstruct the information needed to complete the case study workbook, the richness and depth of the information provided may have been compromised as a result.
- **Recall bias.** Initiatives differed in terms of how long they had been operational. This introduces the risk of recall bias in the information provided in the workbooks, because respondents may find it difficult to remember or accurately recall details that happened in the past. Research studies indicate that 20 per cent of critical details are irretrievable after one year and 50 per cent after five years.²⁹ All studies that rely on self-reported data are prone to this limitation.
- **Quality of evidence provided.** Considerable variability existed in the quality and quantity of evidence provided by organisations to support achievements and successes cited in their workbook. This evidence ranged from the anecdotal to results from administering validated tools. In one case, our request for additional evidence prompted the development and circulation of a survey to the stakeholders involved. Few engaged in formal evaluations of their initiative. This variability in evidence quality not only limits the comparability of innovations between organisations but also limits the objectivity with which successes reported by individual organisations can be assessed.
- **Comparability constraints at sector and region levels.** Multiple case studies were not funded in all sectors and regions. In the MHCSS sector only one case study is available. In two regions (Grampians and Loddon Mallee), only one innovation was funded in each region. This limits the extent of comparison possible within and between sectors and regions.
- **Multiple case studies from single organisations.** While 12 case studies were completed, four of these were submitted by two agencies, with both Latrobe Community Health and Southwest Health funded to complete two case studies each. This reduces the organisational diversity represented by the case studies.

29. E Hassan, 2005, 'Recall Bias can be a Threat to Retrospective and Prospective Research Designs', *The Internet Journal of Epidemiology* 3(2), <<https://ispub.com/IJE/3/2/13060>>, accessed 18 February 2015.

- **Methodological constraints.** Budgetary constraints in this project necessitated the use of a case study workbook methodology rather than in-depth consultations or site visits. As a result, the report findings are reliant on information provided by the grant recipients without opportunity to substantiate achievements through direct observation or by triangulating findings from multiples sources (for example, staff interviews/survey/focus groups, clients and so on).
- **Differences in how responses are articulated.** These differences may influence the interpretability of findings particularly as inclusion or exclusion of factors may relate to narrative style rather than reflect true differences between organisations. In the case of challenges, for example, it is likely that most organisations faced similar challenges but not all articulated these. The true scale of the challenges and facilitators reported by grant recipients may therefore be understated.

Appendix 2: Evidence-based interventions to address rural health workforce issues – a summary of the literature

In 2010 the World Health Organization conducted some analysis of the types of interventions that were crucial in achieving greater retention of health care workers in rural and remote areas. *Increasing access to health workers in remote and rural areas through improved retention – Global policy recommendations*³⁰ identifies four types of interventions crucial in achieving greater retention of rural health care workers. These are summarised in the following table.

WHO evidence-based categories of interventions to improve attraction, recruitment and retention of health workers in rural and remote areas

Category of intervention	Examples
A. Education	A1 Students from rural backgrounds
	A2 Health professional schools outside of major cities
	A3 Clinical rotations in rural areas during studies
	A4 Curricula that reflect rural health issues
	A5 Continuous professional development for rural health workers
B. Regulatory	B1 Enhanced scope of practice
	B2 Different types of health workers
	B3 Compulsory service
	B4 Subsidised education for return of service
C. Financial incentives	C1 Appropriate financial incentives
D. Professional and personal support	D1 Better living conditions
	D2 Safe and supportive working environment
	D3 Outreach support
	D4 Career development programmes
	D5 Professional networks
	D6 Public recognition measures

Source: WHO, 2010, *Increasing access to health workers in remote and rural areas through improved retention – Global policy recommendations*, p. 17.

Education

Recommendations in the education domain are aimed at attracting the ‘right’ students (that is, those who will go on to participate in the rural workforce), increasing the placement of training in rural areas (including training institutions and clinical rotations), ensuring the curricula adequately reflect rural health issues, and providing continuous professional development for rural health workers. Specifically, the WHO recommendations are to:

30. World Health Organization (WHO), 2010, *Increasing access to health workers in remote and rural areas through improved retention*, <<http://www.who.int/hrh/retention/guidelines/en/>>, accessed 24 February 2015.

- use targeted admission policies to enrol students with a rural background in education programs for various health disciplines, in order to increase the likelihood of graduates choosing to practise in rural areas
- locate health professional schools, campuses and family medicine residency programs outside of capitals and other major cities as graduates of these schools and programs are more likely to work in rural areas
- expose undergraduate students of various health disciplines to rural community experiences and clinical rotations as these can have a positive influence on attracting and recruiting health workers to rural areas
- revise undergraduate and postgraduate curricula to include rural health topics so as to enhance the competencies of health professionals working in rural areas, and thereby increase their job satisfaction and retention
- design continuing education and professional development programmes that meet the needs of rural health workers and that are accessible from where they live and work, so as to support their retention.

Australian studies have also highlighted the importance of rural placements and professional development.

Rural clinical school graduate training was found to encourage graduates to pursue a career in rural medicine, and ‘the longer the exposure to training in the rural context, the greater the impact on interest in rural practice and, importantly, the greater the likelihood that some life decisions will also be made in the rural context’.³¹ The Productivity Commission has indicated that a strong focus on regionally-based education and training may be particularly beneficial over the longer term.³²

While rural origin and rural placements are predicting factors of future rural practice for doctors, fewer placements and incentives exist for nurses and allied health professionals.³³

The importance of providing support for further education for the existing rural healthcare workforce was also highlighted in the Australian literature. A recent survey of rural doctors found that continuing professional development, training opportunities, and professional support were key priorities for respondents.³⁴ Similarly, among allied health care workers, professional and clinical support and supervision, continuing professional development, and opportunities for career advancement have been found to be important for retention and satisfaction.^{35, 36, 37}

31. DS Eley, R Synnott, PG Baker, AB Chater, , 2012 ‘A decade of Australian Rural Clinical School graduates – where are they and why?’ *Rural and Remote Health* 12, p. 1937.

32. Productivity Commission, 2005, *Australia’s Health Workforce, Research Report*, Canberra, Research Report, Canberra, <http://www.rhwa.org.au/site/content.cfm?page_id=373159¤t_category_code=1398>, accessed 24 February 2015.

33. J Katzenellenbogen, A Drury, M Haigh, J Woods, August 2013, *Critical success factors for recruiting and retaining health professionals to primary health care in rural and remote locations*, Rural Health West, accessed 24 February 2015.

34. C Alexander, JD Fraser, 2007, ‘Education, training and support needs of Australian trained doctors and international medical graduates in rural Australia: a case of special needs?’ *Rural and Remote Health* 7, p. 681.

35. SG Devine, G Williams, I Nielsen, 2013, ‘Rural Allied Health Scholarships: do they make a difference?’ *Rural Remote Health* 13, p. 2459.

36. S Keane, M Lincoln, M Rolfe, T Smith, 2013, ‘Retention of the rural allied health workforce in New South Wales: a comparison of public and private practitioners’, *BMC Health Services Research* 13, p. 32.

37. J Humpreys, M Chisolm, D Russel, 2010, *Rural allied health workforce retention in Victoria: Modelling the benefits of increased length of stay and reduced staff turnover*, Monash University School of Rural Health.

Heavy clinical workloads and the challenges associated with arranging locum coverage, in addition to time and travel, present particular barriers to the rural workforce accessing appropriate professional development opportunities.³⁸ For this reason, innovative options for continuing training and professional development (for example, remote supervision for registrars³⁹) may have an important role to play in supporting the rural workforce.

Regulatory

Regulatory interventions relate to legislation, administrative change, legal or policy tools. These interventions can be used to provide support for rural health workers or enforce service periods. In particular, the WHO recommends:

- introducing and regulating enhanced scopes of practice in rural and remote areas to increase the potential for job satisfaction, thereby assisting recruitment and retention
- introducing different types of health workers with appropriate training and regulation for rural practice in order to increase the number of health workers practising in rural and remote areas
- ensuring compulsory service requirements in rural and remote areas are accompanied with appropriate support and incentives so as to increase recruitment and subsequent retention of health professionals in these areas
- providing scholarships, bursaries or other education subsidies with enforceable agreements of return of service in rural or remote areas to increase recruitment of health workers in these areas.

Australia's Productivity Commission has noted that while adjustments to institutional, regulatory, and funding arrangements have the potential to encourage some ongoing workforce innovation, they are not sufficient, in isolation, to guarantee that major opportunities for innovation will be considered on a national, systematic basis.⁴⁰ There is also a suggestion that regulations that separate state/territory and federal powers in the healthcare area create a barrier to effective or efficient workforce innovation.⁴¹

Regulation of medical registrations is a strategy used to boost the rural and remote healthcare workforce. For example, in Australia, international medical graduates can apply for specific 'area of need' registration. However, there is evidence that satisfaction (both professional and personal) for these international graduates is low compared to non-mandated international graduates, and this may limit the long-term sustainability of this strategy.⁴² Conversely, it has been suggested that overseas students trained in Australian universities (as opposed to international medical graduates) may represent a valuable resource in rural workforce planning.⁴³

38. AM Campbell, J Brown, DR Simon, et al., 2014, 'Leading the rebirth of the rural obstetrician', *Med J Aust* 201(11), pp. 667–670.

39. SM Wearne, PW Teunissen, T Dornan, T Skinner, 2014, 'Physical isolation with virtual support: Registrars' learning via remote supervision', *Med Teach*. 26, pp. 1–7 [Epub ahead of print].

40. Productivity Commission, 2005, *Australia's Health Workforce*.

41. J Wakerman, JS Humphreys, R Wells et al., 2009, 'Features of effective primary health care models in rural and remote Australia: a case study analysis', *Med J Aust* 191, pp. 88–91.

42. MR McGrail, JS Humphreys, CM Joyce, A Scott, 2012, 'International medical graduates mandated to practise in rural Australia are highly unsatisfied: results from a national survey of doctors', *Health Policy* 108, pp. 133–9.

43. L Hawthorne, J Hamilton, 2010, 'International medical students and migration: the missing dimension in Australian workforce planning?' *Med J Aust* 193, pp. 262–5.

Other regulatory initiatives may involve enhancing the scope of roles to improve professional satisfaction, and therefore recruitment and retention. For example, enrolled nurses with medication endorsement reported greater job satisfaction than those without in a small Australian rural health service.⁴⁴

Financial incentives

Financial incentives recognise the real and opportunity costs of working in rural and remote health workforces. The WHO recommends:

- using a combination of fiscally sustainable financial incentives, such as hardship allowances, grants for housing, free transportation, paid vacations and so on, sufficient enough to outweigh the opportunity costs associated with working in rural areas, as perceived by health workers, to improve rural retention.

A recent Australian study found that locum relief incentives, retention payments, and rural skills loading payments were effective in encouraging GPs to remain in rural practice.⁴⁵ The size of the incentive required to make a rural/remote position attractive varied according to the geographical area, population size, and the characteristics of the job, with the 'least attractive' positions potentially requiring incentives of more than 100 per cent of annual earnings.^{46, 47} There is some evidence that rural nurses and allied health workers may be under-supported in terms of financial incentives, compared to medical staff.⁴⁸ However, while financial incentives may improve recruitment and short-term retention, their value in longer-term retention is unclear.⁴⁹

Personal and professional support

Isolation, both professional and personal, is identified as a key factor influencing rural workforce retention. The WHO guidelines list the following recommendations to provide personal and professional support in the rural context:

- improve living conditions for health workers and their families and invest in infrastructure and services (sanitation, electricity, telecommunications, schools and so on), because these factors have a significant influence on a health worker's decision to locate to and remain in rural areas
- provide a good and safe working environment, including appropriate equipment and supplies, supportive supervision and mentoring, in order to make these posts professionally attractive and thereby increase the recruitment and retention of health workers in remote and rural areas

44. M Hoodless, L Bourke, 2009, 'Expanding the scope of practice for enrolled nurses working in an Australian rural health service – implications for job satisfaction', *Nurse Educ Today* 29(4), pp. 432–8. DOI: 10.1016/j.nedt.2008.09.002. Epub 2008 Oct 14.

45. J Li, A Scott, M McGrail, et al., 2014, 'Retaining rural doctors: Doctors' preferences for rural medical workforce incentives', *Soc Sci Med* 121C, pp. 56–64.

46. A Scott, J Witt, J Humphreys, et al., 2013, 'Getting doctors into the bush: general practitioners' preferences for rural location', *Soc Sci Med* 96, pp. 33–44.

47. JS Humphreys, MR McGrail, CM Joyce, et al., 2012, 'Who should receive recruitment and retention incentives? Improved targeting of rural doctors using medical workforce data', *Aust J Rural Health* 20, pp. 3–10.

48. D Schofield, S Keane, S Fletcher et al., 2009, 'Loss of income and levels of scholarship support for students on rural clinical placements: a survey of medical, nursing and allied health students', *Aust J Rural Health* 17, pp. 134–140.

49. Buykx et al., 2010, 'Systematic review of effective retention incentives for health workers in rural and remote areas: towards evidence-based policy'. *Aust J Rural Health* 18, pp.102-109.

- identify and implement appropriate outreach activities to facilitate cooperation between health workers from better served areas and those in underserved areas and, where feasible, use telehealth to provide additional support to health workers in remote and rural areas
- develop and support career development programs and provide senior posts in rural areas so that health workers can move up the career path as a result of experience, education and training, without necessarily leaving rural areas
- support the development of professional networks, rural health professional associations, rural health journals and so on in order to improve the morale and status of rural providers and reduce feelings of professional isolation.

Evidence related to doctors indicates that health workers who are satisfied with their work and their lives as rural practitioners are more likely to intend to stay in rural areas.⁵⁰ Strategies to ensure/improve work-related satisfaction could include appropriate workforce modelling to anticipate local health care needs, improved use of existing roles, role redesign and the creation of new roles (that is, workforce redesign and/or expansion).⁵¹ The implementation of new roles and the increasing development of inter-disciplinary and multidisciplinary models of care have resulted in improved clinical care and efficiencies in Australia.⁵²

Professional isolation and insufficient supervision are also cited as barriers to the recruitment and retention of the rural health workforce in Australia.^{53, 54}

The 2005 Productivity Commission Report highlights that ‘a number of systemic barriers and impediments have prevented Australia’s health workforce from achieving its full potential and from providing Australians with accessible, high quality and safe health services in the most efficient, effective and financially sustainable manner’.⁵⁵ These include:

- the large number of entities and the resulting fragmentation of responsibilities
- ineffective coordination
- rigid regulatory arrangements
- funding and payment arrangements that inhibit efficient outcomes
- entrenched workplace behaviours and internal resistance.

Personal factors also influence workforce decisions. A study of Australian rural clinical school graduates over a 10-year period found that only 40 per cent of study participants were currently working in a non-urban setting, with personal and family decisions greatly influencing their career path.⁵⁶ Other important individual life decisions can ‘get in the way’ of intentions to go to or stay in rural positions.⁵⁷ A recent evidence review noted that ‘fulfilling the needs and satisfaction of

50. DS Eley, R Synnott, PG Baker, AB Chater, 2012, ‘A decade of Australian Rural Clinical School graduates – where are they and why?’, *Rural and Remote Health* 12, p. 1937.

51. HWA, 2013, *National Rural and Remote Health Workforce Innovation and Reform Strategy*.

52. Productivity Commission 2005, *Australia’s Health Workforce*.

53. N Campbell, L McAllister, D Eley, 2012, ‘The influence of motivation in recruitment and retention of rural and remote allied health professionals: a literature review’, *Rural Remote Health* 12, pp. 1900. Epub 2012 Jun 21.

54. HWA, 2013, *National Rural and Remote Health Workforce Innovation and Reform Strategy*.

55. Productivity Commission, 2005, *Australia’s Health Workforce. Productivity Commission, Government of Australia Research Reports*

56. Eley et al., 2012, ‘A decade of Australian Rural Clinical School graduates – where are they and why?’ *Rural Remote Health*, 12, pp. 1937

57. DS Eley, R Synnott, PG Baker, AB Chater, 2012, ‘A decade of Australian Rural Clinical School graduates – where are they and why?’, *Rural and Remote Health*, 12, p. 1937.

other household members is an important aspect of work-life balance'.⁵⁸ Adequate, affordable accommodation, childcare, and other family support are important in attracting and retaining staff in rural and remote areas. Improving satisfaction levels among spouses and families of healthcare workers may be important in recruitment and retention.⁵⁹

58. P Buykx, J Humphreys, J Wakeman, D Pashen, 2010, 'Systematic review of effective retention incentives for health workers in rural and remote areas: towards evidence-based policy' *Aust J Rural Health* 18, pp. 102–109.

59. Buykx et al., 2010, 'Systematic review of effective retention incentives for health workers in rural and remote areas: towards evidence-based policy'. *Aust J Rural Health* 18, pp.102-109.

Appendix 3: Analysis of the projects included in this project

The following provides a summary of the projects included in this project, not the overall Rural Innovations Grants Program, including how the initiatives were distributed across the various regions and the sector.

Organisational affiliation of grant recipients

In response to the initial expression of interest for participation in the project, a total of 13 responses were received from 11 organisations. As shown in the table below, two organisations identified two individual workforce projects for inclusion, and both were accepted to be included in this project.

Organisational affiliation of grant recipients

Organisation	Number of grants
Albury Wodonga Health Northeast Border Mental Health Services (AWH-NEBMHS)	1
Ballarat Health Services Mental Health Services (BHS-MHS)	1
Barwon Health	1
Bendigo Health Psychiatric Services – Rural North Community Teams	1
Dual Diagnosis Hume Education Collaborative (DDxHECs) *	1
Gippsland Lakes Community Health (GLCH)	1
Goulburn Valley Area Mental Health Service (GV-AMHS)	1
Latrobe Community Health Service (LCHS)	2
Mind	1
Southwest Health (SWH)	2
Victorian Dual Diagnosis Initiative Rural Forum (VDDIRF)*	1

* Auspice: Albury Wodonga Health.

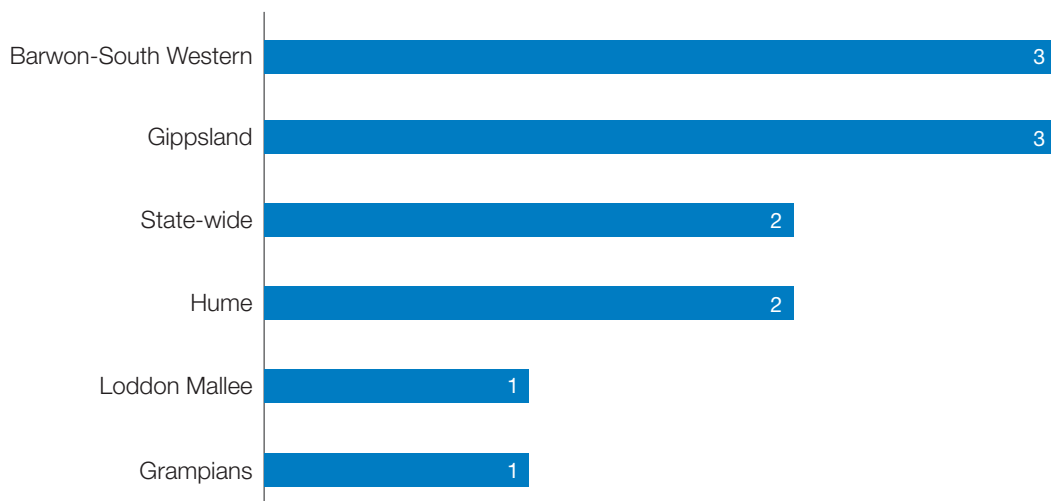
Distribution of projects by region

Case studies were included from all five rural regions in Victoria. Loddon Mallee and Grampians each received funding for one case study while the remainder received funding for multiple case studies. This ranged from two in Hume to three in both the Barwon-South Western and Gippsland regions.

Within regions, some organisations were funded to compile multiple case studies of their organisation as was the case with Latrobe Community Health (Gippsland region) and South West Healthcare (Barwon-South Western).

The majority of innovations (83 per cent) were region specific. A further two (17 per cent) were statewide in focus.

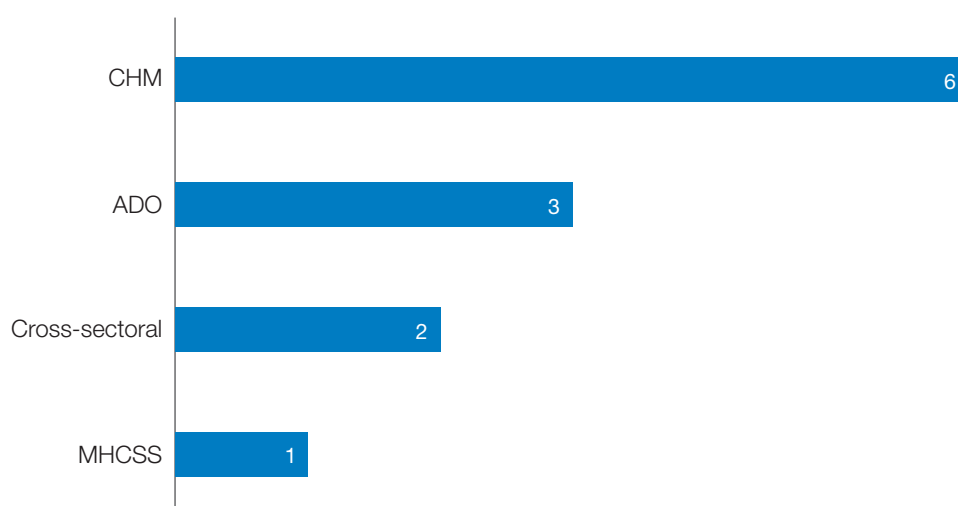
Distribution of innovations by region



Distribution of initiatives by sector

Half of all innovations covered in the case studies were focused on the clinical mental health (CMH) sector. A further three related to the alcohol and other drugs (AOD) sector and one was mental health community support services (MHCSS)⁶⁰ related. Two initiatives were cross-sectoral, spanning the AOD, CMH and MHCSS sectors.

Distribution of innovations by sector



60. The Victorian Psychiatric Disability Rehabilitation and Support Services (PDRSS) program was renamed the Mental Health Community Support Services (MHCSS) program from August 2014.

Distribution of innovations by region and sector

All sectors and regions are represented in the case studies. However, when the distribution of innovations is mapped by region and sector, a more complex picture emerges. AOD sector case studies are confined to the Gippsland region. The MHCSS case study is statewide, rather than region specific. The CMH cases studies span four of the five regions. This distribution and the small number of innovations make cross-sectoral comparisons unviable.

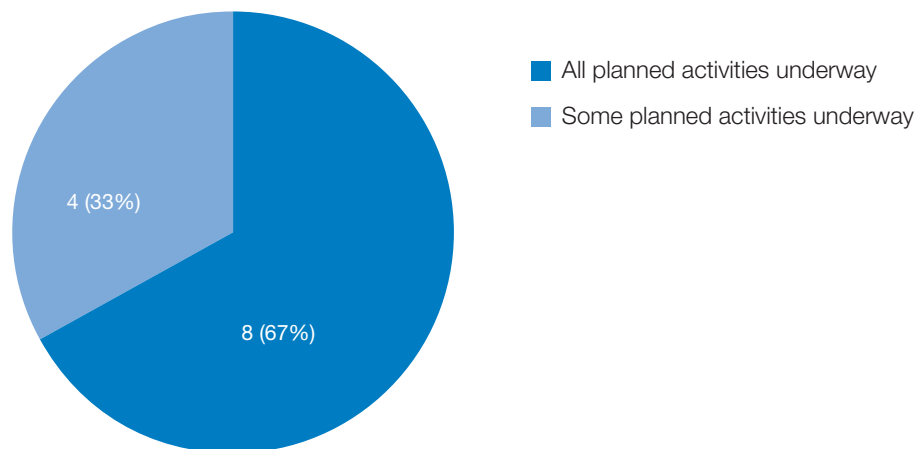
Distribution of innovations by region and sector

Region	Sector			
	AOD	CMH	MHCSS	Cross-sectoral
Barwon-South Western		3		
Gippsland	3			
Grampians		1		
Hume		1		1
Loddon Mallee		1		
Statewide			1	1

Implementation status

The majority (67 per cent) of initiatives were at the stage where all planned activities had been undertaken. The remainder of the initiatives had some planned activities underway.

Implementation status of initiatives



Where only partial implementation had been undertaken, a variety of reasons were cited, ranging from initiatives that had faltered in their development stage (for example, AWH-NEBMHS) to innovations that were partially implemented (for example, Mind) and those that were continuing to evolve and expand over time, thus creating opportunities for further activities in the future (for example, Barwon Health, Bendigo Health).

Innovations differed in terms of how long they had been operating, with timeframes ranging from 18 months to those dating back to 2003. Differences in timeframes not only impacted the maturity of innovations, but also the initiatives exposure and vulnerability to changing environmental circumstances.

Appendix 4: Case studies of projects

List of case studies

Albury Wodonga Health – Northeast and Border Mental Health Service	48
Ballarat Health Mental Health Services	54
Barwon Health – Mental Health, Drugs and Alcohol Services	60
Bendigo Health Psychiatric Services – Rural North Community Teams	66
Gippsland Lakes Community Health	73
Hume Region Dual Diagnosis Education Collaborative	77
Latrobe Community Health Service – Family Support Services	82
Latrobe Community Health Service – DTS consumer position	88
Mind Australia	92
South West Healthcare – Workforce	97
South West Healthcare – Learning Management System	102
Victorian Dual Diagnosis Initiative Rural Forum (VDDIRF)	107

Albury Wodonga Health – Northeast and Border Mental Health Service

Innovation snapshot

Target workforce sector: Clinical mental health (CMH)

Aim: To expand the capacity of the mental health workforce through creating new roles and functions (peer workers and volunteers) that will improve options for service users and embed a recovery approach into the existing service structures

Geographical scope: Hume Region

Date commenced: Project planning began in 2012

Implementation status: Some planned activities underway

The context

Albury Wodonga Health (AWH) is the first cross-border public health service to exist in Australia. It operates under an agreement between New South Wales and Victorian governments to provide the largest regional healthcare services between Sydney and Melbourne. It supports an outer catchment population of 250,000 and covers the north-east of Victoria and southern New South Wales.

The North East and Border Mental Health Service (NEBMHS) sits within AWH. The service encompasses all clinical mental health specialty areas and includes four residential services, two adult community teams, two Child and Adolescent Mental Health Service (CAMHS) teams, one Older Persons Mental Health team and a youth service. It operates across three major townships and nine sites and is staffed by clinical mental health professionals.

Workforce and client profile⁶¹

CMH staff:

- 265 FTE full-time, 87 part-time staff (FTE not stated) and 50 casual staff (FTE not stated)

CMH clients:

- 2,380 clients in the last 12 months
- All age groups
- 53 per cent women, 47 per cent men
- 9 per cent Aboriginal and/or Torres Strait Islander background
- 14 per cent culturally and linguistically diverse (CALD) background
- Up to 85 per cent have a dual diagnosis

61. At August 2014.

An exodus of clinicians through planned retirement (and potentially unplanned early retirement) was projected for the following 2–5 years

The innovation

Aim

To expand the capacity of the mental health workforce through creating new roles and functions (peer workers and volunteers) to improve options for service users and embed a recovery approach into the existing service model.

Workforce issue

A review of the age profile of clinical staff and findings from staff surveys indicates an exodus of clinicians through planned retirement (and potentially unplanned early retirement) was projected for the following two to five years.

Rural positions, particularly in mental health services for adults and older persons, tend not to be filled by applicants external to the service. Furthermore, recruitment to vacant positions is often competitive between sub-specialties and across the sites. As a result, filling a vacancy in one area often relocates the vacancy to elsewhere in the region, rather than reducing workforce shortages. Difficulties filling vacancies impacted the workload of existing staff.

At the time, graduate year programs were the main strategy for filling vacant positions in these areas. However, the small numbers enrolled in the nursing and allied health graduate programs were insufficient to replace the projected shortfall.

NEBMHS was in the process of redesigning its service to be recovery focused. A core component of this redesign was the expansion of the current mental health workforce to include alternative (non-clinical) and supportive roles in the form of consumer consultants and volunteers. It was envisaged that consumer consultants and volunteers would, in time, expand the options open to case managers, reduce the case load of case managers and increase support for the work undertaken by consumer consultants as part of the service's recovery-oriented approach.

While consumer consultants were well established in the service and had already demonstrated the potential for service users to work with and alongside a clinical service, a major review of the role highlighted the need for additional qualifications such as the Certificate IV in Mental Health Peer Work.

No accredited courses were then being offered in Victoria to prepare consumers and carers to work in peer roles in mental health.

Furthermore, opportunities did not exist for non-clinical staff (such as those undertaking the Certificate IV in Mental Health Peer Work) to undertake placements in clinical mental health settings.

Project summary

This initiative sought to expand workforce capacity by:

- preparing the existing workforce for reform by introducing alternative (non-clinical) and supportive roles as part of the mental health workforce to support a recovery approach
- developing a new cadre of accredited peer workers to increase the options available to case managers, provide greater flexibility across roles and reduce case managers' workload by redefining and distributing key tasks
- providing supervised workplace experience for participants to ensure work readiness.

To achieve this, the project had three components:

1. development and delivery of a TAFE course that would create an established entry point for a career in mental health for service users who were currently disengaged from education and employment. It involved a partnership with TAFE to develop the inaugural Certificate IV in Mental Health Peer Work through:
 - contributing to curriculum outline, teaching methods and the development of training resources
 - shared teaching including involvement of consumers and carers as presenters
 - orientation of TAFE staff and participants to the mental health workforce
2. supervised work experience in non-clinical and clinical mental health settings for Certificate IV trainees
3. a pre-vocational volunteer program for consumers and carers.

The initiative involved the development and delivery of a TAFE course, supervised work experience and a pre-vocational volunteer program for consumers and carers

Implementation process and activities

- In 2012, a small working group was established and, following meetings with TAFE senior management, a formal partnership was established, supported by a memorandum of understanding (MoU).
- In October 2012 a community information session was convened by Wodonga TAFE and Albury Wodonga Health, and was attended by 38 people interested in this training, including consumers and carers from the mental health services and staff from the Psychiatric Disability Rehabilitation Support Services (PDRSS)⁶² sector.
- An educational session was provided to 30 teachers at Wodonga Senior Secondary College to promote education and career pathways for persons with mental illness and to explain the principles, values and concepts involved in a recovery-oriented approach.
- Community partnerships were established with:
 - Wodonga TAFE (MoU signed)
 - Wodonga Senior Secondary College (MoU signed).

62. Psychiatric Disability Rehabilitation Support Services (PDRSS) were renamed Mental Health Community Support Services (MHCSS) in 2014.

Coles supermarket Wodonga donated a computer and a coffee machine for the volunteer program.

- Preparation for a pre-vocational volunteer program began and training needs were identified.
- Culture change was promoted by demonstrating service users' strengths and skills through an art gallery space in the waiting room area and shared social activities with clinicians, service users and carers.
- Meetings were held with Charles Sturt University regarding evaluation frameworks and potential partnership opportunities. The university offered two PhD students to undertake an evaluation of the initiative.

Implementation challenges

Key implementation challenges encountered:

- 1. Development of the MoU with TAFE** took considerable time, because each agency was cautious about making commitments involving resources. The final MoU was broad and designed to ensure collaboration without commitment of resources or funds, thereby maintaining the autonomy of each organisation to control their own resources and funds.
- 2. Lengthy Certificate IV in Mental Health Peer Work accreditation process.** A twelve-month delay was incurred in receiving accreditation from the Community Services and Health Industry Skills Council. This resulted in a scenario in which industry partners had resources to contribute, but the course was not available. When the course was finally accredited, industry partners were no longer in a position to continue/contribute.
- 3. Changes to TAFE funding.** This resulted in:
 - introduction of a proposed fee of \$3,000–\$5,000 for each service user to undertake the Certificate IV training with TAFE
 - reduced TAFE resources, including staff
 - TAFE refocusing its efforts on maintaining existing courses rather than commencing new courses
 - reduced interest in the course service user eligibility for fee support.
- 4. Senior staff changes in partnership agencies.**
 - The senior manager at TAFE was seconded to another position. The relieving manager was not prepared to support the development of this new course in a climate of financial uncertainty.
 - The senior member of staff at Charles Sturt University moved on to another position and was unable to continue their involvement at the same level.
- 5. Funding changes at university level** resulted in reduced resource availability for conducting evaluation activities. The university could no longer offer PhD scholarships for the evaluation, but offered to support one or two honours students in the allied health program to undertake some evaluation.

Some challenges remain unresolved and finding new partners is essential to the future success of the initiative

6. Internal barriers.

- The project worker position was initially funded for one year. An additional year was secured in a second funding round. However, ongoing funding was not available and the position no longer exists
- While the project worker was on maternity leave, the development of the pre-vocational program was hindered by a lack of :
 - alternative staff internally with the necessary skills required to develop this program
 - a dedicated coordinator to recruit, train and supervise the volunteers.

How challenges were tackled

- **Project implementation was delayed.** These challenges collectively prevented the project from evolving beyond the development stage.
- **New partners sought.**
 - *Life without Barriers*, a registered training organisation, has been approached with a view to partnering with NEBMHS to develop and deliver the Certificate IV in Mental Health Peer Work. Preparation of training materials and delivery of teaching would be a joint effort under this arrangement
 - Partnerships are being considered with non-healthcare services, such as an employment agency to:
 - source funding for the pre-vocational program
 - provide access to skilled groups for people interested in voluntary work, education or employment.

The capacity to act within a reasonable timeframe is crucial, because delays allow further changes in the external environment to occur

Factors that facilitated development

- **strong leadership** at executive level to trial new recovery-oriented initiatives
- **strong support** from the Department of Health and Human Services (Hume Region) for the redesign of the clinical services along the recovery approach, including funding of a recovery project officer
- **capacity and expertise** within the Mental Health Professional Development Unit to support TAFE partnership
- **multidisciplinary team input** – nursing, education, consumer consultant and occupational therapists and senior management were all represented on the working group
- **a senior manager** championed the project.

The initiative had positive impacts in terms of cultural change, education, support, and increased optimism regarding consumer workforce potential

Organisational learnings and reflections

'Develop and sign the memorandum of understanding quickly before staff move on to other positions.'

'Develop external partners ... There is huge potential to harness community business and organisations to further the work of mental health.'

'Invest ... time in maintaining the relationship with the external partners ... Their initial response and buy in was extremely positive. As this was our initiative and we needed their on-going buy-in ... we should have invested more time in supporting their organisation... so we maintained a profile, instead of ... only early in the engagement process.'

'It would be worthwhile to acknowledge the partners publicly to confirm the value we held for their contribution (academic, support, resources etc).'

'The difficulty is that the external partners cannot control or influence their funding brief so it means they may not be able to deliver even though they are committed to do so.'

'Support the consumer consultant program staff to have more input and promote the project to other service users.'

The outcomes

- **Cultural change.** Activities related to this initiative (such as the art gallery space in the waiting room area and shared social activities with clinicians, service users and carers) resulted in a shift in culture towards greater acceptance of the role of service users in the workforce expansion.
- **Increased collaboration between agencies.** Community partnerships were developed with Wodonga TAFE, Wodonga Senior Secondary College and Coles supermarket Wodonga.
- **Service users enrolled in TAFE.** The public promotional program resulted in three enrolments by service users in the Certificate II Community Studies.
- **Increased staff engagement,** with 33 people participating in case management redesign consultations between PDRSS, carers, service users and clinicians.
- **Increased optimism regarding consumer potential** was evident from the survey of case managers, consumer consultant project workers and managers.

Ballarat Health Mental Health Services

Innovation snapshot

Target workforce sector: Clinical mental health (CMH)

Aim: To improve access to care, through workforce redesign and partnerships across service delivery agencies, for children and youth aged 0–25 years

Geographical scope: Grampians Region

Date commenced: Funding was secured in late 2009. Teams have been operating since 2011

Implementation status: All activities are underway

The context

Ballarat Health Mental Health Services (BMHS) is a recovery-oriented mental health service that provides a comprehensive range of evidence-based services to clients and their families.

Services are open to people of all ages who have, or are at risk of developing, mental health problems.

Workforce and client profile⁶³

CMH staff:

- 190 FTE full-time, 55 FTE part-time, 28 FTE casual staff

CMH clients:

- 2,519 clients in the last 12 months
- All ages
- 54 per cent women, 46 per cent men
- Significant number have a dual diagnosis
- Culturally and linguistically diverse (CALD) and Aboriginal and/or Torres Strait Islander background (% unknown)

The innovation

Aim

To improve access to care, through workforce redesign and partnership across service delivery agencies, for children and youth aged 0–25 years.

Workforce issue

The Grampians Region has a catchment area of 48,000 square kilometres. To ensure young people in rural areas get the same access to services as their counterparts in large regional cities, there was a need to establish and maintain a critical mass of well-trained mental health clinical staff who could assess and treat infants, children and young people and their families using evidence-based, recovery-oriented approaches.

A critical mass of well-trained mental health clinical staff is needed to ensure young people in rural areas get the same access to services as their counterparts in large regional cities

63. At August 2014. Figures refer to whole of service CMH staff and clients.

Feedback from consumers, carers, key stakeholders and partner organisations as well as findings from internal audits indicated that the service system was 'a fragmented and silo-driven patchwork of services that were not well connected'. This, coupled with the Victorian Mental Health Reform Strategy 2009–2019, highlighted the need to implement a model of interagency collaborative practice across the region to ensure coordinated care for children and young people.

This initiative (the Grampians Region Child and Youth Mental Health Service Redesign Demonstration Project) was designed to show how a coalition of providers could plan and deliver an earlier, better-integrated service response to children and young people aged 0–25 years.

Project summary

In late 2009 a 16-agency consortium led by Ballarat Health Services received funding to undertake the Grampians Region Child and Youth Mental Health Service Redesign Demonstration Project.

The project had four main components:

- **Service redesign:** This component focused on establishing and maintaining a critical mass of well-trained mental health clinicians to provide greater access to early intervention, timely advice and treatment for infants, children and youth and their families wherever they reside in the Grampians Region.
- **Formalised secondary consultation:** This was designed to provide non-clinical agencies (such as service providers, teachers and GPs) with access to timely mental health advice and support to increase their capacity for early detection and early intervention for individuals with mental health problems.
- **Interagency collaboration:** This involved interagency collaborative practice and care planning across the region to improve processes for information sharing, reduce the need for young people to repeat their story and provide a clearer understanding of service roles and responsibilities.
- **Enhanced workforce development:** This component focused on increasing mental health literacy and capacity across all sectors in the region.

An executive committee comprised of senior management representatives from the following agencies was established to provide oversight for the project:

- Ballarat Health Services (as lead agency)
- Ballarat Community Health
- Grampians Community Health
- Department of Education and Early Childhood Development
- Catholic Education Office
- Wimmera Uniting Care
- Department of Human Services (Children, Youth and Families)
- Grampians Medicare Local
- Aboriginal Co-operatives

Service redesign,
formalised
secondary
consultation,
systemic reform and
enhanced workforce
development were all
part of the innovation

- Primary Care Partnerships
- Berry Street
- Centacare – Catholic Dioceses of Ballarat
- Department of Health and Human Services (advisory capacity).

Implementation process and activities

- Consortium partners held a number of planning days and attended frequent consortium meetings to define the medium- to longer-term vision for the project. A number of detailed literature reviews were also undertaken to inform this process.
- Consortium governance was established.
- Implementation of the Interagency Collaboration Model involved the development of supporting documentation and culture change across 16 consortium organisations and 20 partner agencies.
- A consultation strategy was developed, and from these consultations gaps and opportunities were identified. The consultations involved consumers, carers and key stakeholder participation in:
 - focus groups/forums
 - expert working groups
 - individual consultations
 - surveys.
- During the planning phase, an extensive review was undertaken of other models of practice in Australia and internationally. The decision was made to develop a new model of service based on addressing local need.
- Yearly Reform Action Plans (RAPs) were developed. The first RAP was finalised in August 2010.
- A training needs analysis was conducted to identify the needs of the sector and the wider regional workforce. This involved interviews, online surveys and forums with 395 people.
- BSMHS was restructured into two integrated and developmentally appropriate teams:
 - Infant and Child Mental Health Service (I&CMHS)
 - Youth Mental Health Service (YMHS).
- A formalised secondary consultation model was implemented in the I&CMHS and YMHS teams.
- Cool at School Together (CAST), an early intervention program for children in early primary school with emerging behavioural disorders, was extended to kindergartens.
- An extensive intersectoral workforce development training program was delivered to increase workforce mental health literacy and capacity across the sectors and across the region. This included rollout of established training programs as well as the development of locally designed interagency training.

The process of breaking down pre existing barriers and silos across the service system took time

- Formal monitoring and reporting mechanisms were established to continually assess, measure and review the performance of governance arrangements, partnerships and service delivery. This information continues to be reviewed regularly by the Consortium Executive Group and relevant working parties.
- Three evaluations of the Child and Youth Redesign Demonstration Project were also conducted by external private consulting groups (Health Outcomes International, completed 2012; Dyson Consulting Group, completed 2013; Deloitte Access Economics, commenced January 2013). Each evaluation provided recommendations and directions for the next stages in the project's development.

Implementation challenges

- **Existing barriers and silos:** For the project to be a true collaboration amongst service providers, it was essential to focus initially on developing respectful and collaborative partnerships. Addressing existing barriers and silos impacted progress in the early stages of the project.
- **Staff resistance:** Initiating the cultural and clinical change involved in providing services to a 0–25 year age group was met with resistance by some mental health service staff. A small number of staff resigned.

How challenges were tackled

- Time spent in breaking down pre-existing barriers and silos across the service system took time.
- Open communication and maintaining the commitment to improve the mental health and wellbeing outcomes for infants, children and young people residing in the Grampians Region was essential to overcoming staff resistance.

Factors that facilitated implementation

- senior management buy-in and support
- local leadership, particularly by local champions, ensured that local people were involved in developing local solutions
- ensuring the voices of clients and their families/carers were kept central to the reform process
- regular ongoing working party meetings, interagency training and partnership surveys were used to sustain the quality and effectiveness of established partnerships
- investment in cross-sector workforce development, particularly upskilling staff in the broader service system to recognise the early signs of mental illness, identify potential mental health related crises, and assist consumers to get the help they need as early as possible
- a strong focus on accurate, timely and quality data to inform interagency decision making.

Extensive consultations with consumers, carers and stakeholders grounded the project in community needs

Significant service system and cultural change was achieved through cross-sectoral commitment and leadership

Organisational implementation learnings and reflections

'Extensive consultation processes with consumers, carers and stakeholders is essential to ensure that plans are informed by and reflect the needs of the community. This will ensure buy-in from the region in particular.'

'This initiative involved significant service system and cultural change that required courage, determination and hard work by all involved. Without cross-sector and organisational commitment, others may struggle to implement change of this scope.'

'Be prepared to have the difficult conversations.'

'Focus on the outcomes for client and their families/carers.'

'Ensure there is committed and united leadership driving the reform.'

Integrated mental health programs are now provided by staff trained to provide all clinical functions

An inter-sectorial workforce development program was developed and delivered to 890 individuals across more than 34 organisations

The outcomes

• Service redesign:

- Structural change is now embedded and two new teams have been established.
- Integrated mental health programs are now provided by both teams, with staff trained to provide all clinical functions across the continuity of care (for example, early intervention, triage, assessment, secondary consultation and treatment).
- Service sector capacity to recognise the early signs of mental illness, identify potential mental health-related crises, and assist adolescents to get the help they need as early as possible, has improved.
- Upskilling of staff has occurred to provide CAST Kindergarten Program across the broader region.
- Additional clinical positions have been filled in the Wimmera Region, a previously problematic area in terms of staff recruitment and retention.
- CYMHS child and youth consultant and family/carer consultant positions have been developed.
- Double servicing of clients has decreased.

• Formalised secondary consultation model: Both the I&CMHS and YMHS teams provide greater access to timely mental health expertise through routinely-available secondary consultation, allowing:

- agencies to continue working with a child or young person without them needing to be directly involved with or referred to a specialist mental health service
- specialist mental health services to become involved in a planned manner rather than at times of crisis
- collaborative working relationships between agencies.

The Child and Youth Mental Health Service Redesign Demonstration Project was awarded the 2013 Minister's Award for outstanding achievement by an individual or team in mental health care

- **Interagency collaboration:** A region-wide and system-wide Interagency Collaborative Care Planning model has been achieved through the:
 - development of formalised collaborative processes
 - identification of a common documentation suite and the establishment of positive interagency culture
 - training of staff across agencies in collaborative practice.
- **Enhanced workforce development:** An intersectoral workforce development program was developed and delivered to 890 individuals across more than 34 organisations, leading to a more sustained, skilled and supported workforce that can meet the mental health needs of children, youth and young people in a coordinated and collaborative way.
- **Expanded service provision:**
 - More 0–25 year olds are now receiving assessment and treatment services from BHMHS. Data from 2010–11 and 2013–14 indicate total referrals, assessments and treatments have increased by 38 per cent, 64 per cent and 61 per cent respectively
 - Functional improvements are evident in children participating in the CAST program as demonstrated by pre- and post-intervention Strengths and Difficulties Questionnaire (SDQ) scores.
 - The number of coordinated and collaborative care plans developed has increased.
 - Young people and families/carers are now an integral and equal part of the collaborative care approaches being implemented across the Region.
- **Attracting and recruiting staff is easier:** Anecdotal evidence indicates the appeal of having a role with integrated functions has assisted in this regard.
- **External recognition of initiative achievements:** The Child and Youth Mental Health Service Redesign Demonstration Project was awarded the 2013 Minister's Award for outstanding achievement by an individual or team in mental health care.

Barwon Health – Mental Health, Drugs and Alcohol Services

Innovation snapshot

Target workforce sector: Clinical mental health (CMH)

Aim: To develop a contemporary service provider-focused training program for clinical psychologists with a view to increasing graduate recruitment and retention in public mental health services in the region

Geographical scope: Barwon Region

Date commenced: The Barwon Health Deakin Psychology Clinic was established in 2011

Implementation status: Some planned activities are underway

The context

Barwon Health is Victoria's largest regional health service, providing services at 21 sites across the Barwon-South West Region. In 2013, the service was awarded the Premier's award for the Regional Health Service of the year for the second time in three years.

Barwon Health's Mental Health and Drugs and Alcohol Services provide a full range of acute and community mental health services, thus offering clients an integrated model of care.

Workforce and client profile⁶⁴

CMH staff:

- 1 FTE full-time, 4.6 FTE part-time, 8 FTE students

CMH clients:

- 140 clients in last 12 months
- 26–75 years old
- 85 per cent women, 15 per cent men
- 35 per cent have a dual diagnosis
- < 1 per cent culturally and linguistically diverse (CALD) background
- < 1 per cent Aboriginal and/or Torres Strait Islander background

The innovation

Aim

To develop a contemporary service provider-focused training program for clinical psychologists with a view to increasing graduate recruitment and retention in public mental health services in the region.

64. At August 2014.

Geelong had challenges recruiting psychologists to work in public mental health

Workforce issue

Regional centres such as Geelong have been challenged by workforce supply issues, particularly in relation to recruiting clinical psychologists to work in public mental health. Clinical psychologists represent an important professional group in the provision of clinical mental health treatment and care.

Recovery-oriented and family-inclusive practice reforms necessitated a significant increase in the number of psychologists within the broader mental health community teams.

Project summary

In 2009 Barwon Health partnered with the Deakin University School of Psychology to explore collaborative opportunities to attract, develop and retain psychologists in the region. This led to the establishment of the Barwon Health Deakin Psychology Clinic in 2011.

The clinic operates under the scientist-practitioner model of therapy, training and research:

- **Therapy:**
 - evidence-based psychological therapies, primarily cognitive behavioural therapy (CBT), are used in the treatment of primary mental health conditions such as anxiety and depression
 - speciality programs for specific psychological disorders have been developed and delivered
 - psychological testing is conducted
 - reports are provided for co-managed primary care team clients.
- **Training:** Clinical psychologists on placement with the Deakin University Masters of Psychology (M Psych) program are trained within a scientist-practitioner model that prepares them for real-world employment.
- **Research:** The clinic's treatment programs are evaluated to contribute to the research on clinical service delivery, psychological treatment, student training and partnerships in Australia.

Traditionally, supervised clinical training occurs in a university-based environment. The establishment of the Psychology Clinic represented a significant development in industry-based clinical experience, and forms an integral part of the clinical placement program for the Deakin University Master of Psychology (Clinical) Program.

Implementation process and activities

- Planning began in 2009, when broad principles of engagement were agreed between Barwon Health and Deakin University.
- An initial clinic was established in Belmont, Geelong in 2011. This required:
 - corporate commitment by Barwon Health and Deakin University to substantial co-funding. The overall budget of the Psychology Clinic is approximately \$700,000

Barwon Health partnered with Deakin University to establish the Barwon Health Deakin Psychology Clinic to provide industry-based clinical experience

- significant restructure of Barwon Health’s Primary Health Mental Health resources.
- The clinic was later relocated to central Geelong in a purpose-designed and built primary care mental health centre. This involved:
 - partnership with Barwon Medicare Local and a strategic co-location with a broader Primary Mental Health Platform
 - local and significant capital investment by Barwon Health and the Barwon Medicare Local estimated at \$500,000.
- The service model was broadened to include group and individual CBT for anxiety and depression, a full dialectical behaviour therapy (DBT) program for borderline personality disorders and most recently, individual based CBT for adults with later onset or chronic enduring eating disorders (CBT-E).
- A range of clinical measures was introduced to measure clinical outcomes for clients as well as their experiences of care. In addition, there is a strong emphasis on evaluating trainee psychologists in the clinic.
- The partnership between Barwon Health and Deakin University has resulted in three joint appointments: an Honorary A/Prof appointment and the appointment of two Barwon Health psychologists as members of the Postgraduate Professional Psychology Course Advisory Board at Deakin. Reciprocally, the course director of the M Psych course has also provided extensive training and supervision to Barwon Health psychologists to enhance their skills, and is a member of the Barwon Primary Mental Health Reference Group.

Implementation challenges

- **Building a local clinical psychology workforce:** Recruitment of suitably qualified and experienced candidates was a significant challenge at the early stages of the initiative, particularly as the broader aim of the initiative was to build a local clinical psychology workforce. Some staff turnover occurred in the first 18 months.
- **Operating cross-sectorally (that is, tertiary institution and health institution):** The challenge was to bridge the gap between the health and tertiary institutions so that they could work together to achieve common goals.

Recruiting suitable candidates was a significant challenge at the early stages

How challenges were tackled

- **Investment in clinician training:** Initially, some psychologists who did not fully meet the qualifications or skills requirements were first appointed to the clinic. Appointees were supported to achieve the necessary skills over a negotiated period of time through training and development opportunities provided through Deakin University.
- **Maximising existing relationships:** Existing positive relationships with Deakin University were leveraged to provide training and development to clinicians. Regular communication/leadership helped to address cross-sectorial operational issues. For example, the course chair of the M Psych program attends business and senior staff meetings at the clinic.

Leadership and strategic partnerships contributed to the success of the initiative

Factors that facilitated implementation

- A strong academic partnership existed between Barwon Health and Deakin University. All students in the M Psych course undertook their first clinical placement in BHMHDA service, and several were undertaking longer second-year placements.
- The initiative had strong strategic intent, sufficient time to plan and develop as well as strong leadership support.
- There was considerable corporate investment and a willingness to bridge the academic and health sectors. The willingness of the leadership team allowed the partnerships to grow and allowed the clinic to promote mutual benefits for the health and tertiary sectors.
- Partnerships with Barwon Medicare Local were strengthened and Primary Mental Health Partners were developed. This enabled co-funding of a significant new clinical space and a strategic position of the clinic in the plans of both Barwon Health and Barwon Medicare Local.
- Leadership qualities of collaboration, trust, respect and innovation were shared across Barwon Health and Deakin University. These were critical to success as established structures and team functions were challenged through the implementation of this initiative.

Organisational learnings and reflections

'Leadership was paramount in articulating and building on a vision for the service.'

'The initiative has been strengthened by the strategic partnership with Barwon Medicare Local and the development of Primary Mental Health Partners.'

'[This] flexible and evidenced-based model of care ... [is] seen as a legitimate and high quality alternative to private psychology services funded through the Commonwealth.'

The outcomes

- **Increased placement opportunities:** Prior to this initiative, Barwon Health provided approximately ten 55-day placements to clinical psychology students per year. Subsequent to the initiative, the number of 55-day placements has risen to approximately 25 in 2014, representing a 150 per cent increase. To date, the clinic has supported 54 Clinical M Psych 55-day practicums, offering observation and practice in contemporary psychological work. This has led to the employment of more than 20 graduates from the M Psych program within the Barwon-South West Region.

The initiative has substantially increased the number of referrals received and the rate of graduate retention in the local region

- **Development of new roles:** The initiative involved appointments to new profession-specific positions and generated roles in clinical psychology that were previously unavailable within the public mental health service.
- **Clinical training and clinical supervision:** The focus on clinical training has resulted in increased clinical supervision and has promoted a culture that supports learning. All staff are involved in supervision at a level commensurate with their experience. The psychology clinic has enabled a significant increase in the provision of clinical services to a wider client group. Targeting consumers in need of psychological treatments has increased clinicians' skills sets.
- **Improved treatment model:** The group treatment model previously used by the primary mental health service was replaced with an evidence-based program. Clients with anxiety and/or depression have access to individual treatment as an alternative to group treatment. Preliminary analysis of clinical outcome data suggests clients are experiencing significant reductions in their perceived levels of depression, anxiety and stress, as well as functional/social improvements. Disengagement rates are approximately 25 per cent which is lower than expected compared to other psychology services such as the Access to Allied Psychological Services (ATAPS), where this figure was 37 per cent.
- **More efficient use of resources:** Group treatment reduced clinical treatment times by 75 per cent. The Primary Mental Health Partners Platform enables a supportive referral process between services, thus minimising the time spent reassessing individuals' needs for treatment programs and reducing clinical time in assessment by 50 per cent.
- **Shared expertise:** Training has been provided for GPs and other health professionals in a range of areas, notably in treating anxiety and depression, self-harm and DBT.
- **Strengthened partnerships:** The initiative has been strengthened by strategic partnerships including:
 - partnerships with Barwon Medicare Local that enabled co-funding and a long-range strategic positioning
 - development of a regional borderline personality disorder working party auspiced by Barwon Health, chaired by SPECTRUM, coordinated by a senior psychologist at the Barwon Health Deakin Psychology Clinic and including community representation from the public and private sectors across Geelong.
- **Expansion of the number of services provided:** The psychology clinic has increased the provision of clinical services to a wider client group. Operational data show referrals for the treatment of anxiety and mood disorders have increased from 58 in 2010 to 239 in 2013. In addition, 153 referrals were received for DBT for borderline personality disorder over 2011–13.

Operational efficiencies include a 75 per cent reduction in clinical treatment times and a 50 per cent reduction in clinical time in assessments

The initiative has improved client treatment choices and outcomes

- **Up-skilling of staff:** When the initiative began, only one staff member was clinically endorsed with the registration board. Currently, all five members of staff have clinical endorsement and are registered supervisors with the Australian Health Practitioner Regulatory Agency (AHPRA).
- **Increased graduate retention:** Prior to this initiative, only 12 of the 63 graduates of the Clinical M Psych course were employed locally: six by Barwon Health, a further three within government-associated services within Geelong and three in surrounding regional services. Subsequent to the initiative, the course has produced 51 graduates. Ten of these have been employed within Barwon Health, three in Geelong-based services and two in surrounding regional public mental health services. This reflects a significant increase in the number of graduates retained within Barwon Health, Geelong and the surrounding region
- **Organisational recognition of achievement:** In 2012 the initiative received a highly commended award in the category of Health Leaders – achieving a highly capable and engaged workforce (Barwon Health).

Bendigo Health Psychiatric Services – Rural North Community Teams

Innovation snapshot

Target workforce sector: Clinical mental health (CMH)

Aim: To use video conferencing and technology in the Rural North community mental health teams to provide effective management, clinical supervision and improved patient care across two geographically separate sites

Geographical scope: Loddon Mallee Region

Date commenced: Planning commenced in 2011

Implementation status: Some planned activities are underway

The context

Bendigo Health provides services in the Loddon Mallee Region, a geographical area covering 26 per cent of Victoria. Services are delivered in more than 40 locations, and health care is provided across the lifespan from prenatal to aged care.

The Rural North community mental health teams consist of two teams based in Echuca and Swan Hill. These teams are multidisciplinary in nature and are integrated with the Bendigo Health Psychiatric Services and other community-based supports and organisations. The teams provide services to patients with serious mental illness who require ongoing treatment and monitoring.

A significant part of the teams' work includes responding to new referrals received through the 24-hour psychiatric services triage service based in Bendigo. Services to patients are delivered in several settings, including centre-based visits, patients' homes, outreach visits to smaller rural towns, local rural hospitals, police stations and other community agencies such as mental health support services or community health centres.

Workforce and client profile (adult psychiatric teams)⁶⁵

CMH staff:

- 6 FTE full-time, 7 FTE part-time, 4 FTE casual

CMH clients:

- Services provided to 472 clients in last 12 months
- 18–65 years old
- 47 per cent women, 53 per cent men
- few from Aboriginal and/or Torres Strait Islander or culturally and linguistically diverse (CALD) backgrounds
- few have a dual diagnosis

65. At August 2014.

The central northern area had difficulty recruiting and retaining clinical staff to their community mental health teams

The initiative involved the use of appropriate technology to improve management, case loads and supervision across two geographically separate and distant sites

The innovation

Aim

To use video conferencing and technology in the Rural North mental health teams to provide effective management, clinical supervision and improved patient care across two geographically separate sites.

Workforce issue

For many years, the central northern area of the Loddon Mallee Region, encompassing Echuca and Swan Hill, has had difficulty recruiting and retaining clinical staff to their community mental health teams. This resulted in increased workloads for existing staff and high levels of fatigue for management because of the amount of time spent travelling between locations.

Access to adequate support and supervision was also problematic. While telephone support was available from regional triage or an on-call duty consultant psychiatrist, rural clinicians often had to make demanding clinical decisions in isolation and without support from senior clinical staff. This often led to staff leaving the community teams.

This situation was further complicated by having one manager providing oversight across two sites located 200 km apart. Initially, this issue was addressed by the manager dividing his time between the two sites. However, the volume of travel involved and team dissatisfaction with the level of access to clinical and management support meant this arrangement was not sustainable.

These operational and management challenges led some team members to explore technological solutions such as smart phones, videoconferencing and Skype.

Project summary

The initiative involved the use of technology to:

- provide effective management across two geographically separate sites
- provide appropriate levels of clinical governance for both Echuca and Swan Hill adult community mental health teams in the management of high case loads
- improve access to clinical supervision and support for staff in rural centres
- increase psychiatric coverage for patients in Echuca and Swan Hill
- improve linkages between the Echuca and Swan Hill community mental health teams and enable more collaborative and supportive practice
- rebuild the clinical team at Swan Hill both in terms of staff, experience and morale.

Implementation process and activities

The initiative was developed over a two-year period and included:

- investigation of appropriate technology
- trial use of videoconferencing by the manager. This was instrumental in securing buy-in from team members, encouraging them to use the technology and give feedback on their experience. Other managers observed the use and efficacy of the technology
- purchase and installation of technology and software, including:
 - the purchase and installation of the Polycom CMA system on recently purchased laptops and computers
 - the installation of smart screens and dual monitors
 - utilising features of the Polycom CMA system to allow concurrent viewing of documents and spreadsheets from multiple sites
 - the reconfiguration of the existing Tandberg Video Conferencing System to link with the ViTCCU system
- working with Bendigo Health Information and Communication Technology (ICT) and the Loddon Mallee Health Alliance to improve facilities and explore options for expanding the use of video conferencing (including identifying and purchasing the technology needed and advocating for simpler methods of integrating existing systems)
- securing support from the Psychiatric Services Executive, in terms of:
 - approving the purchase of additional equipment
 - approving conference attendance and study trips for the manager to investigate options and systems in other services
 - promoting the initiatives implemented
 - approving additional work time spent on investigating technology improvements
- implementing videoconferencing into clinical and administrative practice within the existing team and working with the early adopters
- broadening the reach of the service by involving external services, such as Njernda Aboriginal Corporation and rural hospitals, and establishing working parties with the Partners in Recovery program auspiced by Medicare Locals
- upskilling staff in the use of technology, including peer mentoring by early adopters.

Implementation challenges

The key implementation challenges encountered included:

- **Lack of prior training and confidence:** The absence of on-the-ground assistance to set up the equipment and deal with technology-related problems fuelled concerns among those who lacked prior training in the use of the equipment.

Lack of training, low confidence levels and uneven organisational readiness for change were key implementation barriers

- **Variance in organisational readiness:** Although Bendigo and Swan Hill were part of an original pilot of telepsychiatry, the use of video conferencing was not embraced by the service and there was significant resistance to changing working habits and using the technology.
- **Obtaining staff buy-in:** Other managers within the organisation had to be convinced of the benefits of using the technology.
- **Identifying appropriate technology (equipment and software):** In particular, it was difficult to decide what device(s) best fitted the various portability requirements of staff.
- **Ensuring all staff had access to the technology:** This required funding and prioritisation in purchasing technology.
- **Limitations of existing technology:** Some decisions in the initiative were driven by prior Bendigo Health ICT investment in particular options because replacement costs would have been prohibitive.
- **Investing time:** Time was needed to change and adopt the technology.

How challenges were tackled

- **Change management:** This involved providing leadership, driving the need to change and adopting/exploring new ways of using the technology.
- **Working with early adopters:** These early adopters demonstrated the worth of the technology to their colleagues.
- **Training:** This included training and up-skilling of staff in the use of the technology as well as peer-to-peer training by early adopters.
- **Partnering with others** within psychiatric services, particularly Child and Adolescent Mental Health Services (CAMHS).
- **Investing in mobile technology and upgrading existing technology**
- **High quality documentation:** CAMHS management dedicated staff resources to documenting quality improvement projects (in this case, videoconferencing).
- **Promoting achievements:** The documentation of quality improvement projects led to a quality award which significantly raised the profile of the initiative.
- **Persistent and consistent advocacy:** Advocacy at both local and organisational levels encouraged others to utilise and promote the technology.

Factors that facilitated implementation

- strong leadership and persistent advocacy for the initiative from the Rural North community mental health team manager
- the innovation was driven from within the team, rather than being imposed from outside the organisation
- stakeholders were consulted and feedback sought throughout the process
- use of the 'principles of contagion' and coaching staff in the use of the technology through demonstration and interactions initiated by the manager of the Rural North community mental health team

Coaching staff in the use of technology facilitated uptake

- early adoption of technology by the Swan Hill team
- there was a precedent for adopting new technology. The Echuca CAMHS staff had received clinical supervision via teleconference previously and were quick to embrace the use of videoconference
- support from a clinical informatics specialist from the Loddon Mallee Rural Health Alliance
- increased awareness of the initiative following the quality award, because the benefits of the initiative became more apparent to the broader organisation thereafter
- incorporating the initiative into the 2013–14 and 2014–15 business plans, including specific plans to use videoconferencing to increase participation in ward rounds and to implement a telehealth plan
- building a culture of collaboration and support between the rural sites
- study trips and attendance at the Rural and Remote Mental Health Symposium, and more recently the Success and Failures of Telehealth conference 2014, provided convincing examples of the use of videoconference technology in action
- enthusiasm grew with success as staff began to adopt the technology and demonstrate positive outcomes.

Organisational learnings and reflections

'It was important that clinicians had access to appropriate equipment and the opportunity to experiment with the use before implementing these in the patient's home environment. In addition, time was needed for the development of policies and protocols.'

'It is critically important to have support from work colleagues, ICT and senior management.'

'Change of this type takes time. Appointment of a dedicated person to manage and implement change could have achieved faster results.'

'Learning as implementation occurred meant the manager had a greater understanding of the advantages and disadvantages of what he was attempting to do.'

Uptake of the initiative was facilitated by users having adequate time to familiarise themselves with the technology prior to using it in the patient's home

The outcomes

- **Reduction in travel time between teams:** Travel for the manager of the Rural North community mental health team reduced by approximately 1200 km and 16 hours per month. This has resulted in:
 - reduced risk of being involved in a serious accident
 - reduced physical and mental strain on the manager
 - savings of approximately \$750 per month in travel costs.

Travel between sites has been reduced substantially and travel costs reduced as technology has become more extensively used

- **Increase in the number of applications and users:** The number of virtual meeting rooms at Bendigo Health has increased significantly from three to 30. There has also been a flow-on uptake of videoconferencing facilities by other teams.
- **Significant increase in the number and frequency of clinical supervision that is provided by videoconferencing:** Meetings are now weekly in many cases rather than monthly, and there have been fewer cancellations of clinical supervision due to clinical demands because specialists' and clinicians' time is being more efficiently and effectively used.
- **Extension of existing applications of the videoconferencing:** Videoconferencing has been expanded to include areas such as education (weekly seminars, course participation and access to online training), participation in staff meetings and provision of clinical oversight by the consulting psychiatrist.
- **New applications of videoconferencing:**
 - initial patient consultations
 - clinical handover, intake and consultation
 - psychiatric liaison and review with consultant psychiatrists
 - discharge planning
 - CAMHS daily intake meetings
 - staff performance reviews
 - staff interviews
 - ward rounds
 - hospital reviews
 - GP academic teaching sessions
 - management, staff and other meetings.
- **Improved patient care through:**
 - more frequent and timely access to clinicians and specialist staff
 - improved discharge planning
 - improved liaison, connections and transition from inpatient to community-based settings, ensuring coverage throughout the Bendigo Health catchment area
 - use of notebook computers when on outreach visits
 - reduced travel time for those patients who engage in technology-assisted consultations.
- **Patients have embraced the technology.**
- **Efficiencies achieved, including:**
 - increased capacity of consultant child psychiatrist. The consultant's capacity to see Echuca CAMHS patients has improved from two to three families per month to two families per week, if required
 - reduced travel time by staff

Workforce efficiencies have been achieved as a result of the initiative; staff retention has also increased

- improved access to files
- more staff can participate in meetings and can join/leave meeting easily via virtual meeting rooms.
- **Improved team work:** Staff report improved team cohesion, a better sense of being connected, increased information sharing and increased peer support.
- **Higher levels of participation** by rural clinicians in service-wide forums have been facilitated.
- **Staff retention has increased** and fewer vacancies exist in one campus.

Gippsland Lakes Community Health

Innovation snapshot

Target workforce sector: Alcohol and other drugs (AOD)

Aim: To attract and retain staff and reduce turnover within the AOD program

Geographical scope: Gippsland Region

Date commenced: This model of client service provision has been in operation since 2009

Implementation status: All planned activities undertaken

The context

Gippsland Lakes Community Health (GLCH) provides health, community and outreach services throughout East Gippsland, with sites in Lakes Entrance, Bairnsdale, Bruthen, Metung and Nowa Nowa. These include aged care, clinical and nursing services, community health services, health promotion, childcare, family, youth and children's services and Aboriginal health services. Services are divided into units underpinned with a strong multidisciplinary approach.

GLCH's alcohol and other drugs services fall under the remit of its Family, Youth and Children's Services (FYCS) unit.

Workforce and client profile (adult psychiatric teams)⁶⁶

CMH staff: • 3 FTE full-time, 9 FTE part-time

CMH clients: • 549 clients in the last 12 months

- 14–78 years old
- 53 per cent women, 47 per cent men
- 16 per cent Aboriginal and/or Torres Strait Islander background
- 1 per cent culturally and linguistically diverse (CALD) background
- 85 per cent have a dual diagnosis

The innovation

Aim

To attract and retain staff and reduce turnover within the AOD program.

Workforce issue

Attracting and retaining well-qualified, experienced staff was a key challenge for the AOD service. Prior to the initiative, GLCH regularly had positions vacant and a considerable amount of time and money was spent on recruitment.

66. At August 2014.

On average, between four and five positions were vacant per year, and the service struggled to recruit, often having to re-advertise two or three times.

Project summary

The FYCS unit developed a new multidisciplinary service delivery model based on strong service coordination and case management principles. The model supports staff to work in an outcomes-focused way from entry through to exit from the service. This involves a single point of entry complemented by partnerships and collaborative practice with external agencies. It has a strong focus on staff supervision, and support for professional development and staff wellbeing.

Implementation process and activities

- Implementation was preceded by extensive workshop discussions at the FYCS team managers' meetings over six months in 2008. Discussions focused on developing a vision for the type of service and workplace culture to be established within the unit and identifying the steps required to achieve this vision. Some initial work was then undertaken to develop a core set of FYCS unit values with staff.
- Implementation was a staged process, with the first element of the model implemented in 2009. All planned activities have now been undertaken.
- The model is subject to ongoing evaluation and review using an action research approach that includes the cyclic notion of plan, do, study, act. Feedback is regularly sought from both staff and clients.

Implementation challenges

The three key challenges encountered were:

1. **Time frames.** Time constraints, workload and competing demands meant that the initiative was not implemented as quickly as initially expected.
2. **Change management.** It was anticipated that the acceptance of a change in practice would take about 12 months to become embedded in the work. In reality it took three to four years.
3. **Role boundaries.** There was initial resistance, concern and a protection of defined discipline-based role boundaries that took extensive work over a three- to four-year period to overcome.

How challenges were tackled

- **Management decided to remove implementation deadlines.** Management recognised that it was more important to 'get it right' than meet arbitrary deadlines. Instead, they chose to focus on achieving incremental progress and agreed that the priority was to 'just keep achieving no matter how slowly'.

Attracting and retaining well qualified, experienced, staff was a challenge

Management recognised that it was more important to 'get it right' than meet arbitrary deadlines

- **Role boundary issues were addressed through persistence over a long period of time.** Strategies to address role boundary issues included bringing all staff together, providing extensive cross-disciplinary training, collaborative case meetings and investing time listening to staff concerns. Through these strategies, staff felt their concerns were being heard and that solutions were being worked on.

Factors that facilitated implementation

- endorsement of the model by the CEO
- consistent management involvement in the development, evolution and rollout of the initiative
- repeated opportunities for staff input during the implementation phase and staff involvement in developing solutions for issues that arose
- having a clear vision of what the initiative was ultimately seeking to achieve
- the commitment of middle management to ensuring good communication with staff and providing opportunities for staff to be actively involved
- having adequate time to develop the model and address implementation issues
- having a strong learning culture within GLCH. This prompted high uptake of training opportunities, with the result that clients now receive a service that is based on current evidence and best practice, thus facilitating better client outcomes
- building in opportunities to share learning across programs and between staff
- facilitating ongoing staff and client input and feedback.

Change management requires ongoing consistent messages and a strong belief in what you are doing

Organisational learnings and reflections

'Change management and addressing role boundaries is very draining, can wear you down and requires ongoing, consistent messages. In order to work through this you have to have a really strong belief in what you are doing and be able to bring other people along with you, otherwise it is easy to just give up.'

'The model is constantly evolving, as is the service system, so there is always a process of change management going on.'

'New staff require developmental work around understanding professional role boundaries and respecting transdisciplinary⁶⁷ work.'

67. Transdisciplinary work integrates the natural, social and health sciences and transcends their traditional boundaries.

The outcomes

- **Increased staff retention.** Today, 96 per cent of the AOD staff have been with the organisation for five years or more. Prior to the initiative, length of service ranged from one to four years and AOD vacancies averaged one per year. Since then, only one vacancy has arisen, and this attracted a large pool of applicants. This position was filled first time around.
- **Workforce development.** Unit-wide professional development and regular unit forums are held that focus on a broader range of skill sets and competencies than would normally be provided to an AOD workforce (such as the best interest case practice principles, family-centred approach, strengths-based approach, family violence common risk assessment and management framework (CRAF), Family Partnership model, Outcome Star, Andrew Turnell's signs of safety practice principles, child-focused practice and cumulative harm, the *Children, Youth and Families Act 2005*, family partnership training). Professional development is also promoted through the provision of staff scholarships, study leave, regular staff supervision and annual performance reviews.
- **Improved workplace culture.** Staff now report feeling valued and are able to function at their best, creating a culture that is respectful and affirmative. This has benefits for both clients and staff in that staff work in, and clients receive services in, an optimistic positive environment.
- **Improved client care.** The new integrated model ensures that clients can now tell their story once and are linked into a broad range of supports to meet their needs. Use of the Outcome Star enables measurement of progress towards goals. Workforce stability provides continuity of care and improves clients' experiences with the agency.
- **Staff and client feedback.** Regular staff forums provide a source of staff feedback and input. The first FYCS staff forum was held in March 2012. Service strengths and areas needing improvements were identified and subsequently addressed. A consumer participation plan was developed in 2013 and a consumer registry established. Results from the *Consumer Registry Interim Review Report* (August 2014) show high levels of satisfaction among the nine consumers who participated and feedback provided by these consumers was used to further refine the model.

Today, 96 per cent of AOD staff have been with the organisation for five years or more

Hume Region Dual Diagnosis Education Collaborative

Innovation snapshot

Target workforce sector:	Alcohol and other drugs (AOD) Clinical mental health (CMH) Mental health community support services (MHCSS) ⁶⁸
Aim:	To contribute to better outcomes for people experiencing both mental health and substance use concerns (dual diagnosis) by assisting Hume Region AOD, MHCSS and CMH services to develop their capacities to recognise and provide effective services to people presenting with dual diagnosis
Geographical scope:	Hume Region
Date commenced:	First formal meeting of Hume Region Dual Diagnosis Education Collaborative (Hume DDxHECs) was held in February 2009
Implementation status:	All planned activities are underway

The context

The Hume Region Dual Diagnosis Education Collaborative (Hume DDxHECs) is a multi-agency, multisector partnership of regional education providers who plan, coordinate and deliver strategic dual diagnosis training tailored to the Hume Region. It complements the various Hume alliances and committees formed to oversee, advise and support the rollout of Commonwealth and state initiatives to build the capacity of workers, services and sectors to respond to people experiencing dual diagnosis.

The innovation

Aim

The primary aim of the initiative is to contribute to better outcomes for people experiencing dual diagnosis by further developing staff capacity to recognise and provide effective services to people experiencing dual diagnosis.

Workforce issue

The DDxHECs group arose out of a strong, cross-sector, Hume-wide recognition of:

68. The MHCSS program was renamed CMHSS from 1 July 2014.

- **the prevalence of dual diagnosis** among people receiving services from AOD or mental health agencies (an estimated 45–80 per cent of service users)
- **the significant range of well-documented harms** strongly associated with dual diagnosis clients
- **the potential for AOD and mental health services to be more effective** in treating co-occurring disorders by developing their responses to co-occurring disorders.

The need therefore existed to further develop staff capacity to recognise and provide effective services for the growing number of people presenting with co-occurring mental health and substance use concerns.

Project summary

The DDxHECs group is one of the complementary strategies developed to assist Hume Region AOD and mental health workers in building their capacity to respond effectively to people with dual diagnosis. The DDxHECs group aims to increase capacity, strengthen cross-sector relationships and increase financial efficiencies. By so doing, services will be better able to deliver a more effective and consistent response to people with co-occurring AOD and mental health concerns, regardless of the service they present to.

The DDxHECs core responsibilities are:

- Facilitate the delivery of workshops: Cross-sector training targeting the identified training needs of Hume AOD, CMH, MHCSS and Aboriginal health workers.
- Cross-sector scholarship administration: DDxHECs oversees the advertising, coordination, selection and reporting around scholarships for Hume Region AOD, CMH and MHCSS workers to undertake accredited studies to undertake accredited studies that contribute to their capacity to respond effectively to people with dual diagnosis.
- Identification of annual education and training needs: To inform the delivery of education and training in the following calendar year and to provide data to regional AOD and mental health management groups.

Governance

The DDxHECs group has representation from the AOD, CMH and MHCSS sectors – as well as regional educational providers, capacity-building workers and policy and planning bodies. More recently, a priority has been to have representation from Aboriginal organisations providing Social and Emotional Wellbeing (SEWB) services.

There was a need to further develop staff capacity to recognise and provide effective services for the growing number of people presenting with co-occurring mental health and substance use concerns

The DDxHECs group is one of the complementary strategies developed to assist the Hume Region AOD and mental health workers in building capacity to respond to people with dual diagnosis

Implementation process and activities

- Planning commenced in late 2008. Initially, this involved three state and Commonwealth-funded dual diagnosis/comorbidity capacity-building workers whose roles included provision of education and training around dual diagnosis to AOD and mental health workers. Later this was expanded to include representation from CMH senior nurses, other state and Commonwealth dual diagnosis/comorbidity capacity-building workers, and policy and planning bodies.
- The first formal meeting of DDxHECs was held in February 2009.
- Draft Terms of Reference and meeting schedules were developed.
- A funding proposal was submitted to Hume Department of Health:
 - In its early days DDxHECs was jointly funded by regional Victorian Department of Health and Human Services grants and funds contributed by the then Hume Region Commonwealth Improved Service Initiatives projects.
 - The people who have worked on DDxHECs have been both state- and Commonwealth-funded and have worked on DDxHECs as a component of their existing roles.
- Topic-specific workshops were organised. In some cases, these workshops were co-delivered by DDxHECs members.
- Cross-sector scholarship administration was undertaken.
- The annual identification of education and training needs was only partially implemented.

Implementation challenges

- **Capacity to conceptualise at a systems level:** In busy, time-poor, service systems, managers and workers may be predominantly oriented to the needs, demands and 'target' disorders of their own agency or sector. It can be a challenge to also ask them to also conceptualise themselves as an integral part of a larger No Wrong Door mental health-AOD system and to engender enthusiasm about the benefits of addressing service and workforce development on a multi-agency, multisystem basis as well as on an individual agency and individual clinician basis.
- **Perception issues:** The mental health system is substantially larger and comparatively better funded than the AOD system. In the early days of DDxHECs some AOD stakeholders may have perceived a risk that AOD services were being 'taken over' by mental health services, and initially this may have impacted on their enthusiasm to embrace dual diagnosis capacity-building initiatives.

How challenges were tackled

- DDxHECs engaged in clear, frequent communication using a variety of mediums (email, face-to-face, video-conferencing, telephone).
- System leaders from each of the sectors were invited to participate.
- DDxHECs worked enthusiastically with early adopters.
- Stakeholders' enthusiasm for dual diagnosis capacity building work was encouraged by facilitating reflection on the prevalence, harms and potential benefits associated with dual diagnosis in their own service setting.
- All available opportunities were embraced to bring together managers and workers from different agencies and to encourage formal and informal communication and relationships between them.

Factors that facilitated implementation

- The DDxHECs model was and is supported by a range of other complementary strategies, activities and initiatives (at clinician, agency, sector and systemic levels) designed to contribute to the further development of dual diagnosis capability including:
 - state level:
 - policy: *Dual diagnosis - Key directions and priorities for service development* (DHS 2007)
 - policy: *Victorian strategic directions for co-occurring mental health and substance use conditions* (DH 2013)
 - initiative: *Victorian Dual Diagnosis Initiative*
 - Hume Region level:
 - plan: Hume Region Alcohol, Tobacco and Other Drugs Strategic Plan 2007–10
 - plan: Hume Region No Wrong Door Integrated Dual Diagnosis Protocol 2010
 - initiative: Commonwealth Improved Services Initiative – No Wrong Door Phase 2 Project – auspiced by Ovens & King CHS
 - Sub-regional level:
 - initiative: Victorian Dual Diagnosis Initiative workers in East and West Hume
 - initiative: Commonwealth Improved Services Initiative – Eastern Hume Dual Diagnosis Group – auspiced by Gateway CHS
 - plans: *North East Victorian Dual Diagnosis Plans 2007–10 and 2010–12*.
- Existing enthusiasm, knowledge and long-standing efforts by a range of Hume Region AOD and mental health agencies and policy and planning bodies towards developing systemic dual diagnosis capability.
- Availability of state- and Commonwealth-funded dual diagnosis capacity-building workers who were able, as a core part of their roles, to be responsible for DDxHECs work.

Clear, frequent communication using a variety of mediums was used to tackle challenges

Investing time in communicating with stakeholders and identifying their 'stage of change' can enhance stakeholder engagement

DDxHECs has facilitated more than 500 training attendances and allocated 71 scholarships

Organisational learnings and reflections

'It is important to gain the attention, understanding and support of all service managers.'

'Key stakeholders need to support the rationale for the initiative and be involved in the development, strategies and delivery of the initiative.'

'Strategies to achieve cross-sector, region-wide training needs analysis require extensive planning.'

'It is important to work with individual clinicians and agencies with a recognition of their current stage of change in addressing the issues associated with dual diagnosis'

The outcomes

- **Increased screening for dual diagnosis:** File audits indicate clinicians' recognition of co-occurring disorders has improved as evidenced by increased screening. There are indications that clinicians are providing more integrated treatment of co-occurring disorders.
- **Developmental opportunities:** DDxHECs has provided AOD, CMH and MHCSS workers with opportunities to develop their dual diagnosis knowledge/skills through cross-sector workshops and scholarships. To date:
 - More than 20 training sessions/workshops have been convened.
 - Total attendance has exceeded 500.
 - Topics covered include:
 - motivational interviewing at introductory, advanced and clinical supervisor levels'
 - cognitive behavioural therapy
 - AOD assessment skills
 - dual diagnosis introductory training
 - acceptance & commitment therapy
 - youth and cannabis
 - screening for /assessment of co-occurring disorders
 - trauma-informed service delivery.
 - Five people have been assisted to attend an international symposium on motivational interviewing in Melbourne.
 - Scholarships to participate in accredited education have been allocated to 71 Hume AOD, MHCS and clinical mental health workers.
 - DDxHECs has assisted with the selection of Hume recipients of state-level dual diagnosis education scholarships in 2009, 2011 and 2013.
- **Formation of Hume Motivational Interviewing Network (HuMINS).** This network evolved from members' participation in a DDxHECs-facilitated motivational interviewing-clinical supervisors' course.

Latrobe Community Health Service – Family Support Services

Innovation snapshot

Target workforce sector: Alcohol and other drugs (AOD)

Aim: To develop a highly skilled workforce to deliver client-centred services to clients and families accessing Family Support Services, thus improving service quality

Geographical scope: Gippsland Region

Date commenced: 2013 (18 months)

Implementation status: All planned activities are underway

The context

Latrobe Community Health Service (LCHS) provides services throughout the Gippsland Region, including aged care, disability, youth and family, children's services, palliative care, district nursing, respite, allied health care, psychology and counselling, gamblers help, alcohol and drug services and dementia care.

Within LCHS, alcohol and drug services for are provided by the Drug Treatment Services (DTS) team.

Workforce and client profile⁶⁹

AOD staff:

- 10 FTE full-time, 7 FTE part-time

AOD clients:

- 1,794 clients in the last 12 months
- 16–65 years old
- 66 per cent men, 34 per cent women,
- 9.2 per cent Aboriginal and/or Torres Strait Islander background
- 1 per cent culturally and linguistically diverse (CALD) background
- 72 per cent have a dual diagnosis

The innovation

Aim

To improve service quality and deliver client-centred services to clients and families accessing family support services by developing a highly skilled workforce.

69. At August 2014.

LCHS continually faced difficulties recruiting and retaining highly skilled employees to deliver high quality, person-centred care that focused on families and dependent children

The LCHS initiative involved targeted change at family and carer level, clinician level and external stakeholder level

Workforce issue

As a rural service provider, LCHS is continually faced with difficulties recruiting and retaining highly skilled employees to deliver high quality, person-centred care.

Following the appointment of a new manager in 2012, the service recognised that planned reforms to the alcohol and other drugs (AOD) sector, particularly the focus on families and dependent children, posed particular challenges. Previous file audits and staff feedback identified major gaps in this regard, namely that:

- the inclusion of families in treatment was almost non-existent largely because:
 - clinicians in the Family Support Program (FSP) were predominantly trained to provide services to individuals with minimal focus on families and children
 - there was a lack of information provided to families in dealing with a family member's AOD use
- family support targets were not being achieved. Previously, family services were delivered through eight weekly group sessions which had proven ineffective due to low attendance rates and inability to achieve targets as a result.

Providing a more holistic approach while at the same time aligning with the reforms and meeting targets necessitated further staff training and service delivery changes.

Project summary

The LCHS initiative involved targeted change at three levels:

- **families and carer level:** This included the introduction of a new telephone intake system and improved information provision
- **clinician level:** This included:
 - redesign of an AOD clinician's role to become the main provider and champion of family support services
 - upskilling of clinicians through three days of training on family inclusive practice through the Bouverie Centre
 - improved access to supervision
 - including FSP d on the team meeting agendas for counselling, withdrawal nursing, linkages and support and forensics to induce discussion and increase the profile of FSP
 - all staff meetings also had FSP on the regular agenda and family services were invited to come and educate/discuss their programs with the DTS team
- **external stakeholder level:** This included increased collaboration with other AOD providers.

Implementation process and activities

- Months of planning and the development of an action plan preceded the implementation.
- An AOD worker with skills and interest in family support was approached by the manager to become a champion of family support services. On acceptance, this clinician's role was redesigned to enable them to undertake their new responsibilities: facilitating working with families and assisting in the upskilling of other team members.
- Access to supervision was increased: clinicians were provided with regular supervision in groups and individually by internal and external experts in AOD counselling and AOD nursing.
- Family information packs (electronic and print format) were developed and offered to all families through intake and throughout the duration of their treatment.
- A new database (The Care Manager) was implemented in 2014. The DTS section of the database was tailored for clinicians to record all family work completed. It includes questions regarding whether a family pack was offered to clients, if it was accepted or refused and a section to add notes for family/carer contacts.
- Guidelines on how to conduct family meetings were developed for staff.
- Group training was provided to staff locally, thus increasing the number of staff trained and reducing training costs.
- Project officers and administrative staff were employed to take on the non-clinical aspects of clinicians' roles.
- Partnerships were formed with other organisations to deliver local educational workshops. LCHS's involvement in these partnerships included being training recipients, hosting sessions/forums delivered by partners to local service providers and collaboratively delivering training with partners. Partners included the Self Help Addiction Resource Centre (SHARC), the Bouverie Centre, Anex, the Mirabel Foundation and the Royal Women's Hospital.
- Regular meetings were scheduled with other local family support and AOD services to provide well-rounded support to the client. These included Youth Support and Advocacy Service (YSAS), headspace, Community Mental Health (MIND), Child Protection and Child First.
- The initiative was monitored through the organisation's Reform Action Plan. Activities were reviewed on a monthly basis at the Leadership Meeting.

Implementation was facilitated by organisational changes, the local provision of training and external support and promotion

Implementation challenges

- Initially few staff had the tertiary qualifications to provide role modelling and leadership
- There was some resistance from staff prior to the training. They felt they were 'already providing support' and others felt they were 'here for the client not the family'.

Staff need to be provided with positive feedback, support and supervision as roles change. Managers need to maintain their vision and monitor implementation progress and achievements

How challenges were tackled

- As part of the innovation, staff training was increased (as detailed in the section 'Factors that facilitated implementation' below).
- Staff resistance was overcome by explaining how the education sessions would be beneficial in enhancing the skills staff already had and in developing their knowledge of current techniques and approaches for working with the families of a person with an addiction.

Factors that facilitated implementation

Internal factors included:

- the appointment of a new manager in 2012, who was instrumental in identifying the need for change and implementing the required strategies
- provision of group training sessions at local level: Traditionally, the cost and time involved in sending more than one AOD worker to a specialised educational training session in Melbourne was prohibitive. LCHS negotiated a lower fee for training a large group of people at the Morwell site, thus increasing the number of staff who could access training
- peer support by staff champions: Staff who took on the responsibility of championing the initiative provided post-training follow-up and offered support to staff in their first few family sessions
- dedication and determination of the leadership team and several key staff members
- well-developed working relationships with internal providers
- support from the executive director
- the employment of project officers and administrative staff to take on the non-clinical aspects of clinicians' roles, allowing clinicians to achieve greater efficiency.

External factors included:

- Engagement of local media: In October 2012, an article was published in the *Latrobe Valley Express* highlighting the new family support services available. The article had an immediate impact with families seeking support. LCHS reached its target of 50 episodes within a few months
- Good working relationships were developed with external providers.

Organisational learnings and reflections

'The manager needs to drive the project and ensure that the action plan is monitored and reviewed and that support and positive feedback is provided to the staff taking on extra roles.'

'The availability of a family therapist or someone with advanced skills in family work would have been great to enhance this project.'

'Additional auditing would also have been good as an ongoing measure of achievements.'

'A fortnightly supervision session with the Bouverie Centre could have assisted in keeping the momentum going among all staff.'

'Stay focused and be reminded of your vision. Ensure good monitoring, review and follow up of tasks not completed.'

The outcomes

- The capacity to provide group training has meant that the service can now provide specialised educational training to more than one worker. The skill sets within the DTS team have expanded as a result.
- An AOD clinician has become a champion in driving service changes to support families.
- Supervision has been arranged for workers. Group supervision sessions facilitated the embedding of learnings and education into practice.
- Audits have shown a 38 per cent increase in the offering of and implementation of family sessions since the initiative started.
- Service quality has improved through:
 - partnering and meeting regularly with other regional service providers, creating an opportunity to establish good working relationships and to facilitate coordinated care for clients
 - establishment of referral pathways and access to programs.
- Collaboration with other agencies such as the Self Help Addiction Resource Centre (SHARC), Youth Support and Advocacy Service (YSAS), headspace, Community Mental Health (MIND), Child Protection and Child First has increased.
- Educational sessions were attended by government departments, not-for-profit agencies, emergency services and other LCHS departments.
- Evidence through staff evaluation that the FSP training influenced practice through assisting staff with new knowledge and tools to do the job.
- Anecdotal evidence from employees during performance reviews indicates staff now feel supported and valued by LCHS because of the opportunities offered for skills improvement and career advancement.

Skill sets within the DTS team have been expanded, family sessions have increased by 38 per cent and family support targets were exceeded in 2013

- Anecdotal evidence through staff feedback has indicated the family sessions provided improved family relationships through increased understanding of issues around dependence.
- Family support targets were exceeded in 2013.

Going forward

- The level of education and skills needed to be appointed to a clinician role has been increased, with a diploma-level qualification being required for appointment into the role. An audit is due in February and LCHS is hoping for further improvement in compliance. Their benchmark will be at least 60–70 per cent in providing FSP services.
- LCHS would like to employ a family therapist within its DTS team.
- No client based evidence has been collected. LCHS is looking at implementing the Department of Health and Human Services' Performance Management Framework which is to be developed by Turning Point.
- LCHS is developing an evaluation for families to complete post family sessions.

Latrobe Community Health Service – DTS consumer position

Innovation snapshot

Target workforce sector: Alcohol and other drugs (AOD)

Aim: To address a lack of consumer participation in the LCHS Drug Treatment Services (DTS) area by employing a consumer who had received DTS services

Geographical scope: Gippsland Region

Date commenced: 2013

Implementation status: All planned activities are underway; however, position is currently vacant

The context

Latrobe Community Health Service (LCHS) provides services throughout the Gippsland Region, including aged care, disability, youth and family, children's services, palliative care, district nursing, respite, allied health care, psychology and counselling, gamblers help, alcohol and drug services and dementia care.

Within LCHS, alcohol and drug services for are provided by the Drug Treatment Services (DTS) team.

Workforce and client profile⁷⁰

AOD staff:

- 10 FTE full-time, 7 FTE part-time

AOD clients:

- 1,794 clients in the last 12 months
- 16–65 years old
- 66 per cent men, 34 per cent women,
- 9.2 per cent Aboriginal and/or Torres Strait Islander background
- 1 per cent culturally and linguistically diverse (CALD) background
- 72 per cent have a dual diagnosis

The innovation

Aim

To address a lack of consumer participation in the LCHS Drug Treatment Services (DTS) area by employing a consumer who had been a user of drug treatment services from any provider in the past.

70. At August 2014.

This initiative was designed to employ a casual consumer consultant, someone who had received DTS services, to join the Senior Leadership Group in driving the Victorian AOD reforms in the service

Workforce issue

The innovation was designed to solve a lack of consumer participation in the LCHS Drug Treatment Services (DTS) area and occurred in response to the development and implementation of the LCHS Alcohol and other Drugs (AOD) Reform Action Plan (RAP).

Project summary

AOD services and the Victorian Department of Health and Human Services have invested considerable effort and achieved success in developing consumer participation practices within the sector. Nonetheless, consumer participation in the AOD sector still lags behind that of health and mental health. Many participation activities are isolated, ad hoc and occur at the lowest levels of involvement.

This LCHS initiative involved employing a casual consumer consultant (CC) to join the Senior Leadership Group in driving the Victorian AOD reforms in the service. The CC position was newly created and was designed to add to the overall mix of staff.

The role of the CC was to provide feedback to improve the delivery of services for clients by:

- being involved in the development and implementation of the RAP
- following up clients post discharge to monitor their recovery status.

The initiative was envisaged as a pilot program that would become ongoing.

The decision to employ a CC was informed by Clarke and Brindle's (2010) handbook, *Straight from the Source – A practical guide to consumer participation in the Victorian alcohol and other drug sector*.

Implementation process and activities

- A position description was developed, the position was advertised and a candidate appointed on a casual basis, one day per fortnight.
- The CC telephoned former DTS clients to gauge service satisfaction levels and to obtain a status update on where the client was in their recovery journey three months after discharge from DTS services.
- The CC provided real-life experiences of being a consumer of DTS and associated services and was able to provide the consumer view on all aspects of service provision so gaps could be identified and addressed, this included a review of relevant policies and protocols.
- The CC role enabled DTS staff to appreciate and understand the value of a CC role within DTS and welcome another skill mix to the multidisciplinary team approach.

The biggest challenge was the resignation of the consumer consultant one year after their appointment

Implementation challenges

- The CC resigned after 12 months in the role. Feedback gained from the Consumer upon resignation was:
 - **Personal reasons:** The CC lived out of town and was reliant on public transport when travelling to the office. The unreliability of the transport system reduced their flexibility in terms of start and finish times, as well as their availability to attend meetings.
 - **Role-related reasons:**
 - found working one day per fortnight was a challenge as it was hard to build momentum from week to week: 'It was like starting from the beginning each time'
 - the CC suggested that the client follow-up function was more appropriate for client counsellors as there is a pre-existing rapport
 - the lack of other CCs in a similar role for peer support
 - inadequate workload on some days
 - position has been vacant since June 2014.

How challenges were tackled

These challenges have only been partially addressed. The consumer role remains vacant as per the reasons above. However, going forward, the requirements of the role will be revised in light of the learnings gained from appointing the first incumbent, particularly learnings related to the definition, scope and employment fraction of the role. LCHS hopes to be back on track once the AOD reforms have been implemented and after the first 12 months have been completed. This is to allow time to gauge what impact the reforms have had on LCHS and the DTS team.

Factors that facilitated implementation

- having a project officer available to assist during the planning stage to provide oversight for the project
- receiving support from the DTS leadership team for the consumer consultant position
- having executive management buy-in for the role from the beginning.

Support from management and team members is crucial. Good orientation and support is also needed for the consumer consultant

The consumer consultant's personal story and recovery journey raised awareness of consumer participation among staff

Organisational learnings and reflections

'Executive management and middle management support is essential for this kind of innovative program to work.'

'You also need to have the support of team members to ensure the consumer consultant is welcomed and treated as a member of the team. Support was gained through providing education around what the role of the consumer consultant entailed and having the consumer consultant present [their] role at a team meeting and give background information on [their] own life experiences.'

'Good orientation and ongoing support for the consumer consultant is needed. This could include regular meetings with a senior staff member.'

'Support (peer or otherwise) needs to be provided for the consumer consultant.'

The outcomes

- The CC was able to influence the RAP which in turn enabled the development of services to provide a better outcome for clients.
- The consumer data gathered by the CC provided the ability to measure services provided by DTS and informed improvements to services.
- The personal story of the consumer consultant and their recovery journey raised awareness of consumer participation among staff. This led to the establishment of a consumer-driven activity/working group. Being creative and innovative in implementing the CC role has assisted in ensuring the sustainability DTS services. It has made DTS more marketable and able to attract further funding particularly in the consumer area.

Going forward

- The CC position is currently being reviewed to include feedback from the previous CC and the new needs of the service.
- A casual CC will be employed once the review is complete.

Mind Australia

Innovation snapshot

Target workforce sector: Mental health community support services (MHCSS)

Aim: To provide a coordinated approach to student placements across Mind Australia and, through providing high-quality placements, attract and retain new graduates in the rural sector

Geographical scope: Victoria wide

Date commenced: Project group was established in 2013

Implementation status: Some planned activities are underway

The context

Mind Australia is a leading provider of community mental health services in Victoria and South Australia, supporting clients aged 16 years and older to live independent, productive lives through a range of community and residential services. It also provides training for peer workers and other mental health professionals as well as people in various occupations and industries to increase their knowledge and skills in recovery-oriented practice, undertakes research and evaluation activities and plays a key role in systemic advocacy and community development work.

This case study relates to Mind Australia's activities in Victoria.

Workforce and client profile⁷¹

MHCSS staff:

- 484 FTE, plus an additional 126 casual staff (FTE not stated)

MHCSS clients:

- 4,895 clients seen in last 12 months
- 9–94 years old
- 56 per cent women, 44 per cent men
- 3 per cent Aboriginal and/or Torres Strait Islander background
- 15 per cent culturally and linguistically diverse (CALD) background
- 7 per cent have a dual diagnosis

The innovation

Aim

To provide a coordinated approach to student placements across Mind and, through providing high quality placements, attract and retain new graduates in the rural sector.

71. At August 2014.

Mind's student placement project involved providing a coordinated approach for student placements across the organisation and increasing the number and diversity of student placements

The innovation not only sought to enhance staff recruitment to Mind, but to other rural services also

Workforce issue

Mind Victoria is a large, dispersed organisation. While student placements were commonplace prior to the initiative, placements were not organised in a systematic manner. The organisation recognised that centralised coordination could improve the quality of student placements and increase the number and diversity of students within the organisation while still allowing for local control in terms of their capacity to take students and engage in local partnerships.

This initiative not only sought to enhance recruitment of new workers to Mind, but to other rural services also. Through the strategy of providing positive placement experiences, Mind hoped to increase graduate recruitment.

Mind also anticipated that increased employment in their organisation would have a long-term ripple effect for staff availability in other mental health services in rural and regional communities. As Mind staff gained experience and their career developed, the expectation was that they would move to other mental health providers in the region, thus extending the benefits of the initiative to other providers in the region.

Project summary

Mind's student placement project involved:

- **providing a coordinated approach for student placements across Mind** through the development of consistent policies and procedures for student placements
- **increasing the number and diversity of student placements** within Mind's rural and regional services
- **increasing the quality of placements**, with a focus on:
 - building understanding of recovery-oriented practice within the mental health sector
 - improving the capacity and confidence of Mind's rural and regional workers to support students on placements.
- **increasing collaboration with rural and regional tertiary providers** and exploring opportunities to access funding support from them to support supervision of students on placement
- **attracting and retaining graduates in the rural sector** by
 - increasing the interest and capacity of students to seek employment with Mind's rural and regional services
 - recruiting placement students to the mental health workforce
 - increasing the number of graduates from non-traditional mental health services recruited to Mind's rural and regional services.

Implementation process and activities

- A project group was set up in 2013 to develop this initiative.
- Negotiations with RMIT University began in 2013 to develop a memorandum of understanding (MoU) to take on social work students across all of Mind (rural and metropolitan). Note: This MoU is not yet operational.
- In 2013 Mind Australia partnered with the Northern Clinical Placement Network to utilise the VicPlace system to connect with tertiary student placement coordinators. VicPlace is a secure, web-based information system that helps Victorian clinical placement providers plan and administer clinical placements with partnered education providers. This partnership facilitated:
 - linkages with other networks across the state (for example, Loddon Mallee, Hume, Grampians, Gippsland and Barwon-South Western clinical placement networks)
 - linking into new networks
 - strengthening existing partnerships
 - involvement in the planning process for student placements in 2014.
- Since 2013 rural student placements that had previously been organised locally are now supported centrally.
- An e-learning platform was introduced.

Implementation challenges

- **Operationalising the MoU with RMIT University:** The MoU required RMIT to commit to providing supervisor training and support. In return, Mind to commit to taking on 10–12 social work students per annum. Pending the outcome of the re-commissioning of the Victoria MHCSS and AOD sectors in 2013–14, Mind was unable to meet these commitments.
- **VicPlace system restrictions:** The VicPlace system is restricted to universities, thus excluding TAFE and private registered training organisation (RTO) systems. Because Mind accepts Certificate IV and diploma students, the current system is unable to fully meet its needs.
- **Staffing resources:** Mind lacked key staff centrally to coordinate student placements and provide sufficient support to both local supervisors and students.
- **Discipline-specific placement requirements:** Placement requirements for undergraduate students (for example, social work and occupational therapy) posed considerable challenges, namely:
 - Student supervisors often had to be of that discipline. In the MHCSS sector, staff are employed as generic mental health practitioners and not as social workers or occupational therapists. A lack of suitable supervisors arose in rural areas as a result.
 - Placements are often long (300+ hours), and there is an expectation of students being able to do more complex work with a higher client load during these longer placements. Rural teams often have less capacity to meet these demands.

Supervisors and managers need to be supported and good partnership agreements established with training providers

How challenges were tackled

- **Placements were put on hold.** While awaiting the outcome of the re-commissioning of the Victoria MHCSS and AOD sectors in 2013–14, implementation of the student placement program was put on hold and the MoU with RMIT was not signed. A maximum of two students were placed by August 2014 and four between September–December 2014.
- **Separate booking systems were used for student placements:** Because VicPlace does not cater for non-university courses, a dual system is used to coordinate students.

Factors that facilitated implementation

- **Support from area and service managers.** Managers were keen for student placements to be more streamlined. They also welcomed no longer having to deal individually with student requests.

Organisational learnings and reflections

For an initiative of this kind to work, the following is needed:

'Support from the executive.'

'Sufficient resources to coordinate student placement centrally and student supervisors in the regional areas.'

'Sufficient support to student supervisors and managers to enable them to take on students.'

'Good partnership arrangements with universities, TAFE and private RTOs.'

Mind achieved an increase in the numbers of students from undergraduate and industry-based programs

The outcomes

- **Increased student diversity:** Mind achieved an increase in the numbers of students from undergraduate (social work, occupational therapy, recreation) and industry-based programs (Certificate IV Mental Health, Certificate IV Community Services). Following placements, some students have found opportunities to remain with Mind or work in the sector/geographical region through project work positions for example.
- **Increased workforce capacity:** Often students on placement provide extra support for clients and their families through additional one-to-one support or increased assistance in group work.
- **Opportunity for reflective practice:** This initiative provided staff with opportunities to reflect on their practice when working with students.

Going forward

For 2015 and especially from second semester onwards, Mind plans to:

- Develop formal arrangements with a range of targeted universities, TAFEs and RTOs
- Increase the number of students across Mind
- Expand traineeship initiatives
- Increase student supervision training for staff
- Further improve the student placement administration system by appointing a new student placement coordinator at Mind.

South West Healthcare – Workforce

Innovation snapshot

Target workforce sector: Clinical Mental Health (CMH)

Aim: To 'grow our own' workforce and also bring about workplace culture change to attract and retain staff

Geographical scope: Barwon-South Western Region

Date commenced: 2006

Implementation status: All planned activities are underway

The context

South West Healthcare (SWH) provides a broad range of aged care and allied health services across the south west catchment. As the major specialist referral centre for the Barwon-South West sub-region, SWH provides a comprehensive range of specialist services from campuses located at Camperdown, Portland, Hamilton, Lismore and McArthur.

The Mental Health Division provides clinical specialist services for people of all ages, focussing on those who are seriously affected by mental illness, and their families. Its multi-disciplinary teams comprise psychiatrists, psychologists, social workers, nurses, occupational therapists and peer support workers. These teams work closely with GPs and other health and welfare services. Case management services within the community support people in their homes and other settings. The service has 15 acute inpatient beds and five extended care beds.

Workforce and client profile⁷²

CMH staff:

- 84 FTE full-time, 25 FTE part-time, 1 FTE casual, 5 FTE contract and 10 FTE volunteer staff

CMH clients:

- 2,200 clients in the last 12 months
- All age groups
- 50 per cent women, 50 per cent men
- <1 per cent Aboriginal and/or Torres Strait Islander background
- <1 per cent Culturally and Linguistically Diverse (CALD) background
- 70 per cent have a dual diagnosis

72. At August 2014.

The innovation

Aim

To 'grow our own' workforce and bring about workplace culture change to attract and retain staff.

Workforce issue

Recruitment of staff from outside the local area was causing high rates of attrition, resulting in a workforce that lacked experience and was unable to meet service demands and community expectations. Staff turnover was impacting the sustainability of the service. Staff who remained spent their time addressing the professional development needs of new staff at the expense of addressing their own professional development needs.

The existing workforce culture was also reportedly rigid, inflexible, and unsupportive.

Project summary

A comprehensive range of strategies were developed to 'grow our own' workforce, drawing from the local community and attracting people originally from the area back to the catchment.

Workforce cultural changes were implemented to meet the service and professional needs of staff in a supportive learning environment.

The resultant model was designed to address the continuum of workforce issues, linking improved recruitment to improved retention.

Implementation process and activities

Implementation was preceded by approximately 18 months of planning and consultation with 10 senior managers and 110 staff. Change management involved working closely with the Management Group, ensuring leadership was shared and spread across the service to achieve the multiple strategies planned. Staff surveys were undertaken to assess workplace culture and staff satisfaction. Survey findings were supplemented by findings from the Victorian Public Sector Commission People Matter survey. Information from these various sources was used to inform actions and strategies.

Strategies to address recruitment issues:

- Advertising vacancies in local newspapers as well as state and nation-wide newspapers with a view to attracting local people and those originally from the area into vacancies. Friends and families were found to play a key role in alerting experienced staff living in Melbourne or in other states about local vacancies, thus encouraging them to return to the area.
- Presentations to year 11 students undertaking a psychology unit on the service and career opportunities
- Presentations to undergraduates studying psychology, nursing, social work, and occupational therapy regarding career opportunities in the service

High rates of attrition resulted in a workforce that lacked experience and was unable to meet service demands and community expectations

Recruitment strategies included advertising vacancies in local, state and national newspapers, delivering presentations to students, providing positive placement experiences and creating attractive work positions

Cultural change was achieved through extensive staff consultations, organisational and role changes, and providing additional support to staff

- Positive placement experiences for students (all disciplines, including medical) to encourage them to return after graduation
- Creating positions that are attractive (manageable case loads, good work/life balance, promotional and training opportunities)
- Providing supervision and mentoring
- Generous support for training and ongoing professional development.

Strategies to implement cultural change:

- Consultations with and ongoing engagement of staff to:
 - Develop service-specific values that could be actively promoted across the service from staff selection to performance review and strategic planning
 - Develop comprehensive policies that set standards and provide guidance that support these values
 - Enhance team ownership of issues through annual team planning and team building days
- Reduced role stress by improving staff safety, changing community rosters and establishing a case management system so staff have a manageable case load
- Improved access to training
- Development of a comprehensive modular recovery model to guide new and experienced staff in their work with consumers and carers
- Organisational structure change including:
 - Improving access to senior staff
 - Introduction of a small staff support team
 - Streamlined committee structure that avoids duplication of effort and time wasting
 - Trialling of dedicated intake workers in CAMHS and adult teams
- Supporting staff to take on specialist portfolios that they have an interest in (for example, dual diagnosis, working with families).

Implementation challenges

The challenge faced included:

- Turning around a well-entrenched recruitment strategy and workforce culture
- Staff resistance to change within the service
- Organisational concerns about the industrial unrest potential of implementing a new model.

Factors that facilitated implementation

- Engaging staff and achieving 'buy-in' to ensure the new model and vision were well communicated and understood. High levels of staff dissatisfaction with the old approach helped staff embrace the changes
- Securing support of the senior leadership group early in the process was important

- Persistent leadership and adequate time was needed to overcome resistance
- Acceptance of the long term nature of change. It took nearly five years to embed changes in a sustainable way and turn culture around.

Organisational learnings and reflections

'Plan ahead, engage with staff, and use managers to assist sharing the leadership.'

'[We] intentionally took a slow approach to ensure staff came along with the changes...[we] did not want to make too many changes too quickly without consolidating new initiatives and cementing them in place.'

'It is vital...[to have] the support of the senior leadership group early in the process'

'Confidence in one's own vision and ability ... [and] the support of colleagues and peers is also essential.'

Change is a long-term process best achieved in incremental stages where each new initiative is consolidated before further change is introduced. Ongoing support of management and peers is also crucial

The outcomes

Recruitment outcomes:

- Reduced attrition. A sustained reduction in staff turnover has been achieved, with the number of resignations reduced from 28 (2006), 20 (2007), 18 (2008) to 14 (2009).
- Work arrangements have been changed so that all staff are supported, provided with professional development opportunities and can maintain a work life balance. Changes included:
 - staff in the community adult teams now work varying shift lengths
 - few share an out-of-hours on-call roster
 - staff are supported, celebrated, acknowledged and rewarded for their good work / achievements
 - designated triage roles have evolved in teams.
- Increased interest by student nurses in pursuing mental health as a career in post-placement feedback.
- Cost savings. The costs and other resources associated with continual recruitment have reduced considerably, allowing SWH to redirect valuable resources into service development.

A sustained reduction in staff turnover has been achieved and reduced recruitment costs have generated cost savings to the organisation.

Cultural and performance outcomes:

- A positive staff culture. This not only benefits staff and their families, but also contributes to positive outcomes for consumers. A well-supported and trained workforce offers enthusiastic commitment and expertise to consumers who frequently experience disenchantment and are often disenfranchised.

- Increased staff satisfaction is evident in internal and external staff surveys.
- Consistently high levels of performance were achieved in the Department of Health and Human Services key performance indicators and activity data.
- Improved continuity of care for consumers and carers. Greater workforce stability means that consumers no longer have to retell their story and repeatedly re-engage with new case managers and psychiatrists.
- Anecdotal evidence suggests improvements in organisational culture have been instrumental in encouraging local professionals to join the SWH workforce and to select a career they might not have otherwise considered.

Going forward

The model is now well-developed and continues to evolve in response to staff feedback and service growth. While significant improvements have been made, a range of future challenges remain, including an ageing workforce and difficulties attracting staff into the mental health field.

Among the new strategies under development are:

- accepting high school students on work experience placements to reduce the stigma associated with working in the service at an earlier age
- a collaborative approach to psychiatric registrar training with Barwon Health, building on the Deakin University Medical School partnership
- creating career pathways and further strengthening the specialist mental health workforce in our region, including the development of a consumer peer-led workforce
- development of telepsychiatry to reduce the travel burden on psychiatrists.

South West Healthcare – Learning Management System

Innovation snapshot

Target workforce sector: Clinical mental health (CMH)

Aim: To establish an online mental health learning management system (LMS) for all staff and develop a standardised two-year training pathway for new staff

Geographical scope: Barwon-South Western Region

Date commenced: 2006

Implementation status: All planned activities are underway

The context

South West Healthcare (SWH) provides acute, mental health, rehabilitation, and aged care services as well as an extensive range of primary and community health and dental services across the south west catchment. As the major specialist referral centre for the Barwon-South West sub-region, SWH provides a comprehensive range of specialist services from campuses located at Camperdown, Portland, Hamilton, Lismore and McArthur.

The Mental Health Division provides clinical specialist services for people of all ages, focussing on those who are seriously affected by mental illness, and their families. Its multidisciplinary teams comprise psychiatrists, psychologists, social workers, nurses, occupational therapists and peer support workers. These teams work closely with GPs and other health and welfare services. Case management services within the community support people in their homes and other settings. The service has 15 acute inpatient beds and five extended care beds.

Workforce and client profile⁷³

CMH staff:

- 84 FTE full-time, 25 FTE part-time, 1 FTE casual, 5 FTE contract and 10 FTE volunteer staff

CMH clients:

- 2,200 clients in the last 12 months
- All age groups
- 50 per cent women, 50 per cent men
- < 1 per cent Aboriginal and/or Torres Strait Islander background
- < 1 per cent culturally and linguistically diverse (CALD) background
- 70 per cent have a dual diagnosis

73. At August 2014.

Most new graduates of all health disciplines enter the mental health workforce without the requisite skills and knowledge

The innovation

Aim

To establish an online mental health LMS for all staff and develop a standardised two-year training pathway for new staff.

Workforce issue

Most new graduates of all health disciplines enter the mental health workforce without the full suite of skills and knowledge. Furthermore, access to entry level and/or more advanced training and professional development programs for the rural and regional workforce is expensive and time consuming to attend.

High levels of staff turnover in SWH meant training resources were largely directed in a cycle of orientating and training of new staff. Consequently, limited resources were available for existing staff to extend themselves into advanced practitioner training.

Traditionally, training had been allocated in an unplanned manner, largely in response to staff requests.

Project summary

In 2009 SWH was one of eleven services that participated in a national pilot of MHPOD, an online professional development resource. This experience highlighted to SWH the advantages of online training in a rural setting. Almost half of the SWH mental health workforce participated in the MHPOD trial.

This experience led to the development of an online mental health LMS for all staff, and developing a standardised two-year training pathway for new staff. Course content includes a blend of:

- face-to-face training delivered in-house or as part of the Western Victorian Mental Health Learning and Development Cluster
- online content sourced internally (such as training related to fire safety and OH&S), or determined by a knowledge gap analysis (for example, delirium)
- external training (MHPOD).

The LMS also includes input from invited subject area experts. Strong partnerships were developed with state-wide services such as Spectrum and the Victorian Centre of Excellence in Eating Disorders (CEED).

The training pathway includes progression criteria and linkages to performance management and supervision systems. Staff are allocated time during work hours to complete modules. The LMS is supported by a strategic framework and committee structure, along with an evaluation framework. It is regularly updated in response to new online programs being developed locally or externally (for example, new MHPOD modules).

Implementation process and activities

- A small working party comprised of the manager service development, a training coordinator and senior leadership was established and an action plan developed.
- Past and current training activities were reviewed to identify those courses that could be fully delivered online, those that required a mix of online and face-to-face delivery, and those that needed to retain their face-to-face format.
- Consultations were held with relevant staff at each stage of the project.
- Staff were involved in testing new training programs.
- Strong partnerships were developed with state-wide services (Spectrum, CEED and so on). These partners informed LMS content.

Implementation challenges

- Monitoring staff uptake of the LMS generated additional workload for managers.
- Expanding the LMS for use across the rest of the organisation generated some initial difficulties for the LMS software.

How challenges were tackled

- LMS users were provided with advice and expertise to help resolve usage problems.
- Issues are brought to the attention of the most senior level of the organisation.
- Systems were developed to support ongoing maintenance and updating of the training program within the organisation.

Factors that facilitated implementation

- Involvement of staff with the necessary expertise and passion to drive to champion the project over time.
- The ability to manage the LMS in house means it is very responsive to changing organisational and client needs.
- External expertise was accessed as required while developing the online content.
- Maintaining enthusiasm and commitment to the project.

Organisational learnings and reflections

'This initiative needed leadership at all levels of the service.'

'Staff [need] the chance to see how [the LMS works] in practice to realise its benefits.'

'Systems to support ongoing maintenance and updates of the training program are also vital to the success of the model.'

An online mental health learning management system (LMS) was established for all staff and a standardised two-year training pathway was developed for new staff

An innovation may need to be operational before staff fully realise its

More staff are now accessing more training at substantially lower costs to the organisation

Online training has now been expanded across the organisation

The outcomes

Cost savings:

- The LMS has resulted in more staff accessing more training at substantially lower costs to the organisation. In 2011, 235 staff received 4,552 hours of training at a cost of \$64,054. In contrast, 243 staff received 5,044 hours of training in 2013 at a cost of \$19,965.
- Cost savings render the training program more sustainable.

Time savings:

- Time lost travelling to training has been reduced, thus reducing the amount of clinical time lost and increasing staff availability for service provision to clients.

Training:

- The LMS ensures consistency in the training accessed by staff.
- Training requests from staff are now monitored and are reviewed/approved by a multidisciplinary working party.
- When new training modules are developed, they are now placed online.
- Mandatory competencies have been identified.

Staff:

- Staff have greater access to training and a wider range of topics.
- The clinical expertise of staff has been improved.
- As documented in the SWH strategic plan, all new staff participate in three hours of professional development activity per week via the LMS.
- Staff are empowered to manage their own professional development and are less dependent on the service to manage it for them.
- The level of expertise of new graduates coming into SWH is now standardised.

Managers:

- Managers now have greater autonomy over staff training, with the LMS linked to performance and supervision systems.

Organisation:

- Online training has been expanded across the organisation. Other clinical staff (non-mental health trained) can now access generic training on topics (such as dementia and delirium).
- A set of mandatory competencies have been developed for all staff across the organisation.
- The unit has gained a positive reputation across the organisation for being innovative and supporting workforce development while achieving financial efficiency.

Partnerships:

- Strong partnerships have been established with state-wide services (for example, Spectrum, CEED).
- Active participation in and contribution to the Western Victorian Mental Health Learning and Development Cluster at operational and governance levels has improved access to training delivered locally.

Victorian Dual Diagnosis Initiative Rural Forum (VDDIRF)⁷⁴

Innovation snapshot

Target workforce sector:	Alcohol and other drugs (AOD), Mental health community support services (MHCSS) Clinical mental health (CMH)
Aim:	To provide support and infrastructure to rural dual diagnosis clinicians whose role is to assist AOD and mental health agencies and clinicians to further develop their levels of dual diagnosis capacity
Geographical scope:	Victoria wide
Date commenced:	The VDDIRF first met as a statewide entity in November 2003
Implementation status:	All planned activities are underway

The context

The Victorian Dual Diagnosis Initiative Rural Forum (VDDIRF) is a whole-of-state initiative established as part of the Victorian Dual Diagnosis Initiative (VDDI).⁷⁵ Its purpose is to provide:

- support and infrastructure to rural dual diagnosis clinicians whose role is to enable them to assist AOD and mental health agencies and clinicians to further develop their levels of dual diagnosis capacity
- leadership to ensure the VDDI recognises and supports the development of dual diagnosis initiatives in rural areas.

The innovation

Aim

To provide support and infrastructure to rural dual diagnosis clinicians whose role is to assist AOD and mental health agencies and clinicians to further develop their levels of dual diagnosis capacity.

74. Information for this case study was provided by Albury Wodonga Health.

75. VDDI is a cross-sectoral initiative funded by the Victorian Department of Health and Human Services to contribute to the further development of mental health and drug and alcohol clinicians, agencies and sector's capacity to recognise and respond effectively to people with co-occurring mental health and substance use concerns (dual diagnosis).

Workforce issue

The VDDIRF evolved in response to challenges faced by isolated rural dual diagnosis capacity-building workers and their need to have effective support. The Melbourne-based hub and spoke model initially implemented by the VDDI had inherent challenges in terms of:

- establishing, developing and maintaining the web of relationships necessary to influence practice in rural regions geographically distant from Melbourne
- understanding and responding to the different contexts, challenges, strengths, constraints and opportunities of rural AOD and mental health service provision.

A rural-to-rural model, supported by central planning bodies, with in-person meetings and frequent email and electronic communication evolved to meet the specific needs of rural workers.

Project summary

The VDDIRF is an entirely volunteer-led virtual and in-person collaborative of rural dual diagnosis workers committed to the improvement of health outcomes for people with co-occurring mental health and substance use disorders.

The VDDIRF provides support to its membership through:

- ongoing collegial support and information and resource sharing for all rural dual diagnosis specialists
- identifying, flagging and addressing rural issues and priorities in relation to co-occurring mental health and substance use disorders
- providing a forum for rural clinicians to network and enhance collaborative working relationships
- initiating the development of a rural response that is based on best practice principles
- providing a coordinated approach to education needs in rural areas
- providing feedback to lead agencies, the Department of Health and Human Services and other groups on rural issues
- supporting the capacity-building strategies of the VDDI, including the Education and Training Unit (ETU)
- assisting in the strategic development and delivery of ETU training including online teaching and mentoring
- increasing the skills and knowledge of rural dual diagnosis clinicians, to enhance the capacity of the mental health and AOD workforce throughout the state
- contributing to the partnership strategies of rural services.

The VDDIRF evolved in response to challenges faced by isolated rural workers

The VDDIRF is a virtual and in-person collaborative of rural dual diagnosis workers committed to the improvement of health outcomes for people with co-occurring mental disorders

The core VDDIRF membership is comprised of 12–14 workers funded by the Victorian Department of Health and Human Services

The VDDIRF focuses on rural clinicians in the AOD, MHCSS and CMH sectors who work in the field of dual diagnosis

Governance

The core VDDIRF membership is comprised of 12–14 workers funded by the Victorian Department of Health and Human Services, as part of the VDDI, based in the following regions:

- Barwon-South West
- Great South Coast
- Gippsland
- Grampians
- Hume – Goulburn Valley
- Hume – Hume
- Loddon-Mallee Northern Mallee
- Loddon-Mallee Southern Mallee.

Core members attend in-person meetings. At various times, this core membership has been extended to include participation by representatives involved in other initiatives.

Implementation process and activities

- The VDDIRF was established in April 2001. It was initially composed of rural dual diagnosis workers within the Western part of Victoria and soon expanded to all rural VDDI workers within Victoria.
- The VDDIRF first met as a state-wide entity in November 2003.
- The VDDIRF initially met at rooms donated by the Daylesford Hospital before moving its meetings to Bendigo. Both Bendigo and Daylesford were chosen because of their centrality for most of the rural workers attending.
- Terms of reference were developed and updated as the VDDIRF evolved.
- The DHS provided financial support in 2004 to cover accommodation and general costs.
- VDDIRF meetings routinely include a dedicated professional development education component related to dual diagnosis.
- The VDDIRF has a long ongoing history of trialling different forms of clinical supervision amongst and between members.
- The VDDIRF authored a *Rural Dual Diagnosis Clinical Supervision Manual* describing how rural dual diagnosis specialists can use web-based technologies to participate in clinical supervision.
- The VDDIRF developed a job description template as a resource for recruiting a specialist dual diagnosis worker position.

Implementation challenges

The key challenges encountered were:

- the distance involved in traveling to in-person meetings
- the occasional perception that the VDDIRF was a 'breakaway' group from the main VDDI.

How challenges were tackled

- **Electronic communication** was used to keep in contact with members.
- **Frequency of in-person meetings was reduced** from two-monthly to three-monthly.
- **Representation at VDDI level.** The VDDIRF became a major contributor to the success of the VDDI. VDDIRF representation is built into the structure of the VDDI Leadership Group.

Factors that facilitated implementation

- **Member attributes:** The people involved in the VDDIRF have a strong ethos of sharing resources knowledge and experience.
- **Vision:** Members had the willingness and flexibility to think outside of an agency-specific or location-specific frame of mind.
- **Meeting format:** The two-day format provided members with opportunities to network and fosters collaboration and innovation.
- **Departmental support:** The Victorian Department of Health and Human Services has provided financial and in-person support as well as advice and feedback.
- **In-kind support:** Daylesford General Hospital and Bendigo Health provided space to conduct meetings free of charge.
- **Support from auspice agencies:** Auspice agencies actively supported and encouraged VDDIRF participation.
- **VDDI support:** Metropolitan VDDI managers attended in-person meetings.
- **Membership structure:** The VDDIRF is a broadly self-directed, self-sustaining initiative with voluntary membership and responsibilities shared among members.

VDDIRF members have had a depth of experience and a willingness to contribute to providing support to isolated rural workers

Organisational learnings and reflections

'There are substantial impediments (distance/differing service delivery contexts/competing priorities) to metropolitan to rural support models working effectively – collective rural support models, where they can be fostered, will often be more effective.'

'Peer support models, with collective responsibility for activities, development and direction, are likely to have a greater, enduring impact than top-down, expert to recipient, models of providing support to isolated rural specialist workers.'

There are substantial impediments to metropolitan to rural support models working effectively

The VDDIRF has provided support for rural workers and the resources it has developed are widely used across Australia and New Zealand

The outcomes

- **Support for rural workers:** The VDDIRF has responded to rural workers need for peer support, professional development and clinical supervision through dual diagnosis capacity building. VDDIRF members have used in-person and web-based one-on-one and group approaches to provide clinical supervision to support and develop isolated rural dual diagnosis workers.
- **Skills and knowledge development:** The VDDIRF has been instrumental in developing the capacity of mental health workers to recognise and respond to co-occurring mental health and substance use concerns.
- **Clarification and development of worker roles:** Standardised job description templates for specialist dual diagnosis workers were developed by the VDDIRF.
- **Assistance in recruitment:** The VDDIRF has monitored when rural positions have been vacant and has offered help and support to auspice agencies with recruitment and ongoing support of new workers once employed.
- **Increased use of technology:** The VDDIRF has promoted the use of remote clinical supervision to support capacity building of isolated rural dual diagnosis workers and provided a manual to support rural dual diagnosis specialists in the use of web technologies for clinical supervision.
- **Increased collaborations between services:** The VDDIRF has played a key role in building collaborations and effective working relationships between services and sectors – most particularly between AOD and mental health services.
- **Collaboration with other initiatives:** The VDDIRF has actively collaborated with other initiatives such as the Acquired Brain Injury (ABI) Initiative, the more recent Emergency Department AOD worker initiative, and other dual diagnosis capacity-building initiatives such as the Homeless Youth and Dual Diagnosis Initiative (HYDDI), the Improved Services Initiative (ISI), the Substance Misuse Service Delivery Grants Fund (SMSDGF) and Trauma Service Team dual diagnosis workers.
- **Staff retention:** In a recent survey of VDDIRF members (n = 19), all respondents reported that support from the VDDIRF was the principal factor keeping them working in a solo-worker, rural system-changing role. Likewise, all respondents either agreed or strongly agreed that the VDDIRF had also improved the overall satisfaction of the rural VDDI workforce.
- **Expanded use of VDDIRF materials:** VDDIRF materials have been widely used across Australia and New Zealand as evidenced from the frequency of download from the Dual Diagnosis Australia and New Zealand website. At August 2014, the download history for these resource was as follows:
 - 5,259 downloads of the Rural Clinical Supervision manual
 - 5,404 downloads of the job description template for a specialist dual diagnosis worker position
 - 4,308 downloads of the job description template for a dual diagnosis liaison role

